PROSIDING

Child Poverty and Social Protection Conference

Hotel Grand Sahid Jaya, Jakarta
10–11 September 2013

www.unicef.org/Indonesia;
www.bappenas.go.id;
www.smeru.or.id

DAFTAR ISI

Sambutan Kepala Perwakilan UNICEF

Angela Kearney

Konferensi tentang Kemiskinan Anak dan Perlindungan Sosial

Jakarta, 10 September 2013

Selamat Pagi Dan Selamat Datang di Konferensi tentang Kemiskinan Anak Dan Perlindungan Sosial Saya sangat senang dan bersemangat dengan konfrensi yang penting ini . Terima kasih banyak atas kehadiran anda semua.

Selama dua hari kedepan, kita akan berdiskusi tentang masalah kemiskinan anak dan perlindungan sosial, suatu permasalah yang sangat penting bagi kita semua.

Kita semua gembira dengan adanya Konferensi internasional mengenai Kemiskinan Anak dan Perlindungan Sosial yang diadakan di Jakarta ini dan terima kasih banyak atas kehadiran semua hari ini.

Selama empat tahun saya di Indonesia, sebagai Perwakilan UNICEF , saya telah melihat lagi dan lagi bagaimana komitmen Pemerintah Indonesia untuk mengurangi kemiskinan anak melalui salah satu paket yang paling terkini dari pengurangan kemiskinan yang ditargetkan dan intervensi perlindungan sosial dan melalui kerjasama dengan berbagai berbagai mitra pembangunan .

Saya ingin menggunakan kesempatan ini untuk mengucapkan selamat dan terima kasih kepada mitra kami di Kantor Wakil Presiden , di Kementerian Perencanaan Pembangunan Nasional (Bappenas) , Kementerian Pemberdayaan Perempuan dan Perlindungan Anak dan Kementerian Sosial untuk upaya kolektif mereka dalam memajukan lebih lanjut kerangka kerja di Indonesia.

Ini adalah konferensi ketiga yang kami adakan bekerja sama dengan Pemerintah Indonesia , Bappenas , dan dengan teman-teman kita dari SMERU. Kami bertujuan untuk membawa riset dan bukti inti dari pembuatan kebijakan di Indonesia , terutama dalam kaitannya dengan anak-anak .

Saya sangat bangga bahwa tahun ini kami dapat memperluas dengan partisipasi dari luar Indonesia, untuk memungkinkan berbagi pengetahuan yang lebih luas dan kesempatan belajar dari negara lain , selain pengalaman kita sendiri di Indonesia .

Seperti yang Anda ketahui , kemiskinan mempengaruhi orang dari segala usia, tetapi dampak pada anak-anak sangat merugikan . Studi Kemiskinan Anak Indonesia tahun lalu - studi yang pertama - menunjukkan bahwa 28 % dari semua anak di Indonesia hidup dalam rumah tangga yang berasal dari kuintil termiskin .

Kemiskinan anak bukan hanya tentang pendapatan. Kemiskinan di kalangan anak-anak adalah multi-dimensi dan meluas ke dimensi non - material, seperti akses ke tempat penampungan , air bersih dan sanitasi , pendidikan dan pelayanan kesehatan untuk pencatatan kelahiran serta dimensi lain.

Kemiskinan juga menyebabkan anak-anak lebih teresiko bahaya, p elecehan dan eksploitasi, yang semuanya berkontribusi pada perampasan lebih lanjut dari hak-hak anak .

Mengurangi kemiskinan karena itu penting untuk pemenuhan hak-hak anak . Seperti kita ketahui, kemiskinan sering diturunkan dari satu generasi ke generasi berikutnya. Pengurangan efektif dan

berkelanjutan dalam kemiskinan anak harus dilakukan untuk memutus siklus kemiskinan dan meningkatkan kapasitas sumber daya manusia saat ini dan generasi berikutnya .

Pengalaman dalam beberapa tahun terakhir telah menunjukkan bahwa intervensi perlindungan sosial seperti cash transfer sangat efektif dalam mengurangi dampak kemiskinan anak, terutama jika mereka dirancang dengan cara yang mereka mencapai miskin dan anak-anak yang paling rentan . Perlindungan sosial adalah perlindungan untuk mengurangi kesenjangan dan memastikan bahwa tidak ada anak yang tertinggal dalam pencapaian MDGs .

Studi Kemiskinan Anak Indonesia menunjukkan bahwa sementara lebih dari 50 % dari anak-anak miskin berada di Jawa dan Bali, namun tingkat kemiskinan provinsi tetap tertinggi di Indonesia Timur. Di Nusa Tenggara Timur misalnya tingkat mencapai lebih dari 36 % . Anak yang tinggal di rumah tangga yang dikepalai oleh perempuan lebih berisiko untuk mengalami kemiskinan ekstrim daripada mereka yang tinggal di rumah tangga dikepalai laki-laki . Anak-anak di daerah pedesaan mengalami kemiskinan lebih ekstrim dibandingkan di daerah perkotaan .

Indonesia telah membuat kemajuan besar dalam membangun sistem perlindungan sosial yang sensitif terhadap kebutuhan khusus anak-anak . Bantuan Operasional Sekolah (BOS) dan Beasiswa Siswa Miskin (beasiswa bagi siswa dari keluarga miskin) meningkatkan kualitas dan akses pendidikan dasar bagi anak-anak miskin. Program Keluarga Harapan (PKH) memberikan uang tunai kepada keluarga miskin sehingga mereka dapat mengakses pelayanan kesehatan dan pendidikan. Program Kesejahteraan Sosial Anak (PKSA) bertujuan untuk memberdayakan anak-anak terpinggirkan.

UNICEF senang bisa bekerja sama dengan Pemerintah Indonesia dan lembaga mitra untuk memperkuat fokus dari sistem perlindungan sosial bagi anak-anak.

Namun, meskipun kemajuan menuju MDG pertama pada pengurangan kemiskinan , yang skema Perlindungan Sosial yang ada telah banyak memberikan kontribusi , kita tentu menyadari bahwa masih ada tantangan di depan . Kita harus bertanya kepada diri sendiri:

- Apakah ada cara untuk lebih mengidentifikasi anak-anak yang sangat rentan dan beresiko ? Apakah kita memahami semua kerentanan yang dihadapi anak-anak ? Bagaimana dengan anak-anak dengan disabilitas , HIV / AIDS ? Anak-anak yang ditinggalkan oleh orang tua mereka yang buruh migran ? Anak-anak di daerah konflik ? Anak-anak masyarakat adat ? Anak-anak yang menjadi korban trafficking dan kekerasan ?
- Bagaimana kita bisa memberikan program perlindungan sosial yang lebih terintegrasi dan holistik , sehingga anak-anak yang paling rentan menerima penuh layanan yang mereka butuhkan ? Bagaimana kita memperluas baik kedalaman dan luasnya perlindungan sosial bagi anak-anak yang paling rentan ?
- Dan mengingat keragaman Indonesia , bagaimana kita memastikan bahwa langkah-langkah perlindungan sosial sensitif terhadap konteks lokal dan budaya , serta kerentanan yang berbeda yang dihadapi anak-anak sepanjang masa mereka.
- Semua pertanyaan ini memberitahu kita : Kita masih memiliki " pekerjaan besar " yang harus dilakukan , dan pekerjaan ini membutuhkan kepemimpinan yang kuat dan koordinasi antara semua pihak yang terlibat .

Kami di sini untuk berbagi pengalaman , pengetahuan , dan inovasi untuk menghilangkan kemiskinan anak melalui perlindungan sosial . Potongan kunci penelitian telah dipilih dengan cermat bagi kita untuk membahas dan mendiskusikan ini. Saya berharap konferensi ini dan

berharap bahwa diskusi kami dapat menginspirasi ide-ide baru dan solusi menuju bahkan lebih peka terhadap anak pengurangan kemiskinan dan kerangka sistem perlindungan sosial.

Ini adalah kesempatan langka bagi para peneliti untuk berbagi pekerjaan mereka pada isu-isu anak-anak dengan para pembuat kebijakan dan praktisi di forum ini dan bagi kita semua untuk membina hubungan yang lebih kuat antara bukti , diseminasi dan advokasi untuk membuat kebijakan yang lebih baik - terutama untuk memastikan semua anak mampu mencapai potensi penuh mereka dan memberikan kontribusi kepada masyarakat yang stabil, adil dan merata .

Kami harus berterima kasih terutama kepada Bappenas untuk kepemimpinan mereka dalam mengorganisir Konferensi ini - yang pertama di Wilayah kami - dan SMERU - sebagai mitra kami dalam upaya ini. Ini membutuhkan komitmen , kerja keras dan ketekunan banyak rekan di BAPPENAS , SMERU dan UNICE , serta Kementerian terkait lainnya , dan lembaga-lembaga mitra , untuk membawa kita bersama-sama di sini hari ini.

Good luck untuk Anda semua! Saya berharap konferensi ini dapat memberikan bukti penting untuk meningkatkan kerja kolaboratif dan kebijakan untuk anak-anak. Saya berharap untuk belajar dari Anda dan rekomendasi yang dihasilkan dari konferensi.

Mari kita memanfaatkan kesempatan ini dan membuat sebagian besar dari kesempatan istimewa ini dan bersama-sama membuat tonggak dalam pembahasan tentang kemiskinan anak dan perlindungan sosial.

Bagi peserta dari luar Jakarta dan Indonesia - Saya berharap ini juga kesempatan untuk lebih mengeksplorasi Jakarta yang dinamis dan indah, di waktu luang sedikit apa yang mungkin Anda miliki.

Saya akhiri dengan dua baris puisi oleh Gabriel Mistral , Chili pemenang Hadiah Nobel tentang anak-anak!

Nama saya Hari ini , Besok Terlambat bagi-Ku .

Terima Kasih Banyak, Semoga Sukses .

S A M B U T A N MENTERI SOSIAL RI
P a d a :
CONFERENCE ON CHILD POVERTY AND SOCIAL PROTECTION

Grand Sahid Jaya Hotel - Jakarta,
10 September 2013

Yang saya hormati,

- Ibu Linda Amalia Sari Gumelar, Menteri Pemberdayaan Perempuan dan Perlindungan Anak
- Ibu Amida S. Alisjahbana, Menteri Perencanaan pembangunan Nasional/Kepala Bappenas
- Ibu Angela Kearney, Unicef Indonesia Representative
- Ibu Katja Hujo, United Nation Research Institute for Social Development, UNRISD
- Para Eselon I dan II dari seluruh Kementerian dan Lembaga
- Para Akademisi, Praktisi dan pembuat kebijakan
- Mitra Kerja dan para undangan

Assalamu'alaikum Wr. Wb.
Salam sejahtera untuk kita semua,

Alhamdulillah hari ini kita dapat hadir di tempat ini untuk mengikuti Konferensi Internasional "Kemiskinan Anak dan Perlindungan Sosial". Selain sebagai langkah nyata untuk mencapai Millennium Development Goals di Indonesia, kegiatan ini sekaligus menunjukkan tekad kita untuk terus berupaya menanggulangi kemiskinan dan memberikan perlindungan sosial bagi anak-anak kita.

Saya mengucapkan terimakasih kepada semua pihak, termasuk Unicef, lembaga nasional dan internasional lainnya yang telah berupaya sekuat tenaga dan bahkan menjadi contoh dalam menanggulangi kemiskinan dan perlindungan sosial khususnya untuk anak-anak Indonesia, generasi penerus bangsa.

Kemiskinan adalah suatu keadaan yang sering dihubungkan dengan kebutuhan, kesulitan dan kekurangan dalam berbagai keadaan hidup. Kemiskinan dapat merusak perkembangan fisik, emosional dan spiritual anak-anak. Seringkali korban terberat dari kemiskinan itu sendiri adalah anak.

Biasanya kemiskinan anak jarang dibedakan dengan kemiskinan secara keseluruhan. Padahal kemiskinan anak berbeda dengan kemiskinan secara keseluruhan. Masing-masing memiliki penyebab dan dampak yang berbeda.

Dampak kemiskinan lebih parah terjadi pada anak-anak dibandingkan orang dewasa, karena anak-anak lebih rentan dilihat dari faktor usia maupun ketergantungan pada keluarga (orang tua).

Kemiskinan yang dialami pada masa kecil dapat menyebabkan gangguan fisik dan mental secara permanen. Hal ini dapat dilihat pada anak-anak yang kurang beruntung secara permanen maupun yang terus-menerus berada pada siklus kemiskinan antar generasi. Oleh karena itu, investasi pada anak-anak merupakan kunci utama untuk mencapai pembangunan manusia yang adil dan berkelanjutan.

Hadirin sekalian yang saya hormati

Kemiskinan anak merupakan salah satu hal yang perlu diatasi terutama karena menyangkut pentingnya komitmen negara dalam memenuhi hak anak. Untuk mengatasi hal tersebut pemerintah khususnya Kementerian Sosial telah melaksanakan program penanggulangan kemiskinan yang dikatagorikan ke dalam empat klaster. Program nasional klaster pertama mencakup Program Keluarga Harapan (PKH) didukung oleh Program Kesejahteraan Sosial Anak (PKSA) serta Program Beras untuk Masyarakat Miskin (RASKIN). Selain pada kluster pertama, Kemensos juga melaksanakan program nasional klaster keempat, seperti penanggulangan kemiskinan kota dan desa. Semua program ini yang dilakukan Kementerian Sosial pada hakekatnya bertujuan untuk meningkatkan kesejahteraan dan perlindungan anak dan keluarga.

Upaya Kementerian Sosial melalui Program Kesejahteraan Sosial Anak (PKSA) dari tahun 2009 hingga 2013 sudah menangani 1,37 juta anak. Untuk tahun 2013, misalnya, PKSA ditargetkan terhadap 172 ribu anak dengan alokasi anggaran Rp. 388 Milyar. Sementara itu, Program Keluarga Harapan (PKH) secara nasional sejak tahun 2007 sampai 2013 sudah menangani 2,4 juta RTSM dengan alokasi anggaran Rp. 3,5 Triliun. Namun demikian, target maupun alokasi anggaran ini masih belum cukup jika dibandingkan dengan 4,6 juta anak terlantar serta kebutuhan riil anak untuk pemenuhan kebutuhan dasar dan aksesibilitas kebutuhan dasar ke sekolah, kesehatan, akte kelahiran, hiburan, keterampilan dan lain sebagainya.

Situasi ini menuntut diperlukannya sistem perlindungan anak yang terpadu (*integrated child protection system*) sehingga kebijakan dan program perlindungan anak di Indonesia dapat dilakukan secara sinergis dan tidak terjadi tumpang-tindih diantara berbagai pemangku kepentingan (*stakeholders*). Ini tentunya memerlukan kerjasama dan koordinasi antar kementerian/ lembaga serta pemerintah daerah baik tingkat provinsi dan kabupaten/kota) termasuk dengan lembaga-lembaga lokal, nasional dan internasional.

Sistem peridungan anak yang terpadu ini merupakan tantangan yang mendesak, karena masalah kesejahteraan dan perlindungan anak merupakan masalah lintas sektor sehingga memerlukan sistem yang dikembangkan bukan saja berdasarkan pengembangan konseptual, melainkan pula berdasarkan penelitian berbasis fakta di lapangan (*evidence-based research*).

Hadirin sekalian yang saya hormati

Kementerian Sosial sangat mengapresiasi lembaga pendidikan, lembaga penelitian, lembaga donor dan pihak-pihak yang telah dan terus melakukan penelitian, evaluasi terhadap program-program kesejahteraan dan perlindungan anak yang dilakukan Kemensos. Ini sangat berguna bagi pengembangan program dan evaluasi serta perbaikan dalam pelaksanaan program perlindungan anak.

Konferensi yang membahas hasil penelitian dan berbasis data ini sangat penting diselenggarakan untuk memberikan masukan dan umpan balik kepada pemerintah sehingga dapat meningkatkan kualitas layanan dan mempunyai program yang terarah, terpadu dan berkelanjutan.

Kita berharap rekomendasi dari konferensi ini dapat meningkatkan kesejahteraan dan perlindungan anak di Indonesia. Tentunya, dan ini yang lebih penting, kita kita sangat berharap hasil dari konferensi ini dapat diimplementasikan dan diperluas jangkauan manfaatnya yang pada gilirannya dapat disinergikan dan ditindaklanjuti oleh semua pihak, termasuk oleh pemerintah provinsi, kabupaten/kota, dan lembaga-lembaga pemerhati anak baik pada tataran lokal, nasional maupun internasional.

Hadirin yang berbahagia,

Saya ucapkan terimakasih dan penghargaan kepada penyelenggara Unicef, SMERU, Bappenas termasuk para penyaji yang telah memberikan kontribusi besar untuk perubahan, juga kepada semua pihak yang telah mengabdikan pikiran, tenaga dan waktunya untuk memberikan perlindungan dan meningkatkan kesejahteraan anak-anak kita.

Semoga Konferensi yang kita laksanakan menghasilkan gagasan-gagasan baru, khususnya untuk transformasi dan perubahan paradigma dalam: 1) menciptakan Pelayanan terkoordinasi Berdasarkan sistem yang terintegrasi; 2) pelayanan yang komprehensif, berorientasi pada pencegahan dan intervensi dini; 3) fokus pada pendekatan berpusat pada keluarga; dan 4) menciptakan sistem kemandirian.

Demikianlah sambutan yang dapat saya sampaikan pada kesempatan ini. Semoga kita semuanya menjadi orangtua atau keluarga yang bertanggungjawab dalam mensejahterakan dan melindungi anak-anak Indonesia. Semoga Allah SWT senantiasa melimpahkan karunia dan bimbinganNya kepada kita semua. Amin.

Terima Kasih atas perhatiannya. Wabillahi Taufik Walhidayah. Wasalamualaikum Warohmatullahi Wabarakatuh.

MENTERI SOSIAL RI

SALIM SEGAF AL JUFRI

SAMBUTAN
MENTERI NEGARA PEMBERDAYAAN PEREMPUAN DAN
PERLINDUNGAN ANAK REPUBLIK INDONESIA
PADA KONFERENSI TENTANG KEMISKINAN ANAK DAN PERLINDUNGAN SOSIAL
JAKARTA, 10 SEPTEMBER 2013

Yth. Menteri Perencanaan Pembangunan Nasional/Kepala Bapenas
Yth. Menteri Sosial RI
Yth. Perwakilan Unicef Indonesia
Yth. Pimpinan Lembaga Penelitian SMERU
Yth. Peserta Konferensi dan Hadirin yang berbahagia,

***Assalamu 'alaikum wr.wb*,**
Salam sejahtera bagi kita semua,

Puji dan syukur kita panjatkan kehadirat Allah SWT, Tuhan Yang Maha Kuasa, yang telah melimpahkan rahmat dan hidayah-Nya kepada kita semua, sehingga kita dapat bertemu di tempat ini dalam keadaan sehat wal'afiat untuk mengikuti konferensi untuk membahas kemiskinan anak dan perlindungan sosial.

Dalam kesempatan ini, izinkan saya menyampaikan apresiasi dan penghargaan yang tinggi kepada Menteri Perencanaan Pembangunan Nasional/Kepala Bapenas, Pimpinan Unicef Indonesia dan Lembaga Penelitian Smeru yang telah menggagas Konferensi Internasional ***"Kemiskinan Anak dan Perlindungan Sosial"*** ini. Hal ini saya nilai memiliki makna yang strategis untuk mendukung dan memajukan kualitas hidup dan perlindungan bagi anak Indonesia.

Bapak/Ibu peserta Konferensi yang terhormat,

Sesuai dengan UU Nomor 23 Tahun 2002 tentang Perlindungan Anak, yang disebut Anak adalah seseorang yang belum berusia 18 (delapan belas) tahun, termasuk anak yang masih dalam kandungan. Perlindungan anak adalah segala kegiatan untuk menjamin dan melindungi anak dan hak-haknya agar dapat hidup, tumbuh, berkembang, dan berpartisipasi, secara optimal sesuai dengan harkat dan martabat kemanusiaan, serta mendapat perlindungan dari kekerasan dan diskriminasi.

Sebagai individu, seorang anak, baik dari tingkatan ekonomi miskin maupun kaya, rentan terhadap berbagai hal di lingkungannya yang dapat memengaruhi proses tumbuh kembangnya dari segi fisik, psikis dan intelektual. Masa kanak-kanak meliputi masa perkembangan fisik, emosional dan intelektual yang pesat. Namun, masa tersebut juga merupakan bagian siklus hidup yang paling rentan.

Anak tidak dapat dipisahkan dari keluarga dan pengasuhnya, maka itu anak yang mengalami kemiskinan tidak akan mendapat akses terhadap kesejahteraan fisik, kesejahteraan sosial dan kesejahteraan psikologis. Berbicara tentang kemiskinan anak, faktor penyebabnya dapat dilihat dari sisi ekonomi, dan sisi psikologi. Dari sisi ekonomi, berarti pendapatan keluarga yang kurang dan ketidakmampuan mengonsumsi sandang, pangan, dan papan yang sehat. Sedangkan dari sisi psikologi, kemiskinan anak berarti miskin kasih sayang, perhatian, kenyamanan, keamanan, pengasuhan yang benar, komunikasi yang sehat dalam keluarga, dan panutan nilai moral. Dengan kata lain, terjadi defisit kasih sayang dan nilai moral dalam keluarga dan lingkungan.

Kemiskinan anak dapat terjadi pada keluarga yang mampu maupun yang tidak mampu secara ekonomi. Pada keluarga yang mampu, kemiskinan anak lebih didominasi oleh faktor psikologi; sedangkan pada keluarga yang tidak mampu kemiskinan anak dapat dikarenakan faktor ekonomi dan psikologi. Meskipun demikian, kedua faktor tersebut dapat berdampak pada proses tumbuh kembang anak dimana anak antara lain mejadi tidak mampu berpartisipasi, mengalami perasaan takut, tidak punya harapan masa depan dan tidak memiliki konsep diri yang baik. Mengingat kemiskinan anak berdampak multidimensi, maka penyelesaiannya harus bersifat holistik dan terpadu lintas sektor.

Pada umumnya metode yang biasa digunakan untuk mengukur kemiskinan adalah tingkat pengeluaran atau konsumsi. Berarti seseorang dianggap miskin jika tingkat pengeluaran atau konsumsi di bawah tingkat minimum tertentu atau di bawah garis kemiskinan dalam pemenuhan kebutuhan dasarnya.

Sampai saat ini ukuran kemiskinan yang ada hanya memberikan pemahaman tentang kemiskinan secara makro berdasarkan konsumsi dan pendapatan, tetapi tidak mampu memberikan gambaran tentang kemiskinan dari sisi psikologi/non ekonomi. Sekaitan dengan hal ini, pada tahun 2010 World Bank telah mendefinisikan kemiskinan sebagai ketidakmampuan masyarakat dalam memenuhi kesejahteraannya pada berbagai dimensi. Apabila kemiskinan terjadi terus menerus, maka akan berdampak jangka panjang terhadap pertumbuhan ekonomi, sosial dan budaya suatu bangsa.

Penurunan pertumbuhan ekonomi global dapat diatasi dengan perbaikan program perlindungan sosial agar tidak berdampak kepada orang miskin. Perbaikan program perlindungan sosial tidak berarti penambahan anggaran baru, tetapi perbaikan target penerima program perlindungan sosial yang pada akhirnya akan mengurangi dampak yang ditimbulkan oleh penurunan pertumbuhan ekonomi. Salah satu diantaranya melalui perbaikan distribusi bantuan sosial yaitu menjamin pangan, pendidikan dan kesehatan bagi anak dan perempuan. Dalam jangka panjang hal ini akan memberikan dampak ungkit terhadap investasi sumber daya manusia yang berkualitas dan akan mampu mendukung pertumbuhan ekonomi. Selain itu, dalam jangka pendek akan meredam gejolak sosial.

Hadirin sekalian yang berbahagia,

Secara proporsional jumlah anak di Indonesia cukup besar. Sesuai dengan hasil Sensus Penduduk Tahun 2010, 34,6 persen penduduk Indonesia adalah anak-anak usia 0-17 tahun atau 81,4 juta dari 237,6 juta penduduk Indonesia. Data Susenas tahun 2009 menunjukkan bahwa sekitar 28 persen anak tinggal pada rumah tangga termiskin, 23 persen dalam kelompok termiskin kedua, sedangkan hanya 13 persen berada pada kelompok terkaya. Ini berarti ada sekitar 51 persen anak termasuk berada dalam kondisi rentan karena mengalami kemiskinan (Susenas 2009, diolah SMERU)

Berbagai data menunjukkan bahwa anak-anak didera berbagai krisis multi dimensi yang menimbulkan banyak tekanan dan kecemasan pada anak. Di satu sisi masalah kemiskinan dan kebodohan mengancam anak-anak kita, sementara di sisi lain, pengasuhan anak yang kurang

tepat dalam keluarga dan sistem ekonomi makro yang cenderung mengabaikan perlindungan sosial bagi anak mendorong terciptanya lingkungan yang tidak nyaman dan aman untuk tumbuh kembang anak.

Untuk mengatasi permasalahan yang kompleks tersebut dibutuhkan kebijakan yang holistik dan integratif yaitu Kebijakan Perlindungan Sosial yang ramah anak, yang menjamin tersedianya layanan dasar bagi anak termasuk anak yang berkebutuhan khusus, berupa kesehatan, gizi, pendidikan, PAUD (pendidikan anak usia dini), air bersih dan sanitasi. Selain itu, Kebijakan tersebut harus menjamin adanya bantuan untuk mengurangi dampak dari pengangguran bagi orang tua yang memiliki anak berkebutuhan khusus.

Kebijakan perlindungan sosial yang ramah anak diharapkan memberikan dukungan investasi terhadap:

a) pendidikan tanpa diskriminasi gender, usia atau status anak dalam keluarga (budaya anak sulung);
b) menghindari terhambatnya tumbuh kembang dan perlindungan anak karena kekerasan, ekspolitasi, penelantaran, perlakuan salah (misalnya, anak yang menjadi pekerja anak, pengemis, prostitusi anak), tidak mendapatkan makanan bergizi, akses sekolah dan belajar, akses kesehatan;
c) mendukung adanya pengasuhan alternatif diluar sistem panti bagi anak-anak terlantar yang tidak memiliki pengasuh atau orang tua.

Para hadirin yang berbahagia dan saya banggakan,

> Keberhasilan pembangunan anak tidak terlepas dari keberhasilan pelaksanaan pembangunan pemberdayaan perempuan dan perwujudan kesetaraan gender dalam keluarga. Anak yang berkualitas dihasilkan oleh orang tua yang berkualitas pula, karena pembentukannya terjadi sejak anak masih dalam kandungan. Maka itu, dalam pengasuhan anak peran bapak dan ibu menjadi sangat penting untuk memberikan kasih sayang dan menjadi panutan dalam penerapan nilai moral. Sehubungan dengan hal ini maka dalam pelaksanaan seluruh kebijakan, program, dan kegiatan pembangunan dan perlindungan anak perlu selalu **diintegrasikan dengan pembangunan kesetaraan gender, pemberdayaan dan perlindungan perempuan**.

Demikian beberapa hal penting yang perlu saya sampaikan dalam Konferensi ini. Semoga kita semua mampu menghadirkan Dunia yang Layak Bagi Anak, apalagi dengan dukungan komitmen dan semangat dari berbagai pemangku kepentingan yang hadir pada Konferensi Internasional Kemiskinan Anak dan Perlindungan Sosial ini. Semoga Allah meridhoi upaya kita untuk menghapuskan kemiskinan anak dan memberikan perlindungan sosial yang ramah anak dan optimal.

Terima kasih,
Wabillahi taufik wal hidayah,
Wassalamu'alaikum Wr. Wb.

Menteri Negara
Pemberdayaan Perempuan dan Perlindungan Anak
Republik Indonesia

Linda Amalia Sari, S.IP

REPUBLIK INDONESIA
KEMENTERIAN PERENCANAAN PEMBANGUNAN NASIONAL
BADAN PERENCANAAN PEMBANGUNAN NASIONAL

Sambutan Menteri Negara PPN/ Kepala Bappenas
pada
"Konferensi Kemiskinan Anak dan Perlindungan Sosial"
(Conference on Child Poverty and Social Protection)
Kerjasama Pemerintah RI – UNICEF - SMERU
Jakarta, 10-11 September 2013

Yth. Ibu Menteri Negara Pemberdayaan Perempuan dan Perlindungan Anak
Yth. Bapak Menteri Sosial
Yth. Bapak/Ibu para anggota Dewan Perwakilan Rakyat
Yth. Kepala Perwakilan UNICEF di Indonesia
Yth. Para Perwakilan Mitra Pembangunan
Yth. Bapak/Ibu/Saudara Para Pejabat dari Kementerian dan Lembaga
Yth. Para Nara Sumber, Pembahas, dan Moderator serta
Para undangan dan hadirin yang berbahagia

Assalamualaikum Warahmatullah Wabarakatuh
Selamat Pagi dan Salam Sejahtera untuk kita semua

1. Pertama-tama, marilah kita panjatkan puji syukur kehadirat Tuhan Yang Maha Kuasa atas limpahan rahmat dan karunia-Nya, sehingga kita semua dapat menghadiri "Konferensi Kemiskinan Anak dan Perlindungan Sosial" pada pagi ini.

2. Konferensi ini dilaksanakan dalam kerangka Program Kerjasama Pemerintah Republik Indonesia dengan UNICEF dan Lembaga Penelitian SMERU. Untuk itu kami ucapkan selamat atas terselenggaranya konferensi ini dan terima kasih kepada UNICEF dan SMERU yang telah menjadi mitra kerjasama Pemerintah Republik Indonesia untuk terlaksananya konferensi ini.

3. Konferensi ini merupakan pertemuan yang sangat strategis karena merupakan forum yang mempertemukan para peneliti dengan para perumus kebijakan dan pelaksana berbagai program perlindungan dan peningkatan kesejahteraan anak Indonesia, untuk mendiskusikan isu-isu kemiskinan anak dan perlindungan sosial yang dilaksanakan dalam upaya memenuhi hak-hak anak.

4. Hasil-hasil penelitian yang didiskusikan dalam konferensi ini dikumpulkan melalui proses penjaringan yang diikuti oleh para peneliti dari berbagai daerah di Indonesia dan berbagai negara, khususnya di kawasan Asia. Untuk itu, kepada segenap peneliti yang telah mengirimkan makalahnya kami sampaikan penghargaan dan terima kasih.

Bapak, Ibu, para hadirin yang saya hormati;

5. Isu-isu mengenai anak dan kemiskinan terus menerus menjadi prioritas Pemerintah Indonesia, sebagaimana tercermin dalam berbagai dokumen perencanaan pembangunan Indonesia. Penurunan kemiskinan dan peningkatan kesejahteraan dan perlindungan anak merupakan hasil akhir yang diharapkan dapat dicapai melalui berbagai kebijakan jangka panjang pembangunan sumberdaya manusia dan penguatan ekonomi yang dituangkan dalam Rencana Pembangunan Jangka Panjang (RPJP) 2005-2025. Demikian pula, RPJMN 2010-2014 menggariskan bahwa kebijakan perlindungan anak dilakukan di semua bidang pembangunan, khususnya di bidang pendidikan, kesehatan, dan penanggulangan kemiskinan.

6. Sesuai dengan Undang-Undang No. 23 Tahun 2002 Tentang Perlindungan Anak, anak mencakup penduduk yang belum berusia 18 (delapan belas) tahun - termasuk anak yang masih dalam kandungan. Hak-hak anak yang harus dipenuhi meliputi hak-hak untuk hidup, tumbuh, berkembang, dan berpartisipasi dalam berbagai aspek kehidupan, serta mendapat perlindungan dari berbagai tindak kekerasan, perdagangan anak, eksploitasi, dan diskriminasi.

Bapak, Ibu, para hadirin yang saya hormati;

7. Sejauh ini Indonesia telah mencatat berbagai kemajuan berkaitan dengan peningkatan kesejahteraan dan perlindungan anak. Evaluasi paruh waktu RPJMN 2010-2014 memperlihatkan adanya kemajuan di bidang pendidikan, seperti ditunjukkan oleh peningkatan angka partisipasi murni (APM) sekolah dasar dan sederajat dari 95.41% pada tahun 2009 menjadi 95,69% pada tahun 2012, peningkatan APM sekolah menengah pertama dan sederajat dari 75,6% pada tahun 2009 menjadi 77,7% pada tahun 2012, dan peningkatan APM sekolah menengah atas dan sederajat dari 69,60% pada tahun 2009 menjadi 76,5% pada tahun 2011.

8. Beberapa kemajuan juga dicapai di bidang kesehatan. Hal ini ditunjukkan oleh angka kematian bayi yang menurun dari 34 per 1000 kelahiran hidup pada tahun 2007 menjadi 32 pada tahun 2012, prevalensi kekurangan gizi menurun dari 18,4 persen pada tahun 2007 menjadi sebesar 17,9 persen pada tahun 2010, dan prevalensi anak balita pendek (stunting) juga menurun dari 36,8% pada tahun 2007 menjadi 35,6% pada tahun 2010.

Bapak, Ibu, para hadirin yang saya hormati;

9. Dalam hal pengurangan kemiskinan, kemajuan tercermin dari terus menurunnya angka kemiskinan dari 14,2% pada tahun 2009 menjadi 11,37% pada Maret 2013. Dengan penurunan angka kemiskinan tersebut berarti jumlah penduduk miskin menurun dari 32,53 juta jiwa pada tahun 2009 menjadi 28,07 juta jiwa pada Maret 2013. Penurunan kemiskinan tersebut ditunjang oleh meningkatnya pertumbuhan ekonomi, yang ditandai dengan peningkatan Pendapatan Nasional Indonesia dari 20,7 juta rupiah per kapita pada tahun 2009 menjadi 30,5 juta rupiah per kapita pada tahun 2012.

10. Salah satu upaya penting yang sudah mulai dilakukan Pemerintah adalah melalui program-program perlindungan sosial. Program Keluarga Harapan, misalnya, terus ditingkatkan cakupannya dari 774 ribu keluarga pada 2010 menjadi sekitar 1,5 juta keluarga pada 2012. Pengembangan sistem jaminan sosial nasional, juga akan terus diarahkan untuk mendukung pemenuhan hak-hak anak.

Bapak, Ibu, para hadirin yang saya hormati;

11. Kita semua menyadari bahwa anak merupakan aset utama yang akan menentukan masa depan bangsa. Kesejahteraan anak Indonesia, yang berjumlah sekitar 80,1 juta jiwa berdasarkan Sensus Penduduk 2010, akan ditentukan oleh investasi jangka panjang yang dilakukan oleh keluarga, pemerintah, dan seluruh komponen masyarakat.

12. Dari sudut pandang perencanaan pembangunan, konferensi ini dilaksanakan pada saat yang sangat tepat, karena Pemerintah sedang memulai proses penyusunan RPJMN 2015-2019. Para pembuat kebijakan menyadari pentingnya penelitian dan kajian yang kredibel dan berkesinambungan sebagai masukan untuk perumusan kebijakan mengenai pemenuhan hak-hak anak dan peningkatan kesejahteraan anak yang berkualitas. Hasil-hasil penelitian yang didiskusikan pada konferensi ini diharapkan dapat memberikan masukan, untuk meningkatkan efektivitas upaya peningkatan kesejahteraan dan pemenuhan hak-hak anak Indonesia maupun anak-anak di berbagai Negara lain yang berpartisipasi dalam konferensi ini.

13. Dalam kesempatan ini, kami memohon agar Ibu Menteri Pemberdayaan Perempuan dan Perlindungan Anak dan Bapak Menteri Sosial berkenan untuk membuka acara ini secara resmi.

Terima kasih.
Wassalamu'alaikum Warahmatullahi Wabarakatuh.

Jakarta, 10 September 2013
Menteri Negara PPN/Kepala Kepala Bappenas

Armida S. Alisjahbana

The Role of Social Policy for Combating Child Poverty and Promoting Social Development - a Transformative Approach

Keynote Speech for the Conference on "Child Poverty & Social Protection"
Jakarta 10-11 September 2013

Katja Hujo (United Nations Research Institute for Social Development, Geneva)

ABSTRACT

Child poverty, vulnerability and deprivation are among the greatest challenges we are facing in today's world, both from a developmental and a human perspective. Despite the fact that investing in children is widely accepted as a moral imperative, a human right and an investment in the future, too many children are still suffering from hunger, preventable diseases and lack of access to basic services and participation. On a positive side, there has been visible progress for many children in a great number of countries as a result of national policies and donor-supported programmes. In this context, social protection is considered increasingly relevant, not the least against the backdrop of recurrent economic crises and emergency situations. Social protection policies and programmes are powerful instruments for investing in our future, while reducing poverty, vulnerability and deprivation among children and their families today. Evidence from more developed welfare states and from a wide range of lower- and middle income countries in Latin America, Asia and Africa demonstrates that social protection programmes are producing various positive socio-economic outcomes, for example with regard to nutrition, health, education and gender indicators. What is more difficult to measure, but equally important, are the broader and longer term economic and societal benefits of social policy that largely outweigh their short-term costs. UNRISD has developed the concept of "transformative social policy" to describe the multiple roles of social policy for production, redistribution, reproduction and care, social cohesion, nation-building and democratization. Social policy including social protection programmes can support a process of social and economic change towards better societies, those that place child rights and wellbeing at the core of national development strategies.

INTRODUCTION

Let me first of all thank UNICEF, SMERU and the Government of Indonesia for hosting this conference and for inviting me to open this meeting. It is a huge privilege to be here and discuss with you the potential of social protection for combating child poverty and for increasing the capabilities and well-being of every child. Bringing together such a distinguished group of policymakers, practitioners and academics for the coming two days is encouraging and signals how social protection has evolved from a residual category to a key policy instrument within global and national poverty reduction strategies. We all know that debates and agenda-setting is not enough to change lives on the ground, but it is a first and necessary step in order to raise awareness and to build consensus and a coalition for change.

Widespread poverty, vulnerability and exclusion of children are among the greatest challenges the global community is facing, both from a developmental and a human perspective. When UNICEF rightly states that "(t)he principle of investing in children rarely evokes controversy, (as) to invest in a child is to invest in our common future", why is it then that child poverty persists, despite some progress over the last decades? Is it a lack of understanding that leads to adoption of ineffective strategies? A lack of funding or state capacity? A lack of political will and priorities?

A lack of commitment from the international community to take responsibility and share development gains and losses?

When UNRISD started its work on the 2010 flagship report "Combating Poverty and Inequality", one of our leading questions was "What (then) accounts for the persistence of poverty when concerns for its reduction have been high on the policy agenda"?[1] What we found in our research was that current approaches to poverty often ignore its root causes, focusing on measuring things that people lack to the detriment of understanding why they lack them (UNRISD 2010: 2). A consequence of this line of thinking is to deal with symptoms, without being able to move to the heart of the problem. In the back of our efforts, poverty is reproducing itself quicker than we are able to reduce it.
Instead of trying to find isolated solutions to the poverty problem or to focus excessively on designing programmes for the poor, we suggest in the report to analyse poverty reduction as part of long-term processes of social, economic and political transformation, and to connect the poverty issue with broader development dynamics.

With this holistic approach in mind, in the following I will focus on the role that social policy plays for poverty reduction and child well-being as part of such a longer term process of social change. I will organize my talk around three themes:

SLIDE 1

- Poverty and inequality: Where do we stand?
- Social Protection Programmes: What is their potential for poverty reduction and what are the challenges?
- Child poverty in Asia: Time for social protection

I will argue that child development is a positive development outcome, but more importantly, it is a driver for equitable growth and better societies. However, eradicating child poverty and deprivation requires overcoming political, economic and social barriers as well as developing comprehensive policy frameworks that impact on the root causes of poverty and inequality: lack of employment-intensive growth and decent work; lack of a social contract that combines sustainable and equitable financing with institutionalized social rights; and lack of empowerment and political voice for non-elite groups and the poor.

1) Poverty and Inequality
Poverty reduction has been on international policy agendas for several decades, but the focus of strategies has changed in line with dominant development theories and ideologies:
After two decades of strong reliance on market forces and poverty reduction via growth, alternative approaches such as those promoted at the Copenhagen Social Summit or through the MDGs have regained policy space and have moved social development concerns higher up the development agenda. Whereas the Copenhagen declaration emphasized the interlinkages between full and productive employment, social integration, and poverty reduction, the MDGs set out to address poverty in its multiple dimensions, from income poverty, nutrition, education, health to gender equality and sustainable development.

Two years ahead of 2015, many targets have been achieved or are within reach:

[1] UNRISD Research and Policy Brief No. 10.

SLIDE 2 (The Millennium Development Goals Report 2013)

- The global poverty rate ($1.25 a day) fell from 47% in 1990 to 22% in 2010, less than half the 1990 rate, with a reduction of 700 million fewer people living in extreme poverty;
- The hunger reduction target is within reach by 2015, with the proportion of undernourished people down from 23.2% in 1990-92 to 14.9% in 2010-12;
- 2 billion people gained access to improved sources of drinking water;
- Over 200 million slum dwellers benefitted from improvements in their living conditions, such as water, sanitation and housing (2000-10);
- Mortality rates from malaria fell by more than 25% globally between 2000 and 2010.
- Debt service to export revenue ratio decreased from 12% in 2000 to 3.1% in 2010 for all developing countries.

But: SLIDE 3

- 1.2 billion people still live in extreme poverty (around 600 million children), and 2.4 billion lived on less than $2 a day in 2010 (two-thirds of the population in Sub-Saharan Africa and South Asia)
- 870 million people are estimated to be undernourished;
- More than 100 million children under age five are undernourished and underweight;
- Child mortality under five dropped by 41% (from 12 million 1990 to 6.9 million 2011), but the two-third reduction is still not achieved, with child deaths being increasingly concentrated in the poorest regions and the first months of life.
- Although the number of children out of school declined almost by half between 2000 and 2011, it is unlikely that the target of universal primary education will be met by 2015.
- Maternal deaths declined by 47%, but the target of a three-quarter reduction has not been reached yet.
- The absolute number of poor people has more than doubled in Sub-Saharan Africa between 1981 and 2010, from 205 million to 414 million.
- Environmental sustainability, sanitation and aid disbursements are lagging behind: aid dropped 4% in real terms compared to 2011, which was already 2% lower than 2010. Bilateral ODA to LDCs fell by 13% in 2012.

SLIDE 4: Why inequality matters-for growth, poverty reduction and the social fabric

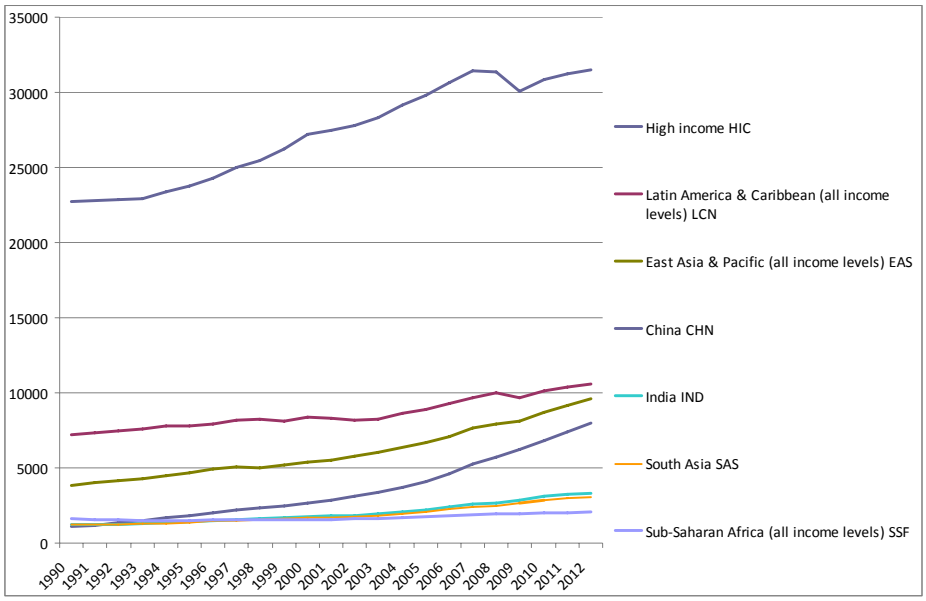
We see many achievements, but we still face huge problems and challenges that demand solutions. As I mentioned before, the best strategy for tackling problems is to attack their root causes. One of the causes and drivers of poverty is inequality. It is pure arithmetic that in two countries with the same GDP per capita, the country that displays higher poverty headcounts is the one with higher levels of inequality. Paradoxically, in the past it was held that inequality was a driver of economic growth, and that growth was good for poverty reduction, hence inequality was deemed good for poverty reduction. We do not want to argue that growth is not important for poverty reduction; it is important, but patterns of growth, job-rich, job-less, inclusive, exclusive, debt-led, export-led etc., matter more than growth rates (which can ultimately be driven by the

price of oil as we observe in many high-growth commodity-exporting countries in SSA). High levels of inequality are not only perceived as unjust, but they are also an obstacle to economic development and poverty reduction and they weaken the social fabric. Research (UNRISD 2012) has shown that

- Higher equality leads to
  - quicker poverty reduction through growth
  - Higher domestic demand and structural change
  - Fiscally and politically stable welfare systems (middle-class buy-in)
  - Higher social cohesion, social mobility and balanced power structures
  - Lower levels of crime and violent conflict
  - Less push factors for migration

Have we made progress towards greater equality over the last decades?

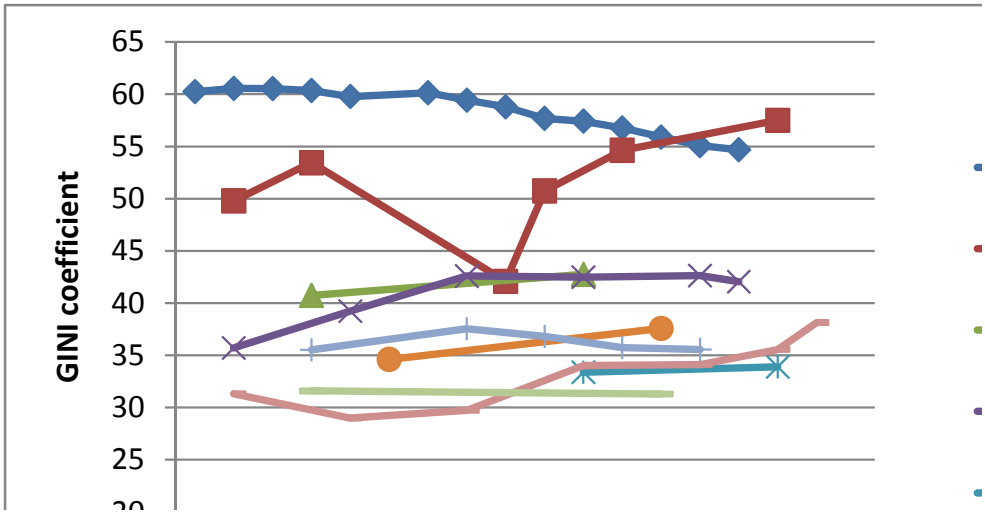
SLIDE 5: Some convergence in income between countries (GDP p.c. in US$)



Source: WDI online.

The answer is yes and no: We see some progress concerning income gaps between richer and poorer countries (though with huge gaps remaining), but at the same time a lot of backlash with regard to inequality within countries (which is also confirmed by available data on functional income distribution between profits and wages).

SLIDE 6: Gini Coefficient



Source: WDI online.

If we zoom in further on patterns of inequality within countries, we see that absolute poverty is no longer concentrated in low-income or least developed countries, but that many poor people and children are living in middle-income countries and emerging markets. A second important point is that national averages often hide important disparities, a fact that several agencies, in particular UNICEF, have pointed out.

SLIDE 7: Looking closer: inequality, disparities, cumulative deprivations

Poverty and deprivation is multidimensional, cumulative and overlapping; the most disadvantaged children are suffering from multiple deprivations in areas such as income security, access to basic services, nutrition, housing, and participation. Not all adults or children that are income poor are suffering from multiple deprivations, and many persons that are above the poverty line are still deprived of basic services and capabilities.

- Multidimensional poverty – examples for deprivation categories for child-wellbeing
  - Income: poverty (e.g. 1.25 $PPP p.d.) or vulnerability (2 $PPP p.d)
  - Health and nutrition
  - Education, early childhood development
  - Water and sanitation
  - Living conditions (housing, electricity etc.)
  - Emotional well-being
  - Information and participation
  - Birth certificates

SLIDE 8: Most disadvantaged – cumulative deprivations

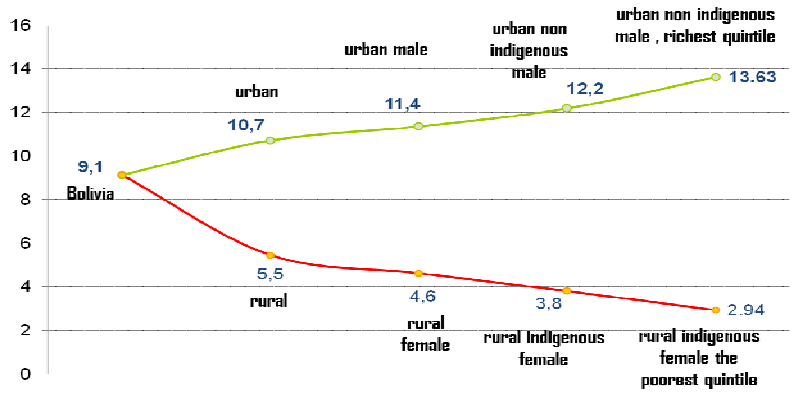
Poverty studies have shown that the most disadvantaged households or individuals are likely to

- Live in rural or remote areas or in urban slum areas
- Be disabled, from an ethnic or religious minority (including migrants), be a girl/women
- Live in a poor household, live in a household with high number of dependents
- Live in a household where head of household is female or unemployed

Interestingly, these risk factors seem to be stable over time, as we find the same enumeration in World Bank reports from the 1970s and 80s.

A good example of how horizontal inequality impacts on social outcomes is education. Let me show you the example of Bolivia. The average years of schooling in Bolivia are 9.1 years. However, for an indigenous woman living in the rural sector and belonging to the lowest income quintile this average goes down to under 3 years; compared to 13,6 years for a non-indigenous man who lives in an urban area and belongs to the highest income quintile. More than 10 years of difference in education, which is considered a crucial opportunity and determinant of human capabilities and life chances.

SLIDE 9: Inequities and what averages hide: educational outcomes in Bolivia – location, gender, ethnicity, income



Source: UDAPE 2011.

Let me now come to my second point.

2) Social Protection Programmes: What is their potential for poverty reduction and what are the challenges?

SLIDE 10: The role of SP in reducing poverty and inequality

Social protection is concerned with preventing, managing and overcoming situations that adversely affect people's well-being. Social protection programmes aim to assist individuals and households in maintaining basic consumption and living standards when confronted by contingencies such as unemployment, illness, maternity, disability or old age, as well as economic crisis or natural disaster. From a development perspective, social protection is not only concerned

with specific risks and shocks in stable life trajectories, but also with reduction of poverty and vulnerability.

Social protection is defined differently by different organizations, but usually comprises:

- *social insurance*: generally employment-related programmes financed from contributions such as unemployment and health insurance and pensions;
- *social assistance*: non-contributory transfers (condition or unconditional; in cash or kind) to those deemed eligible, whether on the basis of income, vulnerability status or rights as citizens or residents. Work-related interventions such as public employment or food for work programmes are also a form of social assistance;
- *labour market policies* that ensure basic standards and rights at work, including collective bargaining, minimum wage policies, unemployment insurance and prohibition of child labour.

Social protection is a subset of social policy, which also includes social services and other policies with redistributive and social objectives (e.g. micro-finance, rural sector policies). There is great value in thinking of social protection within this broader social policy framework, and to design comprehensive and integrated systems that cover social services, income protection and basic rights and legal standards.

While more recently emphasis has been put on the instrumental value of social policy, we should not forget that social security is a value of its own and a basic human right.

SLIDE 11: Social Policy has intrinsic values which are grounded in Human Rights and International Conventions:

- The Right to Social Security (Art. 22)
- The Right to Medical Care and Social Services (Art. 25)
- The Right to Education (Art. 26)
- ILO Conventions (No. 102)
- CRC: Convention on the Rights of the Child
- CEDAW: Elimination of All Forms of Discrimination against Women

This rights-based framework is important and should guide related policies, laws and implementation in every country. However, despite the recognition of these intrinsic values, social policy has been considered a luxury for developing countries, something that would come very late in the development process, basically a development outcome, not a driver. In this regard, a sea change has occurred over the last decade: social policy is increasingly accepted as having multiple positive effects on development performance. UNRISD argues that the *transformative* potential for social policy is grounded in multiple roles that extend beyond social protection and human capital formation to address aspects of production, redistribution, reproduction and care, social cohesion, nation-building and democratization (UNRISD 2006, RPB).

SLIDE 12: SP is developmental and transformative

SP aims to

- ✓ enhance the <u>productive</u> capacities of individuals, groups and communities;

- ✓ reinforce the progressive redistributive effects of economic policies;
- ✓ reduce the burden of growth and reproduction of society, including care-related work, and
- ✓ protect people from income loss and costs associated with unemployment, pregnancy, ill-health or disability, and old age.

Indeed, when we look at international policy debates, initiatives, development agendas, we can see that social protection is becoming more relevant, and that its remit is becoming broader over time: moving from the safety net approach of the Washington Consensus period, to the comprehensive approach of the Social Summit in Copenhagen in 1995, to formulation of PRSPs with a stronger focus on pro-poor spending, the MDGs, strategy documents published by many agencies and institutions, and the last global initiative on National Social Protection Floors, led by the ILO.

SLIDE 13: Current Trends in SP

- The global SP agenda is becoming stronger
  - 1980s/90s: Safety nets and market approaches to social policy
  - Copenhagen 1995
  - MDGs/PRSPs
  - Social protection strategies at international and national level (IFIs and regional development banks, regional commissions, Unicef, FAO, ILO etc.)
  - 2012 ILO recommendation on National Social Protection Floors (access to essential services, income security over the lifecycle

Within this debate, it is clear that social assistance is gaining relevance, because of its great potential for poverty reduction (and achievements of MDGs), but also because of slow progress with regard to social insurance coverage and labour market policies.

SLIDE 14: Social assistance gains relevance

- Social insurance: large coverage gaps and substantive economic costs (but mostly contribution-financed)
- Social assistance: increasing relevance, most dynamic and innovative area, but challenge of universal coverage, adequacy of benefits, programme design, implementation, financing
- Labour market policies: some relevance in MICs and with regard to public works/employment guarantee schemes

Cash transfer programmes have grown immensely over the last years:

SLIDE 15: Cash transfer programmes

- Cover 750 million - 1 billion people in the developing world (DFID, 2011).
- In 2010, operated in 52 countries including 16 LICs
- Measurable impact on:

- Poverty (headcount, gap), inequality (Gini, horizontal)
- Nutrition and food security
- Education
- Health
- Climate change and disaster risk reduction

You can see a short list of some of the largest programmes in the world:

SLIDE 16: examples of large cash transfers programmes

China	Minimum Living Standards Scheme	23.3 million (2008)
Mexico	*Oportunidades* (began in 1997)	5.8 million households (2011)
Brazil	*Bolsa Família* Old Age Pension	13.3 million households (2011) 2.4 million households (2008)
South Africa	Child Support Grant Old Age Pension	10 million children (2009) 2.4 million households (2009)
Indonesia	Safety Net Scheme	15 million households (2009)
India	National Rural Employment Guarantee Scheme	48 million households (2008)
Ethiopia	Productive Safety Nets Programme	1.5 million households (est. 8 million people) (2008)

Social assistance programmes can be classified into different groups:

SLIDE 17 : Types of social assistance programmes

- Unconditional income transfers (targeted to poor; universal social pensions or child benefits, citizenship grant)
- Income transfer conditional on work (public works, employment guarantee schemes etc.)
- Income transfer conditional on human capital investment (CCTs): school performance, health check-ups
- In-kind transfers (e.g. food for education)
- Subsidies (food, fuel etc.)

We observe, that cash transfers are expanded in comparison to in-kind transfers or subsidies, but the actual mix of programmes depends very much on country context. The following slide gives some more concrete examples of social protection programmes in Asia:

SLIDE 18: SP in Asia – some examples

- Conditional Cash Transfers (CCTs) *Pantawid Pamiya* in Philippines, covering 8,5 million children, with ambitious plans for scaling up.
- China: Minimum Living Standard Guarantee, around 75 million beneficiaries in 2012, 71% living in rural areas.
- Social Pensions
  - Targeted: Bangladesh, Viet Nam; universal: Nepal, Thailand

- Unemployment benefits and employment programmes:
  - Unemployment Benefits: Republic of Korea
  - National Rural Employment Guarantee (NREGA) in India: rights-based, 100 days of paid work per year, 50 million workers employed in 2009; infrastructure etc., Bangladesh: Employment generation for the Ultra-Poor: 6 million beneficiaries
- Social Health Insurance:
  - Indonesia: Jamkesmas HI for poor households, 2009 9.34% of all children covered
  - National Health Insurance in Republic of Korea: universal coverage from 2009, HH contribution substantial (55%), but decreasing

The more developed a country, the higher the weight attached to social insurance and labour market policies, although employment guarantee programmes and public works feature prominently in low-income countries as well.

The next slide brings us to the context of the host country of this conference, Indonesia.

SLIDE 19: SP and Child Poverty in Indonesia

- UNICEF Indonesia: Social Protection Country Strategy (Unicef 2012), Comprehensive Child Poverty Analysis (Unicef et al. 2012)
- Main findings:
  - 58% of HH covered by SP, higher incidence for poor and vulnerable groups
  - Transfers used to meet children's nees (food, medical expenses, school fees)
  - Main programmes and % of children covered in 2009: health insurance for poor (9.34), rice for poor (41.22), scholarships (3.65)
  - CCT (PKH): coverage 816'000 HH (2010)
  - Unconditional cash transfer (BLT): compensation for fuel prices increases, time-bound, coverage 18,5 million HH (2009)
- Study recommendations
  - Tackle implementation problems (targeting, overlapping, under-coverage, coordination, distribution) and strengthen M&E
  - Poverty reduction beyond income poverty
  - More focus on long-term SP strategies: health, nutrition, education of poor children, economic assistance for HH
  - Information and awareness raising of families and households about benefits of investing in children
  - Information about recipient's entitlements and rights; facilitation of access (identity cards, transportation etc.)

Let me now in the last part of my presentation summarize briefly the challenges to extending social protection: coverage and adequacy, financing, implementation and governance.

SLIDE 20: Challenges for SP: Coverage and Adequacy

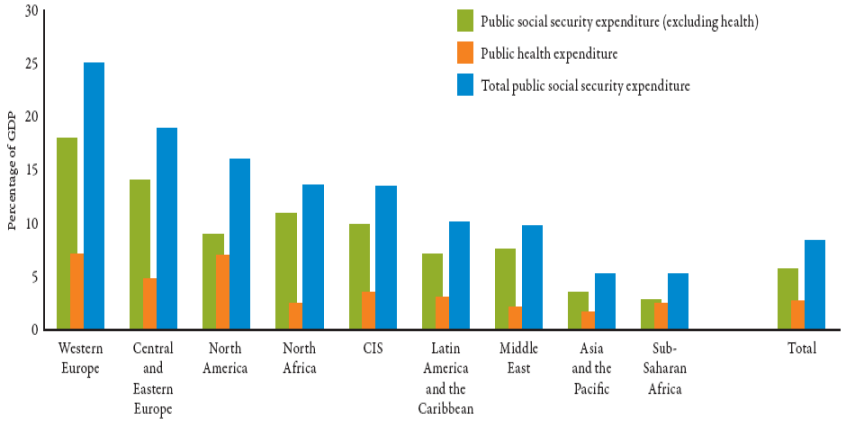
- **Coverage:** difficult to cover groups (especially for contributory social insurance programmes)
  - Migrants
  - Informal workers
  - rural population
  - Vulnerable children: orphans, street children, child workers, child migrants, disabled children, children from excluded families/communities
  - ⇨ILO: only 20% of working population (+ families) has access to comprehensive social security
- **Adequacy:** international benchmarks (ILO), social insurance provides higher benefits, social assistance often not sufficient to lift people out of poverty
  - India NREGA: 1/3 minimum wage; social pensions Asia: ½ Poverty line
  - Brazil: social assisstance benefits linked to minimum wage standard!

SLIDE 21: Challenges for SP: Financing

- Fiscal Space and Affordability: fiscal space increases with income level (graph social expenditure per region)
- BUT: Social expenditure is a policy variable!
- Mobilizing Domestic Resources for SP: taxation, contributions, mineral rents, financial sector/savings/remitttances/OPP
- Aid can complement domestic financing, but in the longer term useful to develop sustainable national financing strategy
- Design of financing instruments: impact on distribution, efficiency, governance!

SLIDE 22: social security expenditure by region

Figure 8.1 Social security expenditure by region, weighted by population, latest available year (percentage of GDP)



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15126

SLIDE 23: Social expenditure is a policy variable

Country	GDP p.c. $	SP exp. % GDP	Health exp. % GDP
Japan	39'714	19,2	7,8
Singapore	35'514	3,5	1,6
Indonesia	2'335	1,2	1,1
Mongolia	1'692	9,6	3,1
Cambodia	731	1,0	2,1
Nepal	463	2,1	1,7

SLIDE 24: Implementation and Governance

- State capacity has three dimensions (UNRISD 2010: 259)
  - Political capacity: coalitions and political settlements to define, adopt, implement policies
  - Resource mobilization capacity
  - Resource allocation and enforcement capacity
- Recommendations:
  - focus on the 3 dimensions instead of broad « good governance » reforms
  - Redistribute power
  - Involve citizens in allocation & monitoring of resources
  - Reform bureaucracy and administration
  - Improve decentralization by involving the poor in local decision-making

I come to my conclusions:

SLIDE 25: CONCLUSIONS: Time for Social Protection in Asia

- Time to scale up social protection in Asia to make growth patterns more inclusive and sustainable. Important to integrate contributory and non-contributory income transfers, access to services, and labour market policies and to strive for universal and rights-based systems
- SP programmes are most effective as an **integral part of a long-term** social protection **strategy**
- SP strategies must
  - be integral to efforts to create sustainable and **employment-intensive growth paths**
  - include the expansion of **basic services** including those that relieve the burden of (unpaid or paid) **care work** particularly of women.
- SP systems need to be built on **financial arrangements** that are themselves sustainable in fiscal and political terms, equitable, and conducive to economic development.
- Political arrangements, strategic alliances and social dialogue are important for building a **national consensus** or social pacts

- **Universal programmes** can generate broad support from groups with ability to pay and political influence; they foster social cohesion and facilitate financing.
- Enhancing equality and equity requires special efforts to guarantee access to social services and transfers for the most disadvantaged: this is part of child-sensitive SP strategy

As I said in the beginning, it is good news that social protection is taken seriously, but it is a long and windy road from agenda-setting and ideas to policies and development results. While we walk down this road it is important not to lose sight of the interlinkages between different policy areas, such as economic and social policies, and to evaluate each programme with regard to its potential contribution to social cohesion, citizen (and child) rights and democratization. It also requires to tackle external factors and to work for a more stable and equitable global system.

It is promising that inequality is taken more seriously in the current debates about a post-2015 agenda. As Richard Jolly put it "though the MDGs are important priorities, concern for children … must be set in a broader frame to reduce inequality and ensure fulfillment of children's rights" (Jolly 2011). Social protection is important, but it should not be reduced to its protective function without considering the other dimensions that are crucial for reducing inequality and poverty: employment-intensive growth and decent work; a social contract that combines sustainable and equitable financing with institutionalized social rights; and empowerment and political voice for non-elite groups and the poor.

REFERENCES:

- ADB. 2013. The Social Protection Index. Assessing Results for Asia and the Pacific. Asian Development Bank.
- Cook, S. and K. Hujo. Forthcoming. Social Protection in Development Context. The Companion to Development Studies. Edited by Vandana Desai and Rob Potter. Third Edition. Taylor & Francis Group.
- DFID 2011. Cash Transfers. Literature Review. Policy Division.
- ILO. 2010. World Social Security Report, 2010-11, Geneva: International Labour Organization.
- Jolly, Richard. 2011. UNICEF, economists and economic policy: bringing children into development strategies. Social and Economic Policy Working Briefs, October 2011.
- UN. 2013. The Millennium Development Goals Report 2013. United Nations, NY.
- UNICEF/SMERU/Bappenas. 2012. National Report Indonesia. Child Poverty and Disparities in Indonesia: Challenges for Inclusive Growth.
- UNICEF. 2012. A social protection engagement strategy for Unicef in Indonesia.
- UNRISD. 2010. Combating Poverty and Inequality.http://www.unrisd.org
- UNRISD. 2012. Inequalities and the Post-2015 Development Agenda. Research and Policy Brief No. 15, October 2012.
- World Bank. 2013. World Development Indicators.

Day I, Tuesday 10 September 2013

THEME 1

Dimensions of Child Poverty

1. **Multidimensional Child Poverty in Papua: Empirical Evidence from 6 Districts**
   Erlangga Agustino Ladiyanto (UNICEF Indonesia)

2. **Inequality and Child Well-Being: The Case of Indonesia**
   Arianto Patunru (Australian National University)

3. **Associations of Child Poverty: Patterns and Differences**
   Grace Hadiwidjaja, World Bank, Jakarta)

1 Multidimensional Child Poverty in Papua: Empirical Evidence from 6 Districts

Erlangga Agustino Ladiyanto
UNICEF Indonesia

Abstract

Childhood poverty is on root of adulthood poverty. It became their barrier and destroyed their opportunities to play successively in adulthood. Poor children are more likely to have worse adult outcomes than non poor children. Poor children with lack of access to survive and develop will likely grow to be poor adult who will more likely to transfer poverty to their children when they become parent. Because of limited sources child poverty in district level in Papua context, this paper would like to explore child poverty analysis using a Multiple Indicators Cluster Survey (MICS) data. The analysis on this paper focused on non-monetary dimension of child poverty and follows the Bristol approach of 8 Dimension of severe and are limited to the dimension of safe drinking water, sanitation facilities, health, shelter, education, information, The findings show that children in Jayawijaya are most deprived in almost all dimension (are most deprived). Jayawijaya also dominates the distribution of poor children from multidimensional perspectives.

Key Words: Multidimensional Poverty, Deprivation, Children, Papua

Introduction

The United Nations Convention on the Rights of the Child (CRC) at 1990 has significant impact to create more attention on fulfilling child rights. Indonesian constitutions provide strong attention on protecting child rights and also had ratified the CRC (Government of Indonesia, 1990). Some government's policies and programs that complementary to protect child right have been launched especially to protect the poor from the impact of 1998 economic crisis (Sparrow, 2006), to provide universal access to basic education (World Bank, 2010) or widening health access for the poor (Sparrow et al, 2010; World Bank, 2011).

Child poverty is evidence on the country cannot provide universal access on fulfilling child rights. With higher attention on child rights, child poverty issues are increasingly discussed and observed in last decade. Studies on child poverty show that child poverty happens not only in third world country but also in developed world (Gordon et al, 2003; UNICEF, 2005a; Eurochild, 2007; Roelen 2010).

Childhood poverty is a root of adulthood poverty. It became their barrier and destroyed their opportunities to play successively in adulthood. Poor children are more likely to have worse adult outcomes than non poor children (Duncan et al 1998; Oshio et al, 2009; Ratcliffe and McKernan 2010) including lower success in labor market than non poor children (Gregg and Machin, 1998). Poor children with lack of access to survive and develop will likely grow to be poor adult who will more likely to transfer poverty to their children when they become parent (Moore, 2005; Bird, 2007).

Poverty has multi-face and multi-dimension and denies children their fundamental human rights. Reducing child poverty means fulfilling child right on required good and service on their survival and development. It also means to provide opportunities for disadvantaged children to participate on society. Without concern to provide universal access to education, health and protection for children, it seems to be impossible to meet equal opportunity for children. In this aspect, governments' roles to provide public services are crucial (Gordon et al, 2003a; 2003b; UNICEF, 2000; UNICEF 2005a, Eurochild, 2007). Unfortunately, even if government provides equal access for children to public access, children are relatively vulnerable to deprivation if they or their parent have obstacle to get benefit from public access (Gordon et al 2003a; 2003b; UNICEF 2005b).

The high level of poverty and challenge on providing access to public services can be found in Tanah Papua. Tanah Papua, the name for the two most eastern provinces of Indonesia (Papua Province and West Papua Province) have higher proportions of populations living below the poverty line than any other provinces in the country (Landiyanto 2011). According Smeru, (2011) Children in Papua is also among the most deprived in Indonesia.

Papua and West Papua Provinces are two of few provinces in Indonesia that have special autonomy status. Special autonomy in Papua and West Papua is a tool of political compromise and the new balancer to accommodate local interests in Papua. As a point of political compromise or balance, Autonomy is expected to be a solution to the various problems faced by Papuans in the past, and also become the basis for the provision or improvement of social, political, economic and cultural. A new development paradigm in Papua is to improve the welfare of native Papuan in which there are provisions that mandated the government to do things related to the rights of the people of Papua in obtaining access to education and health care (Bappeda Papua, 2013).

Contrasting to Law No. 32/ 2004, and PP No. 38/2007) that providing autonomy to district governments, special autonomy in Papua was given to provincial government in which also supported by presidential regulation No. 65 Year 2011 on the Acceleration of Development in Papua and West Papua stating "Accelerated Development in Papua and West Papua Provinces implemented through improved coordination, synergy and synchronization of planning, implementation and control of programs and activities that are derived from various funding sources and agents of development in accordance with the provisions of the legislation in the field of public finance.

Special autonomy law for Papua Province give mandates to Province government that at least 30% of the Papua provincial government revenues from natural resources revenue from the mining of 70% oil and natural gas mining by 70% is allocated for education expenses and 15% for health care costs (Law No 21, 2001, Article 36 Paragraph 2).

Under Special autonomy, Papua and West Province have authority to coordinate districts on the implementation of special autonomy and utilization of special autonomy funds to increase the welfare of Papua people.

Unfortunately, comprehensive child poverty profile did not exist to support government policy to protect the poor children under special autonomy in Papua. The study that discusses more specific aspect on child poverty such as measurement in sub-national level (especially in Papua context) are very limited[1]. The previous study on child poverty and inequality in Indonesia is limited and only discuss on measuring child poverty at national level (Smeru, 2011)[2]. On the other hand, Papua is place where monetary based poverty measurement will be not working well because of inconsistency between high expenditure (high price and lack of supply) and deprivation.

In 2010, UNICEF and Government of Indonesia conducted the piloting of multiple indicators cluster survey (MICS) in Tanah Papua. MICS would be able to provide rich data on health, education, child protection, HIV and AIDS data at district level. MICS conducted in 3 districts in Papua Province and 3 Districts Tanah Papua. MICS also filled the data gap and open opportunity to conduct child poverty measurement at districts level and compare the situation among districts.

Therefore, the research objectives for this study are to identify on the methods on how to measure child poverty and identify the characteristics of poor children based on multiple indicators cluster survey (MICS) in the Tanah Papua context. Based on the findings from this study, it will be expected to provide policy recommendation the appropriate strategy to reduce child poverty and to protect poor children in Tanah Papua.

Literature review

The conceptual debate of poverty measurement rose rapidly since 1970 (Maxwell, 1999). Sen (1979b) proposed two methods to measure poverty. First is direct methods, that is identify whose consumption fails to meet minimum needs. The second method is money methods. Using money methods, the people classified as poor and non poor based on poverty line. People who have

[1]Base on Google search with keyword "Child Poverty Indonesia"

[2]The first child poverty study in Indonesia is conducted by Smeru Research Institute in 2010 with support from UNICEF. The report will be available by 2011. The statement is based on author's observation on the Smeru's report.

income below poverty line would be categorized as poor. Non poor classification is for who have income higher than poverty line. Fusco (2003) classified poverty as traditional a dimensional approach that usually use a single monetary indicators and more recent multidimensional approach. Followed Sen (1979a), Ravallion (1994) and Haughton and Khandker (2009) stated that poverty could be classified as welfarist approach that focus on measuring input to generating "utility" and nonwelfarist approach that focus to measure the reflection of attainment of certain level of "utility."

Consistent with Coudouel, et al (2002), those classifications above (Sen, 1979a, 1979b, Ravallion, 1994; and Haughton and Khandker 2009) can be simplified as monetary approach for poverty measurement for which is consistent with Sen's welfarist classification and non-monetary approach for which is consistent with Sen's non-welfarist approach.

Monetary approach is widely used for poverty measurement. According sen (1979b), the advantage of monetary approach is ability to provide numerical distance from poverty line, in which non-monetary line doesn't provide. Thorbecke (2005) explained that the common approach to measure proxy of income is through aggregation of goods and services consumed or enjoyed by individual that measured in single indicator of monetary value.

Despite the advantages, monetary approach also has some identified weakness. Fusco (2003) and Thorbecke (2005) stated that poverty has multidimensional faces and cannot be measured by singe income indicator. The monetary approach works on basic assumption of equal access of goods and services. When the market goods and services work imperfectly, the same threshold of income cannot generate equal access to utility. Delamonica et al, (2006) argued that the monetary approach gives little consideration to household structure, gender, and age. In child poverty context, It ignores that children's needs are different from those of adults.

Non-monetary poverty measurement provides wider perspective of poverty. The evolution of non-monetary poverty measurement brings holistic approach to capture multi-dimensional aspects of poverty. Poverty can be seen from the wider perspectives such as sufficiency of basic needs, access to education, health, access to political participation (Fusco, 2004; Thorbecke, 2005; Wordsworth et al, 2005) and also includes capabilities variables that may not be so easily measurable – like the capability to participate in society without facing discrimination (Delamonica et al, 2006).

Ravallion, 1994 and Haughton and Khandker (2009) perceived that although the non-monetary approach might useful to measure certain multidimensional picture of poverty, the interpretation will be demanding since possibility of bias because imperfection from input to output.

The debate and evolution of poverty measurement bring new dimension on how to measure children living in poverty (Delamonica et al, 2006). They argued that child poverty should be measured as a multi-perspectives problem that requires comprehensive strategies to address its many features. Their argument conceptually ideal but bring a big question as explained by Roelen (2010) on how to implement the analysis since the debate on monetary versus non-monetary approach also occurs on measuring child poverty. As summary, **Table 1** provides some literature surveys of the debates on how to measure child poverty using survey data.

Table 1. Debates on Methods for Measuring Child Poverty using Survey Data

	Dimension	Advantages	Disadvantages	Sources
Monetary				
Per-capita Approaches	Household Income/ expenditure. Usually based on poverty line	Simple to compare	Cannot capture non-economic dimension	UNICEF, (2000b; 2005c)
Child Cost	Household expenditure on children	More accurate than percapita approaches	Need more detail expenditure data	Lino, 2011
Equivalence Scales	Incremental cost of children	Regard household size and ages	Need more detail expenditure data	White and Masset, (2002a; 2002b)
Non-Monetary				
Bristol Approach	8 Dimension of Deprivation: • Food • safe drinking water, • sanitation facilities, • health, • shelter, • education, • information, • access to services.	Can be generated from household survey data	Did not cover exclusion	Gordon et al, (2003a ; 2003b); UNICEF, (2005a)
Child Well Being Approach	Dimensions of Well Being: • Material well being • Health and safety • educational well being • family and peer relationship • Behavior and risk • Subjective wellbeing.	Provide comprehensive picture	Need specific data collection on subjective well being	Bradsaw et al (2006), UNICEF (2007)
DEV Framework	• Deprivation • Exclusion • Vulnerability	Provide comprehensive picture	Difficult for operationalize	Wordsworth et al (2005)
Young lives multidimensional poverty	• Nutritional status • Physical morbidity • Mental morbidity • Life skills (literacy, numeracy, work skills etc) • Developmental stage for age • Perceptions of well-being and life chances	Provide comprehensive picture	Need comprehensive data	Young lives (2011)

Source: Multiple References, compiled by author

Roelen (2010) compared the result of monetary and multidimensional non-monetary approach in Vietnam. She found that each method provide different picture of poverty that lead to different conclusion that means that multidimensional non-monetary approach cannot serve as proxy of monetary approach and vice versa. Therefore, review and testing each child poverty measurement approach based on local situation and data availability will be essential strategy to eradicate child poverty.

Although the UNICEF global approach for measuring child poverty are using Bristol methods, adaptation of the methods based on data availability and local situation in Papua are very crucial. Multiple indicator cluster survey (MICS) in Papua will be important sources to fill data gap for conducting child poverty measurement. Therefore, adapting UNICEF global child poverty measurement approach based on MICS and local context will be rational strategy for the optimization of MICS data utilization and policy advocacy to address child poverty in Papua.

Methodology

This paper would like to explore child poverty analysis using a Multiple Indicators Cluster Survey (MICS) data that collected by BPS in Papua and West Papua in 2011 with support from UNICEF. The sample size is 5912 households from 6 districts in Papua Province (Biak, Merauke and Jayawijaya) and West Papua Province (Manokwari, Kaimana and Sorong). The analysis focused on selected cases of 10628 children under 18 and households that have children under 18 years old that extracted from the MICS data set.

Following Gordon et al (2003b)'severe deprivation of basic human need in this paper is defined as those circumstances that are highly likely to have serious adverse consequences for the health, well-being and development of children. Severe deprivations are causally related to both short-term and long-term poor developmental outcomes of children.

The analysis on this paper focus on non-monetary dimension of child poverty and follows the Bristol approach of 8 Dimension of severe deprivation and its thresholds (Gordon et al, 2003a; 2003b) that widely used on UNICEF's sponsored in global studies in child poverty. Since MICS data of Papua did not adequately provide food (anthropometrics measurement) and access to services indicators, the analysis in this paper are limited to the following dimensions and selected indicators in which will be analyzed from both uni-dimensional and multi-dimensional lens:

- Safe drinking water ➔ Severe Water Deprivation - children who only had access to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was more than 15 minutes away (e.g. indicators of severe deprivation of water quality or quantity).
- Sanitation ➔ Deprivation of Sanitation Facilities – children who had no access to a toilet of any kind in the vicinity of their dwelling, e.g. no private or communal toilets or latrines.
- Health ➔ Severe Health Deprivation – children who had not been immunized against any diseases or young children who had a recent illness involving diarrhea and had not received any medical advice or treatment.
- Shelter ➔ Severe Shelter Deprivation – children in dwellings with more than five people per room (severe overcrowding) or with no flooring material (e.g. a mud floor).

- Education ➔ Severe Education Deprivation – children aged between 7 and 18 who had never been to school and were not currently attending school (e.g. no professional education of any kind).
- Information ➔ Severe Information Deprivation – children aged between 3 and 18 with no access to, radio, television, telephone or newspapers at home.

Gordon et al (2003a; 2003b) argued that children who suffer from these levels of severe deprivation are very likely to be living in absolute poverty because, in the overwhelming majority of cases, the cause of severe deprivation of basic human need is invariably a result of lack of resources/income. Gordon et al (ibid) also argued that there may also be some children in this situation due to discrimination, (particularly girls suffering severe education deprivation) or due to disease (severe malnutrition can be caused by some diseases). Therefore, they assumed that a child is living in absolute poverty only if he or she suffers from multiple deprivations (for example two or more severe deprivations of basic human need as defined above). Similarly, a household with children is defined as living in absolute poverty if the children in that household suffer from two or more severe deprivations of basic human need.

Alkire and Forster (2011) identified three criterions for identify persons who are multidemensionally poor. The first identification criterion is called union method of identification in which for example was used by Bourguignon and Charavarty (2003). In this approach, a person is said to be multidimensionally poor if there is at least one dimension in which the person is deprived. The other multidimensional identification method is the intersection approach, which identifies a person as being poor only if the person is deprived in all dimensions. A natural alternative is to use an intermediate poverty cutoff level of k between 1 and d dimensions (k=1,…,d). Following the Gordon et al (2003a; 2003b), children will be categorized as deprived if he do suffer according the criteria of union method of identification (k=1) but children will categorized as absolute poor if meet poverty criteria of intersection approach with k=2.

Findings and Analysis

Children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive and develop. It leave them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society (Badame et al, 2005). Household level monetary based poverty analysis will not adequate for supporting child specific social protection because it's left high exclusion of poor children from non-monetary poor household. Especially for areas in which frequently and deprivation are not consistent. Therefore, identification of non monetary dimension and deprivation are very crucial to strengthen targeting and support the child poverty reduction in Papua.

Table 2: Correlation among Child Poverty Indicators (Children)

	Water	Sanitation	Health	Edu	Shelter	Info
Water	1					
Sanitation	.312**	1				
Health	.285**	.262**	1			
Education	.246**	.230**	.b	1		
Shelter	.037**	.103**	.025	.073**	1	
Information	.296**	.405**	.272**	.259**	.129**	1

**. Correlation is significant at the 0.01 level (2-tailed).
b. Cannot be computed because different age groups

Table 2 shows correlation among the indicators of child poverty. Consistent with findings in other country (Roelen 2010), the correlations between severely deprived in accessing water and severely deprived in sanitation without access to any toilet those are considerably high. Additionally, correlation between severely deprived in information, it means without access to, radio, television, telephone or newspapers at home to sanitation is also very high, even it has the highest correlation. On the other hand, the correlation between shelter deprivation and health deprivation on without access on immunization is low in which not surprising since in Papua, lack of immunization is also depend on the quality of health services outreach.

Table 3: Deprivation Headcount of Individual Indicators of Children (%)

	Water	Sanitation	Health	Edu	Shelter	Info
Merauke	12.3	7.4	3.7	2.6	10.7	11.5
Kaimana	6.8	29.6	19.1	2.9	5.8	12.4
Manokwari	3.3	20.3	17.3	2.2	5.1	10
Jayawijaya	38.7	58.1	34.9	16.2	8.8	45.5
Sorong	3.6	9.4	8.3	1.8	5.8	12
Biak	4.2	11.1	7.4	2.1	7.6	12.7
Urban	1	7.5	9.7	1.3	6.2	3.1
Rural	14.9	27.1	16.9	5.4	7.8	21.9
Total	10.5	20.9	14.5	4.1	7.3	16

Source: MICS data 2011, calculated by author

The relationship between clean water, health and poverty has known for a long time. **Table 3** shows that about 38 percent of children in Jayawijaya severely deprived in access of water and only had surface water as drinking water sources, it much higher if compared to Sorong with only 3.6 percent of children. According Gordon et al (2003b) deprivation in water is evidence that health services are unable to meet the basic needs of the population and diseases resulting from a lack of water contribute to the overburdening of the system. Sick children are unable to attend school, so affecting their education and further limiting what opportunities they have. Where people are water deprived, the burden of collecting and transporting water often falls on women and children and fetching water is a activity that takes up valuable time which could be spent at school or working.

Access to improved sanitation facilities has been shown to be the critical factor in improving child health. An improved sanitation facility is defined as one that hygienically separates human excreta from human contact. Improved sanitation facilities for excreta disposal include flush or pour flush to a piped sewer system, septic tank, or pit latrine; ventilated improved pit latrine, pit latrine with slab, and use of a composting toilet. In general, 27 percent of children in rural area in Papua did not have access to improved sanitation in which larger if comparing 7.5 percent of children in urban area. Representing highland area, 58% of children in Jayawijaya is severely deprived in sanitation without access to any toilet that are very high if compared with Merauke that have only 7.4 percent deprived children in sanitation.

Education can have significant benefits with respect to the wider goals of development. Gordon et al (2003b) argued that this is particularly the case when the education of women is improved. The mother's role in relation to her children is significant because it is she who will be responsible for making sure that they have been fed, attended school or are taken to the health services in times of illness. A child who has had no basic formal education is highly likely to be illiterate and have his or her development impaired by modern standards. **Table 3** shows that although in general is only about 4 percent of children age 7-18 years old are severely deprived in education and never been went to schools, in some areas the situation are worse. For example in Jayawijaya, 16 percent of children never went to schools. This figure would much be higher when also regard children who ever attended primary schools but drop out.

Immunization against the main childhood diseases is a universally recommended and cost-effective public health priority, for which internationally agreed targets exist. Immunization plays a key part in reducing under-five and infant mortality. Unfortunately, about 14.5 percent of children in six observed districts never get any immunization. Children in rural area were less likely to get any immunization comparing to urban area. Even in Jayawijaya districts the situation was worse, about 34 percent of children are also severely deprived in health without access to any immunization.

Gordon et al (2003b) argued that a crowded dwelling (more than five people per room) an indicator of severe quantity deprivation of shelter since it highly correlated to slum and poverty. As informed at **table 3**, 7.3 percent of children in Papua, 7.8 percent in rural area and 6.2 percent in urban area, living in overcrowded with more 5 people per-room and poor quality housing. Borrowing Gordon et al (ibid) severe crowding increase risk of fire (firing) and accidents. Those children with a lack of basic services are exposed to diseases such as diarrhea, respiratory infections, measles, malaria, cholera and dengue fever.

Gordon et al (2003b) also argued that lack of access to information is considered to be a characteristic of absolute poverty. Children's access to information is seen as both a basic human right and an important requirement for children's especially for modern societies. Modern societies require a well educated and informed population in order to prosper and eradicate poverty. Children in Papua need access to information in order to know and understand about the world outside their own communities. Unfortunately about 16 percent of children in Papua did not have any access to information with higher proportion in rural area. The largest proportion of children without access of information is in Jayawijaya, one of highland districts of Papua, in which about 45 percent, largest among six observed districts.

Table 4 shows correlation among the indicators of households with poor children. The correlations between severely deprived in accessing of water severely deprived in sanitation without access to any toilet that are considerably high. Additionally, correlation between severely deprived in information, it means without access to, radio, television, telephone or newspapers at home to sanitation is also very high, even it has the highest correlation.

Table 4: Correlation among Child Poverty Indicators (Households with Children)

	Water	Sanitation	Health	Edu	Shelter	Info
Water	1					
Sanitation	.348**	1				
Health	.287**	.335**	1			
Education	.246**	.252**	.c	1		
Shelter	.034*	.084**	-.015	.084**	1	
Information	.303**	.438**	.336**	.264**	.110**	1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
c. Cannot be computed because different age groups

Unsafe drinking water can be a significant carrier of diseases. Drinking water can also be tainted with contaminants with harmful effects on human health. Household level analysis in **Table 5** shows similar result compared to individual children analysis in **Table 3**. About 40 percent households who have children in Jayawijaya severely deprived in access of water and only had surface water as drinking water sources, it much higher if compared to Sorong with only 2.4 percent of households. Safe drinking water is a basic necessity for good health. In addition to its association with disease, access to drinking water may be particularly important for women and children, especially in rural areas, who bear the primary responsibility for carrying water, often for long distances.

Table 5: Deprivation Headcount of Individual Indicators of Households (that have children) with Poor Children (%)

	Water	Sanitation	Health	Edu	Shelter	Info
Merauke	10.1	5.2	2	2.9	6.3	9.3
Kaimana	6.6	27.3	11.2	3.2	4.2	11.6
Manokwari	3.2	19.4	9.2	2.9	2.8	9.2
Jayawijaya	40.0	60.9	20.4	15	6.1	42.9
Sorong	2.4	6.5	3.7	2.2	3.4	7.8
Biak	3.5	10.4	5.4	2.6	5.2	11.9
Urban	0.7	6.9	5.8	1.7	4	3
Rural	14.5	25.7	9.1	5.8	4.9	19.6
Total	10.1	19.7	8.1	4.5	4.6	14.4

Source: MICS data, calculated by author

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrheal diseases and polio. Improved sanitation can reduce diarrheal disease by more than a third, and can significantly lessen the adverse health impacts of other disorders responsible for death and disease among children. **Table 5** shows 60 percent households with of children in Jayawijaya is also severely deprived in sanitation without access to any toilet that are very high if compared with Merauke that have only 5.2 percent deprived children.

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the Millennium Development Goals and A World Fit for Children. Education is a vital prerequisite for combating poverty as well as empowering women and protecting children. 5.8 percent of households with have severely deprived children who are 7-18 years old but never went school. Even in the jayawijaya, the situation are worse, 15 percent households are severely deprived in education because their children never had been went to schools.

Out of all selected districts, the survey results show that Jayawijaya district tended to have most deprived households in health with 20.4 percent households with deprived children under 5 years old without access to any immunization, while the most deprived household in West Papua is Kaimana (11.2 percent).

Children in those districts are also deprived in other dimensions such shelter and information. 4.6 percent of households in targeted districts are deprived in information in shelter. Additionally 14 percent of households in targeted districts are deprived in information in which particularly in rural area with 19 percent.

Table 6: Poverty Headcount

	% Poor Children			% Household with Poor Children		
	K=1	K=2	K=3	K=1	K=2	K-3
Merauke	30.6	10.2	3.8	24.7	7.0	2.9
Kaimana	47.7	16.1	3.9	45	15.5	3.1
Manokwari	32.7	10.5	3.4	31	10.8	3.7
Jayawijaya	70.9	55.9	34.0	73.9	58.5	35.5
Sorong	26.8	7.9	2.2	19.2	4.8	1.6
Biak	32.4	8	2.0	29.5	7.2	1.7
Urban	18.8	3.9	0.9	17.2	3.7	1.0
Rural	47.1	22.3	10.4	43.4	21.3	10.3
Total	38.1	16.4	7.4	35.1	15.7	7.4

Source: MICS data 2011, calculated by author

Table 1 shows that proportion of poor children and proportion of household with poor children in rural areas are higher than in urban area. With K=1 (poor in one of six child poverty indicators) for poverty cut off point (union approach), more than 47 percent of children in rural area categorized as poor in which higher than 18 percent in urban areas. When use K=2 (poor in two of six child poverty indicators) as cut off point, more than 22.3 percent of children in rural area categorized as poor comparing to only 3.9 percent of poor children in urban area.

Consistent to dominance of Jayawijaya on uni-dimensional child poverty indicators, Jayawijaya has highest incidence of multidimensional poverty. Using K=1 for poverty cut off point, more than 70 percent of children in Jayawijaya categorized as poor. Using K=2 as cut off point more than 55 percent of children in Jayawijaya categorized as multidimensional poor under two of 6 child poverty indicators.

Gordon et al (2003b) identify four groups of child poverty. The first groups are demographic factors: such as age, gender, number of adults and children, family structure – child poverty can result if there are too few adults compared with the numbers of children to both adequately care for the children and provide sufficient economic resources to prevent poverty. Despite the various programs under special autonomy initiated to improve the children health condition and survival, and the special attention and assistance being directed to the poor, children in remote areas and highland, in income (asset) poor households are still more deprived.

According Gordon et al (2003b), second cause of child poverty is social class/socioeconomic status: such as occupation and educational attainment or asset. Child poverty can result from parental occupations with low earnings or asset in which can be explained more by **table 7** and **table 8**.

Table 7: Deprivation Headcount of Individual Indicators of Children by Asset (%)

Quintile	Water	Sanitation	Health	Edu	Shelter	Info
Poorest	33.1	68.8	37.8	15.1	12.9	56.6
Second	9.7	20.4	10.4	2.6	9.7	15.0
Middle	5.2	7.0	9.0	1.9	6.2	3.9
Fourth	1.5	2.6	6.0	0.1	4.6	0.0
Richest	0.0	0.0	5.5	0.3	1.9	0.0

Source: MICS data 2011, calculated by author

People who are defined as living in poverty by different measures of poverty are different. This inevitably means that the policy response to poverty will be different depending on which measure is employed. Asset based approach for poverty measurement using wealth indexes identify poor people based as who are at poorest and second lowest quintile. Interestingly, **Table 7** shows that there are some children who are in in middle, fourth and richest quintile that are not categorized as poor based on wealth indexes, deprived in child poverty indicators.

Consistent to **table 7**, **table 8** shows that there are significant exclusions from quintile based wealth indexes when numbers of children poor in one of 6 child poverty indicators for K-1 poverty cut off point (union approach) when are not categorized poor based on wealth indexes from asset perspectives. There are 25 percent of children in middle quintile, 11.9 children in fourth quintile and 4.6 percent of children in richest categorized as poor from non-monetary perspectives with K=1. Even when measuring multidimensional poverty using K=2, there are some poor children in middle and fourth quintile.

Table 8: Poverty Headcount of Children by Asset

Quintile	K=1	K=2	K=3	K-4
Poorest	90.4	63.0	33.0	11.9
Second	50.2	11.3	1.9	0.3
Middle	25.7	2.8	0.1	0.0
Fourth	11.9	0.7	0.0	0.0
Richest	4.6	0.1	0.0	0.0

Source: MICS data 2011, calculated by author

The third cause of child poverty (Gordon et al, 2003b) is recognition factors: such as ethnicity and religion. Child poverty can occur because of discrimination against low status ethnicities, religions, in which there factors have not been adequately discussed in this paper. The fourth cause (ibid) is geographic factors: such as location, region in which need to discussed more. Child poverty can result due to a lack of infrastructure or lack of public services such as no schools or no health facilities in the difficult to access area such as in some parts of highland area of Papua.

Implications and Policy Recommendation

This paper was written with some limitations from methodological perspective, first limitation is unable to conduct overlap and exclusion analysis since there no income and expenditure data in data set, but instead, this paper tried to conduct overlap analysis between child poverty indicators and wealth quintile based on household asset. Second limitation is missing of nutrition dimensions as required on Bristol approach of child poverty because it is not available in the dataset. Additional indicators as defined by Bristol approach need to be integrated in the further research. With nutrition indicators and other indicators that need to be explore, analysis will be more comprehensive.

Papua has very specific social capital, local custom and culture. Therefore poverty reduction strategy for Papua should be local specific. Social capital, local customs and culture are important aspect to be regarded. Further research should elaborate those aspects on child poverty analysis in Papua context as supporting evidence to create stronger poverty reduction strategy.

Identification of additionally non monetary dimension and deprivation that fit into Papua context and have not captured on Bristol approach of 8 dimension of severe deprivation and its thresholds such as distance to schools, are very crucial to strengthen targeting and support the elevation in Papua. Additionally, it is important in further research to consider dimensions and indicators for special protection for children such as birth certificates, violence to be integrated into child poverty measurement to ensure its integration with child protection. Adoption child well being approach is also will be value added for this research.

The fact that poor children are not always part of poor household because of exclusion from monetary based poverty targeting should be addressed well through its integration with non-monetary based poverty on the targeting for social protection and policy development in Papua. The regular government surveys and special data collection for poverty targeting also should be able to provide required information for integration of monetary based and non-monetary based poverty measurement.

Delamonica et al (2006) argued poverty reduction strategies and development planning neglected, or simply did not prioritize the special needs of children living in poverty and the need to adopt direct policies to deal with child poverty. Basically, the initiative and policy strategies to reduce child poverty can be classified as follow:

Development Strategy and Planning

Espey et al (2010) argued that many evidence show that child issues not sufficiently addressed in development planning documents. Most of them tended to focus only on some dimensions of child wellbeing such as access to education and health, and perhaps limited safety nets for vulnerable children, without providing more comprehensive dimensions of child development, wellbeing and poverty reduction. According Espey et al (ibid), one of the important aspects of defining child poverty in the policy document is that it has an impact on the goals and objectives poverty reduction strategies, as well as the development of indicators for tracking the success of poverty reduction strategies.

Therefore the existence of child poverty in policy document should encourage policy makers and organizations to directly address the special needs of Papuan children. Therefore, it is recommended for better integration of child rights and conceptual framework for the poverty reduction strategic plan at provincial and district level, and development planning cycle. Additionally, it is important to increase child protection mainstreaming and child focus into the regular planning document such as RPJMD and RKPD at province and district level.

Budgeting and Social Investment

Every child should have opportunity to break the poverty cycle. The government plays a critical role in achieving this goals and the budget is one of its main instruments. The budget is linked to most of public policy for alleviate child poverty. The Financing for development must aim to give children a healthy start in life. It means that the goals and priorities to eradicate child poverty and fulfill child rights are better reflected in public policymaking, notably in the government budget (UNICEF 2002, UNICEF, 2010).

In order to do that, the government need to increase the effectiveness of budget utilization for health and education at provincial and district level to achieve the level required. In education sectors, government needs to increase the effectiveness of BOSDA. BOSDA is A School operational assistance block grant (BOS) was introduced in 2005 as part of a major school finance reform measure, and is allocated to all schools based on total numbers of students enrolled. The BOS program provides funding to schools for non-salary operational expenditures. It aims to reduce schools fees as well as supports quality-enhancing spending for all public and private primary and junior secondary schools in Indonesia. In Papua, some districts are allocated budget for BOSDA because the substantial resources provided by BOS could not compensate schools for differences in school operating costs associated with the populations they served and their location. For example, the costs of providing basic education (e.g. supplies and travel costs for teachers) in small, remote and rural schools are often higher than in larger, more urban schools. BOSDA provided by provincial or districts as supplement of BOS fund to cover the gap of variability of the cost, especially for rural and remote schools. The transparency and monitoring and evaluation of the implementation of education services service also should be increased in order to improve compliance to the education.

In more specific in health sectors, The budget allocation for child and maternal health should be increased and more equally allocated between curative and preventive efforts; The implementation of primary health care in should be supported by provincial supplement of

operational fund for health (BOK). BOK is a central grant initiated in 2010 to support the operational costs of all public community health centers (Puskesmas) in Indonesia. With a focus on promotive health measures and outreach, it funds preventive health services in Puskesmas, such as maternal and child health, immunizations, nutrition, disease control, and environmental health. The BOK grant cannot be used for curative services, salaries, medicine, vaccines, or health tools but the money can be used for materials for health education within the community, food for meetings, and transportation fees for health volunteers in which directly benefit to the targeted population. The goals of the BOK grant are to ensure that the minimum healthy service standards (SMP) are met at the district level and to meet national health targets. Unfortunately, there is no local (provincial or districts for of BOK) to cover the gap of variability of the cost, especially for rural and remote area in Papua. Therefore, provincial government of Papua needs to do cost analysis and implement BOK especially for health care in rural and remote area.

Universal Access to Public Services

It means child have rights opportunities to access of goods and social services without discrimination. At a minimum, children need a package of basic social services of good quality health care, education and safe water and adequate sanitation, so that they can fulfill to basic right and grow to their full potential, free of disease, malnutrition, illiteracy and deprivation. Without concern to provide universal access to education, health and protection for children, it seems to be impossible to meet equal opportunity for children. In this aspect, governments' roles to provide public services are crucial (UNICEF, 2002; Gordon et al, 2003a; UNICEF, 2000a; UNICEF 2005a, Eurochild, 2007).

There is a need for the provincial government to enhance the education and health access by expanding the availability of educational and health service; to devote more attention to children of the poorest household and those living in highland area. In education sectors, government need to guarantee their participation on formal primary education; to overcome distance problem by providing "one roof school" (primary/junior secondary/high school in one building), providing a dormitory or a free school bus for student living in distant; to increase high school enrollment the government should consider more progressive effort to significantly reduce the school fee, Overall, improving and equalizing school and teaching quality is very critical. This can be done by as improving the quality and distribution of teacher. In health sectors government need to develop more facilities in remote regions, distribute health personnel more equally, and increase the availability of medical equipment for respiratory aid in health centers and in every village and also overcome distance problem, such as flying health care to reach population in remote area. Finally, the involvement of civil society including non-government institution and the community is very important in all the efforts.

Social Protection

Social protection intersects broader traditional debates around, among others, public policies, development strategies and aid effectiveness. The overall frameworks that emerge point to multiple objectives – spanning over assistance, insurance and social transformation A broader approach to social protection that protection the poor children could complement health and education-related social protection programmes to mitigate vulnerabilities more effectively In fact, a more systematized approach to current social assistance and social action interventions that provides some preventive and protective support to the vulnerable is crucial to the development of more structured social protection strategy (Pereznieto, 2009; Gentilini and Omamo, 2011).

The focus on minimum standards and non-discrimination suggests that targeting the poorest and marginalized children may be required in order progressively to attain universal minimum standards. However, there is a technical problem as to whether targeted programmes actually reach the most vulnerable children, providing universal access may in fact provide better coverage than targeted ones (Piron, 2004). For household, investment in human capital is costly and uncertain, even if government provides equal access for children to public access, children are relatively vulnerable to deprivation if they or their parent have obstacle to get benefit from public access and it is therefore understandable that poorer households are less able to make such investments and specific targeted social protection is still needed (Barrientos and DeJong, 2004; Gordon et al 2003a; UNICEF 2005b).

Devereux and Sabates-Wheeler's (2004) proposed transformative framework of social protection, which classifies approaches to social protection as protective (to protect people from acute poverty and deprivation); preventative (to avert deprivation); promotive (to enhance income and capabilities so people are less vulnerable to risks); and transformative (to reduce vulnerability by improving the structural position of disadvantaged groups), and included a mapping of some of the main social protection interventions, such as social assistance, social services, social insurance and social equity measures. Related to social protection, government need to consider the following recommendation:

- It is important to transform Rice for the poor (Raskin) program, subsidized rice distributed as a food security measure to some poor families, into strengthening local food and nutrition strengthening to increase food security.
- Improving national led Scholarships for the poor (BSM) with supplement from social autonomy fund with a certain standard with regards of local context.
- Additionally, government also need to increase the effectiveness Papuan health insurance schemes for referral health system so that all income poor households receive and use it and integrated it with forthcoming BPJS scheme.
- Integrated Universal free coverage of maternity care and delivery (Jampersal) that was instituted at national level as an emergency measure to boost progress in reducing maternal and child mortality rates with Papuan health card scheme
- Papua Province should be adjust national based conditional cash transfer, family hope programme (program keluarga harapan), to fit to the local context.

References

Alkire, S., and J. Foster (2011)." Counting and multidimensional poverty measures". *Journal of Public Economics* 95 pp 476–487

Badame, A., Calabrese, M., Capellan, V., Cela, B and Macio, T (2005) "Are Poverty Reduction Strategy Papers Impacting Child Poverty? A Nicaraguan Case Study" United Nations Children's Fund (UNICEF), Global Policy Section, New York, 2005

Barrientos, A. and DeJong, J., (2004) "Child Poverty and Cash Transfers", CHIP Report no. 4, Childhood Poverty Research and Policy Centre (CHIP)

Bird, Kate (2007) "*Intergenerational Transfer of Poverty: An Overview*." Overseas Development Institute, CPRC Working Paper 99, October 2007

Bradshaw, J., Hoelscher, P., and Richardson, R. (2006) "*Comparing Child Well-Being in OECD Countries: Concepts and Methods*", Innocenti Working Paper No. 2006-03, UNICEF Innocenti Research Centre, Florence

.

Coudouel, A., Hentschel, J and Wodon, Q (2002) "*Poverty Measurement and Analysis*" in PRSP Sourcebook, World Bank, Washington DC.

Bourguignon, Francois and Charavarty, Satya (2003) "The measurement of multidimensional poverty" *Journal of Economic Inequality* **1:** 25–49.

Delamonica, E., Minujin, Davidziuk, A., Gonzalez, D. (2006) "*Children living in poverty: Overview of definitions, Measurements and policy*" UNICEF: Division of Policy and Planning, June 2006

Duncan, G, J., Gunn, J, B., Yeung., W.J and Smith, J, R., (1998) "How Much Does Childhood Poverty Affect the Life Chances of Children?" *American Sociological Review*, 1998, Vol 63 (June 406-423)

Devereux, Stephen and Sabates-Wheeler, Rachel (2004) "*Transformative social protection*" IDS Working Paper 232, October 2004

Espey, J., Pereznieto,P., Harper, C., Jones, N. and Walker, D (2010) "Improving the prominence of child rights in poverty reduction strategy processes" Overseas Development Institute, Background Note, June 2010

Eurochild (2007) "*A Child Rights Approach to Child Poverty*" Discussion Paper, Eurochild[AISBL], 2007

Fusco, Allesio (2003) "*On the definition and measurement of poverty: The contribution of multidimensional analysis*" Presented at 3rd Conference on the Capability Approach: From Sustainable Development to Sustainable Freedom; 7-9 September 2003, University of Pavia

Gentilini and Omamo, (2011) "*Social protection 2.0: Exploring issues, evidence and debates in a globalizing world*" Food Policy 36 (2011), pp. 329-340

Gunn, J, B and Duncan, G, J "The Effect of Poverty on Children" The Future of Children *Children and Poverty* Vol. 7 • No. 2 – Summer/Fall 1997

Gregg, Paul and Machin, Stephen (1998) "*Child Development and Success or Failure in the Youth Labour Market*" Centre for Economic Performance, London School of Economics and Political Science, July 1998

Gordon, D., Nandy, S., Pantazis, C., Pemberton, S., Townsend., P (2003a): "*Child Poverty in the Developing World*", The Policy Press, Bristol.

Gordon, D., Nandy, S., Pantazis, C., Pemberton, S. and Townsend, P. (2003b) "*The distribution of child poverty in the developing world*" Bristol: University of Bristol.

Haughton, Jonathan and Khandker, Sahidur (2009) "*Handbook on Poverty and Inequality*" International Bank for Reconstruction and Development, the World Bank

Liu, Haiyong (2009) "*Growing Up Poor and Childhood Weight Problems*" Institute for Research on Poverty Discussion Paper No. DP 1324-07, University of Wisconsin Madison

Maksum, Chairul (2004) "*Official Poverty Measurement in Indonesia*" Paper Presented at 2004 International Conference on Official Poverty Statistics, 4-6 October 2004, EDSA, Shangri-la Hotel, Mandaluyong City, Philipines.

Landiyanto, E, A (2011) "*Strengthening Evidence Based Social Policy in Tanah Papua*" UNICEF Papua Office Concept Note

Maxwell (1999) "*the Meaning and Measurement of Poverty*" ODI Poverty Briefing, 3: February 1999

Moore, Karen (2005) "*Thinking about youth poverty through the lenses of chronic life-course poverty and intergenerational poverty*" CPRC Working Paper 57, Chronic Poverty Research Centre, the University of Manchester.

Oshio, Takashi., Sano, Shinpei., and Kobayashi, Miki (2009) "*Child poverty as a determinant of life outcomes: Evidence from nationwide surveys in Japan*" Institute of Economic Research, Hitotsubashi University,

Pereznieto (2009) "Social protection to tackle child poverty in Mali" Overseas Development Institute, Project Briefing No. 25, September 2009

Piron, Laure-Helene (2004) "*Rights Based Approach to Social Protection*" Overseas Development Institute

Ratcliffe, Caroline and Signe-Mary, McKernan (2010) "*Childhood Poverty Persistence: Facts and Consequences*" The Urban Institute: Brief 14, June 2010

Ravallion, Martin (1992) "*Poverty Comparison: Guide to Concept and methods*" Living Standards Measurement Study Working Paper No. 88, February 1992

Roelen (2010) "*False Positives or Hidden Dimensions: the definition and measurement of child poverty*" PhD Dissertation, University of Maastricht.

Sen, Amartya (1979a) "Personal Utilities and Public Judgements: Or What's Wrong with Welfare Economics?", The Economic Journal Vol. 89, 1979, pp: 537-558.

Sen, Amartya (1979b) "Issues in the Measurement of Poverty" *Scotland Journal of Economics* 1979, pp: 285-307

Smeru (2011) "*Child Poverty and Disparity in Indonesia*" Draft: Smeru research institute 2011

Sparrow, Robert (2006) "*Health, Education and Economic Crisis: Protecting the Poor in Indonesia*" PhD Dissertation, Vrije University Amsterdam, the Netherlands

Sparrow, R., Suryahadi, A., Widyanti, W (2010) "*Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Program*" Smeru Research Institute Working Paper, May 2010.

Thorbecke, Erick (2005) "*Multi-dimensional Poverty: Conceptual and Measurement Issues*" Paper prepared for The Many Dimensions of Poverty International Conference, UNDP International Poverty Centre, Brasilia, August 29-31, 2005

UNICEF (2000a) "*Poverty Reduction Begin with Children*" Available: http://www.unicef.org/publications/index_5616.html

UNICEF (2000b) "*A League Table of Child Poverty in Rich Countries*" Innocenti Report Card Issue No. 1

UNICEF (2002) "Finance Development Invest in Children" UNICEF New York

UNICEF (2005a) "*State of the World's Children 2005: Childhood Under Threat*" UNICEF HQ New York. Available: http://www.unicef.org/sowc/

UNICEF (2005b) "*A Study of Child Vulnerability in Barbados, St. Lucia and St. Vincent & the Grenadines*" UNICEF Office for Barbados and the Eastern Caribbean, in association with the Governments of Barbados, St. Lucia and St. Vincent & the Grenadines.

UNICEF (2005c) "*Child Poverty in Rich Countries 2005*" Innocenti Report Card Issue No. 6

UNICEF (2007) "An Overview of *Child Well Being in Rich Countries*" Innocenti Report Card Issue No. 7

UNICEF (2010) "*Advancing the Rights of Children, Women and Poor Families Through Better Public Finance Policies*" Social and Economic Policy Working Paper, UNICEF Policy and Practice, August 2010

White, H., and Masset, E., (2002a) "*Constructing the Poverty Profile: An Illustration of the Importance of Allowing for Household Size and Composition in the Case of Vietnam*" Young Lives Working Paper No. 3. London: Young Lives and Save the Children Fund UK.

White, H., and Masset, E., (2002b) "*Using Adult Equivalence Scales to Estimate Income-Poverty for Different Age Groups*" Young Lives Working Paper No. 6. London: Young Lives and Save the Children Fund UK.

Worldbank (2010) "*Making BOS Effective under Decentralization*" Policy Brief, December 2010.

Worldbank (2011) "*Does JAMKESMAS Protect the Population from Health Expenditure Shocks*" the World Bank, Indonesia Health Sector Review, February 2011

Wordsworth, D., McPeak, M., and Feeny, T (2005) "*Understanding Children's Experience of Poverty: An Introduction to the DEV Framework*" Children and Poverty Working Paper 1, Christian Children Fund

Young Lives. (2001). "Summary of the Young Lives Conceptual Framework." Young Lives and Save the Children Fund UK.

2 Inequality and Child Well-Being: The Case of Indonesia[1]

Arianto A. Patunru
ACDE, Australian National University

Santi Kusumaningrum
CCP, University of Indonesia

Abstract

We discuss the issue of inequality in Indonesia with an emphasis on the wellbeing of the children. Inequality is surveyed in two dimensions: vertical, in the form of income and wealth inequality; and horizontal (which includes inequality in access to education, health and nutrition, sanitation, clean water, care and protection) that is presented in snapshots that apply across different age groups, gender, geographical areas and other horizontal settings. This study shows that children are still at a disadvantage in regard to increasing inequality despite national laws and policies guaranteeing specific services and interventions. A large amount of the child population is still deprived of access to birth registration, basic education, nutritional and health services. They are also still prone to a number of vulnerabilities such as falling to early marriage and unfavorable child labor. We then assess the existing, related policies.

Key Words: Inequality, Children, Indonesia

JEL Classifications: I14, I24, I38, J13

[1]This is developed almost entirely on a country report on the same topic funded by Save the Children, U.K which referred in Save the Children (2012) "Born Equal" publication (http://www.savethechildren.org.uk/sites/default/files/images/Born_Equal.pdf).

We thank Michel Anglade and Jessica Espey for commissioning the project to us. We also thank Daniel Suryadarma, Paul Kellner, and participants of seminars in University of Indonesia. All errors are ours.

1. Introduction

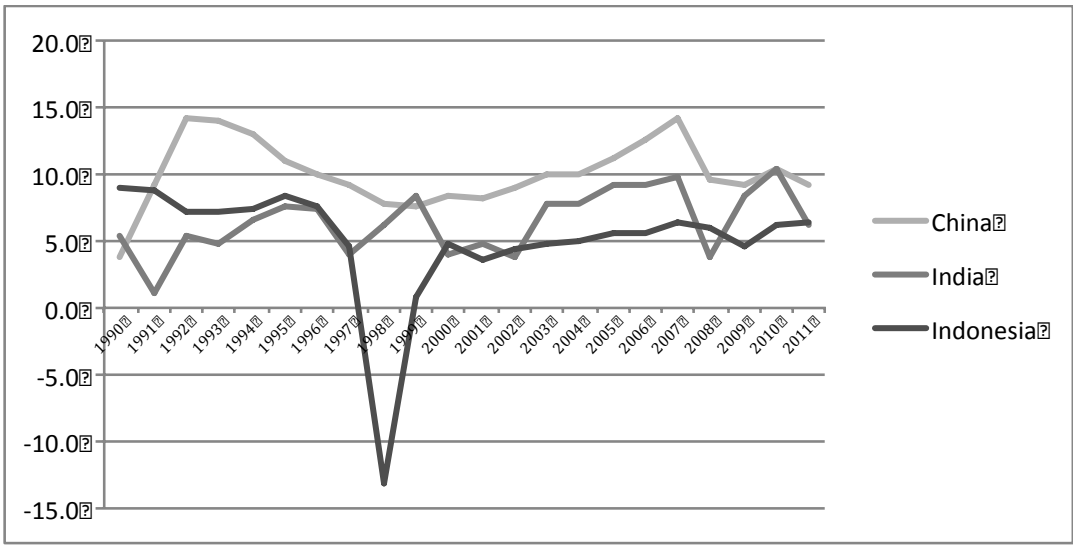
For the past decade, the Millennium Development Goals (MDG) have provided countries – including Indonesia – with a development framework that guides achievement on human rights, global peace and welfare targets. Many countries have successfully reached some of the Goals, especially those relating to tackling the most extreme poverty, mortality and hunger. However, they have not fully addressed vulnerability issues that hinder the enhancement of human capital. The 2015 expiry of the MDGs is fast approaching and we now must consider what to do next, and how to do things better. This paper seeks to contribute to the ongoing thinking around that global agenda, with the assumption that the next development platform needs to consider mainstreaming equality for one of the most vulnerable populations in the world: children.

We therefore discuss the issue of inequality in Indonesia with an emphasis on the wellbeing of the children. Inequality is assessed in two dimensions: vertical, in the form of income and wealth inequality; and horizontal (which includes inequality in access to education, health and nutrition, sanitation, clean water, care and protection) that is presented in snapshots that apply across different age groups, gender, geographical areas and other horizontal settings. The main sources of data for this study are the survey that is conducted by Indonesia's Central Bureau of Statistics (BPS), called SUSENAS (National Socioeconomic Survey), and the survey undertaken by Indonesia's Ministry of Health, named RISKESDAS (National Basic Health Survey). We also draw on previous studies and reports on the issue by UNDP, UNICEF, World Bank, ADB, PUSKAPA, and SMERU.

2. Indonesia's Development: Brief Overview

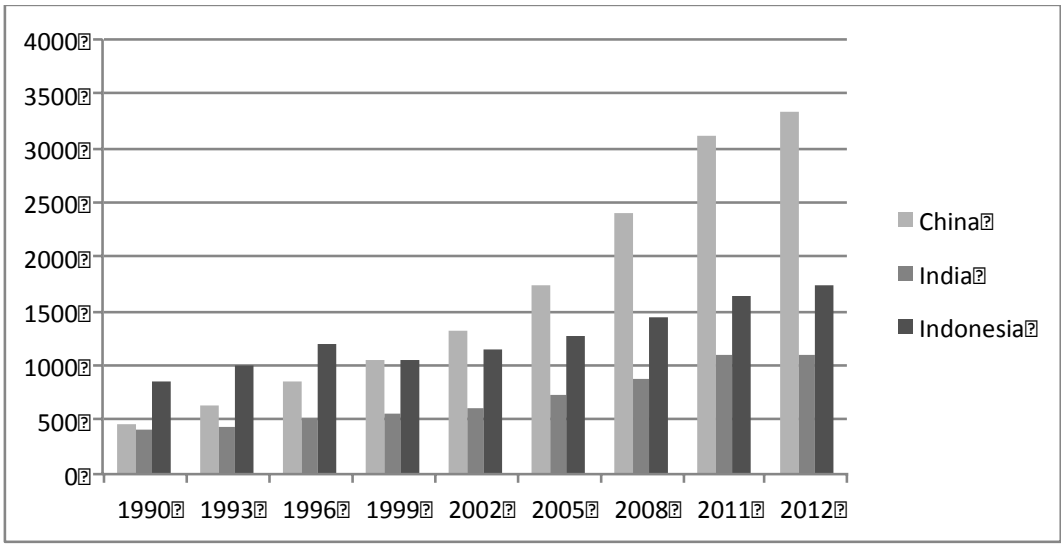
Indonesia's archipelago is not only geographically well positioned, but also economically and politically. After only 67 years of independence, Indonesia has caught the world's eye by overcoming political turmoil and transitioning into democracy in 1998 in a relatively peaceful manner; institutionalizing elections and strong governments afterwards; and by surviving frequent large-scale natural disasters and a few economic crises. Even during the ongoing global crisis, Indonesia has managed to maintain a steady economic growth rate of above 6% per year. Additionally, Indonesia was the country hardest hit by the catastrophic Asian financial crisis in 1997-98. However, it has now recovered and, along with China and India, has shown strong resilience after the 2008 global crisis and the still-unfolding 2011 crisis (Figure 1). Also, in terms of GDP per capita, Indonesia has made remarkable progress, though it has been overtaken by China following the Asian financial crisis (Figure 2).

Figure 1. Real GDP Growth (%, constant 2005 US Dollar)



Source: World Bank

Figure 2. GDP Per Capita (Constant 2005 US Dollar)



Source: World Bank

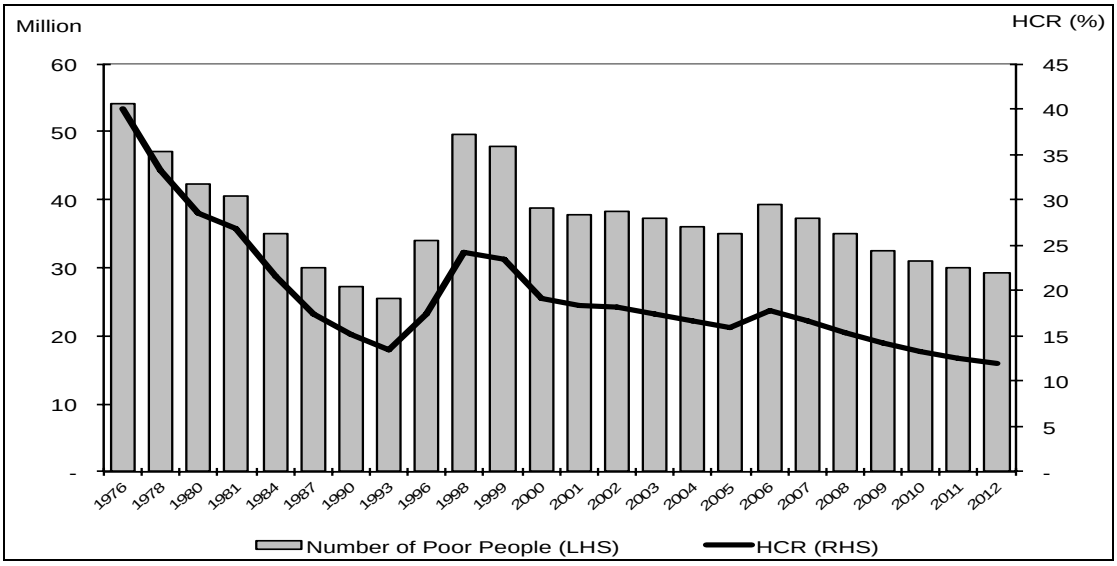
Consequently, Indonesia has garnered global attention. There are a number of other factors that have contributed to Indonesia's prominence. Indonesia is the fourth largest country by population and the sixteenth by land mass. It is geographically vast and has become "the Asia's third giant" (Reid 2012). Indonesia is diverse and home to a Muslim majority where freedom of religion and tolerance are held in relatively high regard, despite a few recent incidents. It is also taking a leadership role on some of the most notable global agenda and human rights platforms.

Nevertheless, Indonesia has also experienced bad times. Higgins (1968) once called the country a case of "chronic drop out" due to the extremely bleak state of economic development under the old regime of the first president, Sukarno. Furthermore, once an oil-rich country (and hence, was a member of OPEC), Indonesia is now a net oil importer thanks to the mismanagement of oil resources in the past, specifically under the second president, Soeharto. However, the country is rising again. As member of G20 and the head of ASEAN 2011 and APEC 2013, Indonesia is gaining

international prominence. On a domestic level, economic growth has been robust, inflation rates have been manageable, and poverty reduction efforts have made good progress (Hill 1996, 2000). Some observers are even more optimistic for the future of Indonesia, provided that some "tests", including MDG are passed well (for example, see Woo and Hong 2010).

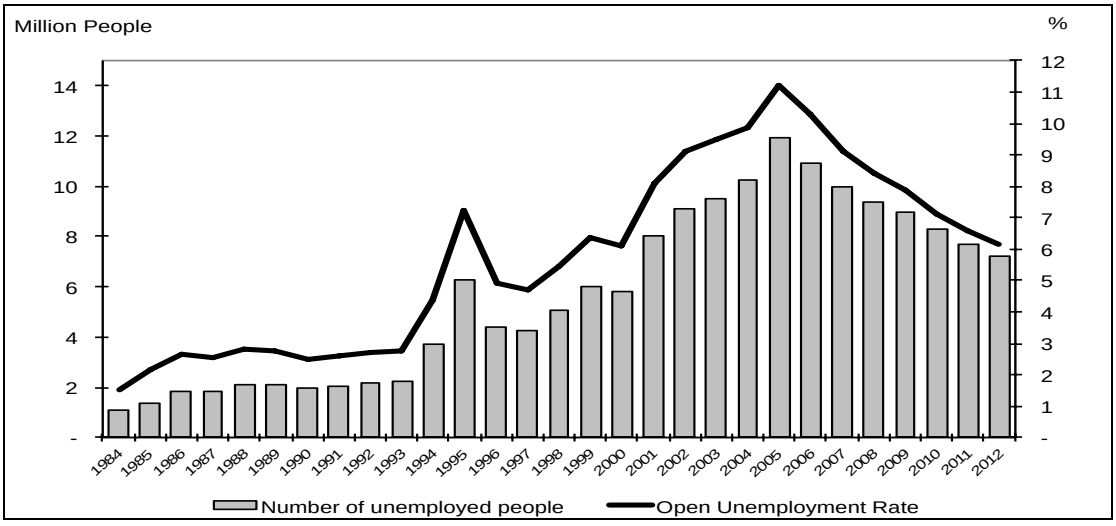
The reductions in absolute poverty and unemployment rates have also been remarkable (Figures 3 and 4). Figure 4 uses the national poverty line as a benchmark, which is approximately USD 1.5/day. The MDGs use a poverty line of USD 1/day. In this regard, Indonesia has surpassed its target of reducing the proportion of population below USD 1/day to 10.3%; in 2008, it was already below 6% (BAPPENAS 2010). As for employment, Indonesia is likely to meet the target of cutting the open unemployment rate to 6% by 2014.

Figure 3. Absolute Poverty



Source: BPS, various years

Figure 4. Unemployment



Source: BPS, various years

However, poverty and unemployment are still among the most important challenges to Indonesia's development. Poverty in Indonesia has three salient features (World Bank 2006). First, there are a large number of poor people just above the poverty line and who are sensitive to changes in where that line is drawn (hence "the vulnerable"). In 2011, although 13-14% of the population lived below the national poverty line (i.e. around USD 1.5/day), nearly half the population still lived on less than USD 2/day, implying that there are a large number of people slightly above the poverty line at risk of falling into poverty. A World Bank report estimates that half of all poor households in recent years were not poor the year before, and that over four-fifths of the next year's poor will come from the households at the 40% lowest expenditure level in the country (World Bank 2012).

Second, non-income poverty is of more serious concern. This includes high malnutrition rates, poor maternal health, weak education outcomes, and low access to safe and clean water and sanitation. Third, regional disparities in poverty in Indonesia are considerable. The poverty rates are far higher in eastern Indonesia, but most of the poor live in western Indonesia. For example, the 2009 poverty rate in Java/Bali islands was 13.7%, while in remote Papua it was 37.1%. However, Java/Bali is home to 57% of Indonesia's poor, while Papua has only 3% (Patunru and Tarsidin 2012). Many of these aspects are linked to the issue of inequality that will be elaborated upon below.

As for unemployment, the country is still facing the task of creating more jobs. The rigid structure of labor market hinders the transition toward flexible movement of workers between sectors (for a discussion on this issue, see for example World Bank 2009 and OECD 2012). The country has yet to find a good compromise between businesses' interests and those of workers. Each claims that the current labor law is unfair. As a result, employers get around heavy regulation by resorting to sub-contracting and outsourcing, which, in turn, are detrimental to workers' welfare. On the other hand, unions' demands indirectly erect barriers for workers who are still unemployed by causing businesses to suppress those demands.

Guided by the MDG framework, Indonesia has been working on the common agenda towards achieving the shared underlying targets for development and poverty reduction. The 2011 MDG status report concluded that Indonesia is making significant progress. However, not all Goals have been fully met. The proportion of the population with sustainable access to clean water and sanitation has not significantly increased; and the proportion of population using improved sanitation facilities in both urban and rural areas is still far below the target. Indonesia's maternal mortality rate (MMR) is 228 per 100,000 live births, remaining one of the highest in Southeast Asia and far from the MDG target of 102. The infant mortality rate (IMR) is 44 per 1,000 live births, while the target is 32. In the meantime, HIV/AIDS infection is reportedly accelerating across the country, in particular in Papua. Prevalence in some high-risk urban areas is also of a particular concern (UNDP 2011). The 2011 MDG status report also found that approximately 95% of children are enrolled in primary school, and found a 95% literacy rate for the population between the ages of 15 to 24. However, a separate study undertaken by UNICEF highlights that, according to the 2009 National Socioeconomic Survey (SUSENAS), there are about 2.5 million children aged 7 to 15 who are out of school, with a large portion of those children (around 1,900,000) being of junior secondary school age (13 to 15 years old) (UNICEF 2011). The next sections highlight these aspects.

3. Vertical Inequality

Table 1. Brief Economic Indicators, 2010-2011

Province	GDP/Cap	Gini Ratio	Poverty	HDI
Aceh	1,898	0.3421	19.57	71.70
North Sumatra	2,337	0.3611	11.33	74.19
West Sumatra	1,980	0.3875	9.04	73.78
Riau	6,809	0.3627	8.47	76.07
Jambi	1,915	0.3586	8.65	72.74
South Sumatra	2,330	0.3662	14.24	72.95
Bengkulu	1,157	0.3733	17.50	72.92
Lampung	1,552	0.3913	16.93	71.42
Kepulauan Bangka Belitung	2,312	0.3004	5.75	72.86
Kepulauan Riau	4,693	0.3338	7.40	75.07
Jakarta	9,875	0.4673	3.75	77.60
West Java	1,970	0.4286	10.65	72.29
Central Java	1,510	0.4067	15.76	72.49
Jogjakarta	1,451	0.4055	16.08	75.77
East Java	2,286	0.4093	14.23	71.62
Banten	1,765	0.4188	6.32	70.48
Bali	1,886	0.4114	4.20	72.28
West Nusatenggara	1,207	0.4236	19.73	65.20
East Nusatenggara	651	0.3982	21.23	67.26
West Kalimantan	1,514	0.3963	8.60	69.15
Central Kalimantan	2,118	0.3388	6.56	74.64
South Kalimantan	1,776	0.3865	5.29	69.92
East Kalimantan	9,945	0.3778	6.77	75.56
North Sulawesi	1,785	0.3904	8.51	76.09
Central Sulawesi	1,539	0.3863	15.83	71.14
South Sulawesi	1,614	0.4156	10.29	71.62
Southeast Sulawesi	1,640	0.4228	14.56	70.00
Gorontalo	852	0.4476	18.75	70.28
West Sulawesi	1,043	0.4750	13.89	69.64
Maluku	580	0.3772	23.00	71.42
North Maluku	571	0.3442	9.18	69.03
West Papua	3,260	0.4215	31.92	69.15
Papua	3,474	0.4174	31.98	64.94
Indonesia	2,981	0.4119	12.49	72.27

Notes: (1) GDP/Capita data are of 2010 current IDR prices (converted into USD using the average exchange rate data of 2010 from Bank Indonesia), divided by the number of population, taken from BPS; (2) Gini ratios are calculated based on SUSENAS (National Socioeconomic Survey), first quarter of 2011; (3) Poverty is headcount index, i.e. percentage of population under the poverty line, taken from BPS; (4) Human Development Index figures are of 2010, taken from BPS.

The preceding section has elaborated on the relative success of Indonesian economic development. Ideally, this progress should be enjoyed by all 237 million people living on Indonesia's vast archipelago of 17,504 islands. Unfortunately, the country faces worsening inequality. Income

inequality is clearly evident both on national and sub-national levels. Table 1 shows regional income per capita in Indonesia along with the respective Gini Ratio (GR), poverty rate, and Human Development Index (HDI). While the country in general has reached an average GDP per capita of almost USD 3,000 in 2010, the provincial figures vary from around USD 600 to USD 10,000. The capital of Indonesia, Jakarta, and resource rich provinces like Riau and East Kalimantan stand out with high incomes per capita. Most provinces with low incomes per capita are located in the eastern part of the country, although in terms of poverty headcount ratio (HCR), the under-the-line poor are more disperse. For instance, some provinces in western Indonesia (including those in Java) show high HCR. These facts suggest a worrying level of inequality – which is confirmed by provincial GRs that hover between 0.30 and 0.40. So, even though the country has gradually seen a reduction in its poverty index, inequality is actually increasing (Patunru and Tarsidin 2012).[2]

Using two measures of income inequality, income ratio between top 20% and bottom 20% and GR, we see that Indonesia is comparable to Vietnam[3], but more inequitable than India and Lao (Table 2). In terms of the percentage of population under USD 2 per day, however, Indonesia is more comparable to Cambodia, better than India and Lao, but worse than China.

Table 2. Poverty and inequality: Indonesia in comparison

Country	Percent of Population below $2 (PPP)/day	Income Ratio of Highest 20 percent to Lowest 20 percent	Gini Coefficient
China	35.7 (2005)	8.3 (2005)	0.415 (2005)
India	75.6 (2005)	5.6 (2005)	0.368 (2005)
Indonesia	54.6 (2005)	6.2 (2007)	0.376 (2007)
Lao PDR	76.9 (2002)	4.9 (2002)	0.326 (2002)
Cambodia	57.8 (2007)	8.1 (2007)	0.442 (2007)
Malaysia	7.8 (2004)	7.0 (2004)	0.379 (2004)
Philippines	45.0 (2006)	9.0 (2006)	0.440 (2006)
Thailand	11.5 (2004)	8.1 (2004)	0.425 (2004)
Vietnam	48.4 (2006)	6.4 (2006)	0.378 (2006)

Source: ADB (2010).

The SUSENAS data series shows that Indonesia is facing a serious issue in income inequality, as measured by GR. All the provinces in Indonesia experienced worsening GR (i.e. higher inequality) in 2011, when compared to 2009 and 2007 figures (Table 3a). Even richer provinces suffered high, if not the highest, income inequality: East Kalimantan (natural-resource rich province, esp. in coal, oil, gas, and gold), Jakarta (the country's capital as well as business hub), Riau, and Kepulauan Riau (both known as suppliers of palm oil, rubber, etc.). All the provinces on Java Island suffer from inequality at a GR of more than 0.4. In the meantime, relatively rich provinces like Papua (timber, gold, copper, and horticultural plantation), and West Papua (oil, gas, and agriculture, with least populous area) have both poor GR and very high poverty rates – implying very skewed income distribution. It is probably not surprising that these provinces have a low HDI ranking (Table 3b). The country as a whole shows a deteriorating level of inequality (a GR increase from

[2]The HDI measures, in the meantime, do not vary significantly across provinces, i.e. around 60 and 70 with the national HDI at 73.

[3]Comparison of Gini Ratios across countries should be taken with caution, as they might come from different methodology and measurements.

0.33 in 2007 to 0.35 in 2009 and to 0.41 in 2011), although poverty measures show improvement (HCR down from 16.58% in 2007 to 14.15% in 2009 and to 12.49% in 2011).

Table 3a. Regional Gini Ratio and Poverty Headcount Index

Province	Gini Ratio			Poverty Headcount Ratio		
	2007	2009	2011	2007	2009	2011
Aceh	0.3063	0.3321	0.3421	26.65	21.80	19.57
North Sumatra	0.2843	0.3080	0.3611	13.90	11.51	11.33
West Sumatra	0.3065	0.3246	0.3875	11.90	9.54	9.04
Riau	0.2802	0.3069	0.3627	11.20	9.48	8.47
Jambi	0.2689	0.2949	0.3586	10.27	8.77	8.65
South Sumatra	0.2689	0.2961	0.3662	19.15	16.28	14.24
Bengkulu	0.2738	0.3084	0.3733	22.13	18.59	17.50
Lampung	0.2835	0.3172	0.3913	22.19	20.22	16.93
Kepulauan Bangka Belitung	0.2430	0.2856	0.3004	9.54	7.46	5.75
Kepulauan Riau	0.3111	0.3230	0.3338	10.30	8.27	7.40
Jakarta	0.3471	0.3797	0.4673	4.61	3.62	3.75
West Java	0.3505	0.3558	0.4286	13.55	11.96	10.65
Central Java	0.3093	0.3260	0.4067	20.43	17.72	15.76
Jogjakarta	0.3709	0.3634	0.4055	18.99	17.23	16.08
East Java	0.3241	0.3477	0.4093	19.98	16.68	14.23
Banten	0.3297	0.3686	0.4188	9.07	7.64	6.32
Bali	0.3110	0.3227	0.4114	6.63	5.13	4.20
West Nusatenggara	0.3210	0.3521	0.4236	24.99	22.78	19.73
East Nusatenggara	0.3236	0.3529	0.3982	27.51	23.31	21.23
West Kalimantan	0.2745	0.3311	0.3963	12.91	9.30	8.60
Central Kalimantan	0.2623	0.2841	0.3388	9.38	7.02	6.56
South Kalimantan	0.3014	0.3266	0.3865	7.01	5.12	5.29
East Kalimantan	0.3200	0.3260	0.3778	11.04	7.73	6.77
North Sulawesi	0.2819	0.3111	0.3904	11.42	9.79	8.51
Central Sulawesi	0.3135	0.3256	0.3863	22.41	18.98	15.83
South Sulawesi	0.3072	0.3460	0.4156	14.11	12.31	10.29
Southeast Sulawesi	0.3161	0.3202	0.4228	21.33	18.93	14.56
Gorontalo	0.2818	0.3278	0.4476	27.35	25.01	18.75
West Sulawesi	0.3075	0.3322	0.4750	19.03	15.29	13.89
Maluku	0.3014	0.3049	0.3772	31.14	28.23	23.00
North Maluku	0.2955	0.2965	0.3442	11.97	10.36	9.18
West Papua	0.3099	0.3401	0.4215	39.31	35.71	31.92
Papua	0.3701	0.3814	0.4174	40.78	37.53	31.98
Indonesia	0.3320	0.3510	0.4119	16.58	14.15	12.49

Notes: All GR figures are calculated from SUSENAS, HCR are taken from BPS website. All 2011 figures are of first quarter

Table 3b. Regional Human Development Index

Province	2007	2008	2009	2010
Aceh	70.35	70.76	71.31	71.70
North Sumatra	72.78	73.29	73.80	74.19
West Sumatra	72.23	72.96	73.44	73.78
Riau	74.63	75.09	75.60	76.07
Jambi	71.46	71.99	72.45	72.74
South Sumatra	71.40	72.05	72.61	72.95
Bengkulu	71.57	72.14	72.55	72.92
Lampung	69.78	70.30	70.93	71.42
Kepulauan Bangka Belitung	71.62	72.19	72.55	72.86
Kepulauan Riau	73.68	74.18	74.54	75.07
Jakarta	76.59	77.03	77.36	77.60
West Java	70.71	71.12	71.64	72.29
Central Java	70.92	71.60	72.10	72.49
Jogjakarta	74.15	74.88	75.23	75.77
East Java	69.78	70.38	71.06	71.62
Banten	69.29	69.70	70.06	70.48
Bali	70.53	70.98	71.52	72.28
West Nusatenggara	63.71	64.12	64.66	65.20
East Nusatenggara	65.36	66.15	66.60	67.26
West Kalimantan	67.53	68.17	68.79	69.15
Central Kalimantan	73.49	73.88	74.36	74.64
South Kalimantan	68.01	68.72	69.30	69.92
East Kalimantan	73.77	74.52	75.11	75.56
North Sulawesi	74.68	75.16	75.68	76.09
Central Sulawesi	69.34	70.09	70.70	71.14
South Sulawesi	69.62	70.22	70.94	71.62
Southeast Sulawesi	68.32	69.00	69.52	70.00
Gorontalo	68.83	69.29	69.79	70.28
West Sulawesi	67.72	68.55	69.18	69.64
Maluku	69.96	70.38	70.96	71.42
North Maluku	67.82	68.18	68.63	69.03
West Papua	67.28	67.95	68.58	69.15
Papua	63.41	64.00	64.53	64.94
Indonesia	70.59	71.17	71.76	72.27

Source: BPS website

4. Horizontal Inequality

Gender inequality

With regard to gender, the MDGs have mandated the elimination of gender disparity in education. However, such inequality still seems evident. It is reported that the ratios of girls to boys in primary and secondary schools have met the target of 100%, and those in senior high school and higher education are on-track (BAPPENAS 2010). However, according to SUSENAS data, on average there are twice as many females than males aged 10 or above who cannot read, and three times as many females who have never been enrolled in school (Table 4). In addition, enrollment is higher for males than females. Overall, the literacy ratio is around 93%, with the male population being higher than their female counterparts (Table 5).

In terms of employment, the government uses gender equality index (GEI) to see the risks or opportunities for women in attaining equal status to men (KPPPA 2010). Table 6 shows the index for 2009. The chance of a woman entering the labor force is one-fifth of that of a man. Conversely, the likelihood of a woman participating in the "non-labor-force" category is five-times higher than that of a man. This includes a 25% higher chance for a woman to be working in the house (i.e. housewife) than a man. Furthermore, the chance of a woman working is 0.88 times than that of a man, but the chance of a woman being unemployed is 1.44 times that of a man. All this suggests that females' access to the labor market is still lower than males' access.

It is also important to understand other key gender-related issues such maternal health, violence against women, human trafficking, etc. The Ministry for Woman Empowerment and Child Protection reported that a large number of women continue to give birth at home without professional health providers (KPPPA 2010). Women often risk delivery complications because they only receive assistance from midwives or traditional birth attendants, some of whom are skilled and some who are not. The decision to utilize a birth attendant is related to the household's income. The same report finds that delivering mothers who come from the richest families are more than four times more likely to have facility-based delivery as compared to those from the poorest families. This decision also relates to education. Mothers with no education are more likely to give birth at home (81.4%) than mothers with secondary or higher education (28.2%). Finally, the disadvantages experienced by poor women in giving birth also extend to abortion. According to a study (Utomo *et al.* 2000) cited by the abovementioned report, 24% of abortions were performed by traditional birth attendants ("dukun") and 60% of women having abortions reported an induction abortion. Again, the decision to abort a fetus or an unborn child is likely to be correlated with income and education levels. Hull and Moseley (2007) reported that one to two million abortions take place in Indonesia each year, many of which are performed by unskilled providers in unsanitary conditions.

Table 4. Population with No Education, 2010

Province	% Illiterate (Age 10+)			% Not/Never in School (Age 10+)		
	Male	Female	All	Male	Female	All
Aceh	1.91	3.55	2.74	2.36	5.98	4.20
North Sumatra	1.47	3.30	2.40	1.71	3.99	2.86
West Sumatra	1.98	3.19	2.60	1.62	3.51	2.59
Riau	1.11	1.90	1.49	1.90	3.97	2.91
Jambi	2.33	5.05	3.67	2.53	7.71	5.08
South Sumatra	1.63	3.08	2.34	2.19	5.32	3.74
Bengkulu	2.19	6.15	4.15	1.93	6.20	4.04
Lampung	3.14	6.44	4.75	2.93	6.93	4.88
Kepulauan Bangka Belitung	2.51	5.84	4.12	3.79	7.33	5.50
Kepulauan Riau	1.62	3.40	2.51	1.93	3.70	2.82
Jakarta	0.52	1.09	0.81	0.87	2.57	1.72
West Java	2.00	4.77	3.38	2.32	5.74	4.02
Central Java	5.72	12.13	8.98	4.53	11.62	8.13
Jogjakarta	3.80	12.77	8.38	2.91	11.75	7.42
East Java	6.51	14.39	10.53	5.51	14.04	9.86
Banten	2.22	4.63	3.40	2.98	7.85	5.38
Bali	6.37	14.64	10.51	6.48	15.43	10.95
West Nusatenggara	12.06	20.60	16.51	10.19	20.19	15.40
East Nusatenggara	7.97	11.64	9.84	6.52	10.76	8.68
West Kalimantan	6.36	10.87	8.57	6.52	14.13	10.25
Central Kalimantan	1.59	2.90	2.22	2.02	4.39	3.15
South Kalimantan	2.20	5.15	3.66	2.29	5.54	3.90
East Kalimantan	2.08	3.25	2.64	2.89	5.52	4.13
North Sulawesi	0.56	0.75	0.65	0.76	1.06	0.91
Central Sulawesi	2.90	4.14	3.50	2.78	4.48	3.61
South Sulawesi	8.68	12.82	10.84	7.23	11.22	9.32
Southeast Sulawesi	4.68	9.48	7.10	4.35	9.27	6.83
Gorontalo	3.23	3.99	3.61	1.69	2.68	2.19
West Sulawesi	8.04	12.13	10.09	7.10	11.85	9.49
Maluku	1.66	2.75	2.21	2.16	3.81	2.99
North Maluku	2.29	4.70	3.48	2.74	4.87	3.79
West Papua	2.75	6.28	4.41	2.37	6.18	4.17
Papua	25.70	33.85	29.59	27.88	37.20	32.33
Indonesia	4.19	8.47	6.34	3.94	9.04	6.50

Source: BPS website

Table 5. Basic Education, 2010

Province	School Enrollment Ratio (Age 7-12)	Literacy Ratio		
		Male	Female	All
Aceh	99.19	97.82	95.97	96.88
North Sumatra	98.90	98.41	96.26	97.32
West Sumatra	98.24	97.82	96.40	97.09
Riau	98.75	98.82	97.87	98.35
Jambi	98.27	97.41	94.31	95.88
South Sumatra	98.00	98.18	96.52	97.36
Bengkulu	98.67	97.58	92.99	95.30
Lampung	98.71	96.45	92.73	94.64
Kepulauan Bangka Belitung	97.10	97.34	93.45	95.46
Kepulauan Riau	99.35	98.20	96.21	97.19
Jakarta	99.16	99.43	98.83	99.13
West Java	98.29	97.76	94.60	96.18
Central Java	98.95	93.59	86.48	89.95
Jogjakarta	99.69	95.83	86.11	90.84
East Java	98.74	92.77	84.16	88.34
Banten	98.01	97.56	94.81	96.20
Bali	98.69	93.01	83.79	88.40
West Nusatenggara	98.26	85.94	76.74	81.05
East Nusatenggara	96.49	90.76	86.56	88.59
West Kalimantan	97.04	92.86	87.58	90.26
Central Kalimantan	98.70	98.21	96.69	97.48
South Kalimantan	97.90	97.60	94.26	95.94
East Kalimantan	98.68	97.69	96.33	97.05
North Sulawesi	98.30	99.41	99.18	99.30
Central Sulawesi	97.52	96.85	95.28	96.08
South Sulawesi	97.00	90.21	85.54	87.75
Southeast Sulawesi	97.81	94.71	89.07	91.85
Gorontalo	96.86	96.44	95.58	96.00
West Sulawesi	95.93	91.00	86.03	88.48
Maluku	98.27	98.11	96.83	97.46
North Maluku	97.23	97.49	94.66	96.08
West Papua	94.04	97.04	92.99	95.12
Papua	76.22	72.86	63.29	68.27
Indonesia	98.02	95.35	90.52	92.91

Source: BPS website

Table 6. Gender Equality Index

	Male (% population)	Female (% population)	Gender Equality Index
Labor force	83.65	50.99	0.20
Work	92.49	91.53	0.88
Unemployed	7.51	8.47	1.14
Not in labor force	16.35	49.01	4.92
In school	51.19	16.21	0.18
Taking care of the household	11.18	76.22	25.48
Others	37.63	7.57	0.14

Source: KPPPA 2010

Spatial inequality

Both Tables 4 and 5 above reveal inequality in terms of spatial or regional groupings.[4] Some points about these values are worth highlighting. For example, one might presume that illiteracy rates correlate with poverty. The case of Papua confirms this fact, its high rate of illiteracy of 30% might correlate with the high poverty rate there, and may suggest problems with access to education. Yet, it is quite a surprise that a relatively modest province in terms of income per capita like East Java has a high prevalence of illiteracy as well. This fact may suggest that literacy and income per capita are mediated by other factors.

Miranti (2011) provides a more systematic and aggregate grouping of Indonesian provinces. Building upon Hill (1989), Miranti divides 26 provinces of Indonesia into 5 groups, namely (1) Resource-rich provinces: Aceh, Riau, East Kalimantan, Papua; (2) Densely-populated provices: Lampung, Jakarta, West Java, Central Java, Jogjakarta, East Java, Bali; (3) Isolated provinces: West Nusatenggara, East Nusatenggara; (4): Settled Outer Island provinces: North Sumatra, West Sumatra, South Sumatra, North Sulawesi, South Sulawesi; and (5) Sparsely-populated provinces: Jambi, Bengkulu, West Kalimantan, Central Kalimantan, Central Sulawesi, Southeast Sulawesi, Maluku.[5] Table 7 summarizes Miranti's study.

[4]Arguably geographical division also reflects ethnic differences. We do not elaborate further on specific issues relating to ethnicity because Indonesia has more than 300 ethnicities. It is safe to say, however, that spatial differences might be represented by regional/provincial groupings.

[5]It is difficult to assess all the 33 provinces, because some provinces are just newly created, making a time-series comparison very complicated. Miranti combined the new seven provinces (Bangka Belitung, Banten, Gorontalo, North Maluku, Riau Island, West Sulawesi, and West Papua) with the respective provinces they separated from.

Table 7. Regional Development Indicators

	Headcount poverty rates, 1984-2002, % change p.a	Non-oil/gas Real GDP/cap, 1984-2002, % change p.a	Junior school secondary net enrolment ratio 1984-2002, % change p.a	Density of paved roads 1984-2002, % change p.a
Resource-rich provinces	-9.50	1.60	2.10	5.40
Densely-populated provinces	5.80	0.80	1.20	2.50
Isolated provinces	-44.80	2.20	0.90	5.50
Settled Outer Island provinces	-39.50	0.90	1.20	4.80
Sparsely populated provinces	-52.10	0.70	1.70	5.10
National average	-38.30	0.90	1.60	3.90

Source: Miranti (2011)

The study shows some interesting patterns. For example, rapid changes in poverty rates are associated with rapid change in one or more other indicators (Miranti used GDP, education, and road infrastructure as proxies, in addition to poverty headcount ratio). But it is clear that the relationship between income poverty (hence vertical inequality) and non-income poverty (e.g. education) is not linear. Therefore, addressing these two forms of inequality might require a complex understanding of other factors affecting the regional development. Furthermore, it is important to recognize differences both between and within groups, as poverty alleviation strategies might work differently from one region to another.

Tables 8 and 9 lay out other factors contributing to differences across provinces, with a focus on health and sanitation. Again, while one could intuit a relationship between "relatively wealthier provinces" and some health and sanitation indicators, such a relationship might not be clearly defined. For example, a poor and isolated province like West Nusatenggara has poor nutrition and poor sanitation. At the same time, a rich province like East Kalimantan can have access to safe drinking water lower than the national average. These two factors, health and sanitation, in addition to education, are among the most important aspects of child wellbeing, which will be discussed in the next sections.

Table 8. Health and Nutritional Conditions, 2010 (% Households)

	Complete basic immunization (12-23 months)	Bad nutrition (of babies < 5)	Age <5 w/ good nutrition (normal H/A & W/H)	Age 6-12 w/ good nutrition (normal BMI/A)	Age 13-15 w/ good nutrition (normal BMI/A)	Age 16-18 w/ good nutrition (normal BMI/A)	Age >18 w/ good nutrition (normal BMI/A)	Normal nutrition (for adults > 18)	Prevalence of daily smokers > 15
Aceh	37.00	7.10	47.20	75.50	92.00	90.50	64.50	64.50	31.9
North Sumatra	33.30	7.80	41.40	77.50	89.20	93.10	65.90	65.90	29.7
West Sumatra	48.10	2.80	59.20	85.20	84.50	88.40	64.10	64.10	33.1
Riau	37.50	4.80	46.90	75.20	89.00	91.20	69.40	69.40	30.3
Jambi	60.90	5.40	49.60	81.20	90.10	93.40	65.90	65.90	32.7
South Sumatra	44.70	5.50	43.90	77.80	87.40	91.20	65.90	65.90	29.9
Bengkulu	46.70	4.30	48.10	82.20	87.70	93.70	68.00	68.00	33.0
Lampung	65.40	3.50	47.40	78.30	88.80	93.80	70.70	70.70	31.4
Kepulauan Bangka Belitung	60.00	3.20	61.00	83.20	90.90	89.80	63.40	63.40	31.2
Kepulauan Riau	74.40	4.30	64.30	79.90	88.60	85.60	60.00	60.00	33.4
Jakarta	53.20	2.60	54.50	76.30	86.10	86.60	61.80	61.80	23.9
West Java	52.30	3.10	52.70	81.40	88.70	88.00	64.80	64.80	30.9
Central Java	69.00	3.30	49.40	75.80	87.30	91.00	67.40	67.40	25.3
Jogjakarta	91.10	1.40	61.30	83.50	86.80	82.00	60.80	60.80	25.3
East Java	66.00	4.80	46.40	74.80	88.20	89.40	67.10	67.10	25.1
Banten	48.80	4.80	50.60	77.50	84.40	88.80	63.00	63.00	29.6
Bali	66.10	1.70	51.90	81.40	88.20	92.30	68.20	68.20	25.1
West Nusatenggara	62.60	10.60	40.10	77.90	81.30	87.00	67.10	67.10	30.5
East Nusatenggara	33.30	9.00	31.90	78.10	79.40	90.70	67.30	67.30	33.0
West Kalimantan	52.10	9.50	44.40	76.70	83.80	88.30	67.20	67.20	29.3

Central Kalimantan	54.80	5.30	45.10	80.40	90.70	90.30	68.40	68.40	36.0
South Kalimantan	52.50	6.00	49.30	76.60	81.20	86.30	60.10	60.10	25.3
East Kalimantan	64.10	4.40	55.40	78.20	88.30	91.60	62.10	62.10	28.4
North Sulawesi	65.50	3.80	62.50	86.00	90.50	94.30	56.80	56.80	29.1
Central Sulawesi	35.40	7.90	51.90	82.60	94.40	91.90	65.70	65.70	30.7
South Sulawesi	50.90	6.40	49.20	83.50	84.80	86.40	64.70	64.70	26.1
Southeast Sulawesi	37.50	6.50	44.00	69.90	86.20	93.10	72.80	72.80	22.0
Gorontalo	54.50	11.20	49.60	85.80	88.90	89.70	60.90	60.90	32.7
West Sulawesi	32.10	7.60	42.90	78.20	90.30	92.10	69.30	69.30	27.6
Maluku	46.70	8.40	50.80	84.00	85.30	91.80	64.80	64.80	26.2
North Maluku	44.80	5.70	52.30	87.60	91.00	91.10	62.40	62.40	31.8
West Papua	39.10	9.10	38.50	74.00	84.00	90.50	62.10	62.10	28.9
Papua	28.20	6.30	54.50	83.10	80.60	91.30	66.00	66.00	28.4
Indonesia	53.80	4.90	49.10	78.60	87.40	89.70	65.80	65.80	28.2

Note: Data from RISKESDAS Survey (Ministry of Health); H: height, W: weight, A: age, BMI: body mass index

Table 9. Housing, Sanitation, Water Conditions, 2010 (% Households

	Floor area < 7.2 sqm	Electricity for lighting	Decent sanitation	Decent drinking water source	Non-soil floor	With good waste mgt *	Access to decent drinking water *	No toilet *	Access to sewerage *
Aceh	16.40	90.98	45.17	29.02	91.19	17.6	62.90	21.00	53.80
North Sumatra	17.75	89.18	57.10	46.06	95.21	21.3	64.50	18.20	57.30
West Sumatra	16.62	84.72	44.26	41.92	97.13	16.9	66.40	25.30	41.50
Riau	12.62	56.18	54.27	40.01	95.93	20.2	58.20	7.30	54.30
Jambi	11.68	74.36	51.98	48.28	94.01	20.0	50.70	18.10	51.30
South Sumatra	20.58	75.44	44.36	45.99	89.49	19.7	48.70	23.80	47.10
Bengkulu	15.60	77.72	41.64	28.23	93.72	23.7	51.10	19.30	57.50
Lampung	7.05	78.75	43.85	38.07	83.40	13.2	46.10	11.00	46.70
Kepulauan Bangka Belitung	9.27	72.78	65.06	38.17	97.81	12.2	63.50	28.70	54.90
Kepulauan Riau	12.18	86.14	72.37	23.82	97.69	48.1	73.90	4.00	68.90
Jakarta	34.67	98.79	84.57	28.41	97.85	84.3	87.00	0.30	82.70
West Java	13.89	97.52	55.57	35.32	94.67	32.7	70.40	7.70	54.30
Central Java	3.21	98.23	57.76	57.44	75.63	25.6	74.00	15.60	58.90
Jogjakarta	5.44	99.59	81.85	60.41	92.28	44.3	76.80	4.50	79.20
East Java	5.94	97.38	52.96	52.94	81.49	28.3	75.10	18.80	54.30
Banten	15.80	96.11	63.78	22.32	93.11	35.5	74.20	21.90	61.20
Bali	16.82	96.83	79.13	48.44	93.97	40.6	79.70	13.00	71.80
West Nusatenggara	22.46	81.52	47.43	46.20	91.74	19.0	65.90	33.10	42.80
East Nusatenggara	29.77	44.37	26.23	49.29	64.34	11.7	53.80	21.60	25.20
West Kalimantan	17.37	68.43	45.32	54.47	97.66	10.5	35.90	33.30	42.70
Central Kalimantan	16.54	62.29	35.14	40.55	95.93	17.7	44.20	21.00	35.90
South Kalimantan	12.66	89.74	48.95	48.97	98.24	23.7	49.50	11.40	50.90
East Kalimantan	15.33	81.79	68.37	43.27	96.77	47.2	63.40	15.50	65.70
North Sulawesi	18.33	92.96	64.87	44.41	91.14	26.9	71.90	12.50	68.10
Central Sulawesi	19.59	68.56	48.25	35.10	91.32	12.9	61.20	38.60	45.80
South Sulawesi	11.43	87.77	61.45	45.12	96.14	24.6	58.80	19.10	60.80
Southeast Sulawesi	16.78	68.62	50.87	50.74	91.40	20.5	60.80	23.40	45.60
Gorontalo	24.20	71.44	45.66	40.09	94.45	6.0	69.70	39.20	35.30
West Sulawesi	21.50	45.97	41.30	37.44	93.09	15.2	63.00	39.10	35.60
Maluku	25.13	74.05	48.28	56.95	86.41	26.4	40.60	29.10	51.00
North Maluku	14.71	64.26	53.26	54.18	85.38	13.7	56.60	18.40	50.60
West Papua	24.40	66.11	46.91	45.26	93.02	23.7	64.50	12.00	48.00
Papua	55.93	32.83	23.97	32.42	70.25	15.1	41.30	16.40	39.10
Indonesia	13.27	89.47	55.53	44.19	88.49	28.7	67.50	15.80	55.50

Note: Data taken from BPS website and those marked (*) from Ministry of Health website. Decent (improved) sanitation refers to a household with toilet facilities of fecal landfills. Decent drinking water source refers to piped water, bottled water, or from water-well more than 10m away from sewerage. Non-soil floor refers to household whose floor area is mainly of materials other than dirt/earth floor

5. Child-related Dimensions of Inequality

Indonesia has set a target within its Medium Term Development Plan (RPJMN) 2010-2014 of reducing the poverty rate from 13-14% in 2009 to 8-10% in 2014. Looking at the current progress, the Government estimates that Indonesia will most likely meet this desired target by 2014. However, Indonesia still faces at least two main challenges in regard to poverty, first, assisting those who are currently poor to meet their basic survival needs and helping them out of poverty; and second, to protect vulnerable people from falling into poverty. More critically, inequality within income groups not only continues to persist, but is getting worse. These challenges have even more pronounced ramifications for children. On both fronts, there are indications that the overall poverty reduction strategy and the various social assistance programs currently being implemented lack the ability to address specific risks experienced by children living in poverty. Further, they are unable to address vulnerabilities that would otherwise enable children to escape poverty in the future. Lastly, the current programs are not yet well distributed.

The 2009 SUSENAS indicates that about 79.4 million people in Indonesia, or more than 32%, are under the age of 18 and are hence categorized as children.[9] According to the 2008 Social Protection Program Data (PPLS), there are more than 21 million Indonesian children living in poor and vulnerable households in Indonesia.

Investing in the quality of children's wellbeing cannot be more critical. Demographic and population estimates conclude that Indonesia will enjoy its *demographic bonus*[10] twenty years from now. This represents a pronounced opportunity and challenge for Indonesia to significantly improve its human development trends, especially those relating to primary and secondary education.

The underlying development and poverty reduction goals within the MDG framework are not always expressed using a comprehensive approach despite the awareness that these goals should ensure that all children have the opportunity to make a positive contribution to society. Some of the current social assistance programs do require specific outcomes for children, however the main indicators of child deprivation still show alarming concerns and thus need further attention and intervention. Below are some highlights.

5.1. Health and Sanitation

In terms of health conditions, Indonesia has improved infant and under-five mortality rates. A recent study shows that Indonesia reduced the IMR from 71 per 1,000 live births in 1990 to 34 in 2007. It is the same case for under-five mortality, the rate declined from 99 per 1,000 live births in 1990 to 44 in 2007, which shows overall improvement on child survival and health. However, progress has been slowing down. According to the same study, the infant mortality rate in Indonesia declined at an average 2.9 percentage points per year in 1990-2007, which is slower than the average decline between 1971-1990 of 3.7 points per year. Similarly, there was a decline in under-five mortality of an

[9]Sex ratio between girls and boys is 0.94; distribution of children in rural area and urban area is 54%-46%; Provinces with the largest number of children are West Java (14.76 million), East Java (10.76 million), and Central Java (10.18 million); Provinces with the smallest number of children are West Papua (312 thousand), Gorontalo (352 thousand), and North Maluku (394 thousand); Proportion of households without children is 27% (rural: 30%, urban: 26%), household with children are: 1-2 (55%), 3-4 (15%), 5 and more (3%) of the overall population.

[10]Where Indonesia will reach the lowest dependency ratio with its productive age population increasing significantly.

average of 3.6 points for 1990-2007, but an average of 6 points per year between 1971-1990. The study indicates disparity across regions as well, which was indicated by 26 provinces that have IMRs and under-five mortality rates that are higher than the national rate (SMERU 2011).

There has been an improvement in access to medical treatment and immunization for babies (Table 10). However, this could deteriorate. For example, the number of households relying on traditional medicine (as opposed to modern medicine) has increased – although admittedly the virtue (or lack thereof) of this approach is empirically unknown.

As shown previously in Table 7, only slightly more than 50% of babies under 2 years old received complete set of basic immunizations. A few provinces show very low percentages, for instance, Papua and West Sulawesi. However, it is apparent from the table that immunization alone does not assure better nutrition for the babies. There may be several other factors that affect the nutritional condition of babies, children and adults.

Table 10a. Some health indicators

	2009	2010
% of population reporting health problem in the foregoing month	33.68	30.97
% of births assisted by medic or paramedic	77.34	79.82
% of babies with BCG immunization	91.89	92.73
% of babies with DPT immunization	89.05	89.79
% of babies with polio immunization	89.88	90.56
% of babies with measles immunization	77.23	77.67
% of population with health self-treatment	68.41	68.71
% of population using traditional medicines	24.24	27.58
% of population seeing a doctor in the foregoing month	44.74	43.99
% of population hospitalized in the foregoing year	2.35	2.51
Avg number of months of breastfeeding to baby age 2-4 years old	20	20
Avg number of months of additional food to baby age 2-4 years old	16	15
Avg number of months without additional food for baby age 2-4 years old	4	5

Source: BPS website

In terms of upper age cohorts, higher percentages of population with good nutrition are found in the groups of ages 13 to 15 and 16 to 18 years old.

In addition to immunizations, living conditions are of importance. Presumably, health outcomes and the related indicators above are correlated with the housing and sanitation conditions in the household. Again, Table 8 depicts some variables related to this. In particular, the table shows housing, sanitation, and drinking water conditions at the provincial level. While some facilities can already be accessed by more than 80% of the households in the respective provinces (such as access to electric lighting and decent floor material), access to decent sanitation and clean water are still low. Most families also live in very small houses and with bad waste management. There is no clear pattern for associating these conditions with location, i.e. the eastern or western parts of Indonesia. If there is any location-related aspect, the capital, Jakarta, stands out in almost every variable. The one exception to this is drinking water, which has been known to be of very low quality in Jakarta.

SUSENAS 2011 reveals that 90% of babies are BCG-immunized, 60% have received DPT vaccinations (three times), 45% have received polio vaccinations (3x), 74% have chicken-

pox/measles vaccinations, and 54% have hepatitis-B vaccinations (3x). Some of these figures are slightly lower than their 2009 counterparts – probably due to the fact that the data are based only on the first quarter of 2011 (which has smaller sample size). However, they are, in general, higher than those of the 2007 figures. One encouraging development is the fact that the percentage of households without health insurance (in any form: JPK, JPKM, JAMSOSTEK, private health insurance, company health insurance, health fund, health card, etc) has declined from more than 70% in 2007 to 44% in 2011 (Table 10b).

Table 10b. Percentage of Households without Health Insurance

	2007	2009	2011
All	71.3	53.9	44.1
Java	74.9	57.1	41.0
Off-Java	67.8	53.4	45.6
Urban	69.0	52.3	48.1
Rural	72.6	54.8	41.2

Source: SUSENAS

To get a better sense of the factors affecting child's health, we explore the prevalence of diarrhea using the 2009 SUSENAS data. Diarrhea is one of the four most important causes of mortality among children in Indonesia (Cameron and Olivia 2011). The SUSENAS survey asked heads of household if any member of the families had experienced diarrhea in the month directly prior to the survey. We use this as a probabilistic dependent variable to see how treatment for babies; household access to clean water, sanitation, and electricity; access to health insurance; and household head's demographics may affect the probability of the children up to 5 years old of getting diarrhea. The results are shown in Table 11.

Among all, we find that the odds of getting diarrhea is 3.4 times greater for children up to 5 years old than the elder family members. The predicted probability of having diarrhea is 8% for a child up to 5 years old with the following characteristics: female, received no immunizations, living in rural area, living in a house of which the largest floor area is dirt/soil, has *no* toilet facility, and has *no* electricity for lighting. Furthermore, he or she is in a family with *no* access to health insurance. The average age of the head of households in this sample is 39 years old, with a mean education level of junior high school. With the *same* child characteristics, the predicted probability of getting diarrhea, given the above characteristics is higher in poor provinces (8%), and lower in non-poor provinces (6%).

Immunizations have a clear impact on diarrhea prevalence. Overall, it can reduce the odds of having diarrhea by 59%, holding all other variables constant. A male child has a higher probability of getting diarrhea than a female child. Furthermore, those living in urban areas have lower probabilities than those in rural areas.

Education matters for health. Household heads with higher education are associated with a lower probability of their children getting diarrhea. As for household income, it seems only to matter in non-poor provinces. However, the sign of its coefficient is contrary to our expectation, so we have refrained from analyzing it further. It appears that in general higher income does not yet necessarily lead to better health care. This requires further study, with more control variables.

Table 11. Results: Diarrhea Prevalence

	All				*Non-Poor Provinces*				*Poor Provinces*			
Diarrhea	**coeff.**		**p>|z|**	**% eff.**	**coeff.**		**p>|z|**	**% eff.**	**coeff.**		**p>|z|**	**% eff.**
Immunization	-0.8806	***	0.000	-58.5	-0.9127	***	0.000	-59.9	-0.8263	***	0.000	-27.0
Breastfed	0.0263		0.317	2.7	-0.0210		0.511	-1.0	0.1072	**	0.022	5.5
Sex	0.1371	***	0.000	14.7	0.1374	***	0.000	7.1	0.1344	***	0.002	6.9
Urban	-0.1770	***	0.000	-16.2	-0.1770	***	0.000	-8.2	-0.0738		0.274	-2.9
Soil floor	-0.0870	***	0.000	-8.3	0.0966	*	0.065	2.8	-0.1738	***	0.002	-16.0
Water	-0.0568	**	0.018	-5.5	-0.1066	**	0.011	-3.7	0.0715		0.278	7.4
Sanitation	-0.1414		0.107	-13.2	-0.2112	***	0.000	-8.6	-0.0768		0.124	-7.4
Electricity	-0.2917	***	0.000	-25.3	-0.1045	**	0.023	-3.2	-0.2941	***	0.000	-25.5
Insurance	0.1375	***	0.000	14.7	0.0886	**	0.003	4.5	0.1381	***	0.002	14.8
Agehead	-0.0540	***	0.000	-5.3	-0.0651	***	0.000	-53.1	-0.0347	***	0.001	-3.4
Agehead2	0.0005	***	0.000	0.0	0.0005	***	0.000	79.5	0.0003	***	0.007	0.0
Eduhead	-0.0402	***	0.000	-3.9	-0.0466	***	0.000	-12.0	-0.0384	***	0.000	-3.8
lnInc	0.0624	*	0.022	6.4	0.1485	***	0.000	8.5	-0.0745		0.130	-4.1
_cons	-1.8184	***	0.000		-2.9995	***	0.000		-0.3804		0.568	
N	134485				101762				32723			
LR chi2(13)	1150.63				765.63				349.52			
Prob > chi2	0.0000				0.0000				0.0000			
Pseudo R2	0.0207				0.0197				0.0213			

*** = significant at the 1% level

** = significant at the 5% level

* = significant at the 1% level

Source: Authors' calculations based on SUSENAS 2009

Note: 1) Diarrhea is 1 if the family member had diarrhea in the last month, 0 otherwise; Immunization is 1 if the baby has at least 1 BCG shot, 3 DPT shots, 3 polio shots, 1 chicken-pox shot, and 3 Hep-B shots, 0 otherwise; Breastfed is 1 if the baby was exclusively breastfed at least 6 months for babies older than a month or any number of days for babies younger than a month, 0 otherwise; Sex is 1 for male, 0 for female; Urban is 1 if true, 0 otherwise; Soil floor is 1 if the floor area in the house is mostly *not* of hardened soil a.k.a. "dirt floor", 0 otherwise; Water is 1 if drinking water source is *not* located within 10 meters of defecation site, 0 otherwise; Sanitation is 1 if the house has a toilet facility, 0 otherwise; Electricity is 1 if the lighting source is electricity, 0 otherwise; Insure is 1 if the household has access to health insurance, 0 otherwise; Agehead is the age of household head; Eduhead is the highest level of education experienced by the household head; lnInc is the log of income. 2) Provinces with HCR (2010 data, for 2009 might be noised by financial crisis) above 15% are included in "poor provinces"; however, Central Java (HCR 15.76%) and Jogjakarta (HCR 16.08%) are excluded due to their proximities to relatively un-poor provinces in Java.

Hygienic floor area does matter in poor provinces. Holding all else constant, having better flooring (than a "dirt-floor") may reduce the odds of getting diarrhea by 8% in the overall sample. In poor provinces the impact is higher at 16%, while in non-poor province it is 0.5%. In non-poor provinces, however, the sign reverses, albeit with weak significance.

Better sanitation, on the other hand, while potentially leading to lower odds of having diarrhea in the overall sample, does not have an effect in poor provinces. Cameron and Olivia (2011) found that having one's own toilet reduces diarrhea prevalence by 14%, and having a flush toilet, in particular, reduces diarrhea prevalence by 25%. The insignificant effect in the poor provinces is rather counter-intuitive, but this might be due to the possibility that there are other factors with higher relative importance than sanitation in the poor provinces.

For example, access to electricity for lighting seems more important, as its unit increase leads to lower odds of getting of diarrhea in poor provinces by almost 26% (the mechanism from electric lighting to diarrhea is of course a point of discussion). In contrast, the effect of sanitation in non-

poor provinces is larger than that of electricity (19% versus 10% increases to the odds of having diarrhea).

Finally, having access to health insurance appears to be *adding* to the odds of having diarrhea. This might suggest an adverse selection issue: those who are insured are actually healthy; or moral hazard, those with insurance become less careful.

5.2. Education

In addition to the enrollment figures presented earlier, the school enrollment ratio of children aged 7 to 12 years old dropped slightly from 97% in 2007 to 96% in 2011 (Table 12). While the school enrollment ratios of children age 7 to 12 are close to 100%, those of age 7 to 18 are less (Table 13), suggesting that many children stopped at primary school either because their family cannot afford to continue or they themselves have to work to support the family. In 2007 only, less than 85% children of age 7 to 18 went to school. This increased to 87% in 2011.

Table 12. Education of Children Age 7-12

	All	Male	Female	Java	Off-Java	Urban	Rural
2007							
Not/never enrolled	1.65	1.78	1.51	0.72	1.98	0.67	2.12
Enrolled	97.00	96.82	97.20	98.32	96.54	98.35	96.36
Drop-out	1.35	1.39	1.30	0.96	1.48	0.98	1.52
2009							
Not/never enrolled	1.84	2.00	1.67	0.70	2.20	0.60	2.40
Enrolled	97.19	96.86	97.54	98.60	96.70	98.70	96.50
Drop-out	0.97	1.14	0.79	0.70	1.00	0.70	1.10
2011							
Not/never enrolled	2.85	3.08	2.60	1.31	3.38	0.93	3.99
Enrolled	95.97	95.48	94.49	97.98	95.27	98.31	94.58
Drop-out	1.18	1.44	0.91	0.70	1.35	0.75	1.44

Note: all data from SUSENAS. Data for 2011 are of first quarter

Table 13. Education of Children Age 7-18

	All	Male	Female	Java	Off-Java	Urban	Rural
2007							
Not/never enrolled	1.45	1.54	1.37	1.45	0.70	0.61	1.89
Enrolled	84.80	84.44	85.20	84.80	84.39	88.99	82.66
Drop-out	13.74	14.03	13.43	13.74	14.92	10.40	15.45
2009							
Not/never enrolled	1.58	1.68	1.48	0.60	1.90	0.50	2.10
Enrolled	85.29	84.82	85.88	84.80	85.50	88.80	83.58
Drop-out	13.13	13.50	12.72	14.60	12.60	10.70	14.32
2011							
Not/never enrolled	2.25	2.31	2.19	0.89	2.74	0.62	3.31
Enrolled	87.06	86.22	87.96	87.87	86.77	90.59	84.79
Drop-out	10.69	11.48	9.85	11.25	10.49	8.79	11.91

Note: all data from SUSENAS. Data for 2011 are of first quarter

Coincidentally, 52% children between the ages of 7 and 18 years old stopped going to school because their family could not afford the school fees, and about 7% stopped because they had to work (Table 14). In 2011, the figures slightly shifted to 44% ("could not afford") and 10% ("had to work"). This might imply that there are proportionally more children now opting for or having to work instead of going to high school. Nevertheless, of this cohort, those with a primary school diploma amount to less than 25%. More than 50% do not have any school certificate (Table 15).

Table 14. Reason for Not Enrolling in School

	2007		2009		2011	
	Age 7-12	Age 7-18	Age 7-12	Age 7-18	Age 7-12	Age 7-18
No money	35.30	52.48	35.30	51.12	32.26	43.58
Have to work	1.63	7.38	2.60	9.70	1.51	10.18

Note: all data from SUSENAS. Data for 2011 are of first quarter

Table 15. Highest diploma obtained

	Male	Female	Age 7-18	Java	Off-Java
2007					
None	29.85	31.39	55.64	26.76	35.25
Elementary	27.40	29.35	24.46	30.40	27.47
Junior High	15.93	14.93	14.86	15.08	15.60
Senior High	12.89	11.43	1.60	11.13	12.63
Vocational	5.13	3.69	0.42	5.67	3.89
2009					
None	31.30	32.60	55.20	28.40	33.40
Elementary	26.50	27.80	24.10	28.60	26.50
Junior High	15.60	14.90	15.30	14.90	15.40
Senior High	13.50	12.00	1.80	11.30	
Vocational	5.13	3.62	0.55	6.09	3.67
2011					
None	30.39	31.89	55.84	27.45	32.73
Elementary	26.65	27.78	24.92	28.43	26.66
Junior High	15.30	14.89	15.47	14.95	15.17
Senior High	13.05	11.31	0.51	11.23	12.62
Vocational	5.40	3.87	0.38	6.08	4.03

Note: all data from SUSENAS. Data for 2011 are of first quarter

Table 16. Results: Child Labor Likelihood

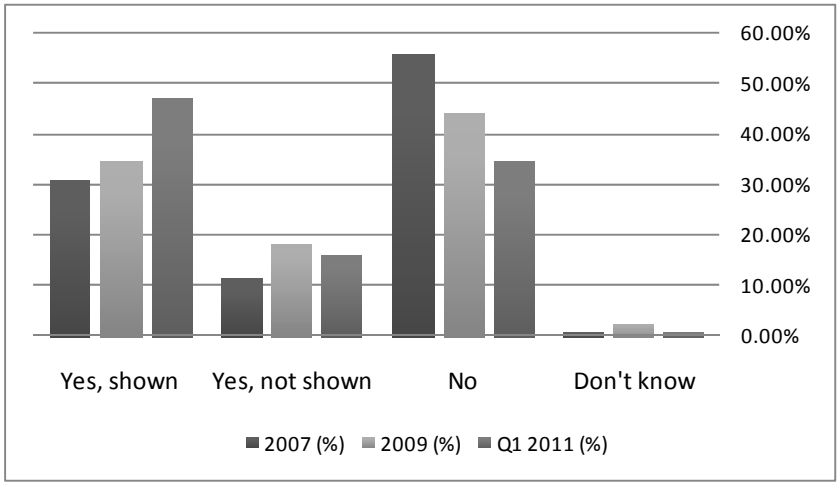
Work	Age < 18				Age 10-18			
	coeff.		p>|z|	% eff.	coeff.		p>|z|	% eff.
Sex	0.0342		0.415	3.5	0.6786	***	0.000	97.0
Urban	0.2851	***	0.000	33	-0.7044	***	0.000	39.3
Age	0.0764	***	0.000	7.9	0.4025	***	0.000	6.8
lnInc	-0.0222		0.612	-2.2	-0.2496	***	0.000	-0.2
Agehead	-0.0677	***	0.000	-6.5	-0.0383	***	0.000	
Agehead2	0.0006	***	0.000	0.1	0.0003	***	0.000	
Eduhead	0.0358	***	0.000	3.6	-0.1152	***	0.000	
_cons	-4.2229	***	0.000		-2.8923	***	0.000	
n	436146				201604			
LR chi2(13)	411.68				29229.44			
Prob > chi2	0.0000				0.0000			
Pseudo R2	0.0143				0.1688			

*** = significant at the 1% level
** = significant at the 5% level
* = significant at the 1% level
Source: Authors' calculations based on SUSENAS 2009
Notes: 1) Work is 1 if the child works, 0 otherwise; Sex is 1 if male, 0 otherwise; Urban is 1 if true, 0 otherwise; Age is the age of household head; Edu is highest level of education of household head; lnInc is the log of income of the family.

5.3. Birth Registration

Based on the population census of 2005, UNICEF estimates that 60% of children in Indonesia do not have a birth certificate. SUSENAS 2011[11] reveals that almost 34.8% of household members age 0 to 17 years old do not have birth certificate, and 16.3% claimed to have one but were not able to show the actual document. When compared with 2009 data, there is an improvement on access to birth certificates from 35% to 47.7% children with birth certificate and able to show it (Figure 5). However, heads of households blame the expensive fee for obtaining a certificate (28%) and the lack of information on how to obtain one (17.25%) as the main reasons for not having a certificate for their children. Absence of a birth certificate is more prevalent in provinces outside of Java than those on Java, and more prevalent in rural rather than urban areas (66.3% of those without birth certificate live in rural areas).

Figure 5. Status of Birth Certificate Among Children

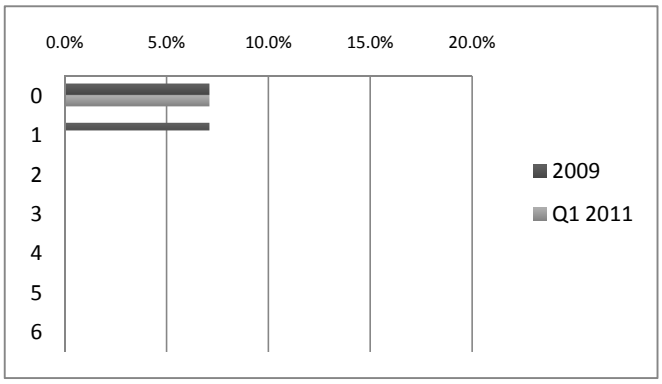


Source: SUSENAS, various years

To have better comparison, one might want to focus only on the 0 to 6 years old age group. This would give information regarding to how development has progressed in recent years. However, as Figure 6 shows, the improvement of access to birth certificates in this age group is inconclusive. If anything, it may only suggest that families take some time before registering their babies or children.

[11]In 2011, SUSENAS was done in quarters. And the data in this section were drawn from the complete raw data we can obtain from the first quarter of SUSENAS 2011.

Figure 6. Absence of Birth Certificate, Age 0-6



Source: SUSENAS, various years

Indonesia issued a national strategy on Universal Birth Registration in 2008, with a target of all children having a birth certificate by end of 2011. The SUSENAS data above shows us that Indonesia still needs to work very hard to achieve 100% registered children. However, there is not data to indicate the success rate of having children registered-at-birth since the issuance of the national strategy. The right of all children to be registered and given a birth certificate free-of-charge is guaranteed by the 2002 Child Protection Law. That law then overlapped with Population Administration Law enacted in 2006, which stipulates that the free of charge birth certificate rule only applies for children who are registered not more than 60 days after being born. This situation had created some confusion, and in the spirit of reaching the 2011 target, the government implemented a 'writing-off' period from 2006 until end of 2011 for everyone, including adults, who did not have birth certificate, so that they could obtain a birth certificate for free. We can see, however, that even with such a discretionary policy, Indonesia is still 40% behind its original target.

Charging an administrative fee for issuance of a birth certificate was, in the past, an income source for local governments. Implementing the policy means advocating for a 'change of business' in more than 450 different district governments. In addition, the cost of registering a child and obtaining a birth certificate afterwards does not come only from the administrative charge, but also from the process cost such as transportation to reach the nearest civil registrars office that usually sits at the district level (and at most of the time this cost is higher than the certificate). Some alternative models have been piloted to overcome this problem. In East Nusatenggara, midwives and other birth attendants in rural and remote areas are mandated to record every birth, to collect the necessary documents and to bring them to be processed at the civil registrar office on a regular basis. In Solo, Central Java, the Mayor took a leadership role and reformed the quality of and access to the registration services. Birth registration in Solo has now reached almost 100%. However, careful evaluation is needed to determine if both models could be recommended for replication in appropriate contexts.

As of now, the new procedure is being enforced. According to the same 2006 law, registration of birth, and therefore issuance of birth certificate, for applicants who have been born more than 60 days prior need to be legalized through a general court. This runs the risk of creating additional costs, complication and confusion around the mechanism. When the report was written, the Supreme Court was working together with the Ministry of Home Affairs to develop a standardized and simplified procedure to accommodate this very situation.

5.4. Child Labor

The SUSENAS survey reveals that in 2011, 7.6% of children age 10 to 15 work, of which 61% are male and 39% female children. The corresponding figures for 2009 were 8.5% child labor, of which 63% were male, and 37% were female. Thirty percent of the working children in 2009 and in 2011 work 7 days a week. Employing a simple econometric assessment of factors that might affect the likelihood of a child working, we find the following (see Table 16).

Being a male child increases the odds of working by 97% when compared to females. Living in urban areas decreases odds by 50%, suggesting that child labor is more prevalent in rural than urban areas. Furthermore, the odds of working increases with the age of the child, decreases with the increased income of the family, and also decreases with increases in both the age and the education level of the Head of Household. As for the nesting cohort of 0 to 18 years old, sex and household income appear to be insignificant, and other variables behave in similar ways as in the 10 to 18 years old cohort. This part of estimate (age < 18), however, should be considered carefully, because SUSENAS only asks working status of family members aged 10 and above.

There are additional issues to be highlighted. Some studies suggest that child labor is related to poverty, and the latest working paper written by SMERU confirms that relationship. The paper notes that being at work does compromise children's ability to access education and schooling in terms of actual attendance and reduced time for study. However, the direct consequence of not attending school and seeking to escape future poverty by having a better-paying job, tends to be weak especially in the context of low quality of education and availability of schools. The paper also highlights the finding that when working and schooling occur in parallel, the extra household income earned by a child increases the opportunity for that child to remain in school. Based on those recent findings, the SMERU working paper (Sim *et al.*, 2012) measures the effect of child labor on the accumulation of human capital that has been seen to influence the chances that a child may have better earnings in the future. Human capital in this case means mathematics skills, cognitive skills, and pulmonary function. Sim et al. (2012) looked at the growth of human capital over a period of seven years, and they found strong negative effects of child labor on the development of mathematics skills in the following seven years. While the negative effect in mathematics skills is only statistically significant for female child workers, lower cognitive skills are seen in male child workers. They also found strong, negative effects on the development of pulmonary function of children who are working.

5.5. Crime against Children

Children (0 to 18 years old) are less exposed to crime than adults, but there has been a slight increase of crime experienced by children. For example, the percentages of theft, robbery and murder that occur to children increased from 9%, 30% and 14% in 2009, respectively, to 9.8%, 33% and 25% in 2011 (in the meantime the crime rates of rape and fraud/deception to children went down) (Table 17).[12]

[12]It is important to note that particular questions about crime against children in SUSENAS do not employ specific indicators of abuse and exploitations experienced by children and/or maltreatments in the context of domestic violence. SUSENAS enumerators were not trained on asking sensitive issues such as child abuse nor that it was designed to investigate such cases. Violence, abuse and exploitation against children are very difficult to measure worldwide, including in Indonesia. In 2006, the Statistic Body (BPS) and the Ministry of Women's Empowerment and Child Protection (KPPPA) collaborated in undertaking a national survey on Violence Against Women and Children. It estimates around 3 million women and children fall victim of violence every year in Indonesia (KPPPA 2006). The survey, however, had been recognized to have weaknesses and the data needs to be improved. Efforts to get better information on those indicators is still being undertaken by the government.

A simple econometric estimation (Table 18) reveals that sex and income factors are not significant in affecting the odds of a child becoming a victim of crime. Hence both sexes appear to have an equal chance to be victimized and crime can happen to a child regardless of the family income. On the other hand, the odds of becoming a victim increase almost 40% for children in urban areas as compared to children in rural areas.
Finally, the odds increase with age.

Table 17. Types of Crime Experienced (%)

Types	Age 0-18	Adult	Male	Female	Urban	Rural
2007						
Theft	14.19	85.81	64.06	35.94	39.52	60.48
Robbery	37.25	62.75	49.42	50.58	39.14	60.86
Murder	40.80	59.20	49.56	50.44	37.80	62.20
Fraud/deception	5.39	94.61	63.03	36.97	49.06	50.94
Etc	23.66	76.34	55.10	44.90	35.21	64.79
Never	39.05	60.95	49.99	50.01	36.23	63.77
2009						
Theft	8.85	91.15	68.06	31.94	42.63	57.37
Robbery	29.85	70.15	49.11	50.89	40.93	59.07
Murder	13.89	86.11	58.33	41.67	25.00	75.00
Fraud/deception	3.62	96.38	64.94	35.06	50.64	49.36
Rape	42.86	57.14	14.29	85.71	42.86	57.14
Others	23.60	76.40	56.96	43.04	35.54	64.46
Never	39.08	60.92	49.95	50.05	35.18	64.82
2011						
Theft	9.81	90.19	69.91	30.09	48.36	51.64
Robbery	32.94	67.06	49.20	50.80	59.71	40.29
Murder	25.00	75.00	50.00	50.00	37.50	62.50
Fraud/deception	2.80	97.20	66.16	33.84	53.40	46.60
Rape	20.00	80.00	40.00	60.00	80.00	20.00
Others	15.77	84.23	59.91	40.09	44.59	55.41
Never	38.78	61.22	50.03	49.97	40.85	59.15

Note: All data from SUSENAS. "Rape" was not asked in 2007. Data for 2011 are for first quarter. These numbers are to be taken cautiously, for some absolute numbers are very small.

When the report was written, the government of Indonesia, under the leadership of the Planning Ministry and the Statistic Body, is developing a national survey plan to be conducted in 2013 to look at prevalence on violence against children, using a population-based approach and measurement.

Table 18. Results: Odds of Crime Victim

Crime	coeff.		p>|z|	% eff.
Sex	0.0264		0.519	2.7
Urban	0.3318	***	0.000	39.3
Age	0.0661	***	0.000	6.8
lnInc	-0.0017		0.967	-0.2
_cons	-6.0040	***	0.000	
n	436146			
LR chi2(13)	338.25			
Prob > chi2	0.0000			
Pseudo R2	0.0118			

*** = significant at the 1% level

** = significant at the 5% level

* = significant at the 1% level

Source: Authors' calculations based on SUSENAS 2009

Notes: 1) Crime is 1 if the child (0-18 years old) had experienced theft, robbery, murder, fraud/deception, rape or others in the last year, 0 otherwise; Sex is 1 if male, 0 otherwise; Urban is 1 if true, 0 otherwise; Age is the age of the child; lnInc is the income of the family.

5.6. Early-Marriage and Pregnancy

The 2009 SUSENAS figures tell us that most households in Indonesia include children. In addition, due to the current Marriage Law that allows girls to be married at the age of 16 and for boys or girls to be married below the legal marital age if given parental approval, there are households in Indonesia that are headed by children. While the average age at first marriage for women in Indonesia is between 19 to 20 years old (SUSENAS 2007, 2009, and 2011) under-age marriage (defined here as marriage under 16 years old) remains high at around 11% in 2011, when compared to 9.4% and 11.2% in 2007 and 2009, respectively (Table 19). Such under-age marriage is more prevalent in rural than urban areas. Interestingly, the incidence of under-age marriage is higher in Java than outside Java. On the other hand, the 2010 RISKESDAS shows that the prevalence of marriage within the age range of 15 to 19 years old is 42%, and almost 5% between the ages of 10 to 14. The prevalence of marriage between the ages of 10 to 14 is 6% higher in rural areas, 10% higher among out-of schoolgirls, and 6% higher within the lowest decile of poverty.

Table 19. Maternal Conditions

	All	Java	Off-Java	Urban	Rural
2007					
Mean age at first marriage	19.9	19.5	20.1	20.7	19.5
% underage marriage (<16)	9.4	12.2	8.0	7.0	10.7
Mean number of children born alive	3.2	2.9	3.4	3.0	3.3
Mean number of children still alive	2.8	2.6	3.0	2.7	2.9
Protection in sex (%)					
Use protection	38.0	39.7	37.1	38.8	37.5
Injection	56.5	57.3	53.3	50.4	57.1
Pill	26.4	20.7	29.4	26.8	26.2
Condom	0.6	0.7	0.6	1.2	0.3
Stopped using protection	27.1	28.1	26.6	30.3	25.3
Never use protection	34.9	32.2	36.3	30.9	37.2
2008					
Mean age at first marriage	19.8	19.1	20.2	20.8	19.3
% underage marriage (<16)	11.2	16.1	8.8	8.2	12.7
Mean number of children born alive	3.2	2.8	3.3	2.9	3.3
Mean number of children still alive	2.8	2.5	2.9	2.7	2.9
Protection in sex					
Injection	54.8	56.6	54.0	50.2	57.4
Pill	25.8	21.1	28.1	26.5	25.4
Condom	0.7	0.9	0.6	1.4	0.4
Use protection	40.0	41.2	39.3	40.4	39.8
Stopped using protection	26.3	27.8	25.7	29.3	24.8
Never use protection	33.7	30.7	35.1	30.3	35.4
2011					
Mean age at first marriage	20.0	19.3	20.3	20.8	19.4
% underage marriage (<16)	11.0	15.3	8.8	8.4	12.7
Mean number of children born alive	3.1	2.8	3.3	2.9	3.3
Mean number of children still alive	2.8	2.5	2.9	2.6	2.8
Protection in sex					
Use protection	39.3	41.1	38.4	39.8	39.0
Injection	50.7	54.3	48.9	52.9	49.3
Pill	24.3	20.6	26.2	25.0	23.8
Condom	0.9	1.2	0.7	1.6	0.4
Stopped using protection	26.9	29.6	25.5	30.2	24.7
Never use protection	33.8	29.3	36.1	30.1	36.4

Note: all data from SUSENAS. The 2011 figures are of first quarter

6. Policy Highlights and Implications

There are many policy interventions related to issues of inequality in Indonesia, both vertical and horizontal. Two sets of them are those related to tax reform and labour market regulations. In terms of tax reform, or more broadly, financial reform, the issue of decentralization is very important. As discussed by Mahi and Nazara (2012), Indonesia has consistently increased fiscal transfers to regions since decentralization began in 2000. However, they note that there have been allocative and productive inefficiency in the transfer processes whereby the budget allocated mismatched the local needs and the spending outcomes have been of low quality. In response to these problems, the government has been revising the relevant laws and regulations, for example, Law 39/2007 on Excise Tax that regulates revenue sharing for tobacco excise tax and Law 28/2009 that changed the property tax from a central government tax shared with local governments to simply a local tax. At present, the government is still revising Law 33/2004 on Central-Regional Government Fiscal Balance. Such revision includes attempts to eliminate the salary component of the general allocation fund, promote capital expenditure, improve budget disbursement, improve the predictability of regional revenue, and attain minimum service standards. While all these seem ambitious, the success of the reform is likely to reduce the regional imbalance while improving the effectiveness of decentralization.

Unfortunately, progress is less rosy in regard to labour regulations. After a failed attempt to revise the exceedingly rigid labour law in 2006, the government has not made further efforts on the matter (see Manning and Roesad 2006; and Manning and Purnagunawan 2011). On the contrary, some local governments have recently accepted workers' demands for significant increases in regional minimum wage levels.[13] While certainly an increase in minimum wage is good for workers, the effect can be detrimental to those who are still unemployed, as the employers see this as an increased financial burden and may prevent the hiring of more people. In addition, spike increases in minimum wage, such as 40%, will likely be followed by the same proportional increase in severance payment (as it is anchored to wage change), and hence exacerbates the above-mentioned effect. Finally, as labour cost is part of production cost, a large increase in minimum wage can be inflationary. This in turn will hurt the poor as the basic needs become more expensive.

The other policies addressing specific problems like education and health will also affect general horizontal inequality. For additional discussion on these policies, see e.g. Suryadarma (2011) on education and Sparrow (2011) on health. Below we focus on policy interventions that directly impact child wellbeing.

6.1. Policies on Children

Indonesia ratified the Convention on the Rights of the Child (CRC) in 1990 and subsequently issued a number of laws and regulations concerning children's wellbeing. Guided by the basic rights outlined in CRC on survival and development, education, participation and protection; and as a signatory of various international instruments, Indonesia has included a series of child-related national laws in its legislative framework.[14] In general, there has been rapid improvement

[13]For example, the minimum wage in Jakarta increased by more than 40% (http://www.thejakartaglobe.com/home/with-jakartas-minimum-wage-to-rise-44-bosses-warn-of-job-cuts/557342) and in Bekasi (West Java) about 25% (http://www.thejakartaglobe.com/home/bekasi-raises-minimum-wage-to-rp-21-million/556693)

[14]Such as Law on Child Welfare (No. 4 of 1979), the Law on Juvenile Court (No. 3 of 1997), the Law on Human Rights (No. 39 of 1999), the Law on Elimination of Domestic Violence (No. 23 of 2004), the Law on Citizenship (No. 12 of 2006), the Law on Protection of Witnesses and Victims (No. 13 of 2006), the Law on Population

of laws and policies on human rights-related issues following the abdication of Soeharto's authoritarian government in 1998. First and foremost, Indonesia amended its Constitution and added a stipulation on child rights to Chapter 10A Section 28b (2) ("Every child has a right to live, grow and develop and to be protected from violence and discrimination"). This was the beginning of a further shift in the policy agenda. This report highlights some of the most recent policies including the Law on Child Protection (No. 23/2002), the Law on Social Welfare (No. 11/2009) and the Medium-Term Development Plan 2010-2014.

Child Protection Law. This law guarantees various means to protect the children's right to health; right to education; cultural rights; economic, political and civil rights; right to care; participation rights and rights of special protection. It stipulates child protection as:

> *All activities designed to guarantee and protect children and their rights so that they may live, grow, develop and participate optimally in society in accordance with the dignity to which they are entitled as human beings, and so that they may be protected against violence and discrimination. (Article 1)*

However, the Child Protection Law sets forth rather ambiguous articles that focus on descriptions of the rights of the child instead of clearly elaborating a mandate on who should fulfill those rights and how to do so. This type of ambiguity can be seen in many Indonesian laws, regardless of whether or not the law 'ground-breaking'. Further, this ambiguity has implications for the implementation of the law, including implications for how the law is articulated in programs and interventions.

Social Welfare Law. This law does not make a specific reference to protecting children's wellbeing, but its accompanying elucidation stipulates that this law is to guide the government in addressing issues relating to neglected children. More specific than Law No. 23 of 2002 (the Child Protection Law), the Social Welfare Law stipulates principles for administration and budgeting for the social services it guarantees, and also regulates the basic aspects of the registration and licensing of social service providers, including legal consequences for non-compliance. This law has becomes the basis for the establishment of a social assistance program for children called PKSA (discussed further in the next section). However, many details concerning how the law should be implemented are delegated to subsidiary government regulations, and some of them are still being developed.

Medium-Term Development Plan 2010-2014. For the first time in decades of development, Indonesia has incorporated child protection as one of the four national priorities (alongside the important arenas of Poverty Reduction, Climate Change, and of Marine Development), in February 2010 as part of the National Medium Term Development Plan (RPJMN) for 2010-2014.[15] This milestone includes a strategic statement and plan to improve the survival and development of children, as well as the protection and welfare of children. It sets clear targets for improving health, nutrition and education for children, as well as for reducing abuse, exploitation and neglect of children. Following the core-planning document, the President of Indonesia issued a Presidential Instruction Number 1/2010 on the Acceleration of the Implementation of National Development Priorities for 2010 and Law Number 3/2010 on Access to Justice. Both set forth child

Administration (No. 23 of 2006), the Law on Anti-Trafficking (No. 21 of 2007), the Law on Social Welfare (No. 11 of 2009), the National Program for Indonesian Children (PNBAI), and a series of national action plans on the elimination of the worst forms of child labor, of the sexual exploitation of children, and of trafficking in women and children, including the 1997 Presidential Instruction on the implementation of child's quality wellbeing, and inclusion of a paragraph on children's welfare in the GBHN 1993.

[15]The particular Child Protection part can be found in RPJMN 2010-2014 Book II Chapter 1 p. 43.

protection and wellbeing programs as priorities, and also categorize social assistance programs for children as one of the national priorities under the poverty reduction sector.

Under the same chapter of crosscutting priorities, the planning document elaborates on how social assistance programs should be undertaken to help families and communities meet their basic needs. Furthermore, the 2010-2014 RPJMN states priorities for social assistance programs to pay more attention to groups of people with disabilities, the elderly from poor families, marginalized communities and children, so that they have access to basic needs, services and productive resources to improve their welfare and eventually be able to actively participate in development.

6.2. Policies on Poverty Reduction and Social Assistance

Commitment from the government to address poverty is reflected in a number of Social Assistance programs targeting the very poor, poor and near poor families, as well as for some individuals. Indonesia had started to implement several programs on various timelines, with variety of model interventions and targeting specific category of beneficiaries, for over more than a decade. These are described in Table 20.

Table 16. Existing Social Assistance Programs as per Actual Beneficiaries in Mid 2011

Program	Target group	Coverage	Benefit
Unconditional Cash Transfers **(BLT)**	Poor & near poor households	18.7 million households	Rp. 100,000/month
Rice for the Poor **(RASKIN)**	Poor & near poor households	17.5 million households	15 kg rice/month *(appr. IDR 1.1 million per year)*
Health Assistance **(JAMKESMAS)**	Poor & near poor households	76.4 million people	Unlimited subject to conditions
Scholarships for the Poor **(BSM)**	Poor students	4.6 million students	IDR 360,000-1.2 million *(based on level of school)*
Conditional Cash Transfer **(PKH)**	Very poor households	810,000 households	IDR 1.3 million per year
Social Assistance for Vulnerable Children **(PKSA)**	Neglected under-5, neglected children, street children, children in contact with the law, children with disability, children in need of special protection	4,187 children	IDR 1.3 to 1.5 million per year
Social Assistance for People with Disability **(JSPACA)**	Severely disabled adults	17,000 people	IDR 3.6 million per year
Social Assistance for Vulnerable Elderly **(JSLU)**	Vulnerable elderly	10,000 elderly	IDR 3.6 million per year

Source: National Team for the Acceleration of Poverty Reduction (TNP2K) & SMERU Research Institute

Despite having good intentions, the combined efforts of those programs do not yet reach the entirety of the vulnerable population at risk of falling into poverty. Each of the programs also has different levels of success or impact on the lives of its beneficiaries, and moreover, and some still lack efficacy. The 2012 World Bank report on social assistance programs explains that

effectiveness varies due to insufficient targeting and the limited ability to identify both poor and vulnerable households; the adequacy of the benefit package to address the needs risk of particular households; the quality of delivery and timing of the benefit disbursement; the poor capacity of local implementation agencies and lack of sufficient financial and/or technical support to overcome those; weak monitoring; and in many cases, a combination of all the aforementioned. The existing social assistance programs implemented by different sectors are also perceived to be fragmented and poorly coordinated (World Bank 2012). Some of the programs and their specific challenges are described below.

JAMKESMAS is tax-financed health insurance for the poor. So far it has reached the biggest number of beneficiaries when compared to other social assistance schemes. Poor targeting and leakage are two of the most common problems faced by these interventions, and JAMKESMAS is no exception. Under utilization of benefits due to beneficiaries' lack of knowledge of the program, as well as unavailability of adequate health services are two of the most highlighted unique challenges for implementing of this program.

BSM is a school-based scholarship scheme for poor students, providing cash assistance to students from the primary level until the university level. BSM is disbursed to students identified by school principals or the authority of an educational institution. Due to this school-based 'targeting' mechanism, BSM is known as the least pro-poor assistance program. Despite its good intentions, BSM has not been successful in reaching children from poor families, is not able to prevent dropouts and to bring out-of-school children back to school. Also, BSM does not accommodate needs regarding early-childhood education into its design.

PKH is a conditional cash transfer program providing direct cash benefits to poor families that are conditional on household participation in locally provided health and education services. PKH is one example of a social assistance program that incorporates an evaluation mechanism from the beginning. It allows for regular monitoring and impact measurement. The latest report shows that the PKH benefits had increased beneficiaries' monthly spending by 10% on protein-rich foods and health services. It also shows positive impact on children's health quality, and has a spillover effect to the quality of child's health in neighboring households who did not receive the cash transfers. It also has a positive effect on children staying in school (World Bank 2012). The program, however, does not address nutritional problems occurring at early ages that have negative results later in life, for instance, stunting and wasting. This is due to the fact that it was designed to reduce infant and maternal mortality. In addition, while it might have a positive impact on children staying in school, it does not address problems around out-of-school children, either on enrollment in formal education or on providing access to alternative education.

PKSA is a smaller-scale, gradual conditional cash transfer program that combines a model of youth savings accounts with assistance for children to access basic care and welfare services. PKSA was launched with the hope of reaching the hard-to-reach population of neglected children, street children, children in contact with the law, children with disability and children in need of special protection (including victims of abuse, exploitation and emergencies); and, further sought to address specific vulnerabilities faced by children and their families. The cash assistance is given to enable families to support the basic needs of their children including birth certificates, transportation to school and some basic health care. Also, the program theoretically provides support from professional social workers, like guidance and counseling services. However, the shortage of social workers and poor capacity of those who are available have prevented PKSA from fulfilling its ideal design. Unavailability of baseline and standardized methods of beneficiaries' identification contribute to the program's poor targeting. In addition, program sustainability may suffer due to the absence of local government commitment and involvement. Some of the shortcomings mentioned have made PKSA ineffective in providing

constructive assistance to parents and families as a means for them to assume their responsibilities to care for and protect children within the family, which is the intended goal of the program (PUSKA PA, 2011).

Looking at the above, we can see progress on both child-specific policies and social assistance policies to reduce poverty. Despite being identified side-by-side in the national development plan as crosscutting priorities, the poverty reduction and child protection agendas did not seem to have been treated as crosscutting. Each works within its respective silo, and missing opportunities for linkage between the two. Poverty reduction strategies often overlook existing child wellbeing-related programs and policies. The social assistance programs are still sector-oriented and were not designed to comprehensively address the interwoven risks faced by children. These overarching strategies were being developed without properly investigating the specific needs of children. On the other hand, child wellbeing-related programs and policies are often developed in an ambiguous manner, using the difficult-to-measure parameter of rights, without connecting them to the "umbrella" of social assistance and poverty reduction. It is therefore challenging to prove that the current poverty reduction strategy and social assistance programs are successful in addressing specific risks experienced by children living in poverty as well as in addressing prevention of vulnerabilities that yield inter-generational poverty.

6.3. Expenditure

Indonesia has the potential to reduce poverty and inequality by leveraging its resources and economy. The current budget allocation and government spending for social assistance programs is much lower than that of neighboring countries like the Philippines and Vietnam, as well as other countries like Mexico, Brazil, Argentina and India.

Compared to the budget allocated to fuel subsidy, the portion that goes to social assistance is very low (Table 21). In the proposed 2012 budget, almost 9% of the total budget (or, almost 13% of central government expenditure) is allocated to fuel subsidy. In 2011 the allocation to fuel subsidy was almost 13% of the total budget, while total allocation for social assistance programs was 2,05%. This current subsidy regime is regressive because almost half of the benefit is enjoyed by the richest 20% of the country, and only less than 2% reaches the poorest 20%. It is also counter-productive because it denies more allocation for social assistance (as part of poverty eradication program) and infrastructure development (the oft-cited most problematic factor in Indonesia's supply side). In addition, it suppresses the incentives to move towards cleaner energy (Patunru and Basri 2012). In 2011, the budget realization for Social Aids was less than one-fourth of that for Subsidies.

Table 21. Government Expenditure for Social Assistance

Categories	2011 Annual Expenditure (IDR)	%
Rice for the Poor (RASKIN)	15.267.000.000.000	56,43%
Health Assistance (JAMKESMAS)	5.100.000.000.000	18,85%
Scholarship for the Poor (BSM)	3.900.000.000.000	14,42%
Conditional Cash Transfer (PKH)	1.610.000.000.000	5,95%
Disaster Assistance & Relief	429.040.000.000	1,59%
Other Social Assistance (for disability JSPACA, for vulnerable elderly JSPLU)	358.890.800.000	1,33%
Social Assistance for Vulnerable Children (PKSA)	287.127.300.000	1,06%
Assistance for Elderly	101.114.400.000	0,37%
TOTAL Social Assistance	***27.053.172.500.000,0***	***100%***
Share to State Budget (APBN)	**1.320.751.300.000.000**	**2,05%**
Share to GDP	**7.226.900.000.000.000**	**0,37%**

Source: Indonesia's Ministry of National Development Planning (BAPPENAS)

6.4. Availability of Health Services

With the growing assistance programs, Indonesia has the potential to eventually reach almost all of the most vulnerable and enables them to access basic services, thereby creating the demand. Unfortunately, access is not an issue of the capacity of the demand alone. It goes hand-in-hand with the availability of services and with the quality of those services – the supply. Ensuring that the country has enough supply remains a matter of concern.

This, for example, is confirmed by a study conducted by The World Bank that looked at the provision of health services in Indonesia. The study highlights that the ratio of health providers in Indonesia (doctors, nurses and midwives) per 100,000 population increased between the period of 1995 and 2006, with an improved geographical distribution. Additionally, Indonesia has around 80 thousand midwives throughout all provinces. However, the distribution of doctors, for example, is still 5 times greater in urban areas than in rural and remote areas. The number of doctors is the highest in Java and Bali, due to the population density of the islands.[16] However, this overall ratio was still considerably low when compared to other countries in the region. When the report was released, Indonesia had a ratio of 21 doctors per 100,000 while the Philippines have 58 and Malaysia has 70 (The World Bank, 2009). The Child Poverty study in 2011 also showed that in general, poor children in rural areas are experiencing more difficulties in accessing adequate basic facilities like education and health when compared to poor children in urban areas (SMERU 2011).

A discussion of supply naturally leads to the issue of resources. No matter how well designed and well-targeted an intervention is, it will only make a significant difference on the wellbeing of children if the country has the ability to implement that intervention long term. Indonesia is very committed in doubling the social assistance programs' coverage over the next two years.

[16]Based on 100,000 ratio, doctors are higher outside of Java and Bali islands.

However, careful calculation needs to be undertaken to support that goal and to anticipate the challenges ahead. Programs need to understand the country's sources of income and how it is being spent. Policies on child wellbeing should be realistic in regard to the state of the economy, the budget mechanism, and also clear about why making an investment in children is important.

6.5. Decentralization

Geographical richness poses one of Indonesia's greatest challenges, and decentralization has magnified this challenge. It is needless to say that a country as large and as diverse as Indonesia must be decentralized to be able to bring development and public services closer to its individual communities. However, this report must highlight some of the policy challenges currently faced by the country, as they might explain the situation and therefore brings us to focused policy recommendations.

After almost fifteen years of implementation, the decentralization process in Indonesia remains a slow and, in some sectors, a halting process. Reiterating the importance of addressing the supply side, Indonesia needs to not only guarantee the availability of quality services, it needs to make sure that those services are locally available. The delivery and management of services at the local level, however, are still perceived as inefficient. Decentralization gives the primary authority to district governments with lack of clarity about the role of the provincial governments and the overlapping responsibilities of the central government. The expensive political process at the district and provincial level is still yielding more cost than benefit for communities. It includes a very sophisticated financial and budgeting mechanism, and further rather complicated accountability procedures, yet the actual allocation of money remains about the same as before decentralization. It has caused district governments, that are still lack capacity, to administer complex planning processes, resulting in confusion in establishing local spending priorities. The ambiguities in roles and responsibilities have made monitoring and reporting mechanism more difficult. All of these challenges are compounded by the shortage of technical assistance from the central government officials who are still implementing their own activities and budgets across different sectors and programs (see more discussion in e.g. Brodjonegoro (2004), Miranti (2011), and Mahi and Nazara (2012)).

7. Conclusions and Recommendations

Guided by the Millennium Development Goals (MDG), Indonesia has been working toward achieving key development priorities, tackling human rights issues and fighting extreme poverty. The latest 2011 MDG status report concluded that the country is making significant progress, despite some goals not yet being fully met. While Indonesia has managed to reduce absolute poverty, inequalities have been on the rise. In addition, some vulnerability issues have yet to be addressed properly, causing the enhancement of human capital to take place at a slower-than-expected pace.

Despite the steady decline in poverty, a significant number of people still live below the poverty line. Income inequality in terms of Gini Ratio has been worsening, both on national and regional levels. Furthermore, there are more than 21 million Indonesian children living in poor and vulnerable households in Indonesia. Gender inequality also remains. Being a female in Indonesia increases the likelihood of experiencing education deprivation.

This study also shows that children are still at a disadvantage in regard to increasing inequality despite national laws and policies guaranteeing specific services and interventions. A large

amount of the child population is still deprived of access to birth registration, basic education, nutritional and health services. They are also still prone to a number of vulnerabilities such as falling to early marriage and child labour.

Based on the assessments, the study recommends the following:

1. The post-MDG goals need to shift the focus from input to output. Indonesia is doing relatively well in meeting MDGs, for example, good progress has been made towards ensuring that children have access to primary education (under the MDG for basic education). This has resulted in a high enrollment rate, especially for basic education. This shows significant progress on the input side, but it overlooks the output side of education. Education is still believed to be one of the most powerful tools to fight poverty, therefore we need to ensure that input in education will result in high quality output of graduates, low number of drop outs (especially from primary to secondary level), increased of individual skills, improved public participation, and the betterment of future earnings with respect to each level of education. The same logic goes for other sector like health. By focusing on outputs, policies and actual investment can be better targeted at improving the quality of human capital, and in the end, reducing poverty.

2. The post-MDG agenda should recognize ongoing country-level social and political dynamics. The direction should move towards making decentralization work for the most vulnerable: Increasing the number of and improving the quality of services. As social assistance schemes expand, Indonesia needs to invest in ensuring that needed services are available at the local level at a good level of quality. The basic infrastructure of education and health services, and those services' workforces, must be prioritized. Increasing the number of schools and training centers focused on developing much needed workers on the local level needs to be combined with the implementation of national standards of competence and enforcement of non-compliance treatment mechanisms.

3. The post-MDG policies should address gender-based and regional disparity by distributing services not only on a ratio basis but also by taking into account need projections. Distribution of services to tackle the issues of regional disparity requires strategy. Not only do overall decentralization policies and implementation need to be improved, but the country needs to take into account the characteristics and needs of the population down to the village level, including factors like demographic and social-epidemiological transitions resulting from natural disasters and migrations. These factors will change the face of the demand. Some provinces or districts might have very specific vulnerabilities that prevent from reaching better growth and welfare status. Therefore, planning needs to consider not only the ratio of demand, but also its characteristics and needs. Such planning processes need to be equipped with better data. Learning needs to take place so as to help identify causes of disparity and how to overcome those in the most effective way.

4. The post-MDG agenda should adopt a comprehensive approach to poverty reduction that recognizes and addresses potential shocks faced by children, and that strengthens the capacity of families and communities to protect and care for their wellbeing. Despite the awareness that the underlying development and poverty reduction goals carried in the MDG framework should ensure that all children would have the opportunity to make a positive contribution to society, it is not always being expressed though a comprehensive approach. Some of the current social assistance programs do consider children's specific outcomes, however common indicators of child wellbeing still show alarmingly high rates of deprivation, which suggests the need for further attention and intervention. Assistance programs need to be far more effective in meeting their goal of assisting vulnerable children and supporting families to fully assume their responsibilities to care for and protect children within their family. This requires an inclusive approach that

targets children and families in need. Indonesia needs to develop assistance programs that can address the care and protection needs of vulnerable children through not only financial, but also psychosocial interventions to support vulnerable families. In order to do so, large-scale learning will have to be undertaken so as to better understand to what extent the existing social assistance programs have contributed to the positive child wellbeing outcomes.

5. A global goal should consider encouraging countries to leverage more resources and investing in where it counts. Indonesia has the commitment to develop bigger and better poverty reduction programs, but the country needs to acknowledge that these programs depend on the wider economy and macroeconomic framework. To invest in basic infrastructure and services of health and education means to provide budget resources to finance them. Helping vulnerable families also means providing employment opportunities, which in the context of decentralization, means improving local economies. Indonesia needs to improve the poor's access to better infrastructure which, along with a more flexible labor market, will allow poor families to move from resource-extracting sectors (such as primary agriculture and forestry) to more productive sectors like manufacturing. All of these functions obviously require financial resources. Better attention needs to be given to increasing the current budget allocation and government spending for social assistance programs. When trade-offs have to be made, the country needs to start spending less on what is currently being spent for fuel subsidies. Overall, Indonesia needs to improve on its budget profile, as well as on other matters like tax policy, as tax revenues are currently a mere 12% of GDP.

8. References

BAPPENAS (Ministry of Planning). 2010. *Report on the Achievement of the Millenium Development Goals Indonesia 2010*. Jakarta: BAPPENAS.

Brodjonegoro, Bambang. 2004. The Effects of Decentralization on Business in Indonesia. In Business in Indonesia: New Challenges, Old Problems, edited by M. Chatib Basri and Pierre van der Eng, pp. 125-40. Singapore: Institute for Southeast Asian Studies.

Cameron, Lisa and Susan Olivia. 2011. Sanitations and Health: The Past, the Future, and Working Out What Works, in C. Manning and S. Sumarto (eds), *Employment, Living Standards and Poverty in Contemporary Indonesia*. Singapore: Institute for Southeast Asian Studies.

Higgins, Benjamin. 1968. *Economics Development: Problems, Principles, and Policies*. Revised ed. New York: Norton and Co.

Hill, Hal and Anna Weidemann. 1989. Regional Development in Indonesia: Patterns and Issues. In H. Hill (ed). *Unity and Diversity: Regional Economic Development in Indonesia since 1970*. Singapore: Oxford University Press.

Hill, Hal. 1996. *The Indonesian Economy Since 1966: Southeast Asia's Emerging Giant*. Cambridge: Cambridge University Press.

Hill, Hal. 2000. *The Indonesian Economy*. Second ed. Cambridge: Cambridge University Press.

Hull, Terrence H. and H. Moseley. 2009. *Revitalization of Family Planning in Indonesia*. Jakarta: Government of Indonesia and the United Nations Population Fund.

KPPPA (Ministry of Women's Empowerment and Child Protection). 2011. *Policy Brief: Gender Equality*. Jakarta: KPPPA.

KPPPA (Ministry of Women's Empowerment and Child Protection). 2006. *Survei Kekerasan terhadap Perempuan dan Anak (Survey on Violence against Women and Children)*. Report

Mahi, Raksaka and Suahasil Nazara. 2012. Survey of Recent Developments. *Bulletin of Indonesian Economic Studies* 48(1): 7-31.

Manning, Chris and Raden Purnagunawan. 2011. Survey of Recent Developments. *Bulletin of Indonesian Economic Studies* 47(3): 303:32.

Manning, Chris and Kurnya Roesad. 2006. Survey of Recent Developments. *Bulletin of Indonesian Economic Studies* 42(2): 143-70.

Miranti, Riyana. 2011. Regional Patterns of Poverty in Indonesia: Why Do Some Provinces Perform Better Than Others, in C. Manning and S. Sumarto (eds) , *Employment, Living Standards and Poverty in Contemporary Indonesia*. Singapore: Institute for Southeast Asian Studies.

OECD (Organization for Economic Cooperation and Development). 2012. OECD Economic Surveys: Indonesia 2012. Paris: OECD.

Patunru, Arianto A. and M. Chatib Basri. 2012. The Political Economy of Rice and Fuel Pricing in Indonesia, in A. Ananta and R. Barichello (eds), *Poverty and Global Recession in Southeast Asia*. Singapore: ISEAS.

Patunru, Arianto A. and Tarsidin. 2012. Recent Indonesian Economic Development and The Urgent Need to Remove Key Growth Obstacles, *Asian Economic Papers* 11(3): 57-77.

PUSKA PA (Pusat Kajian Perlindungan Anak Universitas Indonesia). 2011. *Building Social Protection System for Children in Indonesia; An Assessment on the Implementation of the Ministry of Social Affairs' Social Assistance Program PKSA and Its contribution to the Child Protection System.* Report.

Reid, Anthony (Ed). 2012. *Indonesia Rising: The Repositioning of Asia's Third Giant*. Singapore: ISEAS.

Save the Children, KEMENSOS (Depsos) and UNICEF. 2007. *Someone that Matters: The Quality of Care in Childcare Institutions in Indonesia*. Report

Sim, Armand A., Daniel Suryadarma, and Asep Suryahadi. 2012. *The Consequences of Child Market Work on the Growth of Human Capital*. Working Paper.

SMERU and UNICEF (United Nations' Children Fund). 2011. *Child Poverty and Disparity in Indonesia*. Draft Report.

Sparrow, Robert. 2011. Social Health Insurance: Towards Universal Coverage for the Poor?, in C. Manning and S. Sumarto (eds), *Employment, Living Standards and Poverty in Contemporary Indonesia*. Singapore: Institute for Southeast Asian Studies.

Suryadarma, Daniel. 2011. The Quality of Education: International Standing and Attempts at Improvement, in C. Manning and S. Sumarto (eds), *Employment, Living Standards and Poverty in Contemporary Indonesia*. Singapore: Institute for Southeast Asian Studies.

Utomo, Budi, Vera Hakim, Atas Habsyah, Irwanto Tampubolon, DN Wirawan, Sudjana Jatipura, Kemal Siregar, LK Tarigan, Biran Affandi, and Zafriel Tafal. 2010. *Study Report on Incidence and Scial-Psichological Aspects of Abortion in Indonesia: A Community-based Survey in 10 Major Cities and 6 Districts.* Center for Health Research University of Indonesia.

Woo, Wing T. and Chang Hong. 2010. Indonesia's Economic Performance in Comparative Perspective and A New Policy Framework for 2049. Bulletin of Indonesian Economic Studies, 46(1): 33-64.

World Bank. 2006. Making the New Indonesia Work for the Poor. Report.

World Bank. 2009a. *Labor Market Trends in Indonesia, Indonesia Jobs Report*. Jakarta: The World Bank.

World Bank. 2009b. *Doctors, Midwives and Nurses: Current Stock, Increasing Needs, Future Challenges and Options*. Report.

World Bank. 2012. *Protecting the Poor and Vulnerable Households in Indonesia*. Report.

UNDP (United Nations Development Programme). 2011. *Indonesia MDG Status*. http://www.undp.or.id/mdg/

UNICEF (United Nations' Children Fund). 2011. *Out of School Children (OOSC) Global Initiative: Indonesia Country Study*. Report.

3 The Many Dimensions of Child Poverty in Indonesia: Patterns, Differences and Associations

Gracia Hadiwidjaja, Cindy Paladines and Matthew Wai-Poi[1]
World Bank, Jakarta

Abstract

This paper examines the different dimensions of child poverty in Indonesia, looking at outcomes and opportunities across consumption, health, education, housing, food sufficiency, social assistance and infrastructure. In addition to looking at each of these measures separately, we go further to investigate the associations between them, asking whether it is the same children who are poor on each dimension or different ones. For example, we look at the associations between physical access to education, health and transportation services; and consumption, housing, water and sanitation; whether money poor and food poor children are the same; the linkages between access to health services and social assistance and health outcomes; and associations between barriers to enrolment. These associations have important implications for program design and targeting. We present results over time, as well as for different populations of interest, such as rural, urban regional, and female-headed households.

While poverty on some indicators remains high, in general child poverty has fallen along most dimensions since 2002, including for most health, education, housing and consumption outcomes, and health and education opportunities. However, lack of access to quality housing and proper sanitation remains high. There are few differences between the opportunities and most outcomes of children living in male and female-headed households, with the key exception of consumption poverty. Rural children are more likely to be poor on many dimensions than urban children, often considerably so, and similarly for poorer children compared to richer ones. Poverty in Eastern Indonesia is higher than rest of the country on most dimensions, especially in Papua.

We also find a strong association of poverty for children across a number of dimensions of opportunity in rural areas, but not for urban areas. In all areas, poor housing, water and sanitation are strongly associated with low incomes, but extend well beyond the poor. Interestingly, despite an official poverty line that is largely based on obtaining sufficient calories, the majority of food energy-deficient households are not consumption poor. Moreover, over half of unskilled deliveries (a key driver of maternal mortality in Indonesia) are not associated with low incomes or lack of access to a midwife. Finally, not only is poverty high on most indicators in Maluku and Papua, it is generally the same children who suffer on each dimension, compounding their situation and life chances. Policy implications for program design and targeting are considered.

[1]All authors are with the World Bank, and can be contacted on ghadiwidjaja@worldbank.org, cpaladines@worldbank.org and mwaipoi@worldbank.org. The paper builds on work done by Camila Zepeda. The findings, interpretations, and conclusions expressed in this paper are entirely those of the authors. They do not necessarily represent the views of the International Bank for Reconstruction and Development/World Bank and its affiliated organizations, or those of the Executive Directors of the World Bank or the governments they represent.

Introduction

Poverty and well-being occur on multiple dimensions. The case for this, as well as the need to consider all of these dimensions within a generalised framework, has been made famously by Sen (2000). There have been various attempts to measure and aggregate this multi-dimensionality (both monetary and non-monetary). An early, and perhaps the most well-known approach, is the UNDP's Human Development Index (HDI). However, the choice of dimensions and weights has been criticized (Kovacevic 2010). UNICEF adopted a multi-dimensional framework to analyse child welfare in their recent Global Study on Child Poverty and Disparities (2011). Their approach, the 'Bristol Deprivation method', uses an analytical framework based on the Convention on the Rights of the Child and explicitly examines child welfare vis-à-vis access to severe deprivations of human needs, including shelter, sanitation, safe drinking water, information, food, education, health. This framework was applied to seven countries in the East Asia Pacific in 2011, not, however, including Indonesia.

An alternative approach which has gained popularity is the Multidimensional Poverty Index (MPI) (Alkire and Foster 2011; Alkire and Santos 2010), which introduces a count of the number of dimensions in which people are deprived. The method reflects both the headcount ratio of poverty – the proportion of the population that is multi-dimensionally poor – and the average intensity of their poverty, and introduces both into a composite 'score', the MPI. The MPI specifically looks at ten indicators which measure poverty across three dimensions: education, health, and living standards. An MPI was calculated for Indonesia and its provinces, based on the 2007 Demographic and Health Survey data (Alkire 2012). Although some dimensions pertain to child welfare, such as years of schooling and child mortality, the MPI does not explicitly focus on child welfare as the UNICEF Global Study does.

The results of the MPI in Indonesia broaden the concept of poverty. Officially, 17% of the population lived below the national (consumption-based) poverty line in 2007. Under the MPI approach, where a person is poor if they are deprived on at least one third of the weighted indicators, 21% of the Indonesian population was multi-dimensionally poor in 2007. The average intensity of their poverty, or the average proportion of indicators in which the poor were deprived, was 46%, and around 8% of the population was defined as 'severely poor', facing deprivation in at least half or more of the weighted indicators.

As with other analyses, the MPI also looked at multidimensional poverty at the sub-national level, and found significant disparities, with provincial multidimensional poverty rates ranging from 10% in Jakarta to 44% in Papua. Differences also occur in the ratio of multidimensional poverty to official poverty. In Jakarta, official poverty was 5%, or about half of its multidimensional poverty rate, while in Papua, the official poverty of 41% was very similar to its multidimensional counterpart. 23% of Papuans were 'severely poor' according to the MPI. Elsewhere in Eastern Indonesia, 40% of East Nusa Tenggara was multi-dimensionally poor, and 20% severely so.

The MPI and other composite indices have come under criticism for the sometimes ad hoc, arbitrary or non-transparent way in which they are aggregated, or in which non-monetary poverty lines are set. Rather than aggregating to a single number, which arguably obscures which dimensions are driving overall deprivation, Ravaillon (2010; 2011) suggests a dashboard approach, focusing on indicators separately for each dimension.

Ferreira and Lugo (2012) argue that both the dashboard and index approaches miss an important element of the multivariate nature of poverty. By focusing separately on indicators for different dimensions, or by aggregating them into a single number, they miss (or obscure) the interactions or associations between these dimensions. That is, whether it is the same people who are poor on

selected dimensions, or different people, makes a significant difference to program and policy design and targeting.

They explore three alternative approaches for analysing the dependency structure of the joint distributions: the multivariate stochastic dominance techniques of Duclos et al. (2006); a direct representation of the dependency structure (for example, Atkinson and Lugo 2010; Atkinson *et al*. 2010); and copula functions (Decanq 2009, Quinn 2007). Our paper explores this associative approach with direct representations.

While the MPI requires at least three indicators of deprivation for a given person to be poor, it is agnostic to which dimensions these are and how they relate to each other. As we show in this paper, a closer examination of associations of poverty across *specifically selected* dimensions can provide important guidance for program design and targeting, and directions for future research.

Methodology and Data

A range of dimensions are examined, representing both child outcomes and opportunities. In particular we look at outcomes on the monetary, health, education, housing and food sufficiency dimensions, while considering access to health and education facilities, transportation, and social assistance as opportunities. We begin by looking at poverty on each indicator individually – the dashboard approach.

We then move on to associations of poverty. The degree of interdependence between different dimensions of poverty can be presented in terms of the overlap between individuals identified as deprived under each criterion. For instance, if poverty were defined by indicators on three dimensions (such as education, health, and income), the dependency can be illustrated – at least in part – by the proportion of individuals that are deprived in all three dimensions, those that are deprived in (different) pairs of dimensions, or only in one (Ferreira and Lugo 2012).

Two large, nationally-representative surveys collected by Statistics Indonesia (*Badan Pusat Statistik*, or BPS) are used. The National Socioeconomic Survey (Susenas) began in 1963, was been conducted annually since the early 1990s, and quarterly since 2011. It is now representative at the district level and collects a range of demographic, health, education and other information on households and their members, and includes a consumption module. The Village Potential Census (Podes) collects information on village or neighbourhood[2] characteristics for the entire country three times a decade. (Table 1) summarises the available indicators used from each dataset. Unfortunately, indicators of child malnutrition, which is high in Indonesia (37% of children under five are stunted),[3] are not available from Susenas. Since the association analysis requires that all indicators are measured over the same households, we cannot use alternative data sources to examine this dimension. However, we do examine whether households are consuming sufficient calories.

[2]We refer to *desa* (rural villages) and *kelurahan* (urban neighbourhoods) throughout the paper as villages

[3]http://www.unicef.org/indonesia/children.html

Table 1: Indicators of Poverty and Data Sources

Opportunities	Indicator	Source
Health Access	Access to primary care	Podes
	Access to hospital	Podes
	Access to delivery facility	Podes
	Village has a midwife	Podes
	Health centre has a doctor	Podes
	Health centre has water	Podes
	Health centre has electricity	Podes
	Aggregate health access index	Podes, World Bank (2012a)
Education Access	Access to ECED	Podes
	Access to primary school (SD)	Podes
	Access to junior high (SMP)	Podes
	SD has qualified teachers	Podes
	SMP has laboratory	Podes
	SD and SMP have water	Podes
	SD and SMP have electricity	Podes
	Aggregate education access index	Podes, World Bank (2012a)
Transportation and Infrastructure	Main road is gravelled or asphalted	Podes
	Sufficient bridges	Podes
	Public transport to district office	Podes
Social Assistance	Subsidised Rice for the Poor (Raskin)	Susenas, World Bank (2012b)
	Health Fee Waivers for the Poor (Jamkesmas)	Susenas, World Bank (2012b)
	Unconditional Cash Transfer (BLT)	Susenas, World Bank (2012b)

Outcomes	Indicator	Source
Consumption	National poverty line	Susenas
	1.5 times the poverty line	Susenas
Health	Skilled birth delivery (<5 years)	Susenas
	Immunisation (<5 years)	Susenas
Education	Enrolment (7-12, 13-15, 7-15)	Susenas
	Primary school completion	Susenas
	Literacy	Susenas
Housing	Quality of building materials	Susenas
	Floor space per capita	Susenas
	Drinking water	Susenas
	Sanitation	Susenas
	Electricity	Susenas
	Phone	Susenas
Food Sufficiency	Caloric intake	Susenas, FAO, WHO and UNU

Drawing on two periods (2002 and 2011) of SUSENAS and PODES data, we develop a household-level dataset across all dimensions. Setting arbitrary but natural poverty lines for most indicators, we calculate deprivation on each indicator, of which there are a number per dimension. All results are presented as the percentage of children aged 0-15 years who are deprived on a given indicator, except selected indicators which are age-specific, such as immunisation and enrolment.[4]

We then examine associations across dimensions by constructing multidimensional tables which capture the proportion of children in poverty according to different combinations of dimensions. Analysis of individual indicators and associations across dimensions is conducted at various levels of aggregation, including national, urban-rural, male-headed and female-headed households, by region, and by consumption decile. Data limitations prevent us from using many of the health and education access indicators before 2011, as well as food sufficiency.

Key Findings: Child Poverty by Dimension

General Trends

We first summarise general trends that hold for most dimensions. Although a number of indicators remain at high levels, poverty has fallen along many dimensions in Indonesia between 2002 and 2011,[5] including for most health, education, housing and consumption outcomes, and health and education opportunities.

Furthermore, we observe relatively small differences between the opportunities and most outcomes of children living in male and female-headed households; certainly by 2011, when most gaps had closed. The two main exceptions, discussed later, are with respect to consumption poverty (with children of female-headed households being disadvantaged), and social assistance (where children of female-headed households are considerably advantaged).

Rural children are more likely to be poor on many dimensions than urban children, often considerably so. This holds even more so for children from poorer consumption deciles compared to richer ones.

The following section turns to each dimension in detail, focusing on results which are specific or unusual to each dimension, as well as noting where a particular dimension deviates from the general trends.

[4]A full Data Annex of results for all dimensions and indicators are available from the authors

[5]Maluku and Papua are not included in Susenas 2002. As they are some of the poorest regions in Indonesia, national, urban-rural and female-headed/male-headed household aggregates for 2002 are likely underestimated. However, since the populations in these regions are small, the degree of underestimation is not likely to be high. Full national results are included in the Data Annex for 2003, which include Maluku and Papua.

Poverty of Child Opportunities

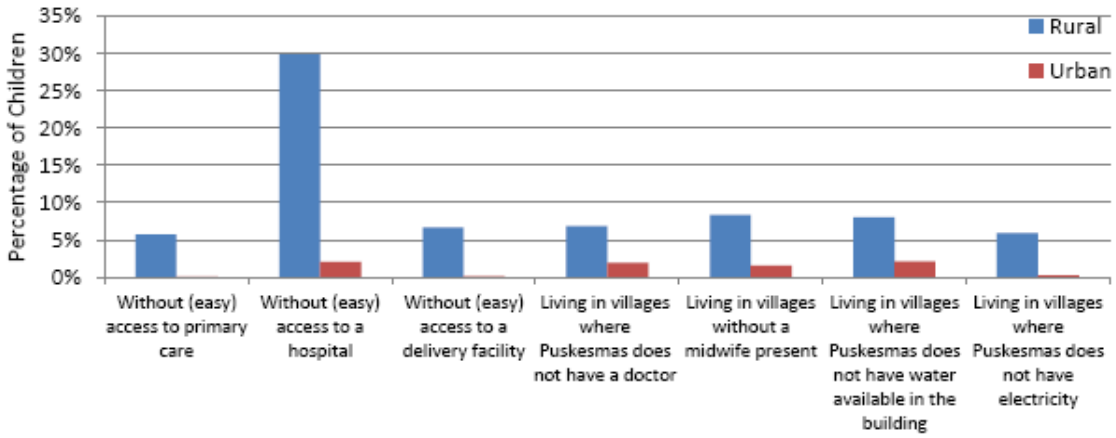
Health Access

Most children in Indonesia now have good access to primary and higher-level care facilities, although there are differences across locations. For example, in 2011, 6% of rural children lacked access to primary care, while almost no urban dwelling children lacked access.[6] 8% of rural children were born in a village without a midwife, compared to 2% of urban children.

Along with ready access to these facilities, primary care facilities were, for the most part, similarly well-equipped for service. At the national level, only 5% of children in the poorest consumption decile report living in a village where the Puskesmas does not have a doctor;[7] 7% and 5% of the poorest children live near a Puskesmas lacking water or electricity, respectively. At the critical referral care level, however, the deprivation of rural children is more apparent, with 30% of rural children lacking access to a hospital, relative to only 2% of urban children lacking this access (see Figure 1).

The rural-urban disparities are echoed along regional lines. In 2011, more than a quarter (26%) of the children living in Papua lacked access to a primary care facility and more than half (60%) lacked access to a hospital. 40% of Papuan children also lived in villages that lacked a midwife, contributing to the region's low rate of skilled attendance at birth (51%). Many children living in Maluku were similarly deprived of basic health care, with one of every ten children lacking access to a primary care facility, and 47% without easy access to a hospital (see Figure 2).

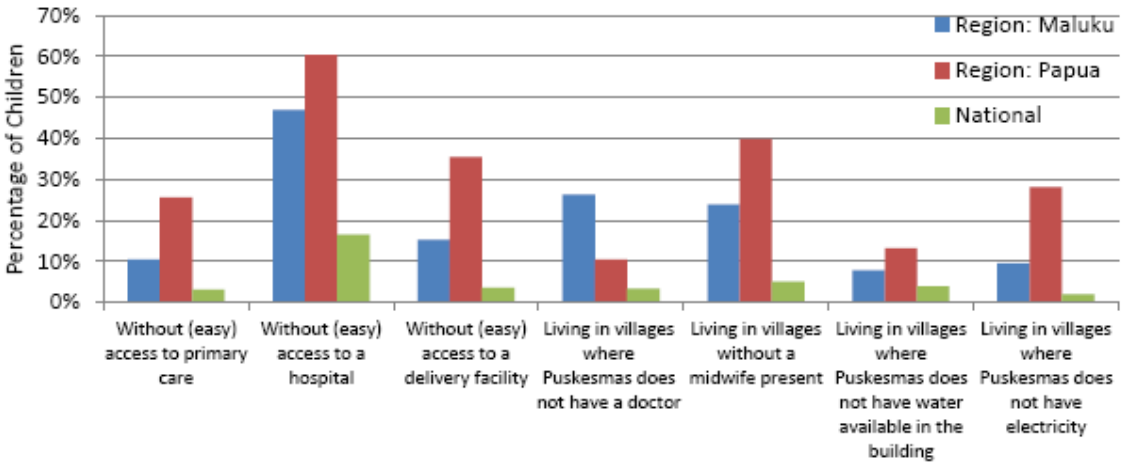
Figure 1: Selected Health Opportunities by Urban-Rural Locations, 2011



[6]Easy access to primary care refers to the share of the population that cannot easily reach a Polyclinic, Puskesmas, Puskesmas Pembantu, or physician's practice.

[7]However, these indicators make no judgment on quality. Studies suggest that doctor and nurse absenteeism can be high – one study measured absenteeism at 40% at the Puskesmas level (Chaudhury, Hammer, Kremer, Muralidharan, and Rogers 2006)

Figure 2: Selected Health Opportunities: Papua, Maluku and the National Average Education Access



Physical access to primary school was high for children living in both rural and urban settings. Nearly all children have a primary school within 1 km of their home, and only 5% of children lack access to an early childhood education and development (ECED) facility within 6 km of their home.

However, 36% of rural children lack access to a junior high school (SMP) within 1 km of their home, compared with 13% of their urban counterparts. 6% of rural children still lack access if we extend the range to 6 km, a not inconsiderable distance in rural settings.

As with health, progress in enfranchising students at the national level masks important regional disparities. Again Papuan children are the most deprived, with 51% of children lacking access to an ECED facility within 6 km of their home. 44% of Papuan children lack access to an SMP within 1km of their home, compared to 29% in Sulawesi, the second most deprived region in this regard. These rural-urban and regional disparities are consistent with disparities between richer and poorer households by per capita consumption (see Figure 3 and Figure 4).

Figure 3: No ECED within 1km of home

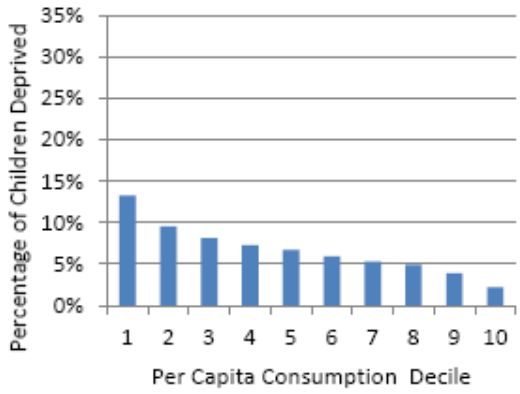
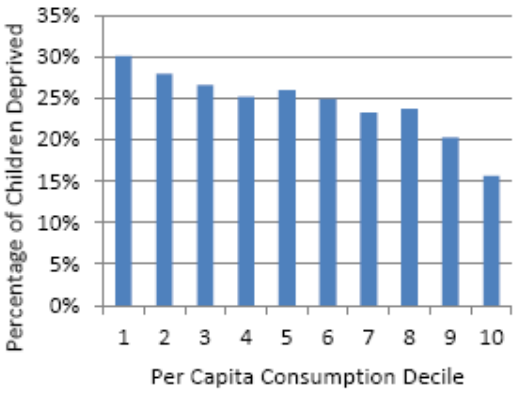


Figure 4: No SMP within 1km of home



Moreover, the schools that are available in Indonesia's most deprived regions are often not properly equipped – 49% of the children in Maluku lack access to a primary school (SD) in their

village with at least two teachers with a Bachelor's degree. A third (34%) of children in Maluku have SD and SMP schools with toilets that lack water, similar to the 30% for Papuan children.

Transportation Access

At the national level, children typically have mixed access to transportation. To explore their deprivation along this dimension, we look at their access to gravelled or asphalted roads, and the main transport infrastructure available in the village. Nationally, 5% of children live in a village with a main road that has not been covered in gravel or asphalt. 17% of children live in villages where more bridges are needed. 27% of children lack access to public transport with a fixed route to the head of district's office – a proxy for access to public transport in a village.

As with education and health, many regions in Eastern Indonesia have more significant transport challenges. There is a lack of good roads in Papua, with 37% of children living in villages where the main road has not been gravelled or asphalted and is therefore subject to damage or impassibility from rain. Many children (17%) live in villages that need additional bridges, though children in Nusa Tenggara are the most deprived in this regard, with 34% of children living in villages facing a shortage of this critical infrastructure.

Social Assistance Access

Indonesia has five main social assistance programs: Subsdised Rice for the Poor (Raskin), Health Fee Waivers for the Poor (Jamkesmas), a temporary Unconditional Cash Transfer (BLT or BLSM), used in times of fuel price shocks, Cash Assistance for Poor Students (BSM) and a Conditional Cash Transfer (PKH). Before the introduction of the government's Unified Database in 2012, targeting of these programs included many errors. Of the three largest programs (Raskin, Jamkesmas and BLT), targeted at the poorest 30% of households, half of the target households were excluded, and half of all benefits went to non-target households (World Bank 2012).[8]

These national averages hide significant differences between rural and urban and male-headed and female-headed households (see Figure 5, Figure 6, and Figure 7). In contrast to most opportunities and outcomes examined in this paper, rural households are actually more likely to benefit from each of the three main social assistance programs, at any given level of consumption, than urban households. Similarly, while children in female-headed households generally have very similar results on most dimensions of poverty as those from male-headed households, with respect to social assistance, they are considerably more likely to receive social assistance at all points of the consumption distribution

[8]Since 2012, all programs have been targeted with the new Unified Database, which is expected to significantly improve targeting. However, accurate results from survey data are not expected until early 2014

Figure 5: Coverage of BLT (2008-09) by Household Per Capita Consumption Decile

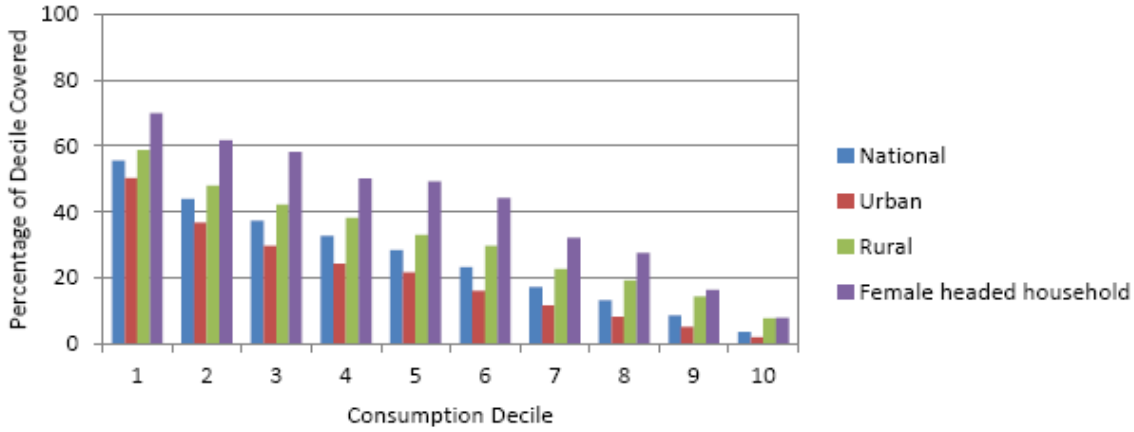


Figure 6: Coverage of Raskin (2009) by Household Per Capita Consumption Decile

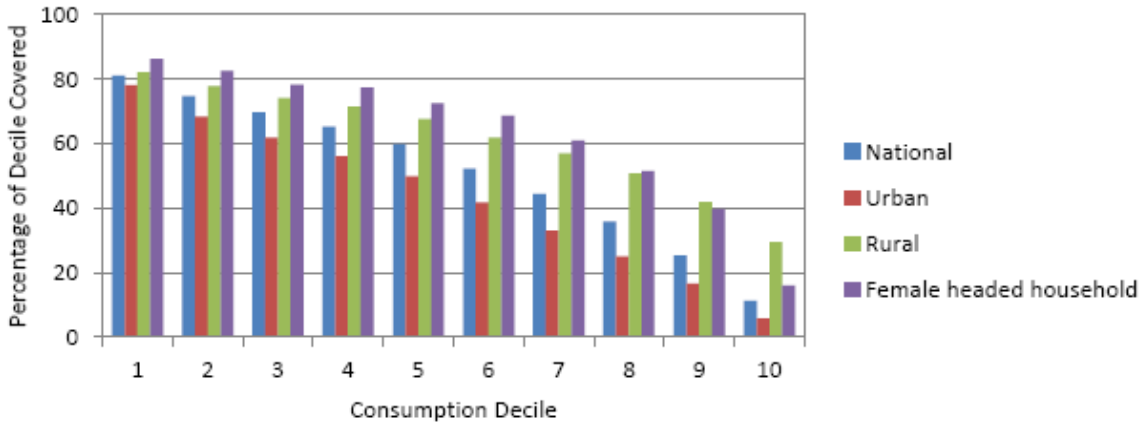
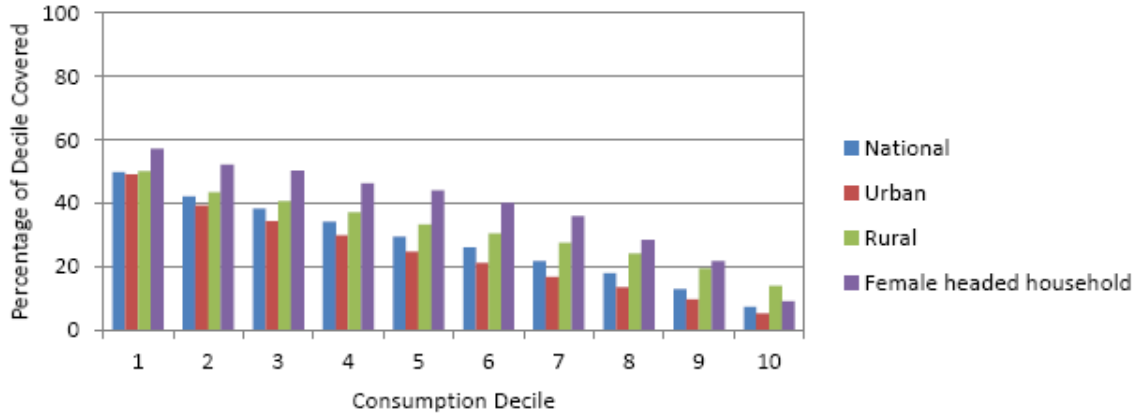


Figure 7: Coverage of Jamkesmas (2009) by Household Per Capita Consumption Decile



Poverty of Child Outcomes

Monetary (Consumption) Outcomes

Poverty in Indonesia is officially defined as living in a household with per capita consumption below the national poverty line, which in 2011 was Rp.233,740 per person per month.[9] Figure 8 presents the percentage of all Indonesians in poverty (national poverty) and that of children in poverty (child poverty). Both show the same pattern of decline between 2003 and 2011, from 17.4% of the total population to 12.5%, and from 21.7% of children to 15.5%. It is clear that the child poverty rate is higher than the national poverty rate, reflecting the well-known phenomenon that poor households are generally younger with more children than non-poor households (see World Bank 2011).

We also look at child vulnerability, using 1.5 times the poverty line as a threshold, a standard of living still below PPP$2 a day. Despite a similar decline in the past decade, levels of vulnerability remain very high, with 44% of children being vulnerable or poor in 2011.

Significant urban-rural differences exist (see Figure 9), with 11.8% of urban children living in poverty in 2011, compared to 19.0% of rural children. Regional patterns reflect other dimensions of poverty, with Eastern Indonesian provinces experiencing much higher levels of child poverty than the rest of the country. Gender differences are driven by differences in household demographics. Amongst the total population, similar numbers of poor live in female-headed households (13.4%) compared to male-headed ones (12.4%). However, this is driven by the larger household size of male-headed households, specifically the extra parent (number of children is similar across both). In fact more female-headed households are poor (15.9%) than male-headed ones (12.0%), and more children in female-headed households are poor (19.8%) than in male-headed ones (15.1%).

Figure 8: Child Poverty Rates, 2002 and 2011

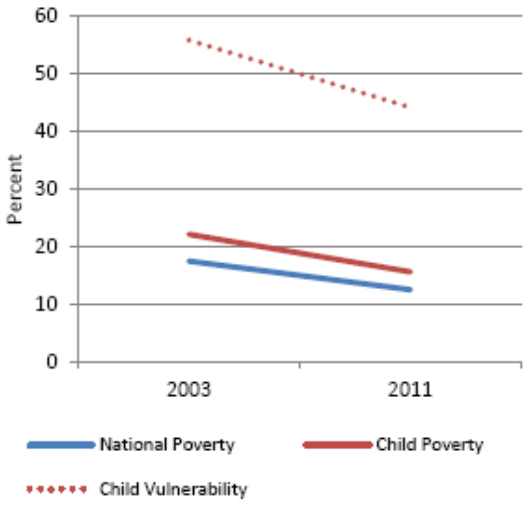
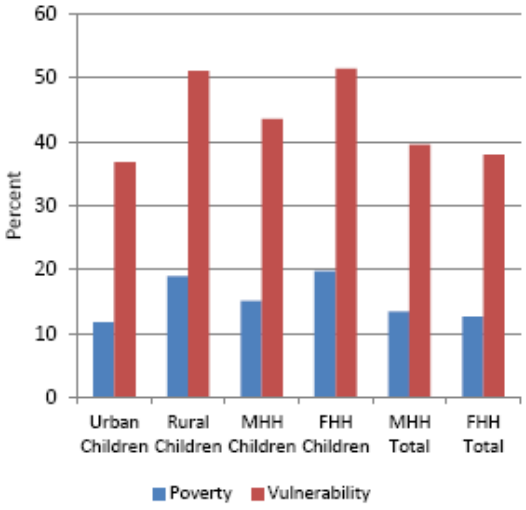


Figure 9: Child Poverty Rates by Household Type, 2011



[9]The official poverty line in Indonesia is based on obtaining 2,100 calories per day, plus a small allowance for non-food expenses such as education, health and housing. Separate urban and rural lines are constructed for each province by BPS. The national average poverty line in 2012 was around Rp.250,000 per capita per month.

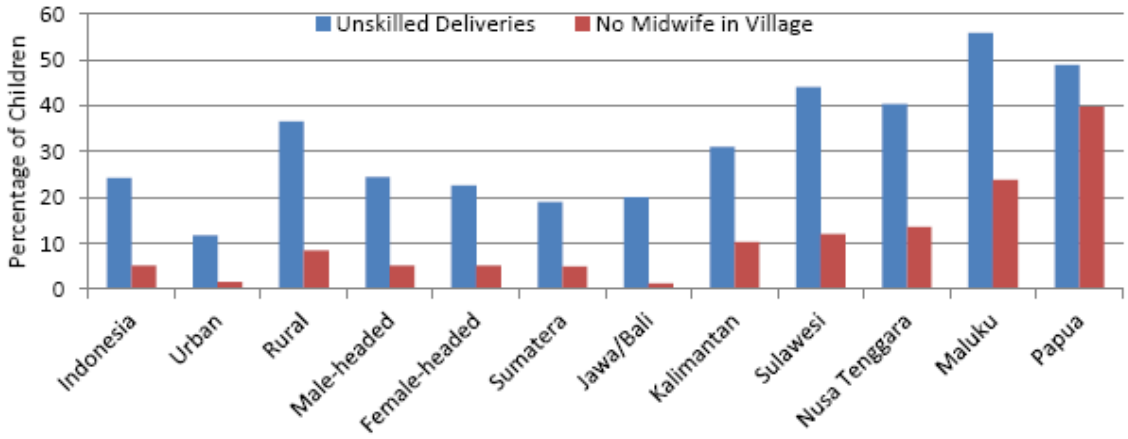
Health Outcomes

In 2002, 42% of children under five were delivered by unskilled workers, a rate which had improved to 24% nine years later. However, for children living in the poorest decile of the consumption distribution, 41% were delivered by an unskilled health worker.

The relatively high incidence of deliveries without skilled attendants is surprising, given good access to such attendants, at all income levels and most regions (Figure 10). Less than one out of ten children from the poorest decile lived in villages where a midwife was not present, suggesting that people preferred delivering without the support of a skilled health worker despite access to one. Moreover, only 6% of children living in households in the lowest decile reportedly were without easy access to primary care services; less than 1% of children living in the highest decile lacked easy access to a functioning primary health facility.10 As with other indicators, children in Maluku and Papua are considerably worse off in this respect, worse even than children in the poorest decile nationally.

Immunisation is a mixed story. 94% of children under five have been at least partially immunised, with similar outcomes regardless of being urban or rural, or the gender of the head of household, although Papua lags somewhat (82%). However, only 1% of children report a full set of vaccinations, and only 19% have received all but the last Hepatitis B shot.[10]

Figure 10: Skilled Birth Deliveries and Access to Midwives, 2011



Education Outcomes

Indonesia has nine years of compulsory schooling (completion of junior high school). Between 2002 and 2011, the percentage of Indonesian children aged 7-15 not enrolled in school fell from 9% to 5%, driven mainly by a fall in unenrolled children aged 13-15 from 21% to 12%. Amongst the urban-rural, gender and regional distinctions we consider, only Papuan children differ significantly from the national average, with 23% of 7-15 year olds not being enrolled. This is reflected in a 26% illiteracy rate for children over 7 years old, compared to 4% nationally.

[10]If we consider just the original 6 diseases which have been traditionally vaccinated against – Diphtheria, Pertussis, Tetanus, Tuberculosis, Measles and Polio, but excluding Hepatitis B – complete immunisation rates remain low: only 23% nationally have had the full non-Hep B schedule of immunisations, although 88% have had at least one shot of each.

Housing Outcomes

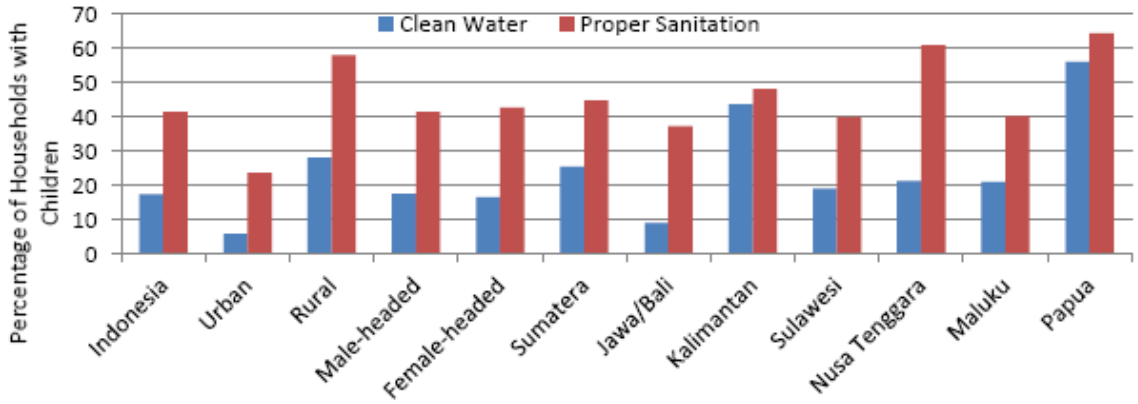
The most severe deprivation of children in Indonesia is in housing conditions. Nationally in 2011, 56% of children live in housing with poor quality materials, 16% in overcrowded conditions,[11] 17% did not have access to clean drinking water, [12] and 41% did not have proper sanitation. When considered across all of these indicators, deprivation exists for all consumption deciles. 90% of children living in the poorest households were deprived on at least one indicator, and even 44% of children living in the most prosperous decile lacked ideal housing. This situation has only marginally improved since 2002. In both Maluku and Papua, 99% of children were deprived on at least one indicator; 98% of Sulawesi's children fared no better.

Poor access to clean water and sanitation is a key concern for children's health. In Indonesia, an estimated 63 million people practice open defecation, which is the second highest number worldwide (UNICEF and WHO 2012). Furthermore, diarrheal disease accounts for more than a quarter of the deaths that occur after the age of 1 month but before 5 years. According to the UN, provision of improved sanitation and higher quality drinking water could reduce diarrheal diseases by nearly 90% (UNICEF and WHO 2012).

Disparity of access to adequate sanitation specifically is alarmingly high, with 67% of children in the poorest households lacking proper sanitation, relative to 12% of children living in the top decile. A rural-urban divide is also evident (see Figure 11). In 2002, 38% of rural children were without access to clean drinking water; by 2011, their access had improved by ten percentage points, to 28%. In contrast, only 11% of urban children were without access to clean water in 2002; by 2011, the share of urban children without access to clean water had improved to 6%. The divide for sanitation is as alarming, with 58% of rural children without access to adequate sanitation, relative to 24% of urban children.

While Eastern Indonesia generally underperforms the rest of the country on most indicators, it is particularly deprived in this respect (see Figure 11). More than half of Papuan children, whether urban or rural, lacked access to clean drinking water (56%) or adequate sanitation facilities (64%). 61% of children in Nusa Tenggara were without access to adequate sanitation.

Figure 11: Access to Clean Drinking Water and Proper Sanitation, 2011



[11]Less than 6.5 square metres per person.

[12]Clean water defined as: piped water, protected well, protected spring, bottled water.

Despite the high incidence of substandard housing and poor water and sanitation, access to grid electricity (PLN) is generally good, with only 11% of children deprived, almost all of whom are rural. Unsurprisingly, Eastern Indonesia also lags considerably in this respect, with 34% of children in Maluku, 38% in Nusa Tenggara, and 62% in Papua without PLN electricity. The same pattern exists for phones. While nationally 17% of children live in a household which lacks a phone, this increases to 25% in rural areas, and over 40% in every region of Eastern Indonesia.

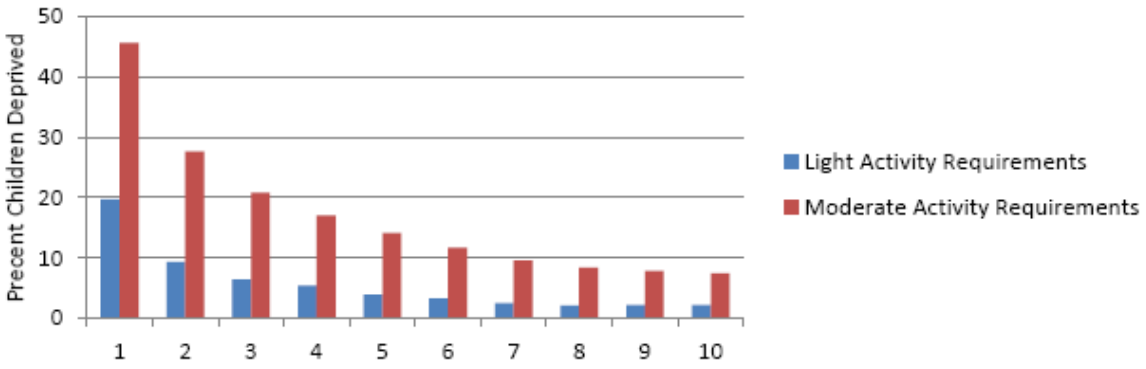
Food Sufficiency Outcomes

The Susenas data contain not only consumption of different food items, but also the total caloric intake for the household. We use the WHO standards for an intake sufficient for light and moderate activity, which vary by sex and age, and combine them with household demographics to determine which households are consuming insufficient calories.

7% of children live in a household with insufficient caloric intake for light activity, rising to 20% if we consider a moderate activity threshold. There are no head of household gender-based differences, and the usual Maluku and Papua disparity with the rest of the country remains. Urban children are more likely to live in a food deficient household than rural ones, with 22% deficiency using the moderate threshold (8% light) compared to 18% (6%), a reversal of the usual urban-rural divide, but not unexpected given the greater levels of self-production and access to food in rural areas.

The surprising results are with respect to consumption deciles. Children living in food-deficient households are much more common in poorer households than richer ones (Figure 12), as expected. However, only 20% of children living in the poorest consumption decile are in a food-deficient household according to the light activity definition, and only 46% by the moderate activity one. All households in the poorest consumption decile are below the official poverty line, and so are poor in a monetary sense. With the official poverty line being largely based on 2,100 calories per household member (with only a small non-food allowance),[13] we should expect almost all of the households in the poorest decile to be food-deficient.

Figure 12: Children Living in Food-deficient Households by Consumption Decile, 2011



This result is probably driven by the differences in the implicit equivalence scale being used in the official poverty line, and that explicitly adopted the WHO caloric intake standards. The 2,100 calories per person assumed in the national poverty line is regardless of sex or age, meaning a

[13]The food component is over 80% of the average urban poverty line, and over 90% of the average rural one.

household with two parents and two young children are required to consume enough food for four adults in order to not be considered officially poor, whereas the food-deficiency thresholds we applied take into account household demographics in estimating caloric needs. As a result, households with children are more likely to be considered poor than households without children.[14] Estimating poverty using alternative equivalence scales may not significantly change the overall poverty rate in Indonesia, but it may well change the profile of poor households.

The second surprising result from Figure 12 is that there are children living in non-poor households (above the first decile) which are nonetheless calorie deficient. This is true of both light and moderate activity caloric requirements, and extends across the entire distribution. It would appear that households which can afford sufficient food are choosing not to consume food at this level. An important area for future research is to understand why this is, and what they are choosing to consume instead. This result provides empirical support for anecdotal accounts of poor households choosing to eat less in order to afford to pay for cultural rites or tobacco (Banerjee and Duflo 2006). Whether this is a matter of the poor defining basic needs in a different sense than the government, or whether it reflects a lack of knowledge on food sufficiency remains to be seen.

Key Findings: Associations across Dimensions of Poverty

Until now, we have looked at child deprivations of individual dimensions of opportunity and outcome. However, children who are deprived on one dimension are not necessarily the same ones who are deprived on another. We now explore exactly who is deprived across these multiple dimensions, to give a fuller picture of the multidimensionality of the poverty faced by individual children. For each set of associations, we select three different dimensions or indicators, and examine to what extent deprivation along each is borne by the same child. This is presented visually in a series of Venn diagrams, where the size of each circle is proportional to the degree of poverty on that indicator.[15]

The associations presented here have been selected from the many different combinations that can be explored. Those selected highlight how effective the associative approach can be in identifying previously unknown issues and raising important policy implications.

Health and Nutrition

The first association has been implicitly introduced already. We have noted that a surprising number of children live in households which are calorie deficient, but not below the poverty line. In fact, of all children who live in calorie deficient (for light activity) households, only 35% live below the poverty line, and the same is true for only 27% of those in calorie deficient (for moderate activity) households (see Figure 13). Even if we consider only children outside of the poorest 40% of Indonesia,[16] they still make up 38% of the light calorie deficiency, and 35% of the moderate deficiency (see Figure 14). This phenomenon repeats itself in both urban and rural settings, and as discussed previously, understanding it will have important policy implications for both poverty reduction and health and nutrition policy.

[14]Households with children also enjoy economies of scale in non-food consumption compared to smaller households, which is also not accounted for in the per capita approach of the official poverty line.

[15]Full numerical results are available in Data Annex available from the authors.

[16]Note: 45% of children are in the poorest 40% of Indonesian households, because poorer households tend to be bigger.

Figure 13: Poverty and Calorie Deficiency

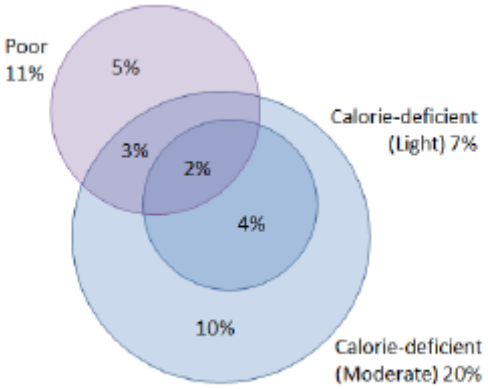
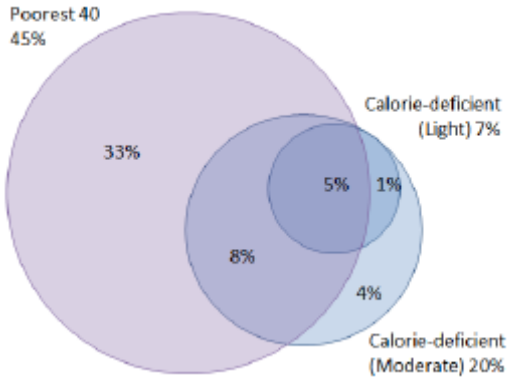


Figure 14: Vulnerability and Calorie Deficiency



Housing, Water and Sanitation

Nationally, around 10% of children live in a house that has not only poor materials, but also lacks clean drinking water and proper sanitation (see Figure 15). An additional 18% of children suffer from both poor housing and improper sanitation, with a further 3% in poor housing and without clean water, and 2% who have proper housing but neither water nor sanitation. That is, a third of Indonesian children are deprived on at least two of these three dimensions. For poor and vulnerable children (those living in the poorest 40% of households), over half lack access to both clean water and sanitation, and two-thirds to at least one (see Figure 16). However, there is little difference in access to water, sanitation and suitable housing based on gender of household head.

Figure 15: Housing, Water and Sanitation

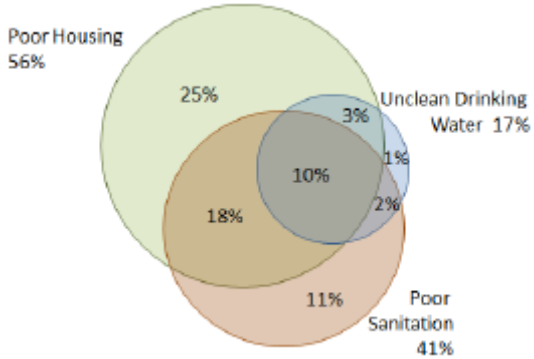
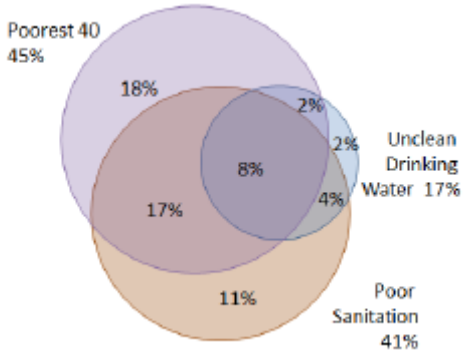


Figure 16: Poverty, Water and Sanitation



These results also mask a sharp urban-rural difference. Overall, 42% of urban children have adequate housing, and access to water and sanitation, compared to only 19% of rural children. Furthermore, urban children are much more likely to be poor on only one of the housing, water and sanitation indicators, compared to rural children; only 2% of urban children have poor housing and lack clean water and sanitation, and another 13% are deprived on two of these indicators, compared to 18% of rural children deprived on all three, and another 32% on two (see Figures 17 and 18)

Figure 17 Urban Housing, Water and Sanitation

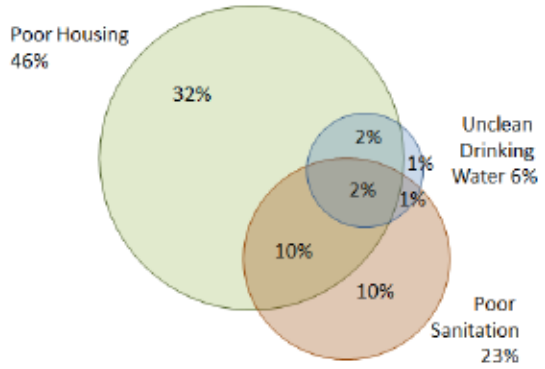
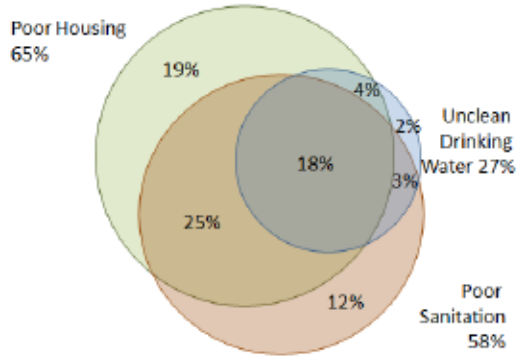


Figure 18 Rural Housing, Water and Sanitation



Urban and Rural Infrastructure

The concentration of rural poverty amongst the same children is also evident when we consider access to physical infrastructure. As Figures 19 and 20 indicate, not only are overall levels of deprivation considerably lower for urban children than rural ones when we look at access to health care, education and transportation, urban children who are poor on one indicator are highly unlikely to be poor on the other two (1%), whereas 20% of rural children are poor on all three dimensions.

Figure 19: Urban Infrastructure

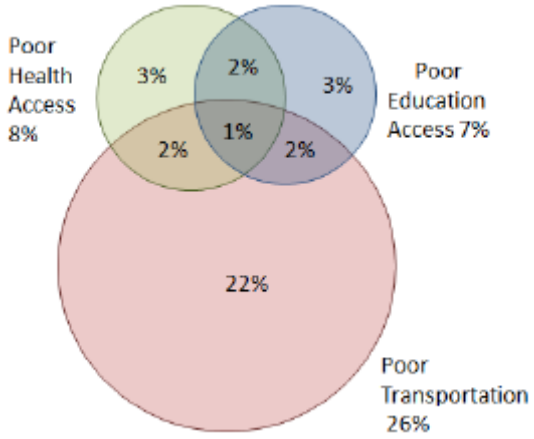
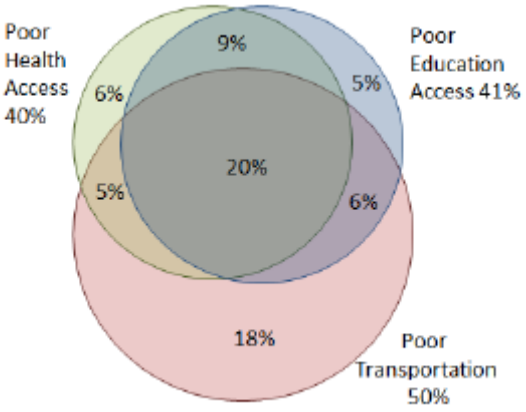


Figure 20: Rural Infrastructure



Poverty, Skilled Delivery and Access to Midwives

We observed earlier that Indonesia's 24% rate of unskilled delivery, a key driver of the country's high maternal mortality rate, is higher than one would expect given that only 5% of pregnant women do not have a midwife in the village. Could low income be a driver, through inability to afford informal user fees? Figure 21 indicates that the significant majority of unskilled deliveries come from families that have access to midwives and are not poor. In fact, a third of unskilled deliveries are still from families with access to midwives and that are not in the poorest 40% of the country. Nor is unskilled delivery strongly associated with low parents' education (see Figure 22); around two thirds of parents having unskilled deliveries have at least a primary education.

Figure 21: Poverty, Midwives and Births

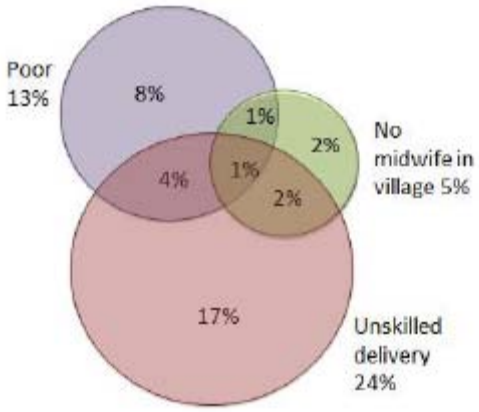
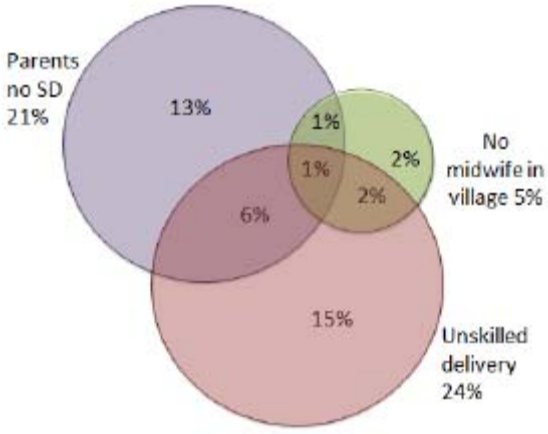


Figure 22: Education, Midwives and Births



Poverty, Enrolment, Access to Education

In contrast to unskilled delivery, most of the children aged 13-15 who are not enrolled in school are also associated with poverty, lack of physical access, and low parents' education (see Figure 23 and Figure 24). Of the 12% unenrolled, less than one in six was not poor on any of these three dimensions, and over half were poor on at least two.

Figure 23: Enrolment, Access and Poverty

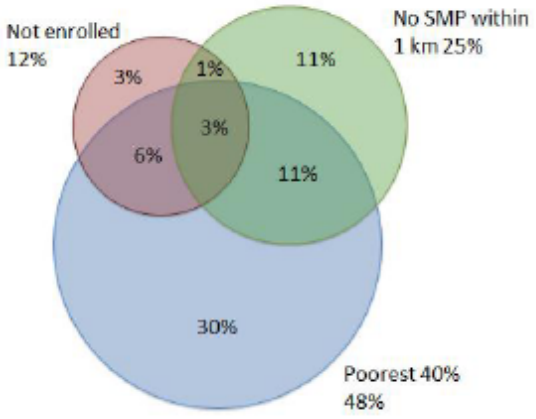
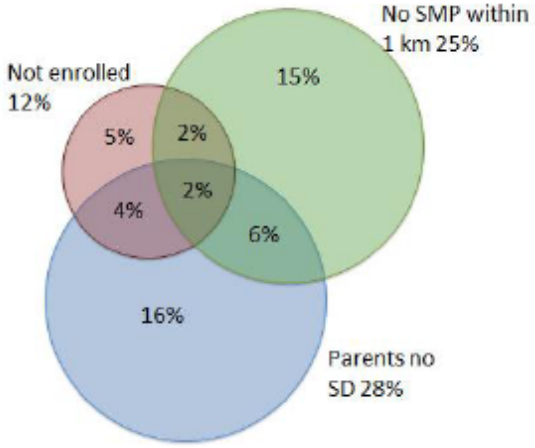


Figure 24: Enrolment, Access and Parents' Education



Sub-national: Focus on Maluku

In Maluku, as at the national level, poverty and lack of access to opportunities are correlated. Nonetheless, poverty does not fully explain many of the deprivations children face. 45% of children are poor or vulnerable, and three fifths of these lack access to sanitation, clean water or both (see Figure 25). However, a third of those without proper sanitation and half of those without clean water are not poor or vulnerable. The same children face many of the same deprivations due to lack of community infrastructure, regardless of income. Besides water and sanitation poverty, many children in Maluku also lack access to mains electricity; of the 33% without PLN electricity, only a quarter are not also poor with respect to water or sanitation (see Figure 26).

Figure 25: Poverty, Water and Sanitation

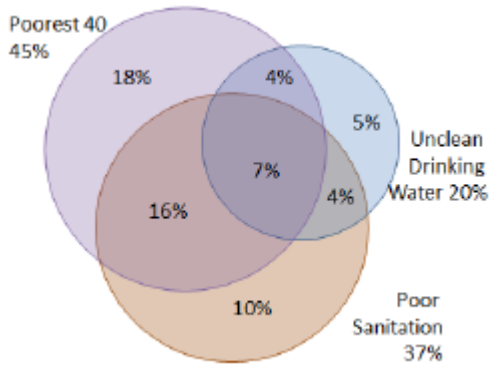
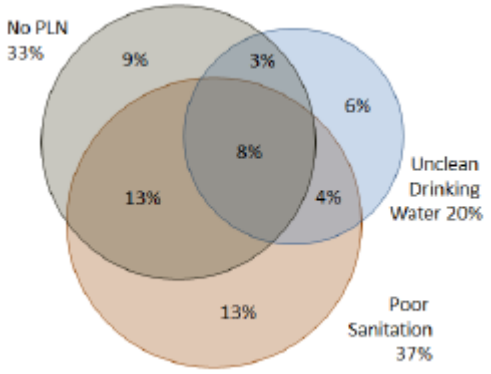


Figure 26: Electricity, Water and Sanitation



Sub-national: Focus on Papua

As we have already seen, even more so than Maluku, Papua generally has the highest rates of child poverty across all indicators. 60% of children are poor or vulnerable, 64% lack proper sanitation, 56% clean water, and 62% PLN electricity. With such high poverty rates on each dimension, this unsurprisingly means many Papuan children are poor on most dimensions. 46% lack electricity, clean water and sanitation. 39% are poor or vulnerable, and also lack clean water, sanitation. The very strong associations of poverty in Papua are strongly visible in Figures 27 and 28, where children not deprived on all three dimensions are the exception.

Figure 27: Poverty, Water and Sanitation

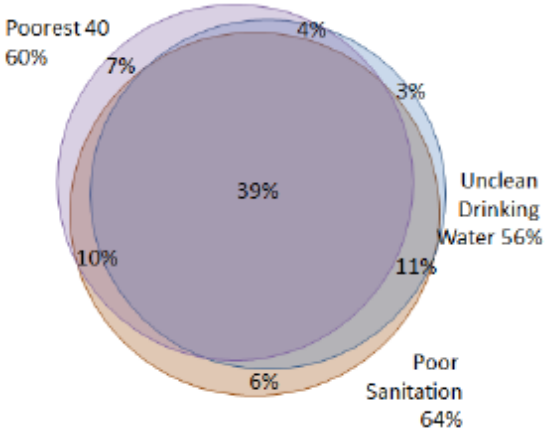
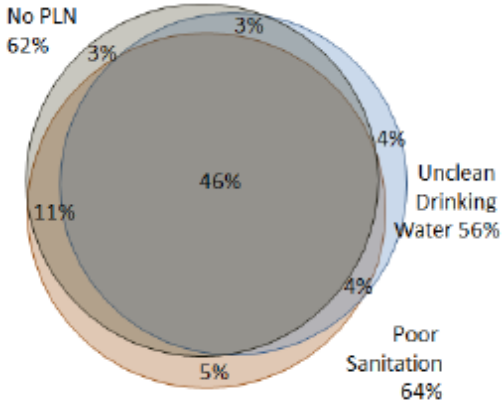


Figure 28: Electricity, Water, and Sanitation



Conclusions and Policy Implications

What can we take from all of this? Some of the analyses simply confirm well-established facts about multi-dimensional poverty in Indonesia, albeit with a comprehensive focus on children that is less common. First, poverty and child poverty has been declining in Indonesia on most dimensions, and this progress has been shared by many different children, including those from female-headed households, living in urban and rural areas, and across many regions of Indonesia. Second, this progress has been uneven, with rural areas continuing to lag urban ones, and in particular, much of Eastern Indonesia being left behind on many dimensions. Third, despite

significant advances in many areas, poverty levels across the country remain high on selected indicators, such as quality housing and access to proper sanitation, or higher than it should be (unskilled birth deliveries).

Beyond these uncontroversial findings, we would suggest four sets of conclusions, the first two substantive and the second two methodological. First, various results have implications for program design and targeting. Investments in infrastructure for health, education and transportation can be focused on pockets of poverty in rural areas. This is a potential role at the local level for the PNPM community development program. However, infrastructure development in urban areas will need a different approach, with deprivations on these three dimensions seldom being associated in the same children. For especially deprived regions, including Papua and Maluku, further investigations should explore how issues of access can be quickly and effectively addressed. Moreover, significantly greater investments in clean water and especially sanitation are needed to, in part, address Indonesia's high and non-decreasing stunting rates. In particular, many children in both urban and rural areas lack access to clean water *and* proper sanitation; addressing just one of these dimensions will be less effective in addressing malnutrition (amongst other public health issues), than addressing both at once.

Second, some findings raise new questions and point towards the need for further research. For example, what are food energy-deficient households who live (often far) above the poverty line consuming instead? What does the consumption patterns of poor and vulnerable households reveal about how they define basic needs for themselves, and how does this compare to the government's definition? At the same time, our results also suggest that the use of alternative equivalence scales in defining consumption poverty may change the profile of the poor from the commonly understood younger families with more children. In health, most households (with the notable regional exceptions) have adequate access to skilled providers of maternal care, yet nearly a quarter of deliveries are unskilled. Moreover, many unskilled deliveries are not associated with low incomes or poor education. Why do many pregnant women choose unskilled deliveries?

Third, with respect to methodology, most of our indicators are simple measures of access, and do not address issues of quality. For example, on access to education and enrolment rates, Indonesia has made strong progress. However, its relatively low position in international tests of students' ability and skills emphasises quality issues (see also World Bank 2013). No doubt quality of education and health services exhibit significant variation in Indonesia, and future research would benefit from incorporating measures of quality, in addition to strict access.

Finally, we believe the breadth of policy implications and new research questions raised underline the usefulness of this relatively simple but effective associative approach. A dashboard approach which examines each indicator independently fails to answer the fundamental question of whether it is the same people who are poor on each. It can be easily complemented (as we have here) with associative analysis. Alternatively, the associations can be easily conducted as part of an MPI. The standard MPI alone, while counting multiple deprivations (and measuring simultaneous deprivations as intensity), misses the many important ways different dimensions *interact* with each other. An associative approach which focuses on theoretically and empirically related dimensions can offer clearer policy implications, particularly where interactions of poverty affect program design and targeting.

References

Alkire, S., Roche, J.M., Santos, M.E. & Seth, S. (2011) Indonesia Country Briefing. Oxford Poverty & Human Development Initiative (OPHI) Multidimensional Poverty Index Country Briefing Series. Available at: www.ophi.org.uk/policy/multidimensional-poverty-index/mpi-country-briefings/.

Alkire, S. and Santos, M.E. (2010) "Acute multidimensional poverty: A new index for developing countries", Oxford Poverty and Human Development Initiative, Working Paper 38, University of Oxford.

Alkire, S. and Reinstadler Foster,J. (2011) "Counting and multidimensional poverty measurement", *Journal of Public Economics.* 95(6-7):476-487.

Atkinson, B., Marlier, E., Monatigne, F. and Reinstadler, A. (2010) "Income poverty and income inequality" in *Income and Living Conditions in Europe,* Atkinson and Marlier (eds), Eurostat.

Atkinson, A. and Lugo, M.A. (2010) "Growth, poverty and distribution in Tanzania", International Growth Centre, Working Paper 10/0831. November.

Banerjee, A. and Duflo, E (2007) "The Economic Lives of the Poor", *Journal of Economic Perspectives*, 21(1): 141-168.

Chaudhury, N., Hammer, J., Kremer, M., Muralidharan, K., and Rogers, F. (2006). "Missing in Action: Teacher and Health Worker Absence in Developing countries", *Journal of Economic Perspectives*.

Decancq, K. (2009) "Copula-based measurement of dependence between dimensions of well-being ", HEDG Working Paper 09/32, University of York.

Ferreira, F. and M. Lugo (2012) "Multidimensional poverty analysis: Looking for a middle ground", Policy Research Working Paper 5964, World Bank.

Kovacevic, M. (2010). "Review of HDI Critiques and Potential Improvements", Human Development Research Paper 33. UNDP–HDRO, New York.

Lustig, N. (2011) "Multidimensional indices of achievements and poverty: What do we gain and what do we lose?", Center for Global Development, Working Paper 262.

Quinn, C. (2007) "Using copulas to measure association between ordinal measures of health and income". HEDG Working Paper 07/24, University of York.

Ravallion, M. (2010) "Mashup indices of development", Policy Research Working Paper 5432, World Bank.

Ravallion, Martin (2011) "On multidimensional indices of poverty", *Journal of Economic Inequality*, 9(2):235-248.

Sen, A. (2000) "A Decade of Human Development", *Journal of Human Development* 1(1):17-23.

UNICEF (2011) *Global Study on Child Poverty and Disparities*, UNICEF.

UNICEF and the World Health Organization (2012) *Progress on Drinking Water and Sanitation: 2012 Update,* WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, New York.

World Bank (2011) "Current Targeting Outcomes in Indonesia", Background Paper, World Bank, Jakarta, Indonesia.

World Bank (2012b) *Podes Infrastructure Survey*, World Bank, Jakarta, Indonesia.

World Bank (2012b) *Targeting Poor and Vulnerable Households in Indonesia*, World Bank, Jakarta, Indonesia.

World Bank (2013) *Indonesia Education Public Expenditure Review*, World Bank, Jakarta, Indonesia.

Notulensi Theme 1:
Dimensions of Child Poverty

Presenter 1:
Name : Erlangga Agustino Ladiyanto (UNICEF Indonesia)
Title : Multidimensional Child Poverty in Papua: Empirical Evidence from 6 Districts

Highlights of Conclusions and Recommendations:

Kemiskinan anak adalah akar kemiskinan saat dewasa. Anak yang lahir miskin biasanya saat dewasa akan tetap miskin. Kemiskinan mempunyai banyak wajah, tidak bisa dilihat dari keuangan saja. Kemiskinan juga bisa ditinjau dari sisi lain, misalnya: pemenuhan hak pendidikan, kesehatan.

Papua adalah daerah unik dan spesifik, kemiskinannya tinggi. Akses terhadap layanan publik terbatas. Data mengenai kemiskinan anak tidak tersedia untuk pemerintah. Diperlukan metode yang lebih baik untuk mengukur kemiskinan anak di Papua.

Dengan data mix, kemiskinan anak diukur sehingga anak termiskin bisa dilindungi. Metode ini diadopsi oleh UNICEF dari penelitian Bristol, dengan melihat deprivasi anak dari berbagai aspek.

Secara konsisten di wilayah pegunungan proporsi anak miskin lebih tinggi karena sulit dijangkau.

Dalam konteks rumah tangga, rumah tangga yang mempunyai anak yang miskin, sama juga dengan wilayah pegunungan yang paling tinggi jumlah rumah tangga miskinnya.

Rekomendasi:

- Banyak konteks lokal yang harus dipertimbangkan
- Dimensi *non monetary* lebih cocok untuk Papua
- Integrating hak khusus anak (bebas dari kekerasan, mendapat perlindungan hukum) dalam kebijakan perlindungan sosial anak.
- Kemiskinan anak tidak secara otomatis tercakup dalam kemiskinan secara umum
- LAKIP memakai indikator output saja, seharusnya terintegrasi antara input dan output
- Makanan lokal sangat penting, bukan hanya raskin
- BPJS Supplemen BSM dan Kartu Papua Sehat.salah satu dari bentuk perlindungan
- Jumlah ideal CCT jangan terlalu banyak, jangan terlalu sedikit.
- Tentang biaya untuk mengantar uang tersebut CCT, jangan sampai lebih besar uang transport daripada bantuan yang harus disampaikan.
- Memanfaatkan *Public private partnership* untuk aspek informasi dan energi.
- Mengambil pendekatan luar biasa: masyarakat harus didatangi (misalnya, *mobile doctor*/dokter berjalan)
- Perlindungan sosial jangan sampai merusak modal sosial yang ada.

Presenter 2:
Name : Arianto Patunru (Australian National University)
Title : Inequality and Child Well-Being: The Case of Indonesia

Highlights of Conclusions and Recommendations:

Paper ini adalah "*Mosaic of Issue*". Metode yang digunakan adalah metode *vertical and horizontal inequality*. *Non income inequality* lebih penting, yaitu akses terhadap air bersih, pendidikan, kesehatan, dll.

Indikator ekonomi Indonesia saat ini cukup bagus, namun kerentanan masih tinggi dan Gini ratio memburuk.

Dalam *"Mosaic of Issues"* ini terdapat fenomena seperti disparitas umur dan gender, kesehatan dan pendidikan, akte kelahiran, pekerja anak, kejahatan terhadap anak, pernikahan dini.

- 30% anak, 21 juta anak miskin dan rentan
- Perempuan lebih rentan terhadap deprivasi di bidang pendidikan
- Jumlah bayi tanpa imunisasi masih tinggi
- Kasus diare 8% untuk anak hingga 5 tahun
- Akses terhadap sanitasi dan air bersih
- Memiliki akte kelahiran adalah hak anak (40% rumah tangga sampai usia 17 tahun tidak punya akte kelahiran, paling banyak terdapat di pulau2 di luar Jawa)
- Pekerja anak: datanya tidak banyak ditangkap oleh Susenas dan Sakernas. Faktanya 8% anak usia 10-15 tahun adalah pekerja anak.
- Anak2 (0-18 tahun) kurang terpapar ke masalah kejahatan, tetapi resiko kriminal sama untuk anak laki2 dan perempuan
- Perkawinan dini (<16 tahun 11%) lebih banyak di Jawa Timur dan Jawa Barat walaupun kedua propinsi ini lebih makmur. Belum diketahui penyebabnya.

Tantangan:

- Penjelasan undang2 yang masih rancu *(ambiguous stipulation of the laws)* dimana agenda kebijakan untuk perlindungan anak dan pengentasan kemiskinan tidak disejajarkan.
- Kesalahan dalam alokasi anggaran (misalnya: BBM yang diberikan besar, tapi bantuan sosial kecil)
- Pelayanan dengan kualitas rendah (kekurangan perawat)
- Kompleksitas desentralisasi (misalnya: alokasi anggaran yang mempengaruhi kinerja).

Rekomendasi:

- *Input base* ke *output base*
- Meningkatkan jumlah dan kualitas pelayanan

Presenter 3:
Name : Gracia Hadiwidjaja (World Bank, Jakarta)
Title : Associations of Child Poverty: Patterns and Differences

Highlights of Conclusions and Recommendations:

Measuring poverty only by income and consumption aspects is not enough. Problem arises on how to measure non income.

Are the poor always calories deficient? Poor and calories deficient are not overlapping. Not poor but don't eat enough. They have other priority, for example: cigarette. Policy implication is that having money does not necessary mean buying food. Also, poverty is not associated with unskilled delivery, but lack of access to skilled delivery.

Conclusion

Association approach challenges the multidimensional poverty. Association method is very simple yet insightful. Deprivation varies across many different situations

Discussant's comments:
Name : Dr. Ir. Rudy Soeprihadi Prawiradinata, MRCP, Ph.D (Bappenas)

Highlights of Conclusions and Recommendations:

Bappenas harus mempersiapkan *background study* untuk RPJMN 2014.
Program kemiskinan terkait anak yang ada sekarang ini adalah PNPM generasi, PKH.

Terdapat beberapa variasi issue, tapi fokusnya seharusnya bukan hanya dari sisi keuangan tetapi juga akses. Kemiskinan terjadi karena akses, bisa juga karena budaya *(case by case).*

Index Kemiskinan Wilayah (multi dimensi) Bappenas dan TNP2K.
Tantangan PNPM Mandiri di Papua sangat tinggi, pendekatan budaya, sosial, semua berbeda dibanding dengan tempat lainnya di luar Papua.

Masukan penting dari konferensi ini akan dipakai untuk persiapan RPJMN 2014.

TANYA JAWAB PUTARAN 1:

1. Harti (UNICEF)

Sejak tahun 2000, anak perempuan lebih baik dalam hal pendidikan. Secara spesifik anak, perempuan 7-24 tahun bukan perempuan yang tertinggal. Di Indonesia, laki2 sebagai *pencari nafkah/breadwinner,* dan ini tidak gampang dirubah.

Bagaimana kalau anak laki2 lebih rendah pendidikannya, dan perempuan lebih bagus angka akademiknya? Jika dibiarkan terus, dampak pendidikan anak laki2 akan lebih rendah. Dampaknya, kemiskinan akan melebar karena anak laki2 yang merupakan *breadwinner* lebih buruk kondisi pendidikannya daripada anak perempuan. Untuk anak laki-laki miskin, kondisinya lebih parah lagi. *Peer effect* perilaku negatif teman2 lebih nyata di antara anak2 di kelompok miskin. Mereka tidak mau sekolah karena teman2nya tidak mau sekolah.

Kalau dimensi budaya dimasukkan, hasilnya lebih bagus potretnya. Ada disparitas lebar antara orang Papua dan orang non-Papua. Orang Papua yang tinggal di Papua lebih buruk kondisinya daripada orang Papua yang tidak tinggal di Papua. Orang Papua di kota lebih baik kondisinya daripada orang Papua di desa. Demikian juga, di Jawa, misalnya, di daerah Tapal Kuda (Probolinggo sampai Madura).

2. Made Sutama (UNICEF)

Pembangunan ekonomi selalu disalahkan karena ketika pertumbuhan ekonomi tinggi kesenjangan muncul, kemiskinan muncul. Social protection (SP) seolah-olah jadi "*hero*".

Pembangunan ekonomi yang *'sensitive'* pembangunan sosial itu seperti apa? Apakah m*ulti dimension child poverty* mengarah pada *non income indicator*? Dengan metode asosiasi, kondisi lokal sangat menentukan. Lalu bagaimana memilih *child poverty indicators*?

Untuk Pak Rudi, Keynote Speaker berkata bahwa tantangan (SP) adalah *fiscal space*. Selama ini SP ditangani oleh pusat. 70% lebih uang di daerah ditangani oleh pusat. Tapi menjadi kontradiktif dengan kebijakan desentralisasi karena kewenangan ada di daerah padahal *fiscal space*nya kecil. Lebih runyam lagi ketika targeting. Kebijakan nasional tergantung pada data nasional tapi orang daerah merasa lebih tahu kondisi di daerahnya.

TANGGAPAN

1. Erlangga Agustino Ladiyanto

Tadinya data Papua dan non Papua akan ditampilkan, tetapi angkanya sangat senjang. Kebetulan disini banyak wartawan, hasilnya nanti dipertanyakan (dari segi metodologinya), maka akhirnya tidak ditampilkan. Memang disain penelitian ini tidak dipersiapkan untuk memilah data berdasarkan suku bangsa. Kedepannya, penelitian yang memasukkan budaya harus dimasukkan, tetapi metodologinya (samplingnya) harus dipersiapkan.

2. Arianto Patunru

Ini memang perdebatan puluhan tahun lalu, yaitu Kuznet curve dimana sampai tahap tertentu ketimpangan membesar lalu menurun. Tapi kelihatannya sekarang sudah *convergen* ke *inclusive growth, quality growth*. Intinya: pertumbuhan dinikmati banyak orang.

Menyalahkan pembangunan ekonomi tidak mungkin saya lakukan karena saya ekonom. Ada ketimpangan, walaupun ini bukan masalah. Yang masalah adalah konsekensinya, yaitu ketegangan sosial. *Inequality* hanya dari aspek pendapatan akan mendorong pertumbuhan ekonomi. Tapi jika ada faktor struktural yang menyebabkan hasil-hasil pertumbuhan tidak dapat dinikmati oleh orang banyak atau adanya kekakuan pasar tenaga kerja, maka ada masalah infrastruktur yang menyulitkan orang berpindah dari satu wilayah ke wilayah lain. Disinilah pertumbuhan ekonomi tidak inklusif. Akar masalahnya harus ditangani, yaitu infrastruktur, *connectivity*, kemudahan pindah dari satu sektor ke sektor lain, dan anggaran yang tidak membebani. Jangan terlalu banyak subsidi BBM, ini akan kontraproduktif karena bisa dialokasikan untuk SP.

Inclusive growth, sustainable development, quality development, ini adalah istilah untuk hal yang sama, yaitu bagaimana supaya pertumbuhan bisa dinikmati oleh banyak orang.

3. Gracia Hadiwijaya

Bagaimana memilih indikator kemiskinan anak? Jawabannya bisa diplomatis, bisa juga fakta. Saat ini intervensi apa yang kita pilih dasarnya adalah intervensi apa yang tersedia. Sekarang yang ada adalah BSLM, Raskin, PNPM, PPLS dari pemerintah pusat yang tidak memasukkan konteks daerah walaupun arahnya sudah ke sana. Contohnya, PPLS sudah mengakomodasi 470 distrik. Dari sisi kebijakan belum banyak pilihan karena ada masalah politik dan anggaran. Mungkin kita harus berpikir sebelum membuat program, biasanya setelah program jalan baru teringat ada yang tidak dimasukkan (faktor budaya, dll).

4. Erlangga Agustino Ladiyanto

Indikator kemiskinan apa yang dipakai? Ada beberapa pendekatan: menentukan issue lalu menentukan indikator. Penentuan issue berdasarkan *expert review* lalu *scoring*. Bisa juga dilihat dari kausalitas.

Setelah indikator terpilih, dilihat datanya bagaimana? Apakah anggarannya ada?

Kondisi saat ini: indikator menyesuaikan dengan data yang ada. Dicari indikator yang mirip-mirip dengan data yang tersedia. *Top down* atau *bottom up*. Indikator ini bisa *pure top down*, bisa *top down* disesuaikan dengan *bottom up*, bisa juga *pure bottom up*. Di Papua kendala utama adalah SDM nya masih terbatas. Ketika aspirasi digali dalam Musrenbang, ada kesan seolah-olah pemerintah menjanjikan. Kalau ternyata tidak dipenuhi, mereka marah. Jadi harus hati-hati ketika menggali aspirasi.

5. Arianto Patunru

Kualitas data sangat penting. TNP2TK sudah melakukan ini untuk tujuan targeting. Mulai 2015 sudah mulai pakai *multidimensional poverty index*. Ada juga masalah budgeting karena 90% dari pusat dan di daerah anggaran terpakai banyak sekali untuk pegawai.

PNPM potensial untuk dikembangkan karena sudah banyak perbaikan dan bisa difokuskan pada transparansi keuangan daerah. Jadi, monitoring anggaran dan eksekusi anggaran sangat penting

6. Rudi Soeprihadi Prawiradinata

Yang ditanyakan issue *fiscal space* di daerah, issue di *fiscal space,* atau di desentralisasinya? Tantangan perlindungan sosial terletak di *fiscal space* karena perlindungan sosial banyak di tingkat nasional. Tapi ketika berhadapan dengan desentralisasi, orang daerah merasa lebih tahu tentang daerahnya, otoritasnya juga ada di daerah. Dalam konteks desentralisasi siapa yang bertanggung jawab atas orang miskin di Maumere, misalnya?

Pak Rudi menjelaskan *fiscal space* di daerah. Tidak berarti bahwa daerah yang *fiscal space*nya tinggi, kemiskinannya rendah. Di Papua, misalnya, *fiscal space*nya tinggi tetapi kemiskinannya juga tinggi. Karena itu, pemerintah mempunyai Indeks Fiskal Kemiskinan Daerah yang dibuat oleh Kementerian Keuangan. Tujuannya untuk meningkatkan *ownership* terhadap program pemerintah pusat. Daerah harus kontribusi. Pada akhirnya ada *exit strategy* dan sudah dipikirkan bahwa program2 kemiskinan akan didesentralisasikan. Dalam MP3KI beberapa program kemiskinan sudah dilepas.

Apakah mau desentralisasi program keseluruhan? Atau mau bertahap? Karena ada juga daerah yang belum mampu. Yang dilakukan sekarang adalah dana dari pusat, dilakukan di daerah dan diserahkan setelah keuangan juga siap. Bagaimana melihat desentralisasi program kemiskinan? Apakah hanya programnya saja atau *resource* nya juga. Saat ini hibah yang melalui pinjaman, harus oleh pusat. Harus hati2 jika berhubungan dengan pinjaman luar negeri.

Untuk jaminan sosial, ini harus melalui kontribusi. Untuk BPJS Ketenagakerjaan harus dianalisis lebih hati-hati karena jangka panjang. BPJS Kesehatan bisa langsung dilaksanakan karena jangka pendek.

TANYA JAWAB PUTARAN 2

1. **Deswanto (UNICEF)**

Ada kegandrungan untuk menemukan orang miskin secara tepat. Tapi kurang imaginasi dalam hal kebijakan. Kita sudah punya kebijakan UHC, SP, CP. Tapi apakah kita sudah *on the right track* dalam mengatasi kemiskinan?

Di zaman Orde Baru kemiskinan 60% lalu ada penurunan drastis. Dulu, kita tidak terlalu gandrung menemukan orang miskin, yang penting bikin sekolah banyak, bikin jalan banyak. Sekarang kemiskinan stagnan pada 12%. Apakah stagnan ini juga karena kegandrungan kita untuk menemukan orang miskin?

2. Budi (UNICEF)

Kita kurang mengambil *weighting* dalam jumlah persalinan di keluarga miskin. Kalau dilihat, angkanya besar sekali. Apakah karena jumlah anak di keluarga miskin memang lebih banyak? Mohon diberi keterangan mengenai proporsi deprivation.

Masalah kekhususan (*local specific*). *Why do we avoid using ethnicity while other countries specifically address SP based on ethnicity? Is it really addressing the issue on ethnicity? Jayawijaya contains 80% of ethnicity, we should acknowledge that in the data.*

TANGGAPAN

1. **Grace Hadiwijaya**:

   Apakah kita *on the right tract untuk SP?* Indonesia terlambat dimulai pada tahun 1998. Walaupun belum beres, tapi sudah di jalur yang benar dan *coverage*nya diperbesar. Dibanding dengan zaman Soeharto, di zaman Soeharto kemiskinan tinggi tapi tidak dipublikasikan.

   Analisis itu dilakukan karena keluarga miskin. Ada asumsi bahwa keluarga miskin biasanya usianya muda dengan anak banyak. Dari analisis saya, misalnya ditemukan bahwa keluarga tidak miskin juga tidak makan cukup. Ini berarti kita harus memikirkan ulang asumsi keluarga miskin itu usianya muda dan banyak anak. Jangan-jangan asumsi itu tidak benar juga.

2. **Arianto Patunru**:

   Kegandrungan untuk targeting penting karena sumberdaya terbatas. Dibandingkan zaman Soeharto, pada tahun 1976, angka kemiskinan 40%, turun terus sampai krisis 12%, lalu naik lagi, dan turun lagi sampai sekarang 12%.

   Sekarang kita menyadari pentingnya targeting. Angka kemiskinan tiba-tiba naik pada saat krisis karena ada *moral hazard*. Artinya targeting sangat penting dan harus terus bisa diperbaiki.

   Mengenai jumlah anak dalam keluarga miskin, masih kelihatan bahwa yang miskin anaknya banyak. Tapi dalam analisis ekonometrik hal ini dikontrol.

   Menurut saya Indonesia tidak cocok menerapkan *ethnicity* (*affirmative policy*) seperti Singapura dan Malaysia. Kita harus hati2 mengenai hal ini.

3. **Erlangga Agustino Ladiyanto**:

   Mengapa sudah ada targeting kita buat lagi United Health Care (UHC)? Di beberapa wilayah, kemiskinan tidak bisa diatasi dari *demand side* saja. Karena beasiswa diberikan di Papua tapi sekolahnya tidak ada. Jadi UHC juga diperlukan untuk memperbaiki akses.

   Konteks budaya bukan hanya terkait masalah *ethnicity*. Di Jayawijaya tidak semua dilihat dari sisi keuangan. Banyak keluarga yang pengeluarannya rendah karena subsisten sehingga dianggap miskin, padahal keluarga tersebut mempunyai babi banyak. Jadi dari segi konsumsi termasuk miskin. Data *ethnicity* tidak dikeluarkan karena tidak meyakinkan dari segi samplingnya.

   Soal Soeharto, hal tersebut karena pendekatannya massif. Perlindungan sosial memberikan intervensi dari hal lain. Pada zaman Soeharto *compliance* juga lebih baik, misalnya: ada sekolah ada guru. Sekarang: ada sekolah tidak ada guru.

4. **Rudi Soeprihadi Prawiradinata:**

Menangkap orang miskin bisa dari data mikro dan data makro. Orang miskin punya banyak babi dari data mikro, orang tersebut bisa dikeluarkan dari data kemiskinan. Melalui PPLS dilakukan perbaikan data kemiskinan.

Zaman Soeharto dan sekarang ini masalah elastisitas. Sekarang ini tingkat kemiskinan sudah mencapai *core poor* sehingga lebih sulit untuk dientaskan. Targeting perlu diperbaik. Peningkatan kemiskinan tahun 1996-1998 juga karena perubahan metodologi penghitungan.

FINAL CONCLUSIONS & RECOMMENDATIONS:

Penyaji 1:
Dalam konteks desentralisasi diperlukan data kemiskinan anak agar targeting program dari pemerintah tepat sasaran.

Penyaji 2:
Perlu diperhatikan cara vertical (miskin dan kaya) dan horizontal (6 aspek yang dianalisis).

Penyaji 3:
Metode baru yaitu metode asosiasi, justru menimbulkan pertanyaan baru.

Rangkuman:

Kemiskinan di Indonesia sifatnya antar generasi, kemiskinan diturunkan dari bapak ke anak, dan selanjutnya ke cucu. Rantai ini perlu diputus.

Kemiskinan anak bersifat multidimensi, karena itu dimensi yang dihadapi oleh anak harus dihadapi dengan hak anak. Kerentanan juga banyak. Deprivasi terjadi bukan hanya pada anak yang miskin tetapi juga pada anak tidak miskin.

Tentang pengukuran dan analisis: banyak cara untuk menganalisis data, misalnya dengan Bristol method (melihat korelasi quintile dengan dimensi kemiskinan), metode horizontal dan vertical, atau dengan metode asosiasi. Cara analisis ini untuk mempertajam targeting.

Kebijakan dan framework yang ada sekarang lebih memperhatikan anak. Tetapi perlu diturunkan dari kebijakan nasional ke kebijakan di tingkat lokal dengan menambahkan kepekaan budaya.

Targeting dan disain dengan dimensi pendapatan saja tidak cukup. Perlu diakomodasi dengan dimensi lain di tingkat mikro dan makro. Beberapa pertanyaan untuk mendukung targeting dan disain program, khususnya anak, misalnya:

1. Targeting.Siapa yang tidak diikutsertakan?

2. Gender.Ternyata masih ada disparitas gender dalam pendidikan.

3. Deprivasi. Apakah program yang sudah ada menjawab permasalahan karena deprivasi tidak hanya terjadi pada masyarakat miskin, juga terjadi pada mereka yang tidak miskin tetapi juga bisa kekurangan gizi. *'Unskilled delivery'* masih menjadi masalah dan bukan hanya pada kelompok miskin.

Perlu upaya untuk meningkatkan akses terhadap pelayanan kesehatan dasar bagi anak. Walaupun sudah ada United Health Care (UHC), harus ditingkatkan juga akses dan pelayanan kesehatan.

THEME 2

Child-Sensitive Social Protection and Poverty Reduction

1. ***Perdagangan Anak Perempuan yang Dilacurkan: Potret Suram Kemiskinan Versus Perlindungan Anak*/Female Child Sex Trafficking: Gloomy Portrayal of Poverty Versus Child Protection**
   Yanuar Farida Wismayanti (Kementerian Sosial Republik Indonesia)

2. **Quality of Life of Deinstitutionalized Children in Biological Families in Georgia**
   Natela Partskhaladze (UNICEF Georgia)

3. **Prevalence of Child Marriage and Its Determinants among Young Women in Indonesia**
   Joseph Marshan (SMERU Research Institute, Indonesia)

1 Perdagangan Anak Perempuan yang Dilacurkan; Potret Suram Kemiskinan *Versus* Perlindungan Anak

Yanuar Farida Wismayanti[1]
Kementerian Sosial Republik Indonesia

Abstract

Kemiskinan seringkali menjadi masalah yang sulit untuk dipecahkan secara menyeluruh. Dampak dari kemiskinan itu sendiri menyentuh hampir seluruh aspek kehidupan manusia, tidak terkecuali pada kelompok anak-anak. Beberapa diantaranya menyebabkan anak-anak tidak bisa atau terpaksa tidak melanjutkan pendidikan, bahkan terpaksa untuk bekerja sebagai bentuk dukungan anak dengan mangatasnamakan tanggung jawab anak atas keluarganya. Kondisi inilah yang seringkali menyebabkan anak-anak harus bekerja, bahkan di sektor yang menbahayakan, salah satunya terjebak dalam perdagangan anak untuk dilacurkan.Jaringan yang terlibat dalam perdagangan anak yang dilacurkan ini memang cukup bervariasi, temuan yang menarik bahwa sistem kekerabatan juga menjadi salah satu pendorong anak-anak terlibat dalam perdagangan anak. Kondisi ini seringkali juga mengatasnamakan kemiskinan. Beberapa peraturan perlindungan anak digulirkan, namun belum mampu menakan kuatnya politik dominasi dalam perdagangan anak perempuan untuk dilacurkan. Strategi melawan pelacuran, sebuah upaya untuk memutus rantai reproduksi sosial atas perdagangan anak yang dilacurkan. Empat upaya penting sebagai strategi melawan pelacuran anak diantaranya: 1) upaya preventif (pencegahan) 2) upaya perlindungan, 3) upaya rehabilitatif (pemulihan), 4) upaya integratif.

Key Words : Kemiskinan, anak yang dilacurkan, perlindungan anak

[1]Penulis adalah peneliti di Pusat Penelitian dan Pengembangan Kesejahteraan Sosial, Kementerian Sosial RI. Sebelum bergabung di Kemensos tahun 2005, penulis pernah menjadi relawan pada sebuah LSM Anak "Bahtera" di Kota Bandung, dan tahun 2000 bergabung di Plan International Surabaya, awal kariernya sebagai *Community Transformation Agent* (CTA) di Kabupaten Gunung Kidul-DIY, kemudian menjadi *Childhelpline Project Officer* dan terakhir sebagai CNSP (*Children in Need Special Protection*) *Project officer* untuk Kota Surabaya. Tulisan ini, didukung dengan data-data dari tesisnya di Program Pasca Sarjana Antropologi Universitas Gadjah Mada, berjudul Dunia Kecil yang Kujalani: Jejak Anak Perempuan yang Dilacurkan di Kota Surabaya, tahun 2010.

I. Pendahuluan

Perdagangan anak yang dilacurkan menjadi issue yang terus bergulir, namun demikian masih sangat minim upaya yang dilakukan untuk mengurangi terjadinya perdagangan anak, khususnya untuk tujuan seksual. Meski dalam perkembangannya mengalami berbagai perubahan serta modus yang berbeda. Kondisi kemiskinan di daerah asalnya, rendahnya tingkat pendidikan, kurangnya informasi dan pengetahuan, dan masih rendahnya upaya perlindungan atas anak-anak, menyebabkan kondisi yang tidak menguntungkan bagi anak-anak. Betapa anak-anak tidak mempunyai posisi tawar untuk mendapatkan perlindungan atas hak-haknya. Keadaan keluarga, ketidaktahuan, serta kondisi anak yang terlanjur menyandang "stigma sosial" negatif, cenderung menjadikan mereka tidak dilirik masyarakat sebagai korban, tetapi justru sebagai sampah masyarakat. Kemiskinan, tingkat pendidikan yang rendah, kondisi keluarga yang tidak mampu memberikan perlindungan kepada anak-anaknya, pergaulan bebas merupakan beberapa faktor yang mendorong anak-anak masuk dalam dunia perdagangan anak, menjadi korban anak-anak yang dilacurkan.

Laporan Tim ESKA Surabaya (Eksploitasi Seksual Komersial Anak) (2009), bahwa anak-anak yang dilacurkan di kota Surabaya, sebagian besar berasal dari keluarga miskin (38 %), selanjutnya berasal dari keluarga *broken home* (keluarga yang orang tuanya bercerai) (23 %) dan juga berasal dari keluarga pada umumnya sebanyak 6 %. Dengan berbagai alasan di antaranya pergaulan bebas (24 %), korban *trafficking* (21 %), himpitan ekonomi (14 %) dan korban kekerasan dalam rumah tangga (9 %). Studi tersebut menujukkan bahwa alasan kemiskinan dan bujuk rayu calo menjadi penyebab utama anak-anak terlibat dalam dunia pelacuran.

Kajian mengenai aspek kemiskinan daerah pengiriman dan jaringan perdagangan pernah dilakukan Habsyah, 1995 :117 dalam Rosenberg (2003), menujukkan bahwa dewasa ini keberadaan pekerja anak masih diterima oleh masyarakat. Sebuah studi penelitian mengindikasikan bahwa anak dianggap sudah cukup usia untuk membantu orang tua dan memikul sebagian tanggung jawab ekonomi setelah ia tamat Sekolah Dasar. Penelitian ini juga menujukkan sebagian anak-anak yang bekerja tersebut datang ke kota karena paman atau bibi, atau bahkan sekedar teman atau tetangga yang bekerja di kota datang ke desa untuk menjemput mereka. Aspek yang berhubungan dengan jenis perekrutan ini adalah praktik di mana orang tua dibayar di muka untuk penghasilan anak mereka di masa yang akan datang, sebuah bentuk perdagangan anak dengan sistem ijon.

Beberapa faktor yang mendorong seseorang menjadi pelacur menurut studi yang dilakukan Saptari (1997) dalam Suyanto (1999:15), menyebutkan paling tidak ada tiga faktor yang mendorong sesorang menjadi pelacur. Pertama, karena keadaan ekonomi atau kondisi kemiskinan rumah tangga perempuan pelacur. Kedua, karena pandangan tentang seksualitas yang cenderung menekankan arti penting keperawanan sehingga tidak memberikan kesempatan bagi perempuan yang sudah tidak perawan kecuali masuk ke dalam peran yang diciptakan untuk mereka. Ketiga, karena sistem paksaan dan kekerasan.

Penelitian yang dilakukan Andri (ed), (2002), tentang anak yang dilacurkan menyimpulkan bahwa faktor pendorong anak terlibat dalam perdagangan anak yang dilacurkan, antara lain disebabkan oleh kemiskinan; utang-piutang; riwayat pelacuran dalam keluarga; permisif dan rendahnya kontrol sosial; rasionalisasi; dan stigmatisasi. Penelitian dengan pendekatan kualitatif dilakukan di Jakarta dan Indramayu dengan informan yang terdiri anak - PSK, orang tua anak, konsumen, calo (kecil dan besar), broker, germo, dan petugas desa.

Pengiriman anak-anak dan perempuan untuk industri seks, memang berlangsung sudah cukup lama, dan beberapa daerah di Jawa merupakan daerah pengirim. Hal ini sejalan dengan studi yang

dilakukan Hull (1999) ; Sulistyaningsih (2002) dalam Rosenberg (2003), yang menyebutkan bahwa di Indonesia, argumen tersebut dapat dibenarkan mengingat industri seks sudah hadir sebelum zaman kolonial Belanda, dan di mana, seperti yang telah disebut di atas, paling tidak sebelas komunitas di Jawa adalah pemasok selir, yang kini merupakan daerah pengirim besar untuk pekerja seks di perkotaan. Diantaranya adalah Indramayu, Karawang dan Kuningan di Jawa Barat; Pati, Jepara, Grobogan dan Wonogiri di Jawa Tengah; dan Blitar, Malang, Banyuwangi dan Lamongan di Jawa Timur.

Hal ini juga sejalan dengan penelitian Mudjijono (2005 : 129), bahwa faktor yang mendorong tetap eksisnya kegiatan pelacuran di Sarkem, yaitu adanya daerah-daerah pemasok pekerja seks. Apabila dirunut ternyata ada benang merah antar daerah pemasok pekerja seks dengan daerah pemasok selir pada masa kerajaan. Studi-studi yang menunjukkan, bahwa ada hubungannya antara daerah pemasok dengan sejarah pelacuran pada masa lalu, sehingga melanggengkan keberlangsungan anak-anak yang dilacurkan sampai sekarang.

Berbagai penelitian berkaitan dengan perdagangan anak yang dilacurkan sudah cukup banyak di lakukan. Penelitian yang dilakukan oleh Imelda, dkk (2004) di Kawasan Jakarta Utara, perdagangan anak untuk kepentingan eksploitasi seksual dilakukan oleh para bos melalui lilitan utang yang tidak ada habisnya (baik utang uang maupun utang budi). Di mana terjadi perbedaan utama antara perdagangan anak melalui sistem ijon dengan *trafficking* terletak pada tingkat kesadaran akan terjadinya eksploitasi. Anak-anak perempuan yang diperdagangkan melalui sistem ijon, yaitu anak-anak terlibat hutang piutang kepada bosnya, dalam hal ini yang mempunyai barang dagangan berupa minuman teh botol dan lainnya, sehingga mereka harus membayar dengan melacurkan diri. Dalam hal ini seringkali anak-anak tidak menyadari terjadinya eksploitasi atas dirinya. Penelitian ini juga menunjukkan adanya tiga aktor utama dalam perdagangan anak melalui sistem ijon, yaitu orang tua dan para kerabat gadis, para bos di Jakarta dan calo-calo di kampung, serta masyarakat di kampung para gadis, termasuk pejabat lokalnya, serta anak perempuan lain yang sudah terlibat dalam perdagangan anak perempuan itu sendiri. Studi-studi ini lebih mengkaji aspek jaringan perdagangan anak yang diletakkan dalam konteks kemiskinan di daerah pengiriman anak yang dilacurkan.

Hal ini memang sejalan dengan apa yang dilakukan oleh *United Nations Global Initiative to Fight Human Trafficking* yang mendaftar sebab-sebab umum terjadinya *trafficking* (dalam Subono, Iman: 2010:31) diantaranya : 1) kekerasan berbasis gender, 2) praktek-praktek ketegakerjaan yang diskriminatif, 3) struktur sosial yang patriarkal, 4) memudarnya jaringan ikatan keluarga, 4) menikah dini, 5) tingginya laju perceraian, 6) terbatasnya pendidikan, 7) terbatasnya kesempatan ekonomi, 8) pemerintah yang korup dan gagal, 9) masrginalisasi etnik, ras dan agama. Dilatarbelakangi kondisi tersebut, Subono, Iman : 2020:31) juga menyatakan bahwa kemiskinan (*poverty*) adalah penyebab utama di balik terjadinya trafficking. Orang-orang miskin seringkali tidak punya banyak pilihan dalam hidupnya, dan krenanya mereka seolah-olah dipaksa untuk meninggalkan kampung halaman atau komunitasnya dalam rangka untuk bertahan hidup, atau untuk mencari kesempatan yang lebih baik secara ekonomi di tempat lain.

Salah satu sumber yang dapat dipakai untuk mendefinisikan perdagangan anak adalah Protokol Opsional terhadap Konvensi Hak Anak, yang telah ditandatangani pemerintah Indonesia pada tanggal 23 September 2001. Dalam pasal 2 (a) Protokol Opsional ini, yang dimaksud dengan perdagangan anak atau penjualan anak adalah segala tindakan atau transaksi dimana seseorang anak ditransfer oleh segala orang atau kelompok orang ke orang lain untuk mendapat imbalan atau pertimbangan lainnya.

Selanjutnya Undang-Undang RI nomor 21 tahun 2007 tentang Pemberantasan Tindak Pidana Perdagangan Orang, mendefinisikan perdagangan orang adalah tindakan perekrutan,

pengangkutan, penampungan, pengiriman, pemindahan atau penerimaan seseorang dengan ancaman kekerasan, penggunaan kekerasan, penculikan, penyekapan, pemalsuan, penipuan, penyalahgunaan kekuasaan atau posisi rentan, penjeratan utang atau memberi bayaran atau manfaat, sehingga memperoleh persetujuan dari orang yang memegang kendali atas orang lain tersebut, baik yang dilakukan di dalam negara maupun antarnegara, untuk tujuan eksploitasi atau mengakibatkan orang tereksploitasi. Sedangkan untuk perdagangan anak, terdapat tambahan dalam pasal 1 (4), bahwa anak adalah seseorang yang belum berusia 18 tahun, termasuk anak yang masih dalam kandungan.

Definisi tersebut menurut Emmy (2007), memberikan gambaran bahwa perdagangan anak ini meliputi tiga elemen kunci, yaitu proses (meliputi perekrutan, pengangkutan, transfer, penyembunyian, dan penerimaan orang), cara (dengan ancaman, atau menggunakan kekerasan atau bentuk pemaksaan lainnya, penculikan, pemalsuan, penipuan, penyalahgunaan kekuasaan, memberikan atau menerima pembayaran, atau keuntungan untuk mendapat ijin dari orang yang memegang kendali atas orang lain) dan tujuan (eksploitasi, paling tidak eksploitasi pelacuran oleh orang lain, atau bentuk lain dari eksploitasi seksual, kerja atau pelayanan paksa, atau pengambilan organ tubuh).

Selanjutnya melalui beberapa aturan perundang-undangan tersebut diharapkan mampu memberikan perlindungan terhadap anak-anak, namun sejarah yang cukup panjang atas perdagangan anak yang dilacurkan, terus memberikan ruang bagi terus berkembangnya praktik perdagangan anak yang dilacurkan. Hal ini menjadi salah satu alasan yang mendorong peneliti untuk melakukan penelitian berkaitan dengan perdagangan anak yang dilacurkan. Fenomena yang menarik untuk menelusuri perjalanan anak-anak yang dilacurkan, di Kota Surabaya, yang sering disebut-sebut sebagai salah satu kota transit, serta daerah penerima[2] yang menjanjikan bagi praktik perdagangan anak yang dilacurkan.

Ditinjau dari berbagai penelitian mengenai perdagangan anak yang dilacurkan, menunjukkan bahwa kondisi tersebut dilatarbelakangi oleh faktor-faktor ekonomi, sosial dan budaya. Hal itu tentunya sudah cukup memberikan gambaran mengenai persoalan anak yang dilacurkan. Sehingga dalam penelitian ini, peneliti ingin mengetahui sebenarnya ada apa di balik itu semua, dengan pertanyan utama, bagaimana proses transformasi anak yang dilacurkan menjadi melacurkan. Selanjutnya dirumuskan beberapa pertanyaan penelitian :

1. Bagaimana anak-anak yang telah dilacurkan terkondisikan secara sosial budaya untuk melacurkan diri, antara jebakan dan imajinasi dan kenyataan?
2. Bagaimana sistem kekerabatan yang berfungsi sebagai jaringan perdagangan anak membangun nilai-nilai mengenai seksualitas dikalangan anak-anak, serta kontestasi berbagai nilai-nilai sosial budaya yang mengkondisikan perdagangan anak yang dilacurkan terjadi?
3. Bagaimana strategi untuk untuk melawan perdagangan anak yang dilacurkan, untuk kepentingan terbaik bagi anak?

Penelitian ini dilakukan di Kota Surabaya, sebagai salah satu kota metropolis, Surabaya menjadi tujuan penting serta menjadi jalur penting dalam agen perdagangan anak yang dilacurkan. Selanjutnya, penelitian ini memfokuskan pada beberapa titik lokalisasi di kota Surabaya, di mana anak-anak dilacurkan berada, di antaranya lokalisasi Dolly, Bangunsari dan Tambakasri. Hampir

[2]Dalam perdagangan anak yang dilacurkan, terdapat istilah daerah pengirim yang biasanya dari beberapa kota dan Kabupaten di wilayah Indonesia, khususnya Jawa Barat, Jawa Timur, Jawa Tengah, dan beberapa wilayah Sumatera, Kalimantan, NTT dan NTB. Serta dikenal juga daerah penerima anak yang dilacurkan, yang sekaligus juga menjadi wilayah transit untuk beberapa daerah tertentu seperti Surabaya, Jakarta, Pontianak, serta Medan.

semua lokalisasi di kota Surabaya tersebut menyatu dengan perkampungan rumah warga, sehingga cukup menarik untuk diteliti terkait dengan keberlangsungan praktik pelacuran di tengah komunitas. Sejak dulu, masyarakat di tempat itu menyatu dengan kehidupan para pekerja seks komersial. Segala aktivitas kelam berbaur dengan kehidupan sosial. Sifat penelitian ini adalah penelitian kualitatif. Adapun teknik yang dipakai dalam pengumpulan data adalah partisipasi observasi, wawancara mendalam (*indepth interview*) dan wawancara bebas serta studi literatur. Dalam penelitian ini, yang dijadikan infoman adalah anak-anak perempuan yang bekerja sebagai pekerja seks, maupun yang sudah berhenti bekerja. Kriteria informan yang diwawancarai adalah korban perdagangan anak perempuan untuk dilacurkan, yang usianya 18 tahun ke bawah, atau mereka yang menjadi korban perdagangan anak yang dilacurkan pada usia 18 tahun ke bawah, baik yang masih bekerja maupun yang sudah berhenti bekerja. Juga akan dilakukan wawancara mendalam dengan informan lain seperti germo, pelanggan, teman sesama pekerja seks, keluarga (orangtua, kakak, atau adik), gendaan atau kiwir[3], aktivis perlindungan anak, warga masyarakat sekitar, pengurus LSM yang menangani perlindungan anak khususnya yang melakukan pendampingan di lokasi tersebut, serta aparat pemerintahan setempat dan informan pendukung lainnya.

II. Jebakan Dunia Pelacuran Anak; Antara Imajinasi dan Kenyataan

Perspektif dalam memahami perdagangan seks dari gaya hidup dan budaya, pada umumnya melihat keterkaitan antara perkembangan kapitalisme yang mempengaruhi tidak hanya ekonomi namun semakin dalam ke wilayah budaya dan gaya hidup. Kapitalisme metropolitan yang berkembang di daerah perkotaan dipandang sebagai faktor penarik terjadinya perpindahan penduduk dari daerah pinggiran ke wilayah perkotaan. Kota tidak hanya dilihat sebagai faktor ekonomi semata namun juga dilihat sebagai faktor yang lebih mampu memenuhi imajinasi budaya kota yang kosmopolitan serta lebih menjanjikan daripada hidup di daerah pinggiran.

Studi mengenai perdagangan seks dari aspek gaya hidup dan budaya tidaklah sebanyak kajian dengan perspketif ekonomi. Misalnya Murray (1991) menunjukkan bahwa salah satu alasan manusia melakukan migrasi, karena kampung tidak lagi mampu menyediakan sumber-sumber daya secara sosial-budaya, ekonomi dan politik yang secara tepat guna dapat diacu untuk menanggapi berbagai kebijaksanaan pembangunan dan kapitalisme serta konsumerisme, maka warga kampung berorientasi keluar dari kampung, yaitu ke kebudayaan metropolitan Jakarta sebagai pedoman bagi interpretasi dan tindakan-tindakan mereka.

Studi yang senada dengan di atas dilakukan oleh Sofian (1999), dalam sebuah laporan mengenai anak yang dilacurkan di Sumatera Utara, bahwa proses perekrutan melibatkan kolektor yang berkenalan dengan remaja kelas menengah ke bawah di tempat-tempat umum, seperti pusat perbelanjaan, dan mengiming-imingi mereka dengan janji akan dibelikan makanan atau mengajak mereka menikmati hiburan. Mereka kemudian akan dijual ke rumah bordil. Pravelensi praktik ini masih belum diketahui benar. Selain itu, juga ditemukan bukti di mana perempuan muda

[3]Istilah *kiwir gendaan,*suami (bojo) seringkali muncul dalam obrolan dengan pekerja seks. Suami (*bojo-bojoan*) istilahnya, merupakan suami yang tidak sah, biasanya laki-laki memberi nafkah untuk perempuan, dalam hal ini pekerja seksnya. Sedangkan *gendaan*, adalah pasangan perempuan pekerja seks, di mana kedua belah pihak saling memberi. Kadang kala laki-laki memberikan uang kalau mereka punya, terkadang perempuan pekerja seks yang memberikan uang, tergantung siapa yang dalam keadaan punya uang. Sedangkan *kiwir,* biasanya hanya mengandalkan uang dari perempuan pekerja seksnya saja, dia hanya menjadi penikmat seks, sekaligus penikmat uang dari perempuan pekerja seks yang menjadikan dirinya *kiwir*.

dijerumuskan ke dalam sektor seks oleh kawan dan kerabat dengan janji akan dipekerjakan di rumah makan. Dalam hal ini Sofian melihat perilaku konsumsi dan gaya hidup yang kemudian menjebak anak-anak perempuan tergiur untuk bergaya hidup kosmopolitan, sehingga anak-anak perempuan tersebut tertipu dan kemudian dilacurkan.

Mengutip Gustav Papanek dalam Ihsan, Soffa (2006:8), bahwa melacur adalah pilihan wajar di tengah belitan kemiskinan. Di banding kelompok migran lainnya, penghasilan pelacur rata-rata empat kali lipat penghasilan rata-rata kelompok paling miskin di kota. Para pelacur kerap berperan dobel, sebagai kepala keluarga dan penunjang kehidupan keluarga. Pelacuran menawarkan jalan singkat untuk keluar dari kemiskinan. Tak perlu modal lain selain usia muda dan pesona fisik.

Kondisi kemiskinan di daerah asalnya, kuatnya imajinasi atas kota, merupakan sesuatu yang melekat pada pikiran anak-anak desa ini. Akibatnya sebagian anak-anak usia sekolah di pedesaan belajar mengenai impian tentang kehidupan kota yang moderen. Selanjutnya, mendorong kontestasi nilai-nilai modernitas dan tradisional bagi kalangan anak-anak dengan bayang-bayang dan impian kota. Hal ini menjadi bagian dari sebuah *habitus* yang lebih longgar bagi anak-anak untuk mewujudkan impiannya datang ke kota, dengan impian modernitas. Namun kadangkala kenyataan tak seindah impian. Pasar pelacuran anak perempuan, menjerat anak-anak masuk dalam dunia pelacuran. Berbagai layanan dan janji "materi", menggambarkan betapa seksualitas menjadi sebuah komoditi yang tak terelakkan sebagai bagian dari kehidupan manusia. Persoalan seksualitas menjadi sebuah atraksi serta tontonan yang menarik, tidak sekedar uang yang dimainkan tapi juga perasaan (*feeling*), serta perputaran pasar yang menyediakan layanan bagi konsumennya. Dentuman musik, bisnis judi, peredaran minuman keras serta narkotika mewarnai kehidupan pasar pelacuran ini. Tidak mengherankan, jikalau aktivitas ini tidak akan pernah ada matinya, kalaupun ada hanyalah sekedar sebuah perubahan yang tersamarkan belaka.

Tidak berbeda jauh dengan kisah beberapa anak perempuan yang berada di lokalisasi, yang tersihir atas imajinasi kota yang serba modern. Salah satunya kisah anak-anak yang ada di Kota Surabaya, awalnya mereka datang ke kota Surabaya tidak langsung bekerja sebagai pekerja seks. Bagi mereka, menjadi pekerja seks memang bukanlah tujuan mereka berada di Kota Surabaya ini. Namun, kenyataan menujukkan bahwa dengan menjadi pekerja seks, mereka bisa mengumpulkan uang jauh lebih besar dibandingkan pekerjaan mereka sebelumnya.

Sebut saja Putik, gaji sebagai *baby sitter* saat itu sebesar Rp. 500.000/bulan. Namun dalam semalam, Putik bisa mendapatkan 5-6 orang tamu dan mendapatkan bayaran setidaknya Rp. 300.000 – Rp. 500.000. Hal ini juga diakui oleh Anita, sebagai mantan karyawan perusahaan biro jasa perjalanan, sebulannya dia mendapatkan gaji sebesar Rp. 600.000. Namun, selama bekerja di lokalisasi Tambakasri bersama kakaknya, dia bisa membawa uang 3-5 juta per-bulannya setiap kali pulang kampung. Sebuah angka yang cukup fantastis. Keduanya memang masih cukup muda, cantik dan menarik. hal ini tentunya mengundang pelanggan untuk selalu datang kembali padanya. Penampilan serta kebugaran tubuh menjadi prioritas bagi kedunya untuk menarik tamu.

Temuan lapangan atas kasus anak-anak yang dilacurkan, memang tidak semata-mata karena persoalan kemiskinan. Kondisi lingkungan pergaulannya, seperti kasus Nia yang dibawa teman bermainnya di desa ke lokalisasi Dolly. Putik, anak tunggal keluarga TKW di Hongkong yang secara ekonomi berkecukupan, terjebak di lokalisasi karena tawaran menjadi operator. Ataupun kisah Anita yang sudah bekerja di perusahaan biro jasa perjalanan (*travel*), yang ditawarin pekerjaan di Makassar dan dijual di sebuah Hotel untuk menjadi pekerja seks. Mata rantainya adalah kemiskinan, pelacuran, dan perdagangan anak perempuan untuk tujuan seksual. Tuntutan atas pemenuhan kebutuhan yang diukur secara materi, membawa mereka tidak bisa keluar dari dunia pelacuran. Jeratan hutang, pelanggan yang sekaligus menjadi "*gendaan*" atau "*kiwir*", kosmetik,

uang yang berlimpah, serta kata-kata manis sang Germo, semakin memposisikan anak-anak perempuan berada pada ”zona” yang nyaman berada dalam dunia pelacuran.

Pengalaman-pengalaman ini dialami oleh anak perempuan dan perempuan lain secara terus-menerus dan berganti-ganti korbannya. Menurut Bourdieu, bahasa yang dijadikan modal untuk menjerat anak-anak perempuan untuk tetap bertahan di dunia pelacuran, merupakan praktik sosial yang terus menerus berlangsung. Bujuk rayu, tipuan dengan dalih bekerja di restoran atau sebagai operator, tentunya dirangkai melalui sebuah bahasa yang manis dan indah.

Jaringan yang terlibat dalam dunia pelacuran, mulai dari germo atau mucikari yang selalu bersikap baik dan bertutur kata manis kepada para pelayannya, yaitu para pekerja seks termasuk pekerja seks anak yang mendatangkan banyak uang. Termasuk teman sesama pekerja seks, yang saling mendukung sesama pekerja seks lain untuk bertahan dalam dunia pelacuran. Sampai pada para pelanggan yang selalu menyatakan kepuasan, atas pelayanan sang pekerja seks, melembaga dalam institusi non formal dunia pelacuran anak.

Tuturan bahasa, dengan berbagai gaya yang khas pada masing-masing, membentuk otoritas tersendiri terhadap pelibat atau aktor dalam dunia pelacuran anak. Otoritas tersebut melembaga melalui bahasa, serta melekat pada penuturnya, yang selanjutnya disebut Bourdieu sebagai sebuah kekuasaan simbolik. Bourdieu (1977b;645) dalam Harker ddk (ed) ; 1990:201), bahwa bahasa merupakan bagian dari cara hidup kelompok sosial dan secara essensial memberikan layanan bagi tercapainya tujuan-tujuan praktis. Dalam hal ini, ia berlawanan dengan filsafat intelektualis yang menjadikan bahasa sebagai objek pemahaman ketimbang sebagai instrument tindakan. Bahasa merupakan bagian dari sebuah aktivitas dimana sebagian orang mendominasi sebagian yang lainnya. Berbagai tawaran, melalui bahasa yang manis inilah selanjutnya menjebak anak-anak perempuan semakin terjebak dalam dunia pelacuran.

Strategi yang dilakukan oleh para pekerja seks, merupakan sebuah pilihan yang dilalui melalui reproduksi sosial yang terus menerus terjadi dalam komunitas mereka. Sehingga menurut Bourdieu (1994) dalam Haryatmoko (2003;15), bahwa mobilitas sosial dan profesional menuntut orang harus sesuai dengan standar perubahan yang terus-menerus (posisi-posisi baru dalam struktur sosial dan ekonomi). Oleh karena itu, mekanisme mempertahankan tatanan sosial atau reproduksi sosial cenderung dominan dalam masyarakat. Untuk melakukan reproduksi sosial, terus mengalami perubahan seiring dengan perubahan sosial dan kultural masyarakat.

Lokalisasi yang tersebar di kota Surabaya, terus mengalami perubahan dengan tetap mempertahankan praktik pelacuran yang melibatkan perempuan, termasuk anak perempuan sebagai daya tarik bagi pelanggannya. Kewenangan para pelaku dalam jaringan dunia pelacuran anak perempuan, berusaha terus mempertahankan tetap eksisnya keberadaan mereka. Mereka membangun mekanisme dalam dunia pelacuran, supaya anak-anak perempuan dan perempuan pekerja seks tersebut terus berada di dalam komunitasnya. Salah satunya melalui arisan yang dilakukan oleh mucikari, ataupun kelompok pekerja seks. Aktivitas ini menjebak mereka untuk tetap bertahan hidup dalam dunia pelacuran. Seperti kisah Eka (21 tahun), perempuan dari Sumenep ini menyatakan bahwa dirinya sudah masuk Tambakasri sejak usia 17 tahun. Kini, dirinya mengikuti arisan harian sebesar sepuluh ribu rupiah, yang sekali tarik bisa mendapatkan 2 juta rupiah. Strategi yang cukup menarik, untuk bisa membuat anak-anak perempuan ini, mau tidak mau terjebak dalam dunia pelacuran.

III. Kontestasi Nilai Seksual yang Menjerat Anak Perempuan yang Dilacurkan

Begitu maraknya jaringan perdagangan anak yang dilacurkan, tidak lepas dari konteks sosial budaya, yang dimanifestasikan dengan keragaman budaya, tradisi, pola pemukiman, kondisi geografis, serta ekonomi sebagai akibat dari rendahnya sumber daya alam yang tersedia di suatu wilayah. Salah satunya daerah asal Watik, yaitu Dusun Mrunggi, Blitar Selatan yang terkenal sebagai daerah yang kering dan miskin mengkondisikan tatanan nilai seksual yang khas. Watik, perempuan yang tidak lulus SD ini harus dengan rela dinikahkan oleh kedua orangtuanya saat berusia 16 tahun. Laki-laki pilihan orangtuanya, bukan semata-mata pernikahan tanpa alasan, kedua orangtuanya yang tidak mempunyai tanah untuk tempat tinggal, dipinjami sebidang tanah untuk didirikan rumah saudara mantan suaminya tersebut. Setelah menikah, suaminya justru meninggalkan dirinya tanpa memberikan nafkah lahir maupun batin. Proses pertukaran anak perempuan, dengan menikahkannya di usia muda justru memberikan beban tersendiri bagi sang anak. Predikat janda muda yang disandangnya, menyebabkan dia merasa tidak nyaman untuk hidup dalam lingkungan daerah asalnya. Sehingga pilihan untuk keluar, mencari pekerjaan di luar daerahnya merupakan sebuah alternatif. Domestifikasi perempuan, juga menjadi faktor penyebab menjadikan mereka sebagai korban perdagangan perempuan. Beberapa kisah anak yang dilacurkan, seperti Ita, maupun Nina yang menikah di usia muda, menjadi faktor yang secara tidak langsung menjadikan mereka sasaran empuk dalam praktik perdagangan anak perempuan. Hal ini didukung juga melalui Undang-Undang Perkawinan No. 1 tahun 1974, bahwa perempuan Indonesia diizinkan untuk menikah pada usia 16 tahun atau lebih muda jika mendapatkan izin dari pengadilan.

Tradisi pernikahan dini, seperti yang dialami oleh Watik dan Nina misalnya, menciptakan masalah sosial ekonomi tersendiri bagi pasangan usia muda ini. Pasangan-pasangan yang dijodohkan tersebut seringkali menghadapi berbagai masalah. misalnya masalah kesehatan reproduksi dimana kehamilan prematur menyebabkan tingginya tingkat kematian ibu, serta rawan terhadap infeksi yang menular. Sebagian besar, anak perempuan yang menikah dini, secara otomatis hak atas pendidikannya juga terampas, akibatnya mereka harus putus sekolah. Kisah Nina, yang tidak bisa menamatkan pendidikannya SD (sekolah Dasar), karena alasan menikah di usia muda. Tingkat perceraian yang tinggi, khususnya pada pasangan yang menikah pada usia dini juga mendorong anak perempuan menjadi sasaran empuk para pelaku perdagangan anak. Bahkan alasan menjadi janda, merupakan alasan yang bisa diterima ketika mereka harus masuk dalam dunia pelacuran, meskipun masih anak-anak.

Nilai yang dilekatkan pada anak, bahwa adanya peran dan tanggung jawab anak, juga merupakan sebuah konteks budaya yang mendorong anak-anak terlibat dalam pekerjaan produktif bagi keluarganya. Beban orangtua, kemiskinan, serta nilai-nilai kepatuhan yang harus dilakukan oleh anak-anak terhadap orangtua sebagai balas jasa, mendorong mereka untuk bekerja di usia muda. Iming-iming pekerjaan di kota yang lebih menjajanjikan, daripada sekedar mengandalkan orangtuanya yang hanya buruh tani di daerah asalnya juga mendorong anak-anak melakukan urbanisasi. Kerelaan orangtua dan kerabat, untuk memberikan ijin bagi anak-anaknya untuk bekerja di kota, mendorong anak-anak terlibat dalam pekerjaan terburuk. Ita maupun Ani yang dibawa *budhe*nya ke Surabaya, menunjukkan orangtua serta kerabatnya memberikan dukungan untuk bekerja di Surabaya. Keterbatasan sistim sumber ekonomi di desa, termasuk terbatasnya lapangan pekerjaan di desa, mendorong komersialisasi seksual sebagai salah satu pilihan alternatif bagi anak-anak untuk melakukan urbanisasi ke Surabaya.

Beberapa kisah lain menunjukkan, bagaimana Irma dari Jombang yang tidak ingin membebani keluarganya di desa, memilih untuk pergi ke Surabaya. Juga kisah Putik, yang menjadi pengasuh anak atau sering disebut sebagai *baby sitter* di Surabaya, ataupun kisah Watik yang berangkat ke

Malang, untuk mencari pekerjaan dan justru dijual ke lokalisasi. Namun demikian, ada fakta yang cukup mengejutkan dimana sesama kerabat, melakukan praktik komersialisasi seks atas kerabat lainnya, seperti kisah Ita dan Ani, yang dibawa oleh *Budhe*nya untuk bekerja di lokalisasi.

Dukungan sesama kerabat dari daerah asal yang sama, bahkan satu keluarga seperti kisah Ita dan keluarganya, Yani dan adiknya Nia, maupun Anita yang dibawa kakaknya merupakan fakta yang ada dalam konteks sosial budaya di masyarakat. Komersialisasi seks, sebagai suatu hal yang mendapat dukungan antar kerabat, dan menjadikanya sebagai sebuah ajang untuk menunjukkan keberhasilan sebuah keluarga, secara ekonomi yang ditunjukkan terhadap masyarakat di daerah asalnya. Keberhasilannya, membawa pulang uang, membangun rumah untuk orangtunya, membeli ternak sapi maupun kambing menunjukkan sebuah peningkatan atas status sosial yang diharapkan.

Selain persoalan materi, anak-anak yang berasal dari kerabat yang sama, biasanya juga saling mendukung ketika ada masalah, termasuk berusaha kompak untuk menutupi pekerjaan di Surabaya sebagai pekerja seks dari keluarganya di desa. Misalkan saja, kisah Anita dan Rina, dua kakak beradik dari Dampit, Malang Selatan ini selalu berusaha kompak ketika pulang ke desanya. Mereka saling mengingatkan untuk mengenakan pakaian yang dianggap sopan, celana panjang dan kaos, atau blus yang tidak terlalu ketat. Termasuk dandanan yang tidak terlalu menor, supaya tidak mengundang kecurigaan.

Namun demikain, tidak hanya orangtua maupun kerabat yang mendukung anak-anak terlibat secara tidak langsung dalam praktik perdagangan anak yang dilacurkan. Faktor kekuasaan yang diwakili oleh aparat desa-pun, yang seharusnya menjaga hak-hak dasar anak, justru memberikan akses untuk mempermudah anak-anak bekerja di usia muda. Contohnya, bagaimana dengan mudahnya Kepala Desa dan aparatnya membuat identitas palsu untuk memuluskan usia pernikahan dini, ataupun untuk pengurusan KTP dan paspor untuk memudahkan mereka bisa mendapatkan kerja di luar kota ataupun luar negeri, seperti kisah Putik dan Anita yang akhirnya memperoleh KTP sebelum usianya mencapai 17 tahun.

Bagiamanapun juga nilai serta tatanan sosial yang melekat pada masyarakat, merupakan bagian tidak terpisahkan dalam melanggengkan praktik perdagangan anak yang dilacurkan ini. Belum lagi, simbol material menjadikan sesuatu nilai yang mempunyai arti penting bagi seseorang untuk mendapatkan status sosialnya. Sehingga pilihan jenis pekerjaan, maupun resiko pekerjaan seringkali diabaikan demi sebuah status sosial.

Seksualitas dalam hal ini tidaklah semata-mata untuk fungsi reproduksi yang berbasis nilai-nilai moral, namun juga terkandung di dalamnya nilai-nilai pertukaran sosial. Hal ini tampak dari fenomena pernikahan dini sebagai sistem ijon dalam hutang piutang antar keluarga. Hal ini secara terus menerus mengalami reproduksi nilai yang kemudian melibatkan anak perempuan sebagai alat tukar menukar. Praktik ini bukanlah semata-mata merupakan dominasi maskulin, namun juga melibatkan perempuan dalam proses reproduksi nilai-nilai seksual sebagai komoditas yang dapat dipertukarkan.

IV. Kekerabatan dalam Praktek Perdagangan Anak yang Dilacurkan

Temuan lapangan menunjukkan, adanya peran kerabat dalam jaringan perdagangan perempuan ini. Sebut saja kisah Ita, yang menjadi pekerja seks atas campur tangan dari budhenya, termasuk Ani yang masih keponakan dari Nia. Peran orang terdekat atau kerabat, menjadikan keberlangsungan perdagangan anak juga perempuan menjadi langgeng. Beberapa penelitian menunjukkan adanya campur tangan orang tua (lihat penelitian Mulyanto, 2002, Ruth Rosenberg,

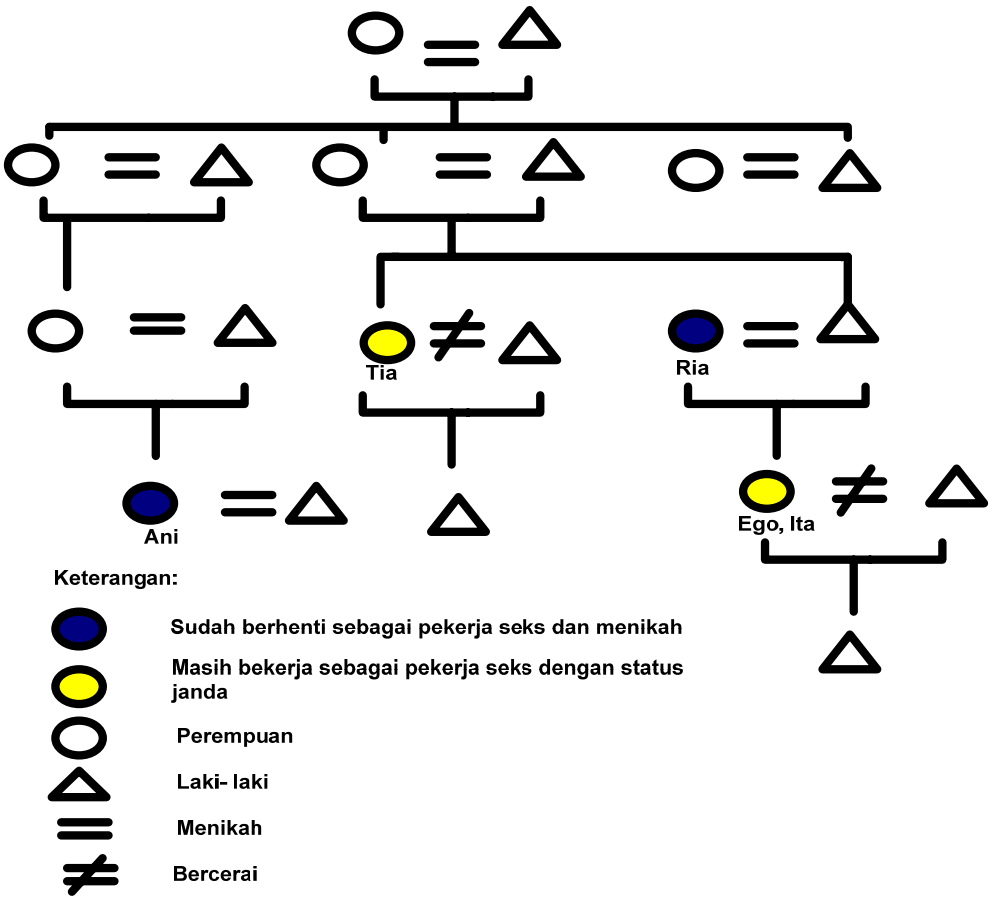
2003), hasil penelusuran terhadap beberapa anak yang dilacurkan menujukkan justru orang tua mereka tidak tahu menahu soal pekerjaan mereka. Untuk mengelabuhi keluarga dan orang tuanya, biasanya mereka mengaku bekerja di *travel* seperti kisah Anita, Yani yang mengaku di Bogasari, maupun Nia yang mengaku kerja di Perak dan lainnya. Hampir semua anak tidak mengakui pekerjaan mereka yang sebenarnya. Selain karena ada perasaan malu dan khawatir akan cercaan keluarga maupun masyarakat di desanya, sebagian di antara mereka juga berasal dari keluarga terhormat atau terpandang di desanya. Sebut saja Yani, keluarga besarnya merupakan penggiat Nahdalatul Ulama (NU) di desanya , atau Putik yang sempat belajar di Pesantren.

Keterlibatan kerabat keluarga, lebih banyak terjadi antara adik kakak perempuan, atau sesama kerabat perempuan yang dianggap bisa menjaga rahasia mengenai jenis pekerjaan mereka. Dalam hal ini, peran kerabat cenderung tidak melakukan penipuan terhadap anggota keluarga lainnya. Sebagian mereka justru baru tahu setelah sama-sama menjadi korban perdagangan, seperti kisah Anita dan Rina yang sama-sama menjadi korban perdagangan anak dan perempuan di Makasar. Awalnya keduanya memang merupakan korban perdagangan anak yang dilacurkan, namun karena merasa sudah masuh dalam dunia pelacuran, mereka selanjutnya masuk kembali dalam bisnis *esek-esek* ini di Surabaya. Keterlibatan sang kakak, untuk mengajak adiknya Anita ke lokalisasi Tambakasri, menjadikan kerabat dekat sebagai pelaku aktif dalam perdagangan anak yang dilacurkan ini. Termasuk kisah Yani dan Nia, kakak beradik yang bertemu di Dolly, dan akhirnya memilih Bangunsari sebagai tempat kerjanya.

Hal ini sejalan dengan pendapat Bourdieu (1990), bahwa kekerabatan mempunyai fungsi dan hubungan yang kuat satu sama lainnya. Bahwa seseorang dapat melupakan bahwa mereka adalah produk dari strategi yang berorientasi terhadap kepuasan material dan simbolis kepentingan dan diselenggarakan dengan mengacu pada jenis tertentu dari kondisi ekonomi dan sosial. Hal ini menunjukkan, untuk sebuah kepentingan materi, kerabat mempunyai fungsi kuat untuk bisa saling memberikan dukungan atas kerabat lainnya, tanpa harus mempertimbangkan aktifitas yang dilakukan maupun produk yang dihasilkan.

Sebagian lagi memang dengan sengaja mengajak mereka untuk bekerja dengan alasan untuk mendukung saudara atau sesama kerabat perempuan. Kisah Tia yang mengajak dua orang keponakannya yang menjanda di usia muda, merupakan sebuah alasan untuk mendukung sesama perempuan yang dikhianati oleh suaminya, dan mencoba peruntungan di lokalisasi. Peran kerabat keluarga, cenderung dianggap tidak bermasalah karena tidak terjadi unsur pemaksaan maupun penipuan. Justru, sesama kerabat yang mempunyai profesi sama, mereka bisa saling mendukung. Termasuk bagaimana ketika mereka harus berhadapan dengan anggota keluarganya kalau pulang ke desanya, ataupun ketika mereka mengalami masalah di tempat bekerjanya.

Temuan lapangan menunjukkan bagaimana sistem kekerabatan juga berperan dalam praktek perdagangan anak yang dilacurkan. Sebuta saja keluarga Ita, yang berhasil dibawa oleh budhenya ke Surabaya untuk bekerja di lokalisasi Bangunsari, termasuk Ani yang juga masih saudara sepupunya. Hal ini juga menjadi mudah, dikarenakan ibu Ita juga mantan pekerja seks di makassar, yang kini telah berhenti. Kerelaan Ibu Ita (Ria) yang mengijinkan anaknya bekerja sekalipun sebagai pekerja seks di Surabaya, serta dukungan Tia yang tidak lain adalah kakak kandung dari bapaknya Ita, menjadikan Ita melenggang tanpa beban untuk masuk dunia pelacuran anak di kota Surabaya. Hal ini bisa digambarkan dalam bagan sistem kekerabatan kelaurga Ita, berikut ini.



Dominasi perempuan, melalui sistem kekerabatan mencoba mempengaruhi anak-anak perempaun bahkan perempuan lain untuk bisa keluar dari masalahnya, tanpa harus tergantung pada laki-laki, meskipun harus mempertaruhkan nilai seksualitasnya. Kepentingan dengan dalih untuk membantu sesama perempuan, menjadi alasan yang kuat. Bahwa menjadi perempuan, bukanlah harus selalu berada di bawah bayang-bayang laki-laki. Perceraian yang terjadi bukanlah alasan menjadikan laki-laki sebagai segala-galanya. Namun menjadikan perempuan ini berusaha untuk bisa mendukung perempuan lain, walau dengan cara berbeda dan dianggap tidak ”sewajarnya” Kondisi ini masuk secara perlahan, melalui sistem kekerabatan, yang saling mendominasi antar kerabatnya untuk sebuah komersialisasi atas seksualitas perempuan dan anak-anak perempuan.

V. Kekerasan Simbolik dalam Praktek Perdagangan Anak yang Dilacurkan

Jebakan dunia pelacuran, jebakan konsumsi dan gaya hidup bagi anak-anak perempuan yang melacurkan diri ini seringkali menjadi hal yang tidak mereka rasakan sebagai sebuah masalah. Baginya itu merupakan tuntutan, dan wajar dalam dunia pelacuran. Seperti yang dituturkan oleh Anita.

> ”kebutuhan hidup terus bertambah kak, kalau ada model handphone baru pengennya beli, kan malu kalau pake yang jelek. Juga baju, setiap minggu saya selalu ke mall, ya palingan beli satu atau dua kaos, untuk ganti-ganti, ntar kalo pake itu-itu dikira tamunya ndak modal banget.”[4]

[4]Obrolan ringan dengan Anita, di warung makan depan wisma, 9 April 2010, pukul 11.30 Wib

Bagi Anita persoalan konsumsi, serta gaya hidup sangat mendukung untuk bisa mendapatkan pelanggan yang maksimal, otomatis bisa meraup uang lebih besar. Hasil yang banyak tentunya kepuasan bagi mereka, untuk bisa memenuhi berbagai kebutuhannya, dengan berbagai cara dan usaha. Demikian juga dengan keinginan Ita maupun Yani, yang ingin selalu dianggap mempuyai pekerjaan bagus di kota oleh orang desanya, menuntut mereka untuk bekerja keras mendapatkan uang. Kalau pulang tidak membawa uang, bagi mereka merupakan hal yang tidak mungkin. Sehingga mereka selalu berusaha untuk pulang, dengan membawa banyak uang, bagaimanapun caranya. Terkadang Anita juga sering dibawa oleh beberapa tamu ke tempat karaoke, seperti Station untuk mendapatkan tambahan tips. Bahkan Yani-pun rela, ketika dia menyanyi di karaoke, tubuhnya digerayangi oleh pelanggan demi tips tambahan.

Namun, ketika harus melayani tamu, seringkali mereka juga mengalami kekerasan. Seperti yang diceritakan oleh Anita, bahwa dia sering bertengkar dengan tamunya karena tidak mau menggunakan kondom. Juga Putik, yang terkadang tidak dibayar tamunya karena dalam kondisi mabuk berat. Belum lagi resiko penyakit menular seksual, sampai virus mematikan seperti HIV, begitu terbuka bisa menjangkit mereka.

Bagi Bourdieu (1990), bahwa kekerasan simbolik ini dimulai dengan adanya pola dominasi. Dimana peran antara laki-laki dan perempuan juga bisa saling mendominasi, sehingga menimbulkan sebuah kepatuhan yang tertanam dalam diri mereka. Bourdieu juga menyebutkan bahwa pelaku sosial menerima kekerasan simbolik sebagai sesuatu yang wajar, karena kekerasan simbolik menggunakan struktur kognitif yang telah dimiliki oleh pelaku sosial sejak lahir, dengan struktur objektif yang ada dalam dunia sosial.

Dalam konteks dunia pelacuran anak, kekerasan simbolik sudah dialami oleh mereka mulai sebelum masuk dunia pelacuran. Sebut saja kisah Putik yang dijual oleh teman laki-lakinya ke lokalisasi, juga kisah Yani yang dijual oleh tukang ojek. Termasuk kisah Santi yang diserahkan kepada maminya di Kremil, oleh tukang becak yang dianggap justru menolongnya. Hal ini tidak jauh berbeda dengan kisah Anita, yang dibujuk untuk diberi pekerjaan di Makassar Sulawesi Selatan, oleh seseorang yang tidak dikenal. Bentuk lain yang lebih tersamarkan, seperti kisah Ita dan Ani yang dengan sengaja dibawa kerabatnya untuk bekerja di lokalisasi, dengan iming-iming uang, serta harta benda dari hasil kerja melacurkan diri di Surabaya.

Sampai di lokalisasi, bentuk kekerasan yang dialami mengalami perubahan bahkan peningkatan. Relasi tidak hanya antara anak-anak perempuan yang melacurkan diri dengan pelanggannya, tapi juga dengan sang mami, gendaan atau biasa disebut kiwir, petugas keamanan, sesama teman bahkan dengan masyarakat sekitar. Pelanggan dengan segala permintaan untuk memberikan layanan seksual yang memuaskan, bahkan dengan bahasa atau perilaku yang menyakitkan-pun menjadi hal yang tidak mereka sadari. Seperti kisah Tia, ketika sedang mencari tamu di depan wismanya, ada seorang pelanggan yang menghampirinya. Dengan kode 2 jari, sambil mengatakan *"dua kali lima puluh ribu ya?"* Sontak, Tia yang merasa ditawar langsung menjawab *"jepitin pintu aja mas",* dan tamunya pun pergi dengan membawa sepeda motornya[5].

[5]Partisipasi observasi di depan wisma Ita, dan Tia, 15 April 2010. Pukul 11.30 Wib, nampak beberapa tamu yang sedang mencari PSK untuk diajak kencan atau "ngamar". Sebagian datang dengan beberapa temannya, sebagian lainnya datang sendirian dengan menggunakan sepeda motor. Dengan berjalan perlan, para laki-laki hidung belang berusaha mendapatkan perempuan untuk diajak tidur. Di antara mereka ada yang langsung masuk ke salah satu wisma langganannya, Namun beberapa lainnya nampak terlihat mencari-cari dengan menegok ke dalam wisma, atau mencoba menawar perempuan yang sedang berada di depan wismanya.

Kekerasan simbolik, bisa dalam berbagai bentuk. Bourdieu juga menyatakan, bahwa manusia sebagai *homo economicus,* sehingga profesi sebagai pekerja seks dijadikan sumber pemenuhan kebutuhan dengan motif ekonomi. Kekerasan simbolik semacam ini, berjalan dengan sangat halus, sehingga sulit untuk dikenali. Inilah yang mebuat kelompok yang terdominasi, termasuk anak-anak perempuan yang melacurkan diri, seringkali tidak merasa menjadi korban ataupun merasa keberata untuk masuk dalam lingkaran dominasi.

Bahkan, kekerasan simbolik juga terus dialami oleh anak-anak perempuan yang telah berhenti sebagai pelacur anak sekalipun. Kisah Watik, yang sudah pulang ke desanya, dan sudah menikah serta hidup bermasyarakat-pun, menurutnya masih ada tekanan dari pihak keluarganya atau warga sekitar. Karena sudah tidak bekerja dan tidak mempunyai uang, seringkali dia dicibirkan oleh warga sekitar, karena rumah yang ditinggalinya sekarang, tanahnya merupakan pinjaman dari seorang warga yang baik di desanya. Belum lagi pihak keluarganya, yang terkadang sering merasa keberatan karena harus membantu membiayai kebutuhannya, karena gaji dari suaminya terkadang tidak mencukupi. Belum lagi mengahadapi sindirian beberapa warga yang tahu masa lalunya, masa menjadi pelacur anak di Surabaya. Cibiran ataupun sindirian itu terasa menyakitkan, walaupun kini dia sudah bisa membuktikan bahwa dirinya kembali menjalani kehidupan keluarga, seperti kebanyakan warga di desanya.

Ungkapan melalui bahasa yang terucap, merupakan bentuk kekerasan simbolik yang tersamarkan, serta mengalami reproduksi sosial yang berulang-ulang. Betapa dahsyatnya kata-kata yang terucap melalui bahasa, sehingga menjadi momok bagi pelaku sosial, untuk cenderung melakukan ”pembalasan” kepada generasi berikutnya, dan dilakukan secara terus menerus untuk direproduksi. Di sini bahasa menjadi sebuah bentuk kekerasan simbolik, yang mengukuhkan anak-anak memasuki dunia pelacuran tanpa mereka sadari.

Kekerasan simbolik dialami oleh anak-anak sejak mereka sebelum masuk dunia pelacuran. Tipu muslihat yang dilacarkan para *trafficker*, paksaan untuk melayani tamu ketika sudah berada di bawah kekuasaan germo, bahkan kekerasan yang dialami ketika harus melayani tamu dengan berbagai servis yang dimintanya. Ataupun kekerasan yang dilakukan oleh pasangan laki-lakinya, yang tidak disadari telah menjeratnya.

> ”Iya mbak, kadang saya lebih suka main dengan perempuan dewasa, ketimbang anak-anak. Kalau yang anak-anak suka ndak mau diajak yang aneh-aneh, sekarang saya punya gendaan di gang Rembang. Dia sayang ma aku, setiap hari saya selalu dijatah rokok sebungkus, juga kadang kalau mau nginap di wismanya, dia yang mbayarin kamarnya.”[6]

Betapa anak-anak yang dilacurkan ini mengalami berbagai resiko kekerasan, yang mereka alami mulai dari mereka berangkat, kemudian masuk dunia pelacuran yang tidak seringkali tidak mereka sadari. Tidak hanya berhenti di situ, kekerasan masih mengantui mereka ketika mereka mempunyai impian dan harapan untuk kembali hidup di lingkungan keluarga, penolakan masyarakat, cibiran serta sikap yang tidak menyenangkan sering mereka rasakan. Belum lagi, ketika mereka harus menanggung resiko atas penyakit yang menggerogoti tubuhnya, berbagai penyakit Infeksi Menular Seksual (IMS), bahkan virus HIV/AIDS yang mematikan.

[6]Wawancara dengan Budi, umur 25 tahun. Salah seorang pemuda di daerah Bangunsari yang mempunyai menjadi gendaan pekerja seks di lokalisasi tersebut. Sehari-hari dia bekerja mengantarkan bir dari satu wisma ke wisma, dan bekerja di salah seorang pengepul bir bintang di kawasan tersebut.

VI. Strategi Melawan Perdagangan Anak

Kondisi anak-anak yang dilacurkan seringkali tidak pernah menjadi topik yang menarik bagi pengambil kebijakan. Kemiskinan seringkali dijadikan "kambing hitam" dalam konteks ini, yang terkadang program yang digulirkan oleh Pemangku kenijakan tetap belum berpihak kepada anak-anak. Untuk itu membicarakan strategi memang bukanlah hal yang mudah, apalagi strategi untuk melawan praktik perdagangan anak perempuan yang dilacurkan. Dalam konteks perdagangan anak perempuan untuk tujuan seksual ini, aktor atau pelaku *trafficking* mempunyai cara serta strategi yang tersembunyi, sehingga sulit utuk dikenali. Belum lagi, melihat sejarah pelacuran di dunia ini, yang menunjukkan keberadaan pelacuran sudah sedemikian panjang sejarahnya. Hampir setiap peradaban umat manusia tidak pernah sepi dari pelacuran.

Melihat kenyataan, bahwa persoalan pelacuran anak ini cukup pelik serta merupakan sebuah proses pengkondisian serta pembiasaan yang sudah berlangsung sangat lama, serta terjadi secara terus menerus. Perkembangan modernitas, yang diaktulisasikan melalu gaya hidup serta pola konsumsi, menjerat anak-anak terlibat dalam buaian materi yang dibangun di atas kepentingan seksualitas semata. Hal ini terus menerus terjadi, serta direproduksi melalui jaringannya baik secara vertikal, maupun horisontal dalam konteks sosial budaya masyarakat. Ada beberapa hal yang penting dalam membangun sebuah strategi untuk melawan pelacuran anak, yang bisa dibagi dalam upaya *preventif* (pencegahan), perlindungan, *rehabilitatif* (pemulihan) maupun *integratif*.

A. Upaya Preventif (Pencegahan)

Sebagai sebuah upaya pencegahan, perlu dilakukan tindakan untuk mencegah terjadinya praktek perdagangan anak yang dilacurkan. Melalui tindakan pencegahan, diharapkan tidak akan banyak korban anak-anak yang terlibat aktivitas eksploitasi seksual. Hal ini penting untuk dilakukan melalui peningkatan kesadaran tentang hak-hak anak, bahaya eksploitasi seksual maupun trik yang digunakan pelaku perdagangan anak. Kegiatan ini dilakukan bagi seluruh elemen masyarakat, khususnya di daerah yang diindikasikan rawan perdagangan anak, maupun area-area yang rawan terjadinya tindakan perdagangan anak yang dilacurkan ini. Hal ini bertujuan untuk memperkuat dan memobilisasi komunitas lokal untuk memonitar dan melindungi anak-anak serta merangsang terwujudnya komunitas yang peduli anak, khususnya issue-issue perlindungan anak.

Beberapa strategi yang bisa dilakukan untuk mencegah terjadinya perdagangan anak yang dilacurkan ini, yaitu 1) pencegahan melalui institusi pendidikan, khususnya melalui integrasi ke dalam kurikulum sekolah mengenai hak anak, pendidikan seks, dan eksploitasi seks serta wacana modernitas. Seperti yang kini dilakukan oleh seorang Guru di salah satu SMPN di salah satu desa di Kabupaten Sukabumi. Kasus yang menimpa anak didiknya Nani, yang dijual ke Medan, mendorong dirinya untuk melakukan pendidikan dini mengenai *trafficking* dan modusnya. Kini pengetahuan mengenai trafficking, selalu dia berikan di sela-sela pelajaran yang diberikan pada muridnya-muridnya. Berharap, cukup satu Nani yang menjadi korban. Dia telah berhasil memulangkan satu Nani, dan sekarang dia memiliki banyak Nani yang masih harus dijaga; 2) peningkatan kesadaran mengenai sindikat perdagangan anak yang dilacurkan, modusnya maupun pola rekruitment yang dilakukan melalui media massa; 3) mobilisasi komunitas untuk mengembangkan sistem monitoring atas upaya perlindungan anak, untuk mendorong masyarakat yang tanggap terhadap pola-pola perdagangan anak yang dilacurkan ; 4) upaya untuk pemberdayaan ekonomi produktif bagi kelaurga miskin, yang diharapkan mampu menekan terjadinya tindakan "pembiaran" terhadap anak-anak untuk terlibat pekerjaan yang beresiko, termasuk keterlibatan anak-anak komersialisasi seks melalui perdagangan anak yang dilacurkan.

B. Upaya Perlindungan

Langkah ini bertujuan untuk memberikan perlindungan terhadap anak-anak korban perdagangan untuk tujuan seksual. Upaya perlindungan ini, dilakukan melalui penguatan jaringan hukum atau implementasi hukum tersebut, termasuk penguatan basis komunitas untuk memberikan jaminan perlindungan terhadap anak-anak dari ancaman perdagangan anak yang dilacurkan.

Strategi yang digunakan diantaranya, 1) peninjauan berbagai aturan perlindungan anak, serta mengawal implementasi atas aturan dan kebijakan yang ada, 2) penguatan jaringan komunitas yang peduli anak, melalui berbagai pelatihan untuk membangun kepekaan terhadap issue-issue anak yang berada dalam situasi khusus, termasuk anak yang dilacurkan, 3) mendorong terbentuknya dan peran aktif dari unit perlindungan khusus, seperti yang sekarang sudah ada di kepolisian melalui RPK Anak dan Perempuan (Ruang Pelayanan Khusus).

C. Upaya Rehabilitatif (pemulihan)

Upaya rehabilitatif ini sangat penting dalam penyelamatan anak-anak pasca mereka keluar dari dunia pelacuran ataupun yang pernah menjadi korban perdagangan anak yang dilacurkan. Meskipun demikian, bagi anak-anak yang sudah terjebak dalam dunia pelacuran, pada kenyataannya mengalami kesulitan untuk bisa keluar dari lokalisasi. Jebakan gaya hidup, konsumerisme, hutang dan keberadaan kiwirnya seringkali menyulitkan anak-anak keluar dari lokalisasi. Belum lagi kekhawatiran mereka kalau mereka kembali pada keluarga atau daerah asalnya. Perasaan bersalah, sudah tidak perawan, maupun resiko atas penyakit yang dideritanya seperti beberapa kisah Putik, Irma maupun Ami yang terinfeksi virus HIV seringkali membuat mereka merasa putus asa, dan mendorong mereka untuk bertahan di lokalisasi.

Untuk itu perlu diupayakan beberapa langkah yang bisa membantu anak-anak korban keluar dari krisis yang mereka hadapi termasuk pesona jebakan dunia lokalisasi yang mendatangkan banyak uang bagi mereka. 1) melalui pemberdayaan hak anak-anak yang dilacurkan. Wacana atas penyadaran hak bagi mereka, diharapkan mampu mendorong pola tindakan yang tidak mengkuti *habitus* yang sudah mengakar, dalam lingkungan lokalisasi. Proses penyadaran, diharapkan mampu memberikan dukungan bagi sesama anak-anak dan perempuan yang melacurkan diri, untuk mendorong mereka keluar dari dunia pelacuran; 2) pembentukan rumah aman (*crisis center*), yang diharapkan mampu menjadi ruang antara bagi anak-anak untuk mempersiapkan diri keluar dari lokalisasi dan kembali ke keluarga serta komunitasnya; 3) pendidikan non formal maupun pelatihan keahlian juga sangat penting bagi anak-anak untuk bisa mendapatkan alternatif pilihan pekerjaan lain ; 4) dan yang paling penting adalah layanan dukungan bagi mereka untuk keluar dari lokalisasi, uang yang berlimpah yang mereka dapatkan harus mampu tergantikan dengan kepercayaan akan keselamatan mereka dari resiko dan bahaya penularan penyakit Infeksi Menular Seksual termasuk HIV.

D. Upaya Integratif

Melalui upaya integratif ini diharapkan bisa mewujudkan kelangsungan hidup yang lebih baik bagi anak-anak, yang diharapkan melibatkan keluarga. Proses reintegrasi sangat penting, dimana penerimaan anak dalam keluarga, masyarakat dan lingkungan pendidikan menjadi kunci penting dalam tahapan ini. Tujuan dalam proses reintegrasi ini adalah untuk memfasilitasi anak-anak korban perdagangan untuk tujuan seksual ini bisa kembali kepada keluarga dan komunitasnya.

Beberapa upaya untuk merealisasikan hal ini diantaranya, 1) upaya pertemuan anak dan keluarga, meskipun untuk kasus ini hanya bisa terjadi bagi anak-anak yang memang sadar dirinya menjadi korban, hal ini akan berbeda tingkat kesulitannya terhadap anak-anak yang akhirnya menemukan

habitus barunya di dunia pelacuran; 2) untuk mendukung pemenuhan hak dasarnya, kesempatan untuk mendapatkan pendidikan dasar juga merupakan bagian terpenting bagi anak-anak yang dilacurkan bisa keluar dari dunia pelacuran. Seperti yang diharapkan oleh Putik, gadis 17 tahun ini hanya sempat menamatkan pendidikannya sampai SMP, dia berharap bisa melanjutkan ke jenjang lebih atas, bahkan bisa kuliah untuk mendapatkan pekerjaan lain yang lebih baik. Pengakuan Yani, maupun Nina yang lulusan SD juga mengharapkan bisa mengikuti Kejar Paket B dan C, untuk selanjutnya bisa mendapatkan pekerjaan lain yang lebih baik tentunya; 3) bantuan penempatan kerja alternatif, hal ini merupakan kelanjutan dari pilihan keahlian yang diberikan bagi anak-anak yang dilacurkan. Karena seringkali pemberian keahlian atau keterampilan diberikan, namun tidak diikuti dengan pertemuannya dengan pasar kerjanya.

VII. Penutup

Upaya perlindungan anak dengan terbitnya berbagai peraturan perundang-undangan, tidak membuat para *trafficker* berhenti bergerilya, mereka terus berusaha dengan caranya masing-masing untuk menjerat anak-anak perempuan. Karena itu perlu diwaspadai, bahwa perdagangan anak yang dilacurkan ini bisa terjadi kapan saja, tanpa mengenal waktu dan korbannya. Bahkan keluarga, sebagai tempat yang paling aman-pun tidak menutup kemungkinan terjadinya perdagangan anak. Justru sistem kekerabatan yang kuat, memberikan peluang untuk terjadinya perdagangan anak dan perempuan untuk tujuan seksual ini. Apalagi tempat-tempat umum, seperti terminal, stasiun, maupun mall juga menjadi sasaran empuk bagi para *trafficker*. Peran pemerintah, dalam penanganan masalah anak juga masih sangat minim, sistem birokrasi yang cukup panjang dalam penyelesaian satu kasus anak, seringkali menjadikan tidak tertanganinya penyelesaian masalah anak-anak yang terlanggar haknya.

Strategi untuk melawan pelacuran atas anak-anak, menjadi penting dengan membangun sistem yang mampu memutus rantai reproduksi sosial, mulai dari hulu sampai ke hilirnya. Proses pembiasaan baru, perlu dibangun melalui penanaman pengetahuan yang bisa diterima, mengandung nilai-nilai lokalitas serta dialektis. Sehingga sangat penting membangun harapan baru, serta akses kehidupan yang lebih baik. Pelibatan anak-anak dalam kegiatan yang eksploitatif, mencerminkan ketidakberdayaan negara dalam memenuhi hak asasi manusia, dalam pemenuhan hak anak. Menjadi penting, untuk membangun tatanan yang memberikan tempat bagi solidaritas, kolektifitas, dengan mengesampingkan egoisme sektoral, untuk memberikan perlindungan yang terbaik bagi anak-anak. Kemiskinan sebagai mata rantai persoalan anak, seyogyanya dibarengi dengan produk hukum, kebijakan dan etika baik dari pemerintah untuk memperbaiki sistem birokrasinya, dalam perlindungan anak.

Daftar Pustaka

Andri (ed), 2002, *Ketika Anak Tak Bisa Lagi Memilih: Fenomena Anak Yang Dilacurkan di Indonesia*, Jakarta ; ILO

Bourdieu, P, 1990, *The Logic of Practice*, Translated by Richard Nice, California, Stanford University Press

_____, 2001,. *Masculine Domination*, Translated by Richard Nice, California, Stanford University Press

Hoigard, Cecilie dan Finstad, Liv, 2008, *Tubuhku bukan Milikku ; Prostitusi, Uang dan Cinta*, Yogyakarta, Pustaka Pelajar

Irwanto, 1998, *Analisa Situasi Anak yang membutuhkan Perlindungan Khusus*, Jakarta, PKPM Atma Jaya, Depsos, Unicef

Imelda, Johanna Debora, dkk, 2004, *Utang Selilit Pinggang ; Sistem Ijon dalam Perdagangan Anak Perempuan*, Yogyakarta, Ford Foundation bekerjasama dengan PSKP Universitas Gadjah Mada

Mulyanto, 2004, *Melacur Demi Hidup ; Fenomena Perdagangan Anak Perempuan di Palembang,* Yogyakarta, Ford Foundation bekerjasama dengan PSKP Universitas Gadjah Mada

Mundayat, Aris, 2009, *Seks: Wilayah Kekuasaan yang Diperebutkan dan Dikontestasikan*, Yogyakarta, Laboratorium Sosiologi Fisip Universitas Atmajaya Yogyakarta

Muray, Alison, 1994, *Pedagang Jalanan dan Pelacur Jakarta ; Sebuah Kajian Antropologi Sosial*, Jakarta, PT Pustaka LP3ES

Mudjijono, 2005, *Sarkem ; Reproduksi Sosial Pelacuran*, Yogyakarta, Gadjah Mada University Press

Haryatmoko, 2003, *Landasan Teoritis Gerakan Sosial menurut Pierre Bourdieu ; Menyingkap kepalsuan Budaya Penguasa*, Yogyakarta, Basis No. 11-12 tahun ke-52, november-desember 2003.

Ihsan, Soffa, 2006, *Now It's Time To Sex: Pelacuran, Legalisasi dan Agama*, Jakarta, Panta Rei

Putranto, Pandji, 2004, *Bunga-Bunga Di Atas Padas : Fenomena Pekerja Rumah Tangga Di Indonesia*, Jakarta , ILO

Setyowati, Retno dkk (2004), *Penelitian Partisipatori Anak yang dilacurkan di Surakarta dan Indramayu*, Jakarta, UNICEF dicetak oleh Citra Grafika

Sofian, Ahmad, dkk 2004, *Menggagas Model Penanganan Perdagangan Anak ; Kasus Sumatera Utara*, Yogyakarta, Ford Foundation bekerjasama dengan PSKP Universitas Gadjah Mada

Subono, Imam, 2010, *Trafficking in Human Beings dalam Angka dan Perdebatan*, dalam Jurnal Perempuan edisi 68, tahun 2010, hal. 21-35

Rosenberg, Ruth, 2003, *Perdagangan Perempuan dan Anak di Indonesia*, Jakarta, USAID bekerjasama dengan ICMC dan ACILS

Richard Harker, Cheelen Mahar, Wilkes, 1990, *Pengantar Paling Komprehensif kepada Pemikiran Bourdieu*, Yogyakarta, Jalasutra

Suyanto, Bagong, 1998, *Pelacuran Anak-anak Wanita di Surabaya : Latar Belakang dan Seluk Beluknya*, dalam Semiloka Nasional : Prostitusi Anak dan Industri Pariwisata, Yogyakarta 1-2 Juli 1998

Suyanto, Bagong, 1999, *Anak-anak Wanita yang dilacurkan,* Surabaya, dalam Majalah Hakiki Edisi Volume I/September 1999.

Sulistyaningsih,E, 2002, *Sex Workers in Indonesia:Where Should They Go?*, Jakarta, Manpower Research and Development Centre

Tim ESKA Surabaya, 2009, *Sisi lain Profil dan Penanganan ESKA*, Surabaya, Plan International bekerjasama dengan Kementerian Pemberdayaan Perempuan dan Bapemas Kota Surabaya

Undang-Undang, Kepres, dan Peraturan Pemerintah ;

Undang-Undang RI No, 23 tahun 2002 tentang Perlindungan Anak

Undang-Undang RI No.21 tahun 2007 tentang Pemberantasan Tindak Pidana Perdagangan Orang

Undang-Undang RI No. 14 tahun 2009, tentang pengesahan Protokol untuk mencegah, menindak, dan menghukum perdagangan orang, terutama anak dan perempuan.

Keputusan Presiden Republik Indonesia Nomor 87 Tahun 2002 tentang Rencana Aksi Nasional (RAN) Penghapusan Eksploitasi Seksual Komersial Anak

3 Prevalence of Child Marriage and Its Determinants among Young Women in Indonesia

Joseph Natanael Marshan
M. Fajar Rakhmadi
Mayang Rizky
The SMERU Research Institute

Abstract

In Indonesia, child marriage (marriage prior to the age of 18 years) has already discussed from various perspectives but little empirical research has been published due to its severe causes and effects that link to them. Through this study, we aim to calculate the prevalence of child marriage using SUSENAS 2010 data as a nationally representative data for Indonesia in 2010. Later on, we use cohort analysis to capture the child marriage profile in Indonesia. Using logistic regression we examine the determinant factor of being child marriage in woman aged 20-24 years old, whose still living with origin household as children. We find several variable that negative and positively affect the possibility of child marriage incidence. We found that child marriage in Indonesia is determined more by social and economic characteristics both within and surrounding the girls. Thus, the policy should focuses on how to create an enabling environment that evolve alternatives to child marriage.

Keywords: child marriage, determinant, cohort analysis.

I. INTRODUCTION

I.1 Trends in Ages of Marriages in Indonesia

Child marriage, or in broader definition early marriage, pretend to be social economic phenomena in many developing countries. Without regarding cultural aspects, economic motives shall be the main driver of early marriage. Around millions of adolescent woman, mostly in South Asia and Sub-Saharan countries, forfeit their freedom into marriage or any other form of union. In modern days, these sad pictures pretend to be unacceptable since in 2001 by the UNICEF, the practice of child marriage was classified as violation of human rights. The issue was no longer about "freedom" of but more accurately about health status and economic impact on a person, especially for woman.

Indonesia, in comparison to other developing countries in Sub-Saharan and South Asia, relatively has a way lower prevalence of child marriage. In recent development, the average age of married are declining no. It Jones and Gubhaju (2008) that there is significant drop in age of married in South East Asia including Indonesia. For instance, Indonesia and India has level of female mean age at married below 20 (Rizky, 2012). In nowadays, India and Indonesia female mean age at married becoming at below 25 years old level. Meanwhile, East Asian Tigers like Japan, Hong Kong, and Korea which started the level below 25 years old in 70's, recently appearing at almost 30 years old.

In Indonesia, using multiple data sources, Jones and Gubhaju (2008) shed light on how people in Indonesia making progress in delaying marriage time. If the causes remain debatable, whether it attributed to improvement in education or better well being in Indonesian families through years, the benefit already arose. Years of schooling for woman in Indonesia increased from 6.91 to 8.83 within four decades (1971-2010). Improved education for women followed by higher labor participation in the same periods. Overall, woman already more engaged to economic activity than in the past

The cultural and religion reasoning can be played some part in child marriage decision. However, the number of child marriage depicts low rate in any place in the world. Child marriage, basically, is not a natural behavior. Even in highly rated as India, the number of child marriage can be far away than less of quarter. Child marriage in terms of cultural and religious consequences, if this true, should be has larger prevalence as other customs already did. In regarding the cultural argument, it seemed to be cultural and religious view played as "permission" rather than "suggestive" role.

The other useful approach to see marriage pattern is by looking at Singulate Means of Age Marriage (SMAM). The concept is pioneered by seminal work of Hanjald (1973). SMAM measured only individual who aged between 15-50 years old on a given time of census data. The calculation in local and region level would be affected by short-term age's variation, migration pattern, and mortality. The rule of thumb is simply the lower SMAM lead to earlier marriage.

In Indonesia, it surprisingly unveiled that the age of marriage was went down. From 1971 to 2010, SMAM Indonesia surely arose. From 1971 to 2010, SMAM hikes from 19.28 to 22.17, meaning Indonesian woman delaying their married about 3 years later in modern days comparing to four decades before. However, surprisingly from 2000 to 2010, SMAM in Indonesia slightly increased. The hypothesis demands that more educated people should delay the marriage. In Indonesia West Java has the lowest SMAM. In 1971, West Java has the lowest SMAM, 17.78. In contrast, DKI Jakarta has the highest SMAM, recorded at 25.21 in 2000. The number decreased slightly in 2010 at population 15-24 years old cohort. Interestingly, the number of never married woman

arose from 1971-2010. As discussed before, SMAM is sensitive to demographic change. The decreasing number of SMAM attributed to decline birth rates in the same year due to successful birth control programs (KB) in Indonesia.

Indeed, the education enrollment picture in Indonesia displayed a positive trend through years, so that we can expect lower SMAM. Delaying marriage can also attributed to regional wealth perspectives. Looking at western and eastern pattern of child marriage, we can see that people in eastern part in Indonesia decided marriage earlier. However, the highest cases of child marriage are still in Java. It seemed to be reasonable if we looked at highlight concentrated poor people in Java Island. From this side, we can argue that child marriage in some extent has relation to economic and education background.

The discussion of child marriage continue to the question why they took marriage decision. As mentioned before, the economic and social status should be laid as the rationale behind. Studies on earlier marriage exposed that family wealth as the main motives of child marriage. Economics motives is the famous explanation if child marriage. In the similar way of thinking, the parents decide to have early brides as the solution of moving out poverty effort.

I.2 The Legal Aspect of Child Marriage in Contemporary Indonesia

According to the Law Number 1, 1974 on Marriage, in Chapter 7, verse 1, a marriage would be acknowledge legally if only female already older than 16 years old (for the man it is 19 years old). In other hand, as comparison, the definition of children as UNICEF recognized is all people under 18 years old. It implies child marriage is all marriage conducted under 18 years old in refers to UNICEF definition. Therefore, the national definition captures less child marriage incidence.

Other issue of starting analyzing child marriage phenomena is not only on definitive effort but also capitulating measurement concept. We understand child marriage was a dynamics phenomena, so that if we looking the data, moreover demographic data, usually we need to isolate the time dynamics to get the prevalence rate. Following the UNICEF (2009), the child marriage prevalence measure on group of women aged from 20 to 24 years old who first married or entered into union before age 18. Some UNICEF report alternatively using percentage of women age 15-19 who are married or union in the given time. However, this measurement will include 19 years old women who excluded from UNICEF's child definition. The second, it may include 15-17 years old woman who possibly shortly after get married.

Referring simply to the definition by UNICEF, we are interested to understand the child marriage phenomena on young woman. The using of UNICEF criteria is to capture larger portrait of child marriage. Thus, in order to have comparability with international experience. The comparability needed to understand the determinants to contribute more on general understanding of child marriage.

Later discussion revealed the importance of measurement as child marriage is a dynamic incidence. Accommodating the issue, cohort analysis approach should help us to understand the problem rigorously. We should ensure that the aspect of lifetime changing can be framed. Presumably, there are changing patterns in child marriage both profile and triggering factors, before fetching more generalize conclusion.

The importance of age of married in young women is the role of women in social economic activities. The link between education and age married become importance since the education has lengthily discussed as economic driver. However, child marriage also comes with high cost both for the individual or as escalated to upper level, to national perspectives. The first negative

impact is education cost. As later the woman decided to get married, essentially they moved out from education. The second negative impact is maternal health problem. From international experiences, maternal problems were the most worrying factor of child marriage. Evidences showed that child marriage led to higher risk of maternal birth. "Pregnancy-related deaths are the leading cause of mortality for 15-19 year old girls (married and unmarried) worldwide" (UNICEF, 2001). The third reason is vulnerability of woman due to both sexual and domestic violence (UNICEF, 2005). Young brides tend to have less bargaining power within the household and may be viewed as the property of their husband.

Our study objectives, as we already discussed, aimed to giving clearer picture of child marriage in Indonesia and what determined it especially from women perspectives. We focused on social and economic factors which can underlay the decision to married at early age. Wealth status, education level background, and external factors somehow are the main causation of child marriage. In order to leap their wealth status or at least helping the origin family wealth status, young woman chose to be married. The decision also highly influenced by limited information of the cost of child marriage which linked to their low education level.

The important thing we pursue is significant change from the policymaker prior to our finding. We expect that Indonesia has better Marriage law who equally met international standard. Besides, the policies related to child marriage also need to be invented.

II. LITERATURE REVIEW

II.1. Previous Empirical Studies and Theoretical Framework

Most of the literatures on child marriage are basically derived from empirical studies concerning for girls in some developing worlds. In terms of gender concern, the practice of child marriage is not as widespread among boys. This may be due to a traditional hypothesis that girls are often being used as an assurance to save the family from financial woes through the practice of child marriage. However, to date, girls become the center of attention in fact much discussions rely on the aspect of consequences. Many of the consequences starting from physical aspects associated with childbirth, status and power in the household, are specific to girls (Jensen and Thornton, 2003). Johnson-Lans and Jones (2011) investigate child marriage among girls in the issue of child preference absenteeism. In the rural customary of India, parental decision plays a larger role in determining marriage, specifically for their daughters. The girl being married has no choice in either whom she marries or the timing of her marriage. Parents use early female marriage for their daughters as a mean to protect family norms because they are forced by the fear of the effect of late marriage for the girl and the family (Sarkar, 2009). Having an older unmarried daughter means a loss of social status as well as additional monetary costs to the family (Johnson-Lans and Jones, 2011).

In terms of geographic concern, countries in Asia and Africa are often appeared as its cope of study because the practice of child marriage among girls is common in such countries. Data from 40 Demographic and Health Surveys around the world reveals that overall 20-50% of women marry or enter a household formation by age 18, and is most prevalent in Sub-Saharan Africa and in South Asia (Singh and Samara, 1996).

Though the universal and early marriage have been a characteristic of almost all of Asia, child marriage is still common in South Asia, but not in South-East Asia, with the exception of some of the Malay populations of Malaysia and Indonesia. Meanwhile, key difference between child marriage pattern in South Asia and South-East Asia resides in the kinship system (Jones, 2010).

The system that produces child marriage is a strongly patriarchal and traditional one in which parents arrange marriage. The Hindu system in India emphasized the absorption of the bride into the husband's family, whereas the bilateral kinship systems of most South-East Asia allow much closer association of the bride with her affine, and a pattern whereby the newly married couple more commonly lived first with the bride's parents rather than the husband's parents, before establishing an independent household.

Determinants of child marriage among females are presumably believed as the factors behind female transition to marriage. Several researches are conducted in determining female age at first marriage. Lung Vu (2009) finds that education, place of residence, wealth, current age, region, and ethnicity are significantly related to age at first marriage in Vietnam while Agaba et al (2011) indicates that educational attainment, religion, district of residence, and birth cohort are strong socio-economic determinants of first marriage in Western Uganda. Both of these studies boldly underline the influence of educational attainment of girls in determining their age at first marriage. This finding is also supported by Manda and Meyer (2005) who find that women with higher levels of educational attainment are far more likely to enter marriage at later age than those without any or with little education, given of different model to approach. This confirms that the issue of development, in which the extended education for girls take place, provides a clearer explanation on why child marriage happens mostly in a lower educated girls characteristics (Jones, 2010; Jensen and Thornton, 2003; Singh and Samara, 1996)

Specific studies investigating the determinants of child marriage are conducted mostly in developing countries. In India, Johnson-Lans and Jones (2011) examines the relative importance of economic and social factors in determining the probability of a girl becoming a child bride. The findings reveal that economic factors is way behind social conformity in explaining child marriage as none of economic variables such as household income, poverty status, and land ownership significantly affect the probability of child marriage in rural India. Qualitative study from Ghosh (2011) in West Bengal divides the causes of child marriage based on four different perspectives in a family; fathers, mothers, elders, and daughters. Fathers and elders are found to put poverty as the first order of preference for the cause of child marriage. Findings from qualitative studies on moving out of poverty in Indonesia also revealed that marriage is sometimes used as a way out of poverty (Febriany, 2005; Febriany, 2006). Mothers and daughters put perceptions that marriage is essential and lack of awareness respectively as the first order of reference. Sarkar (2009) uses logistic regression analysis in order to find determinants of early marriage in Bangladesh. His study shows that education, working status, husband's education, and places of resident exert the significant effect on early marriage. In case of Indonesia, Savitridina (1997) indicates that women's education, work status before marriage, husband's education, and current residence are the predictors for early marriage in Java, with education as the strongest one.

Basic theory of girls' transition to marriage are modeled in the theories of economic independence, the local marriage markets, and cultural theories of marriage timing (McLaughlin and Lichter, 1997). Economic independence theories suggest that as women's education and earnings increase they will be less reliant on marriage for economic support and that women with greater economic independence will delay marriage. This supports for an attempt to explain the theory of modernization on changing marriage pattern (Goode, 1963). Goode states that global industrialization has brought the family systems in developing world toward the European norm. People with higher social status tend to get married late since they want to have more freedom during modernization process. They who were born and live in big cities are more likely to marry later than those living in rural area or small town. This hypothesis may be a result of greater diversity in life and little social control in big cities than in rural areas. Second theory, local marriage market, is defined as the availability of possible spouses and how that influences marriage timing. This becomes the basis for marriage market explanations of marital timing. Areas

where there is a greater availability of unmarried men, especially men with high levels of education or good jobs, should encourage women's marriage. Lastly, cultural explanations of marriage suggest that family background, attitudes toward women's roles, and beliefs about marriage influence women's decision to marry.

II.2. The Decision to Marry and Social Influence

In Indonesia, discussion of child marriage is still less compared to other countries in Asia. Besides the fact that the practice of child marriage is less common in Indonesia than in South Asian countries, also because the trends of traditional arranged marriage which brings child marriage occurs has been weakening over the decades. In Jones (2010), it reflects at the significant behavioral changes in the hands of parents or older generation and in particular by males of the older generation. Rather than one brought on by revolutionary means, it is seen as a voluntary changes due to its relation on the development. Development includes the development in education, increasing urbanization, and involvement of women in the market sector outside the household, among other things--which in a common perception are often referred to in the local dialect as "changing times" or in Bahasa Indonesia, *perubahan zaman*.

Despite the increase over time in age at marriage, the fact remains that early marriage among girls still occurs in Indonesia. It is interesting that the provinces of Java, which used to be in the list of provinces with lower age at marriage, are not as conspicuous as they used to be (Jones and Gubhaju, 2010). The example is West Java province, which used to have the lowest age at marriage of all, but has now been surpassed by a number of other provinces. One might speculate that this is because of the separate province Banten from West Java. However, since early marriage in Banten is less common than in the rest of West Java, the reason therefore stretching in the pattern of lower age at marriage among West Java population. There are two important elements influencing the pattern of population, the first one is the impact of cosmopolitan factors such as a more mixed population from different cultures and ethnics, greater contact with foreigners, high exposure to mass media, higher average education level, and a wider opportunities for women in the market sector. The second one is because of the surge movement of large numbers of citizens from metropolitan city, Jakarta, into the suburban areas which lie side to side with Jakarta. Most of the suburban areas are included in the provinces of West Java or Banten.

The remarkable developments in education, increasing urbanization, and involvement of women in economic activities outside the household may not result only to the falling of child marriage in Indonesia, but also to the pattern of marriage decision among girls. Parents who are the ones considered as the decision maker, may no longer be a single factor. Characteristics of parents are still decisive but other indicators including the characteristics of daughters or individuals who were married as a child and socio-economic indicators inside as well as outside the family may give a greater impact to the girls' decision to marry.

We do not use parental decision as a single source of factor like countries of India did simply because the socio atmosphere of marriage in India and Indonesia differed. In India, it has been known that child marriage appears as the activity of parents arrange marriage for their daughters with the same level of caste spouses (Johnson-Lans and Jones, 2011). Since the ones who often gather socially in the same caste level group are parents, so that parents play a larger role in determining the practice of child marriage in India. Spouses should not come from the same village but the Hindu system of caste level forces the marriage market in India will be only matched if they come from the same level of caste. In fact, this is not similar to happen in Indonesia. Though that parents still remains to arrange marriage, but there is no exact rules that have been traditionally constructed in Indonesia whether the spouses should come from the

same strata or not. This is also forced by the fact that there is no clear division of strata in Indonesia like India has.

Therefore, we still put parental decision as a possible factor of child marriage since the daughters have limited information and authority in determines what is best for her life. The agency problem occurs in this scheme is explained as parents make decisions for their daughters about when and whom to marry but they do not fully internalize the costs of those decisions. For instance, if parents choose to decide a marriage of a pre-adolescent girl without considering how such a marriage will affect her current or future well being, they may select a lower age of marriage. This will create parents to gather more information in determining what is best for her daughter's life or what is best for the family or the combination of both daughter's life and the family.

To estimate the determinants, we assume that parental decision is both constrained or rooted by a number of factors which vary across households and villages, including the characteristics of the daughter itself and surrounding influences nearby households (i.e. the proportion of child marriage within village and the availability of spouses) that turn to be an accumulated factors of the decision to marry.

The inclusion of social influence variable, as defined as the proportion of child marriage within village, captures the potential effect of village-specific norms which relate to the custom of child marriage. Social influence is more likely to affect individuals when they have few information sources. Parents observe the marriage decision for their daughters and consider this information when making decisions about the timing of their own daughter's marriage. We therefore predict that the probability of a girl becoming married below the age 18 years old is positively correlated with the prevalence of child marriage among girls in the same village.

III. DATA AND METHODOLOGY

III.1 Data

To answer the question about the determinant factors of prevalence of child marriage, this study use The National Socioeconomic Survey (SUSENAS) provided by Center Board of Statistic (BPS). SUSENAS is annual socioeconomic survey that conducted by BPS.. SUSENAS 2010 cover 293,715 households that spread in 33 provinces in Indonesia.

This study use SUSENAS 2010 raw data as our main data source and then we extract variables that will be used in child marriage analysis. We define child marriage as UNICEF reference that define child marriage as a marriage are conducted by man or woman under 18 years old. Then, we restrict our samples only in child marriage by women. We exclude child marriage by men because it prevalence is too small.

In regression model analysis, we also restrict our analysis by age group. UNICEF has two standard age groups that usually used to analysis prevalence of child marriage. The first age group is 15-19 years old and the second one is 20-24 years old. We decide to used 20-24 years old group as our based line in analysis. We did not choose 15-19 years old group because it has two main weakness. The first one is that it measurement will include 19 years old child that actually did not include in UNICEF's child definition. The second is that this age group has possibility to exclude 15-17 years old woman shortly get married. After restricting our samples according pervious criteria total observation that are included in our analysis are 468,770persons.

III.2 Methodology

This study use Logistic Regression (Logit) to find keys determinant of prevalence of child marriage. Logit is estimation method which accommodates the use of qualitative value as dependent variable. We assume that even there are another method to analyze qualitative value as dependent variable in a regression model like probit, we keep use logit as our method. Logit and Probit has the same method and there are no compelling reason to use logit or probit to analyze this problem. In practice, most of researcher use logit in their study because logit is simpler mathematical aspect than probit (Green, 1990).

This study define prevalence of child marriage as categorized variable, 1 if the there is prevalence of child marriage and 0 otherwise. The Logit Model that used in this study given by:

$$logit(p) = ln\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + .. + \beta_n X_n$$

Where X_1, X_2 and $X_n$are determinant variables are household head age, household head education level, household economic status, household head job status, household literacy, household electricity, household cooking method, number of schooling child in house, respectively and p denote the probability of prevalence of child marriage.The following is brief description of characteristic of variables used in the analysis:

Tabel 3.1.

No	Variables Name	Description	Classification
1	child_marr	Prevalence of Child Marriage	1 -> Child Marriage, 0 -> No
2	ln_exp_cap	Log natural of Per capita Expenditure	Continous
3	h_pcfloor	Per capita Floor Area	Continous
4	i_internet	Access to open informatio	1-> Yes , 0 - >No
5	i_nethp	Access to internet through mobile phone	1-> Yes , 0 - >No
6	I_warnet	Access to internet through internet cafe	1-> Yes , 0 - >No
7	h_hhagr	Household Head Jobs: Agriculture	1 -> Agriculture, 0 -> Other
8	h_hhind	Household Head Jobs: Industry	1 -> Industry, 0 -> Other
9	h_hhage	Household Head Age	Continous
10	h_hmale	Household Head: Man	1 -> Other, 0 -> Male
11	h_hhsd	Latest Educ. Attainment: SD	1 -> HH Head is SD, 0 -> Other
12	h_hhsmp	Latest Educ. Attainment: SLTP	1 -> HH Head is SLTP, 0 -> Other
13	h_hhsma	Latest Educ. Attainment: SLTA	1 -> HH Head is SLTA, 0 -> Other
14	h_nchildsd	Number of Children, SD	Continous
15	h_nchildsmp	Number of Children, SLTP	Continous
16	h_nchildsma	Number of Children, SLTA	Continous
17	h_nchilddip1_s3	Number of Children, D1 - S3	Continous
18	h_lighting1	Type of Electricity: PLN and Non PLN	1 -> Electric PLN - Non PLN, 0 -> Other
19	h_fcook1	Type of Fuel for Cooking	1 -> Gas/LPG, 0 -> Other
	h_healthcare	Recipients of healthcare program	1-> Yes , 0 - >No
20	e_childmarr	Proportion of 10 Years Old and Over Women who Marriage in Village	Continous
21	e_rjk	Sex Ratio	Continous

III.3 Limitation of Study

Several limitations in this study needed to concern are the following:

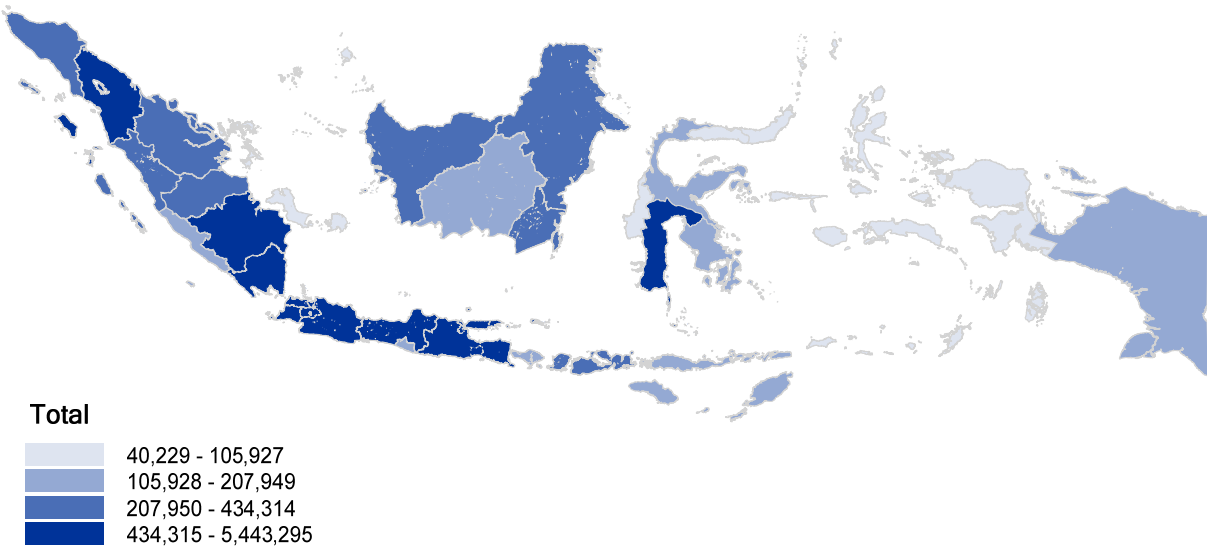
1. We do not use the variable of religion and ethnicity as the determinants of child marriage since there is no available data in SUSENAS 2010 that covers these aspects. Otherwise, we only use the variable of proportion of people who marry at the age below 18 years old in the village level to reflect the influence of social custom surrounding the individuals.
2. Since we only focus to the individuals whose relationship with the household head is daughter and daughter's in law, the analysis is only focus to the individuals who were married at the age below 18 years old and still live with their parents. This also means that we do not include the characteristics of husband in the model. This is because there is no available data that can provide us to trace the child brides who live with their husband. But this limitation is helped by the characteristic of child marriage in Indonesia that most of the bride who marry at the age below 18 years old still live with their parents after the marriage for some years before then living with their husband.

IV. ANALYSIS

IV.1. The Incidence of Child Marriage

We begin our analysis by providing the distributio figure of child marriage across Indonesia. Figure 4.1 display the distribution of woman aged above 10 years, who had child marriage based on SUSENAS 2010. The number of child marriage undeniably concentrated in Java, southern and northern part of Sumatera, and South Sulawesi. As the most populated, yet the main island of Indonesia, Java show two face of center of development. It is a center of growth but also has the largest poor population in numbers in Indonesia. From the total about 96 million woman who had child marriage, 59% of them lived in Java. In Sumatera, we have 21% and the rest its distributed quite equally. respectively from highest to lowest, on Sulawesi, Kalimantan, Bali, and the least numbers in Maluku and Papua.

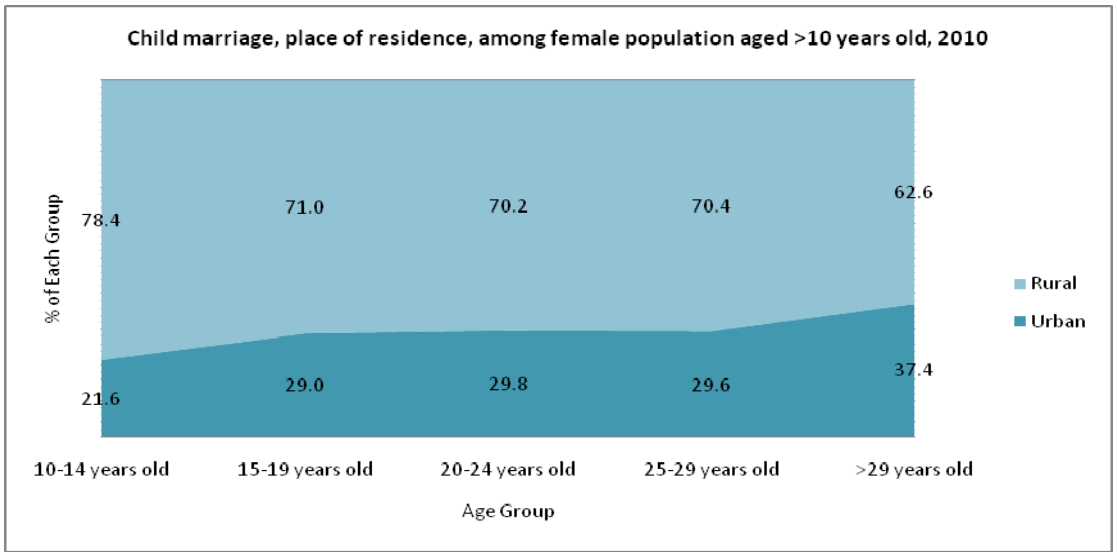
Figure 4.1 The Map of the incidence of child marriage in woman group



The practice of child marriage is alleged to happen more in rural than in urban area due to the different understanding on child marriage between these two places of residence. In rural areas, child marriage can be considered as one form of legacy from the older generation and this has been forced traditionally by the social custom whereby the child marriage takes its place. This turns out to be the case when marry as a child is quite common in rural society, given by the educational background.

SUSENAS 2010 data reveal that 64.2 per cent of female population aged 10 years above who ever married at the age below 18 years old reside in the rural area. Based on the age group, 78.4 per cent of girls aged 10-14 years old who married early live in the area categorized as rural (Figure 4.2). As the figure also illustrates, 71.0 per cent of female population aged 15-18 years old married as a child and live in rural area while for the age group 20-24 years old the number is 70.2 per cent. Child marriage in rural area also occurs at the age group 25-29 years old and 29 years above with the percentage of 70.4 and 62.6 per cent respectively.

Figure 4.2. Distribution of Child Marriage and Comparison Among Age Groups

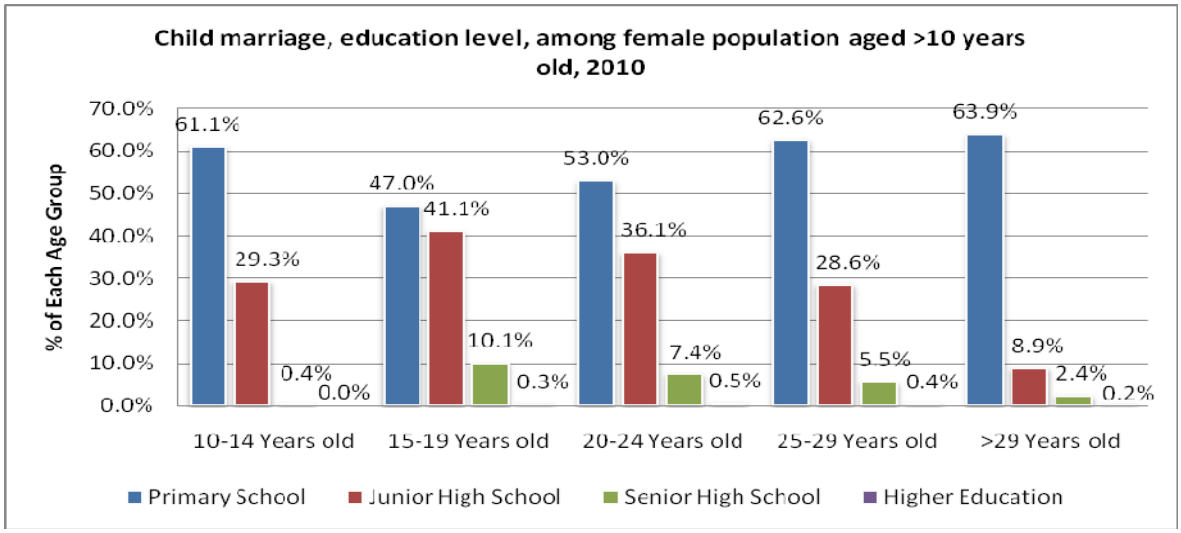


Source: SUSENAS 2010

While the overall percentage of child marriage in rural area for each age group always show a larger number than groups in urban area, interesting fact lies in the distribution for each age group between these two places of residence. There is a tendency that the percentage of child marriage in rural area decreases as the age rising. The figure of child marriage in this lower age group is not valid for the age groups in urban area. However, this can be meant also that most of child marriage in rural area happens at a younger age, meaning that the vulnerability of children in rural to the practice of child marriage is still higher, compared to children reside in urban area.

As Lung Vu (2009) states that poor people in Vietnam tend to get married earlier than people in middle and rich class, as well as some qualitative studies from Ghosh (2011) and Febriany (2005) and Febriany (2006) find that marriage is sometimes used as a mean to get out from poverty, we try to put economic condition as to observe the characteristics of child marriage. However, the cross tab analysis between child marriage and poor status using SUSENAS 2010 data show that 85.2 per cent of female population aged 10 years above who ever married as a child categorized as non-poor while the rest 14.8 per cent are poor.

Figure 4.3

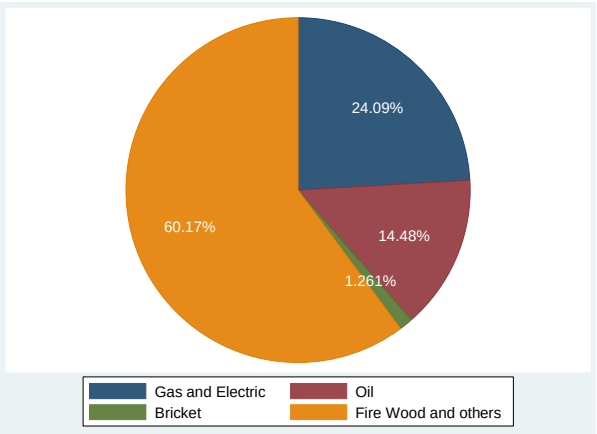


Another issue that related to child marriage is the lack of proper education. Due to their early marriage they lose their chance to afford better education. This issue not only related to child marriage condition but also will effect on their household health condition. WHO (2010) remark that health and education can go hand in hand specifically for women. for instance, a woman who have well-educated tend to have more attention to health care. Then they will become a better mother in the future, it is because they have more awareness of being healthy than less-educated woman.

Figure 4.3 explain child marriage women education level within age group divided into five level of education; Primary School, Junior High School, Senior High School, and Higher Education in 2010. Overall child marriage woman has low education level. Most of child marriage women attain primary and junior high school only. Among child marriage women that are 10-14 years old, 90.4% women attain primary and junior high school only. The percentage of child marriage women that attain primary and junior high school only within 15-19 years old group are 88.1% women, 20-24 years old groups are 89.1% women, 25-29 years old group are 91.1%, and >29 years old group are 72.8%.

Figure 4.4 Source of Energy in Child Marriage Figure 4.5 Source of Light in Child Marriage

Household



Household

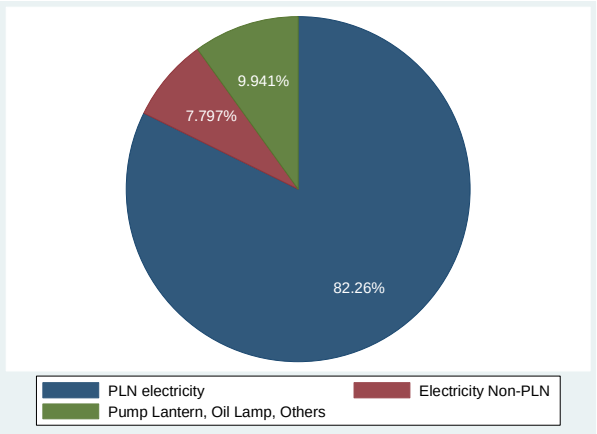
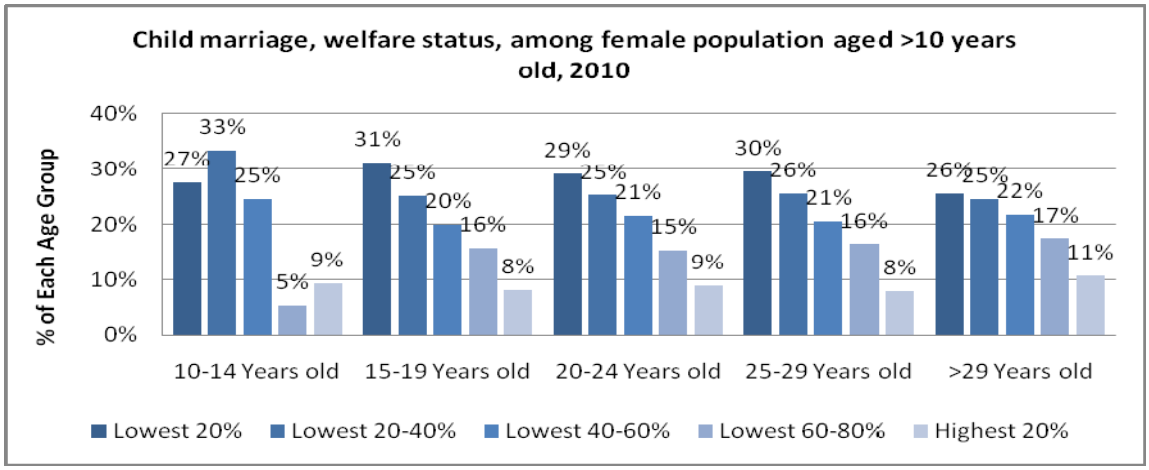


Figure 4.4 and Figure 4.5 show us the household conditions of child marriage. From Figure 4.4, we know that 60.1% of child marriage household using firewood as the main fuel/energy source. It followed by gas and electric, oil, and bricket. The characteristic that shown interestingly represent the characteristic of typical poor household in Indonesia. The second figure show us the source of light of child marriage household. Around 82.26% of the household enjoy electricity from PLN (state-owned enterprise) as the main source of light. About 9.9% use pump lantern, oil lamp, and others as source of light. The rest are use electricity off-PLN as the source. The profile revealed that electricity is no problem to the households. However, electricity from PLN usage also describe the productivity of households since it strongly affect their off-day activity and technology mastery. Approximately 10% of child marriage household do not have access to electricity which would limit their productive activity.

IV.2 Child Marriage of Wealth Status

Figure 4.6 Welfare Status of Female Population Who Ever Married at the Age Below 18

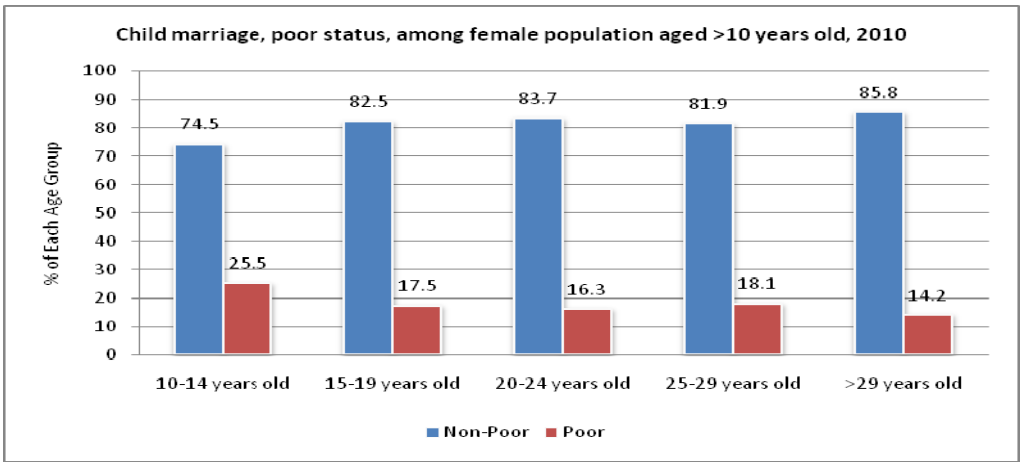


Source: SUSENAS 2010

One of issue that rise from prevalence of child marriage is they live in poverty. Child marriage especially by women has tendency to limited their economic capacity so they can afford better life. Figure 4.6 provide explanation of child marriage women economic condition within age groups and divide into five welfare status; lowest 20%, lowest 20%-40%, lowest 40%-60%, lowest 60-80%, and highest 20%. Lowest 20% and lowest 20%-40% welfare status are categorized as the lowest status and it reflect poor economic condition.

Figure 4.6 shows that most of child marriage women live in poor economic condition. Among child marriage women in 10-14 years old group, only 39% women live in upper three welfare status. The 61% child marriage women in this age group live two lower welfare status. In the 15-19 years old group, child marriage women who live in three upper welfare status are 56% women and 44% other live two other welfare status. Interestingly, the three age group tend to have similar trend. It can be seen from their three upper welfare status 0-24 years old around 46%, 25-29 years old about 45% and >29 years old just over 50%.

Figure 4.7. Welfare Status of Female Population Who Ever Married at the Age Below 18



Source: SUSENAS 2010

Figure 4.7 gives a greater explanation on the distribution of child marriage within age groups and the allotment of each age group into two categories; non-poor and poor status. Among child brides who were 10-14 years old in 2010, 74.5 per cent of them were categorized as non-poor. Only 25.5 per cent of them were coming from poor families. 82.5 per cent and 83.7 per cent of female population in the age group 15-19 years old and 20-24 years old respectively who ever married at the age below 18 years old are categorized as non-poor. In the age group of 25-29 years old, non-poor status is possessed by the 81.9 per cent of females at that range. Finally, for the age group 29 years above, 85.8 per cent of them experience child marriage and are categorized as not poor.

Higher difference of percentage of non-poor and poor status all over the age groups mean that child marriage is not only occur in the poor family. We cannot find whether this higher difference of percentage presumably believed as the impact of child marriage because then we need to observe the economic condition before child marriage takes its place.

IV.3 The Dynamics of Child Marriage

After looking to the current condition of child marriage in several age group, we are interested to see the intergenerational differences in child marriage households. We approach this problem by comparing broader age cohorts. We classify the group into ten years lag per each. Using a decade lagged age group we expected to obtain the dynamics aspect of being child marriage. This effort also useful to be proxy of seeing the impact of having child marriage in the future.

Table 4.2 Proportion of Young Woman Categorized as Poor, 2010

Age Group	Categorized as Poor (%)	
	Not Child Marriage	Child Marriage
<18	0.15	0.23
18-27	0.14	0.21
28-37	0.13	0.20
38-47	0.13	0.17
48-57	0.12	0.16
58 >	0.15	0.20

Source: SUSENAS 2010

Table 4.2 depicts the poverty rate of each cohorts regarding to marriage status. The poverty rate is defined as the proportion of people who classified as poor, using per capita expenditure basis on official national poverty line at districts level, represent to each age groups. In overall, we see that most people who had child marriage do not categorized as poor households. About 80% of woman are non-poor households. However, in non child marriages group, later we mention as adult marriage, we find similar relation. Poverty incidence is smaller also in each cohorts. . In adult marriage group we obtain similar poverty rate with national poverty rate. It support previous indication that poor status is not the main reason to become child brides. In the same way it show weak relationship between poverty and decision on married.

Nevertheless, we cannot neglect, if there is significant difference of poverty incidence between adult marriage group and child marriage group. At any cohorts, the poverty rate of people who had early marriages always higher than adult marriages group. For instances, in age group of below 18 years old, we have 15% of young women categorized as poor in adult marriage group, yet in child marriage group we have 23%. The difference signal, even though poverty is not the main driver of child marriage, the child marriage phenomena related to the wealth status.

The gap of poverty rate within each age group also vary between groups. The youngest age group shows larger difference of poverty rate between adult and child marriage. The poverty rate is about 50% higher at child marriage group. The difference between cohorts refers us to intergenerational aspect of early marriage. It imply that whether today's child marriage and past child marriage resulting on higher poverty rate possibility. Age cohorts is also important to see, so that we can shed light on the evolution of wealth status after doing child marriages. From the table, we argue that there is small significant change of wealth status overtime. It implies child marriage would easily lift up the prosperity of its brides. But , we still can see there is declining pattern of poverty rate as the age group getting older.

From the numbers, we learn at two important issues of child marriage. First, the decision of marriage supposed to be driven by initial wealth condition. If we see in youngest cohorts, we can conclude that more poor people decide to have earlier marriage. However, as a second findings, we can see the benefits of early marriages is unsure, as the motivation of early marriage is to lift up their livelihood.

Table 4.3. Education Status of Woman who had Child Marriage

Age Group	Elementary School		Junior High School		Senior High School	
	Total	%	Total	%	Total	%
<18 years old	880	1%	164	1%	93	1%
19-28 years old	7,517	12%	2,011	17%	1,262	13%
29-38 years old	12,770	21%	3,141	27%	2,399	25%
39-48 years old	14,739	24%	2,215	19%	1,770	19%
49-58 years old	12,014	20%	1,744	15%	1,420	15%
>59 years old	12,577	21%	2,234	19%	2,473	26%
Total	***60,497***	***100%***	***11,509***	***100%***	***9,416***	***100%***

Source: SUSENAS 2010

Table 4.3 above provides information about the condition of child marriage woman last education attendant in 2010. Overall, most of child marriage woman last education attendant are in

elementary school level. The number of child marriage women who are in elementary school level are 60,497 women and this number decreases along with the increasing of level education. The number of child marriage women who are in junior high school level decreases by 81% (11,509 women) and for senior high school level decreases by 18% (9,416%).

Distribution of child marriage last education attendant by age groups show that child marriage woman who are in <18 years old group tend to be the lowest than other age groups. The number of child marriage woman who are in <18 years old group are 880 women for elementary school, 164 women for junior high school and 93 women for senior high school. In other side, the largest age groups in elementary school is 39-48 years old group with 14,793 women (24%), for junior high school is 29-38 years old group with 3,141 women (27%) and for senior high school the largest one is >59 years old group with 2,473 women (26%).

Table 4.4 Highest Education Level of Household Head

Age Group	Primary School	Junior Secondary School	Senior Secondary School	Higher Education
<18	0.33	0.43	0.22	0.02
18-27	0.33	0.41	0.24	0.02
28-37	0.34	0.35	0.26	0.05
38-47	0.36	0.27	0.31	0.07
48-57	0.57	0.14	0.22	0.08
58 >	0.51	0.25	0.16	0.09
Total	0.34	0.38	0.25	0.03

Source: SUSENAS 2010

Table 4.4 depict household head education related to child marriage for each age groups. Interestingly, we find different pattern on younger cohort and older cohort. People who had child marriage recently, mostly has slightly higher education level parents than older cohorts. In under 37 years old group, parents tends to have junior high school certificate. However, the proportion of parents with elementary certificate and junior high school certificate seemingly balanced. In older cohorts, above 50% parents only had elementary school certificate. The differences can be attributed to better education enrollment in Indonesia since 90's. People are easier nowadays to have education up to 9 years education.

Overall, lower education of household head lean to larger child marriage incidence. Lower education imply lower information and opportunities for parents for not let their children to early marriages. The simplistic reason that using marriages as a way out of poverty, partly understand with the cost of being child marriage.

IV.4 Estimation Result

The next effort of our study is to reveal the determinant of being a child marriage. Our strategy is using logistic regression model to obtain what factors that would lead a woman to decide to become child bride. We select several variable that capture individual aspect, household aspects, and social aspect. We believe, as a children, the decision of married would largely influenced by households characteristics. The household characteristics would capture both household heads profile and household physical characteristics. To examine social aspect, we use the prevalence of

child marriage at village level and sex ratio in the same level. The idea is there is a tendency of being child marriage when there is more child marriage in the surroundings. It also came up as the proxy of cultural influence. The sex ratio try to explain if there is supply driven relationship, if there is more man would lead to more child marriage. As individual aspect, we use information exposure aspect rather than education attainment. First, we have variable that describe whether the young woman have more access to information. Second, we use variable which also represent other side of information which also has negative impact like internet from personal phone.

We restrict our cross sectional analysis to woman who had child marriage but still living with their parents as a child. Because we used only one period of time, we need to make sure that we would analyze the household origin effect on the decision to be married. The next challenge is defining which woman that we could analyze. Following the definition of child marriage prevalence we use woman aged 20-24. We isolates only on 20-24 age group because two reasons. First, if we include woman before 20, as our definition of child marriage, we would possibly miss the potential brides who presumably become child marriage in next period. Second, if we include woman after 24, most of the are separated away from household origins. Even though some of them have "children" status, the characteristics of household would possibly changed overtime. We also include the second group as comparison to the selected group. Overall, there is small different between first group and second group. However, later we would focus only to the first group,

Table 4.5 Logistic Regression Result

Independent Variable	Woman aged 20-24 with family status "children"	Woman aged 10-24 with family status "children"
ln_exp_cap	-0.157***	-0.119*
	-2.88	-1.65
i_internet	-1.566***	-1.099***
	-5.26	-2.9
i_nethp	0.505*	0.633*
	1.73	1.67
i_netwarnet	-0.343	0.496
	-1.42	1.55
h_pcfloor	-0.028***	-0.026***
	-8.74	-6.36
h_hhagr	-0.059	-0.045
	-1.15	-0.66
h_hhind	0.008	0.001
	0.11	0.01
h_hhage	0.007***	-0.022***
	2.92	-7.16
h_hhsd	-0.145***	-0.123*
	-3.01	-1.88
h_hhsmp	-0.106	-0.138
	-1.34	-1.32
h_hhsma	-0.161*	-0.100

	-1.75	-0.84
h_hhdip1_s3	-0.152	-0.278
	-0.86	-1.31
h_nchildsd	0.197**	0.224***
	7.4	6.23
h_nchildsmp	-0.114***	0.106
	-2.29	1.61
h_nchildsma	-0.284***	0.243***
	-4.9	3.16
h_nchilddi~3	-0.635***	-0.266***
	-6.08	-2.19
h_lighting1	0.035	-0.276***
	0.46	-2.62
h_fcook1	-0.283***	-0.314***
	-4.75	-3.92
h_fcook2	-0.006	0.003
	-0.09	0.03
h_healthcare	-0.136***	-0.218***
	-2.81	-3.33
e_childmarr	4.883***	4.978***
	33.95	24.33
e_rjk	0.134	0.125
	1.24	0.86
_cons	-1.089	0.926
	-1.55	1

*** significance at 1% level

** significance at 5% level

* significance at 10% level

The estimation confirms our hypothesis on the role of wealth status to child marriage decision. The household status or characteristics seems to be the major determinant of brides decision. The rising expenditure per capita proved to be responsible in decreasing the possibility of child marriage incidence. The wealth status also indicated by looking household head access to source of energy. The possession into gas and electricity as source of energy as proxy to wealth status of the households have negative correlation to the possicility of woman being a child brides.

The individual characteristics appear to be important as a driver. The information exposure variable confirm negative relationship to the incidence of child marriage. As the woman have better information access the tendency to be child brides decrease. However, the possession of internet through mobile phone positively related to the possibility of being child marriage. This variable indicates negative impact of irresponsible usage of technology which mislead the user into negative information.

Household head characteristics largely influence the decision of child marriage. For the beginning, the age of household heads negatively affects the child marriage incidence. As the household head gets older, her or she tends to delay the marriage of their children. The education status of households also significantly matters. Households with primary school education negatively reduce the child marriage. The other significant variable is household heads who earn senior high school degree, which also negatively related to child marriage. Other education level of a household heads only have weak relationship. However, we have negative relationship which are have larger impact alongside higher education

We found that working sectors of household heads are not related to the child marriage decision. It working status that lately emerges matter to child marriage. Households head who works on informal sectors inclined to bring their children into early marriages. The findings represent the role of wealth status into child marriages, since we knows that informal sector offers less than formal sectors in common cases in Indonesia.

Besides the household heads characteristics, the characteristics of the households background alone also significantly affect the decision of child marriage. The child marriage also related to numbers of household members enrolled to certain education level. As the number of household member in primary school's age increase, the probability of being young brides also increase. reversely, an increase on children enrolled in higher education decrease the probability of early marriages. It explain two things. First, the higher numbers of household member on higher education represent higher economically productive member who can help the household heads. Second, it also related to better informed household member since they have higher education siblings.

We also examined possible external factors of child marriages using several variables. First, we use the prevalence of woman who had early marriage on village level as a proxy of environment impact on marriage decision. The result provide a positive relationship between the prevalence of woman married early and the probability of an individual do the same thing. It also can indicates the importance of custom in society that led personal decisions. Second, we use the number of adult male as another environment impact. From our estimation, the availability of adult male do not related to the possibility of being child brides. Last, the external factors come from government aid. The healthcare insurance have negative impact to the possibility of being child marriage. Household with access to healthcare programs tend to influence the young woman household members to have child marriage

The main variable in this model is expenditure per capita. We are not using poor status at the same time because of reverse causality possibility. However, we tried also using the poor status, replacing the expenditure per capita, and found poverty status has positive relation to the possibility of young woman becoming child brides. The other set of variables has no big difference in terms of the direction sign. The result is not shown on the table above.

V. CONCLUSION

V.1 Conclusion

Through this study, we aim to calculate the prevalence of child marriage using SUSENAS 2010 data as a nationally representative data for Indonesia in 2010 and the result shows that the prevalence of child marriage in Indonesia is 13.5 per cent. This number comes from the calculation of female population aged 20-24 years old who indicated that they were married or in union before the age of 18 per total number of women aged 20-24 years old.

In this study, we use age cohort 20-24 years as the measurement of child marriage based on two reasons.[1] Firstly, the percentage of girls aged 15-19 who are married or in union at any given time includes girls who are 18 and 19 and they are no longer children (according to the definition of children based on the international accepted definition). Secondly, if we use an indicator based on the age cohort 15-19, this includes girls aged 15, 16, and 17 who are classified as single, but who could eventually marry or enter into a union before the age of 18. In terms of these limitations, we use age cohort 20-24 as the object of study to analyze child marriage because we assume that it is not affected by these limitations and a more accurately estimates the real extent of child marriage.

However, in order to give a bigger picture of the prevalence of child marriage in Indonesia which considers several numbers of age cohort, we also present a calculation of the prevalence of child marriage for the other each age cohorts. The prevalence of child marriage for the other each age cohorts is 0.09 per cent for the age cohort 10-14 years old, 7.3 per cent for the age cohort 15-19 years old, and 28.5 per cent for the age cohort 29 years and above. The increasing percentage of child marriage prevalence as the age cohort raises is due to the fact that the practice of child marriage is decreasing over time but again, this is limited to the composition of female population who were in those age cohorts in 2010.

Other than the prevalence of child marriage, we also aim to find the determinants of child marriage in Indonesia. Based on previous studies regarding child marriage in several countries, we modeled that the determinants of child marriage in Indonesia is also influenced by three aspects. The three aspects are the condition of individuals, households, and society.

Using logistic regression, we find that there is a negative correlation between child marriage and income per capita, exposure to the media through the internet, floor per capita, education of household head, number of children in a family who are in high school and higher education, source of a family to cooking, and access to the free healthcare. We find also that there are positive correlation between child marriage and the use of internet through cellular phone, age of household head, number of children in a family who are in elementary school,

V.2 Policy Implication

The presence of law on marriage in Indonesia has been proven to be no impact at all. It has been statistically confirmed that although the law restricts girls to marry below 16 years old, the fact unveils that many still marry below that age. Even more to the definition of child marriage based on UNICEF concern (below 18 years old), the prevalence is outnumbering on the surface. This means that the decision of girls to marry does not necessarily include the legal aspect of marriage. Child marriage in Indonesia is determined more by social and economic characteristics both within and surrounding the girls. Thus, the policy should focuses on how to create an enabling environment that evolve alternatives to child marriage.

As the findings of this study reveal that some elements of the three aspects of children's lives, particularly girls, significantly related to the prevalence of child marriage among females in Indonesia, we aim to suggest that the policy must be made in the frame of these aspects. Policies need to reach into the individuals, households, and communities because child marriage is not determined by a single source of factor. One might say that increasing school enrollment of women and girls can contribute to a postponement of the age at marriage among them, but this can only affect if there is a

[1]This measurement is also used by UNFPA Ghana (2012) in the published report of *Marrying Too Young: End Child Marriage* as the measurement to analyze child marriage.

greater presence of school in the society and the understanding of the family on the importance of education. Therefore, forcing people to school per se will not prize the problem of child marriage unraveled.

Yet, there is no one size fits all policy. The upcoming policies then must be developed from the view point of each purpose. It should be kept in mind that child marriage comprises a part of social tradition and the absence of knowledge on the problem of child marriage. For that reason, the strategy needs to be continuous and extensive. In order to make it continuous and extensive, policies consist of preventive and protective action strategies is needed. Both of them constitutes a set of strategies that is not only aimed to reduce the prevalence of child marriage, but also to maintain its prevalence.

The preventive and protective action strategies of individuals must be started through an understanding that child marriage is perceived as 'their problem'. This is then should be maintained by parents through a condition of a stable family life (material and non-material) and supported by the key stakeholders in the community to resist the prevailing social forces. Finally, it is also critical to have a top-down action from government in providing a strong social and economic foundation. This can be done through a larger package of social and economic policies that promote marital, educational aspirations, and needs of low-income families.

VI. REFERENCES

Agaba, Peninah., Leonard K. Atuhaire., and Gideon Rutaremwa. 2011. "Determinants of Age at First Marriage Among Women in Western Uganda". Presented in European Population Conference 2010, Vienna 1-4 September 2010

Febriany, Vita. 2005. "Community Synthesis Report: Bulu-Kraksaan". Jakarta: SMERU Research Institute

Febriany, Vita. 2006. "Community Synthesis Report: Semampir". Jakarta: SMERU Research Institute

Ghosh, Biswajit. 2011. "Child Marriage and Its Prevention: Role of Adolescent Girls". Indian Journal of Development Research and Social Action, Vol. 7, No. 1-2, pp. 49-62

Goode, W. 1963. "World Revolution and Family Patterns". New York Press.

ICRW. 2008. "New Insights on Preventing Child Marriage: A Global Analysis Factors and Program". Retrieved from http://www.icrw.org/docs/2007-new-insights-preventing-child-marriage.pdf

Jensen, Robert., and Rebecca Thornton. 2003. "Early Female Marriage in the Developing World". Gender and Development, Vol. 11 No. 2, Marriage (Jul., 2003), pp. 9-19

Johnson-Lans, Shirley., and Patricia Jones. 2011. "Child Brides in Rural India". Vassar College, Working Papers No. 094

Jones, Gavin W. 2010. "Changing Marriage Patterns in Asia". Asia Research Institute Working Paper Series No. 131

Jones, Gavin W., and Bina Gubhaju. 2008. "Trends in Age at Marriage in the Provinces of Indonesia. Asia Research Institute Working Paper Series No. 105

Manda, Samuel., and Renate Meyer. 2005. "Age at First Marriage in Malawi: A Bayesian Multilevel Analysis Using a Discrete Time-to-Event Model". Journal of the Royal Statistical Society. Series A (Statistics in Society), Vol. 168, No. 2

McLaughlin, Diane K., and Daniel T. Lichter. 1997. "Poverty and the Marital Behavior of Young Women". Journal of Marriage and the Family, Vol. 59, Issue 3 (Aug., 1997), 582-594

Sarkar, Prosannajid. 2009. "Determinants and Effect of Early Marriage in Bangladesh, 2007". Research Journal of Applied Sciences 4 (5): 178-184

Savitridina, 1997. "Determinants and Consequences of Early Marriage in Java, Indonesia". Asia Pacific Population Journal, (Jun., 1997), 12(2): 25-48

Singh, Susheela., and Renee Samara. 1996. "Early Marriage Among Women in Developing Countries". International Family Planning Perspectives, 22: 148-157 & 175

UNFPA. 2005. "State of the World Population, 2005. Child Marriage Fact Sheet". Retrieved from http://www.unfpa.org/swp/2005/presskit/factsheets/facts_child_marriage.htm

UNFPA. 2012. "Marrying Too Young: End Child Marriage". New York: UNFPA

UNICEF. 2008. "Early Marriage: Child Spouses". Innocenti Digest, No. 7. Retrieved from http://www.unicef-icdc.org/publications/pdf/digest7e.pdf

Vu, Lung. 2009. "Age at First Marriage in Vietnam: Trends and Determinants". Presented in the 2009 Annual Meeting Population Association of America. Detroit, 30 April-2 May, 2009

Notulensi Theme 2:
Child Sensitive and Social Protection and Poverty Reduction

Rapporteur: Ali Aulia
Moderator : Destri Handayani (BAPPENAS)

Presenter 1:
Name : Yanuar Farida (Kemensos)
Title : Perdagangan Anak Perempuan yang Dilacurkan: Potret Suram Kemiskinan Versus Perlindungan Anak/*Female Child Sex Trafficking: Gloomy Portrayal of Poverty Versus Child Protection*

Highlights of Conclusions and Recommendations:

Melalui partisipasi observasi dan wawancara mendalam ditemukan beberapa faktor utama yang mendorong adanya perdagangan anak perempuan yang kemudian dilacurkan.

- **Urbanisasi**; kemiskinan di daerah asalnya mengembangkan imajinasi atas kota yang modern dan menjanjikan kemakmuran. Dalam usaha merealisasikan imajinasi tersebut anak terjebak dalam jaringan perdagangan anak dan menjadi pelacur
- **Perceraian akibat pernikahan dini**; tradisi pernikahan dini seringkali diikuti oleh fakta banyaknya perceraian. Kekecewaan akibat pecahnya rumah tangga ini mendorong mereka untuk memasuki pasar pekerja seks komersial atau memfasilitasi perdagangan anak perempuan dan menjadikannya pelacur. Sekalipun pihak yang terlibat dalam perdangan anak ini adalah laki-laki, tapi peranan perempuan di sini juga tidak bisa dikesampingkan
- **Hubungan kekerabatan**. Seringkali anak yang diperdagangkan dan menjadi pelacur memiliki saudara atau orang tua yang juga mengalami hal yang sama.

Rekomendasi:

1. Upaya preventif melalui institusi pendidikan dan kampanye media massa
2. Upaya perlindungan yang lebih menekankan implementasi dari regulasi
3. Upaya pemulihan dengan memberikan pelayanan rumah aman
4. Upaya integratif dengan mengintegrasikan anak dengan keluarga dan masyarakat

Presenter 2:
Name : Natia Partskhaladze (UNICEF Georgia)
Title : Quality of Life of Deinstitutionalized Children in Biological Families in Georgia

Highlights of Conclusions and Recommendations:

Assessing the quality of life of children who are reintegrated to their biological parents. Previously these children were living in the institutions. The measurement is based on psychological and social domains, incorporating subjective and objective measures.

Main findings:

1. The quality of life of the children who are reintegrated to their biological parents become higher than those who are still in the institutions
2. The less the time the children spent in institutions, the more quality of life scale that they achieve.

Recommendations:

The model of deinstitutionalization is the preferred model to ensure the quality of life of children. The way to do it is by reintegrating the children into their biological families or by developing an alternative care setting, such as fostering or SGH care**.**

Presenter 3:
Name : Joseph Marshan (SMERU Research Institute, Indonesia)
Title : Prevalence of Child Marriage and Its Determinants among Young Women in Indonesia

Highlights of Conclusions and Recommendations:

Using Susenas 2010 data sets to figure out the distribution of child marriage, the determinants, the impact on wealth, and the reason of deciding to marry in early age.
Main findings:

- Indonesia population is concentrated in Java and Sumatra, so does the child marriage numbers. Nevertheless, it does not mean that the prevalence of child marriage in other regions is low.
- Some characteristics of people experiencing marriage in child age:
  - Achieve not more than primary level of education
  - Live in rural areas
  - Live in poor households
  - Live in the village where child marriage is a general phenomenon
- No improvement in welfare status even after the marriage.

Recommendations:

1. Poverty and low education attainment are the most drivers of child marriage, therefore, poverty alleviation program and package approach (PKH) will help a lot.
2. Improving environment that discourage the children to marry in child age
3. Improving national standard of eligible age to marry.

Discussant's comments:
Name : Dr. Heru Kasidi (KPPPA)

Highlights of Conclusions and Recommendations:

1. Both presented studies on child marriage and child prostitution are led by the same drivers, namely poverty, low human capital, and poor environment. In addition, the study on child deinstitutionalization shows the importance of nuclear family to assure a better children's quality of life, as well as the need of measurable and comprehensive instrument to monitor the improvement
2. Considering the same drivers of any children problems, a comprehensive study on child protection is needed to enable the integration of child protection policy. In turn, the policy should be translated into applicable implementation, hence its impact can be well measured and monitored
3. Mainstreaming child right fulfilment to ensure child issues is needed to address appropriately any social studies and in any policy making process and implementation.

Comments:

- **Natia Partskhaladze:**
  Children should be included to make a decision of their life.

- **Yanuar Farida**
  Perlu adanya integrasi studi untuk kebijakan yang lebih terintegrasi karena seringkali kebijakan menjadi parsial pada isu-isu tertentu.

- **Joseph Marshan**
  Peranan utama BAPPENAS adalah bagaimana menerjemahkan hasil penelitian menjadi kebijakan.

Questions and Answers:

1. **Esti Susanti (Surabaya Hotline)**
   - Buatlah studi banding tentang urbanisasi dan kemiskinan kota. Urbanisasi mendorong perdagangan anak yang beresiko terhadap pelacuran anak, sedangkan kemiskinan kota menyebabkan anak menjadi pelaku pelacuran
   - Perlunya standar prosedur di Kepolisian untuk penegakan hukum, bukan tentang hukumnya
   - Penguatan komunitas dan sekolah agar lebih ramah anak dengan segala permasahan anak. Seringkali sekolah cuci tangan
   - Perlu memperhatikan isu *parenting*, pola asuh, ketidakperhatian orang tua
   - UU perkawinan masih menetapkan batas usia menikah perempuan 16 tahun, laki2 19 tahun. Pembatasan usia harus lebih konkret, karena 16 tahun sebenarnya masih usia anak.

2. **Marzuki (JARAK, LSM penanggulangan pekerja anak)**
   - Aspek perilaku dan pola hidup berkontribusi pada masuknya anak pada hal-hal beresiko seperti pelacuran, perdagangan anak, atau pernikahan dini
   - Banyak orang miskin tapi masih bergaya hidup *glamour*
   - Penting untuk melihat dari *demand side* terutama dalam isu seksual pada anak
   - Konteks *rural urban* penting untuk intervensi permasalahan anak seperti *trafficking,* pelacuran anak, atau pernikahan dini. Nuansa desa adalah kemiskinan, sedangkan nuansa perkotaan adalah gaya hidup
   - Mengembalikan fungsi peranan orang tua
   - Kebijakan harus tegas

3. **Ilahi (AUSAID social protection specialist)**
   - The need for short-term measure to address the problem, like cash transfer program and how it affects social issues.

4. **Usha (UNICEF Cambodia)**
   - Di India terdapat studi tentang dampak *cash transfer* terhadap perkawinan anak.

5. **Marisa (UNICEF Indonesia)**
   - Kenapa Indonesia tidak merubah UU tentang usia pernikahan yang tidak sensitif terhadap anak?
   - Sudah ada studi tentang evaluasi dampak CCT di Indonesia.

6. **Nuke (LIPI)**
   - *Task force* yang harus dievalusi dalam hal evaluasi terkait dengan *trafficking*
   - Perlunya mempertimbangkan eksklusi sosial akibat pembangunan yang tidak bisa diakses karena masalah pendidikan.

- Perubahan wilayah harus memperhitungkan lebih komprehensif terhadap dampaknya terhadap masyarakat yang *human capital*nya rendah. Hal inilah yang mendorong adanya *trafficking*.
- Melakukan pencegahan ketika anak mulai menikmati menjadi bagian dari *trafficking.*

FINAL CONCLUSIONS & RECOMMENDATIONS:

1. Pemerintah sedang dalam proses penggodokan perubahan UU usia anak
2. Pemberdayaan komunitas dan sekolah adalah intervensi yang akan diusulkan untuk perlindungan social anak walaupun belum jelas bagaimana pelaksanaannya
3. Mengembalikan peran dan fungsi keluarga sebagaimana dalam studi Natia bahwa *care by nuclear family* berdampak positif pada kualitas hidup anak
4. Permasalahan anak berakar pada hal yang sama, kemiskinan dan pendidikan, dsb. Oleh karena itu kebijakan dan implementasi harus terintegrasi dan hasilnya harus dapat diukur seperti metode yang diutarakan dalam studi Natia
5. Perlu adanya survey kualitas hidup anak untuk mengevaluasi dampak program perlindungan sosial
6. Hal paling penting adalah bagaimana ide2 dan kebijakan itu harus diterjemahkan ke hal-hal yang dapat diukur sehingga dapat dievaluasi dampaknya
7. Hasil studi harus aplikatif
8. Istilah yang lebih tepat mungkin bukan pernikahan dini tetapi pernikahan anak. Upaya sosialisasi harus menggunakan UU perlindungan anak untuk menghadapi UU pernikahan
9. Perlu memperhatikan bagaimana dampak negatif *institutionalization of children*, selain memperhatikan positif dampak pengasuhan oleh *nuclear family.*

THEME 3

Inclusive Social Protection

1. **Mapping of Social Protection Measures for Children Affected by AIDS in Asia-Pacific**
   Shirley Mark Prabhu (UNICEF East Asia and the Pacific Regional Office, Thailand)

2. **The Impact of HIV on Children's Education in Indonesia**
   Aang Sutrisna (AIDSina Foundation, Indonesia)

3. **Program Jaminan Hidup untuk Anak Dengan HIV (ADHA) di DIY/Life Insurance Program for Children with HIV in Yogyakarta**
   Juniati Rahmadani (Komisi Penanggulangan AIDS Provinsi DIY, Indonesia)

1 Mapping of Social Protection Measures for Children Affected by Hiv And Aids in Asia and the Pacific

Shirley Mark Prabhu
UNICEF East Asia and the Pacific Regional Office, Thailand

Acknowledgements

This report on "Mapping of social protection measures for children affected by HIV and AIDS in Asia and the Pacific" reviews the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in nine countries – Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam.

The Economist Intelligence Unit (EIU) was commissioned by UNICEF East Asia and Pacific Regional Office (EAPRO) based in Bangkok, Thailand to research and write this report.

During the period of September 2010 - March 2011, the Economist Intelligence Unit research team led by Manisha Mirchandani and Manoj Vohra gathered data, conducted interviews, and authored this report, which presents its findings as of June 2011.

We would like to thank the experts, practitioners and policy makers who shared their invaluable input, advice and comments, and acknowledge the special contribution of Ketan Chitnis, Regional HIV and AIDS Specialist (Knowledge Generation) and Wing-Sie Cheng, Regional Adviser on HIV and AIDS, to the development of this analysis.

Special thanks to Rachel Yates and Patricia Lim Ah Ken from UNICEF New York headquarters and to the UNICEF country officers and experts who provided inputs, comments and feedback including: Juliet Attenborough and Cristiana Morf (Papua New Guinea), Severine Leonardi (Indonesia), Etienne Poirot (China), Penelope Campbell (Cambodia), Robert Gass (Thailand) and Tadashi Yusuda (Viet Nam).

Proofreading and overseeing of final packaging of the document was undertaken by Shirley Mark Prabhu, while the needed administrative support was provided by Thitikorn Trayaporn, UNICEF EAPRO.

The analysis and views expressed in this report are those of the Economist Intelligence Unit, and do not necessarily reflect the views of the individuals or entities acknowledged.

Whilst every effort has been taken to verify the accuracy of this information, neither The Economist Intelligence Unit Ltd. nor its affiliates can accept any responsibility or liability for reliance by any person on this information.

Acronyms

ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARISE	Appropriate Resources for Improving Street Children's Environment (Bangladesh)
ART	antiretroviral therapy
BEHTRUWC	Basic Education for Hard-to-Reach Urban Working Children (Cambodia)
BISP	Benazir Bhutto Income Support Programme (Pakistan)
BKM	Bantuan Khusus Siswa/Special Student Assistance (Indonesia)
BLT	Bantuan Langsung Tunai/Direct Cash Assistance (Indonesia)
BOS	Bantuan Operasional Sekolah Programme (Indonesia)
BPJS	Badan Pengelola Jamin Sosial/Social Security Management Agency (Indonesia)
BPS	Central Statistics Agency (Indonesia)
CABA	children affected by AIDS
CBHI	community-based health insurance
CCT	conditional cash transfer
CFS	Child Friendly School Initiative (Thailand)
CHAC	Child Health Advisory Committee (Papua New Guinea)
CODI	Community Organisations Development Institute (Thailand)
CSC	children in special circumstances
CT	cash transfer
DDC	district development committees
DFID	Department of International Development (UK)
DWD	Department of Women Development (Nepal)
EAPRO	UNICEF East Asia and Pacific Regional Office
EFA	Declaration on Education for All (Thailand)
EGS	100-day Employment Guarantee Scheme (Bangladesh)
EIU	Economist Intelligence Unit
EOBI	Employees Old Age Benefits Institutions (Pakistan)
FBO	faith-based organization
GDP	gross domestic product
GES	Graduate Employment Scheme (Pakistan)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria

GSB	Government Savings Bank (Thailand) GTZ German Technical Cooperation HEF health equity fund HIV human immunodeficiency virus IDU injecting drug user IGVGD Income Generation for Vulnerable Group Development (Bangladesh)
ILO	International Labour Organisation
KPP	Khushal Pakistan Programme/People's Works Programme (Pakistan)
LP	Lukautim Pikinini (Nepal)
MARPs	most-at-risk populations
MLD	Ministry of Local Development Act (Papua New Guinea)
MLSS	Minimum Living Standard Scheme (China)
MOES	Ministry of Education and Sports (Nepal)
MOET	Ministry of Education and Training (Viet Nam)
MOEYS	Ministry of Education, Youth and Sport (Cambodia)
MOH	Ministry of Health
MOHP	Ministry of Health and Population (Nepal)
MOLISA	Ministry of Labour Invalids and Social Affairs (Viet Nam)
MOP	Ministry of Planning
MOSW	Ministry of Social Welfare
MOSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation (Cambodia)
MSM	men who have sex with men
MWCSW	Ministry of Women, Children and Social Welfare (Nepal)
NACP	National AIDS Control Programme (Pakistan)
NEGS	National Employment Guarantee Scheme
NGO	non-government organization
NHA	National Housing Authority (Thailand)
NPAC	National Programme of Action on Children (Viet Nam)
NPC	National Planning Commission (Nepal)
NPCE	National Project on Compulsory Education in Poor Areas (China)
NPCI	National Composite Policy Index
NRCMS	New Rural Cooperative Medical Scheme
NREGS	National Rural Employment Guarantee Scheme (Bangladesh)
NRSP	National Rural Support Programme
NTPPR	National Targeted Programme on Poverty Reduction (Viet Nam)
NZF	National Zakat Foundation (Pakistan)
OD	operational district
OECD	Organisation for Economic Co-operation and Development
OI	opportunistic infection
OPK	Special Market Operation (Indonesia)
OVC	orphan and vulnerable children
PBM	Pakistan Bait-ul-Maal
PCAR	Protection of Children At Risk (Bangladesh)

PEPFAR	President's Emergency Plan for AIDS Relief (US)
PESP	Primary Education Scholarship Programme (Bangladesh)
PESRP	Punjab Education Sector Reform Programme (Pakistan)
PFSS	Punjab Food Support Scheme (Pakistan)
PHCT	Public Health Concern Trust (Nepal)
PKH	Programme Keluarga Harapan/Household Conditional Cash Transfer Programme (Indonesia)
PLHIV	people living with HIV
PML	Pakistan Muslim League
PPTCT	prevention of parent-to-child transmission of HIV
PRSP	Poverty Reduction Strategy Paper
RCIW	Rural Community Infrastructure Works Programme (Nepal)
RGC	Royal Government of Cambodia
ROSC	Reaching Out Of School Children (Bangladesh)
SDDNCF	Socio-economic Development of Destitute and Neglected Children's Families Programme (Pakistan)
SDIP	Safe Delivery Incentive Programme (Nepal)
SEQEAP	Secondary Education and Quality Enhancement and Access Project (Bangladesh)
SHI	Social Health Insurance Plan (Cambodia)
SSMP	Support to Safe Motherhood Programme (Nepal)
SW	sex worker
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
URC	University Research Company USAID United States Agency for International Development VAAC Vietnam Administration for AIDS Control VDC village development committees VGD Vulnerable Group Development (Bangladesh) WHO World Health Organization WFP World Food Programme WWF Worker's Welfare Fund

Part I: Overview

This report reviews the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in nine countries – Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam – in the region. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country trends around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities.

Introduction

Countries in Asia-Pacific have faced a number of challenges in recent years including the global financial crisis, food-price volatility and climatic shocks. Among these, HIV is one of the factors impacting households in the region. The environment for children affected by HIV[1] remains complicated and highly diverse across the region. Regional estimates suggest that there are 180,000 children between 0 and 14 years of age living with HIV[2] and 1.1 million children who have lost one or both parents to AIDS. The number of children affected by HIV – living in a household where at least one adult is HIV-positive, or whose well-being is threatened or altered by the disease[3] – is difficult to ascertain. While HIV in the region is primarily driven by high-risk behaviours related to sex work, men who have multiple sex partners and injection drug use, the epidemic is trickling down to the partners of high-risk groups, therefore putting more children at risk of being affected by the disease.

The socio-economic context for children affected by HIV in Asia and the Pacific

Asia-Pacific's robust economic performance of recent years has brought impressive gains in terms of development and poverty alleviation. The high GDP per capita countries of Thailand and China are achieved relatively strong growth in 2010, at 7 and 10 per cent respectively, as indicated in Figure 1; while the majority of South and South-east Asian countries in the sample have a purchasing power of below US$5,000 per capita, and are expected to attain respectable levels of GDP growth in the wake of the global financial crisis of 2008-09. However, while economic growth has resumed in many economies, the overall employment outlook is uncertain, with unemployment of youth, vulnerable groups, and working poverty continuing to be a driver of vulnerability at the household level.

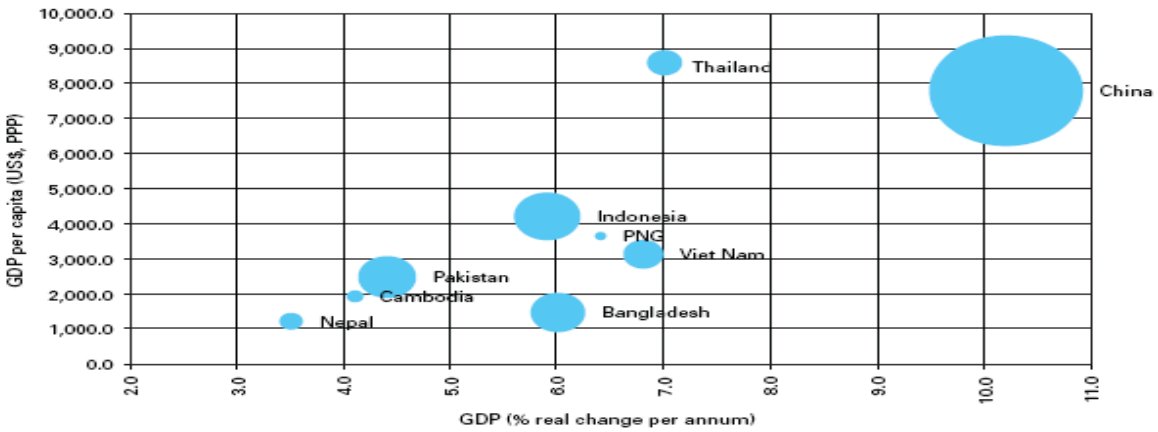
2010, at 7 and 10 per cent respectively, as indicated in Figure 1; while the majority of South and South-east Asian countries in the sample have a purchasing power of below US$5,000 per capita, and are expected to attain respectable levels of GDP growth in the wake of the global financial crisis of 2008-09. However, while economic growth has resumed in many economies, the overall employment outlook is uncertain, with unemployment of youth, vulnerable groups, and working poverty continuing to be a driver of vulnerability at the household level.

[1] The term HIV is used when referring to both HIV and AIDS, The term AIDS is used for specific references to the advanced stage of infection.

[2] United Nations Children's Fund, *'The State of the World's Children 2012: Children in an Urban World'*, UNICEF, New York, February 2012.

[3] United Nations Children's Fund, *'Enhanced Protection for Children Affected by AIDS: A companion paper to The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS'*, UNICEF, New York, March 2007

Figure 1: GDP growth, purchasing power and population of countries, 2010 estimates

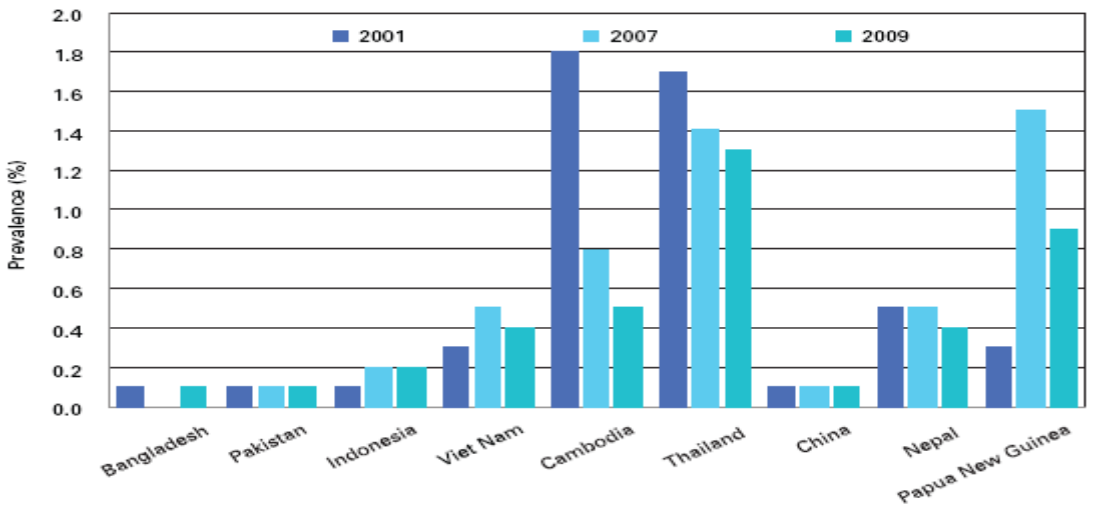


Note: Size of bubble represents population. Source: Economist Intelligence Unit.

Despite the improving economic outlook, access to and equity of resources remain problematic in a region that is largely still developing, and where much of the population remains exposed to a range of economic and environmental risks. Employment in the formal labour market remains predominantly agricultural, leaving the majority of the region's workers exposed to climate shocks such as failure from drought or flooding, and seasonal unemployment. Meanwhile, the informal labour market continues to flourish in developing Asia, exposing millions to income instability.

Vulnerability refers to the risk of an adverse event and the likelihood that the event will have serious negative consequences, and the level of exposure given a subject's economic resources or place within the community. In the context of HIV, both poverty and social stigma are relevant – and interlinked – causes of vulnerability. The robust economic growth experienced across Asian countries in recent years has not reduced vulnerability for affected populations. Not only is HIV infection still a risk, but many exposed groups, especially children, remain ill-equipped to deal with the economic and social consequences.

Figure 2: HIV prevalence trends in Asia-Pacific



Source: UNAIDS (2010).

Poverty is not the sole driver of HIV prevalence in the region. The interactions between socio-economic status and HIV risk are complex, and the impact varies significantly among groups.[4] In fact, in the Asia-Pacific context, higher levels of disposable income are required to purchase drugs and sex, behaviours which remain drivers of the epidemic in the region. A regressive legal environment and a weak human rights context are also important enablers of new infections in low and concentrated epidemics. Given that high-risk behaviours remain unlawful in many countries across the region, social attitudes and the legal environment are important factors in conditioning the HIV response.

Income inequality, though, has a strong association with HIV prevalence. Cross-country analysis has indicated that countries with greater inequality tend to have higher HIV prevalence, particularly in Sub-Saharan Africa, and to a lesser extent, in Latin America.[5] The trend holds true in Asia-Pacific, with the exception of China and Nepal, which have relatively high income inequality, but low HIV prevalence rates. Recent trends in prevalence show progress towards the Millennium Development Goal 6a to have "halted by 2015 and begun to reverse the spread of HIV", with notable successes in Cambodia and Thailand since 2001 (see Figure 2), suggesting that appropriate national responses can be highly effective. However, the prevalence trends exhibited in several countries tell another story – that ongoing vigilance is necessary, even in low-prevalence environments, and that lost ground can be quickly gained, as has been the case in Viet Nam and Papua New Guinea from 2007 to 2009 (see Figure 2).

Social protection and HIV

Global pledges on HIV, such as the 2001 and 2006 UN Declaration of Commitment on HIV and AIDS, affirm care, support and treatment for children orphaned and made vulnerable by HIV and emphasize the need for strengthened social welfare systems to meet the needs of these children. The individual's right to social protection is enshrined in various international covenants, including the Declaration of Human Rights, which ascribes an adequate standard of living and security for all, with "special care and assistance afforded to motherhood and childhood" – speaking directly to the specific, age-dependent vulnerabilities of children. A 'child-sensitive' approach to social protection has been adopted by UNICEF and partners[6] with a focus on recognizing the rights of women and children, achieving gender equality and reducing child poverty. The principles of child-sensitive social protection include early intervention; consideration of age- and gender-specific vulnerabilities; special provisions for the particularly vulnerable and excluded, including children without parental care or who are marginalized by their families or communities due to gender, disability, or other factors; and consideration of intra-household dynamics and mechanisms in reaching children.

The implementation of programmes and policies that are child-sensitive in their design and execution can specifically address the risks and vulnerabilities that children are born into, or later acquire by external shocks. As such, the provision of nutrition and basic needs to children and caregivers is a desired outcome of child-sensitive social assistance, which enables access to cash and food grants for children and families. The mitigation of economic shocks to households with

[4] Greener, Robert, 'Poverty is one part of HIV risk, but not the most important part', Conversations For A Better World, 2009, www.conversationsforabetterworld.com/2009/08/poverty-is-one-part-of-hiv-riskbut-not-the-most-important-part, accessed June 2011.

[5] Gillespie, Stuart, Suneetha Kadiyala, Robert Greener, *'Is poverty or wealth driving HIV transmission?'* AIDS, 2007, 21(Suppl. 7):S5: S5–S16.

[6] Department for International Development, United Kingdom et al., '*Advancing Child-Sensitive Social Protection*', Joint Statement, June 2009.

children can be achieved through access to child-sensitive social insurance, comprising health, maternal support, nutrition and unemployment support targeted at caregivers.

Increasing caregiver's access to employment/income generation, and access to child-sensitive social services in the form of employment initiatives for caregivers and families, as well as supporting families and caregivers in their childcare role, is an important component of child-sensitive social services. The other is to ensure basic services for the poorest and most marginalized through rights to health care, psychosocial support, and alternative care for children and families. Finally, child-sensitive social protection policies, legislations and regulations would facilitate the prevention of discrimination and child abuse in and outside the home. Specifically, this can be achieved through established rights to basic services for children and caregivers and the existence of a legal framework that protects children.

Physical and psychological immaturity and a dependence on caregivers for care and protection translate to a higher level of vulnerability in children to social, economic and health risks,[7] and that vulnerability in turn is highly influenced by the external environment. In addition, the lifecycle-approach to child development suggests that risks are age-dependent, and that the impact of shocks will vary at different stages. The potential of social protection to address the specific risks associated with childhood is well-established in both developed and developing countries,[8] and there is growing evidence for social gains from investment in social protection for children in the areas of poverty alleviation and school attendance.[9] Of particular note are the numerous cash transfer and conditional cash transfer (CCT) schemes, many of which have been modelled on Brazil's flagship Bolsa Família programme, which extends to over 12.4 million households. The scheme, which gives mothers a small grant to keep their children in school and receive medical check-ups, has been credited with significant gains in Brazil's primary and secondary school attendance and income equality.[10]

When compared to food, cash transfer has its strengths and weaknesses in different contexts, and the consideration of this through an HIV and AIDS lens is an important area for further research. Given the potential logistical, economic and political issues involved with the scale up of food transfers, the proliferation of cash transfer schemes in recent years is unsurprising, in light of the lower administrative inputs required and the potential for rapid scalability. In particular, cash transfers have been gaining momentum in recent years in countries looking at bolstering their national social protection systems for children affected by AIDS.[11]

---

[7] Jones, Nicola, William Ahadzie and Daniel Doh, '*Social Protection and Children: Opportunities and Challenges in Ghana*', UNICEF Ghana and Ministry of Employment and Social Welfare, Accra, July 2009.

[8] As evidenced by the substantial body of research by the OECD, UNICEF and others on social protection for children.

[9] Temin, Miriam, Better Care Network, *Expanding Social Protection for Vulnerable Children and Families: Learning from an Institutional Perspective,* Working Paper, Inter-Agency Task Team on Children and HIV and AIDS: Working Group on Social Protection, March 2008.

[10] Findings from Fundaçao Getulio Vargas. See *The Economist*, How to get children out of jobs and into school, July 2010. About one-sixth of the poverty reduction can be attributed to Bolsa Família, the same share as that accorded to the increase in state pensions, but at a much lower cost of around 0.5 per cent of GDP. Despite its stunning success, concerns remain around the impact and gains of the programme in urban areas.

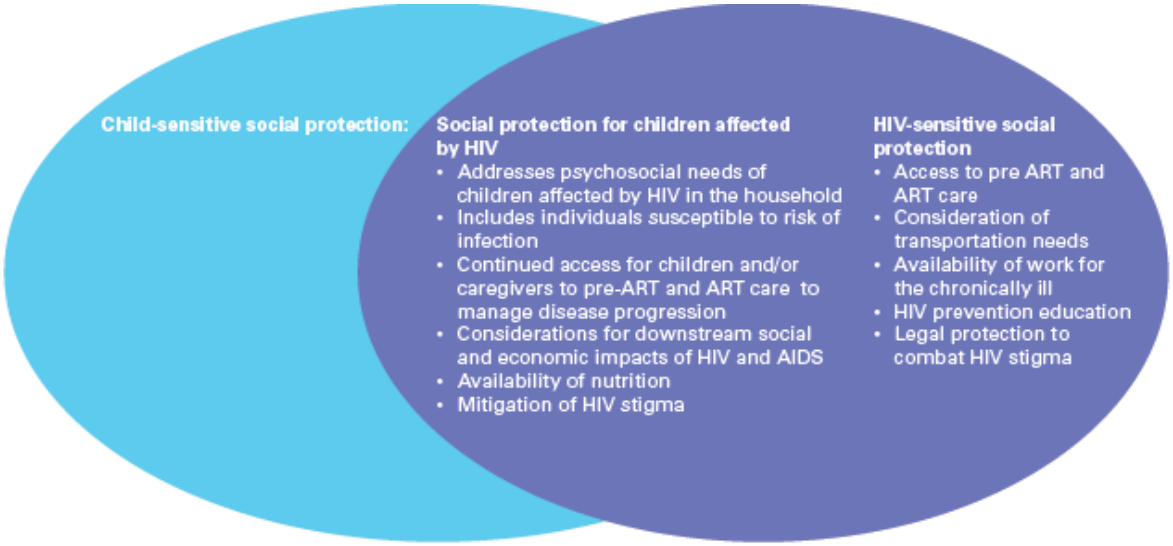
[11] Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates*', Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

Research approach

Social protection has typically been viewed as a means of addressing the specific vulnerabilities faced by children, or as a potential 'booster' for achieving universal access to HIV prevention, treatment, care and support within the national HIV response. Yet, children affected by HIV – those vulnerable to infection, infected and negatively affected by the impact of HIV – are exposed to a troubling configuration of risks that may not be fully addressed by stand-alone child-or HIV-specific social protection approaches. The reduced capacity of families and the fragmentation of the household as a result of chronic illness means that affected children may fall outside the sphere of family care and protection, increasing a child's exposure to exploitation and discrimination. General risks to children such as susceptibility to child labour, psychosocial harm, and children's more limited access to health care, nutrition and education are further magnified in the context of HIV.[12]

HIV-sensitive social protection makes prevention, treatment and care accessible by ensuring that social protection mechanisms address specific needs of people living with HIV, and vulnerable and at-risk populations. Key elements comprise: access to services; ensuring financial protection for households and individuals affected by HIV; and the development of HIV-sensitive social protection policies, legislation and regulation to uphold the rights of vulnerable groups (see Figure 3). These principles can be translated into the design of social protection instruments that facilitate access to pre-ART and ART care, consideration of transportation needs, financial protection in the form of available work for the chronically ill, and legal protection to combat HIV stigma in the case of upholding the rights of vulnerable groups through a favourable policy, regulatory and legal environment.[13]

Figure 3: Identifying social protection policies and programmes for affected children



Source: UNICEF and Economist Intelligence Unit analysis.

To gain a regional perspective of the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in Asia-Pacific, from

[12] Greenblott, Kara, '*Social Protection for Vulnerable Children in the context of HIV and AIDS: Working Towards a More Integrated Vision*', Working Paper, Interagency Task Team on Children and HIV and AIDS, July 2008.

[13] Social Protection Working Group, *UNAIDS Expanded Business Case: Enhancing Social Protection*, Joint United Nations Programme on HIV/AIDS, Geneva, May 2010.

September to December 2010 the Economist Intelligence Unit conducted a nine country review across Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country trends around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities. Guided by a child-sensitive social protection framework,[14] an analytical review of secondary data and documented evidence was conducted to identify key policies and programmes designed to meet the needs of children, with the intention of identifying the initiatives with the widest scope and scale. Using an objective set of criteria, these policies and programmes were then reviewed through a second, 'HIV-sensitive' lens to understand the extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV.

Without addressing the quality of these policies and programmes, a scoring key was developed to convey a sense of programmatic activity and the extent to which existing country initiatives account for children affected by HIV. To represent perceived levels of programmatic and policy action across each social protection instrument and type of transfer, existing programmes and policies were examined against a set of HIV-sensitive criteria.

Access to nutrition and basic needs for children affected by HIV and their caregivers is one desired outcome of HIV-sensitive social assistance – as such social assistance programmes with provision of cash and food grants for at-risk children (orphans, street children, institutionalized and stateless children) and poor families was a key criteria. In considering HIV-sensitive social insurance schemes, the mitigation of economic shocks to households affected by HIV was the key priority, and insurance schemes related to health, maternal support, nutrition and unemployment accessible to poor households and vulnerable groups were considered in the review.

With respect to HIV-sensitive social services for affected children, access to drugs, keeping caregivers alive and the provision of treatment to infected children are priorities. At the same time, social services programmes which enabled access to employment and livelihood initiatives for chronically ill caregivers were also of interest, given the importance of availability of employment/livelihood options for caregivers affected by HIV. Finally, programmes which provided for access to health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children were reviewed.

With respect to HIV-sensitive policies, given the harmful impact of stigma and discrimination in the community, policies and legislation which enshrined explicit rights to essential services for children affected by HIV were examined (as opposed to HIV-specific policies). Finally, the existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration, and school enrolment was considered.

Across the categories examined – social assistance, social insurance, access to social services, and policies and legislation – each programme or policy was conferred a coding from 'limited' to 'extensive'. Countries with a 'limited' coding have few policy initiatives, and nascent programme activity. A 'moderate' code reflects some policy initiatives and programme activity. Evidence of a substantive policy framework and moderate programme activity earned a 'substantial' coding. Programmes and policies were deemed to be 'extensive' if the policy framework was comprehensive, and there was evidence of robust programme activity.

[14] Department for International Development, United Kingdom et al., '*Advancing Child-Sensitive Social Protection*', Joint Statement, June 2009.

Limitations

This review is limited to social protection initiatives of significant scale and reach, and in general captured those managed by government agencies or key development partners. Information on coverage and impact of existing programmes has been collected from the public domain; however, there were many cases where monitoring and impact data was not publically available. Several programmes notable for innovation in design and delivery have also been highlighted as examples of how social protection instruments can be adapted nationally. It should be noted that this analysis is not intended to serve as a study of the efficacy or impact of existing programmes. Rather, this review serves as a snapshot of the regional landscape, with the intention of capturing the extent to which existing national social protection policies and programmes meet the needs of all vulnerable children, as well as the extent to which children affected by HIV could benefit. While the potential of social protection to contribute to HIV prevention is acknowledged,[15] the primary focus of this analysis is to assess the availability of child- and HIV-sensitive social protection, and the extent to which existing policy and programming facilitates access to treatment, care and support for children affected by HIV. Analysis of social protection programmes that aim for HIV-specific prevention responses comprising prevention of mother-to-child transmission and behaviour change communication for primary prevention is outside of the scope of this study.

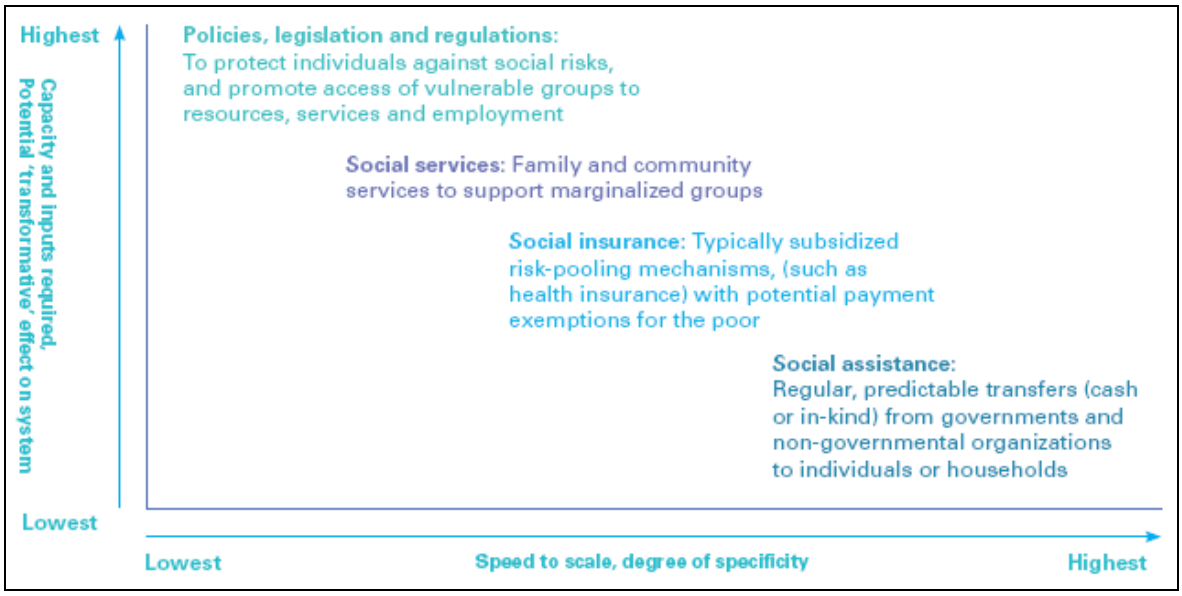
In its broadest sense, social protection is understood to comprise a set of measures to prevent and respond to social and economic risk and vulnerability, with the objective of reducing the economic and social susceptibility of poor and marginalized groups,[16] at the core of which is the concept of predictable and equitable transfers. Modern definitions look beyond the traditional disbursements of education, health care and income support to a set of instruments which can be adapted to mitigate and manage a much more complex spectrum of risks and vulnerabilities.[17] To prevent the chance of infection (susceptibility) and mitigate the consequences of HIV on individuals (vulnerability), social protection in the context of children affected by HIV must address issues of access for the most vulnerable. Social protection can be conceived as a set of transfers and services to reduce economic and social vulnerability, protect against livelihood risks, and ensure a minimum standard of dignity for marginalized people. As such, the 'transformational' potential of equitable legislation and policies that promote access of socially-excluded groups to assistance, insurance and services is also of interest given the possibility of lasting, structural change (see Figure 4 on pg. 9).

[15] United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence',* Brief, 2010.

[16] Devereux, Stephen and Rachel Sabates-Wheeler, *'Transformative Social Protection',* Working Paper, Institute of Development Studies, Brighton, October 2004.

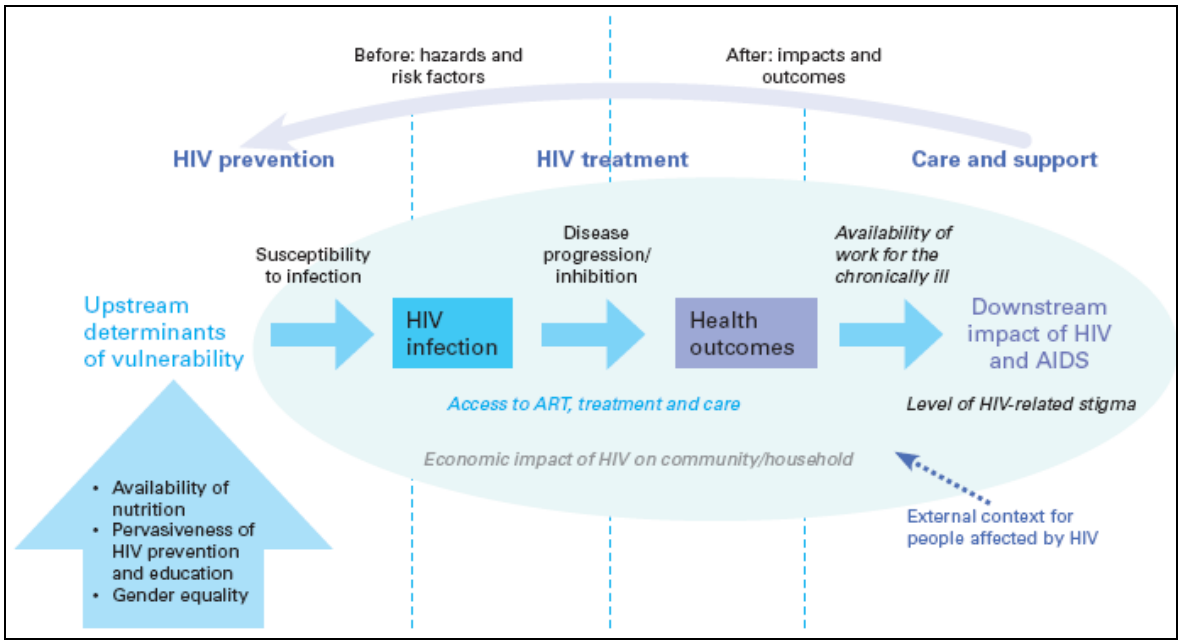
[17] There is no consensus on the types of interventions covered by social protection, and our focus on social assistance, social services and social insurance is determined by the broader, child-sensitive concept of social protection. Microcredit is generally excluded, though the environment for microcredit as an enabler of social insurance is noted.

Figure 4: Range of social protection instruments and specific outcomes



Source: Adapted from Adato and Bassett (2008)

Figure 5: Vulnerability along the pathway of HIV



Source: Adapted from Edstrom (2010).[18]

People infected and affected by HIV are subject to different, but no less complex configurations of risks and vulnerabilities than children. As such, a multi-dimensional approach to social protection which allows for the consideration of transfers, livelihood support and HIV-related rights, is relevant here (see Figure 4 on pg. 9 for a depiction of vulnerability at various stages along the HIV 'pathway'). Social protection has the potential to mitigate risks for individuals susceptible to infection (such as children of most-at-risk population groups), or subject to the consequences of

[18] Temin, Miriam, *'HIV-sensitive Social Protection: What does the evidence say?'*, Joint United Nations Programme on HIV/AIDS, Geneva, October 2010

HIV, and to supplement the response at all points along the pathway: to address susceptibility to infection (improve knowledge and empowerment to prevent HIV), to manage disease progression (enable continued access to ART) and to cushion the downstream social and economic impacts on households and communities.

Table 1: Framework for analysis of social protection measures for children affected by HIV

Social protection instrument	Policy or programme criteria	Anticipated outcomes
Social assistance	Provision of cash and food grants for at-risk children (orphans, street children, institutionalized children, stateless children) and poor families	Access to nutrition and basic needs to children affected by HIV, and their caregivers
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Mitigation of economic shocks to households affected by HIV
Social services (access to)	Availability of treatment (ART and OI) for mothers and children	Access to drugs, keeping caregivers alive and providing treatment for infected children
	Employment and livelihood initiatives for chronically ill caregivers	Availability of employment/livelihood options for caregivers affected by HIV
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Addresses rights to services and the emotional well-being of children affected by HIV Strengthens families and communities, and encourages the development of caregivers to look after the psychological and emotional needs of affected children
Policies, legislation and regulation	Explicit rights to access essential services for vulnerable children	Mitigate impact of stigma and discrimination in the community
	Existence of a legal framework that specifically protects vulnerable children through inheritance rights, birth registration and school enrolment	Legal protection to safeguard the rights of children affected by HIV

Source: Adapted from Nolan, A. (2009) Social Protection in the Context of HIV and AIDS, Irish Aid; Economist Intelligence Unit.

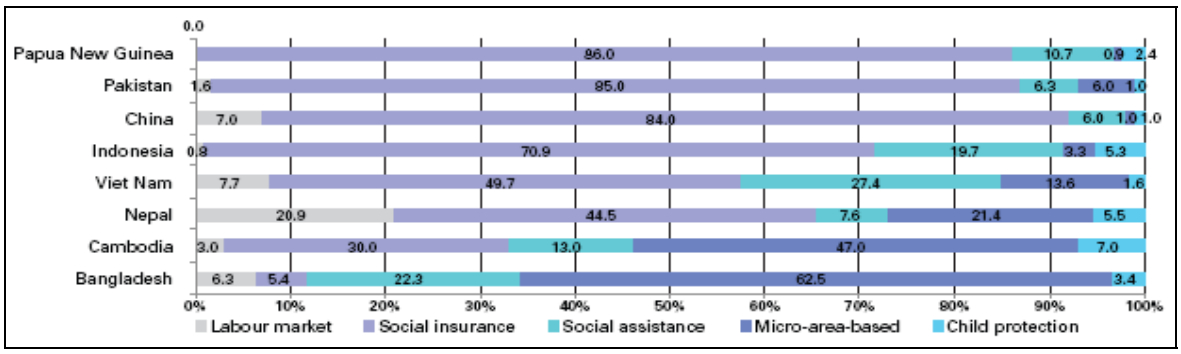
Existing social protection measures in the region

The importance of social protection within the national policy agenda is reflected in the tone of development policy and expenditure on social protection programming. Social protection objectives and their prominence within national development strategies suggest a rising interest and a growing commitment to addressing issues of risk through social protection instruments. While definitions are not harmonized across agencies and countries, data provided by the Asian Development Bank (ADB) classifies social protection expenditure by programme type conveys an approximation of national priorities across the region. Research for over 30 nation states conducted for the Social Protection Index indicated that on average, countries in the Asia-Pacific

region spend around 5 per cent of GDP on social protection, with around 57 per cent of the poor (by national poverty standards) receiving some form of social protection in 2008.[19] This average does mask a high degree of divergence across the region with respect to coverage priorities and preferences for delivery.

Social insurance dominated social protection spending across the countries of interest, comprising over 70 per cent of all social protection expenditure in Pakistan, China, Indonesia and Papua New Guinea, reflecting a historical tendency toward social protection for formal sector or state workers. Social assistance spending featured significantly in Indonesia, Viet Nam and Bangladesh, with about a quarter of the social protection budget allocated to support and services to vulnerable groups. Meanwhile, micro-area-based interventions comprised the majority of expenditure in Bangladesh (62.5 per cent) and Cambodia (47 per cent), highlighting significant micro-insurance and social fund activity occurring in both countries (see Figure 6 below).

Figure 6: Social protection expenditure by category of programme[20] (% share)



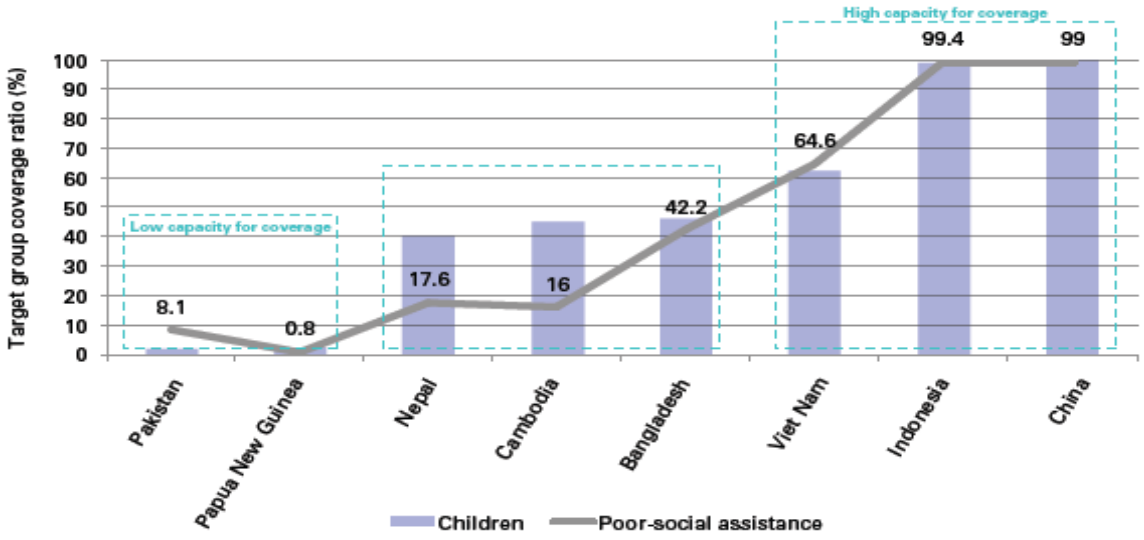
Source: ADB (2008), Social Protection Index for Committed Poverty Reduction – Volume 2: Asia, Manila, Philippines.

The coverage of social protection for targeted groups presents a similarly varied picture across the region. Programmes examined by the ADB in China, Indonesia and Viet Nam perform well across activities for the poor and children, with coverage of both groups reaching almost 100 per cent in Indonesia and China and more than 60 per cent in Viet Nam. Nepal, Cambodia and Bangladesh cover about 40 per cent of the targeted children, but coverage for the poor is less successful. Coverage of intended beneficiaries is low across both groups in Papua New Guinea and Pakistan – as shown in Figure 7 below – reflecting potential issues around capacity, access and resources.

[19] Asian Development Bank, *'Social Protection Index for Committed Poverty Reduction – Volume 2',* ADB, Manila, 2008

[20] According to the Asian Development Bank's *Social Protection Index*, "labour market policies and programmes" are designed to promote employment, the efficient operation of labour markets and the protection of workers; "social insurance programmes" to cushion the risks associated with unemployment, ill health, disability, work-related injury and old age; "social assistance and welfare service programmes" for the most vulnerable groups with no other means of adequate support, including single mothers, the homeless, or physically or mentally challenged people; "micro- and area-based schemes" to address vulnerability at the community level, including micro-insurance, agricultural insurance, social funds and programmes to manage natural disasters; and "child protection" to ensure the healthy and productive development of children. Thailand was not included.

Figure 7: Target group coverage ratio (%)[21]



Source: ADB (2008[22], Social Protection Index for Committed Poverty Reduction – Volume 2: Asia, Manila.

Though in many Asia-Pacific countries, social protection has gained considerable traction as a means of responding to issues of poverty, economic volatility and food insecurity, HIV has not been the primary focus of many existing social protection schemes in the region. However, there is growing recognition of the potential for social protection to contribute to the HIV response[23] and to address both susceptibility to infection and vulnerability to the harmful effects of HIV on individuals and communities.[24]

Impact of HIV on households in China, Cambodia, and Indonesia

There is growing evidence to support the acute and long-term impact of HIV on the dynamics and economics of the household. Chronic illness and the direct and indirect costs to the caregiver means that access to support and coping mechanisms are critical in mitigating the shock of HIV to family members, who are negatively affected across nearly all socio-economic indicators related to livelihood. The impact of HIV on income, employment, education of children, and the role of females in affected families was examined across three of the nine study countries – Cambodia, China and Indonesia (Tables 2, 3, 4) – by the United Nations Development Programme (UNDP) in 2010.[25] Despite the diverse socio-economic contexts, household surveys revealed that affected families and children in all three countries experienced additional economic burdens and reduced

[21] The health care category only includes programmes funded through social insurance or targeted at particular groups of the population; directly-funded health (and education) services are excluded.

[22] The Asian Development Bank's comparative study analysed and distilled data for the *Social Protection Index*. Targeting criteria likely varied slightly across countries.

[23] United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence,'* Brief, 2010.

[24] Bishop-Sambrook, Claire, *'HIV Susceptibility and Vulnerability Pathway: A Tool for Identifying Indicators, Role Models and Innovations'*, Food and Agricultural Organization for the United Nations, Rome, October 2003.

[25] United Nations Development Programme China, *'The Socio-economic Impact of HIV at the Individual and Household Levels in China – a Five Province Study,'* UNDP China, Beijing, December 2009.

access to basic services. Annual household income was found to be lower, health expenditure was higher and the incidence of dropout among school-aged children was also likely to be higher.

Household income

The data collected across the three countries suggests that there is a correlation between the earning potential of HIV-affected households, which tend to earn less than similar unaffected households. While this may be unsurprising given the impediments faced by PLHIV, including chronic illness, discrimination or time lost to treatment and care, trends in household incomes are striking: unaffected households earn 26.5 per cent more across the provinces surveyed in China, and an average of 17 per cent more (for the same occupation) in Cambodia. Therefore, 27 per cent of those diagnosed cease to earn any income, while the average income of households affected by HIV is half of what it was before diagnosis. Across seven provinces in Indonesia, unemployment is much higher for PLHIV, although social support from the government and NGOs goes a long way to redress the income imbalance between affected and unaffected households.

Table 2: Cross-country comparisons on income, UNDP socio-economic impact study

	Household income for HIV-households	Household income for unaffected households
Cambodia (nationally representative)	27% of PLHIV reported that they stopped earning income after diagnosis – higher absenteeism rate – particularly among girls living in HIV affected households.	Earn 17% more on average for same occupation.
China (five provinces)	Rmb14,920 annual average (US$2,238).	Rmb18, 875 (+26.5%) (US$2,838) annual average.
Indonesia (seven provinces)	11.7% income derived from social support.	5.2% of income from social support.

Source: UNDP (2010)[26] .

Health care expenditure

The impact of HIV on health care expenditure is particularly strong in Indonesia, where affected households spend nearly five times as much as unaffected households on health care, while the difference comes in at 49 per cent more in China. Interestingly, there are no significant differences in consumption between affected and unaffected households in Cambodia, which may be attributable to low base income levels, and the support of the country's numerous Health Equity Funds and community care schemes which typically subsidize expenses associated with access to health care. Sustainability of these numerous schemes, however, is tenuous in the medium- to long-term given that they are primarily supported by external resources.

[26] Tables 2, 3 and 4 were created from data reported in three studies: United Nations Development Programme China, *'The Socio Economic Impact of HIV at the Individual and Household Levels in China – a Five Province Study'*, UNDP China, Beijing, December 2009; United Nations Development Programme, *'The Socio Economic Impact of HIV at the Household Level in Cambodia'*, UNDP Phnom Penh, August 2011; United Nations Development Programme, *'The Social Economic Impact of HIV at Individual and Household Levels in Indonesia – a Seven Province Study,'* UNDP Jakarta, September 2010.

Table 3: Cross-country comparisons on health care spending, UNDP socio-economic impact study

	Health care expenditure for HIV-affected households	Health care expenditure for unaffected households
Cambodia (nationally representative)	In terms of overall consumption, HIV-affected households consumed 6% less than unaffected households. Per capita spending US$557. No significant differences in allocation toward health care.	US$590 per capita spending.
China (five provinces)	Rmb3, 700 (+49%) (US$555).	Rmb1,900 (US$285).
Indonesia (seven provinces)	Households spend up to five times more on health care than unaffected households, lowering spending on non-food consumption. Annual average health care expenses are about Rp480,000 (US$53).	Annual average health care expenses around Rp90,000 (US$10).

Source: UNDP (2010).

Education prospects

HIV has had a marked impact on educational prospects for girls, as suggested by the gap in dropout rates between boys and girls in Indonesia and China. Almost twice as many girls drop out of school in the affected households compared to boys in Indonesia, whereas the opposite trend is true of unaffected households. Children in HIV-affected homes are more likely to work in Cambodia, though the school enrolment rate remains on par with that of unaffected homes.

Table 4: Country comparisons on education attendance, UNDP socio-economic impact study

	Education attendance, HIV-affected households	Education attendance, unaffected households
Cambodia (nationally representative)	Workforce participation rate for children is higher, by 50%. School enrolment is 86%. Higher absenteeism rate – particularly among girls living in HIV-affected households.	Statistically equal to affected households at 85%.
China (five provinces)	School dropout rate of 11.1% for children 10-14, and 13.8% for girls.	School dropout rate of 4.4% for children 10-14, and 0.9% for girls.
Indonesia (seven provinces)	School dropout rate of 34.2% for boys, and 54.8% for girls.	School dropout rate of 65.8% for boys, and 45.1% for girls.

Source: UNDP (2010).

A drop in household incomes and diminished educational prospects for children, particularly girls, emerged as key themes. All households bore the burden of increases in health care expenditure; although social protection in the form of the provision of cash or in-kind assistance may have trickled down to alleviate the economic impact of treatment and access in Cambodia. The impact of cash and in-kind support to households appeared to have achieved some degree of success in alleviating the economic impact of income loss and additional health care expenditure in

Indonesia. However, UNDP research suggests that discrimination and stigma in the community also remain a challenge.

Lessons can be drawn from these case studies with respect to the design of social protection for affected children and the mechanisms with which to deploy the most appropriate tools to improve coverage and effectiveness of programmes in Asia. However, by focusing on the household unit, the needs of children who survive outside of family care – orphans, street children, the institutionalized and children who may be economically active across large informal economies in the region – are not necessarily met. These gaps in 'formal' coverage for households and registered workers are of particular interest in considering the most vulnerable children affected by HIV who lack the protection afforded by family care.

Key drivers of social protection for children

This review of nine countries (Table 5) revealed a high degree of diversity in the national response to social protection for children, and in turn, social protection for children affected by HIV. To understand the overall landscape for social protection for children, information was collected on programmes and policies which were 'child-sensitive' in their conceptualization and design, with a specific focus on the needs of caregivers – and children. The key features of some of the major child-sensitive programmes and policies have been identified and collated, giving an overall sense of key areas of activity in each country, the types of instruments preferred and the coverage attained.[27]

In assessing social protection policy and programming for children, there were several points of differentiation in the design of programmes that are specific to the needs of children affected by HIV. Among these were an awareness of the vulnerability of the caregiver to income and shocks, the health status of caregivers and children and an acknowledgement of the informal status of the 'invisible' children, who fall outside the household unit. Programme designers and policy makers in low-prevalence settings face a tricky balancing act in managing limited resources, capturing these most-vulnerable children and at the same time, avoiding potential stigmatization of the HIV-affected. To date, programme activity that is sensitive to the needs of children affected by HIV has varied in intensity across the region, with sectoral responses, historical preferences around social protection instruments and cultural norms defining the context for implementation.

[27] See appendix for country capsules, including information on specific programmes and policies

Table 5: Analysis of activity around social protection for children affected by HIV

	Social assistance	Social insurance	Social services (access to)			Policies, legislation and regulation	
Criteria	Provision of cash and food grants for at-risk children (orphans, street children, institutionalized children and stateless children) and poor families	Insurance schemes – health, maternal support, nutrition, unemployment – for poor households and vulnerable groups	Access to ART for caregivers and children	Employment and livelihood initiatives for chronically ill caregivers	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children (access/ affordability)	Explicit rights to access essential services for children affected by HIV	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment
Bangladesh	Substantial	Moderate	Moderate	Limited	Moderate	Substantial	Substantial
Cambodia	Substantial	Limited	Moderate	Moderate	Substantial	Moderate	Limited
China	Extensive	Substantial	Moderate	Limited	Substantial	Substantial	Extensive
Indonesia	Substantial	Moderate	Substantial	Limited	Limited	Moderate	Moderate
Nepal	Substantial	Moderate	Moderate	Moderate	Substantial	Substantial	Moderate
Pakistan	Moderate	Limited	Moderate	Limited	Moderate	Moderate	Limited
Papua New Guinea	Limited	Limited	Moderate	Limited	Moderate	Substantial	Limited
Thailand	Substantial	Substantial	Extensive	Limited	Substantial	Extensive	Extensive
Viet Nam	Moderate	Substantial	Moderate	Limited	Substantial	Substantial	Extensive
Key Trends	Most extensive in developing countries with a robust civil society network. China's national focus on targeting rural households is notable here.	Many formal high-coverage programmes preclude affected children. China and Thailand's focus on maternal support and improving access to health care for informal workers is notable.	Programmes targeted at mothers and children are scaling up. A history of high prevalence in some countries has resulted in stronger capacity and programme activity.	This is an area that remains weak across the region – employment schemes are often high-impact and unsuitable for chronic illness. An emphasis on service-orientated initiatives may be helpful here.	Many countries have substantial activity in this space. Government or civil society has taken the lead in providing resources and capital, while civil society groups often support access.	A child's right to essential services is high on the agenda across most countries, and enshrined in legal frameworks. Thailand's child protection laws are particularly comprehensive.	The agenda is mixed here – China, Thailand and Viet Nam's histories in addressing children's and women's issues are reflected. Bangladesh's robust civil society has driven progress.

Source: Economist Intelligence Unit analysis.

Key:
Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Civil society continues to be a critical force in capturing affected children. Sub-national government is poised to play a more active role

National governments are key drivers of the social protection agenda, with NGOs playing an active role in the development and delivery of programmes. The most interesting developments have occurred with respect to the role of civil society, which has been at the centre of the efforts to deliver services to affected children in resource-constrained settings. Such efforts, by local NGOs, faith-based organizations (FBO) and other community-based groups often happen at the

grassroots level, where experimentation and 'frugal innovation' is unbridled. Being close to the community, civil society can help address the needs of informal workers and vulnerable children lacking formal paperwork and eligibility for services, who could be missed by government programming. In Papua New Guinea, a monitoring and care programme run by the Catholic Diocese in Kundiawa has had notable success in supporting children in HIV-households and reducing the stigma surrounding HIV for those children. The programme primarily focuses on monitoring the situations of HIV-households, and particularly, the children of those households. If the situation deteriorates, volunteer programme members scale-up their response and support for the affected child. In addition, the group conducts trainings on HIV to build community awareness and reduce popular prejudices, while the church also retains funds for school fees to support the neediest children.

Civil society is often uniquely equipped to reach children who, because of capacity or access, are overlooked; in some cases connecting these children with existing social protection measures. In Thailand, civil society has been instrumental in providing social protection to most-vulnerable children in 'hard-to-reach' urban and border regions. Examples include support and care programmes provided by NGOs to address the health and psychosocial needs of vulnerable persons and their dependants – a PEPFAR initiative provides a range of services in high-risk urban areas of Bangkok, Chiang Rai and Kanchanaburi in the form of telephone counselling, income-generating loans, home-based care and access to ART. In a similar fashion, the faith-based Human Development Foundation runs a home-care visitation programme for 100,000 low-income residents of the Klong Toey slum area in Bangkok, where people living with HIV and children receive medical checkups, counselling and basic commodities. A pilot project in the northern provinces of Thailand conducted by Chiang Mai University and a coalition of NGOs has taken an interesting approach to reaching children by targeting and supporting their elders as a means of impact mitigation.

Civil society does have its shortcomings, however. While often more flexible and more reactive than government, issues arise around scalability and sustainability. Inconsistent funding can be problematic in the long-term, and the grassroots position that is an asset in the community context is not easily applied at a larger scale. State and non-state partnerships between civil society and government are emerging as a way of bridging capabilities.

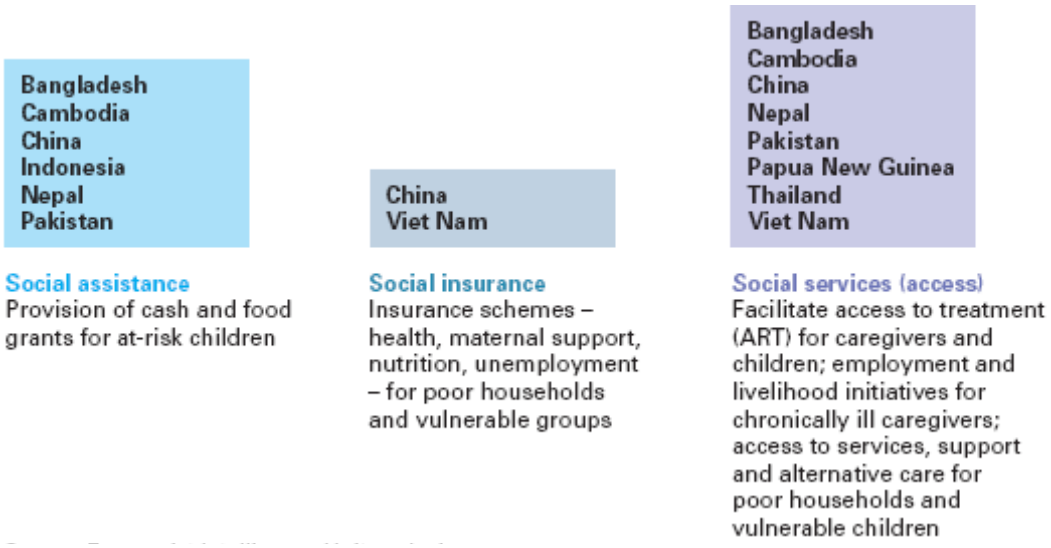
Sub-national governments have traditionally participated in the disbursement of social protection services, but the devolution of funds and decision-making rights to sub-national actors has seen their role evolve in recent years. As only 17 per cent of Indonesians are covered under the nationally-run health insurance scheme, the wealthier provincial and regional governments have begun to set up additional programmes to cover a wider segment of the poor in their areas, but data is not readily available on the extent of coverage from these localised efforts. In Thailand, nearly all government social assistance has been devolved to local, regional and community authorities, on the rationale that these ensure appropriate responses at the local level. Programmes developed by local government in Nepal, Pakistan and Bangladesh have seen sub-national governments taking the initiative in programme design, suggesting that there is opportunity to work more closely with such entities to emphasize the HIV-sensitivity of various schemes. This has been the case with recent 'child-friendly' local government initiatives in Nepal, where efforts were made to advocate and educate the sub-national government on a child-sensitive approach to provincial-level policy making.

Social protection aimed at improving access to social services is the most prominent response in the region

Divergent, and sometimes contradictory needs, are to be met through the social protection safety net for children affected by HIV/AIDS – urgency for nutrition may be more appropriate in some settings, while sustainable support, care and treatment may be a priority in others. Enabling access to social services, employment initiatives, ART treatment and the provision of essential services is challenging by virtue of high resourcing requirements and difficulties associated with co-ordination and outreach. Yet, there is a proliferation of schemes addressing barriers to access of social services, despite the low-resource settings examined in the nine countries covered. Programme activity which included children affected by HIV was moderate in most countries, particularly in relation to accessing essential services, though availability of suitable livelihood initiatives remains limited.

Promoting access to HIV-sensitive social services is a key social protection response to address the needs of affected children in the region, despite capacity and resource constraints, though civil society have been active in supplementing gaps. In particular, access to livelihood initiatives, featuring a cash or in-kind component, is gaining traction as a model in the region. This is particularly the case in South Asia where, for example, food and cash have been applied as incentives to encourage attendance at skills training programmes (see Figure 8 on pg. 20).

Figure 8: Preferred instruments for disbursement of social protection to children affected by HIV



Source: Economist Intelligence Unit analysis.

Employment generation schemes are not currently accounting for the limitations faced by people and caregivers living with HIV

There are a number of successful employment generation schemes in Asia, with the majority of activity emanating from South Asia. Many target poor households with the intention of supplementing household incomes and mitigating the volatility of agricultural and seasonal work. For instance, Bangladesh's 100-day Employment Guarantee Scheme is designed to drive employment generation in the lean seasons, and support the income of the poorest segment of the community; with the intention of generating 100 days of employment, at a wage of Tk100 per

day for 2 million people. The scheme focuses on the landless population, on temporary workers with an income of under Tk300. The "Food-For-Works" Rural Infrastructure Development Programme covers around 1 million participants annually, and provides food assistance for those who partake in rural infrastructure projects. Both programmes are child-sensitive in that key target groups are households headed by vulnerable women, who have been widowed, deserted or left destitute. However employment options are limited for those afflicted by chronic illness. Infrastructure projects require high-impact labour, and there are few options for the physically debilitated, for whom service-orientated, low-impact labour is more suitable.

Employment generation schemes need to be carefully balanced with assistance schemes and made more suitable to the very ill, or households with a high dependency ratio. These households may not be in a position to take advantage of employment opportunities, particularly if the work is 'high impact', or may need more continuous assistance for extended periods of time. Social assistance, in the form of cash transfers and food for education programmes fill these needs, even for households that are labour constrained.

The Food Security Vulnerable Group Development (VGD) in Bangladesh established by the Ministry of Women and Children's Affairs and the Ministry of Disaster Management and Relief is an interesting example of blending social services and social assistance tools to create medium-term employment and skills training for women. An offshoot of the scheme is the Income Generation for Vulnerable Group Development (IGVGD), which seeks to develop life skills for women to encourage savings and to raise social awareness about disaster management and nutrition through training. Focused on women of the household – and by proxy, their dependents – participants receive a monthly food ration of 30kg of wheat, life skills training over a period of 24 months and links to microcredit service providers. To receive benefits, women must demonstrate that they are saving for the household and attending the requisite hours of training and group meetings. Among participants, there has been a noted decline in landlessness and an increase in homestead land ownership; a decline in begging; increased ownership of basic household goods; and a slight rise in income. However, around one-quarter of the respondents found it difficult to cope once food aid was rescinded, and there was evidence of widespread corruption and poor-targeting, encouraging the creation of black markets.

Given the lower capacity required and the speed of implementation of social assistance, there is potential for its further use in resource-constrained settings to mitigate the impact of HIV on children and households, and to achieve high rates of coverage rapidly. For instance, Indonesia's National Independent Community Empowerment programme reports funding more than 180,000 projects in its first year. Pakistan's Child Support Programme began as a pilot scheme in 2006, with plans to scale up by 100 per cent by 2011.

Cash transfers are gaining traction in scope and scale

Unlike Latin America and, to a lesser extent, sub-Saharan Africa, conditional benefits are a relatively new concept in Asia and not as widely utilized. Yet, cash transfer programmes are increasingly perceived as an effective tool for poverty alleviation in the region.[28] These are either unconditional, or conditional (CCT), with a focus on tackling long-term poverty by the transfer of cash to the poor. It requires that beneficiaries accept various conditions related to behavioural change, for instance, the enrolment of children in school, maintaining adequate attendance levels, attending pre- and post-natal care training and participation in skills training.

[28] Asian Development Bank, '*Conditional Cash Transfer Programmes: An Effective Tool for Poverty Alleviation?*', Economics and Research Department, ERD Policy Brief Series No. 51, Manila, July 2008.

The debate on the strengths of CCT programmes versus cash transfer programmes is ongoing worldwide, particularly in Asia. Some studies have shown a marked increase in the likelihood of school enrolment as a result of conditional programmes, while other studies question that validity. In assessing the *Oportunidades* CCT programme in Mexico, Samson et al. summarized the problem. The programme combined grants to increase household income with awareness initiatives emphasizing the importance of human capital and conditions and linked receipt of cash transfers with behaviour that supports human capital development. Evaluations have indicated that all three factors combined can generate good outcomes but studies to date have not been able to isolate, or identify, whether income, awareness or conditionality is the most important determinant.[29]

Proponents of cash transfers argue that the funds and awareness are the most crucial factors to success. CCT advocates propose that the conditionality provides the additional incentive needed for behaviour change. In Asia-Pacific both types of cash transfers are currently being used, though CCT is more common, potentially as a result of favourable reports from other regions.

In high-prevalence environments, evidence suggests that cash transfers have the potential to reduce poverty and support livelihoods.[30] Across the Asia-Pacific countries reviewed, the emphasis of social assistance on education has emerged as a key trend, with studies demonstrating the effectiveness of cash and in-kind transfers in driving educational outcomes and expanding access to the 'social vaccine' of education against HIV infection.[31] Along with fee exemptions, such cash transfers can help cover the costs of school materials for orphans and other vulnerable children, and to improve girls' educational prospects, which are negatively affected by HIV within the household.[32]

CCTs have been employed in Cambodia to provide the families of children at high-risk of non-attendance with stipends and in-kind support for their education. The Scholarship for the Poor programme is one of the largest of these. In 2008, after just two years of operation, preliminary analysis showed that the programme had produced an improvement of between 20 per cent and 25 per cent in school attendance rates among the beneficiaries.[33] In Bangladesh, the Cash for Education or Primary Education Stipend Programme (PESP) has benefited 6 million children, with bank-initiated payments to cardholding mothers or guardians for 85 per cent school attendance and 40 per cent scores on annual exams. Indonesia's Programme Keluarga Harapan (PKH) provides cash transfers based on health and education related obligations, such as complete immunizations for children and 85 per cent school attendance for primary school age children.

There is a strong body of international evidence demonstrating how both conditional and unconditional cash transfers have served as effective risk management mechanisms in the

---

[29] Samson, Michael, Ingrid van Niekerk and Kenneth Mac Quene, *'Designing and Implementing Social Transfer Programmes'*, Economic Policy Research Institute, Cape Town, 2006.

[30] Schubert, Bernd, *'The Impact of Social Cash Transfers on Children Affected by HIV and AIDS, Evidence from Zambia, Malawi and South Africa',* United Nations Children's Fund, Eastern and Southern Africa, Lilongwe, July 2007.

[31] United Nations Children Fund, Joint United Nations Programme on HIV/AIDS and Institute of Development Studies, *'Enhancing Social Protection for HIV Prevention, Treatment, Care & Support – The State of the Evidence,'* Brief, 2010.

[32] See discussion on "Education prospects", p15.

[33] Filmer, Deon and Norbert Schady, *'Getting Girls Into School: Evidence from a Scholarship Programme in Cambodia,* "Cambodia Safety Net Review", Cambodian Council for Agriculture and Rural Development, World Food Programme, World Bank East Asia Human Development Unit, May 2009.

household, from preventing loss of savings to preventing the removal of children from school to earn income.[34] At the same time, cash transfers that depend on girls' school attendance or those that are transferred to female beneficiaries address issues of gender disparity, which is critical to child- and HIV-sensitive approaches. A number of programmes across Bangladesh, Nepal, and more recently, Pakistan have pioneered the placement of the female head of household at the centre of social assistance schemes in the region.

The scalability of cash transfers has led to impressive gains in coverage. In 2008, the Benazir Bhutto Income Support Programme (BISP) was established by the Pakistan's People Party in an attempt to mitigate the impact of food instability and price inflation on the poorest families. Sensitive to the caregiver, the programme is designed around the female adult as the recipient of cash grants. With an initial allocation of US$425 million for its first year of implementation, the programme aims to cover 15 per cent of the country's entire population.[35] Although there have been large-scale 'wins' in the region, cash transfer programmes can be difficult and costly to monitor. Problems with the programmes often revolve around 'leakage', where funds are diverted to ineligible recipients or where recipients do not receive the full funds they are eligible for. For example, Bangladesh's PESP programme, initiated in 2002, has experienced consistent leakage of funds, with evidence that 46 per cent of beneficiaries did not receive the full amount and 27 per cent of children from affluent (and thus ineligible) households received the stipend. A different CCT programme in Indonesia, the Bantuan Operasional Sekolah Programme (BOS) provided grants directly to schools to improve facilities, but allegations of officials appropriating funds for their own use prompted the World Bank to start a partner programme, BOSKITA, to strengthen transparency. The programmes are also subject to political distortion, with some fearing that cash or food transfers to the poor may be used to buy votes or electoral support for a party of candidate. The long-term success of these programmes is unproven in the Asia-Pacific, and there is limited evidence to inform an understanding of the sustainability of cash transfers relative to other services. More research is required to quantify the long-term reach and success of these programmes in the region.

Imperatives to enhance social protection for children affected by HIV

Social insurance is not always inclusive of HIV-affected children. Still, there are opportunities to experiment and innovate in this area

Established to provide protection to private- and public-sector workers, existing social insurance frameworks in many countries across the region have not historically been conceived to meet the needs of those who fall outside the scope of the formal workforce. This is a key problem area in Asia-Pacific given the high mobility of migrant workers, and the large number of affected children and their caregivers outside of the parameters of formal citizenship. Linked to this issue is the vulnerability of migrant workers, with respect to the enforcement of policies and legislations around HIV-related rights and discrimination. There are reports of migrant workers who are tested for HIV without their permission or informed consent, and deported if the test is positive, regardless of whether or not the country has testing laws, with respect to destination countries of Thailand and origin countries of Bangladesh, Cambodia, Indonesia, Nepal and Pakistan.[36]

---

[34] Farrington, John, Paul Harvey and Rachel Slater, *'Cash Transfers in the Context of Pro-Poor Growth'*, Briefing, Overseas Development Institute, London, July 2005.

[35] Jamal, Haroon, *'A Profile of Social Protection in Pakistan: An Appraisal of Empirical Literature'*, Social Policy and Development Centre, Karachi, 2010.

[36] Coordination of Action Research on AIDS and Mobility Asia, '*Malaysia National AIDS Conference*', Presentation, Kuala Lumpur, December 2010.

Informal workers have little or no access to the preventive benefits of social insurance, despite efforts made across several of the larger countries to expand the reach of social insurance beyond the remit of the urban, formal worker. In 2003, China's State Council issued the Decision to Establish a New Rural Cooperative Medical Scheme (NRCMS) to establish health insurance for the rural population, which by 2000 had seen over 87 per cent of the rural sick paying for their own medical treatment, and 25 per cent borrowing to cover costs.[37] The 2003 reform introduced subsidies from multiple levels of administration, at the township, county, principal and central level; while in 2008, basic medical insurance included provisions to cover the health care needs of special groups, including people living with HIV/AIDS. As of the end of 2009, around 833 million people are covered by the NRCMS, according to the Ministry of Health.

While the programme continues to widen in scope and scale, a number of issues; such as payment structure (for users[38] and providers limitations of the service package) continue to hinder the participation of the poorest and most vulnerable segments of the rural population and their dependents. Of the national programmes that do exist in Indonesia, Jamkesmas is a health insurance scheme for the poorest segment of society, which is open to all citizens. Those who are admitted to the programme have the majority of their health care fees waived or reimbursed, although payment mechanisms vary locally. As only 17 per cent of Indonesians are covered under this plan, the wealthier provincial and regional governments have taken the initiative to establish additional programmes to cover a wider segment of the poor in their areas.[39]

Intensive activity in the areas of microfinance and micro-insurance provide a potential solution to improving access. Already, community-based pooled-risk schemes are providing alternative forms of social insurance. In Nepal, the nongovernment Public Health Concern trust has established a pooled co-payment insurance scheme, where more than 45,000 members contribute a small annual fee of US$1.2-US$2.4. Members pay approximately 50 per cent of the cost of medical treatment, and 80 per cent of the cost of an annual check up is covered,[40] while children receive free checkups and subsidized medicine.[41]

However, studies suggest that while microcredit programmes have been successfully utilized by many poor people, they do not tend to benefit the ultra poor who still face barriers to access. Issues of stigma and discrimination mean that microcredit programmes in high AIDS-affected areas can pose risks to borrowers and lenders.[42] At the same time, there are contributory microcredit and insurance schemes run by NGOs which have been adapted to mitigate risk in AIDS-affected contexts, for instance, through death benefit insurance and educational trusts for

---

[37] Dumoulin-Smith, Adrien, '*Social Health Insurance in China: An Example of Nascent Social Security in China*', Cornell University, Ithaca, 2010.

[38] The annual cost of medical coverage is RMB50 (US$7.4) per person. (Utilizing the Economist Intelligence Unit's 2010 average exchange rate in 2011 of US$1: Rmb6.77), Of that amount, RMB20 is paid in by the central government, Rmb20 by the provincial government and a contribution of Rmb10 (US$1.5) is made by the patient.

[39] There is no data available on the extent of coverage from these local programmes.

[40] Tabor, Steven R., *'Community-Based Health Insurance and Social Protection Policy',* Social Protection Unit, Human Development Network, World Bank, Washington DC, March 2005.

[41] Interview with multilateral practitioner involved in social protection and labour issues in South Asia.

[42] Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates*', Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

children.[43] According to the United Nations Capital Development Fund/Special Unit for Microfinance, contributory schemes will reach fewer households and are more likely to miss the most vulnerable groups, but contributory schemes may have some traction where the recipient is still productive, or targeted to living or surviving family members.[44]

For informal worker populations that are not considered to be ultra-poor, the development of various models which confer affordable 'opt-in' access presents a model for the expansion of existing government social insurance mechanisms. In Thailand, the 9th Economic and Social Development Plan extends social security to the informal economy through a mechanism for voluntary self-insurance.[45] Self-insured informal workers who made an annual contribution of THB3,360 were entitled to benefits in maternity, invalidity, sickness, death and old age for the participant and direct dependants, and up to four indirect dependants. While the programme is unique and innovative in its accessibility for informal workers, and child-focused in its coverage of both direct and indirect dependents, it remains optional and cost-prohibitive for many, impeding the uptake and participation of vulnerable households.

Both contributory insurance and tax-based schemes are effective to some extent, but in both cases have faced challenges in reducing financial barriers for the ultra-poor. Vouchers, exemptions, and user-fee elimination can reach the neediest patients, but to be effective in promoting access to services, voucher schemes need to cover transport costs along with medical expenses and all options must ensure that providers are reimbursed.

Through universal or targeted programming, there are opportunities to extend social protection for children affected by HIV

Across the region, there is scope to develop the HIV-sensitivity of social protection instruments for children. While programmes are in place to aid chronically ill caregivers, there is little emphasis on enhancing caregiver capacity through training or support to manage the needs of HIV-affected children. Whether through an HIV- or a child-specific entry point, the heightened vulnerability of the caregiver to shocks must not be overlooked. Likewise, the psychosocial needs of children affected by HIV are not being consistently addressed, and must be taken into consideration in light of age- and gender-specific risks. The informal sector and migrant workers have limited access to formalized social protection instruments. Finally, provisions for suitable employment generation for the chronically ill, or for caregivers in high-dependency households are limited.

Based on a qualitative assessment of programmes across the region, a focus on facilitating access to social services is currently the most preferred instrument for reaching vulnerable children in the Asia-Pacific, while social assistance schemes are now prevalent in almost as many countries. China is the only country in which social assistance, social insurance and social services are all poised to offer children affected by HIV some form of support. Cash transfers, though not extensively proven, are being used in some countries with success, especially to encourage continued education for at-risk children and gender equality by raising the status of women in the household. Civil society and,

---

[43] Adato, Michelle and Lucy Bassett, '*What is the potential of cash transfers to strengthen families with HIV and AIDS? A review of the evidence on impacts and key policy debates*', Working Paper, Joint Learning Initiative on Children and HIV/AIDS, March 2008.

[44] United Nations Capital Development Fund/Special Unit for Microfinance and Joan Parker, *'Microfinance and HIV/AIDS',* Donor Brief, Consultative Group to Assist the Poor, World Bank, Washington DC, July 2003.

[45] International Labour Organization Sub-regional Office for East Asia, Ministry of Labour and the National Statistics Office, *'Thailand Social Security Priority and Needs Survey',* ILO, Bangkok 2004.

increasingly, sub-national governments are crucial to the implementation and oversight of programmes to reach the 'invisible' children. The growing strength of the regional response to women's development holds great promise as a potential 'entry point' for developing social protection that is sensitive to the needs of children affected by HIV.

Yet, social protection for key affected populations – sex workers (SW), injecting drug users (IDU), and men who have sex with men (MSM) – is lacking in the region. Of the reviewed programmes, only a handful focuses specifically on these highest-risk groups. The epidemic in Asia-Pacific is increasingly moving outside of these populations to the children and women who come in contact with IDU, MSM and whose partners visit sex workers. Avoiding specificity and providing sensitive social protection to larger groups through an HIV-sensitive approach may be the best route to decreasing stigmatization and discrimination while reaching the most vulnerable, but at the same time children of high-risk groups are potentially an 'entry point' in responding to the epidemic in low and concentrated settings.

Debates continue around the best approach to designing and delivering social protection for affected children. In a low-prevalence, concentrated setting, approaches that target children affiliated with high-risk populations are valid. The policy direction in some countries is one that supports specification. For example, Viet Nam's National Programme of Action on Children (NPAC) has a wide range of targets, with the objective of increasing medical, educational and psychosocial support specifically to children affected by HIV, by improving the quality of services available to them, although a 2010 UNAIDS Viet Nam National Composite Policy Index notes that many of the programme's elements have yet to be implemented, and the true impact on the ground has still to be ascertained. Meanwhile a strategy for Children Affected By AIDS (CABA) is under development in Nepal.

Table 6: Programme design features for children affected by HIV

	Child-sensitive	Sensitive to children affected by HIV	HIV-sensitive
Coverage	Household and children outside of family care	Household and children outside of family care, informal and mobile populations	Household and informal, mobile populations
Employment generation	Income generation for caregiver	Income generation for chronically ill caregiver and high-dependency households	Income generation for chronically ill and high-dependency households
Insurance	Maternity, health care, nutrition and employment	Maternity, health care, nutrition and employment with provisions for chronic illness and informal workers	Health care, nutrition and employment with provisions for chronic illness and informal workers
Ability of adult to care for dependants	Health and livelihood of caregiver	Health and livelihood of caregiver, and survival	Health and livelihood and survival
Access to essential services	Child and caregiver access to nutrition, education and health care	Child and caregiver access to nutrition, education and health care, including ART and alternative care	Access to nutrition, education and health care, including ART and alternative care

Source: UNICEF, Economist Intelligence Unit.

The stigmatizing effect of an HIV-specific approach presents a case for targeting all vulnerable children and communities[46] to develop the resilience of affected children. In Papua New Guinea for instance, a social protection agenda is being developed around the concept of most-vulnerable children. Potential issues with targeting a broad group include the diffusion of impact, and the danger of programming being spread too thinly. For children affected by HIV, the risks are ubiquitous and multi-dimensional. Gender, age and family relationships matter, while chronic illness in the household and vulnerability to orphanhood also have an impact. As such, support to caregivers is critical to prevent affected children from falling outside the realm of family care, and should be at the centre of any social protection agenda for affected children. At the same time, a more nuanced approach to informal and mobile populations is necessary to ensure that these most-vulnerable children do not fall through the gaps.

Part II: Country summaries

Mapping of social protection policies and programmes for children and children affected by HIV

To gain a regional perspective of the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in Asia-Pacific, the Economist Intelligence Unit conducted a nine country review across Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam, from September to December 2010. A set of child- and HIV-focused criteria were used to examine existing policies and programmes, with the goal of understanding country examples around implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities.

Guided by a child-sensitive social protection framework[47] the research team conducted an analytical review of available documentation, including reports, websites and policy documents to identify the key policies and programmes designed to meet the needs of children, with the intention of identifying a set of initiatives with the broadest coverage. Policies and programmes which were innovative in the delivery of social protection for children have also been included, despite limited coverage in some cases, to highlight new approaches and models.

The policies and programmes identified were then reviewed through a second, 'HIV-sensitive' lens to understand the extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV. Without addressing the quality and impact of policy and programmes, a code was applied to convey a sense of programmatic activity and the extent to which existing country initiatives account for children affected by HIV.

To represent perceived levels of programmatic and policy action across each social protection instrument and type of transfer, existing programmes and policies were examined against an HIV-sensitive criteria, and conferred a coding from 'limited' to 'extensive'. Countries with a 'limited' coding have few policy initiatives, and nascent programme activity. A 'moderate' classification

[46] Levine, Anthony, 'Orphans and Other Vulnerable Children: What Role for Social Protection?', World Bank, Washington DC, 2001.

[47] Department for International Development, United Kingdom et al., '*Advancing Child-Sensitive Social Protection*', Joint Statement, June 2009.

reflects some policy initiatives and some programme activity. Countries with evidence of substantive policy framework and moderate programme activity earned a 'substantial' ranking. Programmes and policies were deemed to be 'extensive' if the policy framework is comprehensive, and there is evidence of robust programme activity. Where programmes are 'blended' and comprise aspects of two or more instruments, it is allocated to the most significant category.

Throughout the tables, 'N/A' has been used where information was not relevant, or not available.

Bangladesh

Bangladesh's most substantial social protection efforts are in the areas of policies, legislation and regulations, and social assistance. The legal framework that protects children affected by HIV is established, and cash and food grant programmes exist for high-risk children. Fitting with the regional trend, Bangladesh's most limited area of social protection lies in employment and livelihood initiatives for chronically ill caregivers.

Table 1: Overview of social protection for children affected by HIV in Bangladesh

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Over 6 million children have benefited from the Primary Education Scholarship Programme cash transfer programme for education.
Social insurance	Insurance schemes – health, maternal support, nutrition, unemployment – for poor households and vulnerable groups	Moderate	
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	Employment for chronically ill caregivers is a weak spot in the region, and is limited in Bangladesh. Areas of activity include: the Sarkari Shishu Paribar children's homes that have rehabilitated over 45,000 orphans since 1961; the Protection of Children at Risk programme for children living and working on the street; and multiple programmes to provide education or enhance education offerings for children.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	Bangladesh has child-sensitive legislation dating back to 2004, with a National Action Plan for Children since 2005.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Substantial	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 2: Overview of key child-sensitive social protection policies and legislation in Bangladesh

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Bangladesh Country Assistance Strategy (2011-2014) Responsible agency: Government of Bangladesh Funded by: World Bank Time frame: Ongoing			
Several new programmes initiated such as: the Bangladesh Food Crisis Development Support Credit (2008-09); Additional Credit for Second Poverty Alleviation Microfinance Project; Emergency 2007 Cyclone Recovery and Restoration Project Additional Financing (2007-10); and the Empowerment and Livelihood Improvement "Nuton Jibon" Project (until September 2010).	Comprehensive programmes from the World Bank have supported Bangladesh's social protection programme. However, recent efforts have failed to get beyond negotiation, such as the Bangladesh National Social Protection Project (2008). Currently, broad development strategies for Bangladesh are in place.	Countrywide; coverage: national	Varied
Programme title: National Children Policy of 1974, Children Act 1974 and the Children Rules 1976 Responsible agency: Ministry of Women and Children Affairs Funded by: Government of Bangladesh Time frame: 2004-2011			
National Plan of Action for Education for All (2001-2015)	The National Children Council was formed to safeguard the interests of children and implement the policy directives. Initiatives for children were laid down in global conventions. Support is also being given to organizations (mainly NGOs) to train teachers and oversee the quality of education in community schools.	Out of school children; coverage: more than 500,000 children	About 5% of the students who are not eligible are excluded from programme.
Programme title: National Education Policy 2000 Responsible agency: Ministry of Education Funded by: Government of Bangladesh Time frame: Not stated			
Poverty Reduction Strategy Paper 1 (PRSP-1)	NEP proposed that a one-year course of pre-primary education should be created to encourage children's interest in education and school. The policy offers a broad educational framework for the country, with the intent to cover all children and adolescents attending school. Broad measures are in place.	Countrywide; coverage: national	N/A
Programme title: National Plan of Action for Children (2005-2010) Responsible agency: Ministry of Women and Children Affairs Funded by: Government of Bangladesh Time frame: 2005-2011			
Various schemes of the Ministry of Women and Children Affairs were made comprehensive under this policy initiative.	To protect children from abuse, violence, discrimination and sexual exploitation, including trafficking, within the framework of the government policies and programmes.	Countrywide; coverage: national	N/A

Table 2: Overview of key child-sensitive social protection policies and legislation in Bangladesh (continued)

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Poverty Reduction Strategy Paper (PRSP) 2009-2011 Responsible agency: Government of Bangladesh, Planning Commission Funded by: World Bank, other donors Time frame: 2009-2011			
The vision is to attain pro-poor growth and economic development that is child-centred and ensures basic rights, as well as fulfilling livelihood needs of the children of Bangladesh.	Children's advancement and protection of their rights are covered by the slogan – World Fit for Children. The strategy provides direction to proposed programmes and schemes.	Countrywide; coverage: national	A consultative process has been created where social protection is integral to the larger development framework.

Table 3: Overview of key child-sensitive social services in Bangladesh.

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: 100-day Employment Guarantee Scheme (EGS) Responsible agency: Department of Local Government, Engineering Department; Department of Social Services; other departments Funded by: Government of Bangladesh Time frame: 2008			
Inspired by India's National Rural Employment Guarantee Scheme (NREGS).	Supports incomes of the poorest community segments. Up-scaling of the 'Cash for Work' programme which generated 6,700,000 person-months of work at the cost of US$15 million in 2007-08. US$293 million has been allocated for the scheme in 2008-09.	Countrywide; coverage: to expand across the country by early 2011	Review ongoing
Programme title: Amader Shishu (Our Children) Responsible agency: Ministry of Women and Child Welfare, Department of Social Service, Ministry of Education and Government of Bangladesh Funded by: UNICEF Time frame: 7 *upazilas* (administrative units: sub-districts)			
Part of the Ministry of Women and Child Welfare, Department of Social Service work plan of 2002.	Supports orphans and vulnerable children by promoting family-based care, providing conditional cash transfers and strengthening the capacity of the social welfare system.	Children; coverage: 2,100 orphans	N/A
Programme title: Food For Work (Rural Infrastructure Development Programme) Responsible agency: Department of Local Government Engineering Department; Department of Social Services; other departments Funded by: Government of Bangladesh Time frame: 1997			
N/A	Intended to create employment for the poor through the construction and maintenance of infrastructure, as well as developing and maintaining rural infrastructure.	No specific entitlement; coverage: about 1 million participants annually	N/A

Table 3: Overview of key child-sensitive social services in Bangladesh (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Vulnerable Group Development (VGD) Responsible agency: Ministry of Women and Children's Affairs and Ministry of Disaster Management and Relief Funded by: World Food Programme (WFP) Time frame: 1997 to present			
An evolution of the Vulnerable Group Feeding (VGF) Programme.	Provides medium-term employment (18-24 months) and imparts 150 hours of training on marketable skills. The VGD programme beneficiaries are selected by local government officials.	Coverage: national. Around 750,000 ultra-poor women, across nearly 300 districts are beneficiaries.	In the 2000s, impact assessment found positive changes in beneficiaries' livelihoods, including an increase in homestead land ownership; a decline in begging; and an increase in ownership of basic household goods.
Programme title: Primary Education Development Programme-II (PEDP-II) Responsible agency: Government of Bangladesh, Planning Commission, Ministry of Education Funded by: Asian Development Bank (ADB)-led donor consortium. Time frame: 2004-2009 (until 2010 in some districts)			
Primary Education Development Programme-I (PEDP-I)	Focused on improving the quality of education and devolving education planning to the district level.	Country-wide; coverage: districts with low school enrolment rates and limited infrastructure	N/A
Programme title: Protection of Children at Risk (PCAR) project Responsible agency: Department of Social Services, Ministry of Social Welfare Funded by: UNICEF (since 2007) Time frame: 2007 to present			
PCAR is the continuation of the Appropriate Resources for Improving Street Children's Environment (ARISE) project under the Ministry of Social Welfare, with financial and technical support of UNDP from April 1999 to March 2007.	Objectives are to protect children living and working on the street without parental care from violence, abuse and exploitation, and to support the development programmes targeted at strengthening survival skills of street children.	Review ongoing	N/A
Programme title: Reaching Out of School Children (ROSC) Responsible agency: Government of Bangladesh, Directorate of Primary Education under the Ministry of Primary and Mass Education Funded by: World Bank, Swiss Development Co-operation initiated support in 2006 Time frame: From 2003			
National Plan of Action for Education for All (2001-15), and complements the government's PEDP II by identifying children who are not yet in school.	Objective to contribute to achieving the government target of universal education. Direct transfers are made in the beneficiary's name to the mother/guardian's bank account.	Coverage: focused on low-enrolment, high-poverty areas	Project encourages out-of-school children to attend learning centres called 'Ananda Schools'. In 60% of the project areas, cash stipends or educational allowances to eligible children and grants to schools are provided. In the remaining 40% grants to Ananda Schools are provided.

Table 3: Overview of key child-sensitive social services in Bangladesh (continued)

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Sarkari Shishu Paribar (State Children Home) Schemes Responsible agency: Department of Social Services, Ministry of Social Welfare (MOSW) departments Funded by: Government of Bangladesh Time frame: 1961 to present			
Bengal Orphan and Widow Act (1944) was promulgated for the management of orphanages. At the government level, the Primary Education Directorate was initially responsible for running state orphanages.	Specific objectives are to protect, and to provide food, education, training, medical care and recreational facilities for orphans.	Children with no parents or guardians; coverage: 76 *upazilas* (district)	85 state children's homes offer services to more than 10,000 orphans. A total number of 45,084 orphans have been rehabilitated through this programme as of December 2009.
Programme title: Test Relief (Rural Infrastructure Maintenance Programme) Responsible agency: Ministry of Food and Disaster Management Funded by: Government of Bangladesh Time frame: 1992 to present			
VGD and Income Generation for Vulnerable Group Development (IGVGD)	The beneficiary receives 3.5kg of food grains per day for a maximum of 30 days. The labour requirement is considerably lighter than other employment generation programmes.	Impoverished communities; coverage: more than 100,000 beneficiaries	N/A

Table 4: Overview of key child-sensitive social assistance initiatives in Bangladesh

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Abashan Project Responsible agency: Abashan Project Management in the Prime Minister's Office, Department of Social Services, (MOSW) Funded by: Government of Bangladesh Time frame: 2004 to present			
Prime Minister's Office	Rehabilitate the landless.	Vulnerable segments of society; coverage: 180 *upazilas*	21,308 beneficiary families
Programme title: Basic Education for Hard-to-Reach Urban Working Children (BEHTRUWC) Responsible agency: Ministry of Education and Government of Bangladesh Funded by: UNICEF Time frame: 2006 to present			
N/A	The programme offers basic education for urban working children aged 10-14 years focusing on comprehensive life skills.	Child labourers; coverage: 170,000 targeted urban working children in six city corporations	N/A
Programme title: Children with Disabilities Stipend Responsible agency: Department of Social Services MOSW Funded by: Government of Bangladesh Time frame: 2007 to present			
The Union Budget	Encourages children with disabilities to attend school.	Children with disabilities; coverage: national	12,000 student beneficiaries

Table 4: Overview of key child-sensitive social assistance initiatives in Bangladesh (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Secondary Education and Quality Enhancement and Access Project(SEQEAP) Responsible agency: Ministry of Education, Directorate of Secondary and Higher Education Funded by: World Bank and donor consortia, Government of Bangladesh Time frame: FSSAP initiated in 1982. FSSAP-II ended in 2008. SEQEP was launched in 61 districts in 2009, and 122 districts in 2010.			
Follow up of FSSAP-I and II, and the Primary Education (Compulsory) Act 1990	FSSAP provided stipends conditional on school attendance and attainment of a certain level in test scores, and tuition assistance to all eligible girls. Under the SEQEP, stipends and tuition are disbursed based on Proxy Means Testing (PMT) to male and female students.	Proxy socio-economic variables are used to select beneficiaries of the programme. Stipends and tuition are given to the ultra-poor students, while poor students receive tuition fees	A total of around 845,000 poor and ultra poor students are beneficiaries of the PMT programme – around 522,000 in 2009 enrolled, and 323,000 in 2010.
Programme title: Primary Education Scholarship Programme (PESP) Responsible agency: Ministry of Education, Department of Primary Education Funded by: Government of Bangladesh Time frame: 2002 to present			
Evolved from the Food for Education scheme which covered economically disadvantaged rural areas.	The largest cash transfer project in the education sector.	6,000 schools; coverage: 40% of primary-level students of each union. The PESP operates in all rural areas	More than 6 million children have benefited from PESP.
Programme title: School Feeding Programme Responsible agency: Ministry of Education Funded by: WFP Time frame: 2005-2011, subject to extension with approval of WFP Executive Board			
Education for All and PRSP.	Fortified biscuits are provided to 600,000 students of primary schools.	School-going children; coverage: by October 2009, 600,000 primary schoolchildren in over 4,000 schools	Extended to urban working children in early 2011.

Cambodia

Cambodia's core activities lie in cash and food grants, and social services. Antiretroviral treatment for mothers and children are extensively available, and Cambodia has a moderate proliferation of employment generation options for chronically ill caregivers, primarily stemming from efforts by civil society. Social insurance schemes for poor households and vulnerable groups, and an existing legal framework to protect HIV-affected children are areas of weakness.

Table 5: Overview of social protection for children affected by HIV in Cambodia

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	There are several social assistance initiatives that have been audited with favourable results by international bodies. There is substantial support for veterans' family members and the Scholarship for the Poor programme has shown between 20% and 25% higher school attendance rates.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	There is a Master Plan for Social Insurance, adopted in 2005, but it is not yet fully implemented.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	The Buddhist Leadership Initiative and other programmes providing care and support to orphans and vulnerable children affected by HIV/AIDS provide a package of support including capacity-building training, community awareness, psychosocial support and income grants in addition to education and food support. Grants are primarily geared to improve health or education access) rather than to generate income. Civil society efforts have added emphasis to income generation for caregivers, as exemplified by SEADO, Save the Children and Salvation Center of Cambodia initiatives. However, activity remains fragmented and not necessarily sustainable, given the reliance on external funding.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Moderate	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	Several national strategic plans were enacted in 2006 to respond to HIV and poverty in the population. The National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children was enacted in 2008 to target at-risk children. A national social protection strategy was developed in 2010; however, it continues to await approval.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 6: Overview of key child-sensitive social protection policies and legislation in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Alternative Care Policy Responsible agency: Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) Funded by: UNICEF technical and financial support Time frame: 2006 to present			
MoSVY	Established a hierarchy of options of care for orphans, with institutional care as a last resort and a temporary option only. Legal regulations have been implemented. However, there is no monitoring system established.	Orphans; coverage: national	Policy implementation is in the testing stage.
Programme title: National Strategic Plan for a Comprehensive & Multi-sectoral Response to HIV/AIDS from 2006 to 2010 (NSP II)Health Strategic Plan, 2008-2015 (HSP2) (BEHTRUWC) Responsible agency: National AIDS Authority Ministry of Health Funded by: Funding for the national response is provided by donors and the government of Cambodia Time frame: 2006-2010; 2008-2015			
National Strategic Plan for a Comprehensive & Multi-sectoral Response to HIV/AIDS from 2001 to 2005 (NSP I) HSP2	The NSP II details high-level goals and specific objectives to achieve them, including improved prevention coverage, with children living and working on the street as one of the target groups; increased coverage of comprehensive care, particularly home-based care and community-based care; increased impact mitigation measures, including increasing nutritional support for families affected by HIV. Aims for universal coverage by 2015.	General population, with some measures specific to HIV affected populations; coverage: national	N/A
Programme title: The National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia, 2008-2010 (to be extended to 2015) Responsible agency: The National AIDS Authority and the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) Funded by: UNICEF, UK Department of International Development (DFID), Save the Children Australia, and Family Health International Time frame: 2008-2010			
Strategic Plan, 2006-2010 (ESP 2006-2010)	Establishes five key strategies for increasing the wellbeing of the target population. The Plan does establish a nationally agreed upon a minimum package of food and support that should be provided to all orphans and vulnerable children (OVC).	Orphans, children affected by HIV and other vulnerable children; coverage: universal	N/A

Table 7: Overview of key child-sensitive social services in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Buddhist Leadership Initiative Responsible agency: Ministry of Cults and Religions Funded by: UNICEF Time frame: Established 2003			
National Policy on the Religious Response to HIV/AIDS	Training programmes for Buddhist monks in psychosocial support for people affected by HIV, mechanisms for raising awareness within their communities about HIV, and home-based care techniques.	People affected by HIV, with a particular emphasis on children; coverage: Takeo Province	In 2010, 400 monks were trained on awareness techniques and psychosocial support. Established home-based care teams of monks caring for 4,977 people living with HIV and 3,358 orphans and other vulnerable children in 329 communes (administrative units, sub-districts), in 12 provinces.
Programme title: Support for OVC affected by HIV/AIDS work platform Responsible agency: National Centre for HIV/AIDS, Dermatology and STD. NGOs (supported by Global Fund and USAID). Funded by: Global Fund, USAID are the two main donors Time frame: N/A			
National Strategic Plan for a Comprehensive & Multisectoral Response to HIV/AIDS, 2011-15 (NSPIII)	Diverse programmes which employ a range of measures to support orphans and other vulnerable children affected by HIV. Programmes provide home-based care, formal education support, transfer of school and food supplies, referral to health care and income generation grants to orphans of HIV and OVCs. They also raise awareness in communities with a high HIV-prevalence about HIV, child transmission and available treatment.	Orphans and vulnerable children	44,371 children's households received external support (UNGASS Cambodia 2010 report).

Table 8: Overview of key child-sensitive social insurance in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Master Plan for Social Health Insurance (2003-2005) Responsible agency: Ministry of Health Funded by: Various donors, NGOs Time frame: Published in 2003; updated and adopted in 2005			
Master Social Health Insurance (SHI) Plan	A policy document designed to consolidate insurance initiatives and move towards universal social health insurance. However, it has not yet been fully implemented. Various organizations still operate health equity funds (HEFs) and community-based health insurance (CBHI), both of which are the major providers for informal sector workers. CBHIs tend to reach the 'not-so-poor', while HEFs reach poorer communities.	Varies; coverage: random (although the government is aiming for universal coverage)	Not yet fully implemented

Table 9: Overview of key child-sensitive social assistance initiatives in Cambodia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: HEF Schemes Responsible agency: Ministry of Planning (MoP) Funded by: USAID, the World Bank, the Asian Development Bank (ADB), and the Royal Government of Cambodia (RGC); implemented by University Research Company (URC), UNICEF Time frame: 2002-2013			
Health Master Plan	Eligible individuals receive the costs of health care, and their transportation is covered. The patient's caregivers are also provided with stipends to cover food costs. Around 32 HEFs exist reaching about 9.8% of Cambodia's population.	Those identified as "poor" by the programme; coverage: 35 Operational Districts (ODs) across Cambodia	In cases where pre-identification was complete, utilisation rates of inpatient services were three times higher than with self-paying users. Suggested linkage between findings that 55% fewer households in districts covered by HEFs had cases of household debt due to health care costs than in the districts not covered.
Programme title: Identification of the Poor system (IDPoor) Responsible agency: Ministry of Planning (MoP) Funded by: German Technical Cooperation (GTZ) Time frame: 2007 to present (ongoing; no information indicating end date)			
Ministry of Planning Initiative	System that identifies the poorest of society, who then qualify for fee exemptions at health facilities in their area, which are run through local health equity funds (HEFs). Specific measures are in place to identify the poor through surveys and interviews. This measure facilitates fee waivers for health care and it is meant to be used for the provision of all social assistance.	Poor communities; coverage: soon to be national	A report on social safety nets, led by the World Bank, reported that a qualitative review of the IDPoor programme indicated general satisfaction with the ability of the system to properly identify the most needy in the community.
Programme title: Invalidity pensions and care services Responsible agency: Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY); Department of Veterans' Pensions; Municipal and Provincial Department of Social Affairs, Department of Finance and Supplies Funded by: The Government of Cambodia Time frame: N/A			
MoSVY work platform	Provides cash and food allowances for parents or guardians of deceased soldiers, spouses of the disabled. Retirees and people who have lost their ability to work receive an allowance of CR3,200 (proposed to be raised to CR6,000).	Veterans, the disabled, and family members; coverage: categorical	N/A
Programme title: Scholarship for the Poor programme Responsible agency: Ministry of Education, Youth, and Sport (MoEYS) Funded by: World Bank, ADB Time frame: 2006 to present			
N/A	Provides $45 and $60 grants for households with children at risk of dropping out of secondary school. Grants are conditional on school attendance. The programme is under the World Bank's Education Support Project.	Households with children at risk of dropping out of secondary school; 'very poor' of poor families; coverage: all provinces except Phnom Penh	Between 20 and 25% higher attendance rates among those who received the scholarships. The project is now being put forth as a model for conditional cash transfers in other sectors (infant health and regular hospital check-ups in particular). MoEYS has also piloted a primary school scholarship programme out of the education budget.

China

China has extensive cash and food grant programmes for vulnerable children, and a well-established legal protection for children affected by HIV. With moderate and substantial programme coverage elsewhere, China's coverage is weak in employment initiatives for the chronically ill.

Table 10: Overview of social protection for children affected by HIV in China

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Extensive	Several social assistance initiatives exist, including one specifically targeted to the caregivers of children orphaned by HIV and one for the elderly and orphans.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	There are several social insurance schemes. The national Basic Medical Insurance programme does not extend to families, but local governments are working to extend coverage to all citizens.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	Since April 2004 AIDS patients are eligible to receive free treatment, and school tuition is waived for children whose parents have died from HIV. Employment options for the chronically ill are still limited.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	China has laws at both national and sub-national levels designed to protect children's safety and give them legal rights.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 11: Overview of key child-sensitive social protection policies and legislation in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Law of the People's Republic of China on the Protection of Minors and Revision Responsible agency: Various ministries (Civil Affairs, Labour and Social Security, Health, Education, Commerce) and government bodies (National Working Committee for Children and Women, National Development and Reform Commission, China Disabled Persons' Federation) Funded by: Various Time frame: Revision effective June 1st 2007			
Adopted on September 4th 1991, effective January 1st 1992. Revision approved in 2002	Designed to protect children's personal safety in school, at home, and in all other social settings. The revised law explicitly specifies the rights of Chinese minors and calls for institutionalizing such protection. The law protects minors' rights in all institutional settings (schools, courts of law, orphanages, hospitals, etc).	All children; coverage: national	N/A
Programme title: National Programme of Action for Child Development 2001-2010 (NPA) Responsible agency: The National Working Committee for Women and Children and local governments. Funded by: Local governments Time frame: 2001-2010			
1992 ratification of the United Nation's Convention on the Rights of the Child	Formulation of policies and adoption of measures specifically targeting children. The programme states that one of its major objectives is to "improve the social security system and promote the survival and development of children in difficulties (poor children, children with disabilities, orphans, children living and working on the street)".	All children; coverage: national	N/A
Programme title: The Shanxi Province Minor Protection Regulation ("Left Behind Children" Draft Regulation) Responsible agency: Shaanxi Women's Union Funded by: Local governments Time frame: December 2nd 2008			
Adoption Law (1999 amendment)	Protect children who have been left behind in the villages while their parents go to find work in the cities. Aimed at reuniting these children with their extended families or created networks of external/institutional care.	Children with no legal guardian; coverage: Shanxi Province	N/A

Table 12: Overview of key child-sensitive social services in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Four Frees and One Care Responsible agency: Ministry of Health and local authorities Funded by: Various Time frame: Launched in 2004			
State Council Notice on China HIV/ AIDS Containment, Prevention and Control Action Plan, 2001-05, (State Council General Office Document. 2001, No. 40)	Aim to address obstacles preventing access to treatment. Provides free education to AIDS orphans and has implemented community-based treatment and care pilot projects in provinces with severe HIV epidemics, providing free counselling, screening and anti-retroviral treatment to HIV-positive pregnant women.	Vulnerable populations (people with HIV, children orphaned by HIV/AIDS, pregnant women); coverage: pilot programmes in seven central Chinese provinces	Pilot programmes implemented in high-prevalence counties covered by China CARES. Existing budgets are not sufficient and the free education for children only applies to those children who have lost both parents.

Table 12: Overview of key child-sensitive social services in China (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Project on Compulsory Education in Poor Areas (NPCE) Responsible agency: Ministry of Education Funded by: A total of Rmb12.4 billion was invested in the first phase and Rmb7.25 billion in the second phrase Time frame: Two phases: 1995-2000 and 2001-2005			
N/A	Aims to extend education providing children with basic learning needs (universal primary and lower secondary education) as a tool for long-term poverty reduction. The project provides basic school facilities, training of teachers and principals, free distribution of textbooks, and information communication technologies.	All children; coverage: 250 million children in 852 poor counties	By 2000, enrolment rates in the project counties reached 99% at the primary level and 91% at lower secondary school levels. Among the 852 project counties, 428 achieved national literacy standards, and 242 counties achieved universal primary education.
Programme title: Notice on strengthening assistance to AIDS patients, their relatives, orphaned children and lonely elders Responsible agency: Ministry of Civil Affairs Funded by: N/A Time frame: May 2004			
N/A	Promotes financial assistance to children and families, foster care and financial assistance to care givers. Stresses that children need to be raised in a family environment, which includes adoption, fostering and facilities which includes institutional care.	HIV orphans, pregnant women, vulnerable/at-risk populations, poor people in highly-affected areas, caregivers; coverage: Hubei Province	N/A
Programme title: Regulation on Free treatment for AIDS patients Responsible agency: Ministry of Health, Ministry of Finance Funded by: Local governments Time frame: April 2004			
Regulations on the Prevention and Treatment of AIDS	Poor PLWHA – urban or rural – are eligible to receive free treatment. School tuition is waived for children whose parents have died from HIV. Free testing. Pregnant women in the 31 areas with highest prevalence can receive free testing and treatment.	'AIDS orphans', pregnant women, vulnerable/at-risk populations, poor people in highly-affected areas	N/A

Table 13: Overview of key child-sensitive social insurance in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Basic Medical Insurance in Urban Areas Responsible agency: Ministry of Labour and Social Security Funded by: Basic medical insurance. Enterprises contribute 6% of the total payroll while the individual pays 2%. The system itself combines a social pooling fund and an individual account Time frame: Launched in 1998			
Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System	Medical insurance in urban areas is composed of three parts: i) basic medical insurance for urban employees; ii) free medicine; and iii) comprehensive insurance for migrants. The social pooling fund pays medical expenses of inpatients and chronic illnesses treated in clinics while the personal account pays outpatient and small illness costs.	The scheme provides for those who have jobs or are retired from jobs covered by the scheme; coverage: urban	The number of beneficiaries of free medicine is estimated at 50 million and the total outlay around Rmb38 billion. Family members are not protected by the scheme, but some local governments are trying to extend the coverage to all citizens (including underage dependants).
Programme title: New Rural Cooperative Medical Scheme (NRCMS) Responsible agency: Ministry of Health (MoH) Funded by: Through a mixture of individual, local and central government funding Time frame: Pilot programmes launched in 2003			
This scheme was first piloted in selected counties in each province with pooling at the county level	Provide basic medical coverage in rural areas. Farmers voluntarily participate by contributing Rmb10 per person per year. An equal amount for each person is added by both central and local governments. In most pilot counties the reimbursement covers the majority of inpatient costs and part of outpatient costs (for household medical care).	Rural population; coverage: 11th Five Year Plan (2006-2010) stipulates that the scheme is aims to cover more than 80% of the rural population by the end of the plan period	So far, 310 pilot projects have been launched in 30 provinces, autonomous regions and municipalities in China, involving 95 million agricultural people, while 69 million farmers have participated in NRCMS (a participation rate of 72.6%).
Programme title: Work Injury Insurance Responsible agency: Ministry of Labour and Social Security, Department of Medical Care Insurance, provides guidance while local social insurance agencies and participating enterprises administer programmes Funded by: Employer contributions vary according to three categories of industry and the assessed degree of risk. The average contribution rate in provinces is 1% of total payroll Time frame: Launched in 1996			
First law: 1951. Current laws: 1953, 1978 (permanent employees), 1986 (contract workers), 1996, 2003 (employment injury), and 2004 (rural migrants)	Temporary disability benefits, permanent disability benefits and medical benefits are given to the affected worker. Survivor benefits are given to the spouse and/or other dependants (children, parents, grandparents, grandchildren, brothers and sisters).	Employees in all enterprises; coverage: formal workforce	Family members and dependants are covered by some of the scheme's packages (permanent disability and death of provider). By the end of 2007, the total number of subscribers was 121.7 million.

Table 14: Overview of key child-sensitive social assistance initiatives in China

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Assistance for the Extremely Poor Households (Tekun) Responsible agency: Ministry of Civil Affairs, Ministry of Labour and Social Security Funded by: Central and local authorities Time frame: N/A			
N/A	*Tekun* schemes have been promoted in less economically-developed rural regions as an alternative to the *Dibao* (Minimum Living Standard Assistance) system to provide temporary relief to households impoverished by major illness or loss of family labour.	N/A	Progressively replaced by the generalization of the *Dibao* in rural areas.
Programme title: Five Guarantee Programme (Wubao) Responsible agency: Central and local authorities Funded by: Central and local authorities Time frame: Launched in the 1950s			
N/A	A collective safety net catering to the rural elderly and orphans without family caregivers or sources of income. Recipients (families) are provided with a locally-defined rate of benefits in cash and in-kind.	Rural elderly and orphans without family caregivers and sources of income	N/A
Programme title: Minimum Living Standard Assistance (MLSA, or Dibao) Responsible agency: Ministry of Civil Affairs through city authorities (civil affairs departments) Funded by: A large part from the central government, the rest from local authorities Time frame: Launched in 2003 for urban households and 2007 for rural households			
The first Minimum Living Standard Scheme (MLSS) was launched in Shanghai in June 1993, reaching 207 cities by July 1997	The *Dibao* programme provides regular cash and/or in-kind support to poor households up to a locally defined poverty line which is based on a means test. The programme ensures a basic safety net for poor urban households.	Households whose per capita income falls below a locally-determined minimum level; coverage: 22.5 million beneficiaries	Excludes unregistered migrants. Local authorities have called for a revision of the means test (toward standardised poverty line).
Programme title: Provision of financial subsidies to families who care for HIV/AIDS orphans Responsible agency: Ministry of Civil Affairs Funded by: Local governments Time frame: N/A			
N/A	Provides financial support to families who care for children orphaned by HIV/AIDS.	Caregivers of children orphaned by HIV/AIDS	Dedicated funds for this group have not yet been fully distributed, but national authorities are in the process of setting measures to do so.
Programme title: Two Frees One Subsidy Responsible agency: Ministry of Education Funded by: N/A Time frame: Launched in 2004, extended in 2005			
N/A	Provides compulsory education to pupils from poor families with free textbooks. Exempts them from paying miscellaneous fees, makes boarding schools affordable, grants living allowances.	Children in poverty-stricken rural areas	Between 2006-07 the abolition of miscellaneous fees for compulsory education was extended to all rural areas in central, eastern and western China.

Indonesia

Indonesia has established social protection for children in the form of cash and food grants for at-risk children, and antiretroviral treatments for mothers and children. However, other social services including the provision of health care, education, welfare, work options for the chronically ill, and psychosocial support remain limited.

Table 15: Overview of social protection for children affected by HIV in Indonesia

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	There are several social assistance programmes in Indonesia and although the programmes have faced some challenges in deployment, overall results look promising. Currently 12 million households are benefiting from the Rice for Poor Households programme.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Moderate	Jamkesmas, which is a nationally run health insurance scheme for the poorest segment of society, though only around 17 % of Indonesians are covered under this plan. Plans are in the works for a reform.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Substantial	HIV-sensitive social services are limited in Indonesia, though there has been significant expansion in the provision of ART to adults. Child protection and HIV responses have been quite distinct to date.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Limited	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	Several national strategies and policies have been written that either do not have national authority or were not implemented. The National HIV and AIDS Strategy and Action Plan does not currently have recorded results.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Moderate	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 16: Overview of key child-sensitive social protection policies and legislation in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: 2010-14 National Medium-Term Development Plan (RPJMN 2010-2014) Responsible agency: Multiple agencies Funded by: Government of Indonesia Time frame: 2010-2014			
Second implementation phase of 2005-2025 National Long-Term Development Plan (RPJPN 2005-2025)	Serves as the basis for all of the ministries' individual strategic plans, focusing overall on building democratic structures and economic growth. Although child protection is not one of the top 11 priorities, it is one of the four cross-cutting issues listed for attention.	Poor communities across the country, with a focus on underdeveloped regions as a whole; coverage: national	N/A
Programme title: Law on Child Protection No. 23 2002 Responsible agency: Ministry for Women's Empowerment Funded by: N/A Time frame: 2002 to present			
N/A	Details a series of rights for children, including the right to education and health care, to protection from violence and discrimination, and the government's obligation to protect children from exploitation.	Children; coverage: national	N/A
Programme title: National HIV and AIDS Strategy and Action Plan 2010-2014 Responsible agency: National AIDS Commission Funded by: N/A Time frame: 2010-14			
National HIV and AIDS Action Plan 2007-2010	The policy has four focus areas: prevention; care, support, and treatment; impact mitigation; and conductive environment. It identifies 137 high-risk districts for focus. While the strategy mentions support for orphans and other vulnerable children, children are not addressed in any great detail.	Sex workers, injecting drug users, men who have sex with men (MSM), children living and working on streets; coverage: national with particular focus on 137 high-risk districts	No results yet available
Programme title: Special Policy in Combating HIV and AIDS in Children Responsible agency: Policy was endorsed at the directorate level Funded by: N/A Time frame: Written in 2007			
N/A	Policy focuses on: • Conducting HIV-prevention education initiatives • Increasing the capacity of families to provide economic and psychosocial support to vulnerable and affected children • Guaranteeing access to essential services across sectors • Building community support and acceptance for children and families affected by HIV • Increasing the use of social service facilities • Increasing participation of children in planning	Children affected by HIV, and other vulnerable children; coverage: national	Endorsed at the directorate level, this policy does not have national authority. No data available on implementation

Table 17: Overview of key child-sensitive social services in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: CAKAP Merauke (HOPE programmes in Papua) Responsible agency: World Vision Funded by: World Vision Australia Time frame: N/A			
N/A	Aims to improve the quality of HIV and AIDS programming in Papua by providing correct knowledge and practical skills.	Faith communities in Merauke, Wamina, and Jayapura, all in Papua; coverage: same	N/A
Programme title: CAKAP Sambas (Prevent AIDS with Love and Care in Sambas) Responsible agency: World Vision Funded by: World Vision Netherlands Time frame: 2009-2012			
N/A	Aims to reduce and prevent the impact of HIV and AIDS; and child and female trafficking.	Youth aged 13-18 years, and AIDS affected people; coverage: Sambas, Borneo	N/A
Programme title: Child Welfare Services Programme (Pelayanan Kesejahteraan Sosial Anak) Responsible agency: Ministry of Social Affairs Funded by: N/A Time frame: 2009 to present			
N/A	N/A	Children; coverage: national	N/A

Table 18: Overview of key child-sensitive social insurance in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Jamkesmas Responsible agency: Social Security Management Agency (Badan Pengelola Jamin Sosial or BPJS) Funded by: Government of Indonesia Time frame: 2008 to present			
Implementation of Law No. 40/2004 on National Social Security System; 2008 Health Insurance Law	Programmes that provide health care fee waivers and reimbursements for the poorest of society. Payment mechanisms vary regionally between fee waivers and disbursements.	'Poor'; coverage: national	Only covers 17% of the population. Out-of-pocket health care spending remains among the highest in the region.
Programme title: Jamsostek Responsible agency: Ministry of Manpower and Transmigration Funded by: Employees and private employers Time frame: 1995 to present			
Government Decree No. 36 in 1995	Benefits are provided for old-age, permanent disability, survivors, and minimal health coverage. There is an opt-out clause for private sector companies with alternative coverage.	Private sector employees of employers with a workforce of 10 or more; coverage national	Currently covers 1.3% of the population, of a potential 40-50% of private sector workers.

Table 19: Overview of key child-sensitive social assistance initiatives in Indonesia

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Direct Cash Assistance (Bantuan Langsung Tunai, BLT) Responsible agency: Co-ordinating Minister for People's Welfare the co-ordinating organ; Ministries of State Development Planning; of Social Affairs; Home Affairs; and of Communication all involved in the implementation Funded by: Government of Indonesia Time frame: 2005; six months			
Instructions of the President No. 2/2005	Provided direct cash transfers to poor families in an attempt to mitigate the economic shock of the removal of government gas subsidies. Poor households were classified as households where monthly per capita expenditure was lower than Rp175,000 (US$17 at the time). Such households received Rp100,000 per month for six months. Until 2006 it was the largest cash transfer programme ever undertaken worldwide, in terms of coverage and total volume of transfers. Due to a lack of formal household income data, they used 14 proxy indicators of household expenditure, collected from the annual national socio-economic survey, Susenas.	All households with a monthly expenditure lower than Rp175,000; coverage: national	Although 94% of funds reached the intended beneficiary, nearly all village heads surveyed in an after programme assessment reported that the programmes created social unrest, and made it more difficult for the local governments to ask community members to participate in mutual assistance programmes.
Programme title: Household Conditional Cash Transfer Programme or Family Hope Programme (PKH) Responsible agency: Ministry of Social Affairs Funded by: N/A Time frame: 2007 to present			
N/A	Provides conditional cash transfers to households classified as 'poorest'. The funds are conditional on families meeting specific health- and education-related obligations. Local health facilities and schools report lack of compliance. If the recipients continue to fail to meet their obligations after a set number of warnings the transfer of funds is terminated. The money is managed and distributed by local post offices.	'Poor' and 'poorest' households in which there is a pregnant mother or elementary school-aged children; coverage of only certain provinces across Indonesia, chosen through a complex selection process	No systematic data is available. Qualitative studies say that the programme has provided some assistance to families, but still does not address the underlying issues of poor health and educational facilities in rural areas.
Programme title: National Independent Community Empowerment Programme or Community Conditional Cash Transfer programme (PNPM) Responsible agency: Coordinator Ministry for the People's Welfare Funded by: World Bank, Government of the Netherlands, and several other small donors Time frame: 2007 to present			
N/A	Builds on the decentralization process in Indonesia to empower local groups to contribute to the development of their community. Creates community planning processes in which local poverty issues are identified. All proposals are from local citizens.	Poor communities across the country; coverage: national, however has not yet been scaled up to reach all rural communities	By 2008 PNPM had funded more than 180,000 infrastructure, economic, and social development projects. The majority appear to have been concentrated on infrastructure and environmental management. There have also been allegations of 'leakage' of funds from the programme, totalling up to Rp100 billion from the start of the programmes in 2007 through mid-2010.

Table 19: Overview of key child-sensitive social assistance initiatives in Indonesia
(continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Rice for Poor Households (known as Raskin) Responsible agency: National Food Logistics Agency (BULOG) Funded by: Government of Indonesia; funded by the extra cash flow from the reduced oil subsidy in 2005 Time frame: 1998 to present			
The successor of the Special Market Operation (OPK) programmes	Originally created in response to the 1997 financial crisis. Distributes rice to households identified as needy in the national government's Central Statistics Agency's data on Poor Households. Each household is entitled to 20kg of rice per month (though there are reports that some have received less due to popularity of the scheme).	'Poor households', as determined by nationally gathered government data through the Central Statistics Agency (BPS)'s data on Poor Households; coverage: national	The programme was originally intended to reach 8 million households, but by 2006 the number of beneficiary households had expanded to 12 million. Problems have included: ineffective targeting; high costs of programme management; poor monitoring and evaluation to measure results; and a low programme transparency.
Programme title: School Operational Aid programme (locally known as BOS) Responsible agency: Ministry of National Education Funded by: Government of Indonesia; the World Bank funds a supporting programme called BOS-KITA to improve transparency Time frame: 2005 to present			
N/A	Direct cash transfer programmes for schools, providing funds that are intended to help buy resources to expand and improve the quality of education. One of the goals is to ensure compliance with the compulsory education rule for children through Grade 9.	Children ages 7-15; coverage: national	The programme is viewed as successful, but in need of adjustments. The programme has had a positive impact on attendance rates and motivation of the poor in school, with government reporting a fall in the dropout rate by 3%. There have also been problems with the misuse of funds.
Programme title: Special Student Assistance (Bantuan Khusus Siswa or BKM) Responsible agency: Ministry of National Education Funded by: Government of Indonesia Time frame: 2003 to present			
N/A	Aims to reduce dropout rates by providing students with monthly stipends. Beneficiaries are identified by the school board. The national government sends cash payments directly into the target students' accounts at their respective schools.	Poor students at risk of dropping out of school	In 2003, the programme spent Rp48,600 million to help 683,550 students.

Nepal

Nepal has either substantial or moderate programme coverage across the spectrum of social services, with strengths in the areas of cash and food grants, explicit rights for access to services for children affected by HIV, and the provision of health care, education, welfare and other social services for vulnerable children. In terms of implementation, civil society activity is dominant.

Table 20: Overview of social protection for children affected by HIV in Nepal

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Education For All Scholarships provide incentives for households to encourage children's enrolment in schools. Focuses on disadvantaged groups.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Moderate	The Public Health Concern Trust reaches 45,000 families with no ethnic, race or caste restrictions.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	HIV prevention programmes within the country have received favourable monitoring reports, and free services and drugs are available to people living with HIV/AIDS (PLWHA) in certain regions of the country.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Moderate	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	Nepal features a number of examples to incorporate children's issues into recent policies and legislation, including the Three Year Plan, Constitution drafting, and a drafting process towards a National Social Protection Framework and initiatives, such as Child Friendly Local Governance.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Moderate	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 21: Overview of key child-sensitive social protection policies and legislation in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Children's Act (1991) Responsible agency: Ministry of Women, Children and Social Welfare (MWSW) Funded by: N/A Time frame: From 1991			
N/A	Specifies the obligations of guardians and other members of society to ensure the rights of children to nutrition, health, education and humane treatment.	All children; coverage: national	From 2001, at least seven schemes have been launched at the national level to address the rights of children, with three focussing on education, one on child labour rehabilitation, one on vulnerable children in urban areas and two addressing home-based care.
Programme title: Child-friendly Governance Initiative Responsible agency: Ministry of Local Development Funded by: N/A Time frame: From 2008			
N/A	Objective to address the needs of vulnerable children at the municipal and city level.	All children; coverage: sub-national	Children's issues have been incorporated into new policy documents. including the municipal plan and poverty reduction strategy in the five pilot municipalities of Jumla, Dang, Sunarai, Tanahu, Kavre and Biratnagar in 2008.
Programme title: National HIV/AIDS Strategy Responsible agency: Ministry of Health and Population (MoHP), National Planning Commission and Government of Nepal Funded by: N/A Time frame: 2006-2011			
N/A	Focuses on universal access and prevention, treatment and care to support at-risk populations and PLWHA.	Specific focus on high risk populations; coverage: national	HIV/AIDS has been accorded high priority in national policy. Yet, around 90% of AIDS spending is being managed outside the public sector. An HIV-specific (rather than sensitive) approach to develop a National Strategy on Children Affected by AIDS (CABA) is in development.
Programme title: National HIV/AIDS Action Plan Responsible agency: HIV/AIDS and STD Control Board Funded by: Grants from United States Agency for International Development (USAID), UK Department of International Development (DFID), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Round 2, 7, and components within the World Bank's revised Health Sector Programme commencing in 2010 Time frame: 2008-2011			
N/A	Implementation plan for the National HIV/AIDS Strategy, with a focus on youth-friendly and targeted services to reach most-at-risk populations (MARPs).	Emphasis on MARP; coverage: national	The epidemic is levelling off in some most-at-risk populations, but there remain concerns around the epidemic evolving and trickling down to the youth.

Table 22: Overview of key child-sensitive social services in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash for Work: One Family, One Employment Responsible agency: Ministry of Local Development (MLD) through district development committees (DDCs) or village development committees (VDCs) Funded by: Government of Nepal Time frame: 2005 to present			
N/A	Funds are disbursed among the 30 VDCs in the Karnali zone. Applicants form a team with at least five unemployed people from separate families and submit a project proposal. Unemployed persons in remote parts of the country are offered jobs yielding between NRs180 and NRs350 per day.	30 VDCs in the Karnali region; coverage: Karnali Zone (Mid-Western Development Region)	Within the 2008/09 budget year, 270,000 people received employment for 100 days through a 'labour-oriented development programme', based on people's participation, local infrastructure development programmes and the Karnali Employment Programme.
Source policy/ initiative	**Brief overview/specific measures**	**Target group/coverage**	**Results/outcomes**
Programme title: HIV/AIDS Prevention among Labour Migrants and Young People and Care for affected Responsible agency: Ministry of Health of Nepal Funded by: GFATM (Round 2) Time frame: 2006-2008			
N/A	Access to services and free drugs; prevent HIV infection from spreading among migrant labourers and young people; and provide care and support to PLWHA.	Migrant labourers, youth, and to provide care and support to PLWHA; coverage: eight districts along the border between Nepal and India	Vulnerable communities were provided access to knowledge, services and drugs. It received a good rating in GFATM quarterly monitoring reports.
Programme title: Integrated Food Security Project within the Rural Community Infrastructure Works Programme (RCIW) Responsible agency: Ministry of Local Development (MLD) Funded by: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), now Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) Time frame: 1996 to present			
N/A	To improve the food supply situation of about 40,000 food-deficit families annually. The project provides rice as a remuneration for the participation of family members in Food for Work (FfW) projects.	Coverage: 25 districts with roughly 1,200 self-help groups in about 1,000 food-deficit villages	More than 2,000 new permanent jobs were created. More than 250,000 food-deficit households found temporary employment for about three months. Improved the self-help capacity of more than 1,200 groups, each comprising about 150 poor rural families.
Programme title: Scaling Up Coverage and Quality of HIV & AIDS Prevention targeted to Most at Risk Population and Treatment Care and Support Services to PLWHA Responsible agency: Save the Children USA, Himalayan Country Office as principal recipient Funded by: GFATM (Round 7) Time frame: 2008-2010			
N/A	Access to services and free drugs.	Vulnerable populations and PLWHA; coverage: west, mid-west and far-west development regions of Nepal	Improvement in health systems, health delivery, targeting ARV drugs and creating systems for delivery. It received a good rating in GFATM quarterly monitoring reports.

Table 23: Overview of key child-sensitive social insurance in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Public Health Concern Trust (PHCT) Responsible agency: PHCT, monitored by MLD for legal compliance Funded by: Village development committees receive donations from donors and the government to supplement premiums Time frame: 1992 to present			
N/A	Established as a cooperative. Members must deposit between 25 to 50 paisa per day (equivalent of US$1.2 to US$2.4 per year). A co-payment structure has members pay 50% of the cost of each treatment. 80% of the cost of a general annual medical check up is covered. Children, orphans and the elderly given subsidized medicines and free check ups.	Families, no ethnic, race or caste restrictions; coverage: more than 45,000	Widely considered as a model of good practice in Nepal.

Table 24: Overview of key child-sensitive social assistance initiatives in Nepal

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Child grant cash transfer Responsible agency: MLD implementation, has links to National Planning Commission (NPC) and MOHP Funded by: Government resources, complementary funds for system and capacity building from UNICEF and Asian Development Bank (ADB) Time frame: Initiated late 2009, first round implemented mid-2010			
N/A	Child grants to promote right-based approach and social cohesion. Linkages to birth registration and nutrition.	Children 0-5	First round in 2010 had high coverage due to complimentary birth registration.
Programme title: Child Labour Elimination Fund Responsible agency: Ministry of Labour and Transport Management (MLTM), municipal offices Funded by: Government of Nepal, International Labour Organization or ILO (the IPEC Core TBP Project supported by the US Department of Labour) and UNICEF Time frame: 2006 to present			
N/A	A mix of schemes offered to households to encourage children to attend schools.	Working children between 5-14 years of age; coverage: 1,000,000 children nationwide	N/A
Programme title: Education For All Scholarships Responsible agency: Ministry of Education (MoE)/ school management committees Funded by: Government of Nepal Time frame: 2004 to present			
N/A	Providing incentives for households to encourage children's enrolment in schools (NRs400 per year).	National programme; coverage: Dalit children, girls (50% dis-advantaged), disabled, Karnali, marginalized and conflict-affected children	N/A
Programme title: Food for Education Responsible agency: Ministry of Education and Sports Funded by: World Food Programme Nepal Time frame: January 2002 to present			
N/A	Increase access to basic education for families in food-deficit districts with high educational needs, and improve the health and nutritional status of school children.	Poor communities and households; coverage: Hills District in the far Western Development Region	For the 2002-2009 period, the World Food Programme implemented operations worth US$282 million; and the portfolio grew significantly from US$25 million to US$98 million.

Table 24: Overview of key child-sensitive social assistance initiatives in Nepal
(continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Government education scholarship Responsible agency: Funded by donors, but funds are channelled through the government Funded by: Government of Nepal Time frame: 1999 to present			
N/A	The primary scholarship programme is aimed at improving access to education for Dalits and disadvantaged girls, quality and management efficiency of basic and primary education in Nepal.	Dalits and disadvantaged girls (50% of those in disadvantaged groups); coverage: entire country	Large-scale misappropriation has been reported in some districts. Also, uneven disbursement has made it difficult for school administration and students to sustain education efforts.
Programme title: Reaching the Most Disadvantaged Groups in Mainstream Rural Development Responsible agency: Department of Women Development, (DWD), Ministry of Women, Children and Social Welfare (MWCSW) Funded by: Funded and designed by ADB Time frame: Completed: 2007-2009			
N/A	Reduce extreme poverty and discrimination among 1,000 of the most socially and economically disadvantaged households through increased effective participation of women. Conditional cash transfer to meet the urgent needs of households (livelihood protection); NRs1200 transfer per month to families with orphans and vulnerable children.	Most disadvantaged households, including those from ethnic and low-caste groups; coverage: four districts of rural Nepal, Bajhang, Jumla, Mahottari and Rahuthahat	Slow uptake and poor absorption of funds delayed the desired trickle-down effect from the project. According to ADB's internal evaluation report, the project strengthened capacity of local bodies, including the most vulnerable households and improved the ability of households to participate.
Programme title: Support to Safe Motherhood Programme (SSMP)/Safe Delivery Incentive Programme (SDIP) Responsible agency: Ministry of Health and Population Funded by: Ministry of Health with support from DFID and NGOs Time frame: January 2005 to present			
N/A	To improve maternal and newborn health and survival, especially for the poor and excluded. The Department of Health Services (Ministry of Health) allocates funds to the districts. The District Public Health Office provides parts of the funds to health institutions for distribution. The health management committee distributes the incentives. Some districts (six) provided emergency obstetric care (EMOC) support.	Adolescent girls and women. All pregnant women and birth attendants; coverage: 19 districts	Some key targets have been achieved. Institutional deliveries have increased, maternal and infant mortality rates have decreased in 25 districts.
Programme title: Welcome to School (WTS) campaign under Education for All Responsible agency: Ministry of Education and Sports (MOES) Funded by: UNICEF Time frame: 2004 to present			
N/A	Increase and hold enrolment rates, especially among female students.	Poor communities and households; coverage: national	In addition to scholarships awarded to girls, some 125,000 scholarships were provided for first time learners by the Ministry of Education and Sports.

Pakistan

Pakistan's social protection offerings are limited in several areas: social insurance for vulnerable groups, employment initiatives for the chronically ill and established legal protection for children affected by HIV. Social protection coverage is moderate in other areas, including cash and food grants, ART availability, and silence on the rights of access to essential services for children affected by HIV.

Table 25: Overview of social protection for children affected by HIV in Pakistan

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Moderate	The Punjab Food Support Scheme has shown increased school enrolment, and the Benazir Income Support Programme specifically targets women without male support.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	There are several insurance schemes available, but only one extends to workers' children, and there is evidence of 'leakage' of funds within the programmes.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	A 100-day employment scheme has been announced, but not yet initiated. A People's Works programme has resulted in a 42% growth in infrastructure projects, but this is commonly work unsuitable for the chronically ill.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Moderate	With limited legal rights conferred to the child, the legal framework for children affected by HIV remains weak.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 26: Overview of key child-sensitive social protection policies and legislation in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Strategic Framework Responsible agency: Ministry of Health, National AIDS Control Programme (NACP) (MLTM), municipal offices Funded by: More than US$17 million has been spent on HIV since 2007, with 97% from external sources and 3% from the government. DFID will fund HIV until 2011, while the World Bank has agreed to fund HIV through a pooled funding mechanism (UNGASS, 2010) Time frame: 2007-2011			
National AIDS Policy (1995)	It aims to broaden the scope of HIV/AIDS control efforts in the country to include women, children and young adults, and stresses the need for the support of spouses and children of key populations.	Entire country, with specific focus on high-risk populations and pregnant women; coverage: national	N/A

Table 27: Overview of key child-sensitive social services in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Rural Support Programme (NRSP) Responsible agency: NRSP Funded by: Government of Pakistan and donor consortia Time frame: Completed: 1991 to present			
N/A	NRSP works with more than one million poor households organized into a network of more than 12,000 community organizations, helping the community to identify and financially support activities to address specific needs.	1.4 million rural men and women; coverage: national;	The Punjab Government expanded the NRSP education project into Punjab Education Sector Reform Programme (PESRP). The programme covers 4,335 schools in Punjab.
Programme title: Socio-economic Development of Destitute and Neglected Children's Families (SDDNCF) (sub-segment of the NRSP) Responsible agency: NRSP Funded by: Government of Pakistan and a donor consortia Time frame: November 1st 2008 - October 31st 2011			
N/A	Project components include small-grant assistance for income generation activities; vocational and technical skills training and microcredit support.	10,250 households; coverage: five pilot districts in Punjab	N/A
Programme title: People's Works Programme Responsible agency: Ministry of Labour, and various other ministries Funded by: Government of Pakistan and a donor consortia Time frame: 2001 to present			
Termed the Khushal Pakistan Programme (KPP) and Tameer-e-Watan Programme in the tenures of the Pervez Musharraf and Pakistan Muslim League (PML) governments respectively	Targeting unskilled labour, the main objective is to provide income support to the poorest households through guaranteed employment of up to 100 days in the year.	Eligible labour force, unskilled workers in poor households; coverage: national	Growth of 42% recorded in terms of infrastructure projects initiated. Based on this, the government has announced two schemes that are not yet implemented. A National Employment Guarantee Scheme (NEGS) for the poor and the Graduate Employment Scheme (GES) for graduates in the country.

Table 28: Overview of key child-sensitive social insurance in Pakistan

Source policy/initiative	Brief overview/ specific measures	Target group/coverage	Results/ outcomes
Programme title: Employees Old Age Benefits Institutions (EOBI) Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1976 to present			
Announced in 1967, but introduced in 1976	N/A	Pensioners from government and public sector organizations; coverage: national	N/A
Programme title: Government Servants Pension Fund Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1954 to present			
Union Budget 1953/54	N/A	Government servants with 20 years or more work experience; coverage: national	N/A
Programme title: Provincial Employees Social Security Scheme (Employees Social Security Institutions) Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1967 to present			
Introduced in the Union Budget 1964, but operationalised in 1967	N/A	Provincial employees and public-sector employees; coverage: national	N/A
Programme title: Public Sector Benevolent Funds and Group Insurance Responsible agency: Ministry of Labour Funded by: Employee-funded Time frame: 1969 to present			
Planning Commission recommendation to Ministry of Finance and Ministry of Labour, presented in Union Budget 1968	N/A	Public-sector employees; coverage: national	N/A
Programme title: Workers Welfare Funds (WWF) Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1971 to present			
Announced in 1969 budget but deferred due to aggression with India. Effective introduction in 1976	N/A	Workers in heavy industry; coverage: national	N/A
Programme title: Workers' Children Education Ordinance Responsible agency: Ministry of Labour and Department of Personnel Funded by: Employee-funded Time frame: 1972 to present			
Announced in 1968 budget but introduced in 1974	N/A	All workers' children eligible for primary and secondary education; coverage: national	N/A

Table 29: Overview of key child-sensitive social assistance initiatives in Pakistan

Source policy/ initiative	Brief overview/specific measures	Target group/coverage	Results/outcomes
Programme title: Benazir Income Support Programme (BISP) Responsible agency: Government of Pakistan Funded by: Government of Pakistan and USAID Time frame: 2008 to present			
The BISP is a new initiative undertaken by the present government	Provides unconditional cash grants to the poorest families in the country. BISP has been initiated with an initial allocation of PRs.34 billion (US$425 million approximately). It is aimed at covering almost 15% of the entire population, which constitutes an estimated 40% of the population below the poverty line.	Widows and divorced women, without adult male members in the family. Any physically or mentally impaired person in the family; any family member suffering from a chronic disease; coverage: national	N/A
Programme title: Child Support Program Responsible agency: Ministry of Social Welfare and Special Education Funded by: World Bank, DFID Time frame: 2006-2010, started as a pilot			
Bait-ul-Maal Act and Programme	N/A	Poor households with children aged 5-12 enrolled in primary school; coverage: in the 2005-06 period, 125,000 households received the benefit.	The programme is projected to scale up by 10% in fiscal year 2008/09; by 30% in 2009/10; by 60% in 2010/11; and by 100% in 2011/12.
Programme title: Pakistan Bait-ul-Maal (PBM) Responsible agency: Ministry of Social Welfare and Special Education Funded by: Government of Pakistan Time frame: 1992 to present			
Under Bait-ul-Maal Act of 1991	N/A	Poor households with young children (5-12 years of age); coverage: in 2008/09, the programme was expanded to districts including Rawalpindi, Multan, Nawabshah, Abbottabad, Kharan, Quetta, Ghanchey and Muzaffarabad	This programme targets the 'deserving needy', but no objective targeting tool (such as proxy means testing) is used. According to the World Bank (2007), "around 27% of *guzara* (monthly cash allowance) beneficiaries and 37% of those receiving rehabilitation grants are not poor, accounting for 32% and 45% of the resources distributed under each modality".
Programme title: Punjab Education Sector Reform Program/Punjab Female School Stipend Program Responsible agency: Ministry of Education Funded by: World Bank, DFID, World Food Programme (WFP) Time frame: 2004 to present			
National Education Policy 2002	N/A	Girls at secondary-school level. Enrolment from grades 6-8 in government girl's schools; coverage: implemented in selected districts of Punjab	Reached 542,259 girls in 2009.

Table 29: Overview of key child-sensitive social assistance initiatives in Pakistan
(continued)

Source policy/ initiative	Brief overview/specific measures	Target group/coverage	Results/outcomes
Programme title: Punjab Food Support Scheme (PFSS) Responsible agency: Government of Punjab Funded by: Provincial government with assistance from donor consortia Time frame: N/A			
N/A	N/A	Coverage: Punjab province	The programme drove school enrolment by 11.1%. The average programme impact between 2003 and 2005 was an increase of six female students per school. Female middle-school enrolment rate increased from 43% (baseline 2003) to 53% in 2005. The share of female enrolment in government primary and middle schools increased from 45% in 2003 to 50% in 2005, and female dropout rates between grade 5 and 6 decreased by 25%, and they in middle school decreased by 20%.
Programme title: Zakat Responsible agency: Ministry of Religious Affairs, Ministry of Finance has created a Ministry of Zakat and Ushr in 2009. New governance is unclear Funded by: Government of Pakistan Time frame: 1980 to present			
Central Zakat Council allocates funds to the National Zakat Foundation (NZF)	N/A	The NZF provides grants to NGOs for rehabilitation of widows, orphans and the disabled; coverage: national	N/A

Papua New Guinea

Given that social protection is a fairly nascent area of policy and programming in the country, Papua New Guinea has the most areas of limited social protection coverage, with social assistance and social insurance programming being limited and little legal framework for children affected by HIV. However, legislation is currently being enacted that should support the most vulnerable children and health provisions are substantial. There are very moderate provisions for education and psychosocial support for HIV-affected children, but little in the way of documented results as yet.

Table 30: Overview of social protection for children affected by HIV in Papua New Guinea

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Limited	UNICEF conducted a feasibility study that shows that a cash transfer model would be successful in Papua New Guinea, but programming is currently limited.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Limited	Social insurance excludes short-term workers and non-citizen participation is voluntary.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	ARV access is fairly well developed by the government and the church, but other social services are less available. Mother-to-child transmission prevention services are being scaled up in more antenatal care (ANC) centres. In 2010, 45 of the 270 ANC sites also offered mother-to-child transmission prevention services; 9 of 59 ART treatment sites also offer paediatric HIV services.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Moderate	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Substantial	A National Strategic Plan on HIV covers prevention, care and community support and a Child Health Plan addresses health issues such as access to ARV and preventing mother-to-child transmission. In 2010, the Operational Plan for PPTCT (prevention of parent-to-child transmission) and Paediatric AIDS for 2011-15 was approved, containing a framework for action to meet universal access targets by 2015.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Limited	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 31: Overview of key child-sensitive social protection policies and legislation in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Lukautim Pikinini (LP) Act Responsible agency: Office of the Director of Lukautim Pikinini in the Department for Community Development Funded by: Government of Papua New Guinea with support from UNICEF Time frame: Enacted in March 2010			
Lukautim Pikinini Act 2009	Contemporary, rights-based child protection legislation. Prohibits institutional care for orphans and other vulnerable children, and recognizes that those groups need rights-based care. Additionally, while parents have a primary mandate to care, this mandate goes to the state if the parents are unable or unwilling.	All children; coverage: national	No measurable results to date; National Lukautim Pikinini Coucil not yet launched; rolling out of training on the LP Act is underway, with the aim to fully develop mechanisms in 2011. measurable results to date; National Lukautim Pikinini Coucil not yet launched; rolling out of training on the LP Act is underway, with the aim to fully develop mechanisms in 2011.
Programme title: National Child Health Plan Responsible agency: Child Health Advisory Committee (CHAC), within the Department of Health Funded by: Supported by WHO/UNICEF initiatives Time frame: 2008-2015			
N/A	A plan built in response to the WHO/UNICEF Child Survival Study conducted in 2006; implementing the majority of recommendations from the study. It focuses on expanding programme of immunization into rural areas, preventing parent-to-child transfer of HIV, increasing hospital access to ARVs nationwide, and increasing coordination between the national and local levels for Integrated Management of Childhood Illness. High-level programmatic plans for a range of child health issues, including HIV. Detailed information to be collected for monitoring and evaluation, as well as planned trainings. It does not delegate responsibility for monitoring to specific governmental bodies or groups.	Children; coverage: national	N/A

Table 31: Overview of key child-sensitive social protection policies and legislation in Papua New Guinea (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Strategic Plan on HIV/AIDS 2006-2010; National HIV and AIDS Strategy 2011-2015) Responsible agency: National AIDS Council Funded by: N/A Time frame: 2006-2010, 2001-2015			
N/A	High-level strategy from prevention through care and treatment. The majority of the 2006-10 framework focuses on the Papua New Guinea population at large or HIV-infected patients, although the section on family and community does prescribe youth-friendly prevention information. For 2011-2015. The National AIDS council has developed a more comprehensive response framework to minimize the impact on individuals, families and communities, and to increase awareness for children who are vulnerable to sexual exploitation.	General population; some components specifically for HIV-infected citizens or HIV-affected communities; coverage: national	N/A
Programme title: Protection, Care, and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea (2008 -2011) or Protection for Vulnerable Children Strategy Responsible agency: Department for Community Development, Government of Papua New Guinea Funded by: N/A Time frame: 2008-2011			
Protection, Care, and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea (2008-2011) or Protection for Vulnerable Children Strategy	High-level policy document, detailing the current situation of vulnerable children within the context of HIV in Papua New Guinea, and also enumerating policy objectives and strategies to meet them. It advocates piloting a social cash transfer programme for the most vulnerable families, and making the formal alternative care system more restricted and child-friendly.	Most-vulnerable children; coverage: national	N/A

Table 32: Overview of key child-sensitive social services in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Most Vulnerable Children Programme Responsible agency: Catholic Diocese of Kundiawa Funded by: Catholic Church with funding from UNICEF (broader HIV and AIDS programmes funded by Australian Agency for International Development, AusAID) Time frame: N/A			
N/A	Members of the church monitor households with HIV-positive parents, and provide support as necessary. Support may include school fees, childcare if parent dies, etc. All volunteer-based. Community awareness to help combat the social stigma of HIV. Care provided to children done in a stigma-sensitive manner. Case-management care includes any measures needed for the patient to have sustainable care: i.e. transportation assistance, water purifying mechanisms, etc.	Children of HIV-infected parents; coverage: sections of the Simbu Province (not fully documented)	Does not appear to have any formally documented results. However anecdotal evidence shows the programme has been successful in providing support for children while avoiding the social stigma often caused by HIV-related social support.
Programme title: Rural Initiative Program Responsible agency: Pilot programme commissioned by the Department of Health; implemented by the Clinton Foundation Funded by: AusAID Time frame: Operating since 2007 (received extension through Global Fund 2010, end date unknown)			
Self-directed	The pilot programme aimed to build a model for providing access to high-quality HIV testing, care and treatment to rural areas in Papua New Guinea. The programme focuses on providing total care to patients by training health extension officers (HEO) in case management and providing support in secondary aspects to treatment, such as stipends for transportation, rain water catchment units to purify water, micro-loans for food or income generating activities to mitigate the economic impact of HIV-related stigmas.	HIV-infected population in the Eastern Highlands; coverage: Eastern Highlands; the programme is being expanded to the Southern Highlands	Opened the first government operated District Health Centre ARV Clinic in Papua New Guinea, followed by many others. Improve paediatric care: from 1 patient on ARV in January 2007, numbers have increased to 60 positive children in care and 35 on treatment by October 2009; scaled-up HIV testing and HIV services in the context of primary health care, TB and STI detection and treatment, and Women's Health Care in the capital and in the pilot district; improved quality and quantity of adult testing, care and treatment at Provincial Hospital.

Table 33: Overview of key child-sensitive social insurance in Papua New Guinea

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/ outcomes
Programme title: Superannuation program Responsible agency: Department of Labour and Industry Funded by: Funds contributed solely by employee and employer Time frame: 2002 - present			
Superannuation Amendment Act of 2002	Government mandated insurance programme for all employees of companies with 20 or more personnel. The programme provides old-age, disability and survivor insurance, with limited health care benefits also covered at government clinics, with a nominal co-payment.	General working population; all employees of firms with over 20 employees; participation for non-citizens is voluntary; short-term workers employed by a firm for three months or less are excluded; coverage: national	N/A

Table 34: Overview of key child-sensitive social assistance initiatives in Papua New Guinea

Source policy/initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash Transfers to Improve the Protection and Care of Vulnerable Children and to Empower Families in the Context of the HIV Epidemic in Papua New Guinea Responsible agency: Department for Community Development, Institute of National Affairs, UNICEF Funded by: UNICEF Time frame: Study conducted and published in 2008			
However, references plan for a pilot cash transfer programme in the National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea	Feasibility study which analyses the compatibility of societal and political structures, and the cultural and economic environment of Papua New Guinea with a social cash transfer programme. Findings indicate that the patterns of poverty, HIV, and child abuse in Papua New Guinea all lend themselves to a cash transfer programme.	Orphans and other vulnerable children; vulnerable women; coverage: recommends focusing on Highlands regions	Recommends developing an evidence-based social cash transfer programme targeted at geographic areas with high concentrations of women caring for vulnerable children. Expected roll out of a cash transfer programme in 2012.

Thailand

Thailand has the most extensive social protection provisions in place for HIV-affected children out of the countries reviewed. However, there are limited employment and livelihood opportunities for chronically ill caregivers. In the region, Thailand has the most explicitly stated rights of access for vulnerable children to essential services.

Table 35: Overview of social protection for children affected by HIV in Thailand

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Substantial	Social assistance provision has been devolved to local and regional governments. An array of local-level initiatives have emerged which are focused on providing targeted subsidies to households.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	Social security covers 20% of the population and coverage for the remainder was a priority of the 9th Economic and Social Development Plan. New initiatives to address the informal population have been piloted.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Extensive	There is Long-Term Policy and Strategy for Early Childhood Development, providing programmes for infants. More than 96% of the population has access to universal health care.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Explicit rights to access essential services for children affected by HIV	Extensive	The Child Protection Act is designed to protect all children from discrimination and ill-treatment in all social contexts, including health. The constitution guarantees women's and children's rights to all Thai citizens.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 36: Overview of key child-sensitive social protection policies and legislation in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Constitution Responsible agency: Government of Thailand Funded by: Government of Thailand Time frame: 1997 and 2007			
National Constitution 1997, 2006 and 2007	The Constitution guarantees women's and children's rights to protection, assistance, livelihood and access to the minimum resources to live adequately. Basic rights of youth and children, and the state's obligation to uphold these rights are integrated into the Constitution.	All Thai citizens, regardless of age, gender, social and health status, and other discriminating criteria; coverage: national	Community-based and locally-implemented initiatives are encouraged and supported by central authorities to best fill gaps in national/central planning, especially concerning poor and vulnerable children (children living and working on the street, migrants, HIV -infected/affected, sexually abused or trafficked children).
Programme title: Child Protection Act Responsible agency: Ministry of Interior, Ministry of Social Development and Human Security, Ministry of Education and Ministry of Justice Funded by: Ministry of Finance through the Child Protection Fund Time frame: Drafted in 1994, adopted in 2003			
Child Protection Act, B.E. 2546 (2003)	Designed to protect all children from discrimination, ill-treatment and violence, and to enforce their well-being in all social contexts (education, adoption, health, etc.). The Child Protection Act led to the creation of a National Child Protection Committee, which has the authority to carry out any tasks related to social welfare, safe protection and promotion of the behaviour of the child.	All children including orphans, street children, disabled children, vulnerable/at-risk children, children in 'difficult circumstances', trafficked children, sexually abused children, neglected children, etc.; coverage: national	One of the most significant results of this Act is the introduction of the Child Protection Committees at the provincial level to develop locally relevant policies.
Programme title: Long-term Plan for Development of Children and Youth (2002-2011) Responsible agency: Government of Thailand Funded by: Government of Thailand Time frame: 2002-2011			
National Children and Youth Development Plan (1982-2002)	The plan aims to streamline all initiatives pertaining to the environment and the well-being of children. It recognizes children in difficult situations as a focus group for social assistance.	All children in Thailand, with a special focus on HIV/AIDS-impacted children; coverage: national	The monitoring and evaluation framework for the plan implementation is under preparation.
Programme title: Child Friendly School (CFS) Initiative Responsible agency: Ministry of Education and UNICEF Thailand Funded by: Ministry of Education and UNICEF Thailand Time frame: Launched in 1999			
1990 Declaration on Education for All (EFA) agreement and 1990 Convention on the Rights of the Child	Enforces education programmes and policies where children are at the centre. The initiative led to the transformation of schools so that they are child-friendly, inclusive, healthy and safe for children's emotional, psychological and physical well-being, equal and actively engaged with communities.	All children from poor backgrounds. In 2008, UNICEF estimated that there were 1,400 participating schools in 25 priority districts.	Development of practices allowing all children (especially vulnerable ones) to benefit from a quality education adapted to their needs.

Table 36: Overview of key child-sensitive social protection policies and legislation in Thailand (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Policy and Strategy on the Prevention of Sexual Exploitation of Children in the Tourism Industry Responsible agency: Government of Thailand Funded by: Ministry of Tourism and Sports, Ministry of Justice, Ministry of Immigration, the Tourist Police and civil society groups Time frame: Launched in 2002			
Child Protection Act (2003)	Designed to protect all vulnerable people from being sexually exploited or abused. Key areas of protection, prevention and sanction are addressed.	All people potentially exploitable; the government estimates the number of women employed in prostitution to be between 150,000 and 220,000. There are no clear estimates for the number of children involved; coverage: national	Over the past 10-15 years better living conditions and better education have led observers to see declines in the number of children being sexually exploited.
Programme title: Long-Term Policy and Strategy for Early Childhood Development (2007-2016) Responsible agency: Ministry of Education, Ministry of Social Development and Human Security, Ministry of Public Health and Ministry of Interior Funded by: Ministry of Education, Ministry of Social Development and Human Security, Ministry of Public Health and Ministry of Interior Time frame: 2007-2016			
National Education Act (1999), Agenda for Children and Youth (January 2007) and National Scheme of Education (2002 -2016)	Provision of quality early childhood development institutions, child development centres and kindergartens. One of the policy's main objectives is to ensure infants are given as much programmatic attention as children and youth.	Children aged 0-5 years old, parents, family members, would-be parents and those directly involved in the provision of childcare services; coverage: national	N/A

Table 37: Overview of key child-sensitive social services in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Fourth Development Plan for Children and Youth Living in Remote Areas (2007-2016) Responsible agency: Ministry of Education Funded by: Ministry of Education and the Royal Projects Fund Time frame: 2007-2016			
Long-Term Policy and Strategy for Early Childhood Development (2007-2016)	The plan focuses on six inter-related objectives, one of which is women and children's health, nutrition, education and vocational training. The plan promotes increased educational opportunities for all, develops the academic potential of individuals, and provides relevant skills and training.	Women and children; coverage: remote rural areas	To date a total of 711 schools are involved in the project.

Table 37: Overview of key child-sensitive social services in Thailand (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Universal Health Care coverage system Responsible agency: Ministry of Public Health Funded by: The bulk of funding comes from public revenues (65% in 2004) Time frame: Launched in 2001			
National Health Security Act B.E. 2545 (2002)	Originally known as 'the 30 baht project', in line with the small co-payment charged for treatment, the universal health care system was designed to replace means-tested health care for low income households with a new and more comprehensive insurance scheme. In 2006 the 30 baht co-payment was abolished and the UC scheme was made free. The system is intended to provide equal access to quality care regardless of income or socio-economic status.	Low income households; coverage: national	The system has proved popular with poorer Thais, especially in rural areas and survived the change of government after the 2006 military coup. In 2005 some 95.6% of the population was covered by the scheme. The remaining 4.4% were not covered because of a lack of awareness, absence of an identification card, and/or incorrect housing registration.
Programme title: Tonkla-Archeep skills training programme Responsible agency: Ministry of Labour and Social Welfare Funded by: Government of Thailand Time frame: Launched in March 2009			
N/A	A mechanism developed for job creation in direct response to the recession of 2008-2009.	Unemployed and new graduates; coverage: national	Trained more than 200,000 unemployed people and re-employed 140,000.

Table 38: Overview of key child-sensitive social insurance in Thailand

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Social Security Responsible agency: Ministry of Labour provides general supervision, the Social Security Office collects contributions and pays benefits, medical benefits are delivered by hospitals contracted by the Social Security Office Funded by: Social security contributions are made at the same rate proportionate to the salary base Time frame: 1990 (revised in 1994 and 1999)			
Social Security Act B.E. 2533 (A.D.1990)	Formally employed workers and their dependants benefit from social insurance and livelihood support in case of work injury, disability, death, maternity, etc. The Social Security Fund (SSF) was introduced in 1991 to cover life-time contingencies like non-work related sickness, invalidity, death or maternity of the private employees, and gradually expanded to include the benefits of child allowance (1998), old-age pension (1998) and unemployment (2004).	Employees of the formal sector aged 15 to 60; coverage: national	Between 1998 and 2004, old age, child support and unemployment benefits were added to the Social Security Act B.E. 2533. Among other priorities, the scheme extends social security coverage to the informal economy through a mechanism for voluntary self insurance, as per the 9th Economic and Social Development Plan.

Table 39: Overview of key child-sensitive social assistance initiatives in Thailand
(continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Community-level social assistance Responsible agency: Community Organizations Development Institute (CODI) Funded by: Government of Thailand. Funds delegated to sub national level Time frame: N/A			
N/A	These are made available to communities in various ways, amongst which the most child-sensitive are: scholarships and loans for school fees; grants for medicines and hospital fees; revolving fund loans for income generation activities for very poor families; the establishment of child development and day-care centres, and funding for community playgrounds. Grants have also been disbursed to provide support and build shelters for PLWHA.	Coverage: sub-national, rural and urban	The majority of social assistance initiatives target medium- to long-term development objectives at the community level.
Programme title: Baan Eur Arthorn and Baan Mankong housing schemes Responsible agency: National Housing Authority (NHA), CODI Funded by: Government of Thailand Time frame: Launched in 2003			
N/A	The programme set out to build 600,000 units and upgrade another 300,000 units.	Households with a monthly income lower than THB15,000 (US$500); coverage: national	Another 100,000 units were assigned to the Government Savings Bank (GSB) for the provision of direct financial support.
Programme title: 15-Year Free Education Policy Responsible agency: Ministry of Education Funded by: The government distributes its funds to all schools nationwide. Schools then manage the funds themselves (THB18 billion for 2009) Time frame: Launched in May 2009			
National Education Act (1999) and Policy statement presented to Parliament in December 2008	Aimed at reducing the financial burden of parents and enabling children to have equal access to quality education. It provides all children with access to 15 years of cost-free education, from kindergarten to secondary education.	Children; coverage: national	The fund covers the costs of tuition fees, textbooks, uniforms, education tools and materials, and school activities. Only the money for uniforms is directly received by parents (two uniforms a year). 12 million students benefit from the 15-year free education policy.

Viet Nam

Like other countries in the region, Viet Nam offers little in the way of employment and livelihood initiatives for chronically ill caregivers, but other social protection offerings are well developed. The legal framework for protection of children affected by HIV is particularly strong, with government attention given to the Law on Child Protection, Care and Education.

Table 40: Overview of social protection for children affected by HIV in Viet Nam

	Criteria	Social protection	Examples
Social assistance	Provision of cash and food grants for at-risk children (orphans, children living and working on the street, institutionalized children, stateless children) and poor families	Moderate	A national cash transfer decree is hindered by the weak capacity of local social welfare agencies, a limited awareness and the stigma associated with seeking aid.
Social insurance	Insurance schemes – health, maternal support, nutrition and unemployment – for poor households and vulnerable groups	Substantial	Approximately 35% of the total population are members of the national Social Health Insurance.
Social services (access)	Availability of treatment (ART and OI) for caregivers and children	Moderate	National policies ensure free primary education for all and free health insurance for vulnerable people including children under the age of six.
	Employment and livelihood initiatives for chronically ill caregivers and high dependency households	Limited	
	Availability of health care, education, welfare, psychosocial support, livelihood training and alternative care for poor households and vulnerable children	Substantial	
Policies, legislation and regulation	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Substantial	Viet Nam's Law on HIV/AIDS Prevention and Control is considered a landmark because it gives people living with HIV the right to employment, education, and health care, and forbids stigmatization.
	Existence of a legal framework that specifically protects children affected by HIV through inheritance rights, birth registration and school enrolment	Extensive	

Key: Limited = Few policy initiatives. Nascent programme activity.
Moderate = Some policy initiatives. Some programme activity.
Substantial = Substantive policy framework. Moderate programme activity.
Extensive = Comprehensive policy framework. Robust programme activity.

Table 41: Overview of key child-sensitive social protection policies and legislation in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Family Strategy Responsible agency: N/A Funded by: N/A Time frame: Issued May 16th, 2005			
Prime Minister Decision 106/2005/QĐ – TTg	Created to address the gap in support for vulnerable children and families.	Poor families and families with children at risk of becoming vulnerable children	N/A
Programme title: Five-year national Social Protection Strategy Responsible agency: At the end of 2009, the strategy had not been finalised Funded by: N/A Time frame: N/A			
N/A	The strategy serves as a legal framework providing national standards and rules, guiding the development of national policies and programmes in response to specific issues regarding poverty reduction, social insurance, health insurance, education for vulnerable children and child protection.	N/A	N/A
Programme title: Implementation of the Law on the Protection, Care and Education of Children Responsible agency: Finance Ministry and the Planning and Investment Ministry Funded by: N/A Time frame: Enacted in 2005			
Decree No. 36/2005/ ND-CP	Enacted to address the fact that children's issues were not given explicit space in the annual budget. The law mandates that the Finance Ministry and the Planning and Investment Ministry ensure that child protection, care and development are incorporated into annual and long-term socio-economic development funds. As well as building mechanisms to 'mobilize funding sources' for such activities.	N/A	N/A
Programme title: Law on Child Protection, Care and Education Responsible agency: None directly, specifies responsibilities for different agencies under child protection, with Ministry of Labour – Invalids and Social Affairs (MOLISA) as the lead Funded by: N/A Time frame: First enacted in 1990; amended in June 2004			
Decree No. 25/2004/QH11	Defines 'children in special circumstances' (CSC), which is used through other programming to direct special attention to vulnerable children. CSC as is defined by the law includes (but is not limited to) children affected by HIV.	Children; coverage: national	Anecdotal evidence suggests that enforcement of some children's rights remains weak.

Table 41: Overview of key child-sensitive social protection policies and legislation in Viet Nam (continued)

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National strategy on HIV/AIDS prevention and control in Viet Nam until 2010 with a vision to 2020 Responsible agency: None directly; however, the Viet Nam Administration for AIDS Control (VAAC) is the primary implementer Funded by: N/A Time frame: 2004-2010			
Prime Minister's Decision 36/2004/QD-TTg	The priorities of the overall programme are prevention via an expanded informational campaign, aimed at changing risky behaviours, expanding interventions to mitigate the medical and psychosocial affects of the disease; improving counselling, care and treatment for those infected; and strengthening programme management and monitoring and evaluation of activities.	General population; coverage: national	Coverage of ARV treatment has improved; from 18.1% in 2006 to 54% (for adults) in 2009 with an HIV prevalence rate, of less than 0.3%
Programme title: National Plan of Action for Children (NPAC) and AIDS Until 2010, with a vision to 2020 Responsible agency: MOLISA Funded by: Government of Viet Nam Time frame: 2009-2010			
N/A	Details high-level strategies for improving services for children in relation to HIV on all aspects: prevention, care and treatment, as well as support for children affected by HIV.	General population; coverage: national	N/A
Programme title: The Law on HIV/AIDS Prevention and Control 64/2006/QH11 (Law on HIV) Responsible agency: N/A Funded by: N/A Time frame: Enacted in 2006			
N/A	The law on HIV Is considered a landmark legislation because it gives people living with HIV and AIDS (PLWHA) the right to employment, education and access to health care services. The law prohibits placing a stigma on PLWHA, people suspected of having HIV or those associated with them.	General population; coverage: national	N/A

Table 42: Overview of key child-sensitive social services in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: National Plan of Action for Children affected by HIV and AIDS (NPAC) Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA), houses coordinating committee, made up of MOLISA, Ministry of Education and Training (MOET), Ministry of Health and other stakeholders Funded by: Government of Viet Nam; Time frame: 2009-2010			
NPAC	Information on programmatic activity only available via the NPAC: Aims to increase access to, and availability of, quality health and education services for children affected by HIV. Sets the target of 70% of adult HIV care clinics offering paediatric diagnosis, care, and treatment by the end of 2010. Also plans to train health care officials in schools and community-based organizations to identify the signs of HIV-affected children and refer them to the appropriate social services facilities. Aims to train local NGOs to provide home-based care and nutritional guidance to children living with HIV. In addition, it includes an information and education campaign.	General population; coverage: national	The 2010 Viet Nam National Composite Policy Index (NPCI) report is the only evaluative information available, which says: "Operational models for the implementation of the National Programme of Action, especially community-based models have not been fully developed or disseminated."
Programme title: National programme on free health insurance for vulnerable people, including children under six Responsible agency: Ministry of Health (MoH) Funded by: Government of Viet Nam; Time frame: N/A			
Law on the Protection, Care and Education of Children (Article 15.2)	Orphans and vulnerable children under six years old have access to free medical care according to the general regulation on the free medical examination and treatment of children under six.	Children under six; coverage appears national	Due to limited funding, difficulty of assessing eligibility and lack of awareness of the programme, people are not always able to access free services through this programme and others.
Programme title: National programme on free primary education for all children Responsible agency: Ministry of Education Funded by: Government of Viet Nam; Time frame: N/A			
Law on Protection, Care and Education of Children (Articles 16, 28)	Provides financial support to local schools to ensure that all children are able to attend primary school.	Primary school-aged children; coverage appears national	Universalization rates achieved in 2005; literacy rates increased to 94.5% among youth. However secondary-analysis suggests that many families still have to pay indirect costs for education, and that poor areas lack quality facilities and teachers.

Table 42: Overview of key child-sensitive social services in Viet Nam (continued)

Programme title: National Targeted Programme on Poverty Reduction (NTPPR), 2006-2010 Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA), housing the Government Steering Committee for implementation of the national target programme on poverty reduction period 2006-2010 Funded by: Government of Viet Nam, with minor support from international donors Time frame: 2006-2010			
Prime Minister Decision No: 20/ 2007/QD-TTg	Vast poverty reduction initiatives that include activities spanning nearly all sectors of social protection. The focus is on vocational training and capacity building for income-generating activities, supporting construction of essential infrastructure, exemption or reduction in school fees for poor families, support for poor households to gain access to clean water and legal assistance for the poor.	Poor households. With priority given to poor households with a female head, of ethnic minorities, or with children with 'special circumstances'; coverage: national	The programme's predecessor, the National Target Programme on Hunger Eradication and Poverty Reduction 2001-2005, was reported by the government to have reduced the rate of poor households from 17.2% in 2001 (2.8 million households) to 8.3% in 2004. For the NTPPR the government has identified remaining 1.1 million poor households to be supported by the programme (7%). No results were available for the NTPPR. No third-party mechanism to verify government results.

Table 43: Overview of key child-sensitive social assistance initiatives in Viet Nam

Source policy/ initiative	Brief overview/specific measures	Target group/ coverage	Results/outcomes
Programme title: Cash transfer programme for vulnerable children (no official name given; typically referred to as 'cash transfer programme from Decree 67' Responsible agency: Ministry of Labour, Invalids, and Social Affairs (MOLISA) Funded by: Government of Viet Nam; information is unavailable on whether international donors also contribute Time frame: Established in 2007			
Decree 67/2007/ ND-CP	Provides subsidies of up to D540,000 – an unconditional cash transfer – to families supporting children labelled vulnerable due to a range of issues, including children orphaned by HIV/ AIDS, and children deprived of, or missing, one parent. The programme specifies different minimum levels of funds that are to be provided for families depending on where the child is housed: a commune, a ward, a social protection centre, etc. Information was not available on the mechanisms for identifying beneficiaries or for delivery.	Vulnerable children; coverage: appears to be national	The only information available on results is from the 2010 NCPI report: "The effective implementation of Decree 67 is hindered by the weak capacityof local social welfare agencies, awareness of the decree, limited monitoring of its implementation and stigma and discrimination preventing those in need from accessing the support."

2 Dampak HIV Pada Pendidikan Anak di Indonesia

Aang Sutrisna
(AIDSina Foundation, Indonesia)

I. Latar Belakang

HIV dan AIDS sudah menjadi masalah yang serius untuk negara-negara berkembang maupun negara maju dalam beberapa tahun terakhir. Sejak awal dekade 20-an, penduduk yang terinfeksi virus HIV di Indonesia jumlahnya terus bertambah secara signifikan. Laporan Komisi Penanggulangan AIDS Nasional (KPAN) yang disampaikan dalam sidang umum PBB tentang AIDS (UNGASS) 2006-2007 antara lain menyebutkan bahwa pada saat sekarang ini negara Indonesia telah menjadi salah satu negara dengan laju pertumbuhan epidemi HIV paling cepat di Asia[1]. Namun dibanding dengan negara-negara di Asia pada umumnya, persentase orang dengan HIV di Indonesia pada tahun 2009 masih tergolong rendah yaitu sekitar 0,15 persen. Angka ini menunjukkan bahwa sekitar 186.000 penduduk dewasa Indonesia hidup dengan HIV[2].

Penyebaran dan penularan HIV di Indonesia secara cepat pada umumnya terjadi pada populasi Pengguna Napza Suntik (Penasun). Di lain pihak, peningkatan prevalensi HIV secara signifikan juga terjadi akibat penularan melalui hubungan seksual yang dilakukan oleh Pekerja Seks (PS) dan Penasun[3]. Interaksi kelompok PS dan Penasun dalam penyebaran dan penularan HIV memberikan kontribusi besar terjadinya gelombang epidemi baru yang akan menjadi pemicu utama meningkatnya epidemi HIV pada masa-masa yang akan datang.

Peningkatan prevalensi HIV pada level makro atau secara nasional belum menimbulkan dampak sosial-ekonomi yang cukup berarti. Dampak tersebut secara signifikan hanya dapat dirasakan pada level mikro, antara lain pada level rumah tangga, khususnya rumah tangga yang salah satu atau beberapa orang anggotanya terinfeksi HIV[4]. Orang yang hidup dengan HIV (ODHA) serta rumah tangganya cenderung dibebani berbagai masalah antara lain menderita berbagai penyakit kronis, kehilangan pekerjaan dan pendapatan, peningkatan pengeluaran untuk kesehatan, menipisnya tabungan atau aset lainnya, tekanan psikologis, diskriminasi dan pembatasan sosial.

[1]Country report on the follow up to the declaration of Commitment on HIV/AIDS (UNGASS), 2006-2007, National AIDS Commission, Republic of Indonesoa, p-9.

[2]Laporan Estimasi Populasi Dewasa Rawan Terinfeksi HIV Tahun 2009. Kementerian Kesehatan Republik Indonesia 2009

[3]Integrated Bio-Behavioral Surveilance Survey Among Most at Risk Population in Indonesia 2007, MoH, BPS, USAID and FHI-ASA

[4]Redefining AIDS in Asia, Report of the Commission on AIDS in AIDS, Oxford, 2006.

Dampak sosial bagi orang yang hidup dengan HIV juga bisa terjadi karena sikap/perlakuan anggota rumah tangganya.

Laporan dari Independent Commission of AIDS di Asia[4] juga menggaris-bawahi pentingnya kesadaran untuk mengakui beratnya beban sosial ekonomi yang harus ditanggung oleh rumah tangga dan anak-anak akibat epidemi HIV dan merumuskan cara mengatasinya. Diperkirakan biaya ekonomi selama setahun untuk AIDS pada seluruh rumah tangga di Asia adalah sekitar US $ 2 milyar. Setiap kematian akibat AIDS mengakibatkan kerugian paling sedikit US $ 5,000 atau setara dengan 14 tahun hidup produktif yang dihitung dengan modus sebesar US $ 1 per hari. Pengeluaran kesehatan tersebut akan mendorong rumah tangga miskin menjadi semakin miskin. Dengan level infeksi yang sama, pada tahun 2015 mendatang, diperkirakan AIDS akan menambahkan sebanyak enam juta orang di bawah garis kemiskinan di Asia.

Pentingnya pendidikan sebagai dasar utama pencegahan HIV menyebabkan semakin besarnya kebutuhan untuk meningkatkan akses masyarakat terhadap pendidikan. Pada tahun 2000, sebuah terminologi baru di dalam pendidikan diperkenalkan, yaitu 'education vaccine'. Pendidikan dilihat sebagai ujung tombak upaya pencegahan penyebaran HIV (World Bank, 2002; Boler Tania and Kate Carroll, undated; Vandemoortele, Jan and Enrique Delamonica, 2000). Namun, fakta menunjukkan hal yang menyedihkan. Walaupun pendidikan dipercaya bisa mengurangi HIV, banyak ODHA terpaksa harus mengurangi bahkan berhenti menjalani pendidikannya karena HIV dan AIDS. Secara global , HIV dan AIDS dipandang sebagai tantangan yang sangat besar dalam sektor pendidikan yang masih merupakan salah satu faktor penghambat pencapaian MDG untuk pendidikan bagi semua pada tahun 2015. (UNESCO, 2001; Wijngaarden Jan and Sheldon Shaeffer, 2004).

HIV dan AIDS memberikan dampak negatif terhadap akses dan kualitas pendidikan yang mungkin didapatkan oleh seorang anak. Sering kali anak-anak dari rumah tangga ODHA terpaksa untuk mangkir dari sekolah untuk membantu memenuhi kebutuhan rumah tangga atau untuk ikut membantu merawat anggota keluarga yang sakit. Biaya untuk pendidikan anak sering juga dikorbankan untuk pemenuhan kebutuhan pengobatan dan perawatan anggota keluarga yang sakit. Dari segi kualitas, selain anak tidak bisa berkonsentrasi sekolah karena permasalahan dan kondisi yang dia alami, sering juga anak harus menghadapi kondisi tidak nyaman karena masih besarnya stigma di masyarakat terkait infeksi HIV yang diderita salah seorang anggota keluarganya.

Sejalan dengan meningkatnya prevalensi HIV di Indonesia, dampak sosial ekonomi termasuk pendidikan untuk anak akibat infeksi HIV mulai dirasakan oleh ODHA dan keluarganya. Indikasi ini antara lain terlihat dari terjadinya kasus-kasus perlakuan diskriminatif terhadap ODHA maupun keluarganya di beberapa wilayah di Indonesia. Kasus-kasus perlakuan diskriminasi pada ODHA maupun rumah tangganya merupakan indikasi adanya dampak sosial ekonomi yang harus diderita oleh ODHA maupun keluarganya termasuk anak-anak. Pertanyaan penting yang muncul di sini adalah apakah dampak tersebut secara makro dirasakan oleh setiap ODHA maupun rumah tangganya di seluruh Indonesia. Hingga saat ini, data/informasi dan analisis yang menyajikan gambaran secara rinci tentang dampak sosial ekonomi infeksi HIV baik bagi ODHA maupun rumah tangganya di Indonesia masih belum tersedia. Padahal data tersebut sangat dibutuhkan untuk perencanaan dan perumusan berbagai program penanggulangan dampak sosial ekonomi dari infeksi HIV.

Pada sisi lain, laporan KPAN juga mengungkapkan bahwa salah satu kendala yang menghambat upaya penanggulangan HIV dan AIDS di Indonesia selama ini adalah keterbatasan data dan hasil analisis mengenai HIV dan AIDS. Ketersediaan data tersebut mutlak diperlukan dalam rangka mempelajari dan memahami epidemi HIV dengan lebih baik dan merancang langkah antisipasi.

Sejalan dengan itu, ketersediaan data dan hasil analisis HIV dan AIDS secara lengkap mulai dari prevalensi, pola penyebaran, kelompok berisiko serta dampaknya, saat ini merupakan kebutuhan krusial yang harus segera dipenuhi.

Dalam rangka memenuhi sebagian kebutuhan tersebut, Badan Pusat Statistik (BPS) bekerja sama dengan UNDP, ILO, UNV dan JOTHI (Jaringan Orang Terinfeksi HIV Indonesia) menyelenggarakan kegiatan Penelitian Dampak Infeksi HIV Terhadap Kondisi Sosial Ekonomi Rumah Tangga Tahun 2009. Penelitian ini diarahkan untuk memperoleh gambaran tentang dampak sosial ekonomi HIV pada rumah tangga di Indonesia dan mengidentifikasi cara penanggulangannya. Penelitian yang serupa telah dilakukan oleh sejumlah negara di Asia, antara lain India (2006), China (2007) dan Kamboja (2008).

Kegiatan Penelitian ini secara keseluruhan dilaksanakan di tujuh provinsi, yaitu DKI Jakarta, Jawa Barat, Jawa Timur, Bali, Nusa Tenggara Barat, Nusa Tenggara Timur dan Papua. Dari ke tujuh provinsi terpilih tersebut, provinsi Nusa Tenggara Barat dan Nusa Tenggara Timur mewakili wilayah yang memiliki prevalensi HIV rendah, sedangkan lima provinsi lainnya mewakili wilayah yang memiliki prevalensi tinggi. Kombinasi dari kedua kelompok wilayah tersebut diharapkan dapat menghasilkan data yang representatif.

II. Metodologi

Dalam upaya memperoleh gambaran mengenai dampak sosial ekonomi infeksi HIV terhadap ODHA dan rumah tangganya secara lengkap dan komprehensif, maka penelitian ini dilakukan dengan menggunakan dua jenis metode, yaitu penelitian kuantitatif dan kualitatif. Penelitian kuantitatif dilakukan melalui penyelenggaraan kegiatan survei yang dilengkapi dengan instrumen-instrumen baku berupa daftar pertanyaan/kuesioner terstruktur dan buku pedoman pencacahan, sedangkan penelitian kualitatif dilakukan dengan penelitian mendalam (*indepth study*) dan *Focus Group Discussions* (FGD).

Rumah tangga yang menjadi unit observasi terdiri dari dua kategori, yaitu rumah tangga ODHA dan rumah tangga Non-ODHA yang berfungsi sebagai rumah tangga kontrol atau pembanding. Rumah tangga ODHA yang dimaksudkan dalam studi ini adalah rumah tangga yang minimal mempunyai satu anggota rumah tangga terinfeksi HIV. Selain rumah tangga, unit observasi dalam studi ini juga mencakup individu yang terinfeksi HIV.

Penelitian kualitatif berupa wawancara mendalam dan diskusi kelompok terfokus, dilakukan dalam rangka memperoleh gambaran atau informasi penting yang tidak dapat diperoleh melalui kegiatan survei. Kegiatan penelitian kualitatif dilakukan melalui wawancara tidak terstruktur dengan responden ODHA terpilih. Wawancara tersebut dilakukan secara langsung tanpa menggunakan kuesioner baku seperti pada kegiatan survei.

Sesuai dengan tujuan utama dari penelitian ini yaitu untuk mendapatkan data dan analisis mengenai dampak sosial ekonomi HIV dan AIDS terhadap rumah tangga ODHA, maka fokus dari penelitian ini adalah rumah tangga.

2.1. Lokasi Penelitian

Penelitian ini diselenggarakan di tujuh provinsi, yaitu DKI Jakarta, Jawa Barat, Jawa Timur, Bali, Nusa Tenggara Barat, Nusa Tenggara Timur dan Papua yang meliputi 13 kota untuk penelitian kuantitatif dan 7 kota untuk penelitian kualitatif. Detail lokasi penelitian tercantum di dalam tabel dibawah. Dari keseluruhan provinsi terpilih, provinsi Nusa Tenggara Barat dan Nusa Tenggara

Timur mewakili wilayah yang memiliki prevalensi HIV rendah, sedangkan lima provinsi lainnya mewakili wilayah yang memiliki prevalensi tinggi. Kombinasi dari kedua kelompok wilayah tersebut diharapkan dapat menghasilkan data yang representatif.

2.2. Rancangan Sampel

Hingga saat ini data yang akurat tentang jumlah dan sebaran orang dengan HIV dan AIDS (ODHA) masih belum tersedia. Padahal informasi tersebut sangat dibutuhkan untuk membentuk kerangka sampel (*sampling frame*) yang akan dijadikan dasar pengambilan sampel untuk keperluan survei-survei yang berbasis pada *probability sampling*. Kendala-kendala tersebut mengakibatkan seluruh penelitian mengenai masalah HIV dan AIDS yang selama ini telah dilakukan di Indonesia masih terbatas pada penelitian mikro atau studi kasus.

Sedangkan data ODHA yang dikumpulkan oleh fasilitas kesehatan masih cenderung *under estimate*, karena tidak semua orang yang terinfeksi HIV datang berobat ke fasilitas kesehatan. Seperti yang diungkapkan oleh Aditya (1994), jumlah kasus AIDS yang tercatat selama ini hanya merupakan puncak dari sebuah gunung es. Secara statistik, data tersebut tidak valid untuk digunakan sebagai dasar untuk penyusunan kerangka sampel yang berbasis *probability sampling*.

Dengan mempertimbangkan berbagai aspek terutama kendala tidak tersedianya data jumlah dan sebaran orang yang terinfeksi HIV, rancangan sampel (*sampling design*) yang digunakan untuk penyelenggaraan kegiatan SDGK09 ini adalah sampling kuota (*quote sampling*). Besarnya kuota jumlah rumah tangga sampel (*sampel size*) pada masing-masing provinsi dilakukan secara bebas/independen. Dimana untuk melihat kelayakannya tetap memperhatikan banyaknya kasus AIDS yang terjadi di masing-masing provinsi sebagai validator. Alokasi jumlah rumah tangga sampel untuk masing-masing provinsi secara rinci disajikan pada Tabel 1.

Tabel 1 Alokasi Jumlah Rumah Tangga Sampel SDGK09 Menurut Provinsi

	Provinsi	Banyaknya Kasus AIDS	Jumlah Rumah Tangga Sampel		
			RT Target	RT Kontrol	Jumlah
1	DKI JAKARTA	2.781	280	280	560
2	JAWA BARAT	2.888	197	197	394
3	JAWA TIMUR	2.591	211	211	422
4	BALI	1.177	56	56	112
5	NTB	80	25	25	50
6	NTT	110	25	25	50
7	PAPUA	2.382	225	225	450
	Total		1.019	1.019	2.038

2.3. Prosedur Pemilihan Sampel

Unit sampel (*sampling unit*) yang menjadi unit observasi dalam kegiatan penelitian ini secara keseluruhan mencakup tiga jenis, yaitu:

1. Rumah tangga dengan ODHA atau rumah tangga target
2. Rumah tangga Non-ODHA atau rumah tangga kontrol
3. Anggota rumah tangga yang terinfeksi HIV

Rumah tangga dengan ODHA atau selanjutnya sering disebut dengan Ruta ODHA dalam studi ini merupakan unit observasi utama atau target yang akan diteliti perilaku sosial ekonominya khususnya yang berkaitan dengan status HIV yang disandang oleh anggota rumah tangganya. Sejalan dengan itu, Ruta ODHA dalam konteks ini disebut juga sebagai rumah tangga target. Rumah tangga Non-ODHA yang selanjutnya sering disebut sebagai Ruta Non-ODHA merupakan unit observasi berikutnya pada studi ini yang juga akan diteliti perilaku sosial ekonominya untuk dibandingkan dengan Ruta ODHA. Sejalan dengan fungsinya, Ruta Non-ODHA disebut juga sebagai rumah tangga kontrol.

Unit observasi ketiga dalam studi ini adalah individu yang terinfeksi HIV atau ODHA yang akan diteliti perilaku sosial ekonominya khususnya yang berkaitan dengan infeksi HIV yang dideritanya. Selain itu, juga akan diteliti perlakuan-perlakuan yang tidak normatif, baik yang dilakukan masyarakat atau bahkan dari keluarganya sendiri, yang terpaksa harus diterima oleh ODHA. Perlakuan tidak normatif tersebut antara lain berupa tindakan diskriminatif, stigma, perlakuan tidak senonoh dan pengucilan/ pengisolasian.

Rumah tangga sampel terpilih, baik Ruta ODHA maupun Ruta Non-ODHA pada pelaksanaan survei SDGK09 akan didatangi petugas lapangan untuk dicacah dengan kuesioner SDGK09-K. Sedangkan keseluruhan ODHA yang terpilih sampel akan dicacah dengan Daftar SDGK09-M dan pada tahap berikutnya sebagian dari mereka akan dipilih menjadi responden penelitian kualitatif.

Pemilihan sampel ODHA, rumah tangga ODHA dan rumah tangga Non-ODHA dilakukan secara serentak, namun prosedur dan cara pemilihan sampelnya dilakukan masing-masing secara independen. Pemilihan sampel ODHA untuk dijadikan responden studi mendalam dilakukan tersendiri oleh petugas penelitian kualitatif. Keterangan detail tentang pemilihan responden dapat dilihat pada lampiran.

III. Hasil

3.1. Karakteristik Responden Rumah Tangga

Secara umum ada 996 rumah tangga ODHA dan 996 rumah tangga Non-ODHA yang menjadi responden penelitian ini. Sedangkan jumlah responden ODHA adalah 1,106 orang. Analisis karakteristik rumah tangga pada bagian ini dilihat melalui dua pendekatan, yaitu pendekatan rumah tangga dan pendekatan individu. Pendekatan rumah tangga dilakukan dengan cara meneliti variabel-variabel yang dapat menunjukkan ciri-ciri rumah tangga, antara lain: struktur rumah tangga, pendapatan rumah tangga, pengeluaran rumah tangga dan jumlah kematian. Pendekatan individu dilakukan dengan meneliti variabel-variabel yang menjelaskan tentang karakteristik individual termasuk kepala rumah tangga, antara lain umur, jenis kelamin dan status perkawinan, pendidikan, kesehatan dan ketenagakerjaan.

Perbedaan struktur rumah tangga Ruta ODHA dan Non-ODHA tidak terlihat dari pendidikan tertinggi yang ditamatkan kepala rumah tangga. Secara umum pendidikan kepala rumah tangga di Ruta ODHA relatif sama dengan Ruta Non-ODHA. Persentase kepala rumah tangga yang berpendidikan SLTA atau jenjang di atasnya pada Ruta ODHA mencapai sebesar 59 persen, sedangkan persentase tersebut untuk Ruta Non-ODHA nampak sedikit lebih tinggi, yaitu sebesar 61 persen.

Tabel 2 Persentase Jenis Kelamin, Kelompok Umur, Pekerjaan dan Pendidikan Kepala Rumah Tangga Menurut Klasifikasi Rumah Tangga

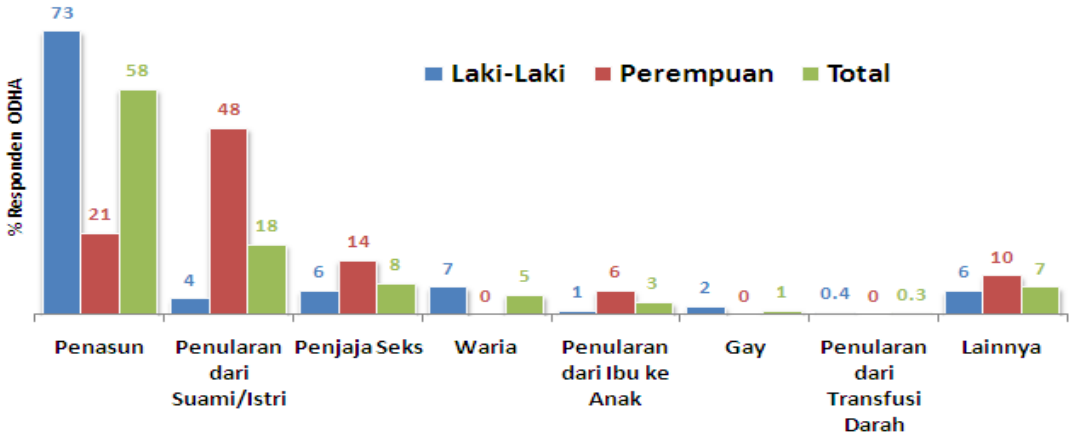
	Ruta ODHA	Ruta Non-ODHA
Jenis Kelamin Kepala Rumah Tangga		
Laki-Laki	75	85
Perempuan	25	15
Kelompok Umur		
15-19	0	1
20-24	5	6
25-49	61	66
50+	34	27
Status Perkawinan		
Belum Kawin	16	13
Kawin	59	73
Cerai mati	18	9
Cerai hidup	8	5
Bidang Pekerjaan		
Jasa Pendidikan/Kesehatan/Kemasyarakatan	22	20
Perdagangan	16	18
Transportasi/Komunikasi	8	9
Jasa perorangan yg melayani ruta	9	8
Admin/Pemerintahan	5	10
Lainnya	13	17
Tidak Bekerja	27	16

Walaupun pemilihan rumah tangga kontrol (Ruta Non-ODHA) sudah diupayakan sedemikian rupa agar memiliki kemiripan karakteristik tetapi pada akhirnya persentase kepala rumah tangga yang tidak bekerja pada Ruta ODHA (27 persen) lebih tinggi dibanding dengan Ruta Non-ODHA (16 persen). Sebaliknya, persentase kepala Ruta ODHA yang bekerja di sektor administrasi/Pemerintahan (5 persen) hanya setengah dari kepala rumah tangga Ruta Non-ODHA.

3.2. Karekteristik Responden ODHA

Separuh lebih dari 1,106 ODHA yang masih hidup dan menjadi responden dalam survei ini, termasuk pada kelompok Penasun yang mencapai 58 persen. Berdasarkan Surveilans Terpadu Biologis Perilaku (STBP) 2007 Penasun merupakan kelompok berisiko yang memiliki prevalensi HIV paling tinggi. Kelompok kedua terbanyak adalah responden yang dikategorikan sebagai kelompok penularan dari suami/istri (18 persen).

Gambar 1 Persentase Responden ODHA Menurut Kelompok HIV dan Jenis Kelamin



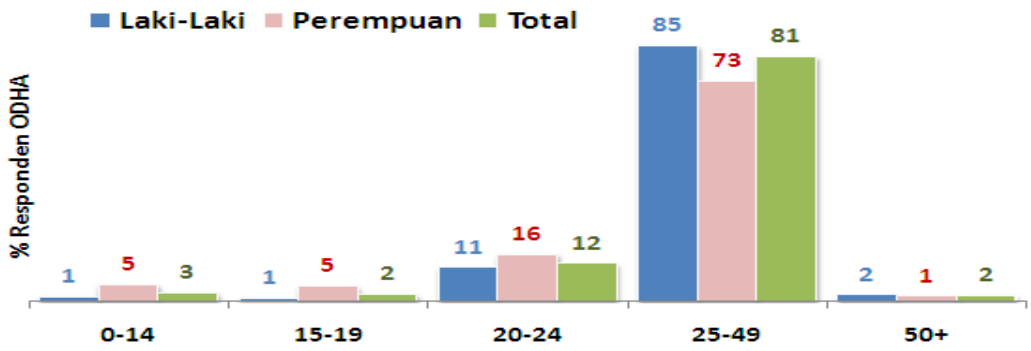
Walaupun tidak sampai seperlima dari semua kasus yang ditemukan, ini merupakan indikasi penularan telah terjadi dalam rumah tangga. Konsekuensi dalam upaya pencegahan HIV adalah diperlukan edukasi tentang HIV dan AIDS di tengah masyarakat yang lebih luas sebagai langkah preventif untuk antisipasi penularan ibu kepada bayinya.

Sebagian besar responden ODHA laki-laki termasuk kedalam kelompok Penasun sedangkan sebagian besar responden ODHA perempuan dikategorikan sebagai kelompok penularan dari suami/istri. Sedangkan responden yang mewakili kelompok Waria dan LSL jumlahnya cukup kecil, oleh karena itu analisa hasil penelitian ini tidak dapat dilakukan menurut kelompok HIV.

Seperti perkiraan banyak pihak, kebanyakan responden ODHA rata-rata berada pada usia produktif yaitu 25-49 tahun. Secara keseluruhan persentase responden ODHA laki-laki (70 persen) jauh lebih banyak dibandingkan responden ODHA perempuan (30 persen). Persentase responden ODHA laki-laki pada kelompok umur 25-49 tahun (85 persen) juga lebih tinggi dari responden ODHA perempuan (73 persen). Sedangkan pada kelompok umur yang lebih muda (0-14; 15-19 dan 20-24 tahun) persentase ODHA perempuan lebih tinggi antara 4 – 5 persen, sehingga rerata umur responden ODHA perempuan (28 tahun) 2 tahun lebih muda dari laki-laki (30 Tahun)

Distribusi kelompok umur responden ODHA tersebut menunjukkan bahwa lebih banyak perempuan yang terinfeksi HIV pada usia lebih muda dibandingkan dengan laki-laki. Hal ini bisa saja terjadi karena perempuan pada usia yang lebih dini sudah terpapar HIV dari pasangannya yang berusia lebih dewasa. Pada bagian berikutnya, kita akan melihat perbedaan kemungkinan sumber paparan HIV pada responden laki-laki dan perempuan.

Gambar 2 Persentase Responden ODHA Menurut Kelompok Umur dan Jenis Kelamin



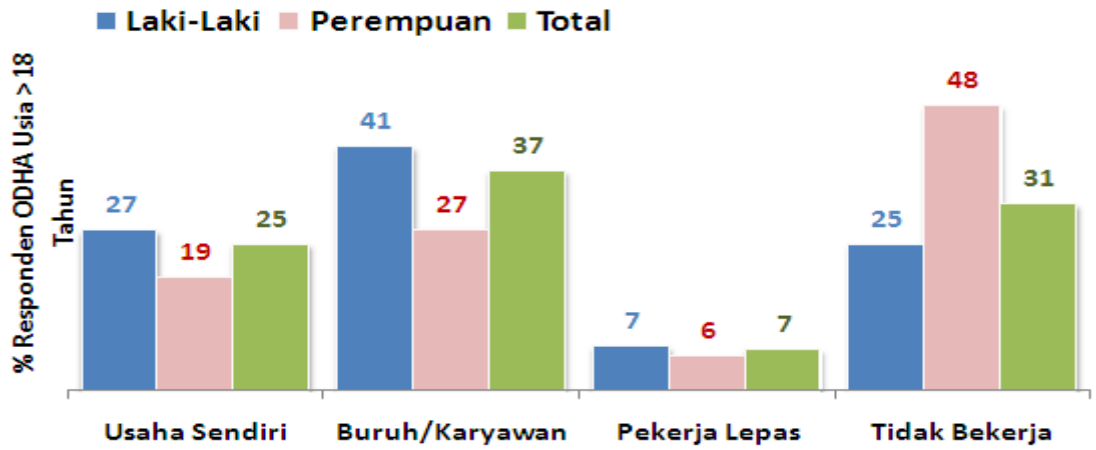
Sama seperti struktur tingkat pendidikan tertinggi yang ditamatkan oleh orang dewasa di Indonesia pada umumnya, sebagian besar (68 persen) responden ODHA berusia 18 tahun keatas juga tamat SLTA atau sederajat. Sedangkan prosentase responden ODHA yang tidak tamat SLTP masih cukup banyak yaitu 14 persen. Berdasarkan status perkawinannya, hampir 90 persen ODHA perempuan pernah menikah, dan hanya 50 persen ODHA laki-laki yang pernah menikah. Hal ini merupakan indikator bahwa perempuan cenderung menikah pada usia lebih muda dibandingkan dengan laki-laki.

Temuan yang menonjol dari status perkawinan responden adalah status perceraiannya. Sebanyak 37% responden ODHA perempuan telah bercerai, baik cerai hidup maupun cerai mati. Angka ini sangat tinggi bila dibandingkan dengan responden ODHA laki-laki yang hanya 16%. Sebaliknya persentase responden ODHA laki-laki yang belum kawin (49 persen) jauh lebih tingi bila dibandingkan dengan responden ODHA perempuan (13 persen).

Data menunjukkan bahwa sebanyak 75% ODHA laki-laki memiliki pekerjaan pada saat disurvei. Umumnya bekerja sebagai buruh/karyawan sebanyak 41%, usaha sendiri 27%, dan bekerja sebagai pekerja lepas sebanyak 7%. Sedangkan untuk ODHA perempuan, hanya setengah dari responden yang memiliki pekerjaan pada saat disurvei. Sebanyak 19% memiliki usaha sendiri, 27% persen bekerja sebagai buruh/karyawan, dan 6 % bekerja sebagai pekerja lepas.

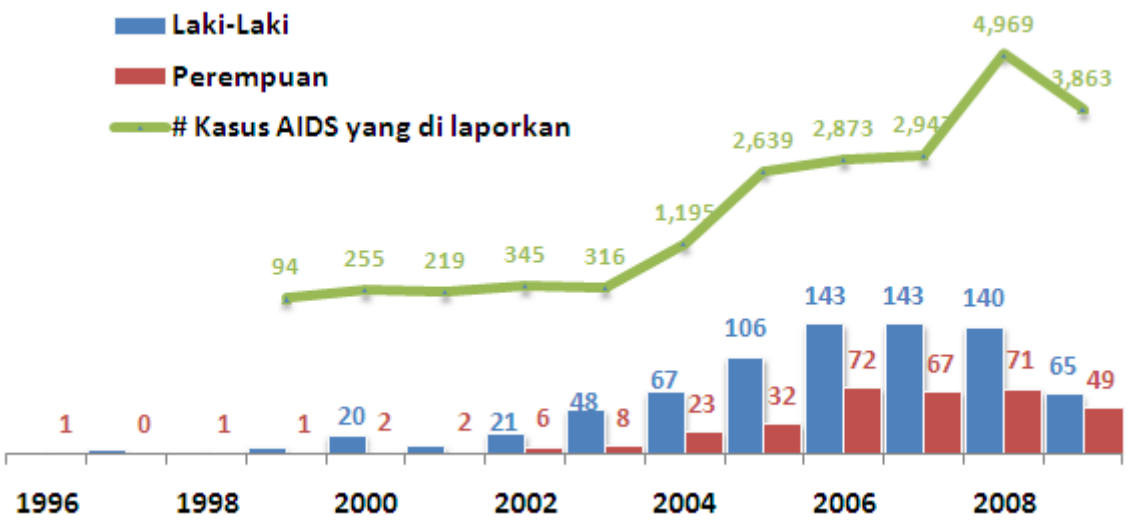
Persentase reponden ODHA perempuan usia 18 tahun keatas yang tidak berkerja hampir 2 kali lipat dari responden ODHA laki-laki. Situasi ini sebenarnya umum terjadi di Indonesia dimana peran perempuan lebih banyak sebagai pengurus rumah tangga dibanding pencari nafkah utama.

Gambar 3 Persentase Responden ODHA Yang Berusia Lebih Dari 18 Tahun Menurut Status Pekerjaan dan Jenis Kelamin



Tahun konfirmasi adalah tahun ketika seorang ODHA didiagnosa terinfeksi HIV. Gambar 4 menunjukkan bahwa sebagian besar ODHA mengetahui dirinya terinfeksi HIV pada periode lima tahun terakhir (2004-2009). Kecenderungan tahun konfirmasi HIV responden ODHA laki-laki maupun perempuan relatif sama dengan jumlah kasus AIDS yang dilaporkan dan dicatat oleh Kementerian Kesehatan. Situasi ini juga sejalan dengan ekspansi tempat layanan konseling dan testing HIV sukarela sejak 7 – 8 tahun yang lalu.

Gambar 4 Jumlah Responden ODHA Menurut Tahun Konfirmasi HIV dan Jenis Kelamin



Sedangkan jika dilihat perbandingan waktu konfirmasi HIV, persentase responden ODHA laki-laki yang sudah mengetahui status HIV nya lebih dari 5 tahun yang lalu (14 persen) 2 kali lebih banyak dibanding ODHA perempuan. Sebaliknya responden ODHA perempuan yang baru mengetahui status HIV nya dalam 1 tahun terakhir jauh lebih tinggi dari ODHA laki-laki. Situasi ini dapat diartikan bahwa infeksi HIV 5 tahun yang lalu lebih banyak terjadi pada laki-laki dengan latar belakang Penasun dan kemudian baru diikuti oleh penularan HIV melalui hubungan seks sehingga perempuan yang terinfeksi HIV meningkat jumlahnya dalam beberapa tahun terakhir.

3.3. Dampak HIV Pada Pendidikan Anak

Pendidikan berkorelasi positif dengan kualitas hidup, makin tinggi pendidikan seseorang maka idealnya makin berkualitas hidupnya karena pengetahuan dan wawasan luas yang dimilikinya. Tabel 3 diatas menggambarkan bahwa secara umum tidak ada perbedaan signifikan pada persentase tingkat pendidikan tertinggi yang ditamatkan oleh responden usia 18 tahun keatas dari rumah tangga ODHA dan Non-ODHA. Bahkan persentase responden ODHA yang tamat SLTA lebih tinggi dari Non-ODHA di rumah tangga ODHA maupun non-ODHA.

Tabel 3 Persentase Tingkat Pendidikan Tertinggi Responden Usia 18 Tahun Keatas Menurut Status HIV dan Klasifikasi Rumah Tangga

Pendidikan Tertinggi	Ruta ODHA			Ruta Non-ODHA
	ODHA	Non-ODHA	Total	
Tidak Tamat SD	4	6	5	5
SD	10	18	15	15
SLTP	18	17	17	18
SLTA	54	46	49	47
Universitas	14	14	14	16

Gambaran tingkat pendidikan responden penelitian ini, secara umum juga relatif sama dengan situasi pencapaian pendidikan tertinggi di masyarakat umum, dimana persentase pendidikan tertinggi yang pernah ditamatkan terbesar adalah tingkat SLTA atau sederajat.

3.4. Tingkat partisipasi sekolah

HIV dan AIDS memiliki dampak besar pada pendidikan anak-anak dengan mempengaruhi akses dan kualitas pendidikan. Keberadaan anggota rumah tangga yang terinfeksi HIV sedikit banyak telah mempengaruhi kemampuan ekonomi rumah tangga, akhirnya mungkin anak-anak usia sekolah menjadi putus sekolah karena orangtua mereka tidak mampu membayar biaya sekolah mereka sebagai akibat menurunnya pendapatan keluarga atau pengeluaran kesehatan meningkat. Anak-anak, terutama perempuan, dapat ditarik keluar dari sekolah untuk merawat orang sakit anggota keluarga atau untuk menambah pendapatan keluarga. Anak yang lahir dari orang tua dengan HIV-positif atau anak-anak terinfeksi HIV mungkin akan ditolak untuk akses ke sekolah karena rasa takut dan stigma.

Pengelompokan umur dalam pembahasan ini dibatasi pada 3 kelompok umur yaitu umur 6-12 tahun yang mencerminkan tingkat pendidikan Sekolah Dasar (SD), umur 13-15 tahun mencerminkan tingkat pendidikan SLTP dan umur 16-18 tahun pada SLTA.

Penelitian ini menemukan bahwa tidak ada perbedaan partisipasi sekolah di tingkat pendidikan dasar (usia 6-12 tahun) antara anggota rumah tangga dari rumah tangga ODHA dan Non-ODHA. Perbedaan tingkat partisipasi mulai terlihat pada jenjang pendidikan diatasnya yang merupakan kelompok usia tingkat pendidikan SLTP (13-15 tahun), dimana secara umum persentasenya jauh lebih rendah dari kelompok sebelumnya dan persentase pada rumah tangga ODHA lebih rendah dari rumah tangga Non-ODHA. Jurang perbedaan persentase partisipasi sekolah antara rumah tangga ODHA dan Non-ODHA semakin lebar sejalan dengan semakin tingginya tingkat pendidikan. Hal ini dapat dilihat pada Tabel 4 dimana persentase perbedaan partisipasi sekolah antara rumah tangga ODHA dan Non-ODHA pada tingkat SLTP adalah 10 persen meningkat menjadi 19 persen pada tingkat SLTA dan 50 persen pada pendidikan yang lebih tinggi dari SLTA. Sehingga dapat disimpulkan bahwa anak-anak dari rumah tangga Non-ODHA cenderung memiliki tingkat pendidikan lebih tinggi dari pada keluarga ODHA.

Tabel 4 Persentase Responden Yang Masih Sekolah Menurut Kelompok Umur, Jenis Kelamin dan Klasifikasi Rumah Tangga

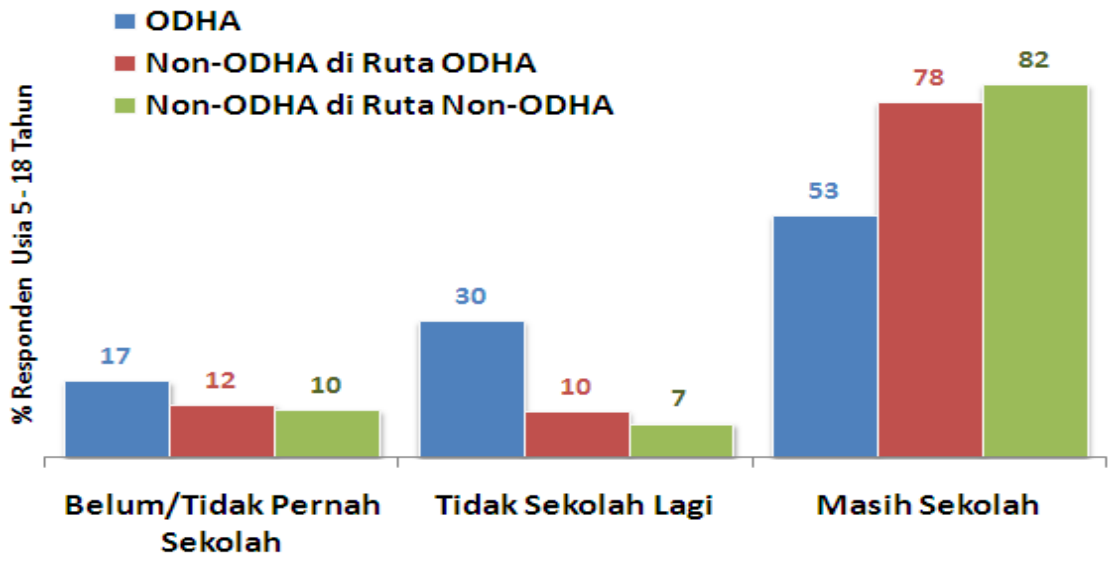
Kelompok Umur	Ruta ODHA			Ruta Non ODHA		
	Laki-Laki	Perempuan	Total	Laki-Laki	Perempuan	Total
0-5 Thn	23	32	29	26	39	31
6-12 Thn	91	91	91	89	93	91
13-15 Thn	92	84	87	93	99	96
16-18 Thn	57	59	58	76	63	69
19-24 Thn	12	12	12	28	20	24
25+ Tahun	1	1	1	1	1	1
Total	15	17	16	23	21	22

Data yang ditemukan mengenai indikasi dampak HIV dan AIDS terhadap tingkat partisipasi sekolah anak usia sekolah pada penelitian ini cukup mengkhawatirkan. Anak usia sekolah dari

rumah tangga ODHA cenderung memiliki kesempatan lebih sedikit untuk mendapatkan akses pendidikan yang lebih tinggi dari rumah tangga Non-ODHA. Hal ini bisa saja terjadi sebagai akibat dari besarnya biaya kebutuhan hidup lainnya yang lebih mendasar seperti kesehatan pada rumah tangga ODHA ataupun juga karena sebagian dari mereka sudah terinfeksi HIV.

Gambar 5 dibawah menunjukkan bahwa persentase responden ODHA berusia 5-18 tahun yang masih sekolah jauh lebih kecil (53 persen) jika dibandingkan dengan responden Non-ODHA dirumah tangga ODHA (78 persen) dan Non-ODHA (82 persen). Sebaliknya persentase responden ODHA usia 5-18 tahun yang belum pernah sekolah dan tidak sekolah lagi lebih tinggi hingga 3 kali lipat lebih dari reponden Non-ODHA di rumah tangga ODHA dan Non-ODHA. Hal ini sudah diprediksi, karena seperti data yang terlihat sebelumnya, rumah tangga ODHA yang miskin cenderung lebih miskin daripada rumah tangga Non-ODHA dan alokasi yang dikeluarkan untuk pendidikan juga lebih kecil.

Gambar 5 Persentase Responden Usia 5-18 Tahun Menurut Status Sekolah dan Status HIV Serta Klasifikasi Rumah Tangga



3.5. Angka Putus Sekolah

Beberapa survei yang berkaitan dengan dampak HIV terhadap pendidikan anak menunjukkan bahwa terdapat korelasi positif antara rumah tangga ODHA dengan jumlah anak putus sekolah. Dimana jumlah anak putus sekolah dalam rumah tangga ODHA cenderung lebih banyak dibandingkan pada rumah tangga Non-ODHA. Pada rumah tangga ODHA, kemungkinan anak perempuan untuk putus sekolah lebih besar daripada anak laki-laki. Hal ini disebabkan karena anak perempuan diwajibkan untuk bisa mengurus rumah tangga dan merawat anggota keluarga yang sakit, sehingga pendidikannya dikorbankan.

Berdasarkan hasil studi ini, ada 69 anak usia 5-17 tahun yang terpaksa harus berhenti bersekolah yang terdiri atas 38 dari 520 anak di rumah tangga ODHA atau sekitar 7 persen, dan 31 dari 656 anak di ruta non ODHA atau 5 persen. Ada berbagai macam alasan yang membuat anak harus putus sekolah antara lain adalah pendidikan dirasakan cukup, tidak punya biaya, malu, membantu orang tua dan lain sebagainya.

Tabel 5 Jumlah Responden Yang Sering Bolos Menurut Alasannya, Jenis Kelamin dan Klasifikasi Rumah Tangga

	Ruta ODHA			Ruta Non ODHA		
	Laki-Laki	Perempuan	Total	Laki-Laki	Perempuan	Total
Pendidikan dirasakan cukup	1	0	1	3	0	3
Tidak punya biaya	7	12	19	8	7	15
Malu	0	2	2	0	0	0
Membantu orang tua	1	1	2	1	2	3
Lainnya	4	10	14	5	5	10
Total	13	25	38	17	14	31

Menurut alasan berhenti sekolah, baik pada rumah tangga ODHA maupun rumah tangga Non-ODHA alasan yang paling banyak diungkapkan responden adalah faktor ekonomi yaitu karena tidak punya biaya. Beratnya beban ekonomi yang harus ditanggung ditambah dengan pengeluaran kesehatan anggota rumah tangga yang terinrfeksi HIV membuat anak usia sekolah terpaksa harus berhenti. Pada rumah tangga ODHA, 19 dari 38 anak menjawab demikian.

3.6. Tingkat Kehadiran

Selain berdampak pada tingginya angka putus sekolah, HIV juga berdampak pada rendahnya tingkat kehadiran anak di sekolah. Persentase anak yang sering bolos sekolah dari anggota rumah tangga yang masih sekolah di rumah tangga ODHA jauh lebih tinggi (17 persen) dibanding rumah tangga Non-ODHA (7 persen).

Pengalaman pernah tidak naik kelas dari anak yang masih sekolah pada rumah tangga ODHA (16 persen) juga lebih tinggi dibanding rumah tangga Non-ODHA. Hal ini bisa saja berkaitan dengan tingkat sering tidak masuk sekolah yang lebih tinggi pada rumah tangga ODHA. Selain itu, pengalaman pindah sekolah pada anak usia yang masih sekolah dari rumah tangga ODHA (16 persen) lebih dari 2 kali lipat rumah tangga Non-ODHA (7 persen).

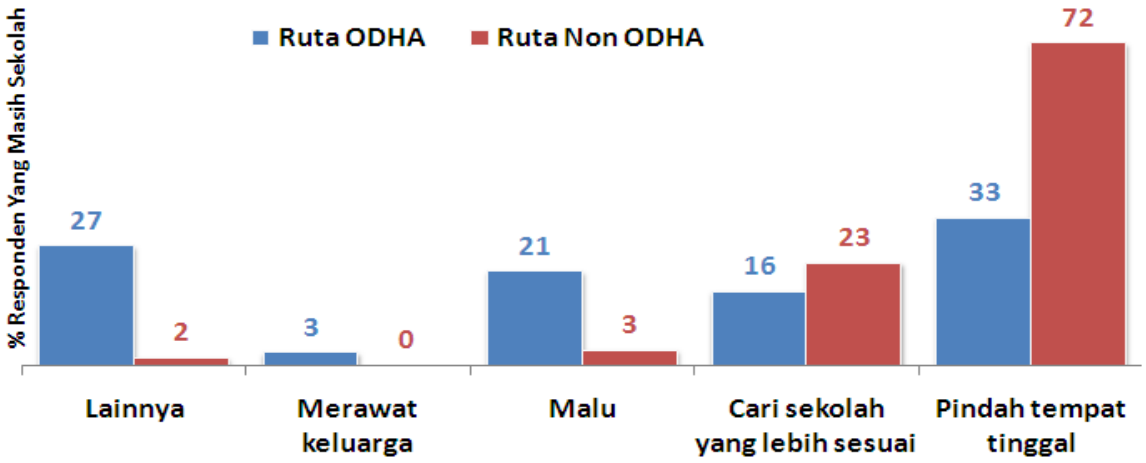
Alasan yang paling banyak diungkapkan oleh 135 responden yang sering bolos sekolah adalah karena malas (58 persen) dimana proporsi responden dari rumah tangga Non-ODHA yang menyatakan alasan tersebut jauh lebih besar (70 persen) dibanding responden dari rumah tangga ODHA (51 persen). Alasan lainnya yang diungkapkan adalah karena bekerja (sekitar 4 persen) dan merawat orang sakit (2 persen).

Tabel 6 Persentase Responden Yang Masih Sekolah dan Sering Bolos, Pernah Tidak Naik Kelas dan Pindah Sekolah Menurut Jenis Kelamin dan Klasifikasi Rumah Tangga

	Ruta ODHA			Ruta Non ODHA		
	Laki-Laki	Perempuan	Total	Laki-Laki	Perempuan	Total
Sering Bolos	17	18	17	8	6	7
Pernah Tidak Naik Kelas	17	14	16	10	10	10
Pernah Pindah Sekolah	17	16	16	8	6	7

Sedangkan alasan pindah sekolah yang paling sering diungkapkan oleh rumah tangga Non-ODHA adalah karena pindah tempat tinggal (72 persen) dan mencari sekolah yang lebih sesuai baik lokasi maupun situasinya (23 persen). Distribusi alasan pindah sekolah anggota rumah tangga ODHA sangat berbeda dengan rumah tangga ODHA, walaupun alasan pindah sekolah karena pindah tempat tinggal (33 persen) juga yang paling sering diungkapkan tetapi alasan lainnya yang cukup banyak adalah karena malu (21 persen), jauh lebih tinggi dari rumah tangga Non-ODHA yang hanya 3 persen. Kategori alasan malu dalam survei ini adalah malu karena keluarga/dirinya terinfeksi HIV atau karena tidak naik kelas, dimana seperti dipaparkan pada tabel sebelumnya persentase anggota rumah tangga ODHA yang tidak naik kelas juga jauh lebih tinggi dari anggota rumah tangga Non-ODHA.

Gambar 6 Persentase Alasan Pindah Sekolah Dari Responden Yang Masih Sekolah Menurut Klasifikasi Rumah Tangga



3.7. Status Sekolah dan Biaya Pendidikan

Sebagian besar anak-anak dari kedua kelompok rumah tangga saat ini bersekolah di sarana pendidikan milik pemerintah. Walaupun demikian, persentase anak dari rumah tangga ODHA (31 persen) yang sekolah di sarana pendidikan swasta lebih tinggi dibanding anak dari rumah tangga Non-ODHA (25 persen). Hal ini cukup menarik karena pada umumnya biaya pendidikan di sarana pendidikan swasta lebih tinggi dari sarana pendidikan pemerindan tingkat kemampuan ekonomi rumah tangga ODHA lebih rendah dari rumah tangga Non-ODHA.

Sebagian besar rumah tangga mampu membiayai pendidikan anaknya saat ini dan persentase rumah tangga ODHA yang mampu membiayai pendidikan anaknya (80 persen) sedikit lebih rendah dari rumah tangga Non-ODHA (84 persen). Sedangkan persentase rumah tangga yang mampu membiayai anaknya hingga tingkat pendidikan yang dianggap mudah mendapatkan pekerjaan secara umum sedikit lebih rendah dari persentase rumah tangga yang mampu membiayai pendidikan saat ini.

Tabel 7 Persentase Rumah Tangga Menurut Kemampuan, Pembiayaan dan Jenjang Pendidikan Ideal Serta Klasifikasi Rumah Tangga

	Ruta ODHA	Ruta Non ODHA
Mampu membiayai pendidikan saat ini	80	84
Mampu membiayai sampai jenjang pendidikan yang harapkan	78	81
Pendidikan anak didukung oleh pihak lain dalam 1 tahun terakhir	26	23
Bentuk Dukungan (% dari yang menerima dukungan pihak lain)		
Biaya Pendidikan	46	56
Uang	43	34
Lainnya	11	9
Pemberi Dukungan Utama (% dari yang menerima dukungan pihak lain)		
Keluarga	56	38
Pemerintah	37	55
Lainnya	3	4
Jenjang Pendidikan Ideal		
SLTA	45	40
Akademi	7	9
S1	44	46
S2	4	6

Jenjang Pendidikan ideal yang paling banyak diungkapkan oleh kepala rumah tangga ODHA adalah SLTA (45 persen) sedangkan dari kepala rumah tangga Non-ODHA adalah Strata 1/sarjana (46 persen). Perbedaan persepsi kepala rumah tangga tentang jenjang pendidikan ideal bagi anaknya sangat dipengaruhi oleh pengalamannya pribadi dan kemampuan ekonomi rumah tangga saat ini.

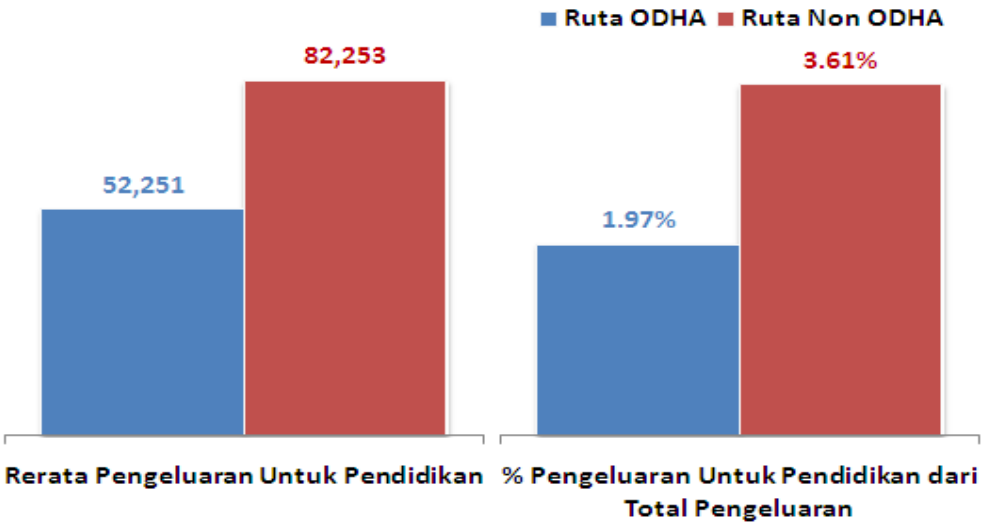
Sebanyak 26 persen rumah tangga ODHA dan 23 persen rumah tangga Non-ODHA mengaku menerima dukungan dari pihak lain dalam 1 tahun terakhir untuk pendidikan anaknya. Sebagian besar rumah tangga ODHA (56 persen) yang menerima bantuan untuk pendidikan, mengaku menerimanya dari pihak keluarga, sedangkan sebagian besar rumah tangga Non-ODHA (55 persen) menerima bantuan pendidikan dari pemerintah. Hal ini tentunya sangat berkaitan dengan persentase anggota rumah tangga ODHA yang sekolah di sarana pendidikan swasta karena jika dilihat dari kemampuan ekonomi jelas sekali lebih banyak rumah tangga ODHA yang memerlukan bantuan untuk pendidikan anak dari pemerintah, tetapi kenyataannya lebih banyak rumah tangga Non-ODHA yang menerimanya.

Bentuk bantuan yang paling banyak diterima berupa biaya pendidikan, diikuti oleh bantuan berbentuk uang dan bantuan lainnya termasuk peralatan sekolah. Persentase rumah tangga ODHA yang menerima bantuan pendidikan berupa uang sebanyak 43 persen, lebih tinggi dibanding rumah tangga Non-ODHA (34 persen). Bentuk bantuan tentunya sangat berkaitan dengan sumber bantuan, dan karena rumah tangga ODHA lebih banyak menerima bantuan dari keluarga daripada dari pemerintah maka wajar saja jika persentase yang menerima bantuan berupa uang juga lebih tinggi.

Sedangkan rerata pengeluaran total rumah tangga untuk pendidikan anak secara umum relatif kecil jika dibandingkan dengan pengeluaran untuk komponen lainnya, bahkan merupakan komponen pengeluaran yang paling kecil dan kurang dari setengah pengeluaran rumah tanggga untuk rokok. Hal ini menunjukan bahwa pendidikan anak kurang menjadi prioritas bagi rumah tangga yang menjadi responden penelitian ini dan hampir sama dengan gambaran struktur pengeluaran masyarakat Indonesia pada umumnya.

Perbandingan rerata pengeluaran untuk pendidikan menunjukan bahwa pengeluaran pendidikan rumah tangga ODHA (Rp. 52,251) jauh lebih kecil dari rumah tangga Non-ODHA (Rp. 82,253) walaupun rerata total pengeluaran rumah tangga ODHA jauh lebih besar dari rumah tangga Non-ODHA. Gambaran tersebut menunjukan bahwa pengeluaran pendidikan lebih menjadi tidak prioritas pada rumah tangga ODHA.

Gambar 7 Rerata dan Proporsi Pengeluaran Pendidikan Menurut Klasifikasi Rumah Tangga



3.8. Stigma dan Diskriminasi di Lingkungan Tempat Tinggal Dan Sekolah

Sebagaimana telah diulas sebelumnya, vonis yang mengatakan telah terjadi diskriminasi terhadap ODHA harus ditempatkan secara proporsional agar tidak bias dalam mempersoalkannya. Ketika membahas diskriminasi yang terjadi di lingkungan tempat tinggal misalnya, maka hal pertama yang perlu dipastikan adalah apakah para tetangga tahu mengenai status ODHA pada ART dari rumah tangga target. Hasil survei yang dilakukan terhadap 996 rumah tangga ODHA di 7 provinsi wilayah penelitian mengungkapkan bahwa hanya 163 rumah tangga (16 persen) yang memastikan bahwa para tetangganya tahu mengenai keberadaan ODHA di dalam rumah tangganya. Ketika ditanyakan kembali kepada 163 rumah tangga tersebut apakah pernah mendapatkan perlakuan diskriminatif dari para tetangga, Sebagian besar rumah tangga di seluruh wilayah penelitian menyatakan tidak pernah menerima perlakuan diskriminasi, hanya 58 rumah tangga atau 36 persen di antaranya yang menyatakan pernah menerima perlakuan diskriminasi dari tetangga tempat tinggal mereka.

Dari 58 rumah tangga yang mengalami diskriminasi tersebut, jenis diskriminasi yang paling banyak dialami rumah tangga di lingkungan tempat tinggalnya adalah, dihindari para tetangga (34 rumah tangga). Diskriminasi terbanyak kedua adalah kekerasan verbal (31 rumah tangga), kemudian rumah tangga HIV tidak diijinkan bermain dengan anak tetangganya (22 rumah tangga). Selain itu,

sebanyak 15 rumah tangga mengaku para tetangganya tidak lagi mau meminjamkan apapun kepada mereka. Sebanyak 7 rumah tangga pernah mendapatkan kekerasan fisik. Bagi rumah tangga ODHA yang memiliki usaha warung, 12 di antaranya mengaku jumlah pembelinya semakin berkurang. Profil lengkap jenis perlakuan diskriminasi yang terjadi di lingkungan tempat tinggal dapat dilihat pada Tabel 8.

Tabel 8 Persentase Rumah Tangga ODHA yang Mendapat Perlakuan Diskriminasi di Lingkungan Tempat Tinggal Menurut Jenis Kelamin Kepala Rumah Tangga

Jenis Diskriminasi dari Tetangga	Laki-Laki	Perempuan	Total
Dihindari	18	28	21
Kekerasan verbal	19	20	19
Tidak diijinkan bermain bersama	11	20	14
Tidak lagi meminjamkan apapun	8	12	9
Tidak mau berteman	7	12	9
Tidak diterima lingkungan	6	12	8
Diboikot secara sosial	6	10	7
Jumlah pembeli berkurang	6	10	7
Kekerasan fisik	4	4	4
Dihalangi menggunakan sumur umum	3	4	3

Dalam kuesioner SDGK09-M, beberapa kemungkinan perlakuan diskriminatif yang terjadi di lingkungan sekolah juga sudah ditampung. Berkaitan dengan hal tersebut, dari 996 rumah tangga yang menjadi sampel penelitian, hanya terdapat 316 rumah tangga ODHA yang memiliki anggota rumah tangga masih sekolah. Dari angka tersebut, hanya 5 rumah tangga yang menyatakan bahwa pihak sekolah mengetahui bahwa di rumah tangganya ada anggota rumah tangga dengan status ODHA. Namun, dari 5 rumah tangga tadi, hanya ada 1 rumah tangga yang mengaku ada diskriminasi dari pihak sekolah, yaitu guru membatasi tanya jawab dengan anggota rumah tangga HIV yang bersekolah tersebut.

IV. Kesimpulan dan Rekomendasi

4.1. Kesimpulan

Penelitian ini menggunakan data yang dikumpulkan langsung dari 996 rumah tangga ODHA dan 996 rumah tangga Non-ODHA sebagai pembanding, yang tersebar di 13 kota dalam 7 provinsi dengan tingkat prevalensi HIV berbeda untuk mengetahui dampak HIV dan AIDS pada rumah tangga. Hasil penelitian ini secara umum menyimpulkan bahwa walaupun secara makro dampak epidemi HIV belum terlalu besar tetapi pada tingkat rumah tangga sudah sangat memprihatinkan

Penelitian ini menemukan dampak HIV pada pendidikan anak-anak dan masalah stigma sosial juga di dapati sebagai masalah serius yang perlu segera ditindaklanjuti karena menyebabkan sebagian besar ODHA tidak membuka status HIV-nya pada lingkungan sekitarnya bahkan pada keluarga dan pasangan hidupnya sehingga mereka tidak mendapatkan layanan dan bantuan yang seharusnya. Penyebab utama stigma dan diskriminasi adalah rendahnya pengetahuan komprehensif tentang HIV.

Infeksi HIV lebih banyak terjadi pada responden laki-laki usia produktif, sehingga menyebabkan mereka menjadi kurang atau tidak produktif lagi dan perubahan sebagian struktur rumah tangga ODHA. Dampaknya yang dapat dilihat dari penelitian ini adalah lebih tingginya proporsi anak yang bekerja dan putus sekolah serta perempuan yang menjadi kepala rumah tangga dan pencari nafkah utama. Sebagian besar perempuan ODHA yang terinfeksi pernah atau sedang menikah memiliki pasangan suami yang terlebih dahulu terinfeksi. Ini menunjukkan bahwa eksistensi penularan HIV dari pasangan intim sudah tampak di Indonesia. Perempuan mengalami dua dampak sebagai korban yang terinfeksi karena relasi dengan pasangan intim dan dampak lanjut sebagai dalam rumah tangga ODHA karena harus menjadi penyokong utama dalam keluarga ODHA tersebut.

Terkait dengan pendidikan anak, sangat jelas terlihat dari hasil penelitian ini bahwa pengeluaran rumah tangga ODHA untuk biaya pendidikan anak jauh lebih kecil dibandingkan rumah tangga Non-ODHA. Secara nominal, rerata pengeluaran biaya pendidikan per kapita per bulan rumah tangga ODHA hanya 43 persen dari rumah tangga Non-ODHA. Sedangkan dari proporsi pengeluaran keseluruhan per bulan, rumah tangga ODHA hanya mengalokasikan 1/3 dari alokasi biaya pendidikan di rumah tangga Non-ODHA. Hasil penelitian ini juga menemukan hampir 50 persen ODHA usia sekolah yang tidak bersekolah dan hanya seperempat rumah tangga ODHA yang menerima bantuan untuk pendidikan anaknya.

4.2. Rekomendasi

Temuan dari penelitian ini membutuhkan tindak lanjut yang perlu segera dilakukan untuk mengurangi dampak HIV dan AIDS. Respon yang terhadap temuan penelitian ini idealnya dilakukan dengan menggunakan pendekatan multi-dimensi mengingat beragamnya isu dan komplikasi permasalahan yang dihadapi. Beberapa rekomendasi yang perlu ditindaklanjuti adalah sebagai berikut:

- Upaya mitigasi dampak HIV dan AIDS harus menjadi bagian yang terintegrasi dari dari strategi penanggulangan AIDS di semua tingkat pemerintahan dan mendapatkan alokasi pendanaan yang memadai. Peran sentral Komisi Penanggulangan AIDS disemua tingkat pemerintahan untuk merespon rekomendasi ini melalui fungsi advokasi dan koordinasi yang dimilikinya akan menjadi salah satu kunci keberhasilan.
- Banyaknya anak usia sekolah dari rumah tangga ODHA maupun anak dengan HIV yang tidak sekolah lagi perlu mendapatkan perhatian khusus dari Kementerian Pendidikan Nasional. Rencana kerja yang terintegrasi untuk memberikan kesempatan bagi anak dari rumah tangga ODHA untuk mendapatkan pendidikan yang lebih tinggi juga dapat membantu pengendalian HIV dan AIDS dimasa depan.

Daftar Singkatan

AIDS	Acquired Immune Deficiency Syndrome
ART	Anggota Rumah Tangga
ARV	Anti Retriviral
Bappeda	Badan Perencanaan Pembangunan Daerah
BPS	Badan Pusat Statistik
CD4	cluster of differentiation four, adalah sebuah marker atau penanda yang berada di permukaan sel-sel darah putih manusia
CDR	Crude Death Rate
DKI	Daerah Khusus Ibukota
FGD	*Focus Group Discussions*
FKUI	Fakultas Kedokteran Universitas Indonesia
GK	Garis Kemiskinan
HIV	Human Immuno-deficiency Virus
ILO	International Labor Organization
IMR	Infant Mortality Rate
JOTHI	Jaringan Orang Terinfeksi HIV Indonesia
KB	Keluarga Berencana
KPAD	Komisi Penanggulangan AIDS Daerah
KPAN	Komisi Penanggulangan AIDS Nasional
KRT	Kepala Rumah Tangga
KTS	Konseling dan Tes HIV Sukarela
LSL	Laki-laki yang suka seks dengan laki-laki
LSM	Lembaga Swadaya Masyarakat
MDG	Millennium Development Goals
ODHA	Orang dengan HIV dan AIDS
PBB	Persatuan Bangsa-Bangsa
Penasun	Pengguna Napza Suntik
PS	Pekerja Seks
Puskesmas	Pusat Kesehatan Masyarakat
RI	Republik Indonesia
RSCM	Rumah Sakit Cipto Mangunkusumo'
Ruta	Rumah Tangga
SD	Sekolah Dasar
SDGK	Survei Dampak Gangguan Kesehatan
SLTA	Sekolah Lanjutan Tingkat Atas
SLTP	Sekolah Lanjutan Tingkat Pertama
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nation Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nation General Assembly Special Session
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

3 Program Jaminan Hidup untuk Anak Dengan HIV (ADHA) di DIY

Juniati Rahmadani
(Komisi Penanggulangan AIDS Provinsi DIY, Indonesia)

A. Pendahuluan

1. Latar Belakang Penelitian

a. Situasi epidemi HIV dan AIDS

Human Immunodeficiency Virus (HIV) telah menginfeksi jutaan orang di dunia. Virus ini menurunkan kekebalan tubuh orang yang diinfeksinya. Ketika kekebalan tubuh menurun maka orang tersebut akan mudah terinfeksi penyakit lain (infeksi oportunistik), kondisi ini disebut tahap AIDS (*Acquired Immuno Deficiency Syndrome*). Mereka yang telah pada tahapan AIDS akan membutuhkan pengobatan dan perawatan lanjutan (WHO, 2013)

UNAIDS melaporkan perkiraan atau estimasi jumlah orang yang hidup dengan HIV pada akhir 2011 sekitar 34 juta orang di seluruh dunia (range perkiraan 31,4 – 35,9 juta orang) (UNAIDS, 2012 p.8). Tahun 2010, diperkirakan 3,4 juta anak usia di bawah 14 tahun terinfeksi HIV (Unicef, 2012 *in* Mann, et al, 2012 p.16). Di Indonesia, laporan kasus HIV&AIDS dari Kementerian Kesehatan RI secara kumulatif sampai dengan Desember 2012 diketahui bahwa HIV sebanyak 98.390 kasus dan AIDS sebanyak 45.499 kasus. Laporan temuan kasus HIV dan AIDS Daerah Istimewa Yogyakarta (DIY) sampai dengan Desember 2012 ada 1.110 kasus HIV dan 831 kasus AIDS. Dari laporan tersebut, secara kumulatif sd Desember 2012 jumlah anak dengan HIV dan AIDS yang ditemukan pada rentang usia kurang dari 19 tahun adalah 126 anak. Kasus anak dengan HIV pertama di DIY ditemukan pada tahun 2003.

Anak yang terdampak HIV adalah anak dan remaja di bawah usia 18 tahun yang hidup dengan HIV (terinfeksi HIV), telah kehilangan salah satu atau kedua orang tua karena AIDS dan rentan kesejahteraan dan perkembangan karena HIV (Unicef, 2007 p.9). Pada rumah tangga yang merasakan dampak HIV dan AIDS, ibu atau bapak bisa kehilangan pasangannya karena AIDS. Mereka akan terbebani dengan kebutuhan ekonomi dan tanggung jawab mengasuh anak. Beberapa kasus, orang tua tersebut juga menjadi sakit dan meninggal. Anak-anak sangat terkena dampaknya karena orang tua mereka yang sakit dan meninggal dunia (Unicef, 2004 p.16). Kerentanan anak yang terdampak HIV sangat banyak, antara lain : kesulitan ekonomi karena pendapatan keluarga dihabiskan untuk biaya perawatan, kapasitas keluarga menyediakan kebutuhan pokok anak bisa berkurang. Anak akan kurang mendapatkan kasih sayang dan

perhatian. Anak dapat berhenti sekolah. Anak mendapatkan tekanan psikologis akibat penyakit dan kematian orang tua serta keadaan sebagai anak yatim. Anak-anak berisiko mengalami tindak kekerasan dan tertular HIV dikarenakan kemiskinan dan tanpa pengasuhan orang tua. Anak-anak ini menghadapi resiko kekurangan gizi, menderita sakit dan tidak mendapatkan perawatan kesehatan yang mereka butuhkan. AIDS telah melemahkan perlindungan dan dukungan orang tua terhadap anak, menurunkan pendapatan keluarga dan kemungkinan mendapatkan stigma dan diskriminasi. Ini meningkatkan resiko anak-anak mengalami eksploitasi, kekerasan dan pengabaian (Unicef, 2007 pp.9-17).

ADHA membutuhkan perhatian khusus karena kebutuhan tambahan untuk memastikan pertumbuhan dan perkembangan serta ketergantungan mereka pada orang dewasa untuk perawatan, termasuk nutrisi dan dukungan pengobatan. Kebutuhan nutrisi memiliki peran penting dalam mendukung pengobatan antiretroviral, terutama bagi anak yang sudah memulai terapi antiretroviral (ART) (WHO, 2009 p.1).

Kerangka kerja yang dikembangkan dalam upaya mengatasi kerentanan yang dihadapi oleh anak dengan HIV ada 5 strategi yaitu :

1. Menguatkan kapasitas keluarga untuk melindungi dan merawat anak yatim dan anak rentan terhadap HIV dengan memperpanjang kehidupan orang tua dan menyediakan bantuan ekonomi, psiko-sosial dan dukungan lain
2. Memobilisasi dan mendukung respon masyarakat
3. Memastikan akses untuk anak yatim dan anak yang rentan untuk mendapatkan pelayanan dasar, termasuk pendidikan, perawatan kesehatan dan akta kelahiran
4. Memastikan pemerintah melindungi anak yang paling rentan melalui peningkatan kebijakan dan perundangan serta menyalurkan sumber daya kepada keluarga dan komunitas
5. Meningkatkan kesadaran di semua level melalui advokasi dan mobilisasi sosial untuk menciptakan lingkungan yang kondusif untuk anak-anak dan keluarga yang terdampak HIV dan AIDS (Unicef, 2004 p.15).

Dalam Undang-Undang (UU) Republik Indonesia Nomor 23 Tahun 2002 tentang perlindungan anak, yang disebut anak adalah seseorang yang belum berusia 18 (delapan belas) tahun, termasuk anak yang masih dalam kandungan. Perserikatan Bangsa Bangsa (PBB) pun juga memiliki pengertian yang sama, hasil dari Konvensi PBB tentang hak-hak anak, yang disebut dengan anak adalah laki-laki atau perempuan yang berusia di bawah 18 tahun. Prinsip-prinsip dasar konvensi hak-hak anak meliputi : Kepentingan yang terbaik bagi anak, tidak ada diskriminasi, hak untuk bertahan hidup, sejahtera, dan berkembang serta menghargai pandangan anak (Unicef, 2004 pp.14-15).

HIV meningkatkan kerentanan ekonomi anak. Infeksi menyebabkan keluarga menjadi lebih miskin ketika orang dewasa sakit atau mengurangi waktu mereka untuk memberikan perawatan, sebagai akibat dari kehilangan harta dan pendapatan lain. Keluarga tersebut juga akan menghadapi naiknya pembiayaan kesehatan, beban dari orang tua yang sakit atau meninggal serta rumah tangga tersebut kehilangan pendapatan (Unicef, 2007 p.13). Kemiskinan menjadi penentu sosial dari akses, cakupan dan kualitas dari pencegahan, pengobatan dan perawatan mengindikasikan kebutuhan untuk mitigasi dampak epidemi pada anak dan keluarga untuk memastikan respon AIDS yang setara. Bukti-bukti menunjukkan bahwa status ekonomi keluarga sering menjadi faktor penentu yang lebih baik dari kebutuhan anak. Meskipun dampak HIV pada anak-anak dan keluarga berbeda-beda tergantung pada epidemi dan keadaannya, HIV dan AIDS sering menambah kerentanan anak-anak dan memiliki dampak negatif pada kapasitas ekonomi

rumah tangga, ketersediaan makanan, akses layanan kesehatan. Stigma dan diskriminasi dapat menjadi penghambat untuk sekolah, ke layanan kesehatan dan layanan lainnya. Tidak perlu miskin untuk menjadi rentan karena infeksi HIV, HIV dan AIDS dapat mendorong orang kedalam kemiskinan dan terpinggirkan yang diakibatkan virus tersebut (Unicef, 2012 pp.11-13).

b. Perlindungan sosial dan HIVdan AIDS

Dalam UU No. 23 Tahun 2002, dalam pasal 4 tentang hak dan kewajiban anak disebutkan bahwa setiap anak berhak untuk dapat hidup, tumbuh, berkembang, dan berpartisipasi secara wajar sesuai dengan harkat dan martabat kemanusiaan, serta mendapat perlindungan dari kekerasan dan diskriminasi.

Perlindungan sosial diperlukan untuk anak-anak yang tidak mendapatkan hak-haknya dengan baik. Perlindungan sosial didefinisikan sebagai semua inisiatif publik dan swasta yang memberikan pendapatan atau konsumsi kepada orang miskin, melindungi masyarakat yang rentan terhadap resiko untuk memperoleh pendapatan, dan meningkatkan status sosial dan hak-hak yang terpinggirkan, dengan tujuan keseluruhan mengurangi kerentanan ekonomi dan sosial yang terpinggirkan oleh masyarakat. Perlindungan sosial dapat membantu mengurangi kekurangan dan kesenjangan yang membuat orang rentan terhadap infeksi HIV, membantu mengatasi hambatan terhadap akses pengobatan, dan mengurangi dampak pada kemiskinan rumah tangga dan pengucilan sosial (UNAIDS, 2011 p.4).

Perlindungan sosial dapat berkontribusi untuk menekan kemiskinan dan pengucilan sosial anak yang terdampak HIV, menekan ketidaksetaraan yang dapat meningkatkan kerentanan seperti ketidaksetaraan gender dan membantu mengatasi kendala dalam mengakses perawatan. Perlindungan keuangan, termasuk transfer tunai adalah salah satu bentuk pendekatan perlindungan sosial yang efektif, menginisasi untuk akses layanan serta kebijakan yang mempromosikan hasil yang adil dan mengurangi pengucilan sosial (Unicef, 2010 p.23).

Perlindungan sosial bertujuan untuk membantu mencapai akses universal untuk pencegahan HIV, pengobatan, perawatan dan dukungan. Pendekatan yang komprehensif untuk perlindungan sosial termasuk perlindungan, pencegahan, promosi dan transformatif. Hal ini dapat mencegah kerentanan (kemungkinan individu terinfeksi HIV) dan mengurangi kerentanan yang dikarenakan dampak dari HIV (UNAIDS, 2011 pp.5-6).

UNAIDS merekomendasikan penentuan perlindungan sosial adalah sensitif HIV daripada eksklusif HIV sebagai upaya untuk mempromosikan program yang adil, inklusif, tidak menstigma dan tidak mendiskriminasi. Pendekatannya, orang yang hidup dengan HIV dan kelompok rentan lainnya dilayani bersamaan, orang yang terdampak HIV tidak sasaran tunggal layanan. Upaya perlindungan sosial yang sensitif HIV termasuk :

- Kebijakan perlindungan sosial, undang-undang atau aturan yang dirancang untuk melihat kebutuhan dan menjunjung hak asasi dari masyarakat yang paling rentan, termasuk yang terdampak HIV
- Perlindungan keuangan untuk individu dan rumah tangga yang terdampak HIV, termasuk melalui transfer sosial
- Akses terjangkau, layanan yang berkualitas bagi mereka yang berisiko, terdampak atau HIV positif.

  (UNAIDS, 2011 pp.5-6)

Pada area pencegahan, bentuk perlindungan sosialnya seperti transfer sosial dalam bentuk uang, makanan dan akses menjangkau pendidikan dapat mengurangi ketidaksetaraan gender, mengurangi perilaku beresiko yang dapat membuat mereka rentan terinfeksi. Bentuk lainnya di area pencegahan adalah kebijakan, perundangan dan peraturan yang sensitif HIV dapat menegakkan hak ekonomi dan sosial dari populasi rentan dan populasi resiko tinggi dengan melindungi hak waris dan mereduksi stigma dan diskriminasi. Pada area pengobatan, transfer sosial dapat mengatasi masalah keuangan dan kendala lain dalam akses pengobatan dan kepatuhan, melakukan terapi antiretroviral dan layanan kesehatan umum, menjadi lebih terjangkau dan dapat diakses (UNAIDS, 2011 p.6).

Banyak bukti yang memberikan gambaran dampak positif dari berbagai perlindungan sosial, termasuk transfer tunai sosial, transfer makanan, perlindungan kesehatan sosial, voucher dan pembebasan biaya dalam pengobatan. Transfer sosial dan makanan memiliki peran yang penting dalam pemulihan nutrisi orang yang terinfeksi HIV, meningkatkan akses ke layanan kesehatan dan melakukan pengobatan. Transfer tunai untuk membiayai transportasi ke klinik kesehatan meningkatkan kepatuhan dalam pengobatan (Unicef, 2012 p.6).

c. Kebijakan perlindungan sosial ADHA di Indonesia

Kementerian Sosial RI melalui Direktorat Pelayanan Rehabilitasi Sosial Tuna Sosial memberikan program perlindungan sosial terhadap anak dengan HIV dan AIDS (ADHA) dan pemberdayaan keluarganya. Program ini dilaksanakan di DIY pada tahun 2009. Program ini merupakan suatu kegiatan yang dilaksanakan dalam rangka pemberian jaminan hidup (jadup) bagi ADHA dan memberdayakan keluarganya. Dengan program ini diharapkan dapat dipenuhinya sebagian hak-hal anak, seperti hak memperoleh pendidikan dan pengajaran, hidup, tumbuh dan berkembang, memperoleh kesehatan dan sekaligus memberdayakan keluarganya (Departemen Sosial RI, 2009 p.2).

Program ini dimulai sejak tahun 2009 sampai dengan 2013. Temuan kasus HIV dan AIDS di DIY selalu ada setiap tahun, tidak hanya temuan kasus pada orang dewasa namun juga anak-anak. Ini menunjukkan bahwa program masih diperlukan di DIY untuk ke depan guna memenuhi kebutuhan ADHA. Pelaksanaan program ini belum dilakukan upaya evaluasi untuk peningkatan pelayanan ke depan, di mana salah satu isu yang masih menjadi tantangan dalam pelaksanaan program adalah status HIV anak, keterbukaan menjadi *point* ADHA dapat mengakses layanan. Di Indonesia, stigma dan diskriminasi masih menjadi hal yang belum terselesaikan yang mengakibatkan ODHA belum mau terbuka.

2. Tujuan Penelitian dan Rumusan Masalah

Penelitian ini bertujuan untuk melakukan evaluasi pelaksanaan program ini pada 4 hal yaitu *coverage, accessibility, adequacy* dan *quality of service* (beberapa pendekatan perlindungan sosial menurut ILO (2008) dan Sepulveda and Nyst (2012)). Adapun rumusan masalah yang muncul dari penelitian ini adalah :

- Berapa besar jumlah penerima jadup di DIY dibandingkan dengan jumlah ADHA yang ditemukan di DIY?
- Seberapa jauh ADHA dan keluarga bisa mengakses program ini?
- Seberapa jauh besaran jadup mampu memenuhi kebutuhan hidup ADHA?
- Seberapa tinggi kualitas pelayanan yang diberikan kepada penerima manfaat program?

3. Manfaat Penelitian

Manfaat dari penelitian ini adalah untuk memberikan gambaran mengenai pelaksanaan program jadup ADHA di DIY dan tantangan yang dihadapi sehingga bisa memberikan rekomendasi dalam pelaksanaan program tersebut.

B. Tinjauan Literatur

Strategi Rencana Aksi Nasional Penanggulangan HIV dan AIDS tahun 2010-2014 memuat rencana aksi dengan salah satu areanya adalah mitigasi dampak. Mitigasi dampak sebagai upaya untuk mengurangi dampak sosial ekonomi HIV dan AIDS pada ODHA dan keluarganya. Program mitigasi dampak diberikan kepada mereka yang kurang beruntung dan membutuhkan dukungan, seperti penyediaan kesempatan pendidikan, pelayanan kesehatan, gizi dan akses pada bantuan ekonomi yang menjadi komponen utama program ini. Program ini dilakukan bekerjasama dengan Depsos, Depdiknas dan dukungan sebaya (KPAN, 2010 p.31). Kerangka monitoring dan evaluasi (monev) dalam program penanggulangan HIV dan AIDS yang dituangkan dalam Strategi Rencana Aksi Nasional Penanggulangan HIV dan AIDS tahun 2010-2014 dilakukan dengan menilai setiap tahapan pelaksanaan program, mulai tahap input, proses kegiatan, output, hasil sampai dengan dampak program (KPAN, 2010 p.49).

Program mitigasi dampak dicakup dalam indikator proses pelaksanaan program. Indikator output dalam kerangka monev ini adalah cakupan program (coverage). Indikator outcome penting untuk menilai perkembangan efektivitas program. Dalam kerangka kerja monev KPAN, kualitas hidup masuk ke dalam indikator hasil sedangkan morbiditas/mortalitas AIDS serta norma sosial dan dampak ekonomi berada dalam indikator dampak (hasil jangka panjang) (KPAN, 2010 p.49). Metode pengumpulan data dalam SRAN untuk mitigasi dampak, bisa dilakukan dengan monitoring perkembangan layanan mitigasi dampak (melalui Depsos) atau pun melalui riset operasional untuk meningkatkan efektivitas program (KPAN, 2010 p.51).

Monitoring dan evaluasi merupakan aktivitas yang berbeda dalam tujuan dan disain kegiatan namun saling melengkapi. Monitoring menyediakan informasi mengenai program pada waktu tertentu, ini dapat memberikan gambaran mengenai situasi atau status program. Evaluasi menyediakan informasi tentang apakah program mencapai tujuan yang diharapkan atau tidak dan mengapa hal itu bisa terjadi. Evaluasi ini dimaksudkan untuk membangun temuan dari pemantauan/monitoring dan memberikan informasi tambahan tentang relevansi dan kesesuaian, jangkauan dan cakupan, kualitas, keberhasilan, efektivitas dan efesiensi dari program tertentu (UNAIDS, 2010 p. 18).

Program yang bertujuan melakukan evaluasi hasil atau dampak harus dilaksanakan pada beberapa tingkat proses evaluasi untuk memeriksa: kesesuaian terhadap rancangan program, kualitas layanan yang diberikan, perekrutan klien dan retensi, jangkauan program, intensitas program yang disampaikan dan diterima, reaksi klien / kepuasan, perubahan kontekstual, dan lain hal. Ini penting untuk mengidentifikasi masalah dalam implementasi yang mana dapat memberikan dampak negatif pada program. Menilai implementasi program sebagaimana dampak program dapat menggunakan beberapa metode yang digabungkan (UNAIDS, 2010 p. 24).

Hal yang penting dalam mengumpulkan data yang dapat mendukung hubungan yang sesuai antara operasional program dan hasil yang diamati untuk meningkatkan reliabilitas dan validitas evaluasi program adalah metode triangulasi data perlu diterapkan (yaitu menganalisis data dari berbagai sumber data, penggunaan gabungan dan melengkapi data membantu untuk mengatasi

kelemahan yang melekat dalam set data) dan dapat membantu menciptakan "konvergensi bukti "untuk menarik kesimpulan yang sesuai/masuk akal (UNAIDS, 2010 p. 42). Melibatkan penerima manfaat dan penyedia layanan untuk memvalidasi temuan evaluasi dari perspektif mereka, merupakan langkah penting dalam membangun bukti yang kredibel untuk efek program. Analisis semua data yang tersedia untuk menentukan apakah perubahan yang diamati cukup dapat dikaitkan dengan program (menggunakan kriteria yang telah ditetapkan sebelumnya). Proses ini disebut sebagai triangulasi data dan harus dilakukan secara partisipatif (termasuk pengambil keputusan, evaluator, manajer program, penyedia layanan dan penerima program) untuk berkontribusi dari perspektif yang berbeda dan meminimalkan potensi bias dalam interpretasi data. Ketika data dari sumber data yang berbeda berkumpul (yaitu konvergensi bukti), memberikan bukti yang cukup untuk hubungan sebab akibat. Idealnya, sumber data dan analisis harus memungkinkan untuk menilai beberapa kekuatan dan kelemahan dari komponen kunci dari program pencegahan HIV, sehingga penyesuaian dalam program ini dapat dilakukan apabila dibutuhkan (UNAIDS, 2010 p. 44).

Menurut *International Labour Organization* (ILO), dalam perlindungan sosial kesehatan pendekatannya melalui konsep *coverage* (cakupan), *access* (akses), *affordability* (keterjangkuan) dan *quality of service* (kualitas layanan). Cakupan mengacu pada perluasan perlindungan sosial sehubungan dengan jumlah penduduk yang dapat mengakses layanan dan sejauh mana biaya perawatan dibiayai. Cakupan berkaitan dengan akses yang efektif terhadap pelayanan, mengacu pada ketersediaan secara fisik, pembiayaan dan area layanan. Kualitas layanan menyangkut etika, seperti kerahasiaan, menghormati gender dan isu-isu mengenai waktu layanan (ILO, 2008 pp.17-18). Prinsip kesetaraan dan non-diskriminasi dalam program perlindungan sosial untuk memenuhi standar *accessibilty* (akses), *adaptability* (kemampuan adaptasi), *acceptability* (penerimaan) dan *adequacy* (kecukupan) dalam kaitannya dengan hak-hak ekonomi, sosial dan budaya (Sepulveda and Nyst, 2012 p.42).

C. Metodologi Penelitian

1. Metode dan Jenis Penelitian

Penelitian ini adalah penelitian kualitatif dengan metode *desk review* dilengkapi dengan *indepth interview* untuk memperdalam hasil *desk review*. *Desk review* adalah pengambilan data dengan menelaah atau mempelajari dokumen-dokumen terkait penelitian.

Analisa hasil dilakukan dengan mendiskripsikan temuan dan dibandingkan temuan dalam *desk review* dan hasil *indepth interview*.

2. Cara Pengumpulan Data

Penelitian dilaksanakan pada bulan Maret 2013 selama 1 minggu, tanggal 1-8 Maret 2013. Penelitian dilakukan di Daerah Istimewa Yogyakarta. Pengumpulan data dilakukan dengan mendapatkan dokumen-dokumen terkait penelitian untuk direview. Dokumen diperoleh dari Dinas Sosial DIY selaku pelaksana program pemberian jaminan hidup ADHA dan Komisi Penanggulangan AIDS DIY serta akses internet (beberapa dokumen perundangan dan peraturan). *Indepth interview* dilakukan dengan *instrument* wawancara terstruktur dengan menanyakan beberapa pertanyaan yang berkaitan dengan 4 hal yang menjadi fokus penelitian. Hal-hal yang ditanyakan dalam *indepth interview*, antara lain :

1. *Coverage* (cakupan) :
    - Jumlah penerima bantuan
    - Sebaran wilayah domisili penerima bantuan
2. *Adequacy* (kecukupan):
    - Besaran bantuan yang diberikan kepada ADHA
    - Besaran kebutuhan ADHA
3. *Accessibility* (akses) :
    - Kriteria penerima bantuan
    - Prosedur pemberian bantuan
4. *Quality of service* (kualitas layanan) :
    - Tingkat kepuasan penerima bantuan
    - Pendapat mengenai program

Wawancara atau *indepth interview* dilakukan kepada 4 bagian yang berperan dalam pelaksanaan pemberian bantuan jadup ADHA :

1) *Provider*/penyedia program pemberian jadup ADHA: Dinas Sosial DIY (1 orang)
2) Lembaga Kesejahteraan Sosial/pendamping : LSM Victory Plus (2 orang)
3) Penerima manfaat : keluarga anak dengan HIV (2 orang)
4) Lembaga koordinasi penanggulangan AIDS : KPA DIY (1 orang)

3. Sumber Data

Dokumen yang menjadi sumber data dalam penelitian ini adalah :

- Panduan Uji Coba Perlindungan Sosial ADHA dan Pemberdayaan Keluarganya
- Surat Keputusan Kepala Dinas Sosial Provinsi Daerah Istimewa Yogyakarta No. 188/2598/II.2 tentang Penunjukkan Penerima Bantuan Jaminan Hidup dan Pendamping Lapangan Bagi Anak dengan HIV dan AIDS (ADHA) Kegiatan Rehabilitasi Sosial Tuna Sosial Tahun Anggaran 2011
- Surat Keputusan Kuasa Pengguna Anggaran Dinas Sosial Provinsi Daerah Istimewa Yogyakarta No. 188/0151/II.2 tentang Penunjukkan Penerima Bantuan Jaminan Hidup dan Pendamping Lapangan Bagi Anak dengan HIV dan AIDS (ADHA) Kegiatan Rehabilitasi Sosial Tuna Sosial Tahun Anggaran 2012
- Surat Keputusan Kuasa Pengguna Anggaran Dinas Sosial Daerah Istimewa Yogyakarta No. 188/1894/II.2 tentang Penunjukkan Penerima Bantuan Jaminan Hidup Bagi Anak dengan HIV dan AIDS (ADHA) Kegiatan Rehabilitasi Sosial Tuna Sosial Tahun Anggaran 2013
- Peraturan Daerah Provinsi Daerah Istimewa Yogyakarta Nomor 12 Tahun 2010 tentang Penanggulangan Human Immunodeficiency Virus (HIV) dan Acquired Immune Deficiency Syndrome (AIDS)
- Peraturan Gubernur Daerah Istimewa Yogyakarta Nomor 37 Tahun 2012 tentang Pelaksanaan Penanggulangan HIV dan AIDS
- Data penerima bantuan Program Perlindungan Sosial ADHA dan Pemberdayaan Keluarganya tahun 2009

- Data penerima bantuan Program Pemberian Jaminan Hidup pada Anak dengan HIV dan AIDS (ADHA) Dinas Sosial DIY Tahun Anggaran 2013
- Instrument Seleksi Calon Penerima Jaminan Hidup ADHA Tahun Anggaran 2013
- Laporan data kasus HIV dan AIDS Daerah Istimewa Yogyakarta tahun 2003-2012

D. Temuan dan Analisis

Program perlidungan sosial ADHA dan pemberdayaan keluarganya merupakan *pilot* program dari Departemen Sosial RI tahun 2009 melalui Direktorat Pelayanan dan Rehabilitasi Sosial Tuna Sosial, Direktorat Jenderal Pelayanan dan Rehabilitasi Sosial dengan dana "luncuran" Anggaran Pendapatan dan Belanja Negara (APBN). Dana luncuran APBN adalah dana program yang langsung dikelola oleh pemerintah pusat tetapi pelaksanaannya di daerah (provinsi). Daerah DIY menjadi salah satu provinsi yang menerima program tersebut. Program ini dalam pelaksanaannya mengacu pada panduan yang dibuat oleh Departemen Sosial RI. Panduan tersebut berjudul "Uji Coba Perlindungan Sosial ADHA dan Pemberdayaan Keluarganya".

Hal yang melatarbelakangi munculnya program ini adalah epidemi HIV dan AIDS di Indonesia yang sudah berlangsung lama sejak tahun 1987, tingkat epidemi HIV dan AIDS masuk kategori terkonsentrasi pada sub populasi tertentu. Masalah HIV dan AIDS merupakan masalah kesehatan masyarakat yang juga mempunyai implikasi sosial. Dampak yang ditimbulkan oleh AIDS tidak hanya pada orang yang terinfeksi namun juga pada keluarga dan masyarakatnya. Kasus HIV dan AIDS di Indonesia yang juga ditemukan pada kelompok anak-anak mendasari diujicobakannya program ini pada tahun 2009. Anak yang terinfeksi akan banyak mengalami permasalahan dikarenakan anak masih dalam tahap tumbuh kembang. Anak tidak boleh kehilangan hak-haknya (Departemen Sosial RI, 2009, p:5).

Program ini dirancang mengacu pada beberapa kebijakan yang telah ada, antara lain : UU No. 23 Tahun 2002 tentang perlindungan anak. Pada pasal 3 tentang perlindungan anak, program ini sebagai bentuk upaya perlindungan anak, yang berfokus pada anak dengan HIV. Program ini juga merupakan upaya untuk melindungi hak-hak anak, yang tertuang pada pasal 4. Program yang diselenggarakan oleh Direktorat Pelayanan dan Rehabilitasi Sosial Tuna Sosial berlandaskan UU No. 11 Tahun 2009 tentang kesejahteraan sosial, dalam pasal 7 tentang rehabilitasi sosial, pada ayat 3, disebutkan bentuk-bentuk rehabilitasi sosial, program perlindungan sosial ADHA dan pemberdayaan keluarganya dalam bentuk pemberian jaminan hidup termasuk dalam bentuk bantuan dan asistensi sosial dalam penyelenggaraan rehabilitasi sosial.

Dalam panduan, disebutkan tujuan program atau kegiatan perlindungan sosial ADHA dan pemberdayaan keluarganya adalah terpenuhinya sebagian hak-hak anak, seperti hak memperoleh pendidikan dan pengajaran, hidup, tumbuh dan berkembang, memperoleh kesehatan dan sekaligus memberdayakan keluarganya. Sasaran dalam program ini :

- Anak dengan HIV dan AIDS (ADHA)
- Anak yang hidup dengan HIV dan AIDS (AHIDHA)
- Keluarganya

Kriteria penerima program adalah :

1. Kriteria keluarga calon penerima bantuan pemberdayaan keluarga sebagai berikut :
    - Penghasilan rendah, atau miskin
    - Salah satu atau lebih dari anggota keluarganya menyandang HIV dan AIDS
2. Kriteria anak calon penerima jaminan hidup adalah sebagai berikut :
    - Berusia 18 tahun ke bawah sesuai dengan UU No. 23 Tahun 2002 tentang perlindungan anak
    - Dinyatakan positif HIV dan atau AIDS oleh instansi kesehatan

    (Departemen Sosial RI, 2009, p:5)

Pada bab yang membahas mekanisme penyaluran bantuan, ada tahapan pendataan calon penerima bantuan. Pendataan dilaksanakan bersama petugas dari Departemen Sosial, Dinas Sosial Provinsi, Dinas Sosial Kota, maupun LSM yang bergerak dalam penanggulangan HIV dan AIDS. Pendataan ini merupakan dasar dalam pelaksanaan pemberian bantuan (Departemen Sosial RI, 2009, p:9).

Informasi yang diperoleh dari hasil *indepth interview*, diketahui bahwa pendataan hanya dilakukan oleh Lembaga Swadaya Masyarakat (LSM) yang menjadi mitra dalam pemberian bantuan ini, serta dalam pendampingan pelaksanaan program. Pada tahun 2009 ada 25 keluarga ADHA dan AHIDHA yang menerima bantuan. Besaran bantuan yang diberikan untuk masing-masing anak adalah Rp. 1.000.000,00 sebulan yang diberikan selama 6 bulan. Bantuan untuk pemberdayaan keluarganya maksimal Rp. 7.500.000,00 setahun (Departemen Sosial RI, 2009, p:10).

Dalam panduan disebutkan pemanfaatan bantuan yang diberikan untuk ADHA digunakan untuk membantu anak agar dapat mengakses layanan kesehatan, layanan pendidikan maupun untuk membeli makanan bergizi untuk dirinya. Pendamping terlibat dalam proses penerimaan bantuan dan pemanfaatannya. Peran pendamping sebagai perencana, pembimbing, pemberi informasi, motivator, penghubung, fasilitator, mobilisator, advokator, administrator, evaluator dan lainnya (Departemen Sosial RI, 2009, p:11).

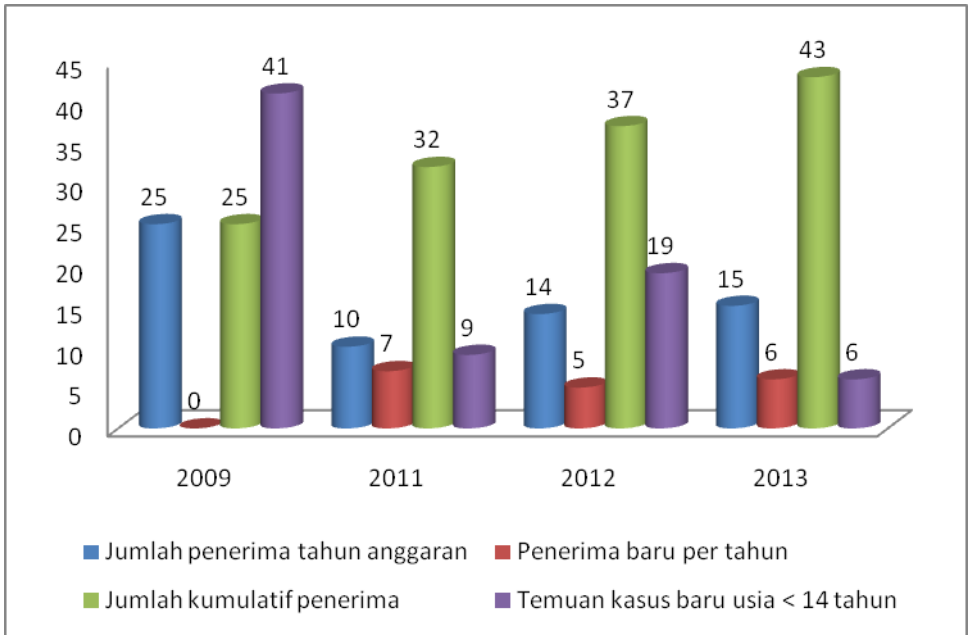
Pada tahun 2010, program ini tidak dianggarkan kembali. Dijelaskan oleh petugas Dinas Sosial DIY yang diwawancarai bahwa pada tahun 2010 merupakan evaluasi pelaksanaan program uji coba tahun 2009. Departemen Sosial RI menganggarkan kembali program ini melalui APBN pada tahun 2011 dengan dana APBN “decon”, pengelolaan keuangannya diberikan kepada Dinas Sosial DIY melalui bidang rehabilitasi sosial pada seksi rehabilitasi sosial tuna sosial dan korban napza. Semula pada tahun 2009 menggunakan dana APBN “luncuran” yang mana Departemen Sosial RI langsung bekerjasama dengan Lembaga Kesejahteraan Sosial (LKS) yang ditunjuk yaitu LSM Victory Plus dalam pendataan dan pelaksanaan program, Dinas Sosial DIY hanya mengetahui dan menginformasikan mengenai program serta koordinasi. Dalam panduan disampaikan mengenai rangkaian kegiatan pemberian program, ada tahapan sosialisasi program di awal pelaksanaan (Departemen Sosial RI, 2009, p:6). Namun, pada program tahun 2011-2013 dengan dana APBN decon, tidak dilakukan tahapan sosialisasi kembali kepada LSM-LSM mengenai program ini. Kerjasama langsung dilakukan dengan LSM Victory Plus yang telah terlibat pada tahun 2009 dan dapat memberikan data ADHA secara lengkap. Sosialisasi atau informasi mengenai program ini disampaikan dalam rapat koordinasi dinas sosial maupun dalam pertemuan yang relevan dengan instansi/lembaga terkait.

Dari *indepth interview* diketahui bahwa dalam sosialisasi program pada tahun 2009 kepada semua LSM yang bergerak dalam penanggulangan HIV&AIDS di DIY, disampaikan bahwa dalam pemberian bantuan ini data peserta program yang diusulkan harus lengkap dan jelas. Data usulan penerima bantuan dituliskan nama dan alamat lengkap. Hanya satu LSM yang menyampaikan usulan penerima bantuan sesuai dengan ketentuan yang dimintakan (data *by name by address*) yaitu LSM Victory Plus. LSM Victory Plus di DIY merupakan LSM yang bergerak dalam penanggulangan HIV&AIDS. LSM ini fokus kegiatan pada pendampingan dan dukungan sebaya untuk orang yang terinfeksi HIV (ODHA) dan orang yang hidup dengan orang yang terinfeksi HIV (OHIDHA).

1. *Coverage* atau cakupan

Jumlah penerima bantuan jaminan hidup (jadup) ADHA tahun 2009, 2011-2013 dibandingkan dengan temuan kasus baru HIV dan AIDS pada anak usia di bawah 14 tahun di DIY maka jumlah penerima jadup lebih sedikit dibandingkan dengan kasus ADHA yang ditemukan.

Gambar 1. Grafik jumlah penerima jadup tahun anggaran dengan dana APBN per tahun 2009, 2011-2013, jumlah penerima jadup baru per tahun, jumlah kumulatif penerima 2009-2013 dan jumlah temuan kasus HIV usia kurang dari 14 tahun di DIY per tahun



Grafik di atas menunjukkan bahwa jumlah ADHA baru penerima program tidak sejumlah ADHA yang ditemukan pada tahun bersangkutan. Misal pada tahun 2011, ada 9 temuan kasus HIV anak usia kurang dari 14 tahun. Jumlah ADHA baru penerima jadup hanya 7 orang. Tahun 2012, jumlah ADHA baru yang ditemukan sebanyak 19 orang. Jumlah ADHA baru penerima bantuan pada tahun tersebut ada 5 orang. Kalau dilihat dari penerima jadup ADHA baru pada tahun 2013, jumlahnya tidak sebanyak yang telah ditemukan pada tahun sebelumnya, yaitu 28 ADHA baru usia kurang dari 14 tahun pada 2011-2012. Hal ini menunjukkan *coverage* atau cakupan jumlah ADHA penerima bantuan belum sejumlah ADHA yang ada di DIY. Jumlah penerima jadup belum menggambarkan keberadaan ADHA di DIY. Data jumlah ADHA yang diusulkan hanya berasal dari LSM Victory Plus selaku LKS program ini.

Dari hasil penelitian diketahui jumlah ADHA dan AHIDHA yang menerima program perlindungan ADHA dalam bentuk bantuan jadup dari tahun 2009-2013 dengan dana APBN sebanyak 43 orang. Pada tahun 2009, jumlah ADHA dan AHIDHA penerima manfaat sebanyak 25 orang, yang mana 18 di antaranya adalah AHIDHA (anak yang HIV negatif namun orang tua HIV positif). Namun, pada tahun 2011-2013 fokus sasaran program hanya pada ADHA. Program pemberdayaan keluarga tetap dianggarkan namun terpisah dari program pemberian jadup ADHA dan melalui dana APBD DIY.

Sejak tahun 2013, dinas sosial DIY telah menganggarkan pemberian jadup ADHA melalui anggaran APBD DIY, jumlah ADHA penerima jadup sebanyak 12 orang. Sehingga pada tahun 2013, program jadup ADHA di DIY ada 2 sumber pembiayaan. Dana APBN tahun 2013, diperuntukkan untuk 15 ADHA.

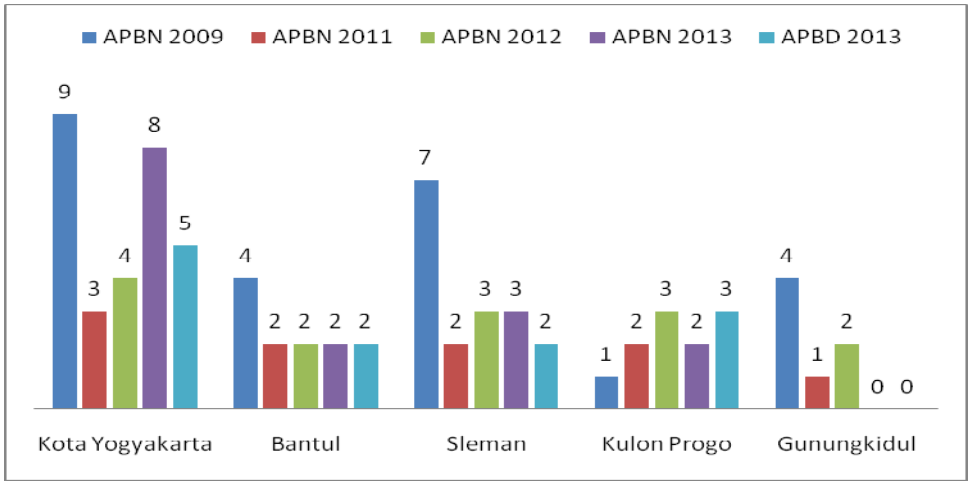
Hasil *interview* kepada dinas sosial DIY, disampaikan bahwa penerima bantuan ini khusus untuk ADHA, meskipun pada tahun 2009 AHIDHA juga menerima bantuan. Dalam menentukan jumlah usulan penerima bantuan, Dinas sosial DIY bekerjasama dengan LKS. Sebelum tahun penganggaran, dinas sosial DIY menerima usulan jumlah ADHA yang akan diajukan menerima bantuan dari LKS. Ketika usulan, hanya baru sebatas jumlah saja. Namun, setelah ditentukan jumlah penerima bantuan pada tahun anggaran tersebut, maka LKS mesti mengajukan data lengkap calon penerima bantuan dengan nama dan alamat lengkap serta valid.

Jumlah ADHA yang menerima bantuan secara rutin tiap tahun jumlahnya berbeda. Hal ini berdasarkan dari usulan dan hasil seleksi. Ada ADHA yang menerima bantuan rutin APBN tahun 2009, 2011-2013 sebanyak 2 orang. Adapula ADHA yang hanya menerima bantuan pada tahun 2011, tahun 2012 tidak menerima bantuan kemudian baru terima kembali pada tahun 2013 sebanyak 1 orang.

Informasi yang disampaikan ketika wawancara oleh petugas dinas sosial DIY bahwa untuk anggaran APBN mekanisme seleksi tidak ada pada tahun anggaran 2011-2013. Penentuan ADHA hasil seleksi diserahkan kepada LKS. Program dengan dana APBD tahun 2013, ada mekanisme seleksi sekaligus seleksi program dengan dana APBN karena jumlah penerima jadup yang diusulkan lebih banyak daripada yang dianggarkan (usulan 20 ADHA, informasi dari LKS). Dari 20 nama yang diusulkan ada 4 ADHA yang tidak menerima program tahun 2013 baik APBN maupun APBD dengan penjelasan hasil seleksi bahwa keluarga masih mampu memenuhi kebutuhan ADHA.

ADHA yang menerima bantuan secara geografis, berada di 5 kabupaten kota DIY.

Gambar 2. Grafik jumlah ADHA penerima jadup berdasarkan wilayah



Dari gambar di atas, jumlah penerima bantuan jadup paling banyak dari Kota Yogyakarta, kemudian Sleman. Dalam temuan kasus HIV&AIDS di DIY, Kota Yogyakarta memiliki temuan kasus paling tinggi di DIY.

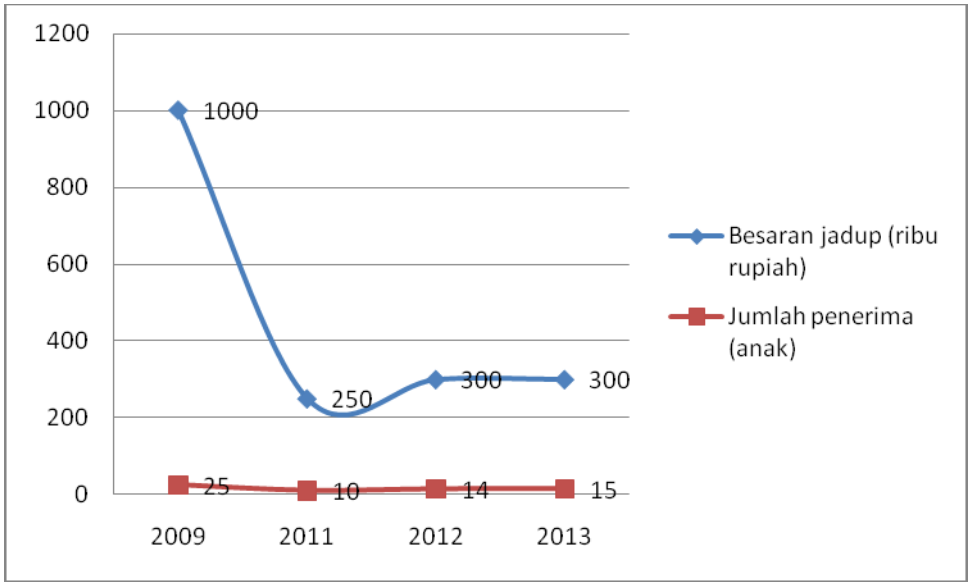
Pemberian bantuan jadup sudah merata di seluruh wilayah di DIY. Pada tahun 2013, penerima jadup dari Gunungkidul tidak ada, hal ini berdasarkan hasil seleksi dari usulan data penerima bantuan yang diajukan.

Disimpulkan dari temuan *coverage* bahwa jumlah ADHA penerima manfaat belum menggambarkan jumlah ADHA di DIY. Jumlah penerima bantuan jadup ADHA tidak sejumlah ADHA di DIY.

2. *Adequacy* atau kecukupan

Besaran jadup yang diberikan dengan APBN pada tahun 2009 adalah Rp. 1.000.000,00 per bulan. Namun pada tahun 2011 menjadi Rp. 250.000,00 per bulan. Tahun 2012-2013 menjadi Rp. 300.000,00 per bulan. Besaran jadup dengan dana APBD tahun 2013 sebesar Rp. 300.000,00 per bulan. Bantuan hanya diberikan selama 6 bulan.

Gambar 3. Grafik jumlah penerima jadup dengan dana APBN tahun 2009, 2011-2013 dan besaran jadup



Bantuan dimanfaatkan untuk membeli kebutuhan pokok ADHA. Hal ini tertuang dalam Surat Keputusan (SK) penetapan penerima manfaat. Pada SK penetapan penerima bantuan tahun 2013 dengan APBN, pada bagian hak dan kewajiban penerima bantuan dituliskan bahwa bantuan jadup hanya digunakan untuk belanja peningkatan gizi.

Dari hasil wawancara dengan penerima jadup, diketahui bahwa penerima manfaat mengetahui bantuan ini harus dibelanjakan dalam bentuk barang. Barang yang dibelanjakan adalah kebutuhan pokok atau nutrisi untuk anak, seperti buah-buahan, susu UHT, makanan, madu, susu, roti, telur, ayam (lauk pauk), beras dan lainnya. Barang yang dibelikan sesuai dengan kebutuhan ADHA. Dalam pembelanjaan, ADHA didampingi oleh pendamping LKS. Penerima manfaat juga mengetahui bahwa bantuan hanya diberikan selama 6 bulan.

Dalam interview ada pertanyaan : Jika bentuk barang, apakah merubah dari uang jadi barang itu cukup? “belum, kalau bisa berupa uang sehingga sewaktu-waktu bisa berobat. Karena dulu kesulitan biaya berobat” (keluarga ADHA 1, penerima manfaat). Ini menunjukkan ada kebutuhan pemberian bantuan dalam bentuk uang yang sewaktu-waktu bisa dimanfaatkan untuk kebutuhan yang lain, termasuk pembiayaan kesehatan. Meskipun sekarang penerima manfaat tersebut telah dimasukkan dalam jaminan kesehatan. “Sebaiknya uang, bebas untuk membelanjakannya. Karena uang biasanya bisa untuk berobat”. Tapi penerima manfaat juga menyampaikan, “sebenarnya dicukupi karena untuk kebutuhan pokok” (keluarga ADHA 2, penerima manfaat). Namun, pemberian jadup diberikan dalam bentuk barang untuk memastikan kebutuhan pokok atau nutrisi ADHA terpenuhi, dikarenakan bantuan ini diprioritaskan untuk pemenuhan gizi anak. Meminimalisir pemanfaatan jadup digunakan untuk hal lain di luar kebutuhan anak.

Penerima manfaat mengetahui nilai barang yang diberikan. Karena dalam pembelanjaannya, yang melakukan adalah ADHA dan keluarga didampingi oleh pendamping LKS. Dijelaskan oleh pendamping bahwa memang aturan dalam pemberian bantuan ini, bantuan dibelanjakan barang kebutuhan nutrisi/kebutuhan pokok ADHA sehingga tidak dimanfaatkan oleh keluarga untuk kepentingan lain, seperti membayar hutang.

Ditanyakan dalam interview “dibandingkan dengan kebutuhan ADHA, apakah dana yang diberikan mencukupi atau tidak?” Dijawab, “kebutuhan anak lebih dari bantuan jadup, jadup ini hanya memenuhi sebagian. Rata-rata sebulan untuk kebutuhan gizi sekitar Rp. 800.000,00 (pokok dan jajan), biaya sekolah Rp. 300.000,00 per bulan”. “Tidak mencukupi, selama 6 bulan tidak cukup, sebaiknya terus” (keluarga ADHA 2, penerima manfaat). Hal ini menunjukkan bahwa besaran kebutuhan biaya hidup ADHA lebih besar dari besaran jadup yang diberikan.

Hasil wawancara dengan LKS, diketahui bahwa dalam pengajuan proposal usulan program disampaikan besaran kebutuhan ADHA yang diperhitungkan oleh LKS yaitu sebesar Rp. 350.000 per bulan. Tetapi program hanya memberikan bantuan sebesar Rp. 300.000,00. “Tidak diketahui dasar atau pertimbangan penentuan besaran program yang ditentukan oleh pemerintah pusat (APBN)” (Dinas sosial DIY). “Besaran usulan program yang dibuat oleh pemerintah daerah dengan dana APBD hanya menyesuaikan dengan program pemerintah pusat, baik besaran jadup maupun durasi waktu pemberian bantuan” (Dinas sosial DIY). Ini perlu dilakukan penilaian kebutuhan hidup ADHA yang sesuai.

Belum pernah dilakukan *assessment* perhitungan kebutuhan tiap ADHA. Tiap ADHA memiliki kebutuhan nutrisi yang berbeda. Kondisi ADHA yang telah mengikuti ART serta yang mengalami infeksi oportunistik juga akan mempengaruhi kebutuhan nutrisi untuk menjaga kesehatannya. Besaran jadup yang diterima tiap ADHA sama. “Jika membedakan maka butuh *assessment* lebih mendalam dan bisa melibatkan medis” (Dinas sosial DIY). Namun, pada tahun 2013 dengan pendanaan APBN dan APBD ada 8 ADHA yang menerima bantuan jadup dari kedua sumber pembiayaan tersebut. Hal ini berdasarkan pertimbangan dari dinas sosial DIY yang menentukan hasil seleksi. Pemberian jadup bisa dilakukan dengan sumber pembiayaan berbeda dengan waktu pemberian bantuan yang berbeda pula meskipun peruntukkan penggunaan bantuan sama yaitu pemberian nutrisi untuk peningkatan gizi. Pada 6 bulan pertama (Januari-Juni 2013), ADHA menerima bantuan dari APBN dan pada bulan Juli-Desember 2013 menerima bantuan dari dana APBD sehingga selama 1 tahun kebutuhan nutrisi ADHA terpenuhi.

Dari temuan mengenai *adequacy*, diketahui bahwa besaran jadup yang diberikan kepada beberapa ADHA penerima manfaat belum memenuhi kebutuhan hidup ADHA. Pemberian bantuan jadup hanya diberikan selama 6 bulan, padahal kebutuhan nutrisi ADHA selalu ada selama setahun.

3. *Accessibility* atau akses

"Kriteria atau syarat ADHA penerima jadup adalah : anak dengan status HIV positif, berusia di bawah 18 tahun, dari keluarga tidak mampu secara ekonomi atau dari keluarga mampu tapi terlantar, terdiskriminasi" (Dinas sosial DIY) mengenai kriteria atau syarat penerima bantuan jadup. "Syarat utama adalah dia ADHA dan berusia di bawah 18 tahun" (Dinas sosial DIY). Hal ini menunjukkan bahwa program pemberian jadup hanya diprioritaskan untuk ADHA.

ADHA yang menerima jadup diakseskan melalui usulan dari LKS. LKS yang terlibat merupakan LSM pendamping ODHA di DIY yaitu LSM Victory Plus. LSM Victory Plus telah terdaftar di dinas sosial sebagai LKS dan memiliki legalitas dan berbadan hukum.

LSM Victory plus menjadi mitra dinas sosial DIY dikarenakan selama pelaksanaan pemberian jadup ADHA di DIY, hanya LSM ini yang dapat menyampaikan data calon penerima bantuan secara lengkap.

"Dinas tidak bisa tentukan jumlah ADHA, yang punya wewenang dinkes" (Dinas sosial DIY). Data ADHA yang ada di dinas kesehatan dan Komisi Penanggulangan AIDS daerah hanya berupa jumlah, tidak ada data lengkap dengan nama dan alamat. Dinas sosial DIY masih mengandalkan mitra (LKS) dalam memperoleh data jumlah ADHA.

Dinas sosial belum pernah melakukan pemetaan keberadaan ADHA. Mekanisme memetakan keberadaan ADHA dengan kerjasama LKS. LKS yang mengetahui keberadaan ADHA yang didampinginya. Ini terkait keterbatasan mengenai kerahasiaan status HIV.

Dinas sosial DIY tidak ada jejaring untuk mendapatkan data ADHA lengkap dengan nama dan alamat ke layanan kesehatan (rumah sakit rujukan untuk HIV dan AIDS). Upaya mendapatkan data ADHA kepada rumah sakit rujukan HIV (CST) pernah dilakukan namun pihak rumah sakit belum bisa memberikan data ADHA, dilihat dari pernyataan berikut "hal ini sudah pernah dilakukan dinas sosial Bantul ke Rumah Sakit Umum Daerah Panembahan Senopati Bantul untuk meminta data namun tidak bisa dapat data" (Dinas Sosial DIY). "Kami bisa mengusulkan banyak asal ada nama dan alamat lengkap" (Dinas Sosial DIY). "ODHA dan ADHA sendiri tidak mau diketahui statusnya oleh orang lain selain petugas medis" (Dinas Sosial DIY). Hal ini menunjukkan bahwa kendala dalam pelaksanaan program bantuan ini adalah ketersediaan data lengkap dan jelas dengan nama dan alamat jumlah penerima program.

Hasil wawancara dengan LKS diketahui bahwa nama ADHA yang diusulkan adalah keluarga ADHA yang bersedia terbuka dengan dinas sosial DIY dan bersedia dikunjungi untuk keperluan program. LKS telah menawarkan mengenai program bantuan ini kepada keluarga ADHA yang menjadi dampingannya. Disampaikan pula bahwa jika mereka ingin menerima bantuan tersebut maka harus bersedia terbuka, jika belum bersedia terbuka maka LKS tidak akan memaksa tetapi ADHA tersebut belum bisa diusulkan sebagai salah satu calon penerima bantuan jadup. Disampaikan dalam wawancara dengan pendamping LKS bahwa memang beberapa keluarga ADHA yang didampingi belum bersedia terbuka sehingga nama ADHA tidak diusulkan dan dialihkan kepada ADHA lain yang sesuai kriteria dan bersedia terbuka. Dalam kegiatan pendampingan ODHA, keluarga ADHA bersedia didampingi namun belum tentu bersedia untuk terbuka dengan dinas sosial DIY. Penyampaian data usulan ke dinas sosial DIY dengan nama lengkap dan alamat sesuai dengan persetujuan ADHA dan keluarga secara lisan.

Dinas sosial DIY juga menyampaikan bahwa keluarga ADHA bisa mengajukan usulan sendiri ke dinas sosial DIY sebagai penerima manfaat tanpa melalui LKS dengan membawa persyaratan

Kartu Tanda Penduduk dan Kartu Keluarga. Hal ini menunjukkan bahwa ADHA dan keluarga sudah bersedia terbuka. Selama pelaksanaan program, ADHA dan keluarga mesti bersedia untuk didampingi oleh pendamping dari LKS. Meskipun hal ini sudah disampaikan namun penerima program yang diusulkan masih melalui LKS. "Memang ADHA harus terbuka sehingga mereka bisa akses layanan kesehatan, sosial dan layanan lain" (KPA DIY). Ini menunjukkan keterbukaan status HIV terhadap pihak yang berkepentingan untuk ADHA perlu dilakukan.

Pemberian jadup tahun 2013 dengan dana APBD, dilakukan mekanisme seleksi/*assessment* menggunakan *instrument* seleksi. *Instrument* diisi oleh orang tua atau wali ADHA dibantu oleh pendamping. Hasil pengisian *instrument* disampaikan kepada dinas sosial DIY kemudian akan dilakukan kunjungan oleh dinas sosial DIY untuk mengkonfirmasi hasil pengisian *instrument*. Kunjungan tidak dilakukan kepada semua calon penerima jadup, hanya dipilih beberapa (sampling). *Assessment* dilakukan bersama antara dinas sosial DIY dan LKS. Hasil pengisian *instrument* tiap calon penerima manfaat dibuat *scoring* oleh petugas dinas sosial DIY, dengan mempertimbangkan kondisi ekonomi keluarga, antara lain : pendapatan keluarga dan kebutuhan pengeluaran setiap bulan, beban yang ditanggung keluarga (misal pendapatan tinggi namun beban biaya hidup keluarga yang mesti ditanggung juga tinggi), keterbukaan status HIV terhadap keluarga untuk menilai kepedulian keluarga yang lain terhadap ADHA dan keluarga (ADHA dan keluarga tidak terlantar, dan tidak mendapatkan diskriminasi). Jika beban keluarga tinggi serta kepedulian keluarga masih kurang maka ADHA menjadi prioritas untuk menerima bantuan jadup.

Dalam kunjungan lapangan, dinas sosial DIY mengalami kendala yaitu kekhawatiran kegiatan kunjungan lapangan akan membuka status ADHA dan keluarga. Ketika meminta stempel surat penjalanan dinas dalam rangka kunjungan keluarga ADHA, dinas sosial DIY tidak meminta stempel di pemerintahan kelurahan wilayah tinggal ADHA. Hal ini dikarenakan untuk meminimalisir diketahuinya keberadaan ADHA dan keluarganya oleh pemerintah kelurahan setempat untuk menghindari munculnya stigma dan diskriminasi dari masyarakat.

Berdasarkan Peraturan Daerah Nomor 12 Tahun 2010 tentang penanggulangan HIV dan AIDS di DIY, pasal 7 disebutkan setiap orang berkewajiban menghormati kerahasiaan status HIV seseorang untuk menghindari terjadinya perlakuan tidak menyenangkan, diskriminasi, atau stigmatisasi, kecuali ada izin secara lisan atau tertulis dari ODHA untuk membuka status HIV. Dalam pasal 9, setiap ODHA harus membuka status HIV-nya kepada pihak yang berkepentingan. Perda ini menjadi tantangan bagi petugas dinas sosial karena mesti menjaga kerahasiaan status HIV ADHA dan keluarga. Jika status HIV ADHA dan keluarga diketahui oleh masyarakat dari kegiatan kunjungan lapangan seleksi jadup ini maupun dalam pelaksanaan program dikhawatirkan hal tersebut melanggar perda dan dikenai sanksi.

Bantuan jadup dengan APBN diberikan kepada penerima manfaat dengan ditransfer ke rekening ADHA. Hal ini sesuai dengan pedoman. Sedangkan bantuan jadup dengan APBD diberikan kepada penerima manfaat melalui LKS. Bantuan ditransfer ke rekening LKS. Kemudian LKS yang akan membelanjakan dan diserahkan kepada penerima manfaat.

Bantuan jadup APBD dibuat mekanisme seperti itu agar pembelanjaan bantuan lebih fleksibel karena ditransfer oleh dinas sosial DIY ke LKS dalam bentuk uang. Pencarian dana dengan post gub (hibah gubernur). Syarat pencairan dana, adanya naskah perjanjian kerjasama antara kepala dinas sosial DIY dengan direktur LSM yang ditunjuk sebagai LKS. Sehingga dana ditransfer ke rekening LSM. Jika pemberian bantuan jadup langsung dari dinas sosial DIY kepada penerima manfaat, pencairan dana APBD mesti merincikan barang kebutuhan yang akan dibelanjakan oleh dinas. Hal ini dinilai oleh dinas tidak fleksibel sehingga dibuat mekanisme pencairan dana sebagai hibah kepada LKS.

Dari *accessibility*, disimpulkan bahwa pemberian jadup ADHA ini mudah, pengusulan bisa melalui LKS maupun per seorangan. Namun kendalanya masih mengenai status HIV, belum semua ADHA dan keluarga bersedia terbuka sehingga program ini belum diakses oleh semua ADHA di DIY.

4. *Quality of Service* atau kualitas pelayanan

Dari hasil *interview* dengan penerima manfaat tentang kepuasan terhadap pendampingan yang dilakukan LKS, diketahui penerima manfaat merasa cukup puas dan sudah puas. Penerima manfaat selama menerima bantuan jadup merasa lancar, tidak ada kesulitan. "Kalau memang aturan bantuan diberikan dalam bentuk barang seperti ini, ya cukup dan mengikut saja" (keluarga ADHA 2, penerima manfaat). Harapan penerima manfaat, "bantuan diperpanjang/diteruskan/tiap tahun ada" (keluarga ADHA 2, penerima manfaat). "Sudah bagus, kalau bisa bantuan berupa uang sehingga keinginan anak bisa dibelikan. Disesuaikan dengan barang-barang yang dibutuhkan" (keluarga ADHA 1, penerima manfaat). Hal ini menunjukkan bahwa penerima manfaat menilai bagus program ini tetapi ada masukan mengenai program ke depan agar bantuan diberikan dalam bentuk uang.

Pendamping dari LKS mendampingi ADHA dan keluarga dalam pembukaan rekening, jika ADHA tidak ada orang tua atau keluarga maka pendamping bisa menjadi wali dalam pembukaan rekening. Buku rekening bank ADHA dibawa oleh pendamping dan dicairkan serta dibelanjakan bersama pendamping sesuai kebutuhan ADHA. Pendamping mendampingi ADHA terkait kesehatan dan keseimbangan nutrisi yang tepat, pemilihan menu yang sesuai. Selain itu, pendamping juga berperan untuk menyampaikan mengenai prosedur bantuan. Pendamping memotivasi keluarga ADHA dan jika ADHA mengalami diskriminasi maka pendamping berperan untuk mengatasi hal ini. Pendamping juga mendampingi secara psikologi anak dan keluarga (orang tua) dengan memberikan konseling tentang HIV dan AIDS serta kesehatan dasar. Pendamping ADHA dari LKS yang sama. Dalam kegiatan pendampingan program ini, pendamping mendapatkan *reward* berupa honor pendamping.

LKS menilai bekerjasama dengan dinas sosial DIY itu mudah dinyatakan dalam pendapat berikut, "Bekerjasama dengan dinsos cukup mudah karena dinsos lebih menyerahkan pada LKS penentuan kriteria, ada form *instrument* yang mesti diisi oleh penerima bantuan. Dinsos akan menilai dari form *instrument* itu" (LKS pendamping) Pendapat LKS tentang program ini dinilai bagus karena membantu ADHA yang membutuhkan. Harapannya jumlah penerima manfaat bisa ditambah, dana jadup ditambahkan dari Rp. 300.000,00 misal menjadi Rp. 500.000,00 karena tiap tahun biaya hidup ada kenaikan. Bekerjasama dengan dinsos, dari sisi administrasi tidak ada kendala, sederhana kelengkapan yang diminta dan masih bisa dipenuhi. Pendamping membuat laporan setiap bulan secara naratif dan laporan keuangan sesuai dengan dana yang diberikan.

Dinas sosial DIY menilai bekerjasama dengan LKS mudah karena memiliki tujuan yang sama yaitu membantu ADHA dan keluarga. Tidak ada yang saling mempersulit ketersediaan data untuk membantu ADHA.

Keterlibatan LKS dalam program ini kembali setelah tahun 2009, berdasarkan informasi dari dinas sosial DIY. Mekanisme kerjasama LKS dengan dinas sosial DIY adalah dengan pengajuan proposal, diserahkan ke dinas sosial DIY dan dinas sosial kabupaten di mana lokasi LKS berada untuk memberikan rekomendasi. Proposal dan rekomendasi dikirimkan ke Depsos RI (disebut juga Kemensos RI, melalui direktorat jenderal pelayanan dan rehabilitasi sosial, pendanaan APBN) oleh dinas sosial DIY.

Perubahan kebijakan atau aturan dalam pelaksanaan program disampaikan secara lisan oleh dinas sosial DIY kepada LKS untuk diteruskan kepada penerima manfaat. Tidak ada penyampaian aturan perubahan secara tertulis. Misal, untuk program jadup dana APBN tahun 2013, pada bulan ke-6 pencairan dana, dana tidak harus habis dibelanjakan dan bisa disisakan. Padahal pada tahun 2012, dana harus habis dibelanjakan pada tahun anggaran tersebut. Selain itu, pencairan dana mengalami keterlambatan. Misal dana jadup APBN untuk pemanfaat bulan Januari-Juni dikirimkan ke rekening anak pada pertengahan periode, misal Maret. Padahal kebutuhan anak sudah dimulai pada bulan Januari.

Dari temuan *quality of service*, disimpulkan bahwa kualitas pelayanan yang diberikan oleh pendamping dari LKS kepada penerima manfaat dinilai sudah baik kualitasnya dalam mendampingi pelaksanaan program pemberian jadup. LKS menilai kerjasama dengan dinas sosial DIY prosedurnya mudah dan memiliki tujuan yang sama dalam membantu ADHA. Hanya mengenai waktu penyampaian bantuan yang tidak sesuai periode pemanfaatan bantuan.

E. Kesimpulan

Dari hasil penelitian diperoleh kesimpulan sebagai berikut :

- Jumlah penerima jadup di DIY dibandingkan dengan jumlah ADHA yang ditemukan di DIY adalah jumlahnya lebih sedikit. Jumlah penerima jadup belum memberikan gambaran jumlah ADHA di DIY
- ADHA dan keluarga bisa mengakses program ini melalui LKS maupun mengajukan sendiri. Namun dalam pelaksanaan, usulan nama penerima bantuan melalui LKS.
- Besaran jadup yang diberikan belum memenuhi kebutuhan hidup ADHA. Jadup hanya untuk memenuhi kebutuhan pokok ADHA, terutama nutrisi.
- Kualitas pelayanan yang diberikan kepada penerima manfaat program sudah bagus, ADHA dan keluarga merasa puas didampingi oleh LKS dalam pemberian bantuan jadup. Tetapi dalam penyampaian bantuan ada keterlambatan.

F. Implikasi/Rekomendasi Kebijakan

Implikasi kebijakan yang muncul dari penelitiannya ini, mengenai *coverage*-nya adalah bagaimana upaya dalam memperoleh data ADHA secara lengkap. Karena data ADHA ada di layanan kesehatan namun belum ada SOP (*standar operasional prosedur*) atau aturan dinas lain diperbolehkan mengakses data tersebut, ini dikaitkan dengan menjaga kerahasiaan status pasien. Dinas sosial mampu mengupayakan usulan nama ADHA penerima jadup yang banyak dalam penganggaran namun data yang diusulkan harus jelas dan lengkap, namun ini masih terkendala data yang sulit diperoleh kecuali bermitra dengan LKS yang mampu menyediakan data tersebut. Terkait *accessibility* ini berkaitan pula dengan kebijakan syarat lain ADHA dapat menerima jadup adalah mesti terbuka dengan petugas dinas sosial atau pendamping ADHA. Jika ADHA dan keluarga tidak terbuka maka tidak bisa mengakses jadup meskipun ADHA tersebut masuk kriteria yang membutuhkan dan dialihkan untuk ADHA lain yang masuk kriteria dan bersedia terbuka. Implikasi kebijakan untuk *adequacy*, kurang memfasilitasi kebutuhan ADHA secara keseluruhan karena bantuan hanya diberikan selama 6 bulan serta besarannya dinilai penerima manfaat kurang mencukupi. Selain itu, kebutuhan tiap ADHA bisa berbeda. Bagaimana agar kebijakan

tersebut bisa bersifat praktis untuk kebutuhan tiap ADHA yang menerima bantuan dalam pengusulan anggaran.

Rekomendasi kebijakan antara lain adanya aturan lain atau SOP untuk memfasilitasi kebutuhan dinas sosial dalam upaya memperoleh data ADHA guna pengusulan penganggaran untuk jadup ADHA. Di DIY, dinas sosial sudah mampu untuk mengajukan usulan jadup melalui APBD sejak 2013, sehingga usulan jumlah penerima bisa diupayakan sejumlah ADHA yang ada di DIY (memenuhi *coverage*) dengan data yang lengkap. Dinas sosial juga dapat melakukan pemetaan atau *mapping* ADHA yang membutuhkan jadup (menyesuaikan kriteria penerima jadup) sehingga jadup bisa tepat sasaran dan efektif. Adanya kebijakan yang mengatur tentang pemberian jadup kepada ADHA yang belum bersedia terbuka sehingga masih bisa menerima bantuan ketika dinilai memang ADHA tersebut membutuhkan. Ada perubahan kebijakan untuk besaran jadup yang diberikan menyesuaikan kebutuhan ADHA sehingga kebutuhan nutrisi/gizinya terfasilitasi dengan baik dan ADHA mampu tumbuh kembang dengan baik.

Penelitian lebih lanjut mengenai program jadup ADHA perlu dilakukan sehingga memperoleh gambaran yang lebih komprehensif dan untuk menilai efektivitas program pemberian bantuan.

Referensi

Departemen Sosial RI, 2009. *Panduan uji coba perlindungan sosial ADHA dan pemberdayaan keluarganya*. Jakarta.

ILO, 2008. *Social Health Protection, An ILO Strategy Towards Universal Access to Health care*. Geneva. http://www.ilo.org/gimi/gess/RessFileDownload.do?ressourceId=5956. Akses 26 Februari 2013

KPAN. 2010. *Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS 2010-2014*. Jakarta.

Mann, Gillian, Sian Long, Emily Delap, and Lucy Conneli. 2012. *Children living with and affected by HIV in residential care*. http://www.crin.org/docs/HIVandResCare_FinalWeb%20%282%29.pdf. Akses 28 Februari 2013.

Sepulveda, Magdalena and Carly Nyst. 2012. *The Human Rights Approach to Social Protection*. Finland. http://www.ohchr.org/Documents/Issues/EPoverty/HumanRightsApproachToSocialProtection.pdf. Akses 26 Februari 2013

UNAIDS, 2010. *Strategic Guidance for Evaluating HIV Prevention Programmes*. http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/12_7_MERG_Guidance_Evaluating%20HIV_PreventionProgrammes.pdf Akses 27 Februari 2013.

UNAIDS, 2011. *HIV and Social Protection Guidance Note*. http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781. Akses 1 Maret 2013.

UNAIDS, 2011. *We Can Enhance Social Protection for People Affected by HIV*. Joint Action for Results UNAIDS Outcome Framework : Business Case 2009-2011. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101031_JC1967_Social-Protection_en.pdf. Akses 1 Maret 2013

UNAIDS, 2012. *Global report*. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf Akses 1 Maret 2013

Unicef, 2004. *Kerangka kerja untuk perlindungan perawatan dan bantuan bagi anak yatim dan anak-anak yang rentan hidup di dunia HIV dan AIDS*. http://www.unicef.org/aids/files/Framework_English.pdf. Akses 28 Februari 2013.

Unicef, 2007. *Enhanced protection for children affected by AIDS. A companion paper to the framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. New York http://www.unicef.org/publications/files/Enhanced_Protection_for_Children_Affected_by_AIDS.pdf. Akses 1 Maret 2013

Unicef, 2010. *Children and AIDS*. Fifth Stocking Report, 2010. http://www.unicef.org/publications/files/Children_and_AIDS-Fifth_Stocktaking_Report_2010_EN.pdf. Akses 28 Februari 2013

Unicef, 2012. State of the world's children. New York. *In* Mann, Gillian, Sian Long, Emily Delap, and Lucy Conneli. 2012. *Children living with and affected by HIV in residential care*. http://www.crin.org/docs/HIVandResCare_FinalWeb%20%282%29.pdf. Akses 28 Februari 2013.

Unicef, 2012. *Promoting equity for children living in a world with HIV and AIDS*. http://www.unicef.org/aids/files/PromotingEquity_Final.pdf Akses 28 Februari 2013.

Unicef, 2012. *HIV-Sensitive Social Protection : State of the Evidence 2012 in Sub Saharan Africa*. http://www.unicef-irc.org/files/documents/d-3826-HIV-Sensitive-Social-Prot.pdf. Akses 1 Maret 2013

WHO, 2009. *Guidelines for An Integrated Approach to the Nutritional Care of HIV-Infected Children (6 months-14 years)*. Handbook preliminary version for Country Introduction. Switzerland. http://whqlibdoc.who.int/publications/2009/9789241597524_eng_Handbook.pdf. Akses 1 Maret 2013

WHO, 2013. *HIV/AIDS*. http://www.who.int/topics/hiv_aids/en/ Akses 1 Maret 2013

THEME 4

Integrated Social Protection

1. **Including Homeless Families and Children in the Social Protection System: A Brief Review of International Experience and Data on a Philippine Pilot Program**
   David Barua Yap (Asian Institute of Management Policy Center, Philippines)

2. **Anak-Anak Miskin di Perkotaan/Urban Poor Children**
   Bagong Suyanto (Universitas Airlangga, Indonesia)

3. **Needs Assessment of Reintegrated Families in Georgia**
   Ia Shekriladze (Save the Children, Georgia)

4. **Challenges in Home-Based Care and Support for Children (0-12 Years Old) in Jakarta, Indonesia**
   Nita Anggriawan (Lentera Anak Pelangi, Atma Jaya University, Indonesia)

2 Perlindungan Sosial bagi Anak-Anak Miskin di Perkotaan

Bagong Suyanto
Dosen Departemen Sosiologi FISIP Universitas Airlangga

Abstract

Anak-anak dari keluarga miskin adalah kelompok anak rawan yang seringkali menanggung beban ganda, yakni sebagai salah satu penyangga ekonomi keluarga dan sekaligus hak dan kewajiban untuk melangsungan pendidikannya. Studi ini menemukan bahwa anak-anak dari keluarga miskin yang terpaksa bekerja mencari nafkah bagi keluarga, cenderung menjadi korban perlakuan dikriminatif, terhambat proses tumbuh-kembangnya secara wajar, dan bahkan tak jarang mereka juga mudah diperlakukan salah. Pekerja anak di mana pun, mereka biasanya akan menghadapi kondisi yang tidak menguntungkan, rentan terhadap berbagai bentuk eksploitasi, mudah terkonatiminasi pengaruh buruk pekerja dewasa dan yang tidak kalah penting pekerja anak umumnya juga kehilangan akses untuk mengembangkan diri secara fisik, mental, dan intelektual. Untuk menjamin perlindungan sosial bagi anak-anak miskin, selain harus dilakukan sedini mungkin, seyogianya juga melibatkan dukungan atau peran serta lembaga sosial-kemasyarakatan (*community support system*).

1. Latar Belakang Penelitian

Di kalangan keluarga miskin di perkotaan --tak terkecuali di Kota Surabaya--, salah satu masalah sosial yang membutuhkan perhatian khusus adalah menyangkut nasib anak-anak yang seringkali tidak berdaya dan menjadi korban situasi kemiskinan yang membelenggu keluarga mereka. Hasil *assessment* yang dilakukan Wahana Visi Indonesia (2009) terhadap keluarga miskin di Kecamatan Semampir dan Simokerto menemukan bahwa berbagai tekanan kemiskinan yang mereka alami ternyata berkaitan erat dengan kondisi kerentanan dan ketidakberdayaan.

Akibat penghasilan yang pas-pasan, atau bahkan sangat kekurangan menyebabkan keluarga miskin tidak memiliki tabungan atau simpanan uang yang cukup, sehingga mereka sangat mudah masuk dalam perangkap utang yang kronis. Di sisi lain, akibat tidak memiliki latar belakang pendidikan yang cukup dan tidak menguasai ragam ketrampilan yang dapat dijadikan bekal untuk mencari pekerjaan alternatif, sering terjadi keluarga-keluarga miskin itu menjadi apatis, cenderung bersikap menerima nasib, pesimis, tidak berdaya, dan enggan beresiko. Kerentanan dan ketidakberdayaan ini sering menimbulkan *poverty rackets* atau "roda penggerak kemiskinan" yang menyebabkan keluarga miskin di wilayah urban tak jarang harus menjual harta benda dan aset produksinya karena tak ada lagi bantalan yang tersisa.

Dengan berbagai keterbatasan yang membelenggu mereka, harus diakui memang tidak banyak pilihan yang tersedia bagi keluarga miskin untuk dapat menyiasati dan keluar dari tekanan kemiskinan yang menjejas mereka. Di kalangan keluarga miskin di wilayah urban, selain melakukan langkah-langkah penghematan, mengurangi kualitas menu makanan, atau meminta bantuan kerabat, mempekerjakan anak dalam usia dini untuk ikut membantu keluarga mencari nafkah dan melibatkan perempuan dalam aktivitas ekonomi, --baik di sektor domestik maupun publik-- adalah salah satu upaya populer yang acapkali dilakukan keluarga miskin untuk mengurangi tekanan kemiskinan yang mereka alami.

Mencari nafkah dan mengorbankan waktu yang seharusnya untuk bermain dan sekolah untuk sepenuhnya bekerja, bagi anak-anak keluarga miskin acapkali harus dilakukan karena memang tidak ada pilihan lain yang bisa dilakukan. Di kalangan keluarga miskin, anak-anak terpaksa putus sekolah di tengah jalan dan tidak melanjutkan pendidikan hingga jenjang SMA atau bahkan SMP adalah hal yang lazim terjadi. Di tengah situasi krisis ekonomi yang berkepanjangan, tidak sekali dua kali terjadi orang-orang dewasa justru kehilangan pekerjaan dan usahanya kolaps, sementara di saat yang sama kesempatan kerja yang tersedia bagi anak-anak justru naik. Studi yang dilakukan LPPM Universitas Airlangga (2007) di sejumlah kota/kabupaten di Provinsi Jawa Timur menemukan bahwa kesempatan kerja bagi anak-anak cenderung naik, sebab yang namanya pekerja anak umumnya lebih memungkinkan untuk dibayar lebih murah daripada pekerja dewasa. Di samping itu, pekerja anak dalam banyak hal juga dinilai lebih penurut, cenderung tidak bersikap radikal dalam menyikapi berbagai isu perburuhkan, sehingga bagi dunia usaha kehadiran pekerja anak wajar jika dinilai lebih menguntungkan daripada mempekerjakan pekerja dewasa.

Studi yang tengah dilaporkan ini bemaksud mengkaji lebih jauh situasi problematik dan berbagai persoalan yang harus dihadapi anak-anak dari keluarga miskin, baik akibat kemiskinan, ketidakberdayaan maupun akibat kerentanan keluarga mereka. Di tengah situasi perubahan kondisi perekonomian yang masih tidak menentu dan kerasnya iklim persaingan di wilayah urban, sejauhmana anak-anak miskin harus menanggung beban dan terpaksa menjadi korban situasi yang tidak diinginkannya itu? Studi sebagaimana dilaporkan bukan merupakan studi kuantitatif yang mengedepankan pengukuran dan analisis statistik, melainkan akan lebih berupa studi kualitatif dalam bentuk paparan *essay* yang mendalam tentang ketidakberdayaan keluarga miskin dan anak di lingkungan keluarga miskin di Kota Surabaya, tepatnya di Kecamatan Simokerto dan Semampir. Secara lebih rinci, fokus studi ini adalah: (1) Bagaimana gambaran tentang kondisi

kerentanan dan ketidakberdayaan yang dialami keluarga-keluarga miskin di perkotaan?; dan (2) Dilema dan beban ganda seperti apakah yang selama ini dihadapi anak-anak yang berasal dari keluarga miskin di perkotaan, khususnya yang menyangkut kelangsungan pendidikan dan kewajiban mereka untuk bekerja membantu orang tuanya?

2. Kerangka Teori

Kemiskinan dan ketimpangan struktur institusional adalah variabel utama yang menyebabkan kesempatan masyarakat —khususnya anak-anak— untuk memperoleh pendidikan menjadi terhambat (Muller, 1980). Di lingkungan rumah tangga desa di Jawa, anak-anak dari keluarga miskin terpaksa ikut bekerja dan mencari nafkah —entah sebagai pembantu di rumahnya sendiri atau pekerja dalam usaha lain. Biasanya, jika tenaga kerja wanita —istri— dipandang belum dapat memecahkan masalah ekonomi yang dihadapi, maka anak-anak yang belum dewasapun tak segan-segan diikutsertakan dalam menopang kegiatan ekonomi rumah tangga. Di sini, anak-anak tersebut tidak terbatas hanya bekerja membantu orang tua saja, melainkan juga bekerja di sektor publik sebagai buruh upahan (Mulandar (ed.), 1996).

Studi yang dilakukan Kuntoro dkk. (1996) di Jawa Timur menemukan faktor utama yang menyebabkan anak-anak terpaksa tidak melanjutkan sekolah adalah karena orang tua mereka kesulitan untuk membiayai sekolah anak-anaknya. Kesimpulan Kuntoro ini sama dengan hasil studi BPS 1994 "Indikator Kesejahteraan Anak", di kalangan penduduk berumur 5-29 yang putus sekolah, alasan yang paling dominan adalah tidak mempunyai biaya (48,8%). Jadi, walaupun pemerintah telah berusaha meringankan uang sekolah bahkan menghapus uang SPP untuk sekolah dasar dan berusaha menekan uang sekolah untuk tingkat lanjut, tetapi karena tidak didukung oleh kemampuan ekonomi yang merata di masyarakat, maka di kelompok masyarakat miskin kesempatan belajar anak menjadi terganggu.

Sementara itu, menurut Maria Fransiska Subagyo (1986), kemelaratan diakui merupakan salah satu penyebab timbulnya kasus pelajar putus sekolah. Namun demikian, di luar itu faktor yang harus diperhatikan adalah cara keluarga mendidik anak, hubungan orang tua dengan anak, dan sikap atau aspirasi orang tua terhadap pendidikan. Di samping itu, tingkat pendidikan orang tua si anak itu sendiri juga tidak dapat dilupakan (Conger, 1978; dan Fahnidal, 1990). Orang tua yang tidak sekolah, biasanya akan mengalami kesulitan membantu anaknya belajar, tidak mampu memecahkan persoalan sekolah yang dihadapi anak, dan cenderung memberikan hukuman pada anaknya untuk berprestasi di luar kemampuan yang ada. Jadi, meskipun di sekolah telah disediakan berbagai kegiatan dan fasilitas pendidikan, tidaklah akan mencapai hasil yang memuaskan tanpa ditunjang oleh peran aktif keluarga —khususnya orang tua si anak itu sendiri (Hadari, 1985). Studi yang dilakukan Irwanto dkk. (1995) menemukan bahwa pendidikan ibu mempunyai peran penting dalam mempertahankan anak di sekolah. Anak dari ibu yang berpendidikan lebih rendah cenderung putus sekolah dibandingkan anak dari ibu yang berpendidikan lebih tinggi.

3. Metode Penelitian

Lokasi studi dilakukan di lima kecamatan yang merupakan wilayah yang dikenal sebagai kantong kemiskinan di Kota Surabaya, yaitu Kecamatan Semampir dan Simokerto. Kedua wilayah ini dikenal sebagai kecamatan yang banyak dihuni kaum migran dan masyarakat marginal kota, dan merupakan sentra pengembangan aktivitas ekonomi yang tergolong informal dan non-formal – jenis lapangan pekerjaan yang *notabene* banyak menarik perhatian migran dan penduduk miskin kota karena daya serapnya yang sangat fleksibel.

Secara garis besar, tahapan dan proses pengumpulan data yang dilakukan dalam studi ini adalah: Pertama, melakukan wawancara mendalam kepada keluarga miskin yang tinggal di kantong-kantong kemiskinan di Kecamatan Semampir dan Simokerto. Jumlah keluarga miskin yang diwawancarai adalah 240 unit keluarga, dengan kriteria: (1) termasuk keluarga miskin, baik penerima BLT (Bantuan Tunai Langsung) maupun keluarga miskin yang nyata-nyata miskin tetapi tidak tercatat resmi sebagai penerima dana BLT, (2) keluarga miskin yang termasuk penduduk permanen Kota Surabaya (ber-KTP Surabaya) maupun keluarga miskin yang merupakan migran dari desa, baik migran sirkuler maupun migran yang semi-permanen, (3) keluarga miskin yang memiliki anak minimal satu orang yang masih berusia 18 tahun ke bawah, (4) tinggal di wilayah Semampir atau Simokerto, dan (5) hidup di bawah garis kemiskinan atau berpenghasilan di bawah Rp. 200.000 per bulan per kapita.

Kedua, melakukan FGD (*Focus Group Discussion*) untuk melakukan konfirmasi dan memetakan situasi problematik yang dihadapi keluarga dan anak-anak miskin, terutama menyangkut persoalan perlindungan sosial anak. FGD dilakukan dalam dua kelompok utama, yaitu: (1) FGD yang mengundang masyarakat miskin, masyarakat marginal kota, aparatur pemerintahan di tingkat lokal, para kader dan tokoh masyarakat setempat, dan (2) FGD yang mengundang perempuan dan anak untuk mendiskusikan isu kesejahteraan ibu dan perlindungan sosial anak, *child abuse*, dengan tujuan untuk memahami problema yang dihadapi anak-anak dalam lingkungan keluarga yang secara ekonomis rentan.

Ketiga, melakukan observasi ke lokasi studi, khususnya ke kantong-kantong kemiskinan yang merupakan tempat tinggal keluarga miskin sehari-harinya di Kecamatan Semampir maupun Simokerto. Observasi yang dilakukan, bukan sekadar untuk mengetahui secara lebih mendalam situasi dan kondisi permukiman kumuh di lokasi studi, tetapi juga ritme sehari-hari kehidupan masyarakat miskin yang tinggal di wilayah itu. Beberapa hal yang diobservasi adalah kondisi infrastruktur, fasilitas layanan publik, dan zona-zona terbuka yang dapat dimanfaatkan warga masyarakat setempat untuk melakukan aktivitas sosial bersama warga yang lain.

Analisis dan pemetaan isu-isu apa saja yang mendesak dan prioritas untuk ditangani di lingkungan masyarakat Semampir dan Simokerto, dirumuskan setelah diperoleh data primer dari berbagai pihak, baik keluarga miskin, masyarakat lewat FGD, aparat pemerintah, LSM dan tokoh masyarakat yang relevan. Lebih dari sekadar sebagai persoalan ekonomi, kemiskinan yang terjadi dan dialami masyarakat di Kecamatan Semampir dan Simokerto dipahami sebagai produk struktur sosial dan konteks historis yang melatarbelakanginya. Artinya, apa yang dimaksud sebagai isu prioritas dan permasalahan keluarga dan anak-anak miskin tidak dirumuskan menurut persepsi peneliti atau persepsi kelas menengah yang seringkali berjarak dengan realitas, tetapi isu prioritas yang dihadapi keluarga dan masyarakat miskin dirumuskan secara kontekstual menurut perspektif keluarga dan masyarakat miskin itu sendiri, termasuk potensi-potensi dan pranata sosial apa yang fungsional mendukung kelangsungan hidup, daya tahan dan keberdayaan keluarga miskin.

4. Temuan dan Analisis Data

Keluarga dan anak-anak miskin di perkotaan sesungguhnya adalah bagian dari kelompok marginal yang mengalami berbagai tekanan ekonomi dan terpaksa harus menanggung beban yang berat akibat efek domino dari krisis ekonomi yang tak kunjung usai. Secara umum, studi ini menemukan bahwa kondisi sosial keluarga-keluarga miskin di kota cenderung rapuh dan rentan terperangkap utang. Di samping itu, kondisi usaha penduduk miskin di kota umumnya juga rawan kolaps akibat makin menipisnya margin keuntungan yang diperoleh karena kenaikan biaya produksi yang tidak sebanding dengan keuntungan yang diperoleh. Tanpa didukung modal yang cukup dan pemilikan

ketrampilan alternatif yang cukup, jelas tidak mudah bagi penduduk miskin untuk melangsungkan kehidupannya jika tidak didukung intervensi dari pemerintah dan pihak-pihak lain yang *concern* terhadap perbaikan nasib penduduk miskin kota.

Di kalangan keluarga miskin di perkotaan, keterlibatan anak-anak untuk ikut serta mencari nafkah bagi keluarga adalah hal yang lazim terjadi. Ketika kondisi ekonomi keluarga tak lagi mencukupi untuk memenuhi kebutuhan hidup sehari-hari, memang tidak banyak pilihan yang tersisa. Anak-anak yang seharusnya masih memperoleh kesempatan untuk melanjutkan sekolah, tak jarang harus putus sekolah di tengah jalan karena terpaksa bekerja, baik membantu usaha orang tua di rumah maupun bekerja di sektor publik –entah di *home industry*, toko atau di pabrik-pabrik layaknya pekerja dewasa.

Menjadi buruh pabrik, pekerja industri kecil, penjaga toko, pembantu rumah tangga, tukang cuci, kuli bangunan, kernet, pengamen, menjaga warung, dan pekerja lain di sektor informal adalah beberapa jenis pekerjaan yang biasanya ditekuni anak-anak dari keluarga miskin. Tidak sedikit anak-anak dari keluarga miskin setiap hari harus bekerja dengan rentang jam kerja yang panjang, dan menanggung beban kerja yang berat –di luar kemampuan dan keterbatasan anak-anak yang sebetulnya masih berhak untuk bermain dan melanjutkan sekolah ke jenjang yang setinggi-tingginya. Tekanan kemiskinan yang luar biasa, kebiasaan komunitas dan keluarga miskin untuk melatih anak bekerja sejak dini, kurangnya apresiasi orang tua terhadap arti penting pendidikan bagi anak, dan sejumlah tekanan yang sifatnya struktural lain adalah faktor gabungan yang acapkali menyebabkan anak-anak terpaksa terlibat dalam kegiatan produktif.

Studi ini menemukan bahwa anak-anak dari keluarga miskin yang terpaksa bekerja di sektor domestik maupun publik, cenderung menjadi korban perlakuan dikriminatif, terhambat proses tumbuh-kembangnya secara wajar, dan bahkan tak jarang mereka juga mudah diperlakukan salah. Pekerja anak di mana pun, mereka biasanya akan menghadapi kondisi yang tidak menguntungkan, rentan terhadap berbagai bentuk eksploitasi, mudah terkonatiminasi pengaruh buruk pekerja dewasa dan yang tidak kalah penting pekerja anak umumnya juga kehilangan akses untuk mengembangkan diri secara fisik, mental, dan intelektual. Marginal, eksploitatif dan tidak bermasa depan adalah sifat-sifat yang sangat tepat untuk menunjukkan kondisi buruh anak yang bertebaran di berbagai pabrik, industri kecil, sektor sektor informal, dan lain-lain (Tjandraningsih, 1996: 1).

Para pekerja anak yang diwawancarai dalam studi ini selain dalam posisi tak berdaya, rata-rata mereka juga sangat rentan terhadap eksploitasi ekonomi. Di sektor industri formal maupun di sektor industri rumahan, mereka umumnya berada dalam kondisi jam kerja yang panjang, berupah rendah, menghadapi resiko kecelakaan kerja dan gangguan kesehatan, atau menjadi sasaran pelecehan dan kesewenang-wenangan orang dewasa. Dalam hal lama bekerja, misalnya studi ini menemukan tak sedikit anak-anak yang terpaksa bekerja selama lebih dari 8 jam sehari, dan terpaksa melakukan jenis pekerjaan tertentu yang semestinya tidak sesuai dengan usia mereka.

Sejumlah pekerja anak yang diwawancarai dalam studi ini, seperti Muksin, Faiza, Suhaimah, Indah, Maisaroh, Hosiyeh, Jamila, Kowi, Faiza, Mujib, Dasuki, Mayfatul, dan lain-lain adalah anak-anak miskin yang sejak kecil telah disosialisasi orang tuanya agar kenal pekerjaan domestik, untuk kemudian tidak lagi kaget ketika harus bekerja di sektor publik. Berbeda dengan anak-anak dari keluarga yang secara ekonomi mapan, yang lebih memberi kesempatan anak untuk terlibat penuh dalam kegiatan belajar, les dan urusan lain di sekolah, orang tua dari anak-anak dari keluarga miskin biasanya lebih senang jika anaknya ringan tangan, mau bekerja di usia dini untuk membantu orang tua, dan jika perlu sepenuhnya bekerja di luar rumah –entah itu di pabrik, di *home industry* atau di tempat yang lain. Seorang anak dari kelurga miskin yang tidak lulus SD, dan

kemudian harus membantu orang tuanya mencari nafkah, tidak jarang di antara mereka yang kemudian terjun sebagai anak jalanan: mengamen dan terpaksa mengemis di berbagai lampu merah untuk mengais belas-kasihan pengendara mobil atau pengendara sepeda motor yang berhenti.

Tabel 1. Isu Prioritas yang Dihadapi Keluarga dan Anak-anak Miskin di PPerkotaan

Rincian Konteks	Situasi Problematik yang Dihadapi/Timbul
Keluarga Miskin di Perkotaan	• Keluarga miskin umumnya mengembangkan mekanisme ”gali lubang, tutup lubang”, serta cenderung terbelit utang dengan bunga yang tinggi (sekitar 20-50% per bulan). Keluarga miskin umumnya tidak memiliki tabungan sebagai penyangga ekonomi keluarga. Penghasilan yang tidak menentu (harian) seringkali menyebabkan keluarga miskin terpaksa harus utang. Serangan penyakit atau kesakitan seringkali menyebabkan keluarga miskin terpaksa harus utang, menggadaikan atau menjual barangnya, termasuk aset produksinya. Masa-masa kehilangan pekerjaan atau menjadi korban PHK adalah masa paling berat bagi keluarga miskin, dan seringkali memaksa mereka harus utang atau menjual barang berharga miliknya. Tekanan dan kewajiban sosial dalam kelompok dan keluarga (misal: hajatan) seringkali menyebabkan keluarga miskin harus meminjam uang. Bagi keluarga miskin, BLT tidak banyak berdampak memperpanjang kelangsungan hidup mereka karena segera terpakai untuk membayar utang. • Margin keuntungan yang diperoleh keluarga miskin dalam mata rantai perdagangan umumnya kecil. Tekanan kebutuhan hidup seringkali menyebabkan terjadi proses pengikisan modal usaha yang ditekuni keluarga miskin. Kemampuan keluarga miskin melakukan diversifikasi usaha rendah, karena keterbatasan modal dan dukungan ketrampilan yang kurang. Kehilangan pekerjaan seringkali memaksa keluarga miskin juga kehilangan aset produksinya. • Ketidakjelasan identitas kependudukan seringkali menyebabkan keluarga miskin harus mengeluarkan biaya yang lebih mahal untuk memenuhi fasilitas air bersih. Program penanggulangan kemiskinan yang bersifat karitatif cenderung malah mematikan potensi *selp-helf* penduduk miskin dan menimbulkan ketergantungan baru. Keluarga miskin cenderung bersikap apatis dan pasrah menerima kondisi kemiskinan yang dialaminya. Mereka lebih terbiasa beradaptasi dengan kondii kemiskinan yag dialami daripada berusaha keluar dari tekanan kemiskinan yang dialami. Keluarga miskin cenderung enggan mengambil resiko untuk mengembangkan usahanya (*safety first*)
Anak-anak Miskin di Perkotaan	• Untuk memenuhi kebutuhan hidup, salah satu sumber daya potensial adalah dukungan anak-anak yang terpaksa bekerja dalam usia dini. Di kalangan keluarga miskin, anak seringkali harus ikut bekerja di usia dini untuk membantu perekonomian keluarga. Kelangsungan pendidikan anak menjadi agak terganggu ketika orang tua dari keluarga miskin tidak memiliki dana yang cukup untuk menjamin kelangsungan pendidikan anak-anaknya hingga setinggi-tingginya. • Anak-anak miskin yang bekerja seringkali harus menghadapi kondisi lingkungan kerja yang berat. Tidak sedikit anak-anak dari keluarga miskin setiap hari harus bekerja dengan rentang jam kerja yang panjang, dan menanggung beban kerja yang berat –di luar kemampuan dan keterbatasan anak-anak yang sebetulnya masih berhak untuk bermain dan melanjutkan sekolah ke jenjang yang setinggi-tingginya.

Di kalangan keluarga miskin, sudah lazim terjadi anak bukan saja dinilai memiliki fungsi ekonomis untuk membantu orang tua mencari nafkah, tetapi membiarkan atau menyuruh anak bekerja sejak usia dini juga diyakini akan bermanfaat positif untuk melatih anak lebih cepat mandiri. Memang, untuk jenis pekerjaan yang ringan dan bersifat mendidik sesungguhnya melatih anak untuk biasa bekerja membantu orang tua bukanlah masalah, dan tak pula dilarang. Tetapi berdasarkan hasil penelitian dan pengamatan yang pernah dilakukan memperlihatkan bahwa keterlibatan anak dalam aktivitas ekonomi ternyata memberikan implikasi yang luar biasa hebatnya. Gootear dan Kanbur (1994) misalnya menyebutkan bahwa anak-anak yang terlibat dalam aktivitas

ekonomi baik di sektor formal maupun informal yang terlalu dini ternyata mengalami berbagai gangguan baik fisik, sosial maupun psikologis.

Secara spesifik dikemukakan bahwa anak-anak yang bekerja terlalu dini ternyata sangat rawan akan perilaku eksploitatif dan jenis-jenis pekerjaan berbahaya serta dapat mengganggu perkembangan psikologis dan sosial anak. Secara lebih rinci Tjandraningsih dan White (1992) mengemukakan bahwa keterlibatan anak dalam kegiatan ekonomi khususnya dalam sektor industri formal akan sangat mencemaskan. Sebab dalam dunia kerja seperti ini akan sangat rawan terhadap tindakan eksploitasi ekonomi, terjebak dalam jumlah jam kerja yang panjang, upah rendah, menghadapi resiko kecelakaan kerja dan ganggugan kesehatan serta menjadi sasaran pelecehan termasuk pelecehan seksual dan kesewenang-wenangan oleh orang dewasa. Di samping itu dari segi pendidikan, tidak jarang anak-anak yang terlibat dalam dunia kerja kurang mendapatkan kesempatan untuk menempuh pendidikan dan cenderung untuk putus sekolah (*drop-out*). Akibatnya angka partisipasi sekolah menjadi rendah (Suyanto dkk; 1997).

Beban pekerjaan yang dialami oleh pekerja anak sesungguhnya tidak terlalu berat jika dalam keterlibatannya dalam aktivitas ekonomi masih diperhatikan jumlah jam kerja yang dibebankan, sektor yang ditekuni dan jenis pekerjaan yang diberikan serta aspek perlindungan terhadap para pekerja anak. Apalagi di sela-sela pekerjaannya anak masih diberi kesempatan untuk dapat menempuh pendidikan atau belajar, bermain serta memperoleh jaminan kesehatan yang memadai sehingga anak-anak masih dapat mengalami tumbuh kembang secara wajar. Tetapi, sebagaimana ditemukan dalam studi ini bahwa sebagian pekerja anak ini justru harus bekerja dan dibebani oleh pekerjaan-pekerjaan yang tidak memungkinkan mereka tetap bersekolah dan tak jarang pula jenis pekerjaan yang dilakukan menganggu proses tumbuh-kembang anak. Anak-anak yang bekerja sebagai kuli bangunan, misalnya jelas pekerjaan yang dilakukan terlalu berat bagi mereka yang belum cukup umur. Anak yang bekerja sebagai kernet di jalan raya, atau anak yang bekerja di pabrik, tentu kondisi lingkungan kerja sangat rawan jika tidak didukung upaya perlindungan yang memadai.

Sejumlah pekerja anak yang bekerja di indutri kecil sablon, misalnya mengaku selama ini mereka bekerja memang agak terganggu dengan bau bahan kimia yang menyengat, yang dipergunakan untuk campuran sablon. Dari majikan tempat mereka bekerja, tidak ada fasilitas penutup hidung dan mulut, sehingga sejak awal masuk kerja di tempat penyablonan, anak-anak miskin itu boleh dikata setiap hari selalu terkontaminasi oleh bau-bau yang sangat menyengat dan dari segi medis jelas berbahaya. Menurut pengakuan sejumlah informan, memang terkadang pihak majikan menyediakan mereka telur untuk diminum agar daya tahan tubuh mereka meningkat. Tetapi, sejauhmana upaya ini benar-benar efektif untuk menangkal bahaya bahan kimia yang dipergunakan di tempat penyablonan sebetulnya masih menjadi tanda tanya.

Dengan usia yang masih relatif sangat muda atau bahkan kanak-kanak sebenarnya tidaklah mengherankan jika saat bekerja anak-anak miskin itu melakukannya sambil bercanda, bersenda gurau dan saling menggoda di antara sesama teman. Mereka, bagaimana pun memang masih dalam usia bermain. Namun yang seringkali tidak disadari adalah unsur kebahayaan yang acapkali datang secara tiba-tiba dan tanpa di duga sebelumnya. Seorang anak yang bekerja sebagai kernet mobil angkutan umum, jika tidak bisa menahan diri dan mengedepankan unsur bermain, maka bukan tidak mungkin ia akan mengalami masalah ketika nasib sedang apes. Studi ini menemukan, sejumlah pekerja anak terpaksa beberapa kali pindah kerja karena tak kuat terhadap beban dan lingkungan kerja yang tidak mendukung. Seorang anak yang bekerja di rumah sarang burung walet, misalnya, beberapa di antaranya mengaku terpaksa pindah kerja karena tak tahan suasana dan beban kerja yang berat.

Yanti Mala (17 tahun), salah seorang pekerja anak yang diwawancarai dalam studi ini menyatakan bahwa sebelum ia bekerja di toko kue seperti sekarang ini, ia pernah bekerja di sarang burung

walet dan tempat penyablonan. Di sarang burung walet, Yanti mengaku hanya tahan bekerja beberapa hari saja karena merasa terganggu dengan suasana kerja di mana ia bekerja hanya dengan memakai pakaian dalam di depan lampu yang menyala terang. Sementara di tempat sablon, Yanti juga tidak bertahan lama karena tak kuat dengan bau menyengat dari bahan kimia yang dipakai untuk menyablon.

Bekerja di toko kue, menurut Yanti memang masih lebih baik daripada bekerja di sarang burung walet atau di tempat penyablonan. Tetapi, satu hal yang membuat Yanti agak kurang nyaman adalah ulah majikannya yang seringkali mengeluarkan kata-kata kasar dan uka memarahi pegawainya ketika mereka dinilai kurang benar dalam bekerja. Jika memungkinkan, Yanti sendiri sebetulnya berkeinginan untuk kembali pindah kerja. Namun, disadari hal itu bukanlah hal yang mudah. Yanti, khawatir jika ia keluar dari tempat kerjaannya sekarang, ternyata kemudian kesulitan mencari tempat kerja baru, maka bukan tidak mungkin ekonomi keluarganya akan makin runyam. Di keluarga Yanti, saat ini hanya ayahnya yang bekerja sebagai tukang becak, sementara ibunya hanyalah ibu rumah tangga. Tanpa dukungan dari Yanti, niscaya sulit bagi orang tuanya untuk dapat memenuhi kebutuhan hidup sehari-hari yang makin lama makin berat.

Di toko kue tempat Yanti bekerja saat ini, upah yang diterima biasanya mingguan. Semula, ketika awal-awal bekerja, Yanti menerima upah Rp. 70.000 setiap minggunya. Upah ini kemudian dinaikkan menjadi Rp.80.000 dan setelah kurang-lebih tiga tahun bekerja di sana upah Yanti sekarang sebesar Rp.90.000 setiap minggunya. Tidak ada jenjang waktu yang jelas kapan upah yang diterima mengalami peningkatan. Semuanya tergantung dari pemilik toko. Jika pemilik toko puas dengan kinerja Yanti, maka ada kemungkinan upahnya akan dinaikkan.

Upah Yanti sebesar Rp.90.000, sebagian digunakan untuk membantu memenuhi kebutuhan keluarganya dan dirinya sendiri. Sebesar Rp.50.000 biasanya diberikan kepada orang tuanya dan kadang untuk melunasi hutang yang dimiliki orang tuanya. Rp.30.000 dari upahnya disihkann untuk memenuhi keperluan dirinya sendiri dan Rp.10.000 yang lain merupakann tabungan yang ditabung Yanti di celengan yang dimilikinya. Yanti tidak membutuhkan pengeluaran untuk transportasi karena tempat kerja Yanti dekat dengan rumahnya, yaitu berada di daerah Donorejo, sehingga untuk pergi ke tempat kerja ia cukup berjalan kaki saja.

Para pekerja anak seperti Yanti atau yang lain, dari hasil studi yang dilakukan diketahui rata-rata lama jam kerja mereka per hari adalah sekitar 8-10 jam. Di sektor perekonomian formal, seperti di pabrik atau menjadi penjaga toko, misalnya tidak ada perbedaan jam kerja antara pekerja anak dan pekerja dewasa. Seorang anak yang bekerja di pabrik, maka ia bukan saja memiliki kewajiban lama kerja seperti pekerja dewasa, tetapi juga harus menanggung beban kerja yang sama dengan pekerja dewasa. Bahkan, dalam beberapa kasus sudi ini menemukan, yang namanya pekerja anak tidak jarang justru harus menanggung beban kerja yang lebih berat karena perlakuan diskriminatif dari pekerja dewasa yang lain.

Sindi (13 tahun), salah seorang anak miskin yang bekerja di sebuah pabrik sarang burung walet seperti yang pernah dilakukan Yanti di atas, menyatakan upahnya setiap hari saat ini adalah 10 ribu rupiah. Di tempat kerjanya Sindi adalah buruh yang paling kecil, sehingga kadang hal ini dimanfaatkan oleh teman-teman di tempat kerjanya yang lebih tua. Ketika bekerja Sindi tidak hanya bertanggungjawab untuk membersihkn sarang burung dan menyapu kotoran burung seperti pekerja dewasa yang lain, namun tidak jarang dia juga disuruh untuk membersihkan kantor tempat ia bekerja seperti menyapu dan mengepel. Sindi mengeluhkan hal ini, karena teman-teman kerjanya yang lain tidak diminta melakukan pekerjaan seperti dirinya. Padahal dari segi upah, uang yang diterima Sindi justru lebih kecil bila dibandingkan teman-teman kerjanya yang lain.

Kalau menurut ketentuan yang berlaku, yang namanya pekerja anak sebetulnya setiap hari maksimal jam kerja mereka adalah 4 jam, tidak lebih, dan itu pun seharusnya mereka tetap dibayar dengan besar upah yang sama seperti pekerja dewasa yang lain. Tetapi, yang namanya ketentuan, ternyata tak selalu diterapkan dalam kenyataan. Alih-alih hanya bekerja maksimal 4 jam sehari, tidak sedikit pekerja anak yang berasal dari Kecamatan Semampir dan Simokerto ternyata harus menangung beban kerja yang lama, dua kali lipat lebih lama dari ketentuan yang ada, yakni 8 jam per hari. Bahkan, tidak jarang, di antara pekerja anak itu juga harus melakukan kerja lembur ketika pabrik tempat mereka bekerja membutuhkannya. Sejumlah anak yang bekerja di pabrik menyatakan, kerja lembur adalah hal yang biasa mereka lakukan, karena jika menolak, tentu pihak pabrik tidak akan segan memberi sanksi, bahkan mungkin mengeluarkan mereka. Di pabrik, meski usia mereka sebetulnya masih di bawah umur, tetapi kewajiban yang mereka emban tidak ubahnya seperti pekerja dewasa.

Meski melelahkan, tetapi para pekerja anak di pabrik tersebut umumnya mereka tidak terlalu mempersoalkan kerja lembur yang terkadang harus mereka lakukan karena kondisinya memang seperti itu. Didesak kebutuhan ekonomi yang tak bisa ditunda terlalu lama, memang pada akhirnya tidak banyak pilihan yang tersedia bagi anak-anak miskin. Bahkan, di luar soal lama jam kerja, studi ini menemukan terkadang para pekerja anak juga harus merasakan berbagai tekanan psikis yang kurang mengenakkan dirinya.

Sebut saja namanya Indah (16 tahun). Indah adalah salah seorang anak miskin yang mengaku pernah bekerja sebagai pelayan toko sepatu di JMP (Jembatan Merah Plaza). Selama bekerja di toko sepatu Indah memperoleh gaji sebesar Rp 500.000,- per bulan dan setiap ada lembur memperoleh tambahan uang lembur sebesar Rp 5.000,- per jam. Dari segi gaji, Indah sebetulnya mengakui jumlahnya cukup besar dan banyak membantu kondisi keuangan orang tuanya. Tetapi, meski memperoleh upah yang lumayan besar, namun Indah tidak merasa nyaman bekerja di toko sepatu tersebut dikarenakan terlalu banyak tuntutan yang diberikan bosnya dan itu harus wajib ditaati. Salah satu tuntutan tersebut adalah memakai seragam kerja yang agak terbuka, wajah yang dituntut harus selalu cerah, bekerjanya dengan berdiri, tidak boleh capek, tidak boleh cuti bahkan jika sakit pun tidak boleh ijin berobat walaupun cuma setengah hari, dan apabila ada pegawai yang lengah sedikit maka tidak segan-segan bos atau tangan kanan bosnya menegur dengan nada yang meremehkan. Selama bekerja di toko sepatu, tidak ada hari libur bagi Indah.

Dibandingkan anak yang bekerja di sektor publik, seperti pabrik atau toko, anak-anak yang bekerja di sektor domestik: membantu usaha orang tuanya di rumah atau membantu kerabat lain untuk mengurus pekerjaan kerumah tanggaan, biasanya jam kerja mereka lebih pendek. Anak-anak yang bekerja di sektor domestik, jam kerja mereka biasanya hanya sekitar 3-4 jam, sehingga sebagian di antara mereka masih memiliki waktu untuk tetap bersekolah. Beberapa pekerja anak yang diwawancarai dalam studi ini, mengaku masih tetap bersekolah karena jam kerja mereka yang fleksibel dan juga tidak terlalu panjang.

Sementara itu, untuk anak-anak yang bekerja di pabrik, di toko atau pekerjaan lain yang lama jam kerjanya lebih dari 7-8 jam, tentu kemungkinan bagi mereka untuk tetap sekolah sama sekali tidak ada. Bahkan, yang memprihatinkan, sebagian anak-anak miskin yang bekerja di sektor publik, ketika mereka pulang ke rumah bukan berarti bebannya sudah selesai. Di kalangan pekerja anak perempuan, sudah lazim terjadi, meski mereka pulang dalam kondisi capek, tetapi kewajiban untuk mengerjakan berbagai tugas kerumahtanggaan tidak sepenuhnya bisa mereka abaikan begitu saja. Menurut penuturan sejumlah informan, anak-anak perempuan miskin yang bekerja di sektor publik, ketika pulang ke rumh tidak jarang mereka masih tetap harus membantu ibunya membersihkan rumah, mengasuh adiknya yang masih kecil, dan melakukan berbagai tugas domestik lain yang tak kalah melelahkan.

Dalam batas-batas tertentu, studi ini menemukan bahwa perlakuan keluarga miskin terhadap anak laki-laki dan anak perempuan memang ada kecenderungan berbeda. Pekerja anak laki-laki, sepulang mereka bekerja, biasanya waktu yang tersisa sebelum mereka berangkat tidur banyak dimanfaatkan untuk bermain, *cangkruk* dengan sesama teman atau pergi ke luar rumah. Studi ini menemukan tidak sedikit pekerja anak laki-laki mengaku sering jalan-jalan dan bergaul dengan pekerja yang lebih dewasa, sehingga sedikit-banyak mereka juga mulai mengenal kehidupan dan gaya hidup orang dewasa. Berbeda dengan pekerja anak perempuan yang selesai kerja biasanya langsung pulang ke rumah dan menghabiskan waktu untuk menonton televisi atau melakukan berbagai pekerjaan domestik yang lain, untuk pekerja anak laki-laki, kegiatan mereka sepulang kerja biasanya lebih bebas.

Tidak sedikit pekerja anak laki-laki diketahui termasuk perokok yang aktif. Setiap hari mereka menghabiskan satu bungkus rokok. Kebiasaan merokok ini, menurut sejumlah informan diperoleh akibat lingkungan pergaulan mereka di tempat kerja yang sebagian besar adalah pekerja dewasa. Meski tidak banyak, namun studi ini menemukan bahwa beberapa pekerja anak terkadang juga mulai mengenal dunia prostitusi dari teman kerjanya pekerja dewasa. Lingkungan pergaulan yang salah dan permisif, bagaimana pun memang tidak semua bisa ditolak pengaruhnya begitu saja oleh para pekerja anak di usianya yang selalu ingin serba tahu dan mencoba hal-hal yang dilarang.

Para orang tua dari pekerja anak yang mulai merokok dan sering dolan ke luar rumah hingga larut malam, mereka bukan berarti tidak mengetahui perkembangan perilaku anak-anaknya yang mulai terkontaminasi pengaruh temannya yang lebih dewasa. Tetapi, di kalangan keluarga miskin, ketika anak-anak telah bekerja secara mandiri dan mampu memberikan bantuan kepada ekonomi keluarga, biasanya pihak orang tua tidak lagi terlalu ikut campur pada urusan anak-anaknya. Anak-anak yang bekerja, dan terlebih mampu memberikan sumbangan yang tidak kecil bagi ekonomi keluarga, niscaya lebih dihargai oleh orang tuanya. Sepanjang bantuan yang diberikan anak masih rutin, biasanya orang tua tidak akan banyak mempersoalkan ulah anak-anaknya. Bahkan, hal itu seringkali dipahami sebagai indikasi dari proses peralihan kedewasaan anaknya.

5. Fokus Program Intervensi

Dari hasil *assessment* yang dilakukan, paling-tidak ditemukan tiga persoalan penting yang perlu digarisbawahi sebelum dilakukan program intervensi untuk memberdayakan keluarga miskin di Kecamatan Semampir maupun Simokerto.

Pertama, berkaitan dengan fokus subyek yang seharusnya diprioritaskan dalam program intervensi. Studi ini menemukan, dua kelompok yang perlu diprioritaskan sebagai subyek program adalah ibu-ibu dan anak-anak dari keluarga miskin. Hampir semua ibu-ibu dari keluarga miskin tidak berdaya dan terjebak dalam kegiatan domestik dan ruang gerak untuk mengembangkan potensinya terhambat karena masih dominan berlakunya ideologi patriarkhis dan beban pekerjaan domestik yang harus mereka tanggung. Sementara itu, anak-anak dari keluarga miskin acapkali mengalami situasi dilematis ketika harus menanggung beban ganda antara melanjutkan sekolah dan bekerja. Tidak jarang terjadi, anak-anak dari keluarga miskin terpaksa putus sekolah di tengah jalan karena harus membantu orang tua mencari nafkah.

Kedua, berkaitan dengan mitra atau jejaring yang bisa dijadikan "pintu masuk" dan pendukung efektivitas pelaksanaan program intervensi. Studi ini menemukan, bahwa di kalangan komunitas masyarakat miskin, ternyata masih ada tersisa daya kohesi sosial dan berbagai pranata sosial, termasuk lembaga-lembaga lokal, seperti *sinoman*, IKAMRA, forum pengajian, umat gereja, arisan, Dasa Wisma, dan lain sebagainya, yang terbukti fungsional

berperan sebagai penyangga atau asuransi sosial bagi keluarga miskin, terutama ketika mereka mengalami musibah tau kesengsaraan. Program pemberdayaan masyarakat miskin yang berkelanjutan, niscaya tidak akan dapat diwujudkan jika dalam proses pelaksanaannya tidak melibatkan dan didukung keberadaan berbagai CBO (*Community Based Organization*) yang memang memiliki akar kultural di lingkungan komunitas masyarakat miskin itu sendiri.

Ketiga, berkaitan dengan substansi program intervensi yang akan dikembangkan di lapangan. Pengalaman selama ini telah banyak mengajarkan bahwa pelaksanaan berbagai program yang diklaim sebagai program pemberdayaan masyarakat miskin ternyata seringkali rawan bias dan tidak mencapai sasaran karena hanya terjebak pada program-program yang sifatnya karitatif-populis, dan tidak benar-benar berorientasi pada upaya pemberdayaan yang berkelanjutan. Untuk lebih menjamin efektivitas program intervensi yang akan dikembangkan, oleh sebab itu langkah awal yang tak kalah penting adalah bagaimana merumuskan program yang kontekstual, mempertimbangkan karakteristik keluarga miskin sebagai subyek program, dan tidak malah mematikan potensi *self-help* yang dimiliki keluarga miskin untuk menolong dirinya sendiri. Berhadapan dengan karakteristik masyarakat miskin yang cenderung apatis dan mendahulukan prinsip *safety first*, tentu membutuhkan program intervensi yang benar-benar mampu menggalang partisipasi atau keterlibatan aktif keluarga miskin itu sendiri, serta mampu membongkar berbagai bentuk hegemoni yang selama ini mensubordinasi peran masyarakat miskin.

6. Strategi yang Dikembangkan

Upaya untuk meningkatkan kesejahteraan keluarga miskin dan meningkatkan perlindungan sosial bagi anak-anak miskin di berbagai kantong kemiskinan di wilayah urban sesungguhnya bukan hanya mencakup upaya pengembangan kegiatan produkif keluarga miskin, tetapi juga menyangkut pada persoalan bagaimana upaya pemberdayaan yang dilakukan dapat menjamin para keluarga miskin memperoleh apa yang sebetulnya menjadi hak mereka, khususnya kesejahteraan dan kondisi yang menjamin anak dapat tumbuh-kembang secara wajar.

Pengalaman di masa lalu telah banyak mengajarkan, bahwa program-program penanggulangan kemiskinan yang dilakukan hanya berdasarkan pertimbangan logika produksi atau sekadar mengejar peningkatan omzet produksi, terlebih program yang sifatnya karitatif semata bukan saja menyebabkan terjadinya *overs stock* dan berhadapan dengan keterbatasan pangsa pasar. Tetapi, juga melahirkan proses marginalisasi dan ketergantungan penduduk miskin yang makin menyolok mata. Kelompok PKL, tukang becak, buruh industri kecil, pekerja di sektor informal, pegawai rendahan, dan sejenisnya mereka umumnya makin tersisih, rawan diperlakukan salah, dan sulit dapat melakukan mobilitas vertikal karena struktur yang ada makin hari terasa makin tidak ramah.

Berbagai bukti di lapangan telah banyak memperlihatkan bahwa berbagai program penanggulangan kemiskinan yang selama ini digulirkan --terutama dalam bentuk pemberian subsidi yang karitatif dan bantuan modal usaha atau pembinaan usaha produktif keluarga miskin-- seringkali masih terkonsentrasi pada rekayasa yang sifatnya teknis produksi dan cenderung hanya beriorientasi kuantitas, sehingga dalam banyak hal lebih menguntungkan kelompok masyarakat yang memiliki modal dan asset produksi yang berlebih.

Kebijakan pembangunan dan berbagai program penanggulangan kemiskinan yang dikembangkan seringkali kurang memperhatikan karakteristik dan konteks lokal masyarakat miskin, sehingga jangan heran jika yang terjadi kemudian adalah paket-paket kebijakan dan program yang bersifat *meritokratis*. Bisa dibayangkan, apa yang terjadi jika Pemerintah Kota

mengucurkan sejumlah dana kepada masyarakat miskin tanpa terlebih dahulu mempertimbangkan struktur sosial di masyarakat lokal yang terpolarisasi atau paling-tidak terstratifikasi atas dasar berbagai demensi? Mungkinkah yang namanya pedagang kecil-kecilan dengan latar belakang pendidikan yang rendah dapat mengembangkan usahanya dan menembus pasar yang lebih luas, sementara di saat yang sama supermarket mini semacam Indomaret, Alfamart, dan sebagainya masuk ke kampung-kampung dan kompleks perumahan? Mungkinkah kelompok buruh industri kecil bisa meningkatkan kesejahteraannya jika paket-paket bantuan teknologi industri lebih diprioritaskan kepada pemilik atau para juragan yang dinilai lebih bisa dipercaya bakal tidak menunggak cicilan pinjamannya? Mungkinkah, anggota masyarakat miskin di lapisan yang paling miskin bisa memperoleh kesempatan memberdayakan dirinya, jika cara pandang terhadap mereka masih dipenuhi berbagai syakwasangka?

Ke depan, untuk mencegah agak tidak lagi terperosok pada kekeliruan yang serupa, dan upaya pemberdayaan masyarakat miskin dan perlindungan anak-anak miskin di Kota Surabaya benar-benar dapat berjalan efektif, maka yang dibutuhkan bukan sekadar kesediaan untuk melakukan introspeksi, tetapi juga revitalisasi program pemberdayaan masyarakat miskin yang benar-benar berpihak kepada lapisan yang paling miskin — khususnya para pelaku ekonomi di sektor informal di wilayah urban.

Tabel 2. Model Pemberdayaan Keluarga Miskin dan Perlindungan Sosial Anak Miskin di Perkotaan

Aspek Pemberdayaan	Strategi	Bentuk Kegiatan
Peningkatan posisi tawar keluarga miskin	- Mengembangkan pola deversifikasi usaha dan efisiensi proses produksi dalam kegiatan usaha kecil - Penguatan dan pengembangan jaringan kelembagaan sosial-ekonomi lokal	- Pelatihan ketrampilan alternatif bagi keluarga miskin, khususnya perempuan - Pelibatan dan intensifikasi tenaga kerja keluarga untuk efisiensi proses produksi
Memperkuat penyangga sosial-ekonomi keluarga miskin	- Perluasan akses pelaku ekonomi rakyat terhadap sumber-sumber permodalan berbunga rendah - Pengembangan program asuransi sosial bagi keluarga miskin	- Peningkatan efektivitas dan pengguliran paket-paket bantuan modal usaha berbunga rendah bagi keluarga miskin di perkotaan - Pemberdayaan forum pengajian, sinoman, IKAMRA, forum arisan, umat gereja dan institusi lokal lain untuk mengurangi kadar kerentanan keluarga miskin
Peningkatan perlindungan sosial bagi anak-anak miskin	- Prevensi untuk mencegah anak putus sekolah	- Penanganan anak rawan putus sekolah, baik di sekolah maupun yang melibatkan dukungan lembaga sosial-keagamaan di masyarakat

Dalam hal ini, langkah awal yang semestinya disadari bahwa pemberdayaan masyarakat miskin, sesungguhnya akan selalu berkaitan atau sekurang-kurangnya mencakup tiga aspek.

Pertama, berkaitan dengan upaya peningkatan posisi tawar (*bargaining position*) masyarakat miskin melawan kekakuan (*rigidity*) dan sifat eksploitatif dari struktur yang membelenggu mereka. Artinya, program pembangunan sosial dan upaya penanggulangan kemiskinan seyogianya tidak hanya terjebak pada program-program yang sifatnya karitatif dan apalagi yang bersifat punitif, melainkan harus lebih mengedepankan program-program yang berorientasi pada proses pemberdayaan, yang intinya bersifat *people centered, participatory, empowering*, dan *sustainable*. Pemberdayaan pada intinya adalah pemanusiaan. Pemberdayaan, mengutamakan usaha sendiri dari orang yang diberdayakan untuk meraih keberdayaannya. Oleh karena itu, pemberdayaan sangat jauh dari konotasi ketergantungan. Dua hal yang menjadi prasyarat bagi upaya pemberdayaan adalah. Pertama, pembentukan kelompok (Pokmas) untuk memperkuat posisi bargaining penduduk miskin, khususnya dalam penentuan harga. Kedua, dalam bentuk pengembangan jaringan (*net working*) dan memperluas akses penduduk miskin terhadap pasar yang lebih luas.

Kedua, berkaitan dengan upaya mengurangi kadar kerentanan dan sekaligus bagaimana memperkuat penyangga sosial-ekonomi keluarga miskin. Dalam hal ini, salah satu hal yang dapat dikembangkan adalah bagaimana mendorong pengembangan kegiatan produktif alternatif keluarga miskin. Selama ini, kekurangan pokok yang perlu diperhatikan dari berbagai upaya pengentasan masyarakat miskin yang banyak dipraktekkan adalah bahwa mereka menjadi begitu memusatkan perhatian pada peningkatkan kuantitas produksi atau hasil kegiatan produktif masyarakat miskin, sehingga kebutuhan sistem produksi mendapat tempat yang lebih utama daripada kebutuhan masyarakat miskin yang lebih substansial. Ke depan, untuk lebih menjamin efektivitas pelaksanaan program penanggulangan kemiskinan, maka seyogianya disadari bahwa meningkatkan kesejahteraan penduduk miskin sesungguhnya tidak selalu harus dengan cara memacu perkembangan dan semata hanya berusaha meningkatkan volume atau jumlah produksi sektor usaha kecil tersebut.

Sebagai salah satu alternatif —dan mungkin juga dapat dilakukan secara bersamaan— pola lain yang dapat dilaksanakan untuk mengembangkan usaha kecil adalah dengan cara melakukan efisiensi proses produksi. Selain itu, untuk meningkatkan kadar keberdayaan keluarga miskin dan sekaligus mencegah resiko kemungkinan terjadinya kegagalan total dari usaha keluarga miskin alangkah baiknya jika di saat yang bersamaan tiap-tiap anggota keluarga yang termasuk tenaga kerja produktif didorong untuk mengembangkan kegiatan usaha yang beraneka-ragam atau satu dengan yang lain saling berbeda. Pengalaman yang sudah-sudah membuktikan bahwa sebuah keluarga yang semata-mata hanya menggantungkan kepada satu matapencaharian —di mana suami, istri dan anak semua bekerja di sektor yang sama— umumnya secara sosial-ekonomi lebih rapuh karena jika suatu saat harga komoditi yang mereka produksi anjlok, maka itu berarti semua anggota keluarga akan kehilangan dan mengalami kerugian yang sama. Ini berbeda jika dalam sebuah keluarga, masing-masing anggota memiliki matapencaharian yang berbeda-beda. Keluarga yang mengembangkan pola diversifikasi usaha, terbukti dalam kehidupan sehari-hari mereka selalu lebih berdaya dan kenyal terhadap tekanan kebutuhan ekonomi.

Ketiga, berkaitan dengan upaya untuk memberikan perlindungan sosial bagi anak-anak miskin. Dalam upaya penanganan pekerja anak dan untuk lebih memastikan kelangsungan pendidikan anak-anak miskin, untuk awal program intervensi ada baiknya jika fokus anak rawan yang hendak ditangani dikonsentrasikan khusus kepada siswa rawan DO di jenjang SD-SMP dan pekerja anak di sektor berbahaya. Kenapa anak rawan DO perlu diprioritaskan, karena kita sadar bahwa mencegah anak putus sekolah dalam banyak hal relatif lebih mudah daripada menarik kembali ke sekolah anak-anak yang sudah terlanjur DO dan bekerja. Sedangkan, pekerja anak di sektor

berbahaya perlu diberi perhatian khusus, karena jika dibiarkan berlarut-larut tidak mustahil anak-anak yang bekerja di sektor berbahaya ini akan terancam keselamatan hidup dan masa depannya. Bagi pihak perusahaan atau majikan, mempekerjakan anak-anak di bawah umur seperti layaknya pekerja dewasa secara ekonomis mungkin lebih menguntungkan. Namun, bagi anak-anak itu sendiri pelibatan mereka dalam pekerjaan yang berbahaya di usia yang terlalu dini jelas akan rawan menimbulkan dampak negatif —terlebih jika pekerjaan itu selain berbahaya, ternyata juga tidak bermasa depan: dalam arti tidak menawarkan jenjang karir yang bermanfaat bagi anak-anak.

Sebagai sebuah masalah, kebiasaan orang tua memaksa anaknya bekerja di usia yang masih dini, sikap acuh tak acuh orang tua terhadap arti penting sekolah, dan lain-lain pada dasarnya adalah masalah yang seringkali ditempatkan sebagai persoalan intern keluarga dan masuk dalam wilayah privat yang sulit diintervensi oleh negara. Untuk perpanjangan tangan dan ujung tombak pelaksanaan program intervensi bagi pekerja anak dan anak-anak miskin yang rawan putus sekolah, oleh sebab itu sudah sewajarnya jika dilibatkan lembaga-lembaga di tingkat lokal (*Community Based Organization*) yang memiliki minat dan potensi untuk menangani masalah tersebut sebagai lembaga perantara untuk menjembatani kesenjangan komunikasi yang terlalu jauh antara keluarga dan negara.

7. Rekomendasi

Menangani dan memberdayakan penduduk miskin di perkotaan harus diakui bukanlah hal yang mudah. Berbeda dengan kaum migran yang status kependudukannya adalah pendatang, dan bahkan acapkali illegal, penduduk miskin kota pada dasarnya adalah bagian dari warga kota yang memiliki status kependudukan yang sah, dan hak-hak yang sama untuk diperlakukan secara adil dalam kegiatan pembangunan dan proses perencanaan program pembangunan. Kendati secara ekonomi penduduk miskin kota tergolong kelompok masyarakat marginal. Namun demikian, mereka sesungguhnya memiliki hak untuk terlibat dalam proses pembangunan dan bahkan memiliki potensi untuk ikut menentukan ke arah mana pembangunan kota akan digulirkan. Beberapa hal yang perlu diperhatikan dalam upaya peningkatan kesejahteraan penduduk miskin di perkotaan adalah:

Pertama, meningkatkan perlindungan dan memberikan ruang yang seluas-luasnya bagi penduduk miskin kota untuk mengembangkan potensi sosial-ekonominya tanpa harus dibayang-bayangi dengan syakwasangka sekecil apa pun. Seperti dikatakan Hernando de Soto atau Muhammad Yunus (pemenang Nobel Perdamaian), bahwa yang dibutuhkan penduduk miskin kota sesungguhnya adalah pengakuan, dan pelibatan mereka dalam berbagai aktivitas pembangunan di perkotaan agar modal atau potensi sosial yang mereka miliki tidak menjadi kapital yang mati (*dead capital*), melainkan dapat dimanfaatkan untuk kepentingan kelangsungan kehidupan mereka secara mandiri. Seorang PKL, misalnya, sepanjang mereka dilindungi dari kemungkinan menjadi obyek perahan preman-preman lokal atau razia yang merugikan kelangsungan usahanya, maka bukan tidak mungkin mereka justru akan menjadi salah satu sumber PAD yang luar biasa besar bagi Pemerintah Kota. Potensi penduduk miskin kota membayar iuran, misalnya, jika dikelola dengan baik dan transparan, maka hasilnya akan sangat luar biasa.

Kedua, membantu penduduk miskin agar tidak mengeluarkan biaya yang lebih tinggi daripada yang seharusnya ketika mereka mengakses fasilitas publik dasar. Seperti sudah diketahui umum, bahwa penduduk miskin kota seringkali harus mengeluarkan biaya ekstra ketika mereka mengakses air bersih atau listrik karena tidak memiliki akses formal yang jelas. Bagi penduduk miskin yang tinggal di wilayah di mana pipa PDAM belum masuk, maka mereka tentunya harus membayar lebih mahal atas air bersih yang mereka pakai sehari-hari, karena harus ditambah

dengan ongkos angkut atau karena membeli pada pedagang air yang jelas akan mencari keuntungan dari barang dagangan yang mereka jual kepada publik, tak terkecuali kepada penduduk miskin kota. Bagi penduduk miskin kota, hal semacam ini bukan saja akan membebani, tetapi juga terasa tidak adil. Akan sangat bijak jika Pemerintah Kota justru mau menyediakan subsidi untuk membantu penduduk miskin kota dapat mengakses berbagai fasilitas publik dengan harga yang wajar, atau bahkan jika perlu dengan harga yang lebih murah.

Ketiga, dalam rangka mendukung peningkatan posisi *bargaining* dan kemampuan *survival* penduduk miskin kota, alangkah baiknya jika Pemerintah Kota bersedia memfasilitasi berbagai upaya pelatihan ketrampilan alternatif dan sekaligus menyediakan dukungan modal usaha dengan bunga yang murah bagi penduduk miskin kota yang berpotensi mengembangkan deversifikasi usaha. Seperti diketahui, bahwa yang namanya penduduk miskin kota umumnya secara ekonomi rentan, terisolasi dan tidak berdaya. Tanpa dukungan Pemerintah Kota, niscaya akan sangat sulit bagi penduduk kota untuk dapat mengakses sumber-sumber permodalan lain yang tidak membebani mereka dengan bunga yang mencekik leher.

Keempat, untuk meningkatkan perlindungan sosial bagi anak-anak miskin. Untuk mencegah dan menangani kasus anak yang sudah terlanjur putus sekolah, harus diakui bukanlah hal yang mudah. Berbagai kajian telah membuktikan bahwa untuk menarik kembali anak-anak yang sudah terlanjur keluar atau *Drop-Out* dari sekolah umumnya bukan hal yang mudah. Untuk itu, kebijakan dan langkah yang paling strategis untuk menangani isu anak-anak di luar sekolah, paling-tidak harus mencakup tiga strategi pokok. Pertama, adalah kebijakan yang sifatnya preventif, yakni bagaimana mencegah agar anak-anak tidak sampai putus sekolah di tengah jalan. Kedua, kebijakan mengurangi resiko atau kemungkinan anak yang sudah masuk sekolah berhenti atau keluar di tengah jalan karena proses pembelajaran yang tidak *joyfull learning* atau karena sebab-sebab struktural lain. Ketiga, kebijakan yang sifatnya kuratif, yakni mengajak anak yang sudah putus sekolah kembali ke sekolah atau paling-tidak memfasilitasi agar mereka tetap dapat mengakses program *life skills* sebagai bekal bagi mereka untuk menempuh masa depan.

Kebijakan mencegah agar anak-anak tidak terlanjur putus sekolah adalah melakukan upaya preventif sedini mungkin, khususnya sejak anak mulai hendak mengenal bangku sekolah dan setelah diketahui ada indikasi bahwa seorang siswa akan putus sekolah. Selain dibutuhkan komitmen pimpinan daerah agar senantiasa pro kepentingan anak, dan memastikan agar anak-anak tetap dapat bersekolah hingga jenjang 12 tahun –bukan sekadar 9 tahun--, upaya untuk mencegah siswa putus sekolah juga perlu didukung proses pembelajaran yang benar-benar *joyfull learning*. Studi yang dilakukan Suyanto *et al.* (2012) menemukan bahwa kecenderungan anak putus sekolah umumnya dapat dilacak jauh-jauh hari, yakni bermula dari sikap dan dukungan orang tua terhadap Program PAUD dan dukungan orang tua plus sekolah terhadap anak-anak yang ditengarai rawan putus sekolah. Seperti telah dipaparkan dalam bab-bab terdahulu bahwa awal-mula atau indikasi yang diperlihatkan siswa yang berpotensi putus sekolah adalah: (1) siswa yang bersangkutan pernah tidak naik kelas, (2) nilai ulangan dan dinilai rapor siswa yang bersangkutan kurang memenuhi standar, di mana biasanya makin banyak nilai yang di bawah standar berarti makin besar peluang siswa yang bersangkutan untuk putus sekolah, dan (3) siswa yang bersangkutan sering membolos.

Siswa yang dikenal bermasalah atau siswa rawan DO ini, bila sejak dini telah dicoba ditangani, maka peluang untuk mencegah mereka putus sekolah akan menjadi lebih besar. Dari pihak sekolah sendiri, seyogianya ada kesadaran bahwa siswa yang rawan DO bukan malah diperlakukan sebagai siswa yang bermasalah dan sering dihukum atau semata menjadi obyek pembinaan BP. Tetapi, justru siswa yang rawan DO ini harus memperoleh perhatian dan bimbingan khusus, termasuk memperoleh dukungan dari kelompok-kelompok sekunder yang ada

di masyarakat untuk ikut memfasilitasi perbaikan prestasi belajar mereka lewat bimbingan dan pembinaan yang sifatnya lebih empatif.

Untuk mencegah dan menangani kasus anak putus sekolah, oleh sebab itu ke depan beberapa program yang direkomendasikan untuk dikembangkan secara terpadu bukan hanya program perbaikan kualitas pembelajaran di sekolah dan program pemberian beasiswa atau program BOS/BOPDA saja. Pada tingkat yang paling elementer, upaya untuk memaatikan anak-anak dapat mengakses pendidikan secara layak adalah dengan terlebih dahulu membangun konstruksi masyarakat tentang arti penting sekolah atau pendidikan pada umumnya. Krisis kepercayaan masyarakat terhadap signifikansi pendidikan formal, bukan saja perlu didekonstruksi, tetapi juga perlu direkonstruksi kembali dengan didukung bukti-bukti yang nyata bahwa perbedaan latar belakang jenjang pendidikan anak memang pararel dengan tingkat kesejahteraan dan peluang mereka meraih masa depan yang lebih baik. Di samping itu, yang tak kalah penting adalah pelaksanaan program perlindungan anak, pemberdayaan ekonomi keluarga miskin secara keseluruhan, program pembatasan pernikahan usia dini, dan program penanganan siswa rawan putus sekolah sebelum mereka benar-benar keluar dari sekolah (*).

8. Daftar Pustaka

Ahmad, Ahmaddin, 2002. ***Re-Desain Jakarta, Tata Kota, Tata Kita***. Jakarta: Kota Kita Press.

Bakhit, Izzedin (ed.). 2001. ***Menggempur Akar-Akar Kemiskinan***. Jakarta: Yakoma-PGI.

Chambers, Robert, 1983. ***Pembangunan Desa Mulai dari Belakang***, Jakarta: LP3ES.

Darmaningtyas, 1999. ***Pendidikan Pada dan Setelah Krisis: Evaluasi Pendidikan di Masa krisis.*** Yogyakarta: Kerjasama LPIST dan Pustaka Pelajar.

Dewayanti, Ratih & Erna Ermawati Chotim. 2004. ***Marjinalisasi dan Eksploitasi Perempuan Usaha Mikro di Perdesaan Jawa***. Bandung: Akatiga dan ASPPUK.

Effendi, Tadjuddin Noer, 1992. "Buruh Anak-Anak, Phenomena di Kota dan Pedesaan", dalam: ***Buruh Anak di Sektor Informal-Tradisional dan Formal***. Pusat Pembinaan Sumber Daya Manusia, Yayasan Tenaga Kerja Indonesia.

Effendi, Tadjuddin Noer, 1993. ***Sumber Daya Manusia, Peluang Kerja dan Kemiskinan***. Yogyakarta: Tiara Wacana.

George, Susan, 2007. ***Pangan, Dari Penindasan Sampai ke Ketahanan Pangan***. Yogyakarta: INSIST Press.

Gilbert, Alan & Josef Gugler, 1996. ***Urbanisasi dan Kemiskinan di Dunia Ketiga***. Yogyakarta: Tiara Wacana.

Hauser, Phlilip M., 1985. ***Penduduk dan Masa Depan Perkotaan, Studi Kasus di Beberapa Daerah Perkotaan.*** Jakarta: Yayasan Obor Indonesia.

Hariadi, Sri Sanituti & Bagong Suyanto (eds.), 2001. ***Anak-anak yang Dilanggar Haknya: Potret Sosial Anak Rawan di Indonesia yang membutuhkan Perlindungan Khusus***. Kerjasama Pusat Kajian Anak FISIP Unair, LPA Jatim, dan UNICEF.

Imawan, Wynandin, 1999. ***Krisis Ekonomi dan Dampaknya Terhadap Perkembangan Terakhir Pekerja Anak***. Makalah untuk Lokakarya Penyusunan Kebijakan Penanganan Pekerja Anak di Indonesia. Diselenggarakan Bappenas, ILO-IPEC dan Depnaker pada tanggal 22-24 Juli 1999 di Bogor.

Irwanto dkk., 1995. ***Pekerja Anak di Tiga Kota Besar: Jakarta, Surabaya, Medan***. Jakarta: Unicef dan Pusat Penelitian Unika Atma Jaya.

Irwanto, 1996. "Kajian Literatur dan Penelitian Mengenai Pekerja Anak Sejak Pengembangan Rencana Kerja IPEC 1993", dalam: ***Konferensi Nasional II Masalah Pekerja Anak di Indonesia***. Kerjasama Yayasan Kesejahteraan Anak Indonesia, Departemen Tenaga Kerja RI, dan ILO/IPEC.

Irwanto, Muhammad Farid & Jeffry Anwar, 1999. ***Anak yang Membutuhkan Perlindungan Khusus di Indonesia: Analisis Situasi.*** Jakarta: Kerjasama PKPM Unika Atmajaya Jakarta, Departemen Sosia, dan UNICEF.

Johan, Maiyasyak dkk. (eds.), 1998. ***Perlindungan Hukum Pekerja Anak di Indonesia.*** Medan: Lembaga Advokasi Anak Indonesia Medan.

JURNAL ANALISIS SOSIAL Edisi 5/Mei 1997. ***Pekerja Anak dan Anak Jalanan Versus Konvensi Hak Anak***. Kerjasama Akatiga dan UNICEF.

Korten, D.C., dan Sjahrir, 1988. ***Pembangunan Berdimensi Kerakyatan***, Jakarta: Yayasan Obor Indonesia.

Kuntoro dkk., 1996. ***Beberapa Faktor yang mempengaruhi Putus Sekolah Siswa Wanita di Sekolah Dasar dan Lanjutan Tingkat Pertama di Beberapa Desa di Jawa Timur***. Kerjasama BKKBN, UNFPA, dan Pusat Penelitian Kependudukan dan Pembangunan Lembaga Penelitian Universitas Airlangga.

Krisnawati, Tati, 1993. “Peluang Kerja Perempuan Miskin dan Strategi Survive”, dalam: Fauzie Ridjal, Lusi Margiyani, dan Agus Fahri Husein (eds.), 1993. ***Dinamika Gerakan Perempuan di Indonesia***. Yogyakarta: Tiara Wacana Yogja.

Manning, Chris, Tadjuddin Noer Effendi & Tukiran, 1990. ***Struktur Pekerjaan, Sektor Informal, dan Kemiskinan di Kota, Sebuah Studi Kasus di Diraprajan***. Yogyakarta: Pusat Kajian Kependudukan.

Mulandar, Surya (ed.), 1996. ***Dehumanisasi Anak Marginal, Berbagai Pengalaman Pemberdayaan***. Bandung: AKATIGA-Gugus Analisis.

Muller, Johannes, "Pendidikan Sebagai Jalan Pembebasan Manusia dari Cengkeraman Kemelaratan", dalam: ***Prisma*** No. 7, Juli 1980.

Mustain dkk., 1999. ***Studi Kualitatif Tentang Pekerja Anak di Jawa Timur***. Kerjasama Pusat Studi Ketenagakerjaan Unair, Bappeda Tingkat I Jatim dan UNICEF.

Raharjo, Yulfita dkk. (ed.), 1998. ***Dampak Krisis Moneter dan Bencana El Nino Terhadap Masyarakat, Keluarga, Ibu dan Anak di Indonesia***. Jakarta: Puslitbang Kependudukan dan Ketenagakerjaan, Lembaga Ilmu Pengetahuan Indonesia bekerjasama dengan UNICEF.

Robinson, Philip, 1986. ***Beberapa Perspektif Sosiologi Pendidikan***. Jakarta: Rajawali.

Romdiati, Haning dkk, 2006. ***Mobilitas Pendudukan di Lingkungan Permukiman Kumuh Kota Surabaya: Pengelolaan dan Konteksnya Terhadap Penataan Lingkungan***. Jakarta: LIPI.

Sherraden, Michael, 2006. ***Aset Untuk Orang Miskin, Perspektif Baru Usaha Pengentasan Kemiskinan***. Jakarta: Rajawali Press.

Sen, Amartya, 1999. ***Development as Freedom***. New York: Alfred a. Knoff, Inc.

Soto, Hernando de, 1991. ***Masih Ada Jalan Lain, Revolusi Tersembunyi di Negara Dunia Ketiga.*** Jakarta: Yayasan Obor Indonesia.

Soegijoko, Budhy Tjahjati S dan BS Kusbiantoro, 1997. ***Bunga Rampai Perencanaan Pembangunan di Indonesia***. Jakarta: Grasindo.

Surbakti, S, dkk. (eds.), ***Prosiding Lokakarya Pesiapan Survei Anak Rawan: Studi Rintisan di Kotamadya Bandung***. Jakarta: Kerjasama BPS dan UNICEF.

Suyanto, Bagong & Sri Sanituti Hariadi (eds.), 2000. ***Pekerja Anak: Masalah dan Upaya Penanganannya.*** Surabaya: Kerjasama LPA Jatim dan UNICEF.

Suyanto, Bagong dkk. (eds.), 2000. ***Tindak kekerasan Terhadap Anak: Masalah dan Upaya Pemantauannya.*** Surabaya: Kerjasama LPA Jatim dan UNICEF.

Suyanto dkk. 2012. ***Anak di Luar Sekolah***. Surabaya: UNICEF dan Dinas Pendidikan dan Kebudayaan Provinsi Jawa Timur.

Suyanto, Bagong & Karnaji, 2005. ***Kemiskinan dan Kesenjangan: Ketika Pembangunan Tak Berpihak Rakyat***. Surabaya: Airlangga University Press.

Saptari, Ratna & Brigitte Holzner. 1997. ***Perempuan, Kerja dan Perubahan Sosial, Sebuah Pengantar Studi Perempuan***. Jakarta: Grafiti Press.

Sularto, St., 2000. ***Seandainya Aku Bukan Anakmu***. Jakarta: KOMPAS Bekerjasama dengan World Vision Indonesia.

Tjandraningsih, Indrasari, 1995. ***Pemberdayaan Pekerja Anak: Studi Mengenai Pendampingan Pekerja Anak***. Bandung: AKATIGA.

White, Ben & Indrasari Tjandraningsih, 1998. ***Child Workers in Indonesia***. Bandung: Yayasan Akatiga.

Yustika, Ahmad Erani, 2003. ***Negara Vs Kaum Miskin***. Yogyakarya: Pustaka Pelajar.

3 Needs Assessment of Reintegrated Families in Georgia

Ia Shekriladze
Save the Children International in Georgia

1. Study Background

Georgia's child welfare reform has made incredible strides over the past eight years focusing largely on ending harmful child institutionalization. The child welfare reform process that started in 2005 is being successfully implemented by the Government of Georgia (GoG) with support from the international community and local NGOs. Today, the progress is evident: the number of children residing in large scale Child Care Institutions (CCI) fell from 4000 in 2005 to 147 in 2013; there are only five CCIs remaining in the country, down from 25 in 2011, and 45 in 2005; more than 1000 children have been reintegrated with their biological families, more than 1000 – placed in foster care and over 300 in family type Small Group Homes[1]. In addition, a new gatekeeping policy is being rolled out across the country to ensure that children are only entering the care system when there are no other options.

The government has committed significant support to family reunification process, ensuring that the biological family of every child placed under state care is assessed by a state social worker and, upon reintegration, provided with support visits by a social worker and monetary monthly support for each reintegrated child equaling to 90 GEL ($55) for a child without disabilities and 130 ($80) for a child with disabilities. Foster care has been expanded and strengthened. Children who could not be reunified or placed in foster care, as a measure of last resort, are placed in small group homes that house no more than 8-10 children.

The Strengthening Childcare Services and Systems (SCSS) project is funded by UNICEF and USAID and aims at helping GoG to carry out child welfare reform. The goal of the project is to: (a) provide protection to vulnerable children in Georgia through strengthened social work and community-based services; (b) increase awareness of and improve access to social benefits; (c) strengthen family support, alternative care and community-based services; (d) strengthen policy, management, oversight and accountability in the child care system; (e) and create sustainable mechanisms to prevent and mitigate the negative impact of family violence[2]. The project is being carried out by GoG and international and local NGOs such as Save the Children, EveryChild, First Step Georgia, Children of Georgia, Georgian Association of Social Workers and others.

[1] Data provided by the LEPL Social Service Agency under the Ministry of Health, Labour and Social Affairs of Georgia

[2] http://georgia.usaid.gov/programs/democracy-and-governance

One of the SCSS objectives is to support the reunification of children placed under State care with their biological families. Within the project, Save the Children and Children of Georgia have been helping the State Social Service Agency (SSA) to reach this goal through providing biological families with one-time assistance in household improvement (repair works, furniture, household technology, other household items, etc.) and additional family support services provided by the project social workers. In particular, Save the Children has been supporting the reunification of children aged 6 to 18. The need for helping a specific family is being determined by the state social worker based on an assessment of the family situation and identification of their most acute needs.

Accomplishments aside, more work is needed to build on positive outcomes to improve the wellbeing of Georgia's most vulnerable children. The current gap, recognized by government and international actors, relates to the limited focus on family strengthening and prevention of family separation which is reflected in the new Child Action Plan 2012-2015. While family reunification is a reform priority, no empirical data is available on the needs of reunified children and their biological families.

2. Literature review

According to the International Social Service/International Reference Center for the Right of Children Deprived of their Family (2006), "family reintegration is the return on a permanent basis to the family of origin"(para.1). While reunification is generally thought of as reintegrating children with their biological parents, its broader definition may include returning a child to live with other relatives (Child Welfare Information Gateway, 2011). Evidence indicates that achieving timely reunification and preventing family separation has multiple benefits as for the wellbeing of children as well as for society at large. These benefits include but are not limited to helping children to be raised in a stable family setting which positively impacts their social, emotional and cognitive development.

In the United States, family reunification studies date back to 1970s. These studies have attempted to identify variables that bear on the issue of reunification (Research Roundup, 2002). A number of them focus on identification of specific predictors of successful reunification as well as the risk factors that may hinder child's return to his/her biological family. Not surprisingly poverty, disabilities and health problems, single parent status and the existence of substance abuse have been associated with lower likelihood of a successful reunification. Other studies looked at the variables at policy and service level and attempted to identify systemic predictors of successful reintegration.

A broad review of empirical data in child welfare suggests that certain characteristics appear to have a higher likelihood of successful reunification of the child with their biological family. These include: meaningful family engagement, individualized assessments and mutually established case planning, and diverse and coordinated service delivery (e.g. specific in-home services, mental health and substance abuse services, culturally competent services, and wraparound[3] services). Systemic supports related to funding relevant services and employing competent staff also appear to have an impact on achieving more successful and long-term reunifications. The findings reiterate that the likelihood of successful reunification is higher when reintegration is properly

[3] Iintensive, individualized supports to families served by multiple systems designed to meet the needs of children and their families by utilizing their strengths to allow children to grow up in a safe, stable, permanent family environment. http://www.childsworld.ca.gov/PG1320.htm

planned from the earliest possible point, family relationships are supported while children are still in care, and pre and post-reunification supports are provided to children and their families based on their individual needs (Child Welfare Information Gateway, 2011).

Although reintegration with the biological family represents the priority of Georgian child welfare reform, no empirical studies had been conducted on the needs and conditions of children and families reunified or to be reunified. In order to ensure a long-term success of family reunification, it is imperative to develop a state strategy geared towards strengthening vulnerable families and preventing separation from occurring in the first place. This, in turn, implies identifying the current needs of the reunified families and providing the state with evidence-based policy level recommendations.

3. Methodology

The study was carried out based on the request of State Social Service Agency. The goal of the study was to: (1) assess the status of reunified children and their families, identifying their acute and longer term needs; and (2) assist the state in the design of relevant family strengthening programs and services. The study population consisted of children reintegrated with their biological families through the state reintegration program which supports family reunification through providing, as a minimum, a reintegration allowance for each reunified child coupled with visits from a state social worker.

In total, 155 reintegrated children with their 93 families participated in the study. The assessed families represented: (a) families reintegrated within the state reintegration program and (b) beneficiaries of SCSS reintegration support of Save the Children.[4]

The majority of families (88 families) were reunified during the project implementation period, namely, from January 2011 to August 2012. Five families, however, were reunified at the end of 2010, but also received the project support. The assessed families resided in different regions of Georgia and constituted 45 percent of all the families reintegrated in the country during the same time period.[5] The assessment was carried out between August and September of 2012.

The study used both quantitative and qualitative methods in the form of checklists, closed and open ended questions. The data was collected by using methods of observation and structured interviews with children and their families. Additionally, information was triangulated with sources such as the state social workers and school teachers. The assessments were conducted by the trained independent social workers from Save the Children. The study adhered to the principle of voluntary participation and informed consent.

The background of each child was also collected including: the demographics of each family member including both reintegrated and non-reintegrated children; the history of the child's institutionalization; the health and education status of each reintegrated child; the health, education and employment status of each caretaker; the family income and financial condition; the type and condition of housing; the satisfaction of basic needs of each reintegrated child; the risks of child abuse and neglect of each reintegrated child; the strengths and risks of each family; the frequency of social workers' visits and types of assistance provided by them; the current

[4] Study population does not include children reintegrated without SCSS Save the Children's support.

[5] According to the data provided by Social Service Agency, in January 2011 - August 2012 overall 323 children were reunified with their biological families.

family needs as identified by families and social workers. Nonparametric statistical measures (Mann–Whitney *U* test, Pearson chi-squared test) were used for determining whether or not there was any association between variables. Symmetric measures (Phi Coefficient and Cramer's V) were used to measure the strength of associations between the variables.

The study had the following limitations:

- As per study objectives, the representative sample was not drawn from a random population. Instead, the study covered all the reintegrated families which were beneficiaries of SCSS Save the Children support. Respectively, the study results cannot be generalized to other reintegrated families in the country that did not receive the same support.
- While the sample size covered a large percentage of the total number of reunified families in Georgia, the sample size was still relatively small (93 families) which may impact the associations found between variables. Further studies across Georgia will need to be conducted to determine if the same associations are found in a larger sample size.
- Due to the time constrains, the study instrument was not piloted prior to its utilization.
- The study did not use an in-depth methodology aimed at exploring child abuse and neglect and other child/family risks. Therefore, further research should be conducted before any conclusions can be drawn.
- Although the participation in the assessment was voluntary and confidentiality of conversation was generally kept, in certain cases, in the best interests of children, the Social Service Agency was informed about the acute needs of a child and family. Children and families were informed about this possibility prior to their participation.

4. Findings

a) Demographics of reintegrated children

Ninety-three families participated in the needs assessment in which 155 children (44 % female, 56 % male) - were reintegrated. The children's birth years varied from 1991 to 2005 and their age from 7 to 21 (at the moment of assessment), respectively, with an average age of 14.

1) History of child institutionalization

The families were reintegrated during 2010-2012 with the majority of reintegrations taking place in 2011 (88 families). Only 11.6 percent of children assessed (18 children) had resided in two Child Care Institutions (CCIs). According to the data, the average (mean) amount of time spent in the CCIs equaled to 5 years with the shortest time being less than a year and longest - 15 years.

2) Health and Education Status of Reintegrated Children

According to findings, the general health condition of the vast majority of children (92.3 %) was satisfactory[6]. Most of them were registered in primary health clinics (94.2%) and had received all necessary immunizations (92.3%). Several (7.7%) children had a government disability status or had no disability status but experienced serious health problems such as hearing, vision, dental, gastroenterological and other complications.

[6] Without acute or chronic health problems

The majority of children (87.7%) were enrolled in schools. While most of the children (77.4%) were enrolled in age/developmental appropriate educational programs, a sizable number of children (10.3% or a total of 16 children) were not. The school achievement of 77.4 percent of those children enrolled in school was satisfactory[7]. A substantial number of children (11.6% or a total of 18 children) appeared in need of special medical care and a relatively larger group (17.4% or a total of 27 children) were in need of special education.

3) Major Needs and Risks of Reintegrated Children

The findings demonstrated that the basic needs of the majority of children were met: Food[8] (96.8%); physical appearance and grooming (96.8%); clothing (96.1%); minimal living conditions[9] (94.8%); healthcare and appropriate medications (97.4%); emotional warmth and care (98.1%); private bed (100%); toys (76.8%). It's worth mentioning that a high number of children (11%-17 children) did not have access to school items (books, notebooks and stationary).

According to the findings, the reported rates of child abuse and neglect were low. The rate of emotional abuse was 3.2 percent (5 children), physical abuse was 1.9 percent (3 children), labor exploitation and street-begging was 1.9 percent (3 children). Besides, labor exploitation, physical abuse and emotional abuse were identified in the same highly vulnerable families. No cases of sexual abuse and neglect were identified. It should be noted, however, that the study design did not allow for thorough examination of complex variables; since the methodology relied mostly on self-reporting and observation, further research should be conducted on the child and family wellbeing outcomes before any conclusions can be drawn.[10]

b) Demographics of Reintegrated Families

1) Number of children in families

The majority of assessed families had three or more children. In total, 14 percent of the families (13 families) had one child, 32.3 percent (30 families) had two children, 25.8 percent (24 families) - had three children, 28% (26 families) - had four or more children.

2) Parents/Caretakers/adults in a Family

Children in the assessed families had one, two or three caretakers. In most cases they had two caretakers (50.5%), primarily a mother and a father. In the majority (81.3%) of families, mothers acted as the primary caretakers, with 15.5 percent of the primary caregiver being the father and 3.2 percent being grandparents. The age of primary caretakers varied from 27 to 82 with the average age of 43. Only 29 percent of primary caretakers were employed, 17 percent were temporarily unemployed[11] and more than a half (53 %) were unemployed[12] (National percentage of people unemployed in Georgia in 2012 was 15 %).

---

[7] Meeting minimal requirements to complete a school semester without failing any class

[8] Access to a diverse diet

[9] Access to heating, electricity, and water supply

[10] Within the study if a researcher was not sure about the risks of child abuse/neglect being present, he/she marked the answer denying the risk; e.g. if a child's physical abuse was not reported or observed, the researcher marked "no" next to the question "Is there any physical abuse of a child?" which does not necessarily exclude the possibility of abuse.

[11] Unemployed for less than a year

As far as secondary caretakers were concerned, in most cases (63.2%) they were fathers and in a considerable number of cases (29.2%) they were other relatives (stepmother, elder siblings). The age of the secondary caretakers varied from 19 to 75 with an average age of 46. Forty-four percent of them were unemployed, with 23.6 percent temporarily unemployed and 32.1 percent employed.

The overall number of all the caretakers in families was 162 (61% female, 39% male). Out of 162 caretakers, 46 were employed, 23 were temporarily unemployed and 65 were unemployed. In addition, 28 caretakers were retired (see Table 1). Male caretakers were more likely to be employed and less likely to be retired than female caretakers.

Table 1: Distribution of Caretakers by sex and employment status

Caretakers	Female	Male	Total
Employed	23	23	46
Temporarily unemployed (less than a year)	14	9	23
Unemployed (more than a year)	41	24	65
Retired (employed)	2	2	4
Retired (temporarily unemployed)	1	0	1
Retired	18	5	23
Total:	**99**	**63**	**162**

Reunified children had two caretakers in 50 percent of families (47 families), a sole caretaker in 38 percent (35 families) of families, and three caretakers - in 12 percent of families (11 families). Single headed families were mostly (85.7%) female-headed (25 mothers and 5 grandmothers). Thirty four percent (12 families) of single-headed families had three or more children and 17 percent of them (6 families) had a family member in prison at the time of the study.

According to the findings, the majority of primary (65.2%) and secondary (64.2%) caregivers reported satisfactory health. In education, the majority of primary caregivers (59.4%) finished secondary school. A small percentage (6.5%) completed or enrolled in higher education, 17.4 percent had some form of secondary education, and 16.8 percent had completed vocational education. Similarly to primary caretakers, secondary caregivers mostly held secondary education degrees (52.8%).

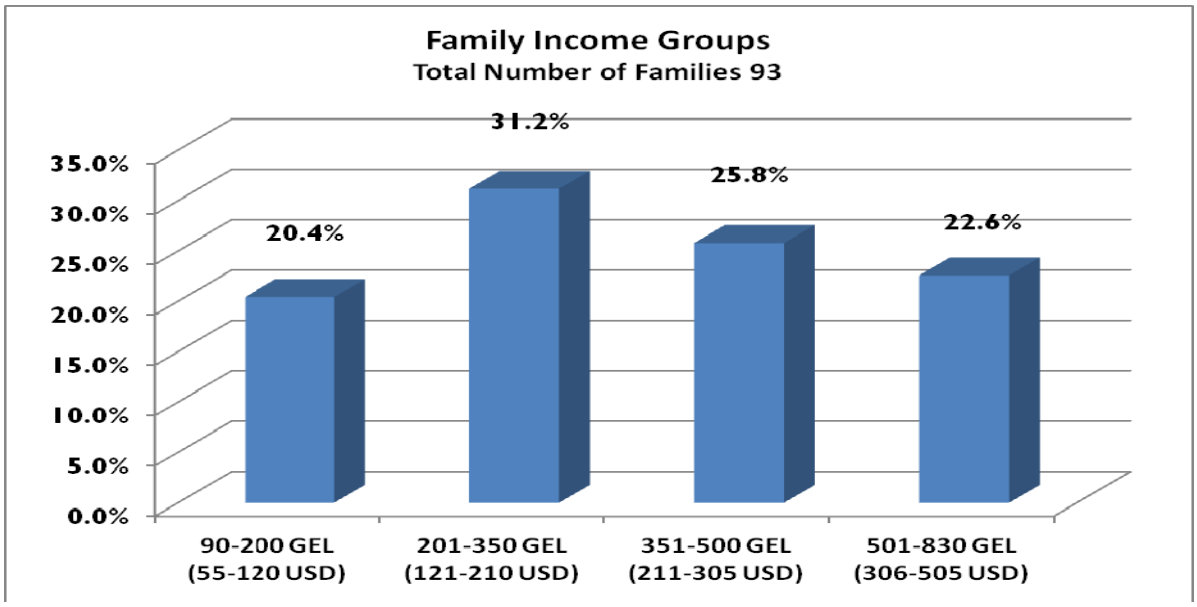
3) Financial condition of families

Less than a half of the families (41.9%) earned salary/wages from at least one family member. A little over a third (37.6%) of families received some type of pension and 22.6 percent reported having unspecified income, which mainly included income accumulated from sources such as alimony or assistance from a relative. Despite the above mentioned types of income, more than a half of the families (53.8%) received Targeted State Assistance (TSA - same as a poverty allowance). A vast majority of families (96.8%) received reintegration support for at least one child. Considering all types of income, the mean income of families was approximately 370 GEL[13] ($225) per month, with the lowest income of 90 GEL ($55) per month and the highest income of 830 GEL ($503) per month. (see Chart 1 below).

[12] Unemployed for longer than a year

[13] *1USD = 1.65 GEL*

Chart 1: Family Income Distribution



In addition to a low income, a high number of families (38.7%) had debts/loans which varied from 100 GEL ($60) to 12 000 GEL ($7272). Out of top four families with the highest earnings, surprisingly each received at least two types of state allowance and only one earned relatively higher salary/wages (500 GEL - $303). The higher earnings of the rest of the families accounted for different types of allowances, including poverty allowance (see Table 2).

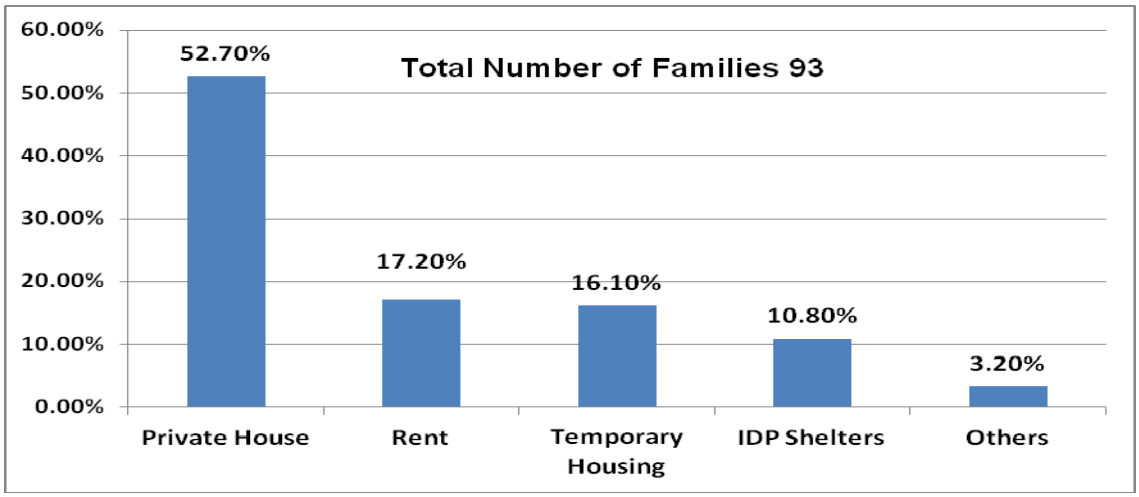
Table 2: Sources of income for families with the highest reported earnings

Four Families with Highest Income Rates (*1USD = 1.65 GEL*)					
Top 4 families	Reintegration allowance in GEL *(USD)*	Targeted Social Assistance (TSA) in GEL *(USD)*	Salary/ Earning in GEL *(USD)*	Pension in GEL *(USD)*	Total in GEL *(USD)*
1	180 (*$ 110)* (2 children)	222 *($ 135)* (9 members)	150 *($ 91)*	275 *($ 167)* (death of breadwinner)	827 *($ 501)*
2	180 *($ 110)* (2 children)	0	500 *($ 303)*	150 *($ 91)* (death of breadwinner)	790 *($ 480)*
3	360 *($ 220) (* 4 children)	150 *($ 91)* (6 members)	0	235 *($ 142)* (death of breadwinner and disability)	745 *($ 452)*
4	360 *($ 220)* (4 children)	174 *($ 105)* (7 members)	150 *($ 91)*	0	684 *($ 415)*

4) Housing types and living conditions of families

Slightly less than a half of the families (46.2%) resided in urban areas and more than a half (53.8%) in rural areas. Approximately 53 percent of families lived in private homes and less than a half (47.3%) did not own the housing they lived in (see Chart 2). It is noteworthy that 64% (32 families) of homeowners lived in rural areas.

Chart 2: Family distribution by types of living chart totals
Percentage of Families

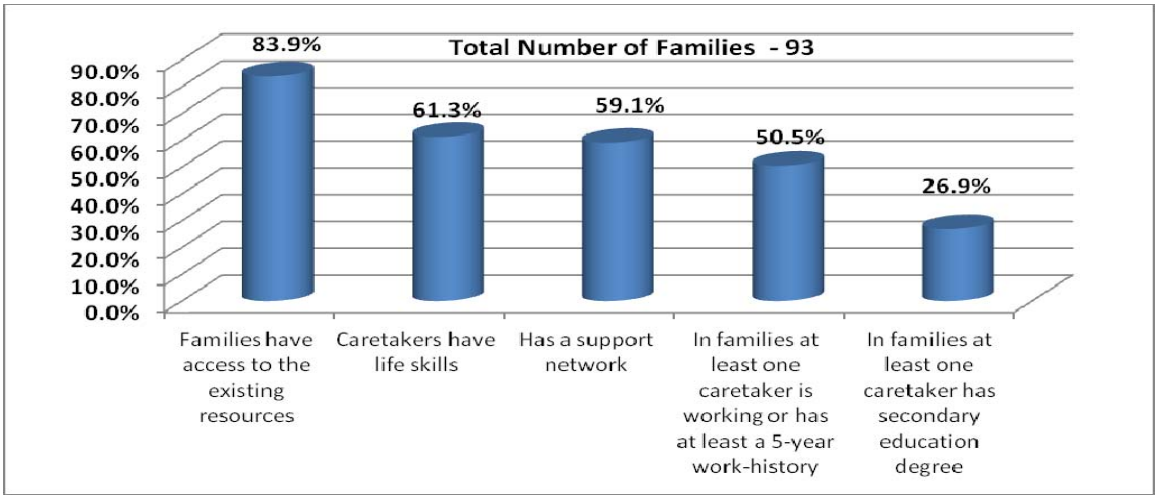


5) Family Strengths and Risks

The strengths and risks of the families were assessed by collecting information on some relatively easily definable variables, such as education and employment history of family members, family household and living conditions as well as more complex variables, such as parental skills, domestic violence, and the use of corporal punishment. In cases of more complex variables, the researchers took into account the information provided by family social workers, children's teachers, and any other reliable sources.

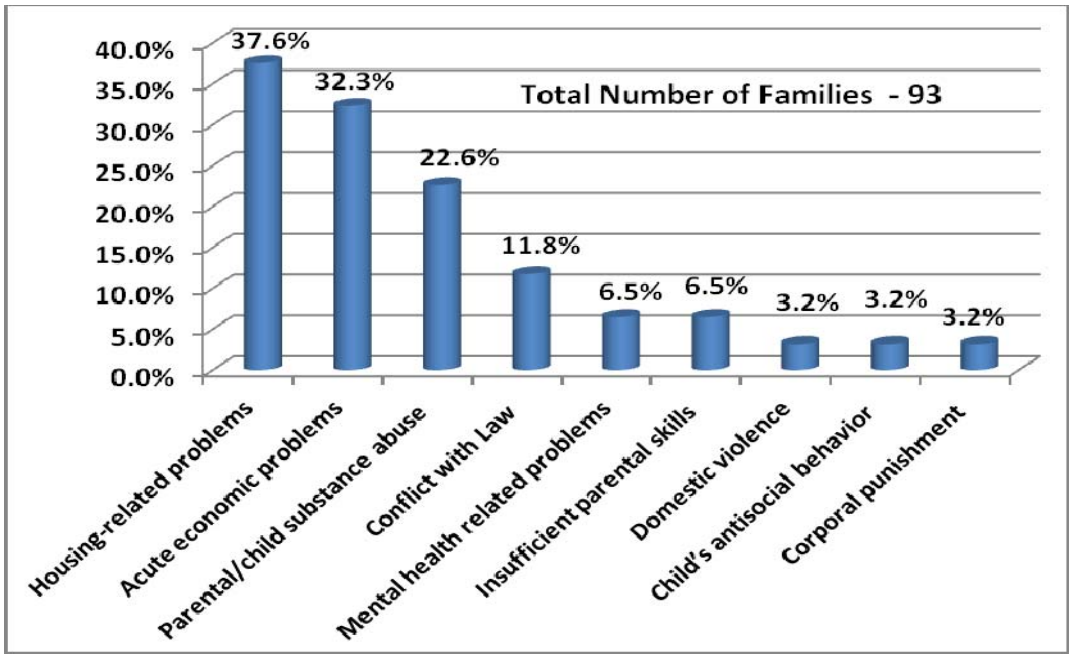
The study results demonstrated that families possessed certain strengths. In the majority of households there were healthy relationships among members and in the majority of families children were provided with adequate care. Half of the families had at least one employed family member or a member with a five-year employement history. Also, a considerable number of families (61.3%) had members with useful life skills (sewing, farming, cooking, etc.) and at least one person in approximately one quarter of them (26.9%) held special or higher education degrees. Most families provided effective parenting with children's behavior, utilized available resources, and more than a half of them reported having a support network (see Chart 3 below).

Chart 3: Family Strengths



Assessment of family risks portrayed the following picture (see Chart 4): housing problems were identified among 37.6 percent of families as the number one risk factor[14]. Acute economic problems, involving the lack of financial and material resources, were identified in 32.3 percent of families as the second most pressing risk-factor. Substance abuse by a family member was identified in 22.6 percent of families (21 families)[15]. In addition, 11.8 percent of families (11 families) had a member with a history of being in prison. Mental health problems were identified in 8.6 percent of cases (8 families) and inadequate parenting skills were identified in 6.5 percent of cases (6 families). Domestic violence among adult family members, child antisocial behavior and usage of corporal punishment as a child rearing method were each identified in three families. Based on the findings, 42 percent of families were reported to exhibit two or more risk factors.

Chart 4: Family Risks



6) Social worker services

The types of support provided by social workers (both state and NGO social workers) to families were:

- Connecting families with the existing resources (95.7%)
- Helping solve school related problems (66.7%)[16]
- Supporting the family in accessing benefits (64.5%)
- Providing psychoemotional support (51.6%)
- Supporting the child and family in managing child's behavior and/or family conflict (32.3%)
- Building life skills such as cooking, farming, sawing, knitting, etc. (28%)

[14] Housing problems include: unfavourable living conditions, risk of homelessness, and limited space.

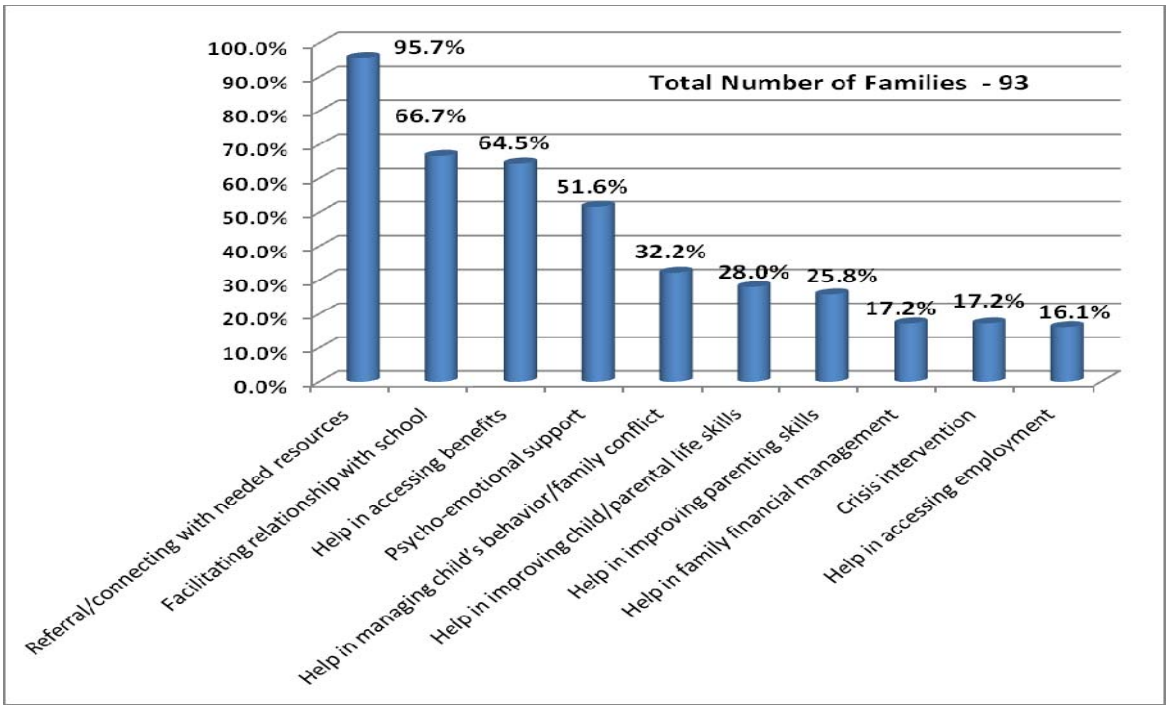
[15] Substance abuse involved excessive consumption of mostly tobacco and alcohol.

[16] Solving school related problems included facilitating children's enrolment, integrating children into public school, and ensuring communication with the teachers and principals.

- Improving parental skills (25.8%)
- Helping in managing the family budget (17.2%)
- Providing crisis intervention (17.2%)
- Providing support in accessing employment (16.1%) [see Chart 5].

A considerable portion of the families (58%) received more than one type of support from social workers.

Chart 5: Services provided to assessed families by social workers

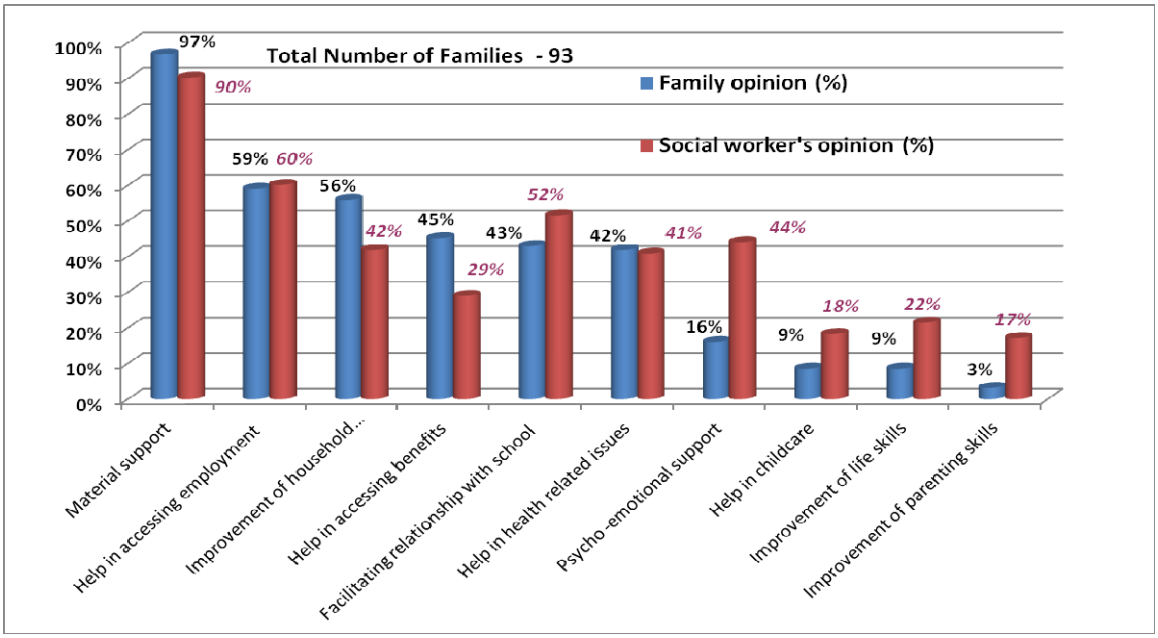


7) Current Family Needs

Interesting similarities and differences were observed between the perceptions of family needs by families and their assessing social workers. Family and social worker opinions coincided about the need for helping families solve employment, health related and financial/material problems. Yet, the social workers saw the need for school related support while the families felt that living condition improvement was more important.

There was also a drastic difference in the perception of the needs for psychoemotional support, child care support, life skills and parental skill building. Interestingly, while families saw little need of all the above, they reported receiving those types of support from social workers on a regular basis. On the other hand, as opposed to families, social workers saw little need in helping families with accessing benefits (see Chart 6).

Chart 6: Perceptions of Family Needs



The study demonstrated that the amount and scope of support provided to families were associated with their vulnerability. Beneficiaries of multiple types of assistance were the families characterized by social workers as more vulnerable and in need of complex support.

c) Associations Between Variables

The study examined relationships between numerous variables in an attempt to identify the sub-groups among the research population that might be facing multiple needs or increased risks. Associations between certain variables appeared noteworthy and are reported below. These associations, however, do not imply the existence of causation. Also given the study limitations and sample size, they should not to be generalized outside of study population.

Findings indicated that families with many children tend to face poorer living conditions ($\chi 2=22.306$, df=7, $p=0.002$, $\phi_c=0.5$ N=93), lower amounts of adequate nutrition ($\chi 2= 12.177$, df=7, $p=0.009$, $\phi_c=0.3$, N=93) and are in higher need for help in childcare ($\chi 2=13.978$, df=7, $p=0.05$, $\phi_c= 0.4$ N=93). In addition, children reintegrated earlier appeared in increased need for medical care whereas newly reintegrated children showed an increased need for emotional warmth.

Notable associations were observed between certain variables. In particular, heavy tobacco and alcohol consumption among caretakers appeared to be more characteristic of families with 3 or more children ($\chi 2= 9.34$, df=4, p=0.05, N=93). Unsurprisingly, families with 5 and more children were reported most in need of childcare support ($\chi 2= 10.71$, df=4, p=0.03, N=93). Child antisocial behavior (2 out of 3 such families), having a member in conflict with law (3 out of 11 such families), and insufficient parental skills (2 out of 6 such families) were observed most frequently in families with three reintegrated children.

Families with three caregivers were more likely to have a member with the history of being in prison ($\chi 2=6.05$, df=2, p=0.04, N=93) while substance abuse was more frequent among families with two caregivers ($\chi 2= 7.17$, df=2, p=0.028, N=93). In addition, families with three caregivers appeared in higher need for improving life skills ($\chi 2=5.9$, df=2, p=0.05, N=93). However, they also were more likely to have a support network ($\chi 2= 7.33$, df=2, p=0.026, N=93).

Certain risks, needs and strengths were associated with whether a family lived in an urban or rural area. Families living in urban areas appeared in higher need of childcare support ($\chi2$= 3.94, df=1, p=0.04, N=93), life skill development ($\chi2$= 5.99, df=1, p=0.014, N=93), school support ($\chi2$= 3.58, df=1, p=0.05, N=93) and accessing benefits ($\chi2$= 6.39, df=1, p=0.01, N=93), and were more likely to face severe economic problems ($\chi2$=5.21, df=1, p=0.022, N=93) and housing related difficulties ($\chi2$= 8.57, df=1, p=0.003, N=93). As it was previously noted, only 36 percent of the assessed urban families were homeowners. Individuals in urban families, however, were more likely to be employed ($\chi2$= 4.8, df=1, p=0.028, N=93) or have professional/higher education ($\chi2$= 9.13, df=1, p=0.003, N=93). Children in rural areas, on the other hand, were more exposed to shortage of food, clothes and toys and their families faced higher risk of substance abuse ($\chi2$= 11.14, df=1, p=0.001, N=93) [see Table 3].

Table 3: Urban vs. Rural differences

Region	Family risks			Family needs				Family strengths		total
	Substance abuse	Economic hardship	Housing problems	Need of support in communicating with school	Support in childcare	Support in obtaining benefits	Support in improving life skills	Caregiver is employed or has a 5 year employment history	Caregiver has professional or higher education	
Urban	7.0%	44.2%	53.5%	53.5%	25.6%	41.9%	16.3%	62.8%	41.9%	46.2%
	3/43	19/43	23/43	23/43	11/43	18/43	7/43	27/43	18/43	43/93
Rural	36.0%	22.0%	24.0%	34.0%	10.0%	18.0%	2.0%	40.0%	14.0%	53.8%
	18/50	11/50	12/50	17/50	5/50	9/50	1/50	20/50	7/50	50/93
Total	**22.6%**	**32.3%**	**37.6%**	**43.0%**	**17.2%**	**29.0%**	**8.6%**	**50.5%**	**26.9%**	**100.0%**
	21/93	**30/93**	**35/93**	**40/93**	**16/93**	**27/93**	**8/93**	**47/93**	**25/93**	**93/93**

5. Analysis (discussion and conclusions)

The study findings demonstrated that the assessed reintegrated children's overall conditions in their biological families were generally satisfactory from the standpoint of their safety and basic need fulfillment. It should be noted that among study population there was no single identified case of a child's re-entry into State care. This situation might partly be accounted for by the fact that the majority of families (96.8%) have been receiving state financial assistance (reintegration allowance) and support from state and NGO social workers that provide, to a certain extent, crisis prevention and intervention. Additionally, within the *Strengthening Child Care Services and Systems (SCSS)* project, all families received one-time material assistance (repair works, furniture, domestic appliances, household items etc.) from Save the Children for improving their household conditions. One might speculate that the conditions of these families would have been less favorable without external material and professional support. One might also presume that these families by definition were more vulnerable than the ones reunified without project support.

Assessment of each family's risks and needs provided substantial insight for the development of family strengthening program. In particular, the study demonstrated that the most acute and widespread problem encountered by the reintegrated families was related to housing: the fact that only 47 percent of the assessed families had permanent dwelling (17% was rented, 16% temporarily lived at someone else's place, 11% stayed in temporary shelters and 3% in other settings) indicates the potential need for developing housing support programs.

Acute economic problems were singled out as the second strongest risk factor. As mentioned earlier, about 60 percent of families did not earn any kind of salary/wages at the time of assessment, which points out the high degree of their dependency on state monetary support. The study also showed that families with a relatively "higher earnings" did not necessarily earn higher salaries/wages but rather received broader state monetary support. Comprised of many individuals, these families are getting various types of state allowances for multiple members of the family. Paradoxically, out of top four families with the highest earnings, only one was not a recipient of the state poverty allowance.

While the need for accessing employment was equally pointed out by both families and social workers (both indicated that in about 60% of cases families needed assistance in accessing employment), in reality only a limited number of families reported obtaining such an assistance. The findings thereby demonstrate the need for developing employment and income generation programs and the importance of increased involvement of the state employment entities in child welfare reform. In addition, they reiterate the necessity for the Government to come up with measures to decrease dependence on governmental allowances and, particularly, reduce the risks (including the one of child's reentry into State care) associated with allowance discontinuation.

Based on the findings, the assessed families are characterized by not only financial difficulties but also such risk-factors as substance abuse (23%), being in conflict with law (12%), mental health problems (8.5%) and insufficient parenting skills (6.5%) among others. The variety of types of assistance provided by social workers to families confirms the wide range of family needs. Apart from material, household and employment support, the families seem to require help in accessing the necessary resources and benefits, addressing school related issues (child's enrollment and integration in public school or any other program) and obtaining psycho-emotional support. Based on the study results, more than a half of the families received the aforementioned types of assistance and more than one fourth obtained support in managing child's behavior and/or family conflicts, and improving life and parental skills (see Chart 5).

In addition, the findings suggested that particular attention should be paid to reunified families with three or more children since children in such families were more likely to experience shortages of food and clothing as well as poor living conditions. In addition, their parents were more likely to need childcare support. Furthermore, certain family risks like child's antisocial behavior, conflict with law and substance abuse in a family were also more frequent in families with three or more children. In addition there are compounding factors such as 24 percent of single-headed families (12 out of 49 families) had more than three children and 12 percent of them (6 families, including 3 families with more than 3 children) had a family member in prison at the time of assessment. The latter, in turn, might be associated with other longer term family risks. Considering that more than a half of the assessed families (50 families) had three or more children and 24 percent of them were single-headed, the study findings indicate the potential value in preventive services including setting up complex and multifaceted family support services.

Interestingly, families with several caretakers also appeared in need of extra attention. In particular, families with two caretakers were at highest risk of substance abuse (34%), and families with three caretakers (27%) were more likely to have conflict with law. Increased rates of risks in families with multiple caretakers might be accounted for the fact that reunifying a child with his/her biological family does not necessarily entail adequate functioning of all the caretakers. This has to be taken into account by social workers and other childcare professionals so that attention to children returned to biological families with multiple caretakers is not reduced merely on the grounds of a child having more than one caretaker in a household while

he/she might, in fact, be facing increased risks. As findings indicate, families with several caretakers were in higher need for life skill development and complex support.

Study results also illustrated that families in rural and urban areas may be exposed to different needs and risks. The most widespread problems in urban areas were lack of housing and/or poor housing, economic hardship and poor living conditions, whereas in rural areas it was more common for families to face shortage of food, clothing, and toys, as well as an increased risk of substance abuse. On the one hand, families in cities were more likely to have a job and were better educated. On the other hand, however, they needed more help in childcare and addressing school related issues - the types of support relevant for working parents (e.g. in home child care providers, day care centers, and help in tutoring). Rural communities, as opposed to urban ones, appear in higher need of programs aimed at meeting basic needs (food, clothing) and reducing community isolation.

In addition, the increased need for emotional warmth among recently reintegrated children pointed out the importance of preparatory and supportive social worker service prior to and immediately after child's reunion with his/her biological family. Relevant child and family preparation and family relationship rebuilding supports (pre and post reunification support) are critical for successful reunification.

Finally, the study findings demonstrated the importance of state's multi-sectorial participation in child welfare reform. The most acute example of this was school/education related problems that study identified, namely, the fact that 10 percent of children were not enrolled in age/developmentally appropriate grades, more than 12 percent of children could not access necessary school materials and more than 17 percent were in need of special education services. This illustrates the limited participation of the Ministry of Education and Sciences (MES) in implementation of child welfare reform and emphasizes the importance of equal involvement in child protection matters of all the state entities responsible for child development.

In conclusion, the findings reiterated that reunified families represent a vulnerable population characterized by the lack of material, economic, and psychosocial support and suggested that the key to successful reintegration may lie in developing and diversifying family strengthening programs.

6. Policy Implications/Recommendations

The findings of the reintegrated family needs assessment demonstrate that the majority of the assessed reunified children live in family environments free of abuse and neglect in which their basic needs are being met. Since the study assessed only SCSS beneficiary families, however, the above findings cannot be generalized to all reunified families in the country. Therefore, it is recommended to conduct a similar needs assessment of a representative sample of families reintegrated without project support.

The study, first of all, began to identify the variety of needs that reunified families face, the effective and timely responses to which are key to ensuring the long-term success of the reform. The study also allows for preliminary evidence based policy-level recommendations.

There recommendations include:

- Increase state multi-sectorial participation in child welfare reform:
  - Increased MES involvement in addressing school and education related issues (including child integration in school environment);
  - Increased participation of local government in solving issues related to housing, shelters, day care centers;
  - Greater involvement of employment entities to reduce unemployment rates;
  - Greater participation of the Ministry of Sports and Youth Affairs in youth skill development;
  - Increased input of law enforcement entities in crime prevention.
- Ensure universal provision of reintegration allowance and subsequent state support and prolong its provision whenever appropriate;
- Expand state inter-sectorial cooperation focused on reducing dependency on public support;
- Ensure reinforced care during pre and post reintegration phases;
- Enhance monitoring and support to families with multiple children and other risk groups;
- Develop housing support programs;
- Increase access to psychological and mental health support;
- Develop programs aimed at reducing substance abuse and fostering pro-social behavior;
- Develop programs tailored to regional (urban vs. rural) and family (single working parent, family with many children, etc.) characteristics;
- Conduct further studies to determine predictors of successful reunification.

In conclusion, the findings highlight a variety of needs of the reunified families and indicate that poverty and material problems - representing a dominant feature of these families - is not a sole reason for their vulnerability. Strengthening vulnerable families of Georgia requires holistic approach that implies implementing policies targeted to: (a) minimizing factors that hinder family functioning and (b) fostering programs that improve family functioning.

References

Child Care Action Plan 2012-2015, Decree of the Government of Georgia # 762 (2012).

International Reference Center for the Rights of Children Deprived of their Family (2006). *Elaborating a lifelong plan: family reintegration.* Geneva: International Social Service General Secretariat.

Child Welfare Information Gateway. (2011). *Family reunification: What the evidence shows*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved April 2012, from the World Wide Web www.childwalfare.gov/pubs/issue_briefs/family_reunification

Research Roundup. (2002). *Family reunification.* Washington, DC: Child Walfare League of America. Retrieved April 2013, from the World Wide Web www.cwla.org

Notulensi Theme 4:
Integrated Social Protection system

Note taker: Armand Sim

Presenter 1:
Name : David Barua Yap
Title : Including Homeless Families and Children in the Social Protection System: A Brief Review of International Experience and Data on a Philippine Pilot Program

Highlights of Conclusions and Recommendations:

- The current trend shows that more Filipinos are residing in urban areas
- Homelessness is correlated with regions of origin. Geographical information is therefore important in considering poverty alleviation-related policies.
- The 4P is critical to the Philippines's long-term program
- Better survey instruments are still highly needed to provide better information for better preparation of 4P and MCCTH programs.

Presenter 2:
Name : Bagong Suyanto
Title : Perlindungan Sosial untuk Anak-Anak Miskin di Perkotaan/Social Protection for Urban Poor Children

Highlights of Conclusions and Recommendations:

- BLT dan program-program social protection masih kurang tepat.
- Terdapat 3 program pokok yang ditawarkan:
    1. Peningkatan posisi tawar keluarga miskin (mengembangkan pola diversifikasi usaha dan efisiensi proses produksi dalam kegiatan usaha kecil; penguatan dan pengembangan jaringan kelembagaan sosial-ekonomi lokal);
    2. Memperkuat penyangga ekonomi (perluasan akses pelaku ekonomi rakyat terhadap sumber-sumber permodalan berbunga rendah; pengembangan program asuransi sosial bagi keluarga miskin)
    3. Peningkatan perlindungan sosial bagi anak-anak miskin (mencegah anak putus sekolah).

Presenter 3:
Name : Ia Shekriladze
Title : Needs Assessment of Reintegrated Families in Georgia

Highlights of Conclusions and Recommendations:

- The goal is to identify multiple needs of reintegrated families
- Housing ownership is the most prevalent problem for reintegrated families
- Children's needs in terms of safety and basic needs are satisfied
- There are different needs for children in urban and rural areas
- The study recommends that the government should increase state multi-sectoral participation in child welfare reform.

Presenter 4:
Name : Nita Anggriawan
Title : Challenges in Home-Based Care and Support for Children (0-12 Years Old) in Jakarta, Indonesia

Highlights of Conclusions and Recommendations:

- Banyak anak yang meninggal karena kurangnya akses terhadap obat-obatan dan layanan kesehatan.
- Tantangan yang dihadapi ODHA anak*: heavy exposure to ARV; incomplete immunization; poor diet causing unbalanced nutrition; lack of knowledge of caregivers about health, nutrition, and sanitation*.
- Terbatasnya jumlah dokter spesialis anak terkait dengan masalah AIDS
- Perlunya memperbaiki pelayanan kesehatan untuk anak-anak ODHA
- Memperluas akses terhadap ARV untuk anak-anak ODHA
- Pemberdayaan *caregivers*
- Sosialisasi prosedur pelayanan standar

Discussant's comments:
Name : Tata Sudrajat

Highlights of Conclusions and Recommendations:

- Tantangan dalam integrasi program perlindungan sosial dengan sektor lain
- Kemiskinan bukan hanya angka saja
- Terdapat peran khusus dalam beberapa profesi tertentu
- Program perlindungan sosial masih belum fokus terhadap kelompok anak secara spesifik

- Sistem perlindungan sosial belum dapat sepenuhnya mencegah eksploitasi terhadap anak-anak
- Pekerja sosial sangat dibutuhkan untuk perlindungan anak
- Program perlindungan sosial perlu diperbanyak

Questions and Answers:

1. Sutji Andari, Balai Besar Pelayanan Kesejahteraan, Yogya:
Bagaimana memformulasikan kategori *homeless* agar tepat sasaran?

Answer: David: the authority identifies homeless through household roster. They are looking for households with children who have left home for a long time. They also use proxy means test out of several relevant variables. Those who lack of basic health and sanitation services are prioritized. The authority imposes conditions on households if they want to receive cash transfers**.**

2. Hanif, Malaysia:
Why sexual abuse and child neglect are not identified?

Answer: Ia: These variables are more complex in a sense that they are more difficult to identify.

3. Purwanto, UNICEF:
Tidak setuju dengan pernyataan Pak Bagong yang menyarankan orang miskin dibiarkan tetap miskin; who are the target beneficiaries in your program?

Answer: Akan lebih baik bila keluarga miskin melakukan diversifikasi usaha. Pemerintah seharusnya memberikan modal kepada keluarga miskin.

4. Anwar Ma'arif, Serikat Buruh Migran Indonesia:
Kebijakan apa yang akan dilakukan oleh pemerintah terkait dengan migrasi agar tidak berdampak buruk terhadap anak?

5. **Mujiati, Menkokesra**:
What is the entry point of children becoming poor, and how to overcome the problem?

THEME 5

Enabling Environment for Social Protection

1. **From Social Protection to Social Inclusion for Children in Poverty: Bridging the Disparities with Integrated Policy Design**
   Tamo Chattopadhay (Institute for Education and Social Development, India)

2. **Children with an Absent Parent: Are They Worse-Off?**
   Melissa Siegel (Maastricht Graduate School of Government, Netherlands)

3. **Enhancing Role of Family and Social Worker For Children with Disability**
   Rini Hartini Rinda A. (Sekolah Tinggi Kesejahteraan Sosial, Indonesia)

4. **One Size Doesn't Fit All: Stunting for Under 5 Children and Social Protection in Tanzania**
   Wei Ha (UNICEF Tanzania)

1 From Social Protection to Social Capital of Children in Poverty: An Argument for Cross-Class Policy Design and Implementation

***Tamo Chattopadhay*[1] &**
***Enrique Delamonica*[2]**
Institute for Education and Social Development, India

1. Introduction

Targeting social protection interventions for children in poverty is a well accepted policy paradigm. However, by virtue of their design, targeted policies - focused exclusively on poor children - remain largely disconnected from the domains of educational and social development of non-poor children in the society. This is because, in stratified societies of the world, rich and the poor children follow vastly divergent paths of education, socialization and social mobility.

In this paper, we present research findings form an intervention that purposively links the well-being of the most vulnerable children with the educational and social development of more privileged children in the society. We submit that for child-focused social protection policies to truly become a transformative force for social inclusion and social mobility, such policies should be purposively conceived in conjunction with the education and developmental imperatives of children from more privileged backgrounds.

Our analysis is anchored in the theories of social capital, and informed by an interdisciplinary literature on child poverty, children's agency, and design thinking in innovation. We build our argument by first framing social protection in theories of social capital. We elaborate our argument by presenting two vignettes of qualitative research that illuminate the complementary aspects of cross-class design approaches in social protection policies for children. Building upon these theoretical and empirical insights, we develop the core tenets of a child-focused social protection framework that is intentional in its design and transformative in its impact to include both children in poverty and those from more privileged backgrounds.

[1]tamo.chattopadhay@gmail.com Corresponding Author, independent consultant, India and USA

[2]edelamonica@unicef.org Regional Advisor, Social Policy, Latin America & Caribbean

2. Social Capital as a Theorizing Lens

There is a growing discourse in the field of social protection that both vulnerabilities and protective measures to overcome them are rooted in human relationships and power-dynamics – as distance from or proximity to power. Indeed, socialization aspects of education remain significant mechanisms of reproducing social inequalities (Apple, 1982; Bourdieu, 1973; Bourdieu & Passeron, 1977). In particular, lack of access to resource-rich networks represents an important dimension of social inequality for low income adolescents since middle class adolescents are routinely provided with explicit and implicit institutional support within the social networks of their families, schools and other social organizations (Stanton-Salazar 2001).

We argue that the concept of adolescent[3] social capital, anchored in the social capital theories of Pierre Bourdieu, presents a robust theoretical foundation to capture the relational nature of social deprivation and social protection systems.

Bourdieu defined social capital as resources that individuals are able to procure by virtue of their relationships with others, or "the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu, 1985, p. 248). Notably, such a framing is distinct from the dominant discourse that considers social capital as norms and networks that create and sustain 'functional communities' through inter-generational and intra-community relational linkages, or closures (Coleman, 1988). As Lareau succinctly observes: "In contrast to Coleman who portrays social relations as intrinsically valuable for helping children comply with dominant standards, Bourdieu critically reflects on the existence of dominant standards (or rules of the game in the field)" (Lareau, 2001, p. 81). Bourdieu's concept of social reproduction introduces notions of power and privilege within the social capital discourse and offers a powerful theory to examine differentiated socialization of adolescents in the context of unequal education in stratified societies (Lareau, 2001; Noguera, 2003; Stanton-Salazar, 1997; Stanton-Salazar, 2010).

Building upon these theoretical foundations, a theoretical framework of adolescent social capital can be conceived in three inter-linked domains: Relationships, Resources and Readiness. A fuller discussion on this 3R framework of adolescent social capital, including empirically grounded indicators specific adolescents in school contexts, is available elsewhere (Chattopadhay 2012); here we briefly present the main concepts. In the broadest sense, the Relationships domain can be understood as the networks that adolescents build among themselves, and with external stakeholders (broadly defined) through formal and informal contexts, processes and protocols. Research on adolescent relationships indicates that socio-economically disadvantaged adolescents might form social networks in ways that differ from their middle-class counterparts, and that these differences could inhibit the accumulation and transmission of important resources embedded within social networks (Stanton-Salazar, 1997).

In the concept of social capital, the resources of 'others', or the 'second-order' resources that are potentially available to the 'ego', occupy critical significance. Such resources could be material, informational, or psychosocial among others. Whether explicated as the ''strength of weak ties'' (Granovetter, 1974), ''bridging'' and ''linking'' social capital (Woolcock, 1998), or ''structural holes'' in overlapping networks (Burt, 2001), the notion of relationships formed across resource differentials emphasizes the idea that simply being in a network is not enough; it is important to be in a resource-rich network. These issues are salient in the context of children in poverty for whose benefit social protection policies are to be conceived. Not only are

[3]We use the term children here broadly as per UN / CRC definition of anyone under 18 – thereby including adolescents. In other words, the terms children are adolescents are used in this paper interchangeably.

resource-rich social networks critical for social mobility (Maeroff, 1998; DeGraaf and Flap, 1988; Lin, 1999, 2001), but also 'resource-deficit' networks restrict one's ability to break out from intergenerational transfer of poverty (MacLeod, 1987) and may significantly increase adolescents' vulnerabilities to risk factors and life-threatening choices (Fernandez-Kelly, 1995). Indeed, the truncation of social networks across resource differentials remains a key mechanism of maintaining the status quo of disempowerment among communities trapped in concentrated poverty (Wacquant and Wilson, 1989; Wilson, 1987, 1996). Notably, resources might also entail important emotional and psycho-social support (Stanton-Salazar and Spina, 2005), and embody a sense of social connectedness, acceptance, and self-esteem (particularly for socio-economically marginalized adolescents) when networks are formed across social class (Putnam and Feldstein, 2003).

Finally, the concept of Readiness stems from the idea that social networks and the resultant social capital do not emerge on their own. Rather, acquisition of social capital requires deliberate investments of both economic and cultural resources for purposive action (Portes, 1998). Bourdieu himself coined the term 'sociability' to distinguish between social networks and the ability to sustain and utilize them over time (Bourdieu, 1987). While the notion of Readiness is akin to Bourdieu's concept of cultural capital, it is distinctive in its embodiment of a set of socially constructed and contextually defined critical skills that enables one to be effective in identifying, nurturing, and mobilizing relational resources. Similarly, while networking skill or network orientation (Stanton-Salazar, 1997) remains a core element of Readiness, the concept extends to the ability to negotiate with and navigate through structures of power and domination. It is in this wider context of social structures and relationships of power that the notion of Readiness needs to be understood.

These three interlinked domains—Relationship, Resource and Readiness—of the 3R framework provide the conceptual framework to capture and interpret how more privileged children and adolescents could act as conduits of social capital for their less privileged – indeed extremely vulnerable – peers. This conceptual framework foregrounds new possibilities for social protection policies for vulnerable children. For example, under the domain of Relationships, one would consider ways in which middle class adolescents can be inserted as meaningful actors in the social universe of vulnerable children. The Resources domain would signify the actions and mechanisms through which the middle class children could enlarge the pool of critical institutional resources for vulnerable children. Finally, the domain of Readiness could capture the policy induced mechanisms that enable middle class children to enhance the capacities of their less privileged counterparts so that they (latter) become adept in accessing privileged institutional contexts and creating resourceful networks on their own.

While it would be easy to understand how privileged children might have many resources to share with underprivileged children; viewing the former solely as the benefactors and the latter solely as beneficiaries in a social capital exchange would be utterly misguided. Indeed, we argue, and demonstrate through our empirical research, that the flow of resources occurs in both directions and that more privileged children have as much to receive as they give in such structured and sustained interactions.

3. Qualitative Insights on Cross-Class Interventions for Children

The qualitative research presented below was undertaken in the urban context of Kolkata (formerly Calcutta) - a metropolis in the eastern part of India.

While India has made important strides in fighting poverty, a stark reality of child poverty and deprivation continues in the country at alarming levels. Forty two percent of Indian children under five-year age are underweight – almost double the rate of sub-Saharan Africa – despite two decades of rapid economic growth (Naandi Foundation, 2011). Besides unequal income and spatial development (World Bank, 2011), gender and caste remain deep-rooted markers of social exclusion in India (Govinda, 2011).

The urban context of Kolkata is an embodiment of the promises and paradoxes that characterize India today in a globalized world. As India's eastern regional hub, Kolkata remains a vibrant city of 10 million with some of the country's most important educational and cultural institutions. At the same time, the prevalence of slums with inhabitable conditions, and the sheer number of poor and destitute people on its streets signal a city with high levels of poverty and disparities in child well-being. It is in this context of urban inequalities, one should situate the unique social interventions of Loreto Sealdah School in Kolkata (LSK) – an English medium, private, all girls K-12 institution catering traditionally to middle-class children.

We present two interventions from LSK - both involving middle class students from a school whose former leader had the vision of cross-class design of social protection – without naming it in so many words. In the first vignette we demonstrate the important benefits to vulnerable children – specifically child domestic laborers - emanating from the unique design of a cross-class intervention involving students from the school. In the second and more elaborate account, we capture the attitudes, values and perspectives of middle class children who go through a prolonged engagement of supporting the educational and social needs of most vulnerable children of the society. It is not a coincidence that both our intervention examples come from the same institution. This underscores the role of organization leadership and culture in embracing intentional designs for social innovation.

The Hidden Domestic Child Labor Program of Loreto Sealdah Kolkata

The problem of child domestic labor is widespread in urban India. Hidden behind closed doors of private homes, children toil often round the clock – with little comfort or opportunity to improve their lives. By many accounts, hidden domestic child laborers (HDCL) are highly vulnerable to physical and sexual abuse at the hands of their employers, with absolutely no recourse for protection from such violations of their rights and dignity. The restrictive access to the outside world – solely determined and enforced by the will of their employers - makes child domestic laborers the invisible children who remain most vulnerable and least accessible by law enforcement and civic support systems. While there are many laws against child labor in India, they are hard to enforce and the social acceptance of child domestic labor is high in a country with growing inequalities.

To combat these multiple violations faced by domestic child laborers, the visionary Principal of LSK Sister Cyril Mooney (retired since 2011) devised a unique action-based child rights advocacy program in 1995. Called the Hidden Domestic Child Labor program or HDCLP, the intervention enlisted LSK students (grades 5 through 7) to identify and support the HDCL-s in a child-to-child framework. The Loreto students would search about in their own neighborhoods and apartment complexes; and wherever they find a domestic child laborer, they approach the employers for permission to take him / her out for an hour or so a week to play with her. Few employers can withstand the persistence of determined 10 to 12 year olds who have made it their mission to befriend the HDCL-s and if possible even get them into school. By 2000, the intervention had been reaching large number of HDCL, and had become more structured – a daily 2 hour study and play session at two "Drop-In Centers" for the child domestic laborers in the neighborhood / borough.

A Monday afternoon visit to the center introduced the research team to 18 such children, best described as bright-eyed, well-mannered, and eager to learn. Atop a narrow staircase of a government building in one of the most upscale boroughs of the city – Salt Lake – the one-room drop-in center is both haven and place of learning, its sparse white walls punctuated with a partial blackboard and several Bengali teaching posters. Here, under the supervision of a "multi-purpose worker" - social worker cum literacy trainer- children would follow a non-formal educational program, as well as take part in group activities and plays in the local park. Interviews with the children reveal both the immediacy of their vulnerabilities, and the singularity of the HDCLP intervention in their lives. Four such thumbnail profiles are presented below, the names of the children being altered.

JS is fifteen years old. She has been coming to the center now for almost two years and has received a scholarship to attend beauticians' school in hopes that she will be able to get a respectable job with a higher income. She started doing house work when she was ten years old. She had previously attended school and dropped out to begin working when she was in class three. She began working because her family needed her income, she never wanted to work. She was a live-in maid at the house she was working at, and her employers gave her meals. JS is unsure of how much she earned because her employers paid her parents directly. She reported that the family that she worked for was very nice although they had a daughter who was just older than JS who was very unkind to her. Now JS is living with her own family, her father a vegetable vendor and her mother a domestic. JS felt that her life has changed for the better ever since she first came to the drop-in center.

NK, aged 11, is a Muslim girl – a minority in the Hindu majority city (and country). She was the only child currently attending the drop-in center who had been physically abused by her formal employer. She started washing and cleaning at two homes beginning at age 9. In one home she labored beside her mother, who continues to hold down the job. Together they earned 350 rupees per month (about USD 7 in then exchange rate). Abuse occurred at the other home, where NJ was employed for one month. The man of that household slapped NJ, scared her with a stick, and used his status as a lawyer to threaten NJ about sending her father to jail. Also was made to do unpaid evening work such as watering the plants, dusting the floor, and washing clothes, NJ was eventually accused of theft. During that month her mother asked her to quit that job, but NJ continued since her family needed the money. Finally NJ decided to quit, called the attention of the people of the neighborhood, and requested her employer to pay her. She did get paid, though only 50 rupees when her owed wages totaled 500.

NJ currently works in one family home, and stays with her grandmother. Her mother has left the city and now lives in the village. Her biological father, described by her as wicked, left the family years ago, but her stepfather is a good man working as a mason. NJ has been attending the drop-in center for a few months and studies in class I at the government school. She cites "studying" as her favorite aspect of school.

SD is about 12 or 13 years old. She has been coming to the drop-in center for two months. She attended school until grade two when she dropped out to start working because her family needed the money for food. She lives with her father who is a mason and her mother (a domestic maid) and younger sister. SD missed school a lot when she first started working. She is currently still working everyday from six to eight o'clock in the morning and four to seven o'clock in the afternoon. She earns 300 rupees (approximately USD 6) per month. All of her earnings go directly to her family. She does not like work, but she thinks she is too old to go to school. She isn't sure what she wants to do when she gets older, but she enjoys learning the crafts at the center.

ML is 10 years old and works in a" nice home" as a maid. She wakes up at 6 am, cleans and dusts the whole house, mops the floors, then cleans the dishes and utensils for breakfast. After the family of four (mother, father, two daughters) eats and heads to work/school, she again cleans the house and kitchen. Around 10 am she has a small lunch and plays with dolls alone on the balcony. She then prepares for the family's noontime meal. After she cleans up, she goes home and then heads to "school" at the drop-in center. She has no idea how much she is paid because her mother collects her wage at the end of each month. When asked how she felt about working in the home, ML simply replied, "I feel bad. I don't like it"

Clearly, the HDCLP program of LSK does not eradicate child domestic labor. However, as these brief sketches of daily lives of child domestic laborers underscore, the program makes a significant contribution to the social protection of children whom the traditional safety nets of social policy have failed to reach. Besides providing immediate benefits of play and study to poor children condemned to domestic servitude, the program is also helping to mobilize a social awareness campaign through middle class children's unique agency a peer campaign that makes it socially unacceptable for adults to tolerate child laborers in their homes and neighborhoods.

HDCLP remains a program whose real strength is derived from its unique design connecting privileged middle class children with the lives of the poorest and most vulnerable children and adolescents. It is this link that makes the rest of the traditional social protection value chain - drop-in center, non-formal education, social worker cum literacy trainer – applicable and relevant.

The Rainbow Program of Loreto Sealdah School in Kolkata

Among the many school-linked social interventions conceived and implemented by Sister Cyril over four decades as the Principal of LSK, the Rainbow program surely qualifies as the signature project of the school that has inspired replication in other schools in the city and across the country.

It all started in 1979 when LSK broke down a major social barrier by opening its premises to young girls living in abject poverty on the streets of Kolkata. Back in 1979, this was an enormously bold experiment whereby the school's "regular" students from fifth grade onwards would be required to act as "instructors" in non-formal education activities for the underprivileged children or the "Rainbows". This model continues to date.

Beginning in 1996, the school converted its terrace to a night shelter for the approximately 200 Rainbow girls from the streets, providing them with a safe and supportive environment they could call 'home.' Today, the Rainbow program is organically integrated with the regular school day. Once registered into the program, the youngest girls are typically admitted to the kindergarten of LSK. However, the older Rainbows are unable to enroll at Loreto Schools since they lack the basic proficiency in English to attend the English medium program. Instead, the older girls are admitted into schools (government and private) where the instructions are in the languages spoken by them – Bengali, Hindi or Urdu. At the same time, for two hours every morning, before heading out to their respective schools, the Rainbow girls receive individual and group tutoring from the Loreto students themselves, who in turn receive pedagogic support from their classroom teachers. In a society with deep historical roots of class and caste divisions and enduring cultural and social stigmas, the notion of middle class and street children playing and studying together within an English medium private school is nothing short of an extraordinary social experiment and challenge to the status quo.

What follows is the summary of a qualitative study whose locus is the self-reported outlooks and attitudes of the Loreto students who participate in the Rainbow program and interact with the Rainbow children.

Research Question: How the multi-year interaction of Loreto students with the Rainbow children affects the attitudes and values of the former?

Methodology: A qualitative case study that employed a survey all LSK students in grades 6 through 10. The survey instrument contained both close-ended and open-ended questions. The students from these grades were selected due to their mandatory participation in Rainbow activities and their ability to complete written surveys in English.

Key Findings and Discussions: Student responses to both close and open-ended questions in the research instrument revealed that an overwhelming majority of students viewed the Rainbow program favorably. While a more elaborate account of these responses and their analyses are available elsewhere (Chattopadhay 2012), for this article we present highlights from three open-ended questions of the survey that in our opinion speak to the promise and limits of cross-class social protection interventions by and for children.

One of the most authentic measures of Loreto students' self-positioning relative to the Rainbow children whom they serve can be found in their responses to the open ended question on the survey that asked, 'How are you different from the girls that you teach in the Rainbow Program?' Overall, it is remarkable that, in a society of entrenched class, religion and caste divisions, the majority of students from one of India's premier English-medium private Catholic schools affirmed that there were no real differences between them and the children from the lower strata of the society they served.

Some younger girls (6th and 7th graders) found sameness in their shared human identity: "I feel no differences between me and them because we all are human beings" (6th grade). Others noted the shared social identity of being Indian citizens: "There is no difference. We all are children of our motherland India" (7th grade).

Although a minority, some students affirmed their difference from Rainbow children in terms of cultural and intellectual superiority: "I am different from them in culture" (8th grade), or: "Our behavior is not similar to them… we are better" (9th grade).

However, even while noting such differences many 9th and 10th graders and a few 8th graders observed that the Rainbow children differed from Loreto girls in terms of access to opportunities for education.

> "We are all equal, but the difference is that we are getting better opportunities than them" (10th grade).

As such, the majority of responses from the Loreto students demonstrated an authentic spirit of respect and hope with regards to the Rainbow children, notwithstanding the different worlds these two groups of children inhabit:

> "We are same, as they need help, we just teach them. After some day, they will be like us only teaching others" (9th grade).

To seek a better understanding of how the Loreto students arrived at their notions of self-identity vis-à-vis children in the Rainbow Program, a second open-ended question asked: 'How have your

feelings about the Rainbow Program students changed since your first day of working with them in the Class Five?' Overall, a clear majority of students across all grade levels responded with visible enthusiasm about how they felt more positively about the Rainbow children compared to the time when they stared teaching in 5th grade.

Only a handful of responses fell into the category of 'negative change' – and dealt with the behavioral aspects of the Rainbow children: "They were very good to me in class five but gradually I realized that they are becoming disobedient" (8th grade). One student did not shy away to express her outright disappointment: "Yeah (the feelings have changed)! Because now it has become boring" (10th grade). A handful of students qualified their "no change" response with a positive undertone: "My idea did not change in any way at all. I always thought they were very friendly" (6th grade). However, the favorable or 'positive change' comments spanned a range of issues and emotions: "I've become more attached with them over the years" (9th grade). a greater level of self-confidence and skills gained through the act of teaching was the recurring theme: "At first I felt like 'how can I teach them,' but now it gives me more pleasure to teach them" (9th grade). considerable number of students - both in lower and higher grades – reflected on how teaching the Rainbow children had affected their own values and attitudes: "They had made me a good girl" (8th grade). Older students reported their own growth as a result of their prolonged interactions with the rainbow children: "I have learnt many things from them as tolerance, being happy with what I have" (10th grade); and: "I have become a genuine person" (10th grade).

Beyond rejecting prevailing stereotypes about poor children in India, and articulating their evolving experience of teaching in the program; many Loreto students indicated their heightened understanding of the hardships of Rainbow children as a key change in their views: "I have realised how difficult it is for them to go through the process of education & hence their attempt makes me respect them" (9th grade). And in emphatic words, a number of Loreto students observed that Rainbow children had potential to be just as good and successful as them:

> "After interacting with them I got to know that they are as good as us & are good friends" (9th grade)
>
> "I learnt that those deprived children have a dream and they try their level best to attain it. They know .. how to be happy in such an awful situation" (10th grade).

In India's deeply class-conscious society, it is not unlikely that the messages the Loreto girls are most likely to receive in their middle -class family and social circles is that poor children are not capable of studying and are pathologically different from middle-class children. Consequently, the positive views of the Loreto students speak to the transformative potential of the cross-class design of the Rainbow Program.

The final open-ended question in the research instrument dealt most directly with the perceived benefit of LSK students from their socialization with the Rainbow children. First students were asked to answer (yes or no) to the question: 'Have the Rainbow Children taught you anything?' Then, the follow-up question asked: 'If you answered yes to the question above, please share what the Rainbow Children have taught you.'

Overall, around third of students surveyed indicated that the Rainbow students had not taught them anything. The proportion of students with the 'no' response was highest among the 6th graders and lowest among the 9th and 10th graders – possibly indicating a change in perspective as students mature through the Rainbow program. Analyses of the affirmative responses of Loreto students is revealing in this regard.

For example, most 6th and 7th graders who gave affirmative answers to this question interpreted it in terms of specific skills and knowledge they have gained from the Rainbow students: "They taught us new games which we don't know" (6th grade). In contrast, the affirmative answers of students in the older grades were rooted much more in critical reflections of their own intellectual growth and social awareness as a consequence of their prolonged interaction with the Rainbow children:

> "They have taught us to think wider. They have taught us to mix with everybody in society no matter if they are poor, low caste or anything else" (8th grade), or: "Humanity, friendliness, and helpfulness does not depend on skin colour, money, or power" (9th grade).

The Loreto students keenly observed that the everyday life of the Rainbow children who called Loreto Sealdah home was marked by a great sense of camaraderie and sharing of resources within a frugal existence. The attributes of this life – in particular relational skills - were important 'lessons learned' by the Loreto students in their socialization with the children of Rainbow program: "They taught us how to stay like a team and share everything with our friends" (6th grade); or: "How to help and protect others" (8th grade); and: "To adjust to the surroundings, to live in a big group and to live without their parents" (9th grade).

Student responses also indicated that the Rainbow program's experiential learning exposed middle-class students to lessons about the hardships of poverty and the dignity:

> "They taught us about the hard life which the poor Indians have" (10th grade); and "They taught that all children in the world have equal rights" (9th grade).

Some of the most poignant responses conveyed a deep self-reflection and awareness of the privileges and opportunity structures that the Loreto students came to discern through their engagement with the Rainbow children:

> "I have got an idea that there are children in adverse situations who are fighting back and coping with the situation. Seeing them my own problems seem small" (9th grade)

Most inspiringly, a majority of responses from 9th and 10th grade students conveyed a deep appreciation of the struggles, resilience, and responsibility of the rainbow children:

> "They taught us how to face problems in life. How to stay without parents, leading life alone, sacrifice every wish and how to cooperate with others and respect elders. To stand in life" (10th grade).

The fact that middle-class children recognized that they could learn something from the poorest children of the society is itself quite unique in an Indian social context. The emotional depth and intellectual authenticity of the responses of the LSK girls between sixth and tenth grades further speak to the transformational potential of the cross-class design of the social intervention where the conventional benefactor-beneficiary boundaries are blurred through mutual enrichment and growth.

Framing Mutual Enrichment and Growth in 3R-s of Social Capital

It is evident that there are significant benefits and enrichments that both the LSK students and their vulnerable cross-class counterparts – HDCL and Rainbows - derive from the interventions

discussed above. We illustrate below that the 3R domains of social capital outlined earlier in the paper – Relationship, Resources and Readiness - provide a powerful conceptual framework to capture the scope and dynamics of these enrichments.

Relationships: As elsewhere in the world, the relatively better-off children in the Indian society do not experience class-based oppression, nor may they notice the intensity of poverty all around them in the city. Often, visible human suffering is internalized and justified in the middle class ethos as an 'unfortunate situation' about which some abstract notion of national development is to be blamed. Against this backdrop, by providing an authentic context for participation and relationships across social class boundaries, the Loreto Rainbow model makes the issues of oppression, human rights and everyday suffering real and relevant to those who are born into relatively privileged circumstances. Their 'near-peer' (Herzog, 2012) mentoring and counseling roles in the Rainbow and HDCLP programs provide LSK students with socialization opportunities to form new and abiding relationships beyond traditional social boundaries.

At the same time, the interventions enrich the relational universe of vulnerable children by socializing them with peers and near peers in middle class – providing new role models, cultural references and critical perspectives. The ingenious aspect of the LSK cross-class design lies in the fact that the interventions find opportunities for better-off children to build relationships with severely disadvantaged children in a manner that is developmentally appropriate.

Resources: Clearly, LSK is a "Myth Challenging" institution where it is possible for rich and poor children to come together, and for the school to function both as a day school and as a night-shelter (Flatt, 2008). The purposive cross-class engagement strategies manifest in the LSK interventions create and sustain multiple relational contexts that are focused on building the intra- and interpersonal assets of all children (Noguera & Boykin, 2011), promoting an ethos of inclusion (Zollers et al 1999) and providing all children an opportunity to thrive (Rodriguez, 2008).

However, it is necessary to recognize that the resources accruing to the child participants of LSK interventions are flowing from an organizational culture of LSK that anchors and provides institutional leadership to these interventions. A trusting, inclusive, and relational school culture enables LSK and its interventions to become a source of social and cultural capital (Noguera, 2003; Stanton-Salazar, 1997; Warren, 2005) for all children who walk through the door of the school or are affiliated with its social interventions.

Readiness: The cross-class interventions of LSK challenge the assumptions adults hold for children and the assumptions children hold about themselves and their futures.

It would be fair to say that interventions such as HDCLP and Rainbow go a long way to enhance the Readiness of the vulnerable children they serve. While the vignettes do not elaborate these aspects in great details; even the brief profiles of children in HDCLP demonstrate how they acquiring important cognitive and psycho-social skills through their engagement with the Drop-in Center activities. Similarly, there are studies that have shown how the Rainbow program benefits the Rainbow children in elevating their self-esteem as well as providing them with new social markers of aspirations and capacity for critical appraisal of their own reality.

It is probably expected that programs intended to truly empower vulnerable children should do so in the realm of Readiness. However, the Readiness premium of cross-class interventions can be also seen with regards to the "benefactors" – the students of LSK.

As evident in the words of LSK girls, participation in the Rainbow program provides them with an opportunity to develop whole new cultural repertoires (Rogoff et al., 2007) and roles to

experience the power of their agency. Critical awareness of one's own agency is Readiness at its most profound. As noted by Sister Cyril herself: "It is important that our children are helped to distinguish between justice and charity and to be engaged in works of justice, and be helped to reflect on why such action is necessary." (Cyril, 2002, as quoted in Flatt, 2008, p.35). This combination of theory and practice, of reflection and "hands-on compassion" (an expression coined by Sister Cyril), offers a vigorous foundation of civic education, democratic citizenship, and human rights (Bajaj, 2012; Banks, 2004; Levinson, 2011) to the students of Loreto Sealdah. Finally, the idea of socializing young girls to become aware of their own agency and to see themselves as change-makers (Flatt, 2008, p. 26) is equally significant in the context of the widespread gender bias against women in India's conservative, patriarchal society.

We revisit the centrality of children's agency in design of cross-class interventions later in the Policy Implications section of the paper.

4. Cross-Class Design – Policy Perspectives for Social Protection of Children

The preceding discussions – both the empirical and analytical segments – demonstrate that a social capital framework helps qualify the value propositions of cross-class social protection interventions involving children. The combined dynamics of intentional relational contexts and purposive exchange of resources lead to a readiness that can be best described as transformation of awareness or conscience (Freire, 2000) for both groups of children across boundaries of social class. This carries great potential for bridging the social divides in unequal societies. At the same time, the wider replication, adaptation and scalability of such cross-class interventions are not self-evident. They would require sustained efforts in and attention to a number of key areas and issues. These are discussed below.

Design as a Purpose

Designing cross-class interventions require a certain of level deliberation – since the forces of social and cultural reproduction can only be met with purposive counter-stratification efforts (Stanton-Salazar 1997). As the vignettes demonstrate, there is a palpable intentionality with which the school scaffolds its interventions in core values of service and compassion.

It should be also noted that resistance to the Rainbow program was formidable at the beginning, particularly from many middle class parents who did not want their children to socialize with children from the streets of Kolkata. However, three decades later, the Rainbow Program – founded on the belief that 'everyone receives to give' – has transformed Loreto Sealdah School into a unique laboratory of educational and social innovation.

The intentionality with which Loreto Sealdah designs its cross-class social interventions, also distinguishes it from more traditional cross-class strategies of reaching out to the vulnerable segments of the population – such as service learning (Cipolle, 2010). At Loreto Sealdah, service and learning are not merely connected; they are embedded in each other through a seamless integration within the regular school day. Teaching Rainbow children is not an activity outside of the Loreto students' schooling; it is an essential part of their education. Such a design gives a whole new meaning to the notion of 'service' in the case of Rainbow program.

Organizational Culture and Capacity

Intentional designs are products of purposeful organizations, and more specifically of purposeful organizational cultures. As one explores the LSK school, shares a cup of tea with the administrative staff, or speaks with the teachers about the Rainbow Program or the HDCLP, it becomes clear that every adult in the school believes in the vision that a school for the privileged few can be transformed to empower the most vulnerable and disenfranchised children of the society. In other words, the cross-class interventions of LSK described here are more than just programs for street children or child labors run by a school; they are the manifestation of an organizational culture of social inclusion and human dignity that defines the very character of LSK as an institution.

Agency of Children

At the core of the cross-class interventions discussed so far, there is recognition of the power of human agency (Emirbayer & Mische, 1998), specifically agency of children. While a growing body of literature celebrates children's agency and adolescents' participation for social justice; the power of that agency in cross-class contexts is rarely explored.

It can be argued that a cross-class intervention like HDCLP could only have been conceived with children – and not adults – as the protagonists. The structural and conceptual nuances of the design –initiated by a child (LSK student) and later complemented by an adult (multi-purpose worker at the Drop in Center) –masterfully builds on the agency of children in the delicate and complex terrain of 'shaming' a middle class norm.

As the vignettes establish, the unlocking of the agency of a child is intertwined with that child's formative identity. For young people, school remains an important site in formulating identities (Eckert, 1989). Adolescents are significantly influenced by their peers (Coleman, 1963) as they negotiate the boundaries of family, school, and community and derive their meanings and understandings of these multiple worlds (Phelan, Davidson & Cao, 1991). For students of Loreto Sealdah, their emerging identities are framed in the discourse of social inclusion and human rights and situated in the micro-context of their Rainbow / HDCL peer relationship within the macro-context of their schooling in a structurally unequal society.

As their own words indicate, the majority of Loreto students participating in the Rainbow program begin to identify and question the "normalcy" of entrenched social injustices, and indeed dare to imagine an alternative to the status quo relationships of power ((Bajaj, 2012; Tibbitts, 2005). Such constitutive processes create the praxis of identity and agency (Emirbayer & Mische, 1998; Holland et al., 1998) that enables Loreto Sealdah to avoid the unintended reinforcement of marginality prevalent in the poor and non-poor normative interactions in India and elsewhere in the world.

The fact that all LSK students – the future female professionals of India – are growing up with a deep appreciation and empathy for the needs of the less privileged in the society is probably the most promising aspect of the cross-class interventions carried out by the school. An equally powerful and promising aspect of the cross-class design is the enrichment of relational universe of vulnerable children for whom a whole new range of "possible" can finally come into existence. In other words, the cross-class interventions are promising for children because they simultaneously transform critical consciousness of the relatively privileged – while "demystifying success" (Noguera) for the relatively underprivileged.

Undoubtedly, in a society with deeply entrenched class, caste and religious structures, the barriers to motivate and enable middle class and elite children to share their resources for poor children's wellbeing are formidable. Similarly, the internalized oppression (Stanton-Salazar) of vulnerable children remains a powerful deterrent to their aspirations, and help seeking strategies for fulfilling those aspirations. However, the LSK experience shows that there is great promise in developmentally appropriate cross-class interventions as they unlock the intrinsic agency and curiosity of children and young people by transforming their relational identities.

Relevance for Social Protection of Children in Urban Contexts

It can be argued that the urban context – with its proximity of the poor and non-poor – presents the most potent context for conceiving and implementing cross-class design in social protection policies for children.

Rapid urbanization is a hallmark of globalized commerce, culture and movements. The emergence of "global cities" as hubs of economy and politics is transforming the demographic distributions between the rural and the urban spaces around the world. Majority of adolescents in the developing countries live today in urban contexts. At the same time, the urban context today is increasingly unequal around the world – with large proportions of children and adolescents living in absolute and relative disadvantage and deprivations. A recent study (Born et al 2012) from Latin America demonstrates this intra-urban inequality and questions the conventional wisdom of "urban advantage" over rural under-development. According to the classification of that study, almost three out of every ten urban children and adolescents live in highly deprived households. This is significant given that three out of every four adolescents in LAC live in urban areas. In absolute terms, around 45 million children and adolescents live under highly deprived conditions; this is comparable to those living in rural areas of LAC region.

We argue that urban inequality presents the most natural setting for cross-class design of social protection policies towards children. As the LAC study asserts: "It is precisely the fact that their neighbors, i.e. children in not deprived households, are doing so well that the intra-urban disparities are so high." The study goes on to observe that the levels of deprivation are inadmissible given the rest of the urban context. Intra-urban inequality is disempowering to disadvantaged children not only for the physical deprivations they suffer; but also for the internalized oppression, alienation and 'non-belonging" that result from their co-existence with the rich in the urban space. This disempowerment is aggravated by the social distancing by the middle class in most urban contexts around the world – in some more visibly than others. In their most recent work, Amartya Sen and Jean Dreze discuss the "opting out" of the urban middle class that is destroying the foundations of social development in India.

The intra-urban inequality is precisely the premise and inspiration for design thinking in social innovation in general and for cross-class child intervention design in particular. We argue that the widening gap and worsening vulnerabilities in social context of children require a "solution-based" approach – the hallmark of design thinking in innovation (Brown and Wyatt 2010). Our research from the urban context of India presents one such solution-driven approach to social protection of children. Clearly, the shape of the "solution" and the scope of cross-class design will vary greatly in different socio-cultural contexts.

5. Concluding Remarks

This paper has attempted to present the emergent contours of cross-class design for social protection policies for children. We also affirmed that the cross-class design approach is situated

within the emergent literature of design thinking in innovation. For policy makers and practitioners, below are the conceptual markers that they need to consider in pursuit of such policy solutions:

- Integrate social protection policies for children in poverty with authentic engagement opportunities for non-poor children and adolescents.
- Scaffold the engagement in a developmentally appropriate discourse of children's rights
- Prioritize urban contexts and intra-urban inequality
- Embed such policies in institutional contexts that are normative "sites" for children and adolescents – school, sports, culture, and so forth. The key is to move beyond the dialectic of benefactor-beneficiary, and instead champion the universality of rights and interdependencies of all members of the society
- Find conceptual intersection between the constructs of disparities, adolescent participation and social protection of children.
- Have cross-class policy design informed by the differentiated reward and incentive structures that must be carefully aligned to bring together young people with pronounced disparities reflected in their identities and aspirations.

References

Apple, M. W. (1982). *Cultural and economic reproduction in education: essays on class, ideology, and the state*. London; Boston: Routledge & Kegan Paul.

Anand, G. (2011, June 4). Class struggle: India's experiment in schooling tests rich and poor. *Wall Street Journal Asia*. Retrieved January 7, 2012, from http://online.wsj.com/article/SB10001424052748704083904576337373758647478.html

Bajaj, M. (2012). *Schooling for social change: the rise and impact of human rights education in India*. New York: Continuum International Publishing Group.

Banks, J. (Ed.) (2008). *Diversity and citizenship education.* San Francisco, CA: Jossey-Bass Bourdieu, P. (1973). Cultural reproduction and social reproduction. In Brown R. (Ed.), *Knowledge, Education and Social Change.* London: Tavistock.

Bourdieu, P., & Passeron, J. C. (1977). *Reproduction in education, society and culture.* California: Sage Publications.

Brown, Tim and Jocelyn Wyatt. 2010. Design Thinking for Social Innovation. Stanford Social Innovation Review. Winter 2010

Carnoy, M., & Levin, H. M. (1985). *Schooling and work in the democratic state*. Stanford, CA: Stanford University Press.

Cipolle, S. (2010). *Service-learning and social justice: engaging students in social change*. Lanham, MD: Rowman & Littlefield

Coleman, J. S. (1963). *The adolescent society: the social life of the teenager and its impact on education.* New York: Free Press.

Cyril, S. M. (2002). *Identity, Integrity and Interconnectedness.* Keynote address at International Conference of Loreto Educators. Loreto House Kolkata. 5 November, 2002

Eckert, P. (1989). *Jocks and burnouts: social categories and identity in the high school.* New York: Teachers College Press.

Emirbayer, M., & Mische, A. (1998). 'What is agency?' *American Journal of Sociology, 103*(4), 962-1023.

Finnan, C., & Swanson, J. (2000). *Accelerating the learning of all student: cultivating school, classroom and individual change*. Westview Press

Flatt, John. (2008). *Loreto day school Sealdah: meeting the challenges of a changing India.* Lulu Publishers.

Freire, Paulo. 2000. *Pedagogy of the Oppressed*. London: Continuum. (First published 1970) Freire, Paulo. 1998. *Pedagogy of Freedom: Ethics, Democracy and Civic Courage*. Lanham, MD: Lanham, Rowman & Littlefield. (First published 1974)

Govinda, R. (Ed.) (2011). *Who goes to school? Exploring exclusion in Indian education.* New Delhi: Oxford University Press.

Herzog. (2012). *Reflecting on Compagnonnage*. Learning In and Out of School: Education Across the Globe Conference. Kellogg Institute for International Studies, University of Notre Dame.

Holland, D., Lachicotte, W. J., Skinner, D., & Cain, C. (1998). *Identity and agency in cultural worlds.* Cambridge, MA: Harvard University Press.

MHRD - Ministry of Human Resources and Development. (2009). The right of children to free Naandi Foundation. (2011). The HUNGaMA (Hunger and Malnutrition) Survey Report 2011.Retrieved August 31, 2012 from http://hungamaforchange.org/ HungamaBKDec11LR.pdf

Noguera, P. (2003). *City schools and the American dream: reclaiming the promise of public education.* New York: Teachers College Press.

Noguera, P. A. and A. Wade Boykin. (2011). *Creating the Opportunity to Learn: Moving from Research to Practice to Close the Achievement Gap*. Washington, ASCD

Nurenberg, D. (2011, March 21). What does injustice have to do with me? A pedagogy of the privileged. *Harvard Educational Review, 81*(1), 50-64.

Phelan, P., Davidson, A. L., & Cao, H. T. (1991). Students' multiple worlds: Negotiating the boundaries of family, peer, and school cultures. *Anthropology & Education Quarterly*, 22(3), 224–250

Pratham. (2011). *The annual status of education report for 2010*. New Delhi: Pratham

Born, Diego, Colamarco, Delamonica and Minujin. Children, Adolescents and Intra-urban inequalities in Latin America and the Caribbean. 2012. Diego Born, Victoria Colamarco, Enrique Delamónica, and Alberto Minujin

Rogoff, B., Moore, L. C., Najafi, B., Dexter, A., Correa-Chávez, M., & Solís, J. (2007). Children's. In J. Grusec & P. Hastings (Eds.), *Handbook of socialization* (pp. 490–515). New York: Guilford Press.

Stanton-Salazar, R. (1997). A social capital framework for understanding the socialization of racial minority children and youths. *Harvard Educational Review, 67*(1), 1-40.

Tibbitts, F. (2005). Transformative learning and human rights education: taking a closer look. *Intercultural Education, 16*(2), 107-113.

World Bank. (2011). *Perspectives on Poverty in India*. Washington, D.C.: World Bank

2 The Impacts of Migration on Multidimensional Child Well-Being: Comparative Analysis between Moldova and Georgia

Jennifer Waidler[1]
Michaella Vanore[2]
Franziska Gassmann[3]
Melissa Siegel[4]
Maastricht Graduate School of Government, Netherlands

Abstract

Using novel household survey data collected between September 2011 and December 2012 on migrant- and non-migrant households in Moldova and Georgia, this paper proposes a method for measuring and comparing multidimensional child well-being in a migration context. While a growing body of literature addresses the effects of migration for children "left behind", relatively few studies have empirically analysed if and to what extent migration implies different well-being outcomes for children. To compare the outcomes of children in current- and non-migrant households, the present paper defines a multidimensional well-being index comprised of six dimensions of wellness: education, material living standards, protection, physical health, emotional health, and communication access. The results of both bivariate and multivariate analysis suggest that migration bears limited consequences for different domains of well-being. In both Moldova and Georgia children in migrant households were found to have a slightly lower probability of attaining material well-being, but in Georgia migration was linked to higher probabilities of children attaining well-being in physical health, communication access, and on total index level. The results suggest that when migration has any statistically significant effect on child well-being, it is generally positive and relatively low in magnitude. The impacts of migration appear to differ widely between Moldova and Georgia, however. While migration was seen to have limited effect on the well-being of children in Moldova, it seemed to bear more consequences for children in Georgia, which likely reflects different migration trajectories, mobility patterns, and levels of maturity of each migration stream.

Key words: migration, children, multi-dimensional poverty, Moldova, Georgia

[1]Corresponding author: jennifer.waidler@maastrichtuniversity.nl

[2]michaella.vanore@maastrichtuniversity.nl

[3]Franziska.gassmann@maastrichtuniversity.nl

[4]Melissa.siegel@maastrichtuniversity.nl

I. Introduction

Particularly in societies experiencing large-scale mobility transitions, migration has become a powerful phenomenon that incites dialogue and discourse on both public and policy level, some of which is woefully uninformed. This is especially true when the discussion turns to the "costs" and the "benefits" of migration, particularly for children 'left behind'.

Migration and its outputs are notoriously difficult to quantify. The development-boosting potential of remittances is one of the best-explored benefits of migration, which is understandable given the substantial financial flows it can generate: in Moldova, remittances accounted for over 23 percent of GDP in 2009, and in Georgia, remittances were the equivalent of 6.4 percent of GDP (Ratha *et al*, 2010). Such remittance flows can play a key role in protecting recipient households from economic shocks and income vulnerability, yet at the same time it is unclear to what extent such transfers replace the contributions that a migrant would make to the household if s/he were present. The impact of a migrant's absence is particularly pertinent to explore within the context of child well-being, but relatively few empirical studies have attempted to define and measure child well-being to the end of measuring migration's impacts on it. As noted by Kandel and Kao (2001), relatively little analysis has been conducted on the trade-offs between increased material resources and less-easily quantified consequences of parental absence, and this is especially true of Moldova and Georgia, where limited research is available to document specific channels through which migration can affect the well-being of children. As with other Eastern European and former Soviet states, Moldova and Georgia have experienced a rapid rise in emigration that has inspired policy makers and civil society organisations to raise concerns about the potential impact these growing migration flows have on society. While public discourse generally recognises the inflow of remittances as a positive outcome of migration, the perceived social impacts of migration are less well understood.

The present paper bridges this gap by elaborating a multidimensional well-being index for children in Moldovan and Georgian households. This index provides a means through which the specific impact of migration on multiple aspects of well-being can be measured. Through the construction of an index comprised of six dimensions representing different facets of a child's life, the relationship between migration and a child's holistic well-being is made measurable. The implications of migration—beyond remittance receipt—for a child's physical health, emotional health, protection, educational outcomes, material living conditions, and communication access are explored. While the results are oriented within the unique contexts of Moldova and Georgia, the instrument has been constructed to enable cross-country comparability. This characteristic of the index provide important analytical power to the method, particularly as it allows for discussion of how deviations in country context correspond to different well-being outcomes. The results from the following analysis provide important insights into the potential social impact of migration, not only for Moldova and Georgia but also for other countries in the region that are characterised by similar migration experiences. The results may provide appropriate guidance for policy makers in their effort to increase the well-being of children in general, and those living in migrant households in particular, by highlighting the domains in which children face deprivation. From a scientific perspective, this paper benefits from data collected specifically for the purpose of this analysis. The use of identical survey instruments in both countries makes the data comparable for two countries with divergent migrant profiles.

The first section of this paper explores the theoretical relationship between migration and well-being and provides a brief overview of previous studies on the effects of migration on child well-being. The second section then addresses the fundamental dilemma of how child well-being should be defined and made measurable. Following the suggestion of a definition of child well-being, brief backgrounds are provided for both Moldova and Georgia before the data utilized in

the following analysis is described. The indicators and methodology for constructing and using the specified child well-being index are then explained, followed by a summary of results. This paper concludes with a discussion of the results.

II. Migration & Well-Being

By assessing the impacts of migration on child well-being, an implicit assumption is made that migration bears unique consequences for the individuals and households it affects. The intuitive logic behind this assumption bears further exploration, particularly given the emphasis placed on migration as a uniquely disruptive agent. Migration and the well-being of children 'left behind' can be expected to be linked through several avenues, the most obvious of which is that migration can directly affect the resources available to a household, both withdrawing and adding resources to be shared on the household level. Within this rationale both positive and negative repercussions can be envisioned, which both theory and prior research have explored.

The suggestion that migration and well-being are linked through the transmission of resources from the migrant to the household has formed a cornerstone of migration theory since the early 1980s. The new economics of [labour] migration (NELM) theory originally posed by Stark and Bloom in 1985 suggests that migration is a decision jointly made by migrants and a group of non-migrants—namely the family—with whom potential costs and returns are shared according to implicit agreement about the distribution. Within this theory the migration decision is a mutually-beneficial one in which remittances are transmitted from the migrant abroad as a means of sharing income and providing coinsurance (Stark & Bloom, 1985). Migration can be seen as means of not only increasing the potential volume of income received by a household but as a means of diversifying income sources and thus hedging the risks associated with reliance on a small number of income sources. Particularly in countries with inefficient or missing insurance and credit markets, migration can act as a means of smoothing consumption over time, supplementing lost income during unemployment spells and providing additional capital for use in the development of small-scale enterprise (Massey *et al*, 1993; Taylor, 1999; Stark & Bloom, 1985). As household members children would be expected to benefit from the resources provided by migrants, particularly given use of those resources for expenditures such as healthcare and education.

The resources a migrant can potentially share with the household in the country of origin can include not only financial capital, through monetary remittances, but human capital, through the transmission of knowledge, values, and ideas in the form of "social remittances" (Levitt, 1998; Acosta, Fajnzylber, & Lopez, 2007). A range of prior studies has explored the potential uses of both financial and social remittances for children "left behind". Yang (2008) in the Philippines and Mansuri (2006) in Pakistan, for instance, both suggest that the receipt of remittances can loosen economic constraints on households, enabling children to pursue education and reducing child labour rates.

Other studies have found a positive relationship between migration and child health outcomes: remittances can enable investment in more and higher quality foods, vitamins, and medicines (Salah, 2008) as well as in preventative and curative healthcare (Cortés, 2007). The receipt of both monetary and social remittances has been further correlated to higher rates of educational attainment, greater rates of participation in extra-curricular activities, and better schooling outcome measures such as grades in diverse countries such as Guatemala (Moran-Taylor, 2008), El Salvador (de la Garza, 2010), the Philippines (Edillon, 2008; Yang, 2008), and Pakistan (Mansuri, 2006).

The positive relationship among migration, remittances, and increased child well-being is not without its negative counterbalance, however. Much of the benefit migration can bring to children "left behind" relies on the transfer of remittances, but the act of migration in and of itself is no guarantee of remittance receipt. Particularly when migration is undertaken as a survival strategy and is funded through loans, children left behind may be placed in an even more tenuous economic situation than prior to migration, particularly if they shoulder the migration debt burden (van de Glind, 2010). In some situations, as a study of Kandel (2003) in Mexico found, migration may increase child labour rates, particularly among male children who must work to support the household. While remittances may enable greater expenditure on healthcare inputs, positive outcomes may develop only over time: in Mexico McKenzie (2007) observed that migration was initially correlated to lower use of preventative healthcare, incomplete adherence to vaccination regimes, and lower rates of breastfeeding. While infant mortality was observed to decrease over time (Hildebrandt *et al*, 2005; McKenzie, 2007), parental migration during a child's infancy can lead to less-than-optimal health behaviours. Migration can also bear negative potential consequences for child educational outcomes, with studies in Albania (Giannelli & Mangiavacchi, 2010), Ecuador (Carillo & Herrera, 2004, in Cortés, 2007), and Moldova (Salah, 2008) finding a relationship between parental absence and higher rates of school absenteeism, declining school performance, and declining graduation rates.

Despite the categorization of potential effects into "positive" or "negative" outcomes, most prior studies caution that the relationship between migration and child well-being outcomes is dynamic, depending on a number of situational and contextual features such as a child's age, post-migration caregiving arrangements, a household's socio-economic status, and the retained ties between a migrant and the household members remaining in the origin country. The generalizability of insights provided from past studies is also low, particularly as many have not relied on large-scale, nationally-representative data using the child as the unit of analysis but more often on household surveys with few questions related directly to migration. Among those studies that have explicitly focused on children in migrant households, few have explored the situation of children remaining in the country of origin, and fewer still have engaged an appropriate control group against which the outcomes of children in migrant households can be compared (Graham & Jordon, 2011). Past studies have also largely focused on singular aspects of well-being such as physical health or educational outcomes, but given the complex interplay between migration and the conditions that affect household members, a more encompassing assessment of migration's impact on well-being is needed. The present study is well-oriented to fill the identified gaps in past research, particularly as it defines and operationalizes well-being in a more holistic framework.

III. Defining Well-Being

One of the first challenges faced in the assessment of child well-being is in defining the concept. In constructing a concept of child well-being, the inherent assumption is made that children are unlike adults: the components of child well-being, while shared to a certain extent with that of adults, differs according to the different needs and vulnerabilities children face (White, Leavy, & Masters, 2003; Brooks-Gunn & Duncan, 1997; Waddington, 2004). In acknowledging that children are a unique population group with differentiated needs, one makes the commitment to emphasise the child as the unit of observation—to measure the phenomenon and characteristics of a child's life on his or her own level and not exclusively on the household level (Ben-Arieh, 2000). While in much research on child poverty, "children are routinely considered as a property of their households and are assumed to share equally in its fortunes (or misfortunes)" (Gordon *et al*, 2003; pg. 3), there are many inherent flaws to assessing child poverty in this way. The first is that children may not share equally in the resources available to a household, and even if equal

access is guaranteed, the actual consumption behaviour of children is uncertain[5] (Gordon *et al*, 2003). Issues of access and consumption also make measurement of child well-being (or its inverse, poverty) incompatible with the monetary approach of poverty measurement in which deprivation is assessed exclusively on the basis of material means such as income or expenditure (Minujin, Delamonica, Davidziuk, & Gonzalez, 2006; Gordon *et al*, 2003; Roelen, Gassmann, & de Neubourg, 2009). This hints at a key hurdle to assessing child poverty: identifying and defining dimensions or domains of child well-being.

As for any population group, decomposing the "contents" of child well-being or poverty requires a conceptual basis. Deprivation—and its end result, poverty—can be defined according to many different sources such as national norms and legislation, internationally-agreed definitions and conventions, scholarly theories, public consensus, and empirical evidence (de Neubourg *et al*, 2012). Given increased recognition that childhood is not only a means to an end (adulthood) but rather an end to itself[6], one of the most important sources for defining deprivation is international instruments such as the Convention on the Rights of the Child (CRC), which provides a rights-based framework for approaching well-being. The CRC, which was adopted by the UN General Assembly in 1989, is a legal instrument for promotion and protection of children's rights that outlines minimum standards for "the treatment, care, survival, development, protection and participation that are due to every individual under age 18." (UNICEF, 2009; pg. 2). Within the CRC children are envisioned as rights holders, yet this entitlement to rights is both challenged and complemented by dependence on families, communities, and societies to attain minimum standards of well-ness. Within this rights-based framework, child well-being can be understood as the realization of children's rights and the fulfilment of opportunities for a child to reach his/her potential, both at the present moment (well-being) but also in the future (well-becoming) (Bradshaw, Hoelscher, & Richardson, 2007). Interpreted this way, well-being in the context of child's rights has strong parallels with the human development and capabilities approach championed by Amartya Sen. The capabilities approach envisions well-being as the product of an individual's effective opportunities or capabilities to attain a desired.

outcome; lack of capabilities, or the freedom to choose among them, limits the range of realizable functionings, leading to deprivation or poverty (Sen, 1993; Robeyns, 2005). Both the child's rights-based framework and capability approach to defining well-being envision well-being as inherently multidimensional, comprised of opportunities and entitlements in multiple facets of life; deprivation in single dimensions can thus lead to failure to attain well-being in total (Alkire, 2002; Sen, 1993; Robeyns, 2005; Alkire & Foster, 2011).

To translate concepts of well-being into functional measurement instruments, a list of dimensions of well-being—and the indicators by which they can be measured—must necessarily be elaborated. A significant body of literature has addressed the multidimensional nature of child poverty (see Roelen & Gassmanm, 2008, for a review), and much follows a rights-based perspective in which the CRC and other international summits and instruments provide initial lists of domains (Alkire & Roche, 2011). The first internationally-comparable estimates of child poverty in the developing world produced by the research team at Bristol University's Townsend Centre

[5]While the use of adult equivalence scales attempts to "approportion" household resources to account for economies of scales within households according to the consumption behaviours of certain members, it is unclear how universal or appropriate widely-used scales (like the OECD 1982 scale) are for all country contexts

[6]This is related to the discussion of *well-being* versus *well-becoming*. While much discussion of childhood poverty relates to the potential effects of deprivation for future growth, development, and eventual functionality as adults (that is, a child's *well becoming*), a child's wellness can also be assessed as it exists at the present moment, in terms of access to equivalent rights and privileges as other members of a society (Ben-Arieh, 2000; Roelen, 2010).

for International Poverty Research[7] relied on indicators of poverty that aligned with the internationally-agreed definition of poverty proposed during the World Summit for Social Development in Copenhagen in 1995. The resulting instrument was comprised of eight dimensions across which children could experience deprivation: food, safe drinking water, sanitation facilities, health, shelter, education, information, and basic social services (Gordon *et al*, 2003). A 2007 study by Bradshaw and colleagues on child well-being in the European Union drew from the CRC to construct an index that similarly defined well-being in terms of eight "clusters" of indicators: material situation, housing, health, subjective well-being, education, children's relationships, civic participation, and risk and safety. Drawing from a different source of inspiration—a review of 27 subjective well-being studies conducted by Cummins and colleagues—Land, Lamb, and Mustillo (2001) developed a child well-being index for the United States that bore striking resemblance to the previously-mentioned studies. The index elaborated by Land and colleagues was comprised of seven domains: material well-being, health, safety/behavioural concerns, educational attainment, place in the community, emotional/spiritual well-being, and social relationships (Land *et al*, 2001).

While it is impossible to say that consensus on defining and measuring child poverty has been reached on the basis of this small number of studies, the overlap in dimensions and convergence toward similar operationalisations of more abstract frameworks such as the CRC provides initial guidance on key components of child well-being, particularly in a cross-country comparative context. Based on reviewed literature, functionality in a cross-cultural context, and availability of data, the following definition of child well-being is operationalized in this study:

Well-being is a multidimensional state of personal being comprised of both self-assessed (subjective) and externally-assessed (objective) positive outcomes across six realms of rights and opportunity: education, physical health, emotional health, material living standards, protection, and communication.

This definition recognises the inherent complexity and multidimensionality of well-being. Individual components of well-being and their expression are the products of on-going and dynamic processes that change the risk factors and resources within a child's immediate and more distant development environment (Bradshaw *et al*, 2007). Migration is one such process that alters the context in which individuals develop and function, but its effects are not universal and homogenous. While the aim of the present study is to assess the potential implications of migration on well-being attainment in two separate countries, such comparison must necessarily be oriented in the migration context of each study country.

IV. Country Backgrounds

Before analysis of child well-being can be compared across the two study countries of Moldova and Georgia, the rationale in choosing these two countries must be made clear. Both countries have experienced rapid mobility transitions that have brought with them increasing concerns over the potentially disruptive effects of migration for the 'left behind'. Both countries experienced economic and political transitions following the collapse of the Soviet Union in 1991 that enabled and encouraged international migration. Despite the shared Soviet past and the many changes the post-Soviet transition brought, each country has developed unique migration trends and trajectories that make the experiences of each country valuable to compare and contrast, particularly in the context of the effects of migration on the 'left behind'.

[7]The basis for the "Bristol approach" of child poverty measurement adopted by UNICEF's Global Study is derived from this report

Over the past two decades, migration from Moldova has been largely driven by economic crises. Following the dissolution of the Soviet Union, the Moldovan economy remained closely tied to the Russian economy: until 1998, Russia received over 60 percent of the total exports produced in Moldova. The economic crisis that swept Russia in the end of the 1990s inspired severe consequences for Moldova, where industrial output plummeted by 25 percent and agricultural production by 20 percent between 1998 and 1999. This crisis compounded existing economic problems related to the loss of control over the separatist territory of Transnistria, which was home to most of Moldova's energy and industrial plants (Pantiru, Black, & Sabates-Wheeler, 2007). The loss of Transnistria and the downturn of the Russian economy contributed to the dire economic situation Moldova found itself in 1999: gross domestic product was just 34 percent of the level experienced a decade earlier (Pantiru *et al*, 2007; CIVIS/IASCI, 2010), and 71 percent of the population lived below the poverty line (IMF, 2006). The extreme level of economic vulnerability provided the first initial "push" for large-scale emigration, which has continued relatively unabated since (CIVIS/IASCI, 2010). As of 2010 it was estimated that over 770,000 people—equivalent to 21.5 percent of the total population—was living abroad, the majority of whom were in the Russian Federation, Ukraine, Italy, and Romania (Ratha *et al*, 2010). Most migrants are of prime working age, with approximately 80 percent between the ages of 18 and 44 (CIVIS/IASCI, 2010). As of 2008 the majority of migrants (58 percent) were male (Salah, 2008), but a greater proportion of women have entered international migration, particularly to destination countries in the European Union for work in the home-care sector (CIVIS/IASCI, 2010).

Mobility trends in Georgia bear some similarity to those of Moldova, but the origin of large-scale migration following the Soviet collapse is somewhat different. In the first years following independence, migration flows were largely dictated by the ethnic return of non-Georgians to countries such as Russia, Greece, and Israel as well as by conflict-induced displacement that promoted both internal and international migration (CRRC, 2007). Internal conflict and ethnic strife. during the early 1990s resulted in a several waves of migration from the *de facto* independent regions of Abkhazia and South Ossetia, and the 2008 Russian-Georgian war over the territory of South Ossetia promoted additional waves of conflict-driven migration. As in Moldova the post-Soviet period in Georgia has been characterized by the deterioration of the economic system and state infrastructure, and despite reforms and political transitions in the early 2000s, wide-scale poverty and economic insecurity have remained a concern, with over half of the population living under the national poverty line in 2007 (Hofmann & Buckley, 2011). The ongoing economic insecurity has contributed to continuing emigration, which in recent years has been characterised by the movement of prime working-age individuals to foreign labour markets. As of 2010 it was estimated that the emigrant stock represented 25.1 percent of the total population (Ratha *et al*, 2010), and a significant volume of individuals are thought to leave Georgia every year[8]. While the Russian Federation and other Commonwealth of Independent States countries represented the most important destinations of migrants during the early years of free mobility, the migration stream has diversified, with the Russian Federation, Armenia, Ukraine, Greece, and Israel representing the most important destination countries for migrants in 2010 (Ratha *et al*, 2010). The country of destination differs considerably for men and women: while migration to the Russian Federation is dominated by men, female migration is increasingly directed to Greece and other European Union countries with growing elder/home care markets (IOM, 2009).

The different origins of migration flows from Moldova and Georgia correspond to different migration experiences for individuals from each country. While the migration stream from Moldova can be considered relatively "immature", with low rates of settlement and family reunification in destination countries (CIVIS/IASCI, 2010), emigration from Georgia has included more significant

[8]While emigration flows are seldom provided, the IOM estimated the net emigration rate at -10.8 migrants/1000 population in 2008, which suggests a significant flow of outward migration (IOM, 2008).

levels of settlement in host countries and lower rates of return, particularly among those individuals and households that left during the conflict period (CRRC, 2007). Moldovan emigration is now characterized by high levels of circularity, facilitated by favourable visa regimes with the Russian Federation and by access to the European Union among dual Moldovan-Romanian passport holders. Many Georgian emigrants are in a more disadvantaged position, particularly those residing in the EU without legal right to residency or work. These factors influence the capacity migrants have to maintain contact with their families and communities, thus Moldova and Georgia—and the differential patterns of emigration they experience—provide interesting case studies for exploration of how migration can affect the lives of those 'left behind'.

V. Data & Methodology

While in the past analysis of the potential links between migration and the well-being of migration-affected households has been challenging due to lack of (child/migration-specified) data, nationally-representative household data collected in the course of the project "the Effects of Migration on Children and the Elderly Left Behind in Moldova and Georgia[9]" has enabled detailed, in-depth analysis of various aspects of child well-being and their links to household-member migration. In Moldova 3,571 households were surveyed between September 2011 and March 2012. In Georgia 4,010 households were surveyed between March and December 2012. Given the project's focus on specific subset of the population (children and the elderly), a high number of households in both countries contained either children or the elderly: in Moldova 1,983 households contained one or more children under the age of 18, while in Georgia the sample of households with children included 2,394 households. As the project explicitly focused on children, the survey was designed to retain the child as the unit of analysis, collecting detailed data on the conditions in which children live in both countries. In both countries all regions were sampled, excepting the breakaway territory of Transnistria in Moldova and the *de facto* independent regions of Abkhazia and South Ossetia in Georgia. While the survey collected information on all children in the household aged zero to 18, the present analysis focuses on children aged 5-17, for whom the most complete data are available[10]. Table 1 below provides an overview of characteristics of households used in the present analysis containing at least one child aged 5-17, split by household migration status to provide initial descriptive differences.

[9]More information on the project and its outputs is available at the University of Maastricht Graduate School of Governance website at: http://mgsog.merit.unu.edu/research/moldova_georgia.php.

[10]Note that throughout the analysis, sample numbers vary due to missing data for particular indicators or variables

Table 1: Characteristics of Household Containing One or More Children Aged 5-17

	Moldova		Georgia	
	Migrant11 HH	Non-migrant [11]HH	Migrant HH	Non-migrant HH
Total unweighted[12] sample	516 (39.5%)	789 (60.5%)	821 (51.4%)	776 (48.6%)
Total weighted sample	33.5%	66.5%	17.6%	82.4%
Total child sample (# of individuals)	735	1,206	1,135	1,164
Average HH size	4.6	4.4	4.9	4.6
Average HH dependency ratio	1.06	1.04	0.96	1.12
Average nº people employed in the HH	0.5	1.2	0.51	0.86

Source: Authors' calculation based on migration survey. Note: dependency ratio is calculated as the ratio of children and elderly in the household to the number of working-age adults; all results represent sample averages unless indicated otherwise.

Descriptively the two survey samples differ from one another in several ways. The sample collected in Georgia is larger than that collected in Moldova, and while the Georgian sample featured a larger number of households containing a migrant absent at the time of the survey, such households actually represent a smaller proportion of the total population in Georgia than in Moldova. Reflecting the larger sample size, the total number of children included in the sample is larger in Georgia than in Moldova, and a nearly equal number live in migrant- as non-migrant households. The differences between households in each country extend to migration-related characteristics as well. Table 2 shows key characteristics of migrants as well as the relationship with the children left behind.

Table 2: Key personal and demographic characteristics of migrants, weighted to represent total population

	Moldova	Georgia
Gender		
Male	509 (59.5%)	902 (46.3%)
Female	346 (40.5%)	1045 (53.7%)
Average age	35	41
Most prevalent level of education	Lower secondary	Incomplete tertiary
% Holding a residence permit	64%	67%
% HH receiving remittances	40.6%	60.5%

Source: Authors' calculation based on migration survey.

[11]Within the survey a migrant was defined as any person who had been absent for three or months at the time of the survey. A household was classified as a migrant household of it contained a migrant. Households with a returned migrant (someone who had lived abroad for three or months but who had since returned for residence) were dropped from the sample to enable clearer comparison between current- and non-migrant households

[12]Unweighted numbers reflect the actual number and proportion of households with a given characteristic in the survey sample; the weighted sample reflects the proportion of households sharing a given characteristics when proportional weights are applied, providing a sense of the proportional distribution of a characteristic across the whole country (as based on the distribution within the survey sample).

The selectivity of migrants also differs between the two countries: in Moldova almost 60 percent of migrants were male, while in Georgia a larger proportion of migrants were female (53.7 percent). Georgian migrants also tended to be slightly older than migrants in Moldova and to have a slightly higher level of education: while the average migrant in Moldova had attained lower secondary education, Georgian migrants achieved, on average, a secondary degree and had incomplete tertiary education. Within households with a current migrant, a larger portion in Moldova than in Georgia featured an absent father of children in the household, while in Georgia a larger proportion of absent migrants were non-parents of children in the household. Almost 20 percent more households in Georgia than Moldova received remittances from an absent migrant, which likely reflects differences in migration patterns such as degree of circularity, duration of migration, etc.

These initial descriptive differences may suggest that the experiences of children "left behind" differ between the two countries. The different migration histories, trajectories, and selectivity are just a few of the factors that would likely influence how children in post-migration households are affected by the migration experience.

A. Indicators

To analyse multidimensional well-being rates, it is necessary to construct a child-specific well-being index comprised of different dimensions of well-being. Based on the definition of child well-being adopted for this analysis, six dimensions of child well-being are included: education, health, material living standards, protection, communication, and emotional well-being. The current analysis has the advantage of being able to draw from measurement tools expressly designed for the particular population of interest (children). The survey was designed to retain the child as the unit of analysis, thus while some household-level indicators such as income and assets are included, many of the indicators chosen reflect the unique situation of children in Moldova and Georgia. Table 3 contains the list of dimensions and indicators chosen for measurement of children well-being.

Table 3: Well-being indicators per dimension

EDUCATION
Child attends school at an appropriate grade
HEALTH
Child has received all vaccinations
MATERIAL WELL-BEING
Child is living in non-poor household
COMMUNICATION
Child lives in a household with a cell phone
PROTECTION
Child is not abused
EMOTIONAL WELL-BEING
Child attains a normal score on the Strengths & Difficulties Questionnaire

The educational well-being dimension is measured by school enrolment; **f**or children aged five and six, school enrolment is measured by pre-school attendance, as in both Georgia and Moldova compulsory education starts at the age of seven. Physical health is measured by a child's receipt

of the full regime of required vaccinations. This provides an objective instrument of health standard that is comparable between the two countries. Material living standards are measured using average household expenditures per adult equivalent. Children living in households with average expenditures below 60 percent of the median are considered to be deprived. The dimension of protection is measured by whether a caregiver reports repeatedly beating a child as punishment, defined here as child abuse. Communication well-being is measured by access to a modern source of communication, in this case a mobile phone. While this indicator is measured on the household level, it can be expected that children living in households with technologies that facilitate communication will benefit individually from the greater level of connectedness. Finally, emotional well-being is measured for children aged five to 17 by the total difficulties score of the Strength and Difficulties Questionnaire (SDQ), a behavioural screening instrument that uses 25 questions on psychological attributes to identify potential cases of mental health disorder (Goodman, 1997).

B. Methodology

Child well-being was calculated in two steps. First, well-being with respect to each indicator was analysed separately. A child is considered not deprived if s/he meets the established well-being threshold set for a given indicator. Indicator well-being rates *(IWB)* are calculated by counting the number of children who meet the requirement, expressed as a share of all children (Roelen et al., 2011; Roelen & Gassmann, 2012):

$$IWB_x = \frac{1}{n}\sum_{i=1}^{n} I_{ix}$$

where n is the number of children for which the indicator is observable and *Iix* is a binary variable taking the value 1 if the child *i* has reached the threshold and 0 if the child has not with respect to indicator *x*. The denominator, *n*, differs across indicators depending on the number of actual observations. Indicators observed at household level, such as for monetary well-being, are translated to all children living in the respective household, assuming equal access and intra-household distribution.

A second step involved building a multidimensional well-being index inspired by the Alkire and Foster (2011) methodology for the measurement of multidimensional poverty. A child is considered to be multidimensionally well if the weighted combination of dimensions is equal to or exceeds 70 per cent of the total, which means in the present case that a child has to do well in at least four out of six indicators to be considered well off. Each domain is assigned equal weight, which facilitates the interpretation of results (Atkinson et al. 2002) but also asserts that each dimension is considered of equal importance. The decision to set the cut-off at 70 per cent of the aggregated indicators follows the cut-off used for multidimensional child well-being indices (Roelen & Gassmann, 2012; Gassmann et al., forthcoming).

The analysis is further expanded to analyse whether child well-being differs according to who migrated within the household. Multivariate analysis is subsequently applied to control and identify other correlates that determine child well-being, such as personal characteristics of the child and regional or household characteristics. Separate binary outcome models are estimated for selected indicators using standard probit models:

$$\Pr(y_i = 1 \mid x_i) = \Phi(x_i\beta), \qquad \text{with i = 1, ... , N}$$

where *yi* is the binary outcome variable, *Φ* is the standard normal distribution function, ***xi*** is a vector of explanatory variables, and ***β*** is a vector of coefficients to be estimated. In this case the dependent variable is the probability that an individual is vulnerable with respect to a specific

indicator. In order to assess whether the effect of migration is significantly different between countries, models for each country are estimated separately, and a Wald chi square test is performed to establish if the coefficients indicating migration significantly differ from each. The formula for this statistic can be written as follows:

$$\frac{(b_M - b_G)^2}{[se\ (b_M)]^2 + [se\ (b_G)]^2}$$

Where is the coefficient for Moldova and is the coefficient for Georgia[13]. Differences in the migration coefficients may not always indicate true differences in causal effects, however, if the two models differ in the degree of residual variation (or unobserved heterogeneity). If this is the case, the test would report a misleading result, as the differences in the migration coefficient would be driven by other unobserved correlates that are not included in the model. To correct for potential deviation in residual variation, ordinal generalized linear models (oglm) in Stata are used that estimate heterogeneous choice models that allow for heteroskedasticity for the specified variables (in this case, the country)[14].

The following section describes the results of the multidimensional index. Descriptive statistics for indicator and multidimensional well-being are presented, testing for group differences both within and between countries. On the basis of bivariate analysis, differences in child well-being rates between migrant and non-migrant households are revealed, and the analysis also reveals differences in domain well-being rates between Moldova and Georgia. Results of the bivariate analysis are followed by the outcomes of the multivariate analysis, which assess the effects of migration when taking into account other variables that can help to predict child well-being.

VI. Results

Table 4 below provides an overview of well-being rates achieved by children in each study country for each indicator and for the total multidimensional well-being index. Well-being rates are expressed for children in migrant and non-migrant households, and differences in outcomes between children in Moldova and Georgia are indicated at the bottom. In Moldova achieved rates of well-being ranged from a low of 57 percent in the domain of material well-being to a high of 96.2 percent within the protection domain. On the total index level, over 77 percent of children can be considered well, which reflects the overall high level of child well-being across the six dimensions. Children in Georgia expressed a similar level of well-being, with over 80 percent considered well on the total index level. Across the different dimensions, children in Georgia achieved the worst outcomes in the domain of physical health, with only 66 percent of children considered well, and the best outcomes in the domain of protection, where 94 percent were considered well.

When looking at the distribution of well-being outcomes across household migration types, surprisingly few significant differences appear. In Moldova significant differences between children of different household types can be observed only in the dimension of education, where children in migrant households achieved lower well-being rates. In Georgia children in migrant households were better off in the single dimensions of education, health, and communication, as well as in the overall multidimensional index, compared to their peers in non-migrant households.

[13]Taken from Allison (1999).

[14]For more information on these tests, see Williams (2009) and Allison (1999).

Based on the bivariate analysis, one may be led conclude that migration is an important factor that explains differences in child well-being rates in Georgia to a much greater extent than in Moldova. One potential explanation for this differential impact is that more migrant households in Georgia than in Moldova receive remittances, which are one of the easiest-to-identify ways in which migrants contribute to household well-being. Increased household income coupled with the transmission of knowledge from a migrant abroad have been linked to better nutrition, increased access to consumption items (food, housing rental, clothing, etc.), and increased human capital investment through education (UNDP, 2009). Given differences in migrant selectivity between the two countries, it could also be suggested that the relatively higher level of education of Georgian migrants as well as the lower rate of parental migration may lead to more positive impacts of migration on child well- being.

Across all of the dimensions of well-being, only two—education and emotional well-being—were not significantly different between the two countries. Children in Georgia appeared to attain higher levels of wellness in the domains of material well-being and communication as well as in the total index, while children in Moldova appeared to attain better well-being outcomes in the domains of physical health and protection. To a certain extent these differences reflect larger contextual features of each country. In the 2012 Human Development Index, for example, Moldova ranked 113 and Georgia 72 of 186 countries

Table 4: Domain and multidimensional well-being rates

MOLDOVA	Education		Health		Material		Protection		Communication		Emotional		MWI	
	N	%	N	%	N	%	N	%	n	%	n	%	N	%
Migrant	681	89.2	735	82.6	735	53.9	684	97.2	735	87.4	604	89.6	565	78.7
Non migrant	1136	92.2	1206	80.9	1206	58.4	1113	95.8	1206	85.9	1002	89.4	944	76.8
Total	1817	91.3	1941	81.5	1941	57	1797	96.2	1941	86.4	1606	89.4	1509	77.4
Sig		*												
GEORGIA														
Migrant	1063	94.9	1135	70.3	1135	69.5	967	94.9	1135	96.4	873	91.8	824	86.8
Non migrant	1110	91.5	1164	65.2	1164	67	1068	93.9	1164	91.5	933	90.6	897	79
Total	2173	92	2299	66	2299	67.4	2035	94	2299	92.3	1806	90.8	1721	80.2
Sig		**		**						***				***
Differences between countries in each domain[15]			***		***		**		***					*

*Source: authors' calculations based on migration survey. Note: *** p<0.01; ** p<0.05; * p<0.1 significance levels based on chi2 test of independence*

These rankings reflect underlying differences in income standards: while the average GDP per capita was US $2,975 (2005 ppp) in Moldova in 2011, the average was US $4,826 (2005 ppp) in Georgia. At the same time a higher proportion of people in Georgia than in Moldova lived below both the $1.25 per day poverty line (15.3 percent versus .4 percent) and the respective national poverty lines (24.7 percent versus 21.9 percent)[16] (UNDP, 2013). These trends likely suggest that while the average Moldovan family has fewer financial resources to invest in children, families in Georgia face higher levels of income inequality that may be reflected in migrant selection trends.

[15]T-test were calculated to assess whether total domain well being were significantly different between countries.

[16]Estimated according to surveys conducted in 2005 (UNDP, 2013).

To determine the extent to which the migration of a household member affects child well-being when taking into account other relevant covariates, multivariate analysis utilising probit models are more appropriate. In addition to the migration status of the household, other explanatory variables were included that may partially explain indicator well-being outcomes. These include personal characteristics of the child (such as age, sex, or caregiver) and household characteristics like household size, rural/urban locale, number of children, number of adults, and highest level of education attained in the household. Table 5 shows the results of these models. The reduced model contains only the variable for household migrant status, whereas the extended model contains the above-mentioned control variables. Given the focus of the analysis of the role of migration, however, the marginal effects and significance levels of other covariates are not displayed here but can be found in tables 1 and 2 in the annex.

The table displays how the addition of covariates changes the magnitude and significance of the migration variable, and it also confirms some of the results of the bivariate analysis. Based on the multivariate analysis, migration appears to have a more significant effect on the well-being of children in Georgia than in Moldova. While in Georgia children in migrant households are more likely to attain well-being in physical health, communication, and on total index level than children in non-migrant households, in Moldova migration does not appear to correspond to any positive well-being outcomes. Contrary to the bivariate analysis, in both countries migration was linked to lower material well-being rates, which may be at least partially attributed to sample attrition. The negative impact of migration on material living standards in both Moldova and Georgia may also be explained by migrant selectivity. If migration is undertaken in desperation, as a means of providing income to the household in the absence of other employment options, migration would not be expected to correspond to positive material well-being outcomes.

Table 5: Marginal effect of migration status as a determinant of well-being

Dimension	Reduced model			Extended model		
	Moldova	Georgia	Testa	Moldova	Georgia	Test
Education	-0.02	0.03	*	0.00	-0.01	
	(0.02)	(0.02)		(0.02)	(0.02)	
Health	-0.01	0.09**	**	-0.03	0.11*	**
	(0.02)	(0.03)		(0.03)	(0.04)	
Material	-0.03	-0.03	**	-0.18**	-0.16**	
	(0.03)	(0.03)		(0.04)	(0.04)	
Communication	0.02	0.06**	+	0.04	0.08*	*
	(0.02)	(0.02)		(0.02)	(0.03)	
Emotional	0.00	0.01		-0.01	0.01	
	(0.02)	(0.02)		(0.03)	(0.02)	
Protection	0.01	0.01		0.02	0.01	
	(0.01)	(0.02)		(0.02)	(0.02)	
MWI	0.06	0.09***	*	0.05	0.12**	
	(0.08)	(0.03)		(0.03)	(0.04)	
Nº Observations	1509	1721		1499	1715	

Source: authors' calculations based on migration survey. Reported results are average marginal effects (dx/dy) for children living in migrant households. Robust standard errors in parentheses; +p<0.1; * p<0.05; ** p<0.01. Full model in annex. a Differences between countries in the migration coefficient are significant at a +10% level, *5% level, and **1%level based on Wald chi square test (corrected for unequal residual variation or unobserved heterogeneity).

In terms of other correlates that affect child well-being (see tables 1 and 2 in appendix), variables like education, household living area, and child age are important determinants of child well-being in both Moldova and Georgia. Who the caregiver is appears to be significant in the dimensions of protection, communication, and material living standards in both countries as well: in Moldova, having a non-parent relative as a caregiver (as compared to a mother) increases the likelihood of belonging to a non-poor household, whereas in Georgia, having a father caregiver decreases the likelihood of being well-off in this dimension. Having an other relative as a caregiver is positively associated with protection, but negatively associated with communication in both countries. Moreover, while the sex of the child does not appear to have a significant effect on well-being in Georgia, in Moldova being female increases the chances of not being abused and achieving emotional well-being. Number of siblings is also more important in Moldova for determining well-being, as a higher number of co-resident children corresponds to decreased chances of attaining material, emotional, educational well-being. In Georgia, this variable only affects material living standards and has, as expected, a negative influence.

VII. Conclusion

Using novel household survey data collected on migrant- and non-migrant households in Moldova and Georgia, the presented analysis has provided one of the first attempts to measure the effects of migration on holistic child well-being in a cross-country, comparative context. By constructing a multidimensional well-being index comprised of six dimensions and comparing the outcomes of children in current- and non-migrant households, several potential implications of migration for the well-being of the "left behind" have been uncovered.

Despite the growing discussion on the potential benefits or costs of migration, particularly for the "left behind", the current study has found a limited impact of household migration status on different domains of well-being. Based on bivariate analysis, household migration status appeared to influence child well-being in Moldova in only one dimension, education, where children in migrant households were found to achieve slightly lower rates of well-being than children in non-migrant households. Household migration status was found to be insignificant once additional confounding variables were included in the multivariate probit model, suggesting that the observed effects could be attributed to other factors such as highest level of education in the household or caregiver type. Children in migrant households in Georgia achieved higher rates of well-being than children in non-migrant households in the domains of education, physical health, communication, and the total multidimensional well-being index. In the multivariate analysis migration status was no longer found to influence education but was still found to increase the likelihood of a child attaining well-being in the other domains. While in the bivariate analysis migration status did not contribute to significant differences in material living standards, the results of the probit model suggest that having a household member in migration corresponds to a lower probability of attaining well-being in this dimension.

Two important observations should be made about these outcomes. The first is that if migration is found to have any statistically significant effect on child well-being, it is generally positive and relatively low in magnitude: in the extended multivariate probit model, children in migrant households were found to have higher chances of attaining well-being in the significant dimensions by between eight and 12 percentage points. It is interesting to note the relatively higher magnitude of the effect of migration on material well-being, however, where children in migrant households had a lower chance of attaining well-being in this domain by 18 percentage points in Moldova and 16 in Georgia. This could suggest that the products of the migration

episode itself are difficult to disentangle from the process by which individuals are selected into migration, as many of the characteristics that may promote an individual into migration (such as low household incomes or expenditures, unemployment, or education level, for example) will also influence child well-being outcomes. The second observation is that migration appears to behave as a very different agent in Moldova and Georgia. While migration was seen to have limited effect on the well-being of children in Moldova, it seemed to bear more consequences for children in Georgia. Given the very different migration trajectories, mobility patterns, and levels of maturity of both migration streams, this is an unsurprising conclusion. What is surprising, however, is the limited role of migration in Moldova, where a great deal of research has focused on the dire consequences of migration for the "left behind".

VIII. References

Acosta, P., P. Fajnzylber, and J.H. Lopez (2007). "The Impact of Remittances on Poverty and Human Capital: Evidence from Latin American Household Surveys." World Bank Policy Research Working Paper 4247.

Alkire, S. (2002). "Dimensions of Human Development". *World Development* 30(2): 181-205.

Alkire, S. & J. Foster (2011). "Counting and Multidimensional Poverty Measurement." *Journal of Public Economics* 95: 476-497.

Allison, Paul D (1999) "Comparing logit and probit coefficients across groups". *Sociological Methods & Research* 28 (2):186-208.

Ben-Arieh, A. (2000). "Beyond Welfare: Measuring and Monitoring the State of Children—New Trends and Domains." *Social Indicator's Research* 52: 235-257.

Bradshaw, J., P. Hoelscher, and D. Richardson (2007). "An Index of Child Well-Being in the European Union." *Social Indicators Research* 80: 133-177.

Brooks-Gunn, J., and G. Duncan (1997). "The Effects of Poverty on Children." *The Future of Childre, 7*(2): 55-71.

Caucasus Research Resource Centres (CRRC) Georgia, 2007. "Migration and Return in Georgia: Trends, Assessments, and Potential". Project reported submitted to the Danish Refugee Council within the project "Toward Durable Reintegration Mechanisms in Georgia."

Centre of Sociological, Politological, and Psychological Analysis and Investigations (CIVIS) and International Agency for Source Country Information (IASCI) (2010). "Strengthening the Link Between Migration and Development in Moldova." Report prepared for the World Bank within the Migration and Remittance Peer-Assisted Leanring Network (MIRPAL) initiative.

Cortés, R. (2007). "Children and Women Left Behind in Labour-Sending Countries: An Appraisal of Social Risks." *United Nations Children's Fund Working Paper*. United Nations: New York.

Edillon, R.G. (2008). "The Effects of Parent's Migration on the Rights of Children Left Behind." *Asia Pacific Policy Center working paper.* United Nations Children's Fund.

(de la) Garza, R. (2010). "Migration, Development, and Children Left Behind: A Multidimensional Approach." *UNICEF Social and Economic Policy Working Paper*. United Nations Children's Fund, Division of Policy and Practice: New York.

Giannelli, G.C. and Mangiavacchi, L. (2010). "Children's Schooling and Parental Migration: Empirical Evidence of the 'Left Behind' Generation in Albania." Institute for the Study of Labour Discussion Paper No. 4888 (van de) Glind, H. (2010). "Migration and Child Labour: Exploring Child Migrant Vulnerabilities and Those of Children Left Behind." International Labour Organisation: International Labour Office, International Programme on the Elimination of Child Labour (IPEC) working paper. ILO: Geneva.

Gordon, D., S. Nandy, C. Pantazis, S. Pemberton, and P. Townsend (2003). *Child Poverty in the Developing World*. The Policy Press: Bristol.

Graham, E. and L.P. Jordan (2011). "Migrant Parents and the Psychological Well-Being of Left-Behind Children in Southeast Asia." *Journal of Marriage and Family* **73**: 763-787.

Hildebrandt, N., D.J. McKenzie, G. Esquivel, and E. Schargrodsky (2005). "The Effects of Migration on Child Health in Mexico." *Economía* 6(1): 257-289.

Hofmann, E.T. and C.J. Buckley (2011). "Cultural Responses to Changing Gender Patterns of Migration in Georgia." *International Migration* 50(5): 77-94.

International Monetary Fund (2006). "Republic of Moldova: Poverty Reduction Strategy Annual Evaluation Report 2005." IMF Country Report No. 06/185. IMF: Washington, D.C.

International Organisation for Migration (IOM), 2009. "Testing New Channels and Products to Maximise the Development Impact of Remittances for the Rural Poor in Georgia: Tianeti Household Census 2008 & Tianeti Emigrants to Greece 2008 Fieldwork Report". IOM: Georgia.

Kandel, W. (2003). "The Impact of U.S. Migration on Mexican Children's Educational Attainment." In M. Cosio, R. Marcoux, M. Pilon, and A.Quesnel (eds.), *Education, Family and Population Dynamics*. Paris: CICRED.

Kandel, W. and G. Kao (2001). "The Impact of Temporary Labor Migration on Mexican Children's Educational Aspirations and Performance." *International Migration Review* 35(4): 1205-1231.

Land, K.C., V.L. Lamb, and S.K. Mustillo (2001). "Child and Youth Well-Being in the United States, 1975-1998: Some Findings from a New Index." *Social Indicators Research* 56(3): 241-320.

Levitt, P. (1998). "Social Remittances: Migration Driven Local-Level Forms of Cultural Diffusion." *International Migration Review* 32(4): 926-948.

Massey. D.S., J. Arango, G. Hugo, A. Kouaouci, A. Pellegrino, and J.E. Taylor (1993). "Theories of International Migration: A Review and Appraisal." *Population and Development Review* 19 (3): 431-466.

Mansuri, G. (2006). "Migration, School Attainment, and Child Labor: Evidence from Rural Pakistan." World Bank Policy Research Working Paper No. 3945.

McKenzie, D.J. (2007). *Beyond Remittances: The Effects of Migration on Mexican Households*, in Ç. Özden and M. Schiff (eds.), International Migration, Remittances, and the Brain Drain. Palgrave Macmillan: New York.

Minujin, A., E. Delamonica, A. Davidziuk, and E. Gonzalez (2006). "The Definition of Child Poverty: a Discussion of Concepts and Measurements." *Environment and Urbanisation* 18(2): 481-500.

Moran-Taylor, M.J. (2008). "When Mothers and Fathers Migrate North: Caretakers, Children, and Child Rearing in Guatemala." *Latin American Perspectives* 35: 79-95.

(de) Neubourg, C., J. Chai, M. de Milliano, I. Plavgo, and Z. Wei (2012). "Step-by-Step Guidelines to the Multiple Overlapping Deprivation Analysis (MODA)". United Nations Children's Fund, Office of Research working paper WP-2012-10.

Pantiru, M.C., R. Black, and R. Sabates-Wheeler (2007). "Migration and Poverty Reduction in Moldova." University of Sussex, Development Research Centre on Migration, Globalisation, and Poverty Working Paper C10.

Ratha, D., Mohapatra, S. and Silwal, A. (2010). *Migration and Remittances Factbook 2011*. World Bank.

Robeyns, I. (2005). "The Capability Approach: A Theoretical Survey." *Journal of Human Development and Capabilities* 6(1): 93-117.

Roelen, K. (2010). *False Positives or Hidden Dimensions?: the Definition and Measurement of Child Poverty*. Dissertation, Maastricht University.

Roelen, K., and F. Gassmann (2009). "Equal Opportunities for All Children in Vietnam: Assessing the Distribution of Child Poverty from a Monetary and Multidimensional Perspective". *Journal of Income Distribution* 18(3-4): 206-231.

Roelen, K., F. Gassmann, and C. de Neubourg (2009). "The Importance of Choice and Definition for the Measurement of Child Poverty—the Case of Vietnam." *Child Indicators Research* 2: 245-263.

Salah, M.A. (2008). "The Impacts of Migration on Children in Moldova." *United Nations Children's Fund Working Paper*. United Nations Children's Fund, Division of Policy and Practise: New York.

Stark, O. and D.E. Bloom (1985). "The New Economics of Labour Migration." *American Economic Review* 75: 173-178.

Taylor, J.E. (1999). "The New Economics of Labour Migration and the Role of Remittances in the Migration Process." *International Migration* 37(1): 63-88.

United Nation Children's Fund (2009). *The State of the World's Children, Special Edition: Celebrating 20 Years of the Convention on the Rights of the Child*.

United Nations Development Program (2009). Human Development Report 2009: Overcoming Barriers - Human Mobility and Development. United Nations Press: Tokyo.

United Nations Development Program (2013). Human Development Report 2013: The Rise of the South—Human Progress in a Diverse World. United Nations Development Program: New York.

Waddington, H. (2004). "Linking Economic Policy to Childhood Poverty: a Review of the Evidence on Growth, Trade Reform and Macroeconomic Policy." CHIP Report No. 7. CHIP.

Williams, Richard (2009) "Using heterogeneous choice models to compare logit and probit coefficients across groups". *Sociological Methods & Research 37 (4):531*-559

White, H., J. Leavy, and A. Masters (2003). "Comparative Perspectives on Child Poverty: A Review of Poverty Measures." *Journal of Human Development* 4(3): 379-396.

Yang, D. (2008). "International Migration, Remittances and Household Investment: Evidence from Philippine Migrants' Exchange Rate Shocks." *The Economic Journal* 118**:** 591-630.

IX. Appendix

Table 1: Determinants of dimension well-being in Georgia. Full model

	education	Health	material	Communication	Emotional	protection
Migrant household	-0.01	0.10*	-0.16**	0.08*	0.01	0.00
	(0.02)	(0.04)	(0.04)	(0.03)	(0.02)	(0.02)
Male	-0.02	-0.02	0.05+	-0.01	-0.03+	-0.01
	(0.01)	(0.03)	(0.03)	(0.01)	(0.02)	(0.01)
Caregiver (ref category: mother)						
Father	0.00	-0.09	-0.17*	0.06	-0.02	-0.00
	(0.05)	(0.06)	(0.07)	(0.04)	(0.04)	(0.04)
Other relative	0.03	-0.07	-0.01	-0.05*	-0.03	0.06*
	(0.03)	(0.04)	(0.05)	(0.02)	(0.03)	(0.03)
Age	0.13**	0.02	0.01	-0.03*	-0.02	-0.01
	(0.01)	(0.02)	(0.03)	(0.01)	(0.02)	(0.01)
Age2	-0.01**	-0.00	-0.00	0.00*	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
Urban	-0.00	-0.11**	0.09**	0.07**	0.00	-0.02
	(0.02)	(0.03)	(0.03)	(0.02)	(0.02)	(0.01)
Highest level of education in the household (ref category: higher education)						
upper secondary	-0.05	-0.38**	-0.06	-0.11**	-0.19**	-0.08*
	(0.04)	(0.08)	(0.09)	(0.04)	(0.04)	(0.03)
post secondary	-0.05**	0.03	-0.14**	-0.05**	-0.02	-0.03+
	(0.02)	(0.04)	(0.04)	(0.02)	(0.02)	(0.02)
Nº siblings	0.01	0.03+	-0.05*	0.00	-0.01	0.01
	(0.01)	(0.02)	(0.02)	(0.01)	(0.01)	(0.01)
Nº adults	0.00	0.02*	0.00	0.01	0.01+	0.00
	(0.00)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Mig*remittances	0.03	0.03	0.33**	-0.03	0.02	-0.01
	(0.03)	(0.05)	(0.04)	(0.03)	(0.02)	(0.02)
Poverty Status	0.02	-0.01		-0.03*	-0.02	-0.02
	(0.01)	(0.03)		(0.02)	(0.02)	(0.02)
Observations	1705	1705	1705	1705	1705	1705
F stat	6.5	6.2	8.8	6.3	3.1	4.6
Prob>F	0.00	0.00	0.00	0.00	0.00	0.00

Source: authors' calculations. Robust standard errors in italics; +p<0.1; * p<0.05; ** p<0.01.

Table 2: Determinants of dimension well-being in Moldova. Full model

	education	Health	material	Communication	Emotional	protection
Migrant household	0.00	-0.03	-0.18**	0.04	-0.01	0.02
	(0.02)	(0.03)	(0.04)	(0.02)	(0.03)	(0.02)
Male	-0.00	-0.02	-0.01	0.01	-0.04*	-0.03**
	(0.01)	(0.02)	(0.03)	(0.02)	(0.02)	(0.01)
Caregiver (ref category: mother)						
Father	-0.04	-0.02	0.05	0.05+	-0.01	-0.01
	(0.03)	(0.03)	(0.05)	(0.03)	(0.03)	(0.02)
Other relative	0.01	-0.04	0.10*	-0.05+	-0.00	0.04*
	(0.02)	(0.03)	(0.04)	(0.03)	(0.03)	(0.02)
Age	0.09**	0.06**	0.02	0.01	0.01	-0.03**
	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)	(0.01)
age2	-0.00**	-0.00**	-0.00	-0.00	-0.00	0.00**
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
Urban	-0.01	-0.08**	0.10*	0.22**	-0.01	0.04*
	(0.03)	(0.03)	(0.04)	(0.04)	(0.03)	(0.02)
Highest level of education in the household (ref category: higher education)						
lower secondary	-0.04+	-0.05+	-0.29**	-0.19**	-0.05+	-0.04**
	(0.02)	(0.03)	(0.04)	(0.03)	(0.03)	(0.01)
upper secondary	-0.02	-0.02	-0.23**	-0.11**	-0.03	0.04
	(0.02)	(0.03)	(0.05)	(0.03)	(0.03)	(0.02)
post secondary	-0.03	-0.02	-0.12**	-0.11**	0.01	0.01
	(0.02)	(0.03)	(0.04)	(0.03)	(0.03)	(0.01)
Nº siblings	-0.02*	-0.01	-0.09**	-0.00	-0.02**	-0.01+
	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)
Nº adults	-0.01+	0.00	0.01	0.00	-0.00	-0.00
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.00)
Mig*remittances	-0.03	0.03	0.31**	0.03	0.02	-0.03
	(0.02)	(0.03)	(0.04)	(0.03)	(0.03)	(0.02)
poverty status	-0.02	0.01		-0.06**	0.00	0.01
	(0.01)	(0.02)		(0.02)	(0.02)	(0.01)
Observations	1499	1499	1499	1499	1499	1499
F stat	9.0	2.9	13.3	10.6	1.8	5.8
Prob>F	0.00	0.00	0.00	0.00	0.03	0.00

Source: authors' calculations. Robust standard errors in italics; +p<0.1; * p<0.05; ** p<0.01.

Table 3: Determinants of multidimensional well-being

	MDI Moldova	MWI Georgia
Male	-0.04+	-0.03
	(0.02)	(0.02)
Caregiver (ref category: mother)		
Father	0.03	-0.04
	(0.04)	(0.05)
Other relative	-0.02	-0.07+
	(0.04)	(0.04)
Age	0.07**	0.05*
	(0.02)	(0.02)
Age2	-0.00**	-0.00+
	(0.00)	(0.00)
Urban	0.06	-0.01
	(0.04)	(0.02)
Highest level of education in the household (ref category: higher education)		
lower secondary	-0.16**	
	(0.03)	
upper secondary	-0.05	-0.29**
	(0.04)	(0.06)
post secondary	-0.06+	-0.05+
	(0.03)	(0.03)
Nº siblings	-0.04**	0.01
	(0.01)	(0.02)
Nº adults	0.00	0.03**
	(0.01)	(0.01)
Migrant household	0.05	0.12**
	(0.03)	(0.04)
Poverty status	-0.26**	-0.29**
	(0.02)	(0.02)
Mig*remittances	-0.02	-0.04
	(0.03)	(0.04)
Observations	1499	1705
F-stat	20.2	19.2
Prob>F	0.00	0.00

Source: authors' calculations. Robust standard errors in italics; +p<0.1; * p<0.05; ** p<0.01.

3 Enhancing Role of Family and Social Worker For Children with Disability

Dra. Rini Hartini Rinda Andayani, M.Pd
Sekolah Tinggi Kesejahteraan Sosial, Indonesia

Abstract

Children with disabilities are faced with several problems. The series begins with the obligation of children to be able to accept and adjust to their disabilities, as well as the reaction of the surrounding environment. Children with disabilities in developing countries are also faced with a lack of social services and education that can be accessed, especially disabled children from poor families. Another problem for the poor is the father of mother's education is generally low, leading to a lack of knowledge of their parents and families in the care of children with disabilities, so that children with disabilities are neglected and cannot develop optimally (Tillie Curran, 2008). Unfavorable conditions that have to be faced by children with disabilities are low social support from family and environment around children.

This research is aimed to know exactly how the physical characteristics of children with disabilities and their families in one of the rural areas in the border city of Bandung. How family social support in the form of child care and how to support the environment and its implications for the development of children with physical disabilities. Researchers also analyze and find the right model to improve social support and family environment for children with physical disabilities.The highlight literature is focused related to disability problems, social support, systems theory to see the various systems that affect the condition of children with disabilities, The concept of person in environment in social work, the concept of ecological perspective and role theory.

The research methodology was qualitative approach, this type of action research with the aim not only to conduct research, but also to solve problems encountered in the field. The research was conducted on eight physically disabled children (7-13 years old). Another informant was the child's family and community social worker. The characteristic of physically disabled children consist of disability, speech and hearing disabilities with few multiple disabilities. Children belonging to poor families with children the whole family incomes below the minimum wage of West Java Province. Low parents education mostly elementary and only 1 person could reach high school.

Action research is done by developing a model of increased parents social support and environment with the hope of a positive implication on the development of children with physical disabilities. The substance model contains parents' capacity building in the care of physically disabled children, as well as improving environmental understanding of disability problems.

The results showed after the implementation of the model, parents social support is increased and Implications for the child's development appears on several aspects of the development. On physical development especially activity daily living (ADL). 7 children have been able to perform ADL and only 1 child who has not been able to perform ADL independently.

On children's cognitive development, the changes quite significant. Children who previously have not reached the aspects of cognitive development, after the application of model 7 children are able to achieve these aspects of cognitive development for his age. On emotional development, seven children have been able to achieve some satisfying emotional development as capable of displaying a normal emotion, good and bad conscience development and have the motivation. At the end of the age of the child, the child has achieved self-acceptance and positive self-concept.On social development, only 6 children who experience positive change, 2 children are not able to achieve significant change. Failure to achieve the optimal development of the two children after the implementation of the model can be predicted due to two significant obstacles before. Previous children not in school and at home were not getting the proper stimulus for development, so the delay progress far enough. Time in action research has not been sufficient to keep pace with the developments before.

Significant changes to the development of children can be affected by various factors that have collaborated in the action research. The role of the social worker as facilitator and mediator in the application of the model is very important as a central figure who can provide guidance and psychosocial approaches that fit the characteristics of the target.

The results of this research have implications for government policies related to disability issues. That the problems of disabled children in poor families are not just a question of basic needs such as food, education and health. Psychosocial condition problems of parents of a disabled child are also needs serious attention. Disabled child development is strongly influenced by the care provided by his parents. It was also influenced by the parents' support and also environments that enable children with disabilities to participate.

Recommendations to the relevant government policies and programs that can be run to the public:

1. The need to develop psychosocial support program for families with children with disabilities.
2. The need to develop community-based programs so that related to the characteristics and needs of the community.
3. The need for synergy program between the various agencies involved, so that the government would like the program puzzle sequence complementary to help especially the poor families with disabled children.
4. The need to increase programs to raise awareness and public understanding of disability problems, the rights of children with disabilities and participation opportunities that can be provided by the community.

Recommendations for the practice of social work in community :

1. Conducting participatory assessment.
2. Perform the action plans agreed with the target group.
3. Social workers can also run role activity and to facilitate the implementation of the model :
    a. Evoking the spirit, motivation, stimulate and build commitment target group.

b. Build awareness their condition and beliefs to change for the better related to the development of their children.

c. Organizing the target and source systems can be invited to engage in the activity.

d. Using sources that are within the community itself, and social workers can build networking with government and non government agencies involved.

Keywords: Family Social Support, Social Workers and the Development of Child with Physical Disabilities.

LATAR BELAKANG

Anak dengan disabilitas (ADD) dihadapkan dengan berbagai permasalahan lain yang harus mereka hadapi. Rentetan persoalan diawali dengan keharusan anak untuk bisa menerima dan menyesuaikan diri terhadap kedisabilitasan, kemudian anak harus berhadapan dengan reaksi lingkungan sekitar yang tidak berpihak. Permasalahan fisik akibat disabilitas, masalah sosial psikologis menjadi masalah berat yang harus dihadapi ADD, terlebih lagi bila dukungan sosial dari keluarga dan lingkungan tidak diperoleh anak.

Pemenuhuhan kebutuhan dan perlindungan terhadap ADD sesungguhnya telah menjadi perhatian dunia. Konvensi Hak Anak (KHA) yang diratifikasi berbagai negara di dunia mencakup didalamnya adalah perlindungan dan jaminan bagi ADD, namun dalam pelaksanaannya belum maksimal terwujud. Wescott and Cross (1996) menjelaskan hasil penyelidikannya bahwa ADD banyak yang kurang beruntung kerana *abuse* dan *neglect* dibanding anak normal. Anak disabilitas perempuan mendapat kekerasan fisik maupun seksual (UN ESCAPE, 2010). Anak disabilitas kurang terwakili dalam sistem perlindungan anak (Morris, 1999). Anak disabilitas kesulitan menjangkau pendidikan (Escape Survey, 2004), dan hampir 90% anak disabilitas di negara berkembang tidak akses ke sekolah. (United Nations, 2006).

Masalah yang ditemukan di Indonesia juga tidak jauh berbeda, banyak ADD belum bisa mengakses sistem pendidikan. Menurut estimasi Ketua Umum Persatuan Penyandang Disabilitas Indonesia, hanya 10 % ADD yang akses ke sistem pendidikan. Data Susenas 2009 menunjukkan (43.87 %) anak disabilitas usia sekolah usia (7-17 tahun) belum pernah mengikuti pendidikan, sepertiganya (35.87 %) sedang sekolah dan sekitar 20.26 % berstatus tidak sekolah lagi.

Anak dengan disabilitas yang jumlahnya masih cukup besar di Indonesia, menurut hasil pendataan Direktorat Rehabilitasi Sosial Penyandang Cacat Kementerian Sosial (2009) di 24 propinsi, terdapat 65.727 anak, yang terdiri dari 78.412 anak dengan kedisabilitasan ringan**,** 74.603 anak dengan kedisabilitasan sedang dan 46.148 anak dengan kedisabilitasan berat.

Kajian Kementrian Sosial tahun 2008 menunjukkan sebagian besar ADD berada dalam keluarga miskin, yang faktanya menunjukkan mereka sulit mendapatkan hak dasarnya sebagai anak secara wajar dan memadai. Banyak situasi ADD pada keluarga miskin tidak terpenuhi kebutuhan nutrisi, tidak mendapatkan pengasuhan dan perawatan khusus sesuai dengan kedisabilitasannya dari orangtua/keluarga, kondisi khas karena berbagai keterbatasan kemampuan keluarga miskin. Orientasi orangtua lebih prioritas pada upaya untuk memenuhi kelangsungan hidup keluarga, dan mengabaikan keperluan anaknya yang disabilitas karena sumber dana yang terbatas. Tingkat pendidikan ibu bapa yang rendah, mengakibatkan ketidaktahuan ibu bapa tentang bagaimana mengasuh atau memberi stimulus yang tepat bagi perkembangan anaknya yang disabilitas. Kondisi lain ada ibu bapa secara sosial dan psikologis belum siap menerima anak denga disabilitas, bahkan ada ibu bapa menolak kehadiran anaknya disabilitas. (Harry Hikmat, 2010 ; Ho & Keiley, 2003; Sullivan, Bolyai et al.,2003). Stigma masyarakat terhadap anak disabilitas terkadang masih kuat pada kumpulan masyarakat ini, karena rendahnya pengetahuan dan faktor sosial budaya (Janene Byrne, 2002). Anak diisolasi didiskriminasi dalam pengasuhan dan tidak tersentuh oleh pelayanan sosial dasar, antara lain pelayanan kesehatan, pendidikan, pemukiman yang layak serta tidak memiliki alat bantu kecacatan.

Kondisi di atas menunjukkan dukungan sosial yang rendah diberikan oleh orang tua/keluarga dan masyarakat sebagai lingkungan terdekat anak. Rothman (2003) mengemukakan bahwa ibu bapa yang memiliki ADD sering dihadapkan dengan banyak keperluan, banyak masalah, karena kondisi disabilitas anaknya. Demikian pula dengan anggota keluarga yang lain seperti adik, kakak ataupun

kerabat tidak dapat menerima anggota keluarganya yang disabilitas, menampilkan sikap penolakan secara halus maupun terang terangan.

Bila dilihat dari aspek-aspek dukungan sosial seperti dukungan instrumental yang terwujud dalam pemenuhan keperluan fisik anak seperti makan, pakaian, tempat tinggal dan pemeliharaan kesehatan, juga penyediaan keuangan untuk anak. Kasus yang muncul terkadang ADD dinomor duakan. ADD dianggap tidak memberikan keuntungan, atau tidak dapat dikembangkan, sehingga keluarga lebih mengutamakan memenuhi keperluan anaknya yang normal.

Dukungan informasional yang berupa pemberian saran, nasihat, bimbingan dan petunjuk. Bentuk dukungan ini dalam kenyataannya dapat terhambat karena pengetahuan ibu bapa yang minim khususnya tentang masalah kedisabilitasan dan pengasuhan ADD. Demikian pula dengan dukungan emosional dan dukungan pada harga diri yang akan membuat anak merasa lebih nyaman, merasa dipedulikan dan dicintai. Bagi keluarga yang menolak atau tidak dapat menerima kedisabilitasan anaknya, dukungan emosional dan dukungan pada harga diri ini sangat kurang diterima anak, sehingga anak merasa tidak diperhatikan dan semakin terpuruk dengan kondisinya.

Aspek dukungan sosial yang lain seperti dukungan yang diperoleh individu karena adanya respon dan perhatian dari persekitarannya. Kenyataannya masih banyak anak disabilitas yang terpinggir, terasing dari interaksi sosial dan layanan sosial, Marchant (2001). Misalnya dalam aspek pendidikan beberapa hasil kajian menunjukkan bahwa akses anak disabilitas ke sistem pendidikan sangat rendah. Rendahnya akses terhadap pendidikan disebabkan karena pelbagai faktor, seperti minim nya ketersediaan sekolah khusus bagi ADD (Survey ILO, 2010). Sedangkan bila akses ke sekolah umum, anak mengalami hambatan psikologis, dan faktor ketidaksediaan sekolah menerima ADD.

Pada anak disabilitas fisik yang secara mental mereka sehat, kecuali pada disabilitas *cerebral palsy*, reaksi persekitaran dapat langsung dirasakan oleh anak. Penolakan, ejekan, cemoohan dari teman sebaya merupakan sebagian reaksi negatif yang harus dihadapi anak. Marchant (2001) mengemukakan bahwa ADD sering terpinggirkan dan terpisahkan dari komunitas dalam waktu bersenang-senang, pendidikan, dan kesempatan dibandingkan dengan yang dapat diperoleh oleh anak yang normal. ADD terpisah dari kumpulan sebayanya dalam komunitas (O'Loughlin, 2008). Kajian EveryChild (2001) menyatakan bahwa anak dengan kedisabilitasan sering berhadapan dengan stigma yang buruk dan pengucilan sosial.

ADD yang menghadapi berbagai macam persoalan membutuhkan dukungan yang kuat dari lingkungannya, terutama dari keluarga anak sebagai lingkungan terdekat. Pentingnya keluarga bagi anak disabilitas dikemukakan Somantri (2007), yaitu ibu bapa dan keluarga merupakan lingkungan pertama dan juga terdekat yang dapat menjadi sumber dukungan utama bagi ADD. Keluarga yang menerima keberadaan anak dengan kondisi disabilitasnya, beberapa kajian dan kertas kerja dalam jurnal ilmiah menunjukkan, bahwa ADD yang mendapat dukungan dari persekitarannya, tidak mengalami banyak masalah perilaku maupun masalah dalam penyesuaian sosialnya. Dukungan persekitaran merupakan sistem dukungan yang dapat mengurangi resiko depresi dan tekanan pada penyandang disabilitas fisik (Turner dan Noh, 1988).

Keadaan tersebut dapat difahami karena persekitaran sosial yang memberi dukungan kepada ADD memberikan suasana kondusif, bahwa anak merasa diterima dan dibantu, sehingga keadaan ini dapat memotivasi anak untuk beraktivitas dan berkarya.

Rendahnya akses kepada pendidikan, dukungan sosial yang minim dari keluarga dan persekitaran menjadi "potret buram" bagi anak disabilitas di Indonesia. Kondisi ini tidak boleh dibiarkan begitu

saja karena anak disabilitas memiliki hak yang sama dengan anak normal lainnya untuk mendapatkan kesempatan dan peluang tumbuh kembang yang optimal.

Profesi pekerjaan sosial yang memiliki fokus kepada peningkatan kefungsian sosial, dalam penelitian ini tertumpu kepada bagaimana meningkatkan kefungsian keluarga dan persekitaran anak dalam memberikan dukungan sosial, sehingga berimplikasi kepada perkembangan ADD. Dukungan sosial dari keluarga maupun persekitaran anak selaras dengan prinsip *person in environment or person in situation* (Charles H. Zastrow, 2004 ; Brenda DuBois, 2005). Bahwa pekerja sosial memandang ADD tidak boleh terlepas dari persekitarannya atau situasi yang dihadapinya. Peran pekerja sosial menjadi penting karena memiliki peluang besar untuk bekerja bersama keluarga dan masyarakat.

Penelitian ini dilakukan di wilayah pedesaan di daerah Kabupaten Bandung yang memiliki jumlah anak disabilitas yang cukup tinggi. Hasil pendataan Dinas Sosial Kependudukan dan Catatan Sipil Kabupaten Bandung tahun 2010, anak disabilitas 0 – 18 tahun berjumlah 1811 orang. Jenis kedisabilitasan anak bervariasi antara disabilitas fisik, disabilitas mental maupun disabilitas ganda. Penelitian ini fokus kepada ADD fisik tidak termasuk ADD mental, dengan tujuan agar mendapatkan informasi secara langsung dari anak.

Hasil asesmen ILO (2010), di Kabupaten Bandung menunjukkan layanan bagi ADD masih minim, termasuk layanan pendidikan yang jarang dan jaraknya jauh. Data Kabupaten Bandung, menunjukkan tingkat ekonomi penduduk sebagian besar pada tingkat sedang dan rendah, sehingga orientasi lebih kepada kelangsungan hidup keluarga. Hasil asesmen ke lapangan menunjukkan stigma masih ada sehingga masih banyak ibu bapa yang merasa malu memiliki ADD dan tidak mau bila anaknya keluar rumah.

Tipikal kondisi masyarakat seperti ini banyak diwilayah Indonesia lainnya, sehingga penelitian ini menjadi penting untuk memperoleh solusi tentang bagaimana meningkatkan dukungan dari keluarga dan lingkungan ADD, agar menjadi sistem dukungan yang memadai bagi perkembangan ADD. Indonesia dengan warisan budaya kegotong royongan juga menjadi kajian yang menarik. Bagaimana nilai budaya tersebut dapat dikembangkan sehingga persekitaran ADD dapat memberikan dukungan bagi anak untuk lebih berperan serta dan mengembangkan dirinya tanpa stigma dan penolakan.

Rumusan Masalah

Tujuan utama penelitian ini adalah untuk memperoleh penjelasan secara faktual tentang bagaimanakah dukungan sosial yang diberikan ibu bapa dan persekitaran anak, dapat mempengaruhi perkembangan anak disabilitas fisik. Berdasarkan tujuan tersebut, maka dirumuskan persoalan utama penelitian adalah bagaimana dukungan sosial dan implikasinya terhadap perkembangan anak disabilitas fisik, dirumuskan secara lebih terperinci ke dalam aspek sebagaimana berikut :

1. Bagaimanakah ciri anak disabilitas fisik dan keluarganya di Kabupaten Bandung ?
2. Bagaimana dukungan sosial yang diterima anak disabilitas fisik dari keluarga dan persekitaran sebelum dan selepas penerapan model ?
3. Bagaimana perkembangan anak disabilitas fisik di Kabupaten Bandung sebelum dan selepas penerapan model ?
4. Bagaimana model peningkatan dukungan sosial ibu bapa dan persekitaran, dalam meningkatkan perkembangan anak disabilitas fisik.

TINJAUAN LITERATUR

Kedisabilitasan / Disability

Anak disabilitas fisik adalah anak yang mengalami kelainan pada satu atau lebih organ tubuh tertentu, sehingga mengakibatkan gangguan pada fungsi tubuh. Akibat kelainan tersebut mereka mengalami hambatan dalam pergerakan tubuh (body movement), kemampuan melihat (visual ability), kemampuan mendengar (hearing) atau kemampuan bicara (speaking). (JICA, 2002). Kerusakan struktur dan fungsi saraf juga terjadi pada anak disabilitas fisik, seperti pada anak *cerebral palsy* (CP), namun berkaitan dengan keterbatasan penelitian, anak CP tidak menjadi fokus dalam penelitian ini.

Anak dan Perkembangan Anak

Merujuk pada Konvensi Hak-hak Anak United Nation Children's Found (UNICEF) dan disetujui oleh Majelis Umum PBB pada tanggal 20 November 1989 yaitu: "Anak adalah setiap orang yang berusia dibawah 18 tahun, kecuali berdasarkan undang-undang yang berlaku bagi anak, ditentukan bahwa usia dewasa dicapai lebih awal". Anak berhak atas kelangsungan hidup, tumbuh dan berkembang, berpartisipasi serta berhak atas perlindungan dari tindak kekerasan dan diskriminasi. (Undang-undang no 23, 2002). Perlindungan bagi anak tersebut juga ditujukan bagi anak disabilitas yang berhak untuk memperoleh kehidupan yang layak secara fisik, mental, spiritual dan sosial. Anak disabilitas diamanatkan untuk mendapatkan kemudahan-kemudahan atau aksesibilitas dalam memperoleh hak-haknya.

Perkembangan anak adalah sebagian dari perubahan yang dialami anak berkaitan dengan adanya perubahan yang bersifat kualitatif. (Van den Daele, 1969, ms. 114). Perkembangan bererti serangkaian perubahan progresif yang terjadi sebagai akibat dari proses kematangan dan pengalaman (Hurlock, 1997). Ada tiga kondisi yang mendorong perubahan dalam perkembangan anak. *Pertama,* perubahan dapat terjadi apabila individu memperoleh bantuan atau bimbingan untuk membuat perubahan. *Kedua*, perubahan cenderung terjadi apabila orang-orang yang dihargai memperlakukan individu dengan cara-cara yang baru atau berbeda. Kondisi *ke tiga,* apabila ada motivasi yang kuat dari pihak individu sendiri untuk membuat perubahan. (Hurlock, 1997). Fakta penting perubahan perkembangan di atas menunjukkan bahwa banyak hal yang harus diperhatikan agar perkembangan anak disabilitas fisik dapat mencapai hasil yang optimal.

Mengkaji fakta penting perkembangan yang telah diuraikan di atas, maka nampak bahwa perkembangan anak memerlukan dukungan dari lingkungannya. Konsep dukungan sosial dapat menjadi komponen penting untuk mendukung perkembangan anak.

Dukungan sosial

Dukungan sosial adalah derajat yang memenuhi keperluan dasar individu akan cinta dan kasih sayang, restu, rasa memiliki dan rasa aman, yang memberi kepuasan karena interaksi dengan orang lain (Troits dalam Rutter, et al., 1993 : 17). Dukungan sosial menjadi komponen penting bagi manusia, berkaitan dengan hakikat manusia sebagai mahluk sosial yang senantiasa memerlukan orang lain. Kondisi empirik menunjukkan bahwa ADD sangat memerlukan dukungan sosial dari keluarga maupun dari lingungannya. Masalah yang dihadapi oleh ADD adalah masih rendahnya dukungan sosial, terutama karena rendahnya pemahaman, pengetahuan, keterampilan dan kepedulian keluarga ADD.

Bentuk dukungan sosial dapat disinkronkan dengan jenis-jenis dukungan sosial yang dapat diterima seseorang dari orang lain atau dari lingkungannya. Sarafino (2001) membagi dukungan sosial dalam 5 bentuk, yaitu :

a. Dukungan instrumental (instrumental support)
   Dukungan instrumental berupa dukungan dalam bentuk materi yang dapat memberikan pertolongan langsung kepada individu yang membutuhkan, misalnya pemberian uang, pemberian barang, makanan dan bentuk materi lain.

b. Dukungan informasional (informational support)
   Bentuk Dukungan informasional merupakan pemberian informasi berupa saran, nasehat dan petunjuk tentang situasi dan kondisi yang dihadapi individu.

c. Dukungan emosional (emotional support)
   Dukungan emosional mewujud dalam perhatian, kehangatan relasi, dan refleksi kasih sayang lainnya, yang membuat individu merasa lebih nyaman, merasa yakin, merasa dipedulikan dan dicintai oleh sumber dukungan sosial.

d. Dukungan pada harga diri (esteem support)
   Bentuk dukungan ini berupa penghargaan positif terhadap individu, pemberian semangat, persetujuan pada pendapat individu, perbandingan positif dengan individu lainnya. Dukungan ini dapat membantu individu untuk membangun harga diri dan meningkatkan kompetensi.

e. Dukungan dari kelompok sosial (support from social group)
   Dukungan yang diperoleh individu kerana adanya respon dan perhatian dari lingkungan sekitarnya. Bentuk dukungan ini akan membuat individu merasa menjadi anggota dari suatu kelompok.

Pentingnya dukungan sosial dari lingkungan ADD, bisa dikaji dari teori sistem (system theory), bahwa anak ADD sebagai bagian dari sistem keluarga maupun kemasyarakatan, akan terpengaruh dan mempengaruhi secara timbal balik.

Teori Sistem

Sistem sendiri menurut Zastrow dan Kirst Ashman (2004 , ms. 4) *is a set of elements that orderly and interrelated to make a functional whole*. Teori sistem termasuk konsep yang menekankan interaksi dan hubungan antara berbagai variasi sistem, termasuk antara individu, keluarga, kelompok, organisasi dan masyarakat. Pendekatan teori sistem juga berkaitan dengan beberapa konsep dasar dari perspektif ekologi. Gabungan teori sistem dan perspektif ekologi bisa juga merujuk ke perspektif ekosistem. (Beckett & Johnson , 1995; Kirst Ashman, 2000 ; Charles H. Zastrow, 2004). Pandangannya bahwa individu selalu berada dalam interaksi dengan berbagai sistem dalam lingkungannya.

Mendukung keluarga merupakan jalan terbaik untuk membantu perkembangan anak secara sehat (Dubois, 2005). Kondisi tersebut bila kita memandang keluarga sebagai suatu sistem messo, yang akan berpengaruh terhadap sistem mikro yaitu anak disabilitas fisik dalam keluarga. Sifat suatu sistem bahwa elemen-elemen atau bagian-bagian sistem akan saling berinteraksi agar keseluruhan sistem dapat berfungsi.

Mengkaji teori sistem keluarga, bahwa keluarga yang tidak berfungsi menunjukkan akibat dari subsistem atau anggota keluarga itu sendiri. Oleh karena itu perbaikan kapasitas atau perbaikan peranan salah satu anggota keluarga dapat mempengaruhi anggota keluarga lainnya, memperkuat pengaruh positif dari sistem keluarga, sehingga keluarga sebagai suatu sistem dapat mencapai homeostatis.

Berdasarkan teori sistem, penelitian ini mengarah kepada *action research* untuk memperkuat dukungan keluarga, dan lingkungan anak sebagai sebuah sistem yang memiliki kemampuan untuk memberikan dukungan terbaik bagi perkembangan anak disabilitas. *Family support* dalam teori sistem adalah upaya untuk membuat perubahan fungsi keluarga. Menurut Newman, (2004) bahwa satu satunya cara guna membuat perubahan fungsi salah satu anggota keluarga adalah dengan mengubah fungsi dari anggota keluarga lain dalam sistem keluarga tersebut.

Berkaitan dengan teori sistem, pekerjaan sosial memahami anak bersama dalam konteks keluarganya. Keluarga sebagai lingkungan pertama dan utama bagi tumbuh kembang anak (Gerungan, 1987). Pekerjaan sosial juga memandang keluarga sebagai kerangka kerja untuk analisis, asesmen, dan intervensi dalam praktek pekerjaan sosial dengan anak. Prinsip ini dikenali dengan pendekatan "*person-in-environment* dan *person-in-situation*", dalam artian melihat klien selalu berada dalam pengaruh lingkungannya atau situasinya. (Charles H. Zastrow, 2004 ; Brenda DuBois, 2005).

Keluarga tinggal dalam komunitas lokal, dan menjadi subsistem dari sistem yang lebih besar yaitu masyarakat dikenal juga dengan sistem makro. Pengaruh lingkungan sosial akan terasa pula oleh anggota keluarga. Komunitas penting bagi anak dengan kedisabilitasan dalam dua hal, menurut Louise Hanvey (2002), yaitu *pertama* dapat mendukung anak disabilitas dan keluarganya rasa memiliki sebagai bagian dari anggota komunitas, merupakan jaringan dukungan sosial informal karena dapat berpartisipasi dalam kehidupan komunitas. *Kedua*, merupakan sumber dukungan seperti pengasuhan anak, pendidikan, dukungan layanan bagi anak disabilitas, pelayanan kesehatan dan rekreasi.

Perspektif teori sistem dilengkapi dengan perspektif ekologi, untuk praktek pekerjaan sosial secara umum (Zastrow, Kirst-Astman, 2004, ms. 7). Istilah ekologi berasal dari ilmu biologi, merujuk kepada interelasi antara kehidupan organisma dengan lingkungan biologi dan fisik mereka. Memindahkan prinsip-prinsip ekologi kepada relasi antara orang dengan lingkungan sosial mereka, ilmuwan sosial menekankan konteks lingkungan terhadap keberfungsian manusia dan relasi transaksional yang terjadi (Holahan, Wilcox, Spearly, & Campbell, 1979, DuBois, 2005).

Teori Ekologi

Perspektif ekologi memberikan suatu dasar untuk model kehidupan dalam pekerjaan sosial yang dikembangkan oleh Germain dan Gitterman (1996) (Germain *& Gitterman's life model*). Model ini menyarankan bahwa sifat dari transaksi antara orang dengan lingkungan mereka adalah sumber keperluan manusia dan masalah sosial. Lingkungan yang dimaksud adalah lingkungan fisik maupun sosial (DuBois, 2005). Tujuan pekerjaan sosial adalah untuk meningkatkan transaksi klien dengan lingkungan, sehingga memaksimalkan pertumbuhan dan perkembangan dengan memadukan kapasiti adaptif orang dengan lingkungannya.

Kemungkinan-kemungkinan adaptif dari anak disabilitas fisik terhadap lingkungannya, perlu mendapat dukungan yang optimal dari orang-orang dipersekitaran anak. Merujuk kepada bagaimana peranan dari orang-orang di sekitar anak yang berpengaruh terhadap anak.

Konsep Peranan

Peranan merujuk kepada karakteristik perilaku yang berkaitan dengan tugas karena posisi sosial seseorang. Peranan adalah pola aktivitas yang dipelajari atau ditampilkan oleh seseorang dalam interaksinya. (Turner, 1996, ms. 584). Peranan-peranan merupakan klasifikasi dari perilaku berkolaborasi dalam fungsi yang resiprokal diantara pasangan suatu relasi (role partner). Misalnya peranan pekerja sosial akan terkait dengan peranan klien.

Peranan ibu bapa merujuk pada apa yang perlu dilakukan oleh ibu bapa sesuai dengan harapan dari persekitarannya dan sesuai dengan norma-norma yang berlaku di masyarakat. Kondisi ini dinamakan *role complementarity* yaitu ketika perilaku dan harapan peranan seiring harmonis.

Kegagalan atau ketidaktercapaian *role complementaity* dapat disebabkan oleh beberapa hal menurut Turner (1996) dan kegagalan tersebut akan menyebabkan ketidaknyamanan dalam relasi dan interaksi serta menimbulkan stres individual. Kaitannya dengan pengasuhan ibu bapa terhadap anak disabilitas fisik, kegagalan atau ketidaktercapaian *role complementaity* juga bisa diakibatkan kerana kegagalan pelaksanaan peran yang menurut Turner (1986, ms. 586) bisa diakibatkan karena ; *parenting incapacity,* tidak terlaksananya peranan kerana kapasitas ibu bapa terbatas. *Role ambiguity,* tidak terlaksananya peranan kerana kebingunan pelaksanaan peranan. *Child incapacity or handicap,* tidak terlaksananya peranan kerana anak mengalami kedisabilitasan dan ibu bapa tidak memiliki kapasitas untuk pengasuhan.

Pengaruh peranan terhadap perkembangan anak dikemukakan oleh Newman (2006) bahwa ada beberapa dimensi yang dapat digunakan untuk menganalisis pengaruh peranan sosial dalam perkembangan anak yaitu : banyaknya orang yang memiliki tanggungjawab untuk melaksanakan peranan, intensitas pelaksanaan peranan, penguasaan peranan, jumlah permintaan daripada pelaksanaan peranan dan penyesuaian antara harapan peranan dengan kemampuan improvisasi.

Terpenuhinya harapan peranan yang menciptakan kenyamanan dalam relasi, mendukung terciptanya *attachment* yang baik antara ibu bapa dengan ADD. Kondisi ini sangat penting untuk memberikan stimulus yang positif bagi perkembangan ADD. *Attachment* atau hubungan yang lekat, harmonis antara ibu bapa dengan anak disabilitas fisik sehingga anak merasa dicintai, dihargai dan diperlukan, sesuai dengan aspek dukungan sosial emosional dan dukungan pada harga diri anak.

METODOLOGI

Penelitian ini menggunakan pendekatan kualitatif, jenis penelitian tindakan (action research) dipilih berdasarkan tujuan penelitian yaitu untuk menemukan model yang sesuai untuk meningkatkan perkembangan anak disabilitas melalui peningkatan dukungan keluarga dan lingkungan persekitaran anak. *Action research* menurut Nazir (1994) merupakan kajian empiris yang didasarkan pada observasi objektif pada masa sekarang untuk memecahkan masalah yang ditemui dilapangan, bersifat praktis dan aktual dalam aktivitas kerja.

Waktu satu tahun digunakan peneliti khusus di lapangan yaitu untuk melakukan proses dari mulai penilaian kondisi awal sampai dengan melakukan tindakan atau penerapan model dan penilaian kondisi akhir. Penilaian bersifat terus menerus terutama untuk mengamati bagaimana perkembangan anak disabilitas fisik dan bagaimana perkembangan perubahan dukungan sosial dari keluarga dan lingkungan persekitaran anak. Berikut gambar kerangka proses *action research* dilakukan :

Gambar 1. Lingkaran proses *action research*

Informan

Informan penelitian sebagai nara sumber utama yaitu anak-anak disabilitas fisik dan juga ibu bapa atau anggota keluarga lain yang terlibat secara langsung dalam pengasuhan anak. Sesuai dengan kepentingan penelitian dan keterbatasan penelitian, maka ditentukan teknik pemilihan informan sebagai sampel dengan *purposive sampling*, yaitu mengambil sampel dengan pertimbangan tertentu. Karakteristik anak disabilitas fisik yang akan dijadikan informan dengan kriteria sebagai berikut :

1. Tidak ditentukan jenis kelamin
2. Berusia antara 5 – 18 tahun (dimulai pada usia 5 tahun agar dapat diajak berkomunikasi secara aktif).
3. Anak disabilitas fisik saja tanpa gangguan mental, yaitu anak disabilitas tubuh (body impaired), anak disabilitas netra (visually impaired), anak disabilitas rungu wicara (speech and hearing impaired).
4. Tahap kedisabilitasan anak dari yang ringan sampai yang berat untuk anak disabilitas netra (visually impaired) dan anak disabilitas rungu wicara (speech and hearing impaired)., kecuali untuk anak disabilitas tubuh (body impaired) dari yang kategori tingkat kedisabilitasan ringan sampai sedang, tidak termasuk yang disabilitas berat.

Jumlah sampel informan yang sesuai dengan kriteria didapat 8 orang anak beserta keluarganya. Ke delapan orang anak terdiri dari disabilitas tubuh dan disabilitas rungu wicara tidak ditemukan anak disabilitas netra di daerah Kecamatan Pameungpeuk. Jumlah 8 orang dirasakan cukup apabila sudah diperoleh informasi yang memadai, mengacu pada pendapat Lincoln dan Guba dalam Sugiyono (2005) : *"if the purpose is to maximize information, then sampling is terminated when no new information is forth-coming from newly sampled units; thus redundancy is the primary criterion"* (Sugiyono, 2005, ms. 55).

Informan keluarga anak terdiri daripada ibu bapa juga ada seorang tante dan seorang nenek. Informan utama dari keluarga yaitu ibu, karena ibu yang memang terlibat secara penuh dalam pengasuhan anak. Informan pendukung yaitu nara sumber lain yang memiliki informasi yang diperlukan tentang fokus kajian yaitu pekerja sosial masyarakat, tetangga dan teman anak, yang sering berinteraksi dengan subjek kajian.

Teknik Pengumpulan Data

Teknik pengumpulan data utama adalah wawancara mendalam dan observasi. *Focus Group Discussion* (FGD) dilakukan untuk menggali dukungan sosial yang diberikan oleh ibu bapa/keluarga

anak. Wawancara mendalam dilakukan terhadap seluruh informan utama dan informan pendukung. Observasi dilakukan terhadap karakteristik anak disabilitas fisik, karakteristik keluarga, dukungan sosial yang diberikan keluarga dan persekitaran, perkembangan anak pada berbagai aspeknya.

Keabsahan Data

Penelitian ini memperhatikan keabsahan data, merujuk kepada pendapat Sugiono (2009) dengan menggunakan teknik-teknik kaji *uji kredibilitas*, dengan melakukan triangulasi, perpanjangan penyertaan, *member check, audit trail* dan ketekunan pengamatan. *Transferabilitas* agar penelitian ini dapat diterapkan atau digunakan dalam konteks dan situasi sosial lain, sehingga laporan penelitian dilakukan dengan uraian yang lebih terperinci, jelas, sistematik, sehingga orang lain yang membaca laporan penelitian ini dapat menerapkan hasil peneliian ini di tempat lain dengan situasi dan keadaan yang hampir sama. *Confirmabilitas* dilakukan oleh supervisor sebagai penguji penelitian ini. Supervisor memeriksa dan mengarahkan agar penelitian tetap dalam alur nya. *Dipendabilitas* dengan cara : 1). Mencatat dan merekam semua hasil wawancara, observasi dan aktivitas. 2). Data tersebut disusun dalam bentuk hasil analisis dengan cara menyeleksi, kemudian merangkum dalam bentuk deskripsi yang lebih sistematis. 3). Membuat penafsiran sebagai hasil analisis data. 4). Melaporkan seluruh proses penelitian dari tahap persiapan sampai pada penulisan laporan sesuai dengan apa yang benar-benar terjadi di lokasi penelitian dan sesuai dengan proses penelitian.

Analisis Data

Teknik analisis data yang akan digunakan adalah model analisis data interaktif berdasarkan konsep Miles & Huberman, yaitu melalui langkah-langkah sebagai berikut :

*Pengumpulan Data***,** mengumpulkan data-data yang diperlukan berkaitan dengan kepentingan penelitian. Pengumpulan data termasuk data-data yang berkembang/temuan selama dalam proses penelitian. *Reduksi Data***,** mereduksi data yaitu merangkum, memilih hal-hal yang pokok, memfokuskan pada hal-hal yang penting, dicari tema dan polanya. Data tersebut juga kemudian dipilih mana yang penting dan mana yang tidak penting, dan dinilai secara seksama, mencari penjelasan data, membuat kesimpulan. *Penyajian Data***,** digunakan dalam bentuk teks naratif, bagan, grafik atau matrik, sehingga memudahkan untuk analisis dan penarikan kesimpulan. *Penarikan Simpulan/Verifikasi***,** dilakukan terhadap data-data yang telah disajikan. Simpulan dilakukan dengan cara mempelajari dapatan, pola, tema, topik, hubungan persamaan, perbedaan dan hal yang paling banyak timbul, konfigurasi-konfigurasi yang mungkin, alur sebab akibat dan proposisi.

Definisi Operasional

Anak disabilitas fisik yaitu anak berusia 5 – 18 tahun yang mengalami kedisabilitasan atau memiliki kelainan/perbedaan dari anak normal dalam struktur tubuh, kemampuan melihat, kemampuan mendengar dan atau kemampuan bicara.

Keluarga anak disabilitas fisik adalah ibu bapa atau keluarga lain yang secara langsung melakukan pengasuhan terhadap anak.

Perkembangan anak adalah perubahan yang terjadi pada anak disabilitas fisik, merujuk perubahan pada aspek sosial, yaitu anak disabilitas fisik lebih mampu berpartisipasi dan memiliki relasi yang baik dengan anggota keluarga lainnya mahupun dengan persekitarannya. Pada aspek fisik anak disabilitas fisik lebih sehat, tidak mudah sakit, dan lebih mampu melakukan aktivitas

sehari-hari tanpa hambatan, pada aspek emosi anak disabilitas fisik lebih stabil dalam emosi dan lebih percaya diri, pada aspek kognitif anak disabilitas fisik lebih mampu berpikir kreatif, dan memiliki motivasi berprestasi.

Dukungan Sosial adalah dukungan dari ibu bapa maupun dari pengasuh lainnya dalam keluarga, yang meliputi dukungan dalam bentuk materi/biaya untuk keperluan anak, dukungan dalam bentuk petunjuk, nasehat, dan bimbingan. Dukungan dalam bentuk perhatian, kasih sayang dan cinta. Dukungan dalam bentuk penghargaan dan motivasi, dukungan dari kelompok teman sebaya, di lingkungan rumah atau di sekolah, serta dukungan dari lingkungan sekitar berupa penerimaan anak untuk berpartisipasi dan bebas stigma.

HASIL PENELITIAN

Hasil penelitian yang diperoleh dari proses *action research* yaitu dimulai dengan melakukan asesmen atau identifikasi awal sampai kepada penarikan kesimpulan diperoleh data/informasi :

Karakteristik anak

Anak yang menjadi informan sebagian besar bersekolah di sekolah umum, satu orang anak bersekolah di SLB dan satu orang anak tidak bersekolah. Jenis kedisabilitasan anak adalah disabilitas tubuh *orthopedic* serta disabilitas tuna rungu. Keadaan psikologis anak menunjukkan beberapa respon emosional yang muncul pada anak, secara dominan tiga orang anak mudah marah dan menangis, tiga orang anak tenang dan pendiam, dan dua orang anak yang ceria. Keadaan sosial anak menunjukkan ada tiga anak yang perhubungan serta interaksi dalam keluarga baik begitu pula dengan teman. Lima anak yang perhubungan serta interaksi dalam keluarga baik tetapi kurang baik dengan teman. Perkembangan anak pada beberapa aspek menunjukkan keterlambatan, khususnya dalam aspek emosional dan sosial (lihat table).

Karakteristik keluarga

Keseluruhan informan utama (ibu/bapak) dalam status menikah dan tinggal bersama, dalam artian tidak ada bapa atau suami yang bekerja di luar kota. Jumlah anggota keluarga antara empat sehingga sepuluh orang. Umur informan utama ibu berkisar antara 28 sehingga 57 tahun. Lama perkawinan ayah dan ibu antara 7 tahun sampai 35 tahun. Kepala keluarga adalah bapa dan sebagian besar pekerjaan mereka adalah menjadi buruh, sebagai buruh tani seramai lima orang, satu orang kepala keluarga bekerja di pondok pesantren, satu orang menjadi petugas keamanan di masyarakat dan satu orang berjualan makanan kecil. Ibu dari seluruh informan tidak bekerja secara resmi, empat orang menjadi ibu rumah tangga, dua orang ibu membantu ekonomi keluarga dengan menjual makanan kecil, satu orang kadang-kadang bekerja sebagai buruh tani bila ada yang menyuruh, dan satu orang bekerja di salon. Keluarga anak tergolong keluarga miskin dengan penghasilan di bawah upah minimum regional Provinsi Jawa Barat Rp. 1.2 jt/perbulan.

Pendidikan ibu bapak rendah sebagian besar tingkat SD, SMP dan hanya 1 orang yang SMA. Keadaan psikologis keluarga khususnya ibu bapa yang terlibat dalam pengasuhan anak menunjukkan rata-rata dalam keadaan stabil, tidak menunjukkan atau mengungkapkan kekecewaan mendalam ataupun frustrasi. Bapa ibu sebahagaian besar menerima keadaan kedisabilitasan anaknya, sebagai ujian Tuhan yang harus dijalani. Namun ada pula ibu yang merasa bingung dan sedikit stres dengan keadaan anaknya. Keadaan sosial atau relasi keluarga bahwa ada lima keluarga yang baik dalam relasi dan interaksi sosialnya dengan anggota keluarga maupun dengan persekitaran. Keluarga lainnya adalah tiga keluarga yang mengalami hambatan atau masalah dalam relasi dan interaksi sosialnya baik di dalam keluarga maupun dengan

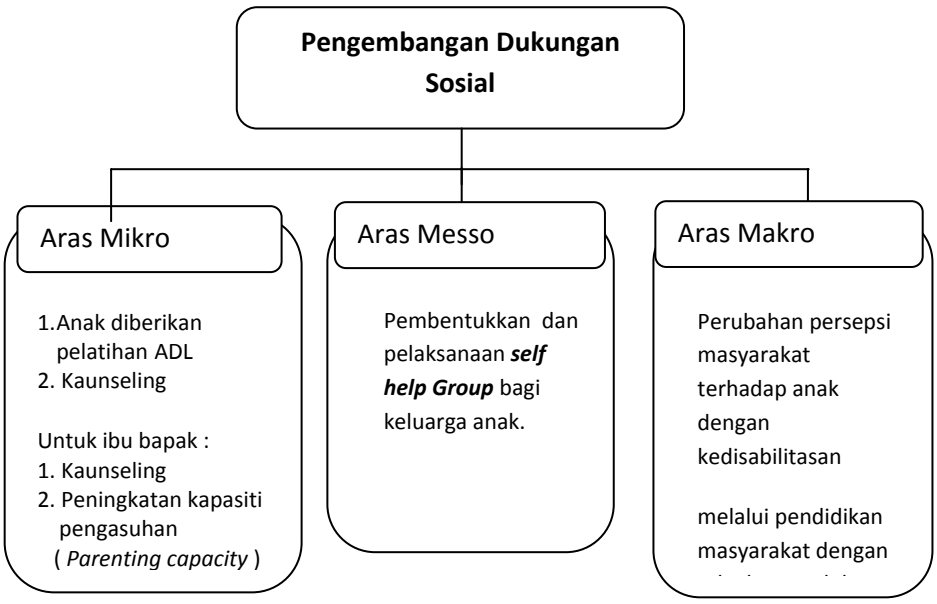
persekitaran. Pengasuhan terhadap anak pada seluruh keluarga secara dominan dilakukan oleh ibu dan ada yang dibantu oleh anggota keluarga lain, misalnya bapa, tante dan nenek. Dalam pengasuhan terhadap anak, ibu mengasuh berdasarkan naluri dan rasa sayang bercampur rasa kasihan, sehingga ada kelompok ibu yang memberikan perhatian lebih kepada anaknya yang disabilitas, ada yang memberikan perhatian yang sama kepada seluruh anaknya dan ada kelompok yang bingung bagaimana seharusnya mengasuh atau mengajarkan atau mendidik anaknya yang memiliki kedisabilitasan.

Hasil penelitian secara umum menunjukkan rendahnya pengetahuan ibu bapak dalam mengasuh anaknya yang disabilitas. Kondisi psikologis ibu bapak sebagian besar cukup tenang namun sedikit stres dengan kondisi anak. Relasi dan interaksi di dalam keluarga maupun dengan persekitaran cukup baik. *Action research* yang dilakukan dengan mengembangkan model peningkatan dukungan sosial ibu bapak dan persekitaran dengan harapan dapat memberikan implikasi positif pada perkembangan anak disabilitas. Substansi model berisikan peningkatan kapasitas ibu bapak dalam pengasuhan anak disabilitas fisik, serta peningkatan pemahaman lingkungan tentang masalah kedisabilitasan. Rancangan model pengembangan sosial dengan skenario dibawah ini :

Model Pengembangan Dukungan Sosial Ibu Bapa dan Persekitaran Anak Disabilitas melalui *Action Research*

Model ini menyentuh tiga aras yaitu pada aras mikro, mezzo dan makro. Aras mikro bertujuan untuk mengembangkan kapasitas individual khususnya peningkatan kemampuan ibu bapa dalam memberikan dukungan sosial bagi anak. Anak juga dirasakan memerlukan intervensi karena ada beberapa anak yang tidak mampu melakukan ADL dan ada anak yang mengalami gangguan perasaan karena keadaan kedisabilitasannya. Aras mezzo bertujuan untuk memperkuat kapasitas ibu bapa dengan adanya dukungan sosial dari sesama, yaitu dari ibu bapa lain yang memiliki anak disabilitas. Hasil refleksi dari ibu-ibu menyatakan bahwa mereka membutuhkan teman senasib tempat berbagi perasaan.Intervensi pada aras makro ditujukan agar masyarakat khususnya persekitaran anak dapat memberi perhatian dan dukungan kepada anak disabilitas dan keluarganya. Sedikitnya persekitaran tidak memberikan stigma atau mencemooh kepada anak dan keluarganya.

Bagan di bawah ini menjelaskan model pengembangan dukungan sosial ibu bapa dan persekitaran yang diharapkan memberikan implikasi terhadap perkembangan anak disabilitas fisik.



Hasil dari penerapan model dapat dilihat perbedaan pada 2 aspek variabel utama yaitu dukungan sosial ibu bapa dan variabel perkembangan anak.

Dukungan sosial sebelum dan selepas penerapan model

Aspek Dukungan	Dukungan Sosial		
	Jenisnya	Sebelum penerapan model	Sesudah penerapan model
Instrumental	Pakaian	Rata-rata setahun sekali	Setahun sekali yang utama ditambah sesekali kalau ada uang
	Makanan	Seadanya saja	Seadanya saja
	Sekolah dan alat sekolah	Dipenuhi	Dipenuhi
	Rekreasi	Tidak dipenuhi pada semua anak	Sebagian anak sudah terpenuhi
	Permainan	Seadanya	Sebagian ditambah jenis dan jumlahnya
Informasi	Menasehati	Seluruh Ibu melakukan, bapa tidak	Seluruh Ibu melakukan, 4 orang bapa juga turut melakukan
	Memberi petunjuk	Sebagian Ibu melakukan, satu orang bapa melakukan	Seluruh Ibu melakukan, 4 orang bapa juga turut melakukan
Emosional	Menghibur anak bila sedih	Sebagian Ibu melakukan, bapa tidak	Seluruh ibu melakukan, 2 orang bapa juga turut melakukan
	Memuji anak	Sebagian Ibu melakukan, bapa tidak	Sebagian Ibu melakukan, pada sebagian anak bapa juga turut melakukan
	Mengajak berbincang	Sebagian Ibu melakukan, pada 3 bapa juga turut melakukan	Seluruh Ibu melakukan, pada 4 orang bapa juga turut melakukan
	Memanggil dengan panggilan baik (kata sayang)	Sebagian Ibu melakukan, bapa tidak	Seluruh Ibu melakukan, 1 orang bapa melakukan
Harga diri	Tidak berbual kasar	Dilakukan oleh seluruh ibu, seorang bapa suka agak mengejek anak	Dilakukan oleh seluruh ibu dan bapa
	Tidak memberikan perlakuan berbeda	Dilakukan oleh seluruh ibu dan bapa	Dilakukan oleh seluruh ibu dan bapa
	Memuji bila melakukan perbuatan baik	Dilakukan sebagian ibu	Dilakukan oleh seluruh ibu dan 4 orang bapa
Dukungan dari kelompok sosial	Daripada ketetanggan	Tetangga acuh, tapi sebagian bertanya-tanya	Tetangga tidak pernah bertanya tanya lagi
	Daripada teman sebaya anak	Ada yang mengejek	Masih ada sebagian
	Daripada tokoh masyarakat	Ada perhatian sedikit	Ada perhatian banyak

Perkembangan anak sebelum dan selepas penerapan model

Aspek	Perkembangan anak					
	Jenisnya	Sebelum penerapan model			Sesudah penerapan model	
		Usia 6 tahun (3 orang anak)	Usia 7-12 tahun (3 orang anak)	Usia 13 tahun (2 orang anak)	Usia 7-12 tahun (6 orang anak)	Usia diatas 13 tahun (2 orang anak)
Fisik	Tinggi dan berat badan	R.6 112/19 R.7 100/15 R.8 112/20	R.3 130/36 R.4 132/30 R.5 117/19	R.1 150/44 R.2 139/40	R.3 130/36 R.4 125/28 R.5 115/21 R.6 97/20 R.7 98/19 R.8 92/20	R.1 142/43 R.2 140/36
	Kemampuan ADL	3 anak mampu ADL dengan bantuan	1anak mampu ADL 1anak mampu ADL dengan bantuan 1 anak tidak mampu ADL	2 anak mampu ADL	5 orang anak mampu ADL sendiri 1 anak masih perlu bantuan	2 anak mampu semuanya
	Bermain/ berolah raga	3 anak bermain	2 anak bermain 1 anak tidak bermain	2 anak bermain	6 anak bermain	2 anak bermain
	Aktiviti kerja rumah	3 anak tidak melakukan kerja rumah	1 anak melakukan 2 anak tidak	2 anak melakukan kerja rumah	2 anak melakukan kerja rumah	2 anak melakukan kerja rumah
Kognitif		1 anak mencapai seluruh aspek 1 anak mencapai sebahagian 1 anak belum mencapai	1 anak mencapai seluruh aspek 2 anak belum mencapai	2 anak mencapai sebahagian aspek	5 orang anak mencapai hampir seluruh aspek 1 anak mencapai 1 aspek	2 anak mencapai seluruh aspek perkembangan
Emosional		1 anak mencapai seluruh aspek 2 anak mencapai sebahagian	1 anak mencapai seluruh aspek 2 anak belum mencapai	2 anak mencapai sebahagian aspek	4 anak mencapai hampir seluruh aspek 2 anak mencapai beberapa aspek	2 anak mencapai seluruh aspek, hanya pengendalian emosi masih kurang
Sosial		2 anak mencapai sebahagian 1 anak belum mencapai	1 anak mencapai hampir seluruh aspek 2 anak belum mencapai	1 anak mencapai seluruh aspek 1 anak mencapai beberapa aspek	3 orang anak mencapai hampir seluruh aspek 3 orang anak mencapai beberapa aspek	2 anak mencapai seluruh aspek perkembangan

Dari tabel di atas dapat dijelaskan :

Implikasi pada perkembangan anak nampak pada beberapa aspek perkembangan yaitu pada perkembangan fisik, ditinjau dari tinggi dan berat badan anak yang menunjukkan tidak mengalami perubahan yang besar. Aspek perkembangan fisik lainnya yaitu kemampuan ADL anak, nampak ada perubahan setelah penerapan model, tujuh anak telah mampu melakukan ADL dan hanya tinggal satu anak saja yang belum mampu melakukan ADL secara mandiri.

Pada perkembangan kognitif anak, perubahan cukup signifikan. Anak yang sebelumnya belum mencapai aspek-aspek perkembangan kognitif, setelah penerapan model tujuh orang anak mampu mencapai aspek-aspek perkembangan kognitif untuk anak seusianya.

Pada perkembangan emosional, tujuh orang anak telah mampu mencapai beberapa perkembangan emosional yang memuaskan seperti mampu menampilkan emosi yang wajar, pengembangan hati nurani baik buruk dan punya motivasi. Pada kelompok anak usia akhir, anak telah mencapai penerimaan diri dan konsep diri yang positif.

Perkembangan sosial ditinjau dari kemampuan anak untuk bertingkah laku sesuai dengan tuntutan-tuntutan masyarakat. Setelah penerapan model enam orang anak yang mengalami perubahan yang positif, dua anak tidak mampu mencapai perubahan yang cukup signifikan. Tidak tercapainya perkembangan yang optimal pada ke dua anak selepas penerapan model dapat diprediksi karena ke dua anak mengalami hambatan yang cukup berarti sebelumnya. Anak sebelumnya tidak bersekolah, dan di rumah pun tidak mendapatkan stimulus yang tepat untuk perkembangannya, sehingga keterlambatan perkembangannya cukup jauh.

Perubahan yang cukup signifikan terhadap perkembangan anak, bisa dipengaruhi oleh berbagai faktor yang telah berkolaborasi dalam *action research*. Asesmen partisipatif memungkinkan diperoleh kebutuhan yang sebenarnya dari anak dan keluarga. Peran pekerja sosial sebagai fasilitator maupun mediator dalam penerapan model sangat penting sebagai tokoh sentral yang bisa melakukan pendampingan psikososial dan melakukan pendekatan yang pas sesuai dengan karakteristik sasaran.

Hasil penelitian ini membawa implikasi terhadap kebijakan pemerintah terkait permasalahan kedisabilitasan. Bahwa permasalahan anak disabilitas pada keluarga miskin bukan hanya persoalan pemenuhan kebutuhan dasar seperti makanan, pendidikan dan kesehatan saja. Permasalahan kondisi psikososial ibu bapak dan juga masalah psikososial anak disabilitas perlu mendapat perhatian serius. Perkembangan anak disabilitas sangat dipengaruhi oleh pengasuhan yang diberikan oleh ibu bapak. Perkembangan juga dipengaruhi dukungan ibu bapak serta lingkungan yang memberi kesempatan kepada anak disabilitas untuk berpartisipasi.

REKOMENDASI

Rekomendasi kepada pemerintah terkait kebijakan dan program yang dapat dijalankan kepada masyarakat :

1. Perlunya mengembangkan program pendampingan psikososial bagi keluarga dengan anak disabilitas. Keluarga yang memiliki anak disabilitas terkadang mereka dihadapkan kepada persoalan sosial psikologis akibat kedisabilitasan anaknya. Khususnya pada keluarga-keluarga miskin ibu bapa tidak memiliki akses terhadap pelayanan dan solusi masalah. Pekerja sosial ini bisa difungsikan untuk melakukan pendampingan psikososial, dengan melakukan beberapa aktivitas terhadap keluarga dan anak-anak disabilitas, yaitu :

a. Konseling keluarga maupun individual, untuk membantu anak dan keluarga menyelesaikan permasalahan sosial dan psikologis.

b. Pendidikan pengasuhan anak dengan kedisabilitasan (parenting skill)

c. Pengajaran *activity daily living* (ADL)

d. Peningkatan pengetahuan ibu bapa tentang masalah kedisabilitasan, hak dan keperluan khusus anak disabilitas, serta pentingnya dukungan ibu bapa terhadap perkembangan anak dengan kedisabilitasan.

e. Membantu akses anak disabilitas kepada pendidikan, kesehatan mahupun bermain dan rekreasi, karena pelayanan publik di Indonesia belum responsif terhadap masyarakat dengan keperluan khusus, termasuk bagi anak dengan kedisabilitasan.

f. Mengidentifikasi potensi, bakat dan minat anak dengan kedisabilitasan dan membantu akses untuk pengembangan potensi, bakat dan minat anak tersebut.

g. Membantu akses keluarga terhadap pelayanan-pelayanan yang dibutuhkan baik oleh keluarga maupun dibutuhkan anak.

2. Perlunya mengembangkan program yang berasaskan masyarakat (*community based rehabilitation*/CBR) sehingga benar-benar sesuai dengan karakteristik dan kebutuhan masyarakat. Program ini perlu didukung oleh keberadaan SDM Pekerja sosial yang professional di masyarakat, sehingga dapat melakukan asesmen dan intervensi secara tepat.

   Konsep ini dikembangkan berdasarkan pertimbangan bahwa pemerintah memiliki keterbatasan dalam anggaran maupun sumber daya manusia, dan komunitas memiliki kapasitas yang bisa dikembangkan untuk membantu ADD beserta keluarganya. Konsep CBR juga selaras dengan pergeseran paradigma pembangunan dari *rules based approaches ke outcome oriented aaproaches*, bahwa pelayanan terhadap masyarakat bergeser dari yang berdasarkan peraturan normatif menjadi pendekatan yang berorientasi kepada hasil. Persoalannya di Indonesia pelaksanaan CBR ini mengalami stagnasi dalam pelaksanaannya. Evaluasi boleh ditinjau karena kurangnya sosialisasi, aktivitas yang parsial hanya menyentuh peningkatan ADL orang dengan kedisabilitasan, kurang membangun sistem dalam komunitas yang menaruh perhatian terhadap masalah kedisabilitasan, serta kurangnya supervisi daripada pemerintah.

   Beberapa aspek penting yang perlu mendapat perhatian dalam program berbasis komuniti ini adalah :

   a. Perlu melibatkan partisipasi aktif dari kelompok sasaran. Pekerja sosial perlu mengajak kelompok sasaran untuk menemukan permasalahan dan yang mereka hadapi. Rencana aktivitas dan pelaksanaan aktivitas juga perlu melibatkan partisipasi aktif kelompok sasaran.

   b. Aktivitas yang dilaksanakan harus berdasarkan asesmen yang dilakukan terlebih dahulu, sehingga pelaksanaan program selaras dengan kebutuhan nyata di komunitas.

   c. Asesmen juga perlu melibatkan anak. Berbagai program untuk anak biasanya berdasarkan pandangan orang dewasa, suara anak sama sekali tidak mendapatkan perhatian. Kondisi ini dapat menghasilkan program yang tidak menyentuh keperluan anak yang sesungguhnya. Perlunya memperhatikan suara anak juga selaras dengan konsep pelayanan sosial berbasi hak (right based services), bahwa program bukan saja sekedar merespon masalah anak namun dilakukan untuk memenuhi hak anak.

3. Perlunya pendekatan komprehensif untuk mensinergikan program antara berbagai instansi yang terkait, sehingga program pemerintah akan seperti rangkaian puzzle yang saling mengisi untuk membantu khususnya para keluarga miskin dengan anaknya yang menderita kedisabilitasan.

   Berbagai kebijakan yang mendasari program di Indonesia ditetapkan secara terpisah oleh berbagai kementrian, tidak berbeda dengan kebijakan yang terkait dengan permasalahan anak, padahal kebijakan tersebut sasarannya sama misalnya anak dengan kedisabilitasan. Akibatnya pelaksanaannya dilapangan tidak sinergis. Penjangkauan berbeda dengan anggaran dan SDM yang terbatas menyebabkan pelayanan yang diberikan menjadi minimal dan parsial.

   Kondisi lebih baik apabila kebijakan perlindungan sosial bagi anak dengan disabilitas dari Kementrian Sosial terintegrasi dengan kebijakan lainnya misalnya kebijakan Kementrian Kesehatan untuk pencegahan disabilitas dengan program imunisasi, kesehatan rumah dan sekolah, pendidikan gizi, perawatan kehamilan dan kelahiran. Kementrian Pendidikan melalui program pendidikan inklusi, bantuan operasional sekolah (BOS), keringan bagi siswa tidak mampu, kemudahan akses bagi anak dengan disabilitas. Sinergitas program dapat menghasilkan beberapa manfaat yaitu :

   a. Sinergitas program bagaikan *the building blocks of development*, yakni rangkaian yang berkaitan satu sama lain sehingga membentuk proses sekaligus wujud sebuah aktivitas pembangunan yang saling mengisi kekurangan ataupun kelebihan setiap departemen.
   b. Sinergitas memberikan sentuhan yang cukup luas dan mendalam terhadap satu permasalahan anak dengan disabilitas, karea satu masalah disentuh oleh berbagai perogram dari berbagai departemen, sehingga komprehensif penanganannya.
   c. Memberikan solusi terhadap minimanya sumber daya, baik itu sumber daya anggaran, sarana prasarana serta minimanya sumber daya manusia untuk melaksanakan program.
   d. Memperkuat kebijakan pemerintah, karena kebijakan disokong implementasinya oleh berbagai program yang memiliki sasaran yang sama dan tujuan akhir yang sama.

4. Perlunya meningkatkan program-program untuk meningkatkan kesadaran dan pemahaman masyarakat terhadap permasalahan kedisabilitasan, hak – hak anak disabilitas dan kesempatan partisipasi yang bisa diberikan oleh masyarakat.

   Aktivitas yang dapat dilakukan adalah melalui kampanye, sosialisasi maupun penyuluhan kepada masyarakat, dunia usaha dan lembaga-lembaga pelayanan untuk memperkuat kebijakan inklusifitas anak dengan disabiliras yang telah ditetapkan oleh pemerintah. Isi kampanye dapat memuat pokok-pokok informasi yang meningkatkan kesadaran masyarakat seperti :

   a. Kebijakan pemerintah terkait dengan pemenuhan keperluan, dan pemenuhan hak-hak penyandang disabilitas.
   b. Hak-hak penyandang disabilitas dalam setiap aspek kehidupan (pendidikan, pekerjaan, kesehatan, rekreasi).
   c. Melarang diskriminasi serta eksploitasi terhadap anak dengan disabilitas.

5. Perlunya mengimplementasikan produk hukum yang terkait dengan perlindungan anak, yang juga menyentuh persoalan anak dengan disabilitas.

   Undang-undang perlindungan anak no 23 tahun 2002 dan konvensi hak anak yang diratifikasi pemerintah Indonesia melalui Keppres no 36 tahun 1990, serta UU no 19 tahun 2011 tentang

pengesahan konvensi hak-hak penyandang disabilitas sekarang ini menjadi dasar perlindungan dan pemenuhan hak anak dengan disabilitas. Namun demikian perlu ditindaklanjuti dengan penyusunan peraturan yang memadai dan SOP yang jelas di daerah.

Strategi yang bisa dilakukan adalah menyusun sistem perlindungan anak dengan disabilitas yang harus jelas SOP nya dipandu secara jelas, terpadu dan berkelanjutan. Strategi tersebut juga menempatkan keluarga sebagai pusat pelayanan untuk memperkuat tanggung jawab mereka dalam memberikan perawatan dan perlindungan bagi anak dengan disabilitas, serta menempatkan pengembangan kelembagaan dan program-program terkait kesejahteraan sosial dan sistem layanan yang profesional; sejalan dengan gagasan perubahan paradigma.

6. Meningkatkan jumlah pekerja sosial pendamping melalui rekruitmen yang jelas dan terukur, sehingga diperoleh pekerja sosial yang kompatibel untuk melaksanakan pendampingan terhadap anak disabilitas dan keluarganya.

   Pendamping anak dengan disabilitas beserta keluarganya memiliki peranan besar sebagai *change agent* atau sistem pelaksana perubahan. Pendamping dapat memperkuat kapasitas anak dengan disabilitas beserta keluarganya juga sekaligus dapat memberdayakan masyarakat atau komunitas di sekitar anak dan keluarganya melalui serangkaian aktivitas yang mendorong partisipasi masyarakat dan berbagai unsurnya.

Rekomendasi terhadap praktik pekerjaan sosial di masyarakat yang saat ini bisa dilakukan oleh pekerja sosial kementrian sosial :

1. Lakukan proses asesmen secara partisipatif melibatkan kelompok sasaran, terkait karakteristik kelompok sasaran, kebutuhan kelompok sasaran, sistem sumber di masyarakat.
2. Lakukan penyusunan rencana tindakan yang disepakati dengan kelompok sasaran
3. Gunakan kaedah case work, group work dan community organization untuk menjangkau permasalahan lingkup individual, kelompok dan masyarakat.
4. Pekerja sosial juga dapat menjalankan peran dan aktivititas untuk memudahkan dalam penerapan model, dengan cara-cara :
   a. Membangkitkan semangat, motivasi, menstimulasi, memberikan energi dan membangun komitmen kelompok sasaran.
   b. Membangun kesadaran (consciousness raising) terhadap kondisi mereka dan keyakinan terhadap perubahan ke arah lebih baik terkait perkembangan anak-anak mereka yang menderita disabilitas fisik.
   c. Mengorganisasikan kelompok sasaran dan sistem sumber yang dapat diajak terlibat dalam aktivitas.
   d. Menggunakan sumber-sumber yang berada dalam komunitas itu sendiri, seperti misalnya tenaga pekerja sosial masyarakat, pekerja sosial pemerintah dalam bidang kedisabilitasan, tokoh masyarakat serta *non government organization* (NGO) apabila tersedia pada local komuniti.
   e. Pekerja sosial dapat membangun *networking* atau jejaring kerja dengan instansi pemerintah maupun non pemerintah yang terkait. Menghubungkan kelompok sasaran dengan sistem sumber, mulai dari tingkat Kelurahan, Kecamatan, Dinas Sosial, Dinas pendidikan, pihak sekolah dengan guru-guru, ataupun dengan NGO yang bekerja untuk masalah kedisabilitasan.

RUJUKAN LITERATUR

Beckett, J.O., & Johnson, H. C. (1985). *Human development*. Encyclopedia of social work (19th ed., vpl 2). Washington, DC : NASW Press.

Bowlby, J (1988). *A secure base: parent-child attachment and healthy human development*. London: Routledge; New York: Basic Books. ISBN 0-415-00640-6

DuBois Brenda and Miley Karla K. (2005). *Social work an empowering profession.* USA. Pearson Education, Inc.

Germain, C.B., & Gitterman, A. (1996). *The life model of social work practice: Advances in theory and practice* (2nd Ed.) New York: Columbia University Press.

Gerungan, WA., (1997). *Psikologi Sosial*. Bandung : Refika Aditama.

Hanvey, Louis. (2002). *Children with disabilities and their families in Canada*. www.national**children**salliance.com/nca/pubs/2002/hanvey02

Harry Hikmat. (2010). *Jumlah anak cacat di Indonesia*. Antara News. http://antajawabarat.com.

Ho, K.M., & Keiley, M.K. (2003). Dealing eith denial : *A systems approach for family professionals working with parents of individuals with multiple disabilities*. The family Journal : Counseling and Therapy for Couples and Families, 11 (3), 239-247.

Hurlock, Elizabeth.B. (1997). *Developmental psycology a life span approach*. Fifth edition. McGraw Hill, Inc.

Janene Byrne. (2002). Disability in Indonesia : life is challenging for people with disabilities in Indonesia. Copyright 1996-2009 © Inside Indonesia

Japan International Cooperation Agency (JICA) Planning and Evaluation Department. 2002.Country profile on disability Republic of Indonesia.

Kirk, S.Ashman. (1970). *Educating exceptional children*. New Delhi : Oxford & IBH Publishing Co.

Marchant R.(2001).*Working with disabled children. In:* Foley P., Roche J., Tucker S., *editors.* Children in Society: Contemporary Theory, Policy and Practice. Basingstoke: Palgrave in association with Open University Press.

Maureen O'Loughlin., Steve O'Loughlin. (2008). *Social Work with Children and Family*. Glasgow.

Miles, M & Huberman, A. (1994). *Qualitative data analysis : an expanded sourcebook*. 2 nd edn. Sage Publication, Thousand Oaks, CA, USA.

Newman. Barbara M and Philip R. (2006). *Development through life*. Ninth ed. USA. Thomson Wadsworth.

Rothman, Julliet. (2003). *Social work practice across disability*. Pearson education.

Rutter, M. (1993). *Developing minds : challenge and continuity across the life span*. Penguin Books, Harmondsworth.

Sarafino, Edward. P. (2001). *Health psychology* : Bio-Psychosocial Interaction. New York

Somantri, Sutjihati. (2007). *Psikologi Anak Luar Biasa*. Bandung. PT. Refika Aditama.

Sullivan-Bolyai, S., Sadler, L., Knafl, K.A., et al. (2003). *Great expectations : a position description for parents as caregivers* : Part 1. Pediatric Nursing, 29 (6), 457-461.

UN ESCAP (2002), *Disability and the Biwako Millenium Framework for Action*.

Van den Daele, L. D. (1969). *Qualitative models in developmental analysis*. Developmental Psychology, 1, 303-310.

Wesscot & Cross. (1996). *The abuse of disabled children*. Journal of Child Psychology and Psychiatry (1999), 40: 497-506

Zastrow H. Charles and Kirst Ashman Karen K. (2004). *Understanding human behavior and the social environment*. USA. Thomson Learning Inc.

BIOGRAFI PENULIS

Dra. Rini Hartini Rinda Andayani, M. Pd. Pendidikan terakhir di Magister Pendidikan dari Universitas Pendidikan Indonesia lulus tahun 2002. Tahun 2010 menempuh program doctoral Social Work di University Sains Malaysia. Bekerja sebagai dosen di Sekolah Tinggi Kesejahteraan Sosial (STKS) Bandung, fokus pada mata kuliah metode-metode pekerjaan sosial, kajian anak dan kajian disabilitas. Penelitian yang dilakukan dalam 3 tahun terakhir adalah penelitian tentang anak, yaitu anak di panti asuhan dan anak dengan disabilitas. Pengabdian masyarakat dalam bidang anak dan disabilitas banyak dilakukan di wilayah Kota dan Kabupaten Bandung. Praktek pekerjaan sosial dalam Pusat Dukungan Anak dan Keluarga (PDAK) Save the Children sejak tahun 2010. Praktek pekerjaan sosial melalui praktek managemen kasus untuk mendukung keluarga agar mampu memberikan pengasuhan yang terbaik bagi anak, sehingga anak terhindar dari penelantaran, kekerasan maupun pengabaian hak.

4 One size does not fit all: stunting and social protection in rural Tanzania?

Wei Ha
UNICEF Tanzania[1]

1. Abstract

Tanzania has been at the forefront on the global fight with malnutrition first in the Iringa nutrition programme in the 1980s and 1990s which facilitated the application and perfection of the UNICEF conceptual framework of malnutrition and now as one of the first member countries of the global Scaling Up Nutrition (SUN) movement. Yet, nutrition status of children under 5 years old has not dented much in the last twenty years. This paper intends to examine the associational factors of stunting for under 5 children in Tanzania using the Tanzania Demographic and Health Survey 2010 data and to shed lights on the directions of its nutrition programming.

Multivariate linear probability regression model is established to study the relative contribution of various risk factors identified by the UNICEF conceptual framework of malnutrition (1990). Empirical findings from the full sample of under 5 children indeed suggest that stunting is a manifestation of **multi-dimensional** factors as stipulated in the conceptual framework. Food intake, food security, caring practice of children, healthy environment and family control of resources are all significant predictors of children's chances of being stunted. Childhood illness is not found to be associated with stunting but it is also the least well-measured risk factors in the survey data. Therefore we should be cautious on our inference. More importantly, not all factors count equal. Mother's height, children's birth weight, mother's working status, mother's age, children's age in months and maternal education are the top risk factors for stunting, followed by access to safe water and sanitation, mother's BMI, number of under 5 children in households and the size of the households. Food intake and food security variables are worth special attention here. These critical measures of nutrition intake at the household level start to lose both power and significance in predicting stunting once family household characteristics and wealth quintile are controlled for. Richer families are better positioned to eat well and more regularly and more likely to secure access to food. This pattern is driven primarily by the 2-5 years old sample. Food security significantly reduces children's odds of being stunted for children between 2 and 5 years old, a topic we will return in the following section.

The determinants of stunting also **vary by children's age**. For children less than 2 years old, stunting is more strongly determined by mother's work status than 2 to 5 years old especially in rural areas. In contrast, as children age, wealth and food insecurity factors become much

[1]The author acknowledges the comments from various UNICEF colleagues at the meeting of Strategic Moments of Reflections on Nutrition in March 2012 held in UNICEF Tanzania.

stronger predictors of stunting than before. The size of the households and the number of under 5 in the family hold much more sway in determining stunting status than under 2 years old. It suggests that the caring from one's mother related to IYCF practices is most probably indispensable and irreplaceable at this early stage but as they age, substitute care can be sought to replace the maternal care if there is such supply readily available to meet the demands in the households. This suggests that biology and maternal attention trump other more medium-term and long-term causes in the beginning of the children's life but as children age, family resources, food security and access to healthcare gradually start to exert their influence. It also provides evidence on the **cumulative effects of biological factors** as the correlation between mother's height and children's stunting status is much stronger for 2 to 5 years old compared to those below 2.

These findings have important policy implication for Tanzania. First, the results necessitate the **multi-sectoral nature of interventions** to tackle stunting in Tanzania, a well-known fact since the early days of Iringa Nutrition Programme but not always followed in practice. Nutrition interventions need to go hand in hand with other sectoral intervention in water and sanitation, maternal and child health but also it has to involve programmes and policies on girls education, social protection, livelihoods and decent employment if we are to sustain the gains in nutrition interventions. Jonsson (2012), one of the key architect behind the conceptual framework of nutrition, cautioned that we face the risk that "priority is given to addressing the immediate and underlying causes (Nutrition specific interventions), while the basic causes are perceived as politically too sensitive to address (Nutrition sensitive interventions)". Second, the multi-sectoral package also needs to be **age-specific**. One-size does not fit all. Mother's attention and care is indispensable and irreplaceable when children are less than 2 years old. Therefore intervention at this stage should avoid diverting maternal attention away from children. Also when we deal with older children, more attention should be given to the address the basic causes of malnutrition if we are to consolidate and sustain the gains made with younger kids.

The Productive Social Safety Net Programme (PSSN), a multi-sectoral social protection intervention led by the Tanzania Social Action Fund and supported by the World Bank and other development partners (DPs), is to be rolled out in 13 Local Government Authorities in financial year 2013/14. As is currently designed, moms with young children including those less than two years old are eligible to public work component for 15 days per month for 4 months during the lean season of the year. While there is plan to provide on-site childcare as part of the public work component, this could potentially put their children at heightened risk of stunting and the extra income and consequential rise in household consumption may not be enough to compensate the loss of mother's care. In order to reduce stunting, the PSSN should provide additional incentives for poor mothers with young children to spend more of their time with their children to counterbalance the economic pull factors.

1. Background

Malnutrition in Tanzania

Nutrition has featured prominently in Tanzania's quest for prosperity and development. Malnutrition was identified as one of the big three enemies of the people alongside poverty and ignorance in the 1967 Arusha Declaration which set out the vision and direction for Tanzania's development in the following two decades. The Iringa Nutrition Project initiated by Tanzania Food and Nutrition Council (TFNC) under WHO/UNICEF support between 1979and 1992 not only reduced prevalence of underweight from 56% to 38% in five years (TFNC, 2004) but also

facilitated the development of the UNICEF conceptual framework of malnutrition and greatly influenced the global thinking on how to improve nutritional wellbeing in developing countries.

However, consolidating the earlier gains in tackling malnutrition (primarily underweight) has proved to be much more challenging. Government was preoccupied by the economic restructuring and liberalization since the early 1990s and diverted attention and resources from community based activities (Jonsson, 2003). As a result, the situation of malnutrition in Tanzania has improved but remained serious between 1992 and 2010. Stunting among under-5 children has reduced from 50 per cent to 43 per cent while underweight among under-5 has declined from 25 per cent to 16 per cent (WHO, 2011).[2] Given the rapid population growth, there are more chronically malnourished children in Tanzania today than have ever been recorded before. Between 2005 and 2010, the number of stunted children rose by about 300,000 to over 3 million. This burden of stunting is higher than any other Africa countries with the exception of Ethiopia and the Democratic Republic of Congo.

Riding on revived interest in nutrition by the global development community,[3] the country's top leadership has made several important commitments towards improving nutrition recently. A high level meeting on nutrition was convened in June 2011 by the Prime Minister together with the US Secretary of State and Deputy Prime Minister and Minister of Foreign Affairs and Trade of Ireland where the Prime Minister of Tanzania "fully endorses and supports" the Scaling Up Nutrition (SUN) movement.[4] The National Nutrition Strategy (NNS) was launched by the Prime Minister in September 2011 and the Implementation Plan of the National Nutrition Strategy (2011/12 to 2015/16) was endorsed by the government with a budget of US$ 528 million. On 16th May 2013, President Kikwete launched a National Call for Action to scale up nutrition in Tanzania where he stressed the importance of nutrition advocacy at all levels of government and urged the stakeholders from the public sector to secure adequate budget for addressing nutrition within their respective sectors – from national to local/district levels.

Social Protection and Nutrition in Tanzania

Since the 1970s, malnutrition has been understood as a multisectoral problem and requires multisectoral interventions (Garrett and Natalicchio, 2011). The UNICEF conceptual framework on nutrition provided the best summary of this development. Since the late 1990s, social protection agenda has been gaining momentum in the development discourse spearheaded by the conditional cash transfer programmes originated in the Latin America. Broadly speaking, social protection refers "to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society" (FAO, 2012). More recently, social protection has been identified as a potential solution to address the

[2]Stunting is defined as having height-for-age below 2 standard deviation of the WHO 2006 reference group

[3]"Offi cial development assistance to the basic nutrition category has increased from US$259 million in 2008, to $418 million in 2011—a rise of more than 60% (although it was $541 million in 2009).1 Furthermore, the G8 countries reported increases of almost 50% in bilateral spending on nutrition-specifi c and nutritionsensitive interventions between 2009 and 2011.2 According to Google Trends, "malnutrition", now matches "HIV/AIDS" in terms of internet interest, whereas 5 years ago, HIV/AIDS received twice as much interest as malnutrition." *(Gillespie et al, 2013).*

4The SUN movement is a multi-stakeholder global effort to reduce hunger and under-nutrition and to contribute to the realization of all of the MDGs, with particular emphasis on MDG 1. The SUN road map encourages countries to better focus on nutrition within development programs as they scale up nutrition activities and identify investments that have been shown to work if implemented within the context of nutrition-focused development policies.

immediate and underlying causes of malnutrition which have been confirmed by empirical evidences from Latin America (Leroy et al, 2009).

The 2008 Lancet Series on Maternal and Child Undernutrition cited the conditional cash transfers with nutritional education and micronutrient-fortified food supplements as an effective nutrition sensitive intervention to tackle malnutrition. The 2013 Lancet Series on Maternal and Child Nutrition has shown a deepening understanding of the social protection issues by including unconditional cash transfers, school feeding programme, and in-kind food distribution as part of the package. Tanzania is a case in point for this global trend.

Tanzania Social Action Fund (TASAF), which has been in operation since 2000 under the President's Office, is being transformed from a traditional social fund operation that mostly finances community infrastructure/rehabilitation projects, e.g. health facilities, schools and teacher dorms, etc. into a productive social safety net (PSSN) that will pay monthly cash transfers to Tanzania's poorest and most vulnerable households. Households receiving the cash transfer will also qualify for participation in seasonal public works for up to 60 days per year, if they have an adult able-bodied person willing to work in a community project in return for a wage income. The purpose of the public works component is to provide consumption smoothing to eligible poor households during the lean season when food and cash are scarce. A related aim of the seasonal public works is to help create productive assets through, e.g. small scale irrigation, watershed management, etc. that can benefit the whole community, and to add to the cash income that eligible families will receive every month so as to increase their chances of 'graduating' out of extreme poverty.

The basic features of PSSN are such that, depending on family composition and size, PSSN households can receive anywhere from $60 to $200 per year. This compares with an extreme poverty line in Tanzania of nearly TSH 10,000 or US$6 per person (adult equivalent) per month (Household Budget Survey, 2007). Participation in the program, therefore, can bring substantial extra income into a household such as to make up for a significant part of the consumption shortfall that will otherwise keep the household below the food poverty line.[5] Other non-cash linkages of PSSN with nutrition include regular checkup at health facility by under 5 children and prenatal and natal mothers; attendance at community health and nutrition sessions when such health services are not available; attendance at workshops to reinforce nutrition practices and investment in human capital.

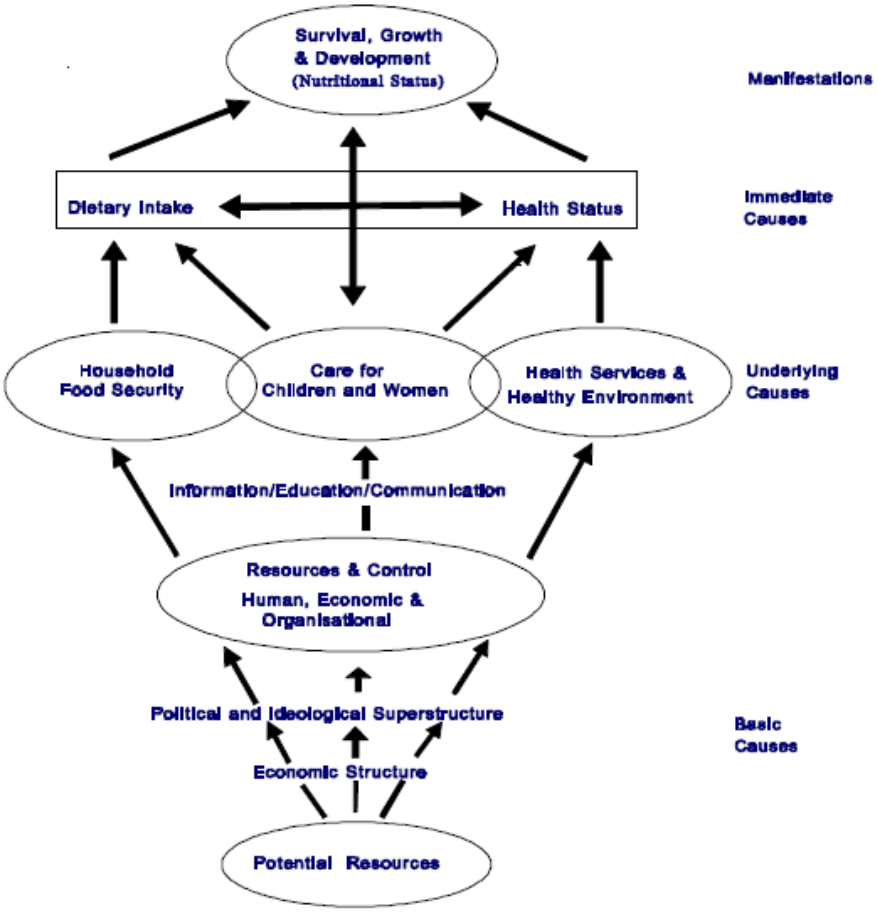
2. Objective of the Study

The objective of this study is to provide updated empirical evidence on the associational factors of under-5 stunting guided by the UNICEF Conceptual Framework of malnutrition and inform the design of PSSN to reduce stunting in Tanzania. This framework examines the multidimensional causes of malnutrition and also the multi-sectoral nature of the problem at both macro- and micro-levels. It also classifies the causes of malnutrition at different levels including Immediate Causes (dietary intake and disease at individual level), Underlying Causes (health services, healthy environment, maternal and and child caring practices, and food insecurity at individual child and

[5]With a $220 million concessional loan from the World Bank and other funding, TASAF III seeks to roll out its package of cash transfers and seasonal wage income from public works to an estimated 250 to 275 thousand poor households within five years (2013-17), covering every district in the country. Additional funding could be made available at that point to expand the reach of the program even further. The aim is to gradually make the PSSN into the cornerstone of a permanent social safety net in Tanzania, which can help poor families weather the effects of recurrent shocks and chart pathways out of chronic poverty.

household level) and Basic Causes (socio-economic and political factors at the household and societal level). Underpinning the framework is the assumption that factors at one level influence factors within the same level and other levels. For example, a household's wealth (a basic cause) can affect its ability to access health services and food (underlying causes) which in turn determines their children's dietary intake and health status (immediate causes). To illustrate this point, UNICEF (1990) uses the formal education system as an example. Schools "play an important role as the interface between underlying and basic causes as they provide basic services but also promote improved practices regarding food production and child care (underlying causes)." In short, malnutrition and death in children and women are the results of a long sequence of interlinked events that should be analyzed holistically so that a local model can emerge.

Figure X. UNICEF Conceptual Framework of Malnutrition



Source: UNICEF 1990.

3. Methodology

We employ linear probability regression models to establish the relationship between stunting status of children (binary outcome) and the various potential causes identified in the UNICEF conceptual framework. Linear probability regression model expresses the stunting status of under 5 children as a function of the five groups of predictors or variables as suggested in the conceptual framework.

$$Y_i = \beta_0 + \beta_1 Food_i + \beta_2 Ill_i + \beta_3 Care_i + \beta_3 Health_i + \beta_4 Resources_i + \varepsilon_i$$

Y_i indicates the stunting status, 1 being stunted, 0 being not stunted; Food, IllNESS, Care, Health, and Resources represent variables vectors derived from UNICEF conceptual framework that will aid in predicting the chronic nutrition status of children; β_0 is the intercept, and other β are the effects of each variables vectors on the likelihood of a child being stunted; ***i*** indicates individual children; ε_i is the error term.

Given that we have dichotomous dependent variables, logit regression model is also exploited to estimate the relationship between dependent variable and other predictors of stunting. However, coefficient estimates from a logit model is not easy to interpret. Therefore we also calculate the marginal effects from logit model where continuous variables are set at mean values and median are used as reference values for discrete variables.[6] However, we found these results comparable to those reported and discussed in the results section below.[7]

We also run different specifications of the linear probability model to see if the relationship is robust to adding more variables step by step following the hierarchy of the conceptual framework. We first examine the correlation between the immediate causes such as food intake, illness of children and food security (specification 1) and then add the measures of underlying causes on children's individual characteristics (specification 2); care vector (specification 3); health environment vector (specification 4) and eventually the basic causes on households' resources and control vector are included (specification 5).

4. Data: TDHS 2010 and summary statistics[8]

Tanzania Demographic and Health Survey 2010 (TDHS 2010) is the most recent in a series of nationally representative surveys of 10,300 households selected from 475 sample points throughout Tanzania. All women aged 15-49 years in these households and all men aged 15-49 years in a subsample of one-third of the households were individually interviewed. The survey collected information on fertility levels and preferences, maternal and child health and mortality, nutritional status of women and children aged 0-59 months, use of health services, and prevalence of malaria and its prevention and knowledge on HIV/AIDS along with household and demographic characteristics.[9]

---

[6]Marginal effects are calculated using command margins in Stata 11.0.

[7]Full results from the logit regression models are also available upon request from the authors.

[8]Difference between the summary statistics here and those in dhs could be due to weighting. Dhs report uses weighted averagess whereas we only use unweighted ones. There is a huge and unsettled debate on whether weight should be used for regression analysis. In addition, it is also related to the fact that the unknown/missing category of the reponses is also included in dhs report tabulation. Difference on ari, however, seems to be quite big.

[9]While the TDHS 2010 is the most suitable and latest household survey in Tanzania with the largest set of variables covering all potential causes identified in the UNICEF conceptual framework, it has several key shortcomings that limit the depth of our analysis and its interpretations. First, certain questions in the survey are only asked for the most recent birth of the women or for children in specific age groups. For example, antenatal care of women is only collected from respondents on their last delivery. Questions on women's decision making power within the households are only applied to women who are currently married or living with a man. Second, data on some indicators such as feeding practices relates to a short recall period, and may not reflect the longer term practices. Data on complementary feeding practices is only available for children aged less than 2 years and is only collected over the past 24 hours. There is no childhood disease information beyond the past two weeks. However, we need to have a child's history of illness in order to predict the effects of illness on stunting because

The analytical sample we constructed here consists of all under-5 children in rural Tanzania matched up with their maternal and household characteristics. As mentioned in the methodology section above, these variables are grouped into five categories. Variables in the **Food** category measure the security and availability of food at household and individual children level and include whether households have three meals a day, the frequency of being food insecure throughout the year. The **Ill** vector measures the status of children with three common childhood illness in the last two weeks before the day of the survey. The **Care** vector covers a much larger set of variables from maternal nutrition indicators such as children's birth weight and maternal boss mass index to whether children were delivered at home as opposed to be in medical facilities and whether a child was breastfed within 1 hour from birth and whether the salt used by the household is adequately iodised and slept under bed-nets as well as mothers' age and marital status. It also contains measure of the pull and push factors of the care of children by adults in the family such as mother's time spent on work throughout the year, number of under-5 children in the family and size of the households. Whether households have access to safe water and sanitation and whether the floor is made of materials and use charcoal as opposed to fire food and the distance to the nearest health facilities are used to proxy the **Healthiness** of children's environment. We proxy the household' control of **Resources** or entitlements of resources in the broader society with mother's education, wealth quintile of the households, whether the households own any land jointly or alone and the residence status. Last but not least, we also include some biological and demographic characteristics of individual children that are known predictors of their nutrition status such as children's age, children's sex, the birth order of a child and their mother's height for age.

For under 5 years old (see Table 1), 42% are stunted in rural Tanzania and 52% of children live in households which are able to have three meals per day. 20% of children live in household reporting **food security** problem sometimes. In the last two weeks before the survey, children experienced prevalence of common childhood **illness** such as diarrhea, fever and acute respiratory infection at 14%, 21% and 7% respectively.

Huge gaps in terms of **caring practices** for women and children exist in Tanzania. Less than half of all births are delivered in a health facility. 8% of children are reported to have been smaller than average at birth by their mothers. Yet, vitamin A supplementation and use of bednets while sleeping are found to be at reasonably high levels although less than ideal. Close to 64% of children's mothers[10] have to work seasonally or occasionally while 24% have full time job. Average household size is fairly large at 7.4. There are also on average 2.2 children under 5 years old per household. The overall rate of the initiation of breastfeeding within one hour is high at 61%

Children face significant challenges in **Health Services and Healthy Environment** in Tanzania. 41% of children have access to safe water and a mere 13% have access to safe sanitation facility, 5% use charcoal as cooking fuel as opposed to firewood and 78% live in households with earth, sand or dung floor. The average distance to a health facility is 4.4 kilometers in Tanzania. Less than half of all under 5 children live in households which consume adequately iodized salt.

---

stunting is a long-term measure of the nutrition of a child.. Third, like any other household surveys which faces a binding budget constraint, TDHS 2010 has to economize on questions outside the demographics and health field that forms the context under which household operates. Despite the shortcomings identified above, TDHS 2010 is still the most comprehensive survey on health and nutrition matters that facilitate the stunting analysis.

[10]Here mothers actually mean individual children under five years old. It is used interchangeably because the wording would be otherwise lengthy, i.e. children who are born to mothers who.

There are huge disparities among households of the **Resources/Controls** they have. Slightly less than half of all mothers of children under 5 years old completed primary education and another 46% either never got to school or could not finish primary schooling. Only 8% children have mothers who are able to attain some secondary education or higher. Sole or joint ownership of land by rural mothers with under 5 years old are less common at 34% and 9% respectively.

Summary statistics is also presented in Table 1 for children under 2 years old and children between 2 and 5 years old respectively. Most of the variables show similar patterns described above with a few exceptions. Vitamin A supplement increases across the two age groups from 50 per cent to 60 per cent. 2 to 5 years old are at much lower risk to develop childhood illnesses compared to the under 2 children more so for diarrhea than fever and acute respiratory infections.

There is an additional variable included in the under 2 years old sample. Approximately a quarter of children aged 0-23 months are fed according to recommended practices on Infant and Young Child Feeding (IYCF).

5. Results

This section presents the regression results from the linear probability models by the hierarchy of causes in the conceptual framework followed by heterogeneity analysis by age groups of children (see Table 2).

6.1. Immediate causes

When only immediate causes are included in specification (1), all food intake and food security variables are statistical significantly predicator of children's stunting status with the expected direction of correlation whereas children diseases have very small and statistical insignificant effects. To be specific, children under 5 years old living in households who eat three meals per day is 4.3 percentage points less likely to be stunted compared to those who only eat one or two meals per day. Children who living in households seldom or never experiencing any food insecurity are 3.6 and 4.9 percentage points less likely to have their children stunted compared to those reporting food insecure throughout the year. These effects are attenuated slightly when individual children's characteristics are introduced. But they are attenuated by around half and are no longer statistically significant when underlying causes on Care and Healthiness are included in the specification. When we further control for the basic causes of stunting such as family wealth quintile and maternal education, all of the coefficient estimates continue to be reduced and remain statistically insignificant.

This overall picture belies the heterogeneity among the under 5 population. The food security significantly reduce the probability of stunted for children between 2 and 5 but are rather weak predictors for children under two years old even after controlling for all possible factors. In fact, results suggest that food security may even increase the chances of stunting for children under two.[11]

Childhood illness is not found to be associated with stunting but it is also the least well-measured risk factors in the survey data. Therefore we should be cautious on our inference.

[11]I have to admit that this comes as a surprise. It is possible that relatively food secure household may be tempted to give complementary food too early and reduce intake of mother's breast milk.

6.2. Individual characteristics

Results show that boys are at 6 percentage points more likely to be stunted than girls, a difference constant across these specifications.[12] Being a younger sibling seems to increase the chance of stunting but only statistically significant for children less than two years old. It is found that one standard deviation increase in mother's height will reduce the chances of stunting by around 11 percentage points with the effects on under-2 children 3 percentage points smaller.[13]

6.3. Underlying causes

1. Care

Among the Care vector, a proxy of maternal nutrition, children's birth weight is the strongest predictor of stunting status. The probability of stunting for a child whose birth weight is larger than average is 10 percentage points lower than those who are reported as smaller than average at birth constant across the two age groups of children. Another measure of mother's maternal nutrition, body mass index is also negatively correlated with stunting although it has a much lower effect (1 percentage point). Mother's time spent working outside the household is another powerful predictor of children's stunting status. Compared with mothers who do not work at all, children with mothers who work either seasonably or full time is 5 percentage points more likely to be stunted. However, it seems to be primarily driven by the under-2 sample. Results also show that stunting rises with number of under 5 children in the family but declines with the total size of the household but primarily for the sample of two to five years old. Children's stunting status is a convex function of mother's age, suggesting that adolescent pregnancy is a risk factor for stunting. On the other hand, indicators on place of birth delivery, whether children were given vitamin A supplementation in the past six month and whether children sleep under bednet last night have no predictive power on stunting. All the coefficient estimates mentioned above are rather stable and not sensitive to the addition of healthy and resources variables.

2. Healthy environment

Access to safe water and sanitation seem to reduce the risk of being stunted but they are not statistically significant after controlling for the basic causes. These results have to be interpreted with caution because the water and sanitation questions are already used to generate the wealth indexes in TDHS.[14] Cleaner means of cooking fuel, poor floor materials, consumption of adequately iodised salt and distance to health facility remain insignificant predictor of stunting across all the specifications.

---

[12]It is consistent with earlier findings on stunting in Sub-Saharan Africa (Wamani et al 2007). The literature I have seen so far is only speculative except one 2004 working paper at East-West Center in University of Hawaii looking at if it can be attributed to differential feeding practices or care in the context of India (Mishra, Roy, and Retherford, 2004).

[13]These results indicate strongly that some of the biological factors are most important risk factor for childhood stunting. It is worth noting particularly because it is outside the UNICEF conceptual framework.

[14]"The wealth index was constructed using household asset data and principal components analysis. Asset information was collected in the 2010 TDHS Household Questionnaire and covers information on household ownership of a number of consumer items, ranging from a television to a bicycle or car, as well as information on dwelling characteristics, such as source of drinking water, type of sanitation facilities, and type of materials used in dwelling construction" (TDHS Report, 2010).

6.4. Basic causes

Mothers who finished secondary education or higher are 6 percentage points less likely to have stunted children. This effect is larger but also only statistically significant for under-2 sample only. There are no statistical significant difference between those with complete primary education and those below them.

Family wealth also shows a similar hurdle effects. There is no difference between the poorest and the second poorest quintile on stunting. The middle quintile seems to be doing better but the effect is not statistically significant. On the contrary, the rich quintile and the richest quintile are 6 percentage points less likely to have stunted children compared to the poorest quintile. The effects are primarily driven by results from the 2-5 years old sample. The rich wealth quintile and the richest wealth quintile are 10 and 19 percentage points less likely to have stunted children.

Landownership of mothers has no explanatory power on stunting.

6. Policy Implications and Recommendations:

Multivariate linear probability regression model is established to study the relative contribution of various risk factors identified by the UNICEF conceptual framework of malnutrition (1990). Empirical findings from the full sample of under 5 children indeed suggest that stunting is a manifestation of **multi-dimensional** factors as stipulated in the conceptual framework. In this section, we discuss the results in relation to the Productive Social Safety Net progrmame.

As shown in previous section, the determinants of stunting **vary by children's age**. For children less than 2 years old, stunting is more strongly determined by mother's work status, birth weight, mom's height, children's gender and mother's education attainment. Family wealth and food security are not significant predictors. In fact, children less than two years old from the relatively wealthy and better food endowed families seem to do worse on stunting.

In contrast, for children between 2 and 5 years old, wealth and food security factors become much stronger predictors of stunting than before. The size of the households and the number of under 5 in the family hold much more sway in determining stunting status than under 2 years old. The effect of height of mother on children's chance of stunting intensifies. So did birth weight variables.

It suggests that the caring from one's mother is most probably indispensable and irreplaceable at this early stage but as they age, substitute care can be sought to replace the maternal care if there is such supply readily available to meet the demands in the households. This suggests that biology and maternal attention trump other more medium-term and long-term causes in the beginning of the children's life but as children age, family resources, food security and access to healthcare gradually start to exert their influence. It also provides evidence on the **cumulative effects of biological factors** as the correlation between mother's height and children's stunting status is much stronger for 2 to 5 years old compared to those below 2.[15]

[15]This can be rephrased into intergenerational effects. I think what is interesting here is to try to link it with mother's age and make a stronger case of the links between the stunting risks associated with teenage pregnancy, lower education level of teenage girls (who drop out of school because of pregnancy) and consequent inadequate knowledge of appropriate IYCF practices and lower prospects of escaping the poverty trap with the vicious circle of stunting perpetuating itself across generations.

What does this mean for the Productive Social Safety Net programme? How can PSSN utilize these evidences to make informed decisions about the design of their programme to achieve impact on stunting? First of all, the effects of cash transfer which is designed to improve food consumption may take time to affect children's anthropometric measures and for children younger than 2 years old, the effects may be very minimal. One has to be cautious also not to put burden on mother's time or distract mother's attention away from their children under 2 for collecting the cash (FAO, 2012). The detrimental effect of such a cash transfer will outweigh the benefits from additional incomes as shown in the paper. For older children, however, the tradeoff may be in the favor of cash against mother's time to care. Second, women with young children less than two years old should not be eligible for the Public Work Component or if they are indeed eligible, the time they can spend has to be limited not to compete with their time for breastfeeding and other care to the children. This is indeed practiced in Ethiopia's Productive Safety Net Programme (Save the Children 2012). Lesson could also be learned from the experience of Ethiopia's Tigray cash transfer programme supported by UNICEF which integrates community health extension services into the public work component (Save the Children 2012).

References:

Alderman H, H, Hoogeveen and M. Rossi M (2006). Preschool nutrition and Subsequent Schooling Attainment: Longitudinal Evidence from Tanzania. Mimeo.

Black RE, Cousens S, Johnson H, et al. Global, regional, and national causes of child mortality, 2008. Lancet 2010; 375: 1969–87.

Crookston BT, Penny ME, Alder SC, Dickerson TT, Merrill RM, Stanford JB, Porucznik CA, Dearden KA. 2010. Children who recover from early stunting and children who are not stunted demonstrate similar levels of cognition. Journal of Nutrition. 2010 Nov;140(11):1996-2001.

Food and Agriculture Organization. 2012. Social Protection and Nutrition.

James Garrett and Marcela Natalicchio. 2011. Working Multisectorally in Nutrition: Principles, Practices, and Case Studies.

Stuart Gillespie, Lawrence Haddad, Venkatesh Mannar, Purnima Menon, Nicholas Nisbett. 2013. The politics of reducing malnutrition: building commitment and accelerating progress The Lancet 10 August (Volume 382 Issue 9891 Pages 552-569 DOI: 10.1016/S0140-6736(13)60842-9)

Kavishe, 1993. Nutrition−Relevant Actions in Tanzania. UN ACC/SCN country case study supported by UNICEF United Nations Children's Fund. A case study for the XV Congress of the International Union of Nutritional Sciences, Adelaide.

Jef L. Leroy, Paola Gadsden & Maite Guijarro, (2012) The impact of daycare programmes on child health, nutrition and development in developing countries: a systematic review. Journal of Development Effectiveness 4:3, pages 472-496.

Marie T Ruel and Harold Alderman. 2013. Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition?,the Maternal and Child Nutrition Study Group. The Lancet - 10 August (Vol. 382, Issue 9891, Pages 536-551) DOI: 10.1016/S0140-6736(13)60843-0

Save the Children. 2012. Realising the nutrition potential of social protection: progress and challenges.

Tanzania Food and Nutrition Center. 2004. Causes of malnutrition and Tanzania's nutrition programs past and present.

UNICEF, 1990. Strategy for improved nutrition of children and women in developing countries: a UNICEF policy review.

Henry Wamani, Anne Nordrehaug Åstrøm, Stefan Peterson, James K Tumwine and Thorkild Tylleskär. Boys are more stunted than girls in Sub-Saharan Africa: a meta-analysis of 16 demographic and health surveys. BMC Pediatrics 2007, 7:17.

Table 1. Summary Statistics for Children by Age Group

Variable	Under 5 sample					Under 2 Sample					2-5 yrs old Sample				
	Obs	Mean	Std. Dev.	Min	Max	Obs	Mean	Std. Dev.	Min	Max	Obs	Mean	Std. Dev.	Min	Max
Stunting==1	5017	0.419	0.494	0	1	2154	0.350	0.477	0	1	2863	0.472	0.499	0	1
Have three meals/day==1	5017	0.53	0.499	0	1	2154	0.531	0.499	0	1	2863	0.530	0.499	0	1
Often food insecure==1	5017	0.219	0.414	0	1	2154	0.217	0.412	0	1	2863	0.220	0.415	0	1
Sometimes food insecure==1	5017	0.208	0.406	0	1	2154	0.200	0.400	0	1	2863	0.214	0.410	0	1
Seldom food insecure==1	5017	0.197	0.398	0	1	2154	0.194	0.395	0	1	2863	0.199	0.399	0	1
Never food insecure==1	5017	0.377	0.485	0	1	2154	0.390	0.488	0	1	2863	0.367	0.482	0	1
Diarrhea in last 2 weeks	5017	0.14	0.347	0	1	2154	0.197	0.398	0	1	2863	0.097	0.297	0	1
Fever in last 2 weeks	5017	0.221	0.415	0	1	2154	0.244	0.430	0	1	2863	0.204	0.403	0	1
ARI in last 2 weeks	5017	0.075	0.263	0	1	2154	0.083	0.276	0	1	2863	0.068	0.252	0	1
Age of child in months	5017	28.45	17.184	0	59	2154	11.546	6.828	0	23	2863	41.164	10.281	24	59
Age of child in months squared	5017	1105	1034.714	0	3481	2154	179.913	163.539	0	529	2863	1800.129	853.720	576	3481
Male child==1	5017	0.497	0.500	0	1	2154	0.482	0.500	0	1	2863	0.509	0.500	0	1
Children's order of birth	5017	4.459	2.557	1	11	2154	4.083	2.528	1	11	2863	4.742	2.543	1	11
Mother's height for age in standard deviations	5017	-1.232	0.984	-4.81	3.66	2154	-1.233	0.984	-4.81	3.66	2863	-1.231	0.985	-4.48	3.66
Birth weight small==1	5017	0.075	0.264	0	1	2154	0.078	0.269	0	1	2863	0.073	0.260	0	1
Birth weight average==1	5017	0.742	0.438	0	1	2154	0.736	0.441	0	1	2863	0.746	0.435	0	1
Birth weight larger than average==1	5017	0.183	0.387	0	1	2154	0.185	0.389	0	1	2863	0.181	0.385	0	1
Body Mass Index of Mom	5017	22.13	3.368	12.08	41.36	2154	21.972	3.231	12.08	41.36	2863	22.249	3.464	14.54	41.36
Home delivery==1	5017	0.573	0.495	0	1	2154	0.563	0.496	0	1	2863	0.581	0.494	0	1

Size of households	5017	7.323	3.870	2	38	2154	7.435	4.203	2	38	2863	7.239	3.597	2	38
Number of under 5 children in hhlds	5017	2.269	1.291	1	13	2154	2.345	1.385	1	13	2863	2.211	1.213	1	13
Mom not working==1	5017	0.11	0.313	0	1	2154	0.115	0.319	0	1	2863	0.107	0.309	0	1
Mom working seasonally or occasionally==1	5017	0.65	0.477	0	1	2154	0.662	0.473	0	1	2863	0.641	0.480	0	1
Mom working all year long==1	5017	0.24	0.427	0	1	2154	0.223	0.416	0	1	2863	0.253	0.435	0	1
Vitamin A supplement last 6 months==1	5017	0.584	0.493	0	1	2154	0.500	0.500	0	1	2863	0.647	0.478	0	1
Children sleep under bednet==1	5017	0.784	0.412	0	1	2154	0.786	0.410	0	1	2863	0.781	0.413	0	1
Current age of mom	5017	29.84	7.120	15	49	2154	28.363	6.982	15	49	2863	30.958	7.020	16	49
Current age squared of mom	5017	941.3	446.018	225	2401	2154	853.164	418.681	225	2401	2863	1007.691	454.454	256	2401
Married or with partner==1	5017	0.882	0.323	0	1	2154	0.876	0.330	0	1	2863	0.886	0.318	0	1
Safe water==1	5017	0.417	0.493	0	1	2154	0.403	0.491	0	1	2863	0.428	0.495	0	1
Safe sanitation==1	5017	0.13	0.336	0	1	2154	0.136	0.343	0	1	2863	0.125	0.330	0	1
Earth, sand or dung floor==1	5017	0.812	0.391	0	1	2154	0.807	0.395	0	1	2863	0.816	0.388	0	1
Type of cooking fuel==charcoal	5017	0.047	0.211	0	1	2154	0.049	0.216	0	1	2863	0.045	0.207	0	1
Salt has 15 ppm of iodine==1	5017	0.453	0.498	0	1	2154	0.454	0.498	0	1	2863	0.453	0.498	0	1
Distance to nearest health facility	5017	4.275	5.071	0	51	2154	4.356	5.182	0	50	2863	4.215	4.986	0	51
Distance squared to nearest health facility	5017	43.99	134.122	0	2601	2154	45.818	132.579	0	2500	2863	42.619	135.278	0	2601
Mom has incomplete primary or below==1	5017	0.455	0.498	0	1	2154	0.452	0.498	0	1	2863	0.458	0.498	0	1
Mom has primary education==1	5017	0.466	0.499	0	1	2154	0.457	0.498	0	1	2863	0.473	0.499	0	1
Mom has secondary education or	5017	0.078	0.269	0	1	2154	0.091	0.288	0	1	2863	0.069	0.253	0	1

above==1															
Poorest quintile	5017	0.236	0.425	0	1	2154	0.236	0.425	0	1	2863	0.236	0.425	0	1
2nd poorest quintile	5017	0.274	0.446	0	1	2154	0.283	0.450	0	1	2863	0.268	0.443	0	1
Middle quintile	5017	0.247	0.432	0	1	2154	0.235	0.424	0	1	2863	0.256	0.437	0	1
Rich quintile	5017	0.194	0.395	0	1	2154	0.195	0.396	0	1	2863	0.194	0.395	0	1
Richest quintile	5017	0.048	0.213	0	1	2154	0.051	0.220	0	1	2863	0.045	0.208	0	1
Mom owning no land==1	5017	0.555	0.497	0	1	2154	0.596	0.491	0	1	2863	0.524	0.500	0	1
Mom owning land jointly==1	5017	0.357	0.479099	0	1	2154	0.327	0.469	0	1	2863	0.379	0.485	0	1
Mom owning land alone==1	5017	0.088	0.284048	0	1	2154	0.077	0.266	0	1	2863	0.097	0.297	0	1

Table 2: Full Regressions Tables by Age Group

	Under 5 sample					Under 2 sample					2-5 sample				
VARIABLES	(1)	(2)	(3)	(4)	(5)	(1)	(2)	(3)	(4)	(5)	(1)	(2)	(3)	(4)	(5)
Have three meals/day==1	-0.043***	-0.035***	-0.021	-0.018	-0.015	-0.033	-0.030	-0.020	-0.019	-0.017	-0.051***	-0.040**	-0.024	-0.018	-0.016
	(0.014)	(0.013)	(0.014)	(0.014)	(0.014)	(0.021)	(0.020)	(0.020)	(0.020)	(0.020)	(0.019)	(0.018)	(0.018)	(0.018)	(0.019)
Sometimes food insecure==1	-0.010	-0.009	-0.009	-0.007	-0.004	0.076**	0.069**	0.065**	0.068**	0.072**	-0.074***	-0.069**	-0.063**	-0.060**	-0.060**
	(0.021)	(0.020)	(0.020)	(0.020)	(0.021)	(0.032)	(0.030)	(0.030)	(0.030)	(0.030)	(0.028)	(0.027)	(0.028)	(0.028)	(0.028)
Seldom food insecure==1	-0.036*	-0.026	-0.025	-0.021	-0.017	0.008	0.009	0.002	0.004	0.008	-0.069**	-0.059**	-0.053*	-0.046	-0.043
	(0.022)	(0.021)	(0.021)	(0.021)	(0.021)	(0.032)	(0.030)	(0.030)	(0.030)	(0.031)	(0.029)	(0.028)	(0.028)	(0.028)	(0.028)
Never food insecure==1	-0.049***	-0.040**	-0.029	-0.021	-0.015	0.011	0.005	0.010	0.013	0.017	-0.088***	-0.078***	-0.062**	-0.050**	-0.042*
	(0.019)	(0.018)	(0.018)	(0.018)	(0.019)	(0.028)	(0.026)	(0.026)	(0.027)	(0.027)	(0.025)	(0.024)	(0.025)	(0.025)	(0.025)
Diarrhea in last 2 weeks	-0.005	0.004	-0.000	0.001	0.002	-0.001	-0.013	-0.018	-0.015	-0.016	0.046	0.026	0.026	0.026	0.030
	(0.020)	(0.020)	(0.020)	(0.020)	(0.020)	(0.027)	(0.026)	(0.026)	(0.026)	(0.026)	(0.032)	(0.031)	(0.031)	(0.031)	(0.031)
Fever in last 2 weeks	0.013	0.002	0.003	0.004	0.004	0.045*	0.025	0.025	0.027	0.028	-0.006	-0.010	-0.006	-0.007	-0.006
	(0.018)	(0.017)	(0.017)	(0.017)	(0.017)	(0.026)	(0.024)	(0.024)	(0.024)	(0.024)	(0.024)	(0.023)	(0.023)	(0.023)	(0.023)
ARI in last 2 weeks	-0.016	-0.013	-0.009	-0.007	-0.007	-0.036	-0.038	-0.038	-0.034	-0.037	0.002	0.009	0.014	0.018	0.018
	(0.028)	(0.027)	(0.027)	(0.027)	(0.027)	(0.039)	(0.036)	(0.036)	(0.036)	(0.036)	(0.039)	(0.038)	(0.039)	(0.038)	(0.038)
Age of child in months		0.027***	0.027***	0.027***	0.027***		0.013**	0.016***	0.015***	0.015**		0.004	0.003	0.002	0.004
		(0.001)	(0.001)	(0.001)	(0.001)		(0.005)	(0.006)	(0.006)	(0.006)		(0.008)	(0.008)	(0.008)	(0.008)
Age of child in months squared		-0.000***	-0.000***	-0.000***	-0.000***		0.000	0.000	0.000	0.000		-0.000	-0.000	-0.000	-0.000
		(0.000)	(0.000)	(0.000)	(0.000)		(0.000)	(0.000)	(0.000)	(0.000)		(0.000)	(0.000)	(0.000)	(0.000)
Male child==1		0.062***	0.065***	0.064***	0.064***		0.078***	0.087***	0.086***	0.087***		0.049***	0.047***	0.048***	0.047***
		(0.013)	(0.013)	(0.013)	(0.013)		(0.019)	(0.019)	(0.019)	(0.019)		(0.018)	(0.018)	(0.018)	(0.018)
Children's order of birth		0.002	0.009**	0.008*	0.007		0.004	0.015*	0.014*	0.014*		0.000	0.004	0.002	0.001
		(0.003)	(0.005)	(0.005)	(0.005)		(0.004)	(0.008)	(0.008)	(0.008)		(0.004)	(0.006)	(0.006)	(0.006)

Mother's height for age in standard deviations	-0.107***	-0.108***	-0.108***	-0.108***	-0.071***	-0.071***	-0.072***	-0.073***	-0.134***	-0.134***	-0.134***	-0.134***
	(0.006)	(0.006)	(0.006)	(0.006)	(0.009)	(0.009)	(0.009)	(0.010)	(0.009)	(0.009)	(0.009)	(0.009)
Birth weight average==1		-0.058**	-0.062**	-0.064**		-0.043	-0.048	-0.044		-0.064*	-0.067*	-0.071**
		(0.025)	(0.025)	(0.025)		(0.036)	(0.036)	(0.036)		(0.035)	(0.034)	(0.035)
Birth weight larger than average==1		-0.098***	-0.104***	-0.108***		-0.100**	-0.106***	-0.102**		-0.096**	-0.101***	-0.110***
		(0.028)	(0.028)	(0.028)		(0.040)	(0.040)	(0.041)		(0.039)	(0.039)	(0.039)
Body Mass Index of Mom		-0.012***	-0.011***	-0.010***		-0.006**	-0.006*	-0.006**		-0.015***	-0.013***	-0.012***
		(0.002)	(0.002)	(0.002)		(0.003)	(0.003)	(0.003)		(0.002)	(0.003)	(0.003)
Home delivery==1		0.015	0.008	0.008		0.003	-0.001	-0.004		0.020	0.011	0.011
		(0.014)	(0.014)	(0.014)		(0.021)	(0.021)	(0.021)		(0.019)	(0.019)	(0.019)
Size of households		-0.007***	-0.007***	-0.006**		-0.004	-0.003	-0.004		-0.010***	-0.010***	-0.008**
		(0.003)	(0.003)	(0.003)		(0.004)	(0.004)	(0.004)		(0.004)	(0.004)	(0.004)
Number of under 5 children in hhlds		0.018**	0.015*	0.014*		0.002	-0.002	-0.002		0.034***	0.031***	0.029**
		(0.008)	(0.008)	(0.008)		(0.011)	(0.011)	(0.011)		(0.011)	(0.011)	(0.011)
Mom working seasonally or occasionally==1		0.067***	0.053**	0.045**		0.154***	0.143***	0.140***		0.008	-0.011	-0.019
		(0.021)	(0.021)	(0.022)		(0.028)	(0.029)	(0.029)		(0.030)	(0.031)	(0.030)
Mom working all year long==1		0.048**	0.046**	0.046**		0.120***	0.118***	0.116***		-0.002	-0.006	-0.003
		(0.024)	(0.024)	(0.024)		(0.032)	(0.032)	(0.032)		(0.033)	(0.033)	(0.033)
Vitamin A supplement last 6 months==1		-0.007	0.003	0.005		-0.040*	-0.030	-0.028		0.006	0.017	0.019
		(0.014)	(0.015)	(0.015)		(0.022)	(0.022)	(0.023)		(0.019)	(0.020)	(0.020)
Children sleep under bednet==1		-0.017	-0.011	-0.010		-0.002	0.002	0.001		-0.032	-0.026	-0.026
		(0.016)	(0.016)	(0.016)		(0.023)	(0.023)	(0.023)		(0.022)	(0.022)	(0.022)

Current age of mom	-0.016**	-0.015*	-0.016**	-0.030***	-0.028**	-0.027**	-0.005	-0.004	-0.006
	(0.008)	(0.008)	(0.008)	(0.011)	(0.011)	(0.011)	(0.011)	(0.011)	(0.011)
Current age squared of mom	0.000*	0.000*	0.000*	0.000**	0.000**	0.000**	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Married or with partner==1	-0.001	-0.004	-0.003	0.022	0.018	0.028	-0.023	-0.023	-0.029
	(0.021)	(0.021)	(0.021)	(0.029)	(0.029)	(0.030)	(0.029)	(0.029)	(0.030)
Safe water==1		-0.028*	-0.021		-0.030	-0.031		-0.021	-0.010
		(0.014)	(0.014)		(0.020)	(0.021)		(0.019)	(0.019)
Safe sanitation==1		-0.036*	-0.019		-0.040	-0.051		-0.028	0.008
		(0.021)	(0.023)		(0.030)	(0.032)		(0.030)	(0.032)
Earth, sand or dung floor==1		0.023	-0.019		-0.007	0.019		0.050*	-0.032
		(0.019)	(0.027)		(0.028)	(0.040)		(0.026)	(0.035)
Type of cooking fuel==charcoal		-0.020	-0.006		0.043	0.021		-0.075*	-0.028
		(0.032)	(0.033)		(0.046)	(0.049)		(0.043)	(0.045)
Salt has 15 ppm of iodine==1		-0.008	-0.007		-0.013	-0.014		-0.001	0.001
		(0.013)	(0.013)		(0.019)	(0.020)		(0.018)	(0.018)
Distance to nearest health facility		0.003	0.003		0.005	0.005		0.003	0.002
		(0.003)	(0.003)		(0.004)	(0.004)		(0.004)	(0.004)
Distance squared to nearest health facility		-0.000	-0.000		-0.000	-0.000		-0.000	0.000
		(0.000)	(0.000)		(0.000)	(0.000)		(0.000)	(0.000)
Mom has primary education==1			0.014			-0.009			0.032
			(0.014)			(0.021)			(0.019)

Mom has secondary education or above==1					-0.056**					-0.070*					-0.034
					(0.028)					(0.038)					(0.040)
2nd poorest quintile					-0.008					-0.005					-0.008
					(0.019)					(0.028)					(0.026)
Middle quintile					-0.028					-0.014					-0.034
					(0.020)					(0.030)					(0.028)
Rich quintile					-0.060**					0.015					-0.104***
					(0.029)					(0.044)					(0.039)
Richest quintile					-0.063					0.110					-0.193***
					(0.049)					(0.073)					(0.066)
Mom owning land jointly==1					0.009					-0.027					0.030
					(0.015)					(0.023)					(0.021)
Mom owning land alone==1					0.004					0.019					-0.003
					(0.025)					(0.038)					(0.032)
Constant	0.469***	-0.026	0.487***	0.442***	0.488***	0.339***	-0.014	0.479***	0.471***	0.449**	0.557***	0.416***	0.894***	0.818***	0.873***
	(0.017)	(0.027)	(0.126)	(0.129)	(0.131)	(0.025)	(0.040)	(0.174)	(0.179)	(0.182)	(0.022)	(0.159)	(0.248)	(0.251)	(0.252)
Observations	5,017	5,017	5,017	5,017	5,017	2,154	2,154	2,154	2,154	2,154	2,863	2,863	2,863	2,863	2,863
R-squared	0.004	0.111	0.127	0.130	0.132	0.006	0.132	0.154	0.158	0.161	0.009	0.096	0.115	0.121	0.126

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Notulensi Theme 5:
Enabling Environment for Social Protection

Notetaker: Sofni Lubis

Presenter 1:
Name : Tamo Chattopadhay - Institute for Education and Social Development, India
Title : From Social Protection to Social Inclusion for Children in Poverty: Bridging the Disparities with Integrated Policy Design

Highlights of Conclusions and Recommendations:

- It is essential to integrate poor children in the policy design as part of the design
- Child-focused policy truly becomes one of the results of poverty reduction
- Poverty and lack of access in many ways is the ground analysis of the study
- Suggesting 3R model in thinking about social capital: relationships, resources, readyness. This enabled the writer to look at the relationship between children and social capital
- Child abuse always takes place inside the home
- If you identify a domestic child labor, then you have to send him/her to school
- School is a kind of shelter for street children
- Using social capital for both disadvantaged and non-disadvantaged groups is a useful theory and relevant in the urban context.

Presenter 2:
Name : Melissa Siegel - Maastricht Graduate School of Government, Netherlands
Title : Children with An Absent Parent: Are They Worse Off?

Highlights:

- There is extreme out migration particularly in Moldova
- There is a growing concern on children left-behind, especially those left by their mothers
- There is a growing sentiment that women leaving the country at the first place as more and more migration is feminized
- The study uses a multidimensional wellbeing approach
- The studied 6 dimensions are: education, health, material, communication, protection, emotional
- The indicators used are those that are relevant for one country
- The study looks at children 0-18 years old, but it particularly it looks at 5-17 years old children because it's quite problematic to look at for children under 5

- The study is more on descriptive statistics
- Children have lower access to material well-being in migrant households in Moldova but we found a quite positive impact on returning migrant HHs
- In Moldova, the mothers of children under 18 are leaving. In Georgia, the mothers of children above 18 years are leaving.
- We found children living with their caregivers under 40 years old in multigenerational households.

Presenter 3:
Name : Rini Hartini Rinda A. - Sekolah Tinggi Kesejahteraan Sosial, Indonesia
Title : Enhancing Role of family and Social Worker for Children with Disability

Presenter 4:
Name : Wei Ha – UNICEF Tanzania
Title : One Size Doesn't Fit All: Stunting for Under 5 Children and Social Protection in Tanzania

Highlights:

- UNICEF Tanzania has two papers on Indonesia
- The study is an empirical study looking at the risk factors of stunting in Tanzania
- The study tries to draw some implications on stunting and see if it is relevant to Indonesia's case which has PKH Prestasi
- There`s a global focus on nutrition. The linkage between nutrition and social protection has forced the release of social protection program and policy
- In order to tackle malnutrition a multi sectoral intervention is needed. Social protection alone will not be effective.
- For children under 5 years old there are 2 groups: under 2 years old and 2-5 years old. There is a huge heterogeneity between these two groups.
- For children under 2, the mother`s time factor does matter for children stunting, but for children under 5 years old, many other indicators may determine the children stunting.

Discussant's comments:
Name : Dr. Ir. Harry Hikmat

Highlights:

- Isu terbesar saat ini adalah anak-anak dari keluarga miskin
- Ada hubungan antara norma, lingkungan yang kondusif, *parenting skill* untuk perlindungan sosial anak

- Anak-anak dari keluarga miskin beresiko terkena malnutrisi and hak-hak mereka terlanggar. Anak-anak dari keluarga migran menjadi terlantar, menjadi korban eksploitasi seksual komersial, atau pekerjaan terburuk. Begitu juga anak-anak yang mengalami masalah dalam pendidikan. Faktor kemiskinan menjadi isu utama.
- Pemerintah Indonesia sangat penting melakukan reorientasi kebijakan dan pembangunan social, terutama perlindungan sosial yang berbasis pada keluarga.
- Dalam konteks Indonesia, kita sering mengedepankan anak-anak yang diterlantarkan untuk ditempatkan di panti-panti asuhan/*institutional care* tanpa pengasuhan orangtua
- Persoalan-persoalan yang ada sudah cukup memberikan pemahaman pada pelayanan perlindungan secara langsung.
- Bagaimana kita memperkuat *family support program* yang diarahkan pada keluarga miskin sehingga anak-anak tidak beresiko menjadi anak-anak yang marjinal.
- Ada *in-home care services* dan *out-home care services* untuk melindungi anak-anak dari keluarga miskin.
- *Family support* untuk keluarga yang mempunyai anak dengan disabilitas menjadi penting
- Pendekatan-pendekatan yang berbasis keluarga menjadi sangat penting.
- Untuk anak-anak yang terpisah dari orangtua perlu ada *home visit* atau *outreaching*
- *Out-home care services* berbasis pada *kinship care*
- Indonesia saat ini sedang memproses suatu instrumen nasional bagi terbangunnya system pengasuhan alternative yang berbasis *foster parent*s (orng tua asuh) yang bisa memberikan status kepastian untuk kuasa asuh terhadap anak.
- Pada prinsipnya layanan-layanan di komunitas lebih pada pendekatan keluarga dan sudah dikembangkan oleh Kementerian Sosial sejak tahun 2004.
- Jika sistem pengaduan dan perlindungan anak sudah berjalan maka *institutional care* menjadi *alternative care* terakhir.
- Yang menarik bagi Kemensos, berbagai presentasi tadi akan memberi gambaran tentang perlindungan social, dan dapat dimanfaatkan untuk perbaikan kebijakan
- Ada dua *social/welfare system: basic social services and community empowerment*
- Presenter pertama mengungkapkan betapa pentingnya *social capital* dalam masyarakat. Perlindungan sosial bisa bersyarat/*conditional*, bisa juga tidak bersyarat/*unconditional*.
- Di Tanzania sudah ada *community work*.
- Bappenas saat ini mengetahui bahwa menghadapi masalah anak bukan hanya dengan perlindungan sosial saja tetapi harus diintegrasikan dengan pemberdayaan masyarakat.
- Pemerintah Indonesia fokus pada kebijakan yang *pro poor*
- Skala prioritas pada keluarga miskin harus menjadi prioritas utama
- Perlu sebuah strategi baru dengan *one-stop service*, tapi di Indonesia baru layanan satu atap, belum satu pintu.

Questions and Answers:

1. Alfiasari, IPB

Melissa Siegel
Question: Regarding children left-behind who are taken care by grandmother, why in Moldova's case there is no significant effect between migrant and children's wellbeing?

Answer: There`s a clear selection on the mothers. On average we don`t find any negative impact but of course there`s an outlier. The children are worst off, but I would put some cautionary notes. Migration was negative for children in Moldova. We can find negative cases anytime, anywhere, this study just wants to be careful there.

Tamo Chattopadhay, Institute for Education and Social Development, India
Question: Regarding 3R (relationships, resources, readiness) framework to explain the social capital, how to ensure that social network is ready to share their experience with poorer people?

Answer: We have to look at the issue of readiness to share experience in different ways. There was a very strong leadership in the school principals (there are 5 schools). There is a tendency and intention in terms of making it sustainable in other context.

2. Fuad, PUSKAPA- UI

Melissa Siegel
Question: Do you also cover children with disability in your research? When we talk about social wellbeing, CWD should be counted in. In your scheme I don't find the accessibility for disability. You just mentioned about communication, but how about children with hearing problem? What is your research's perspectives on CWD?

Answer: In our study the number of children with disability was very small. I don't feel comfortable to mention any number. For the comparative analysis we also look at the access to this.

3. Sabarina, UI

Wei Ha
Question: In regard to the groups comparing under 2 and 2-5 years old, how do you deal with this different determinant?

Answer: I`m using longitudinal or cross sectional data. The distribution of household across the quintiles. There are two layers on policy implications. We cannot expect policy implications to have an immediate impact. If we cannot tackle inequality we may not be able to have an immediate impact.

Rini Hartini Rinda A
Question: You mentioned about "pendampingan psikososial" for the family and CWD. You also mentioned about the existence of the social workers and the limitation of the number of the social workers. How do you deal with this problem?

Answer: Program psikososial ini penting untuk anak dengan disabilitas dan untuk ibu-ibu dengan anak disabilitas, bagaimana memberikan pengasuhan yang baik? Bagaimana mengimplementasikan program yang baik untuk anak? *Agent of change* yaitu pekerja social, sangat diperlukan. Upaya lain adalah melalui *social campaign*. Kementerian Sosial bekerja sama dengan Save the Children membuat buku tentang *parenting skill* untuk anak-anak dengan disabilitas.

4. Pitoyo Susanto, WVI Indonesia

Tamo: Thank you for sharing with us the Child Rainbow program. My question is in your research is there any questions regarding the impact on non-poor children when they interact with poor children? Regarding the sustainability of the project, how is the connection between the project and the Ministry of Education?

FINAL CONCLUSIONS & RECOMMENDATIONS:

1. We have to look at the issue of service providers, community structure and infrastructure
2. Develop comprehensive and holistic approach in looking at the different dimensions of child wellbeing when looking at the social protection program which requires multi sectoral approach. Therefore some elements in an enabling environment are including: policy framework that defines norms, resources (financial and human resources to ensure the availability of a service, and involvement of children as active agent of change
3. The presence of caregivers is expected to provide consistent care for the wellbeing of the children. As long as there is somebody consistently giving care
4. Availability of qualified and professional service providers (social workers), health care workers and others
5. The readiness of community's involvement, whether a self-help group or networks
6. Develop evidence for policy and program on social protection based on the local context whether it is modeling or piloting.

Policy Discussion I

1. **How Can Indonesia's Social Assistance Program Be More Child Sensitive?**
   Dr. Bambang Widianto (Executive Secretary of TNP2K

2. **Child Poverty in East Asia and the Pacific: Deprivations and Disparities: A Study of Seven Countries**
   Lena Nguyen (UNICEF East Asia and Pacific Regional Office, Thailand)

3. **Strengthening Community-Based Social Protection Practices for Child Protection**
   Ei Ei Thu (Social Policy and Poverty Research Group, Myanmar)

4. **Child Protection and Social Protection: Two Sides of the Same Coin?**
   Keetie Roelen (Institute of Development Studies, UK)

1 How Can Indonesia's social protection programs be more child sensitive?

Dr. Bambang Widianto
Deputy for Social Welfare and Poverty Alleviation/Executive Secretary to The National Team for the Acceleration of Poverty Reduction Office of the Vice President

Poverty in Indonesia

Indonesia is located within a region that has maintained high rates of economic growth for many years. Economic growth in Indonesia has been strong, averaging around 6% p.a. during the previous 4 years and it is estimated to reach 6,6% in 2013. GNI per capita has risen from $2,200 in 2000 to over $3500 in 2012, meaning Indonesia achieved Lower Middle Income status. As a result, poverty rates have declined from 17.8% in 2006 to 11.6% in 2012, and are expected to further reduce this year.

However, the rate of poverty reduction within Indonesia is slowing as the number of people positioned immediately below the poverty line starts to fall, reflecting those people who are partially or fully excluded from the growth of the economy due to factors such as geography. The national poverty rate of 11.6% means that 28.59 million people are still poor, and approximately 40% of Indonesians are living just above the poverty line and are therefore vulnerable to falling back into poverty.

As national poverty levels reduce, poverty becomes increasingly concentrated in regions where poverty reduction rates are weakest. In 2012 rural poverty rates were 14.7 percent, significantly higher than the urban poverty rate of 8.6 percent. The greatest percentage of poor people are living in Eastern Indonesia, but the largest number of people living in poverty are in Central and Western Indonesia. By 2015, more people will live in urban areas, and the whole of Java will be urbanized by 2025. Rising urbanisation in Indonesia provides opportunities as a one percent increase in urbanization is generally associated with a 2 percent increase in growth in Indonesia. However, economic growth has *not* progressed evenly, nor has poverty reduced evenly within the country, and Indonesia is now faced with rising inequality. Economic growth alone was not sufficient to lift lagging regions out of poverty, create enough jobs for our youth or fill in the gaps in education and infrastructure among our regions.

Child Poverty

Indonesia has approximately 85 million children, comprising 30% of the Indonesia's total population, and each year about 4-5 million babies are born. The most significant indicators of child poverty are health and nutrition, education and child labour.

Indonesia has seen steady declines in Infant Mortality Rates (IMR[1]) from more than 42.2/100 in 2000 to 34/100 births in 2007 and around 27/100 in 2010, and more recently 25/100 according to the WHO World Health Statistics 2013 report[2]. In 2010 maternal mortality rates (MMR[3]) were estimated at 220 per 100,000 births indicating Indonesia is unlikely to achieve the MDG target of 102 per 100,000 births by 2015. Chronic energy deficiency is a risk for 13% of women aged 15-45 compared to 24% of pregnant women, while anaemia among pregnant women is 44% and among non-pregnant women is 33%[4]. Nationally, the 2010 prevalence of stunting among children under-5 was 35.6 per cent, a fall of only 1.2 per cent since 2007, signifying that there are around 7.8 million stunted children in Indonesia. Rates for under-5 wasting and low birth weight in 2007 were 13.6% and 11.5% respectively; reducing only slightly to 13.3% and 11.1% in 2010. Indonesia is among 10 countries with the highest number of pre-term births, 15.5 babies out of every 100 live births are born too early — about 676,000 babies annually. The number of infants with low birth weight *increased* from 2.6% in 1991 to 5.5% in 2007[5]. Low birth weight is in part a reflection of maternal nutritional status. Maternal and neonatal death and of stunting are higher in the poorest provinces and among the poorest women and children.

Despite impressive increases in primary school enrolment and gender parity during the previous 10 years, most of the increase in education attainment rates is coming from the non-poor deciles. Children in poor families are still dropping out of school, often limited to only primary level education, late entry into school and consistently high repetition rates in primary schools resulting in large numbers of over-age poor children in the education system. There are significant discrepancies in educational attainment across the different regions, with a number of poor provinces lagging far behind the more prosperous provinces. According to the 2010 Census, more than 3.5 million children aged between 7 -15 years are out of school, comprising 1.4 million of primary school age and 2.1 million of Junior secondary school age, the majority of whom leave school during the transition from primary to junior secondary school. The 2010 Census 2010 also reported 848,951 children aged between 7 – 12 years who have never attended school. Data analysis of PPLS 2011 reported 815.483 children (437.028 boys and 378.455 girls) aged 7-12 years from the bottom 40 % of the population who have never attended school. Children with less than 4 years of education risk becoming functionally illiterate adults, and therefore are at a higher risk of living in poverty. Only 30% of children with disabilities go to school[6] compared to 90% of children without disabilities. The Ministry of Education and Culture reported that 295,763 children with disabilities are able to go to school in Indonesia in 2012, less than 30% of estimated

[1]The Infant Mortality Rate(IMR) is the annual number of deaths of infants under one year old in a given year per 1,000 live births in the same year; included is the total death rate, and deaths by sex, *male* and *female*.

[2] WHO World Health Statistics 2013.

[3] The maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year.

[4] WHO Databank of Anaemia 2005.

[5] Riskesdas 2007

[6] World Report on Disability 2011 jointly published by WHO and World Bank

school-aged children with special needs. The Education and Culture Ministry aims to reach 65% percent participation in primary education for children with disabilities by 2015.

Child labour has reduced but an estimated 3 million children aged under 15 years are working in potentially hazardous occupations. Some of these children may also be going to school. The majority of child work in Indonesia occurs in rural areas in agriculture (palm oil, cacao, tobacco, rubber, tea, and sugar plantations) and fishing and fisheries, small-scale mining and construction sectors. Children are also working in manufacturing, footwear production, food processing, woodworking and furniture carving, and textile production. In urban areas children are working in the informal sector, including those living on the street, selling newspapers, shining shoes, street vending, scavenging, and working beside their parents in family businesses or cottage industries. Indonesia's National Commission for Child Protection reported the number of child labourers under the age of 17 years had reached 4.7 million children in Indonesia in 2013. Analysis of the UDB found more than 500,000 children aged between 5 and 14 years of age were working. Male children aged 10 -14 living in rural areas were more likely to be working and working children aged 5 – 9 worked on average 16 hours per week compared to 23 hours of work per week by children aged 10 -14 years. SUSENAS 2012 revealed that 25.8% of children aged 10-14 do not go to school and are working. Indonesia has set an ambitious target to be free of child laborers by 2020[7].

Social Protection

There is clear evidence that social protection can reduce poverty and support inclusive development. Indonesia's international economic integration makes social protection programs more, rather than less, important. The poverty reduction strategy for Indonesia is based on 3 clusters:

- Cluster 1 comprises social assistance programs targeted to poor families including the conditional cash transfer, *Program Keluarga Harapan* (PKH); the education assistance program - *Beasiswa Siswa Miskin* (BSM). The food transfer program, *Beras untuk Keluarga Miskin* or Raskin, and the health assistance program, *Jaminan Kesehatan Masyarakat* - or Jamkesmas.
- Cluster 2 comprises the National Program for Community Empowerment (*Program Nasional Pemberdayaan Masyarakat* – PNPM). PNPM's objectives are to increase poor communities' welfare and employment opportunities by providing funds in the form of community grants (Bantuan Langsung Masyarakat, BLM). The grants are designed to deliver essential village infrastructure through directly engaging and funding communities.
- Cluster 3 is designed to improve economic opportunities for poor households including financial inclusion and employment.

Household-based social assistance programmes have increasingly become one of the cornerstones of Indonesia's overall poverty reduction strategy. The BSM program covered more than 8 million students across the country, ranging from primary school to tertiary education levels. However reviews and evaluations[8] of the BSM program have identified significant program weaknesses. BSM targeting accuracy has been very weak, covering mostly children from non-poor households (inclusion errors), while many children from poor households do not receive BSM

[7] Analysis by TNP2K of UDB and SUSENAS

[8] World Bank Review of the BSM, 2012; TNP2K slide presentation, 2012

(exclusion errors). Analysis of SUSENAS 2009 revealed that less than 4% of poor and vulnerable households with Grade 1 or Grade 7 age children received BSM. Rates of coverage for poor SMA-age children were even lower, estimated at 2%. These targeting errors occur in part due to the selection process of eligible students being conducted by schools, based on those students already enrolled in schools and attending classes.

Enrolment rates of students from poor families are particularly low in secondary education, suggesting the need to improve the BSM program to address inequalities in children's progression through school, focusing on their transition from primary to higher levels of education. An estimated 3.3 million young people in Indonesia leave formal schooling before completing high school. Approximately 27 percent of any given cohort drop out or do not continue past Primary School; that number increases to 57 percent past Junior Secondary School and more than 80 percent past Senior Secondary. Many students from poor families drop out of Grade 6 either because they did not pass the elementary school exams or they are already out of school, and some do not continue to Grade 7 after finishing elementary school due to financial constraints. The quality of education remains a challenge, particularly in remote areas where facilities are poor and qualified teachers are scarce. Additional contributory factors include geographical disparities in Net Enrolment Rates (NER), inadequate transportation for reaching schools in remote areas, language barriers, and teacher absenteeism (as high as 19% for primary schools in some eastern provinces[9]). The limited value and the often-late disbursement of the cash transfer to the eligible students also reduced the BSM program's effectiveness.

Jamkesmas is social assistance in the form of providing subsidised health services for the poor paid for by the government and implemented by the Ministry of Health. The policy provides access for members to all health care facilities administering the Jamkesmas program.

By May 2013 72 per cent of the population, (more than 176,84 million Indonesians), was covered by some type of health financing scheme. Among the different schemes, Jamkesmas is the largest, covering 86.4 million people, followed by the local government health financing scheme– Jamkesda – covering 45.6 million people. These programs combined enable more than 52 percent of the population, comprising poor and vulnerable families, to access health care facilities. The health facility utilization rate of children from households possessing Jamkesmas or Jamkesda cards was larger than that of children who did not have a health card.

The poor are disproportionately affected by food price shocks as food comprises two-thirds of their consumption. Raskin is a programme of subsidized rice delivery targeted towards the poor that was designed to stabilize rice prices. Price shocks, especially to rice, have the potential to significantly harm the nutritional status of poor and near-poor households. Raskin is therefore a crucial component of Indonesia's poverty alleviation strategy. Initiated in 1998 as a response to the Asian Financial Crisis, it has become the largest household-based social assistance programme of the country in terms of government expenditures, and together with Jamkesmas, the largest by the number of beneficiaries. Raskin has a stabilizing effect on rice prices, offering large quantities of rice at a predetermined cost. Raskin has some undeniably positive effect providing up to 50 percent of rice consumption at highly subsidized prices for poor households. By providing rice at a subsidized cost, families are able to consume more because their staple food has now become cheaper. Increased consumption provides increased food security and will improve health outcomes because of higher calorie intake. Funds that would otherwise be spent on rice can be used to purchase more nutritious food or other necessities. The Raskin programme does contribute to household food security, particularly for children, and this has important indirect

[9] Investing in Indonesia's Education, World Bank 2007

benefits particularly for children's schooling, as greater food consumption has been found to increase educational attainment and improve their health over the longer term, and also for smoothing seasonal income deficits.

However, Raskin has had little impact on household food and nutrition security largely due to implementation issues. The average amount of Raskin purchased by poor families is only around 4 -6 kilograms per month per household, compared with the intended 15 kilograms per month. The resulting impact is that Raskin only covers 5% of food expenditures and only 6% to 11% of the required household rice needs. This dilution of the intended benefit means that Raskin does not have a significant impact on household food security for the poor. Additionally, rice does not provide a significant level of the essential micronutrients and protein required to stave off malnutrition.

The Family Hope Program (PKH) was first launched by the Government of Indonesia in 2007 as a program of social transfers *(conditional cash transfers - CCT)* for *very poor* households/families. The PKH program seeks to improve human capital through the provision of cash transfers conditional on households/families accessing specified health and education services. The PKH program helps to reduce the burden of household/family expenditure for the very poor *(immediate consumption effect),* while investing for future generations through improved health and education *(human capital development effect).*

The PKH program is targeted to poorest households with the aim of prevent the transmission of poverty to next generations through increasing the take up of basic services in health and education by providing the cash transfer to households with pregnant women and/or children. Pregnant women benefit from the program through conditioned attendance in 2 pre-natal and 4 post-natal visits as well as the provision of iron tablets to prevent anaemia. Children benefit through the conditioned receipt of vaccinations, child growth monitoring and de-worming as required, as well as school attendance.

A series of evaluation surveys were implemented to rigorously assess the impact of PKH on household health and education, consumption and targeting indicators. These studies found that PKH had a positive impact on the usage of primary healthcare services, increasing the likelihood of completing four pre-natal check-ups, and completed vaccinations and weighing checks for their children. PKH has proven to be most successful in areas where the supply side facilities are considered sufficiently ready to handle the increased demand for health and education services by program beneficiaries. However, the MER did not observe any substantial impact in child malnutrition. According to the MER, PKH had minimal impact on education participation as the households in the treated group did not significantly increase their participation in education, which may be due to pre-existing high rates of participation or the program selection of households with children already enrolled in school[10]. Throughout the implementation period 2007 – 2010 the PKH program expanded slowly with coverage restricted to only 816,000 households in 20 provinces.

Are these social protection programs child sensitive?

Eliminating poverty further relies on better than expected consumption growth and distributional trends in favor of the poor. It also requires the strengthening of the resilience of vulnerable households and local economies to other kinds of shocks and more deliberate and efficient

[10] There is some anecdotal evidence that this may be a result of implementation practices in selecting households whose children were already enrolled in school.

targeting of the poor, including the poorest of the poor, at a country and sub-national level. Indonesia's main social protection programmes comprise those that are targeted directly on households with children, such as BSM and PKH; and programmes that although not directly focussed on children (e.g. Raskin and Jamkeasmas), impact on them through different mechanisms of transmission. The Government's focus has been to increase the coverage and improve the targeting of the main social protection programs through the application of the Unified Database. Indonesia's Unified Database for Social Protection Programs (UDB) was created in 2011 and provides a credible targeting mechanism using Proxy Means Test scores for the poorest 40% of the population. It is used for the planning, implementation and coordination of social protection programs, at national, regional and local levels. Governments at both provincial and district levels are also able to request data from the UDB for local government use in planning and delivering local social assistance and poverty reduction programs. The development of the UDB has enabled the implementation of a national Integrated Social Protection Card (Kartu Perlindungan Sosial/KPS) for identifying eligible beneficiaries across the main social protection programs. The cards are linked to the UDB with the ultimate goal of having beneficiaries across all programs encapsulated in an integrated Management Information System (MIS).

BSM provides an example of how the UDB has been implemented to improve this program's targeting to reach students from poor families, focussing on reducing drop outs from primary to junior secondary school and reaching out of school primary school children. The UDB targeting mechanism allocated the BSM quotas to provinces and districts based on poverty incidence, age ranges and education access variables. The poverty incidence by district is collected from the Unified Database (UDB). The age ranges of potential eligible students are identified according to geographic factors, where students from eastern provinces of Indonesia start primary school at a later age (e.g. for primary school between 6-8 years poor children in eastern provinces compared to ages 5-7 in western provinces). Education access data is collected from PODES and the education ministries. In addition, a weighting was applied to those districts that have lower nett enrolment rates (NER) for primary school to allocate more BSM to these areas. The quota of BSM by districts for SMP used a weighting based on education drop-out rates (within a school year) and discontinuity rates (finishing a school level, e.g. primary, but do not continue to the next level, e.g. junior secondary).

In June 2013 the Government of Indonesia (GOI) approved the Program for the Acceleration and Expansion of Social Protection (Program Percepatan dan Perluasan Perlindungan Sosial/P4S). This program seeks to ameliorate the effects of a reduction in the amount of the fuel subsidy and the subsequent short-term inflationary impacts in the economy. The P4S is being implemented through the *national Integrated Social Protection Card (Kartu Perlindungan Sosial/KPS) that* will be used as identification for beneficiaries to receive a temporary unconditional cash transfer (UCT), known locally as BLSM (Bantuan Langsung Sementara Miskin). In addition, the GOI will expand benefit amounts and coverage of the Raskin, BSM and PKH social protection programs. P4S reaches the poorest 25% of the population comprising approximately 60 million people living in 15.5 million households. Most significantly, P4S expands the BSM program to more than 16.6 million school age children.

Program	P4S	
	Volume	Total Targeted
Subsidized Rice (Raskin)	*Additional 3 months of allocation (@ 15 Kg/mth)*	*15,5 Million RTS-PM (Poor HHs)*
Family Hope Program CCT (PKH)	*Cash transfer raised to Rp 1,8 Milion per/HH/yr*	*2,4 Million Poor HHs*
Cash Transfers to Poor Students (BSM)	*Value of cash transfer raised to:* *SD: Rp 450,000 per year* *SMP: Rp 750,000 per year* *SMA: Rp1 million per year*	*16,6 Million School Children*

Raskin is being reformed to better target households who are food insecure and living in poverty. The proposed food transfer amount of 15 kg/month represents around 20% of household monthly food expenditure for families in the lowest decile. Jamkesmas , has been expanded to reach the poorest 30% of Indonesia's population. Since 2011 the UDB has been utilised to assist in the identification of eligible PKH families. In 2011, PKH reached 1,116,000 households in 25 provinces and in 2012, PKH reached all 33 provinces and covered 1.5 million very poor households. Expansion priority is given to areas with high concentrations of very poor households, but where health care and education facilities are available. PKH is being expanded to cover 2.4 million families in 2013 and is planned to reach 3.2m families by 2014 covering more than 6m poor children.

In addition to doubling coverage of poor students, BSM payments are also being increased and disbursements changed to twice per year. One payment is disbursed at the beginning of the academic year to help cover associated education costs and to reduce the risk of students from dropping out from school or failing to enter primary school (proposed in August/September of the Academic Year). Another payment is to be distributed to the eligible students before the end of the school year, prior to students moving to another education level (proposed for either March/April of the Academic Year). This is particularly important to reduce the risk of students not continuing from primary to junior secondary school, and should further reduce the incidence of child labour. BSM also supports an increase in the population's average years of schooling (education) from the 2009 average of 7.92 years of schooling for the population aged 15 and older. This is an investment in children's futures to build a better educated workforce capable of accessing new employment opportunities. Expanded coverage of the BSM program will maintain school participation rates among students, for both girls and boys from poor and vulnerable households.

An adaptation of the PKH program was launched in 2008 known as Program Keluarga Harapan (PPA-PKH) to reduce child labour through bridging education courses for more than 11,000 child labourers from PKH families to help them transition into the formal education system; while nearly 5,000 street children received scholarships and life skills training[11]. The Government also implements the Program Kesejahteraan Sosial Anak (PKSA) program for most vulnerable children including:

- abandoned infants/infants with special needs (five years or younger),
- abandoned children (6-18 years old),
- street children (6-18 years old),

[11] ILO 2012.

- children with criminal charges (6-16 years old) and
- children with disabilities (0-18 years old)

Unfortunately this program covers only a small fraction of the children in need of this support. A major problem with the program is targeting, as it is difficult to collect reliable data on children within these sub-groups. Most children receiving this program are identified by NGOs/social organizations, and proposed by those organizations to the PKSA program. Very few children with disabilities are covered by this program.

How can Indonesia's social protection programs become more Child Sensitive?

The principles proposed by UNICEF to make social protection "child-sensitive", include:

- avoid adverse impacts on children;
- address age specific vulnerabilities through a life-cycle approach;
- make specific provisions for children with specific vulnerabilities or belonging to specific groups;
- take into account the mechanisms of intra-household dynamics; and
- promote a legislative framework to protect children.

Considering the main social protection programs reviewed in this paper, the PKH program is most compatible for addressing age-specific vulnerabilities of children from pregnancy through to the completion of secondary education. BSM is designed to support children's education outcomes for school-aged children from primary through to the completion of secondary education and its recent expansion supports many more poor and vulnerable children to participate in education. The Jamkesmas and Raskin programs do not directly target children, but do support a significant number of children to meet their basic health and food security needs. The PKSA program supports children with specific vulnerabilities, albeit with limited coverage, and the Government is extending the program through to 2015. The challenge for the government now is how to expand program coverage to poor and vulnerable living in underserved areas, especially in eastern Indonesia, where the availability and quality of health and education still lags behind the other parts of the country.

The Government is currently reforming the PKH program design for implementation in lagging regions, so as to maintain incentives for parents to invest in the children's health and education without imposing conditions that may be too difficult to comply with due to inadequate infrastructure or service availability. PKH will also support improvements in nutrition for pregnant women and children aged under 2 years as part of the Scale Up Nutrition strategy of the Government. Some initial program reforms are currently being piloted with UNICEF in 2 districts, including investments in training of local health staff and midwives as well as PKH facilitators. In order to sustain the gains made by PKH households in moving out of extreme poverty, *Group Family Development Sessions* are being developed to promote changes in behavior of mothers and fathers related to care and education of their children and themselves. The Group Family Development Sessions will comprise a series of modules covering early childhood development and basic education, economy and financial literacy, health and nutrition, and identity[12].

[12] The modules for the Family Development Sessions are being developed with technical inputs from the Indonesian country offices of the World Bank, UNICEF, and ILO as well TNP2K.

Targeting effectiveness for each program is improved when using the same data base (UDB). As families graduate from the PKH program the UDB can ensure they are receiving the Raskin, BSM and Jamkesmas programs. Increased access to PKH, BSM, and Raskin programmes will support improved health and education outcomes for boys and girls from poor families. The challenge is how to ensure all poor and vulnerable individuals and families are included in the UDB so they are able to access their program entitlements, especially children outside the school and family systems.

Both the BSM and the PKH programs need to assess how they can better support Children with Disabilities. The UDB records a total of 1,038,782 disabled persons of which only 90,000 children in decile 1 are identified as having disabilities. However accurate data for people with disabilities, and for children with disabilities in particular, is limited and incomplete; partly due to a lack of common definition and reliable data collection methods. Legal identity of adults and children is limited among poor families with less than 40 per cent of children under five years old having birth certificates; and about half of child births are not registered. The KPS can provide proof of entitlement for poor families and individuals to fee waivers for court issued legal identity documents.

There is an urgent need to improve the health and nutritional status of mothers and children; and this requires the availability of good quality health services. Indonesia's social protection programs support the poor and vulnerable to access services, but there is a need for local government to invest in the quality of health services, especially in lagging regions. This is also true for achieving better education outcomes for children. Clearly there is a need for better integration of the existing programs and services at all levels of government, as well as the expansion of social protection programs that are demonstrating significant impacts on reducing poverty across all regions of Indonesia, including child poverty rates. More work is needed to integrate child protection within social protection policies and programs, to monitor the impacts of social protection programs on children and to ensure the multi-dimensional aspects of poverty capture child vulnerabilities in nutrition, secondary education, child labour, early child development, disability, and identity. At the macro level, the governments' commitment to inclusive growth is essential to further reduce poverty, and social protection programs provide the means to achieve greater equity in the distribution of growth so that families are able to access better employment opportunities that improve their livelihoods and those of their children.

References:

ADB - Asian Development Bank 2013. Asian Economic Integration Monitor—March 2013.

ADB - Asian Development Bank 2010. Technical Assistance Report on Education Sector Analytical and Capacity Development Partnership, 2010.

AIPA -ASEAN Inter-Parliamentary Assembly. 2012. 3rd AIPA Caucus Report: Indonesia's Country Report On Welfare And The Protection Of Children

Ananias P. Accelerating the reduction of maternal and child malnutrition: Contributions to the debate based on the Brazilian experience. Geneva: SCN News, United Nations System Standing Committee on Nutrition; 2008.

Basset, Lucy. October 2008.Can conditional cash transfers pay a greater role in reducing child undernutrition?

Berlingieri, Francesco. 2010. Fighting child malnutrition in Indonesia: evaluation of two recent pro-poor policies.

Countdown 2015. 2013. Accountability for Maternal, Newborn & Child Survival: The 2013 Update. http://www.countdown2015mnch.org/documents/2013Report/Countdown_2013-Update_withprofiles.pdf

Government of Indonesia. 2010. BPS: 2010 Population census

Government of Indonesia /World Food Program: Food Security and Vulnerability Atlas.2010

Government of Indonesia, Buku Saku: Book of Priority Areas for Nutrition. Ministry of Health 2011

Government of Indonesia. Ministry of Health - Health Research and Development Agency. Basic Health Research Evaluation Report (Riskesdas) 2010

Government of Indonesia. Policy framework - nutrition awareness movement within the framework of the first thousand days of life. August 2012

Government of Indonesia. 2008. PODES (Local Area Potential Survey)

Government of Indonesia. 2011 Unified Database TNP2K analysis.

Government of Indonesia. 2012 SUSENAS March 2012. TNP2K analysis.

Government of Indonesia. National Action Plan for Food and Nutrition (RANPG) 2011-2015.

ILO. 2013. Economic class and labour market inclusion: poor and middle class workers in developing Asia and the Pacific / Phu Huynh and Steven Kapsos; ILO Regional Office for Asia and the Pacific, International Labour Office, Economic and Labour Market Analysis Dept.. - Bangkok: ILO, 2013

ILO. 2012. Eliminating Child Labour in Indonesia: 20 years of support.

IMF Working Paper 'Growth Slowdowns and the Middle-Income Trap" Shekhar Aiyar, Romain Duval, Damien Puy, Yiqun Wu, and Longmei Zhang. WP/13/71 March 2013.

IRIN Humanitarian news and analysis. October 10, 2012. Analysis: Do subsidies improve nutrition?

Jakarta Post June 26, 2012. http://www.thejakartapost.com/news/2012/06/26/indonesia-3rd-lowest-ranked-asean-country-terms-sanitation-quality.html#.T-l8OOVqX_o.email

Jakarta Post Nov. 11, 2012. http://www.thejakartapost.com/news/2012/11/10/government-campaigns-women-children-health.html

Landscape Analysis: Indonesian Country Assessment Final Report. 6 September 2010

Molyneux, Maxine. Pathways Brief July 2009. Conditional Cash Transfers: A 'Pathway to Women's Empowerment'?

OECD. 2013. Economic Policy Reforms 2013: Going For Growth. Country Notes: Indonesia OECD 2013

Scaling Up Nutrition (SUN) Movement, A Framework for Action. September 2010

SMERU Research Institute. 2011. Are conditionalities pro-woman? A case study of a conditional cash transfer in Indonesia. Institute for Development Studies, 2011

SMERU Research Institute. 2010. Gender and social protection in Indonesia: Raskin, the food subsidy programme. Sirojuddin Arif, Rebecca Holmes, Muhammad Syukri and Vita Febriany © Overseas Development Institute 2010 ISSN 1756-7602

SMERU, BAPPENAS and UNICEF 2013. Child Poverty and Disparities in Indonesia: Challenges for Inclusive Growth.

UCW – Understanding Childrens' Work - Inter-Agency Research Cooperation Project. 2012. Understanding children's work and youth employment outcomes in Indonesia. (ILO, UNICEF and World Bank) June 2012.

UNICEF September 2012. Every Woman Every Child. UN COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN: Commissioners' Report

Victora, C. G., L. Adair, C. Fall, P. C. Hallal, R. Martorell, L. Richter, H. Singh Sachdev, for the Maternal and Child Undernutrition Study Group. 2008. "Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital." The Lancet 371 (9609): 340–357.

World Bank 2011. Indonesia's PNPM Generasi Program : final impact evaluation report (English)

World Bank 2012. Policy Note on BSM, Social Assistance Program and Public Expenditure Review 5.

World Bank. Global Monitoring Report 2013: Rural-Urban Dynamics and the Millennium Development Goals. Washington, DC: World Bank.

World Development Indicators Report – Indonesia 2011: http://data.worldbank.org/country/indonesia

World Health Organization (WHO) Global Database on Aneamia 2005.

WHO World Health Statistics 2013.

2 Child Poverty in East Asia and the Pacific: Shared Vision, Different Strategies *A Study of Seven Countries in the EAP Region*

Lena Nguyen
UNICEF East Asia and Pacific Regional Office, Thailand

Executive Summary

Poverty reduction begins with children. A child's experience of poverty is very different from that of an adult. Income is but one dimension among many that should be assessed when analyzing child poverty and disparity. Non-monetary deprivation in dimensions such as shelter, food, water, sanitation, education, health, and information is equally, if not more, revealing. Since deprivation along these dimensions can have significant negative consequences on a child's development and future, an examination of multidimensional child poverty and associated disparities is clearly warranted.

As part of UNICEF's Global Study on Child Poverty and Disparity, several countries in East Asia and the Pacific have undertaken national child poverty and disparity studies. In this paper, results from seven of those countries, Cambodia, Lao PDR, Mongolia, the Philippines, Thailand, Vanuatu and Viet Nam, are reviewed. The objective is to identify trends and lessons, generate strategies for UNICEF EAPRO, and to contribute toward a richer conceptualization of the situation of children in the region.

Data from the aforementioned countries indicates substantial reductions in the percentage of children who are severely deprived, with rates falling by one third from 56% in 2000 to 36% in 2006. The percentage of children who suffer from multiple severe deprivations nearly halved, from 27% in 2000 to 14% in 2006. While improvements can be observed in most dimensions of child wellbeing, the multidimensional deprivation analysis reveals that the most statistically significant improvements were found in the water and sanitation dimensions.

However, the analysis also reveals that despite these gains, over 30 million children in the seven countries suffer from at least one severe deprivation. This is more acute in certain segments of the population, representing critical equity challenges. The most notable dimensions of inequity include disparities between rural and urban areas, between provinces or sub-national regions, between different ethnic groups, between small and large households, and between households headed by well-educated and poorly educated adults. Although severe deprivation is visible across all wealth quintiles, children from the poorest and second poorest wealth quintiles are much more likely to be severely deprived compared to children from the richest quintile. Much

more can and must be done in each of the seven countries to reduce inequities that block opportunities for children.

Patterns of child poverty in the region are suggestive of a natural clustering of countries. Cambodia, Lao PDR and Mongolia (Cluster A) consistently exhibit higher child poverty rates than the sub-regional average. The Philippines, Thailand, Viet Nam, and Vanuatu (Cluster B) have child poverty rates around or lower than the sub-regional average.

Comparisons within and across these clusters might be useful in guiding regional policies and programs. In Cluster A countries, a significant proportion of the child population is poor, often severely and multiply deprived. UNICEF strategies in these countries must remain focused on ensuring that basic social infrastructure is in place and that universal access to basic services is pursued. In Cluster B countries, a much lower proportion of the population is severely deprived and for the majority of the population the quality of basic services is a more pertinent issue than access. In these countries UNICEF strategies should focus on the extension of basic services to marginalized subgroups, as well as on improving the quality and scope of services provided.

Addressing disparities within countries in both clusters will require focused policies and approaches. Social protection is a key underdeveloped policy area that should be tailored differently in Cluster A and Cluster B countries based upon the different nature of affordability in these clusters and the infrastructural capacity to deliver universal social services. Universal child benefits or targeted cash transfers should be investigated at the country level to assess their feasibility and effectiveness.

Given the multidimensional nature of child poverty, policies and programs for child poverty reduction must go beyond the sectoral approach and promote an integrated strategic vision. Child-sensitive budgeting, monitoring, and analysis can be used to promote child equity. Strategic communication and advocacy, based on evidence from the country studies on child poverty, should be used to influence policy and maintain the momentum of multi-deprivation research and analysis carried out as part of the Global Study.

In all countries, UNICEF's programmatic support of national policies must be increased in order to fulfill child rights. National policies in the seven countries frequently reflect internationally accepted child rights standards, but programmatic, administrative and infrastructural support for these policies are often lacking. Since child poverty is a challenge shared by countries across the region, horizontal collaboration among the seven countries will be invaluable as they work to strengthen child rights and reach the most vulnerable.

Introduction to Child Poverty and Disparity in EAP

This report on child poverty and disparity in East Asia and the Pacific is based on the studies of Child Poverty and Disparity developed by Cambodia, Lao PDR, Mongolia, the Philippines, Thailand, Viet Nam and Vanuatu. These seven countries carried out comprehensive child poverty studies between 2007-2010 as part of UNICEF's Global Study on Child Poverty and Disparity. It will also draw upon conversations and reflection sessions with UNICEF EAPR country officers as well as data from MICS and DHS, which was processed by Bristol University for UNICEF.

The Global Study on Child Poverty and Disparity was launched in 2007 in order to draw attention to the daily deprivations suffered by children throughout the world. As part of the Global Study, forty-eight countries from across the globe have completed, or are presently in the process carrying out national studies following UNICEF's global study guidelines. The Global Study aims to

generate quality analytical studies that use evidence, in the form of child deprivation analysis, to identify gaps and opportunities in child poverty policy and practice. Several countries from the East Asia and Pacific region that are participating in the Global Study were also included in an earlier landmark study on child poverty developed by UNICEF by 2000 and published in 2003 (Gordon 2000, SOWC 2005, Minujin 2003).[1] This study estimated for the first time child deprivation and poverty in the developing world using a multidimensional methodology and child-specific indicators.

There was a crucial difference, however, between that first study and the present Global Study on child poverty and disparity. The former was conceptualized and directed in a top-down fashion, while the present round of studies has been country-driven under a common methodological framework. Participating countries developed their own studies and utilized local teams to conduct all aspects of the research.[2] As a consequence, each country has taken critical steps towards the institutionalization of child poverty and disparity analysis, and has enhanced domestic capacity to conduct child-centric monitoring and evaluation. In the process, they have developed a more holistic vision of child wellbeing and recognized the critical need to pursue integrated policies and programmes.

The objective of the present report is to analyze the situation of child deprivation and inequality in the seven countries and assess the evidence, trends, and themes that emerge. Furthermore, the analysis will discuss implications for child poverty reduction policies and programming, which it is hoped will be useful to the UNICEF EAP Regional Office and each of the seven country offices as they attempt to build upon the momentum generated by the study.

The sample size of the seven countries included in this report is quite large. The representative sample provides information on 146,000 children, and so is statistically descriptive of nearly 93 million children in the seven countries. This scope will generate important insights for regional development discourse on the nature and variability of child deprivation and disparity. It is hoped that the report will serve as a useful evidence-base for advocating and developing integrated policies and programmes for the reduction of child poverty and disparity – a principal challenge for countries and development partners in the region.

It is clear from the seven country reports that the child deprivation approach has enabled child development actors in the region to clearly capture the multidimensionality of child poverty, which in turn, has helped practitioners and policymakers alike to better understand the concept and experience of child poverty as distinct from adult poverty. As stated in the Philippines study, “recognition of child poverty as a distinct issue in the study of poverty is a new development and only achieved universal recognition recently…thorough conceptualization and empirical studies are needed to capture the nuances of child poverty and their implications for policymaking in order to address them” (UNICEF Philippines and PIDS, 2009).

This report aims to capture such nuance and assist in the process of conceptualizing regional child poverty and disparity. Analysis reveals that the seven countries can be grouped into two clusters based on the incidence of national child deprivation. As the title of the report suggests, each

[1] UNICEF commissioned The Peter Townsend Poverty Centre at the University of Bristol to conduct this study. The researchers, in collaboration with UNICEF, developed the multidimensional deprivation approach. The study used available data from DHS and MICS ca. 2000. The following countries from EAP were included: Cambodia, China, Lao PDR, Mongolia, Myanmar, The Philippines, Indonesia, and Viet Nam

[2] The common methodology included a comparable set of tables on child deprivation that were estimated for UNICEF by the University of Bristol. Those tables were the source of information used in Section II of this report

cluster, despite sharing a common vision for reducing child poverty and disparity, may need to approach this task differently.

The report will proceed as follows:

Section I will address contextual, conceptual and methodological issues related to child poverty and inequity. It will start with an examination of the macro-level characteristics of the seven countries in order to ground the situational analysis that follows. We will move on to make the case that focusing on child poverty makes development sense and that a holistic methodology is critical for understanding and reducing childhood deprivation.

Section II discusses child poverty trends in the seven countries, with a particular focus on deprivation and disparity, and also draws distinctions between income and deprivation poverty. Data for this section was obtained from the tables produced for UNICEF by the University of Bristol.

Section III deepens the general analysis presented in the previous section with an examination of the reports produced by each country as part of the Global Study of Child Poverty and Disparity between 2007 and 2010. In particular, this section focuses on the five pillars of child wellbeing and analyzes the policy and programmatic environment in each country in order to identify gaps and opportunities in each domain.

Finally, ***Section IV*** presents a series of recommendations and lessons learned from the preceding analysis. The objective is to provide some strategic suggestions that could help orient future action at the regional and country level. The overarching objective is to open the debate about how to transform into action the rich evidence on child poverty gathered as part of the Global Study.

SECTION I: Child Poverty and Disparity in EAP: Background

This section begins with a brief overview of the macro-level context in each of the seven countries in order to ground the following conceptual and methodological discussion. It will be shown that despite steady economic growth, the inability for such growth to alone improve the wellbeing of children – particularly those in marginalized populations – demands that the child poverty conceptual framework move beyond monetary deprivation. We will thus introduce a more holistic approach to conceptualizing and measuring child poverty. Such a perspective broadens not only the scope of potential policy and programming, but assists the generation of evidence that can be used to develop and support it.

1.1 Macro-level Characteristics of Countries

Table 1 summarizes population statistics and some basic development indicators for the seven countries included in this study. In general, each of the seven countries exhibited good macroeconomic performance over the last decade. As observed in Table 1, GNI per-capita ranges from $1,570 in Cambodia to $6,970 in Thailand. Thailand's GNI per capita is over twice as high as the second highest of the seven countries, the Philippines. The seven-country average GNI per capita is $3,153, although without Thailand this falls to $2,517. GDP in the region has increased beyond most analysts' projections. Cambodia's GDP growth averaged almost 10% between 2000 and 2006, while in Mongolia, Lao PDR, and Viet Nam growth rates averaged between 6-8% during the same period. In Thailand and the Philippines, GDP growth was around 5%, and despite Vanuatu's GDP growth being considerably lower than the seven-country average, it was still over 2%.

Table 1: Country Context, 2000-2006

Country	Population (thousands)	Population under 18 years (%)	GDP growth (annual average 2000-2006, %)	GNI per capita, PPP ($)	Human Development Index		U5MR (per thousand)
					Index value	World ranking	
Cambodia	14562	41.6	9.5	1570	0.575	136	82
Lao PDR	6205	45.5	6.5	1700	0.608	133	75
Mongolia	2641	33.2	5.9	2850	0.720	112	43
Philippines	90348	40.7	4.8	3380	0.745	102	32
Thailand	67386	26.7	5.1	6970	0.786	81	8
Vanuatu	234	45.7	2.2	3290	0.686	123	36
Viet Nam	87096	32.9	7.5	2310	0.718	114	17

Source: World Bank Data (http://data.worldbank.org), UNICEF Statistics (http://www.unicef.org/statistics/index.html) and Human Development Report 2008.

However, it is now well established that GDP growth and poverty reduction are neither automatically nor linearly correlated and that it is possible for a country have a simultaneous growth of GDP and of income poverty (Stiglitz, 2003; Chang H, 2008). How much poor families and children benefit depends on several factors, among them the pattern of the economic development - in terms of economic sectors driving growth – labour components, income distribution, and social redistribution mechanisms. In countries with high levels of inequality, inequity constitutes a barrier to poverty reduction (UNRISD 2010; Wilkinson, 2010). In the following table, income poverty and inequality are presented and reveal that inequity in terms of

income distribution remains a critical issue in the seven countries. The Gini Index in Cambodia, Philippines and Thailand is over 40, while in the rest of the countries it is over 32.

Table 2: Income Inequality and Income Poverty

Country	Income share held by		Ratio Highest/Lowest	Gini Index (%)	Income poverty ($1.25/day at PPP) (%)
	Highest 20%	Lowest 20%			
Cambodia	52.0	6.5	8.0	44.2	25.8
Lao PDR	41.4	8.5	4.9	32.6	44.0
Mongolia	44.0	7.1	6.2	36.6	2.2
Philippines	50.4	5.6	9.0	44.0	22.6
Thailand	49.0	6.1	8.0	42.5	2.0
Vanuatu	47.5	5.7	8.3	0.41	9.2
Viet Nam	45.4	7.1	6.4	37.8	21.5

Note: Data corresponds to Cambodia 2007, Lao 2002, Mongolia 2008, Viet Nam 2006, Philippines 2006, Thailand 2004 and Vanuatu 2008.
Sources: World Bank Data (http://data.worldbank.org); Vanuatu National Statistics Office.

Inequality, however, also manifests in dimensions other than income and must be analysed not only in terms of poverty conceptualized using the adult-centric income and consumption approach, but also in terms of more holistic multidimensional child poverty approach that will be discussed in Section 1.2 and 1.3. Inequality refers to unequal opportunities to pursue a life of one's choosing and these opportunities span multiple dimensions. A recent report by UNICEF EAPRO (2010) systematically presents, for the Asia-Pacific region, the various types of inequities faced by children in several dimensions using the MDG framework. Since the MDGs cover almost all the dimensions of child poverty addressed in the Global Study on Child Poverty and Disparity, no attempt will be made to replicate that effort here but some additional insights are presented in Section 2.7.[3] Channeling resources towards the most vulnerable first, as is being promoted by UNICEF Executive Director Anthony Lake, is an efficient and effective strategy for MDG achievement and poverty reduction. Disparity analysis in the aforementioned report and in the country reports conducted as part of the Global Study will be instrumental, it is hoped, in the design and implementation of strategies based on the equity approach being advocated.

1.2 Why Focusing on Child Poverty Makes Development Sense

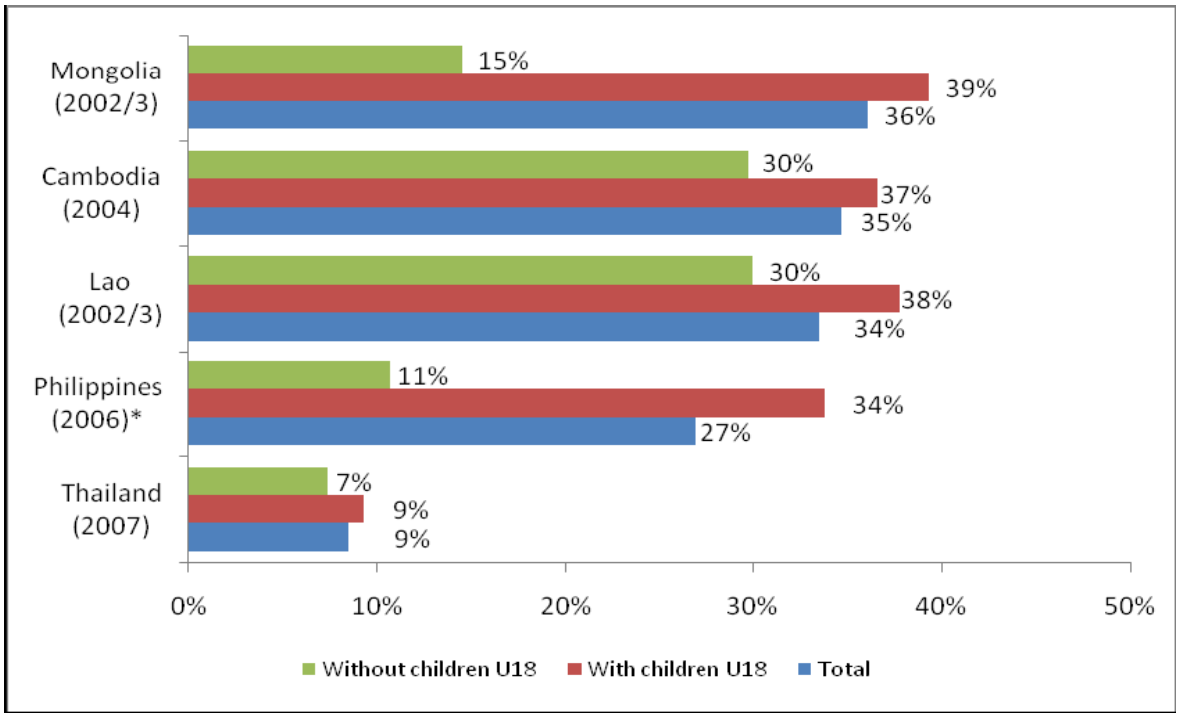
As Section 1.1 shows, a focus on macroeconomic growth alone is not likely to improve societal wellbeing and human development, particularly as it relates to children. For a long time children were, and in many instances remain, absent in poverty reduction discussions. When the conceptual framework is driven by the income and consumption approaches, the resultant policy and programs are predominantly adult-centric. In 2000, UNICEF published, "Poverty Reduction Begins with Children," hoping to influence the orientation of the Poverty Reduction Strategy launched by the World Bank and World Social Summit. In it UNICEF argued that "poverty reduction must begin with the protection and realization of the human rights of children. Investments in children are the best guarantee for achieving equitable and sustainable human

[3] Section 2.7 of the present report complements the work on equity by highlighting 'disparity ratios' or 'relative gaps' instead of 'disparity gaps', which were used in the MDGs paper. It will also complement this work by presenting some analysis on disparities by household characteristics such as household size and education of household head, which were not included in the MDGs paper

development" (Vandermoortele, 2000). Indeed, childhood is a time of rapid development, physically, emotionally, and intellectually. Throughout childhood and into young adulthood individuals develop the capabilities needed to be productive members of their society. Childhood, however, is also one of the most vulnerable times in the life cycle. As stated in the UNDP Human Development Report 2004, "By the time we are ten, our capacity for basic learning has been determined. By the time we are 15, our body size, reproductive potential and general health has been profoundly influenced" (p.3). Due consideration, therefore, must be paid to children as individuals and citizens whose wellbeing is inextricably linked to that of the future wellbeing of society at large.

In order to break the scourge of inter-generational transmission of poverty, as the aforementioned report suggests, the region must invest in children. Evidence shows that children living in poverty have an elevated probability of experiencing poverty in adulthood. As such, the fact that such a large share of the child population in the region is income-poor (as shown in Figure 1), is troublesome.

Figure 1: Income Poverty in Select Countries, 2002-2007



*Includes only children under 16 years.
Note: Lao PDR figures are based on population data. Figures for Cambodia, Mongolia, Philippines and Thailand are based on household data.
Source: Own elaboration from national child poverty reports.

One must also remain mindful that children make up a significant portion of the region's population and therefore merit, in fact demand, greater attention in poverty reduction and macroeconomic strategies in general. In some countries, like Lao PDR and Vanuatu, over 40 percent of the population are children. In Mongolia, Viet Nam, and the Philippines, approximately one third of the population are children. It is argued here that children constitute the most important resource countries in the region have this century. In order to face the challenges of development and globalization, the young people of the region must be equipped, nurtured, protected, educated and empowered to lead their countries out of poverty.

1.3 Conceptualizing Child Poverty: A Multidimensional Deprivation Approach

Conceptualizations of child poverty require a multidimensional approach, one that takes monetary and non-monetary indicators into consideration. This vision of child poverty is in line with the internationally recognized Convention on the Rights of the Child (CRC). The CRC holds that children have the right to a core minimum level of wellbeing, including the right to nutrition, basic education, survival, protection, and the right to grow up in a family. It is clear, when viewed in this light, that the CRC demands that the international community take a multidimensional approach to child poverty.[4]

Mindful of the implications of a more nuanced conceptual framework, UNICEF's Global Study on Child Poverty and Disparity promotes the use of a holistic combination of child poverty measures. Many of the rights enshrined in the CRC, such as education and health, are treated as dimensions of child poverty in the Global Study methodology[5] and the denial of those rights are treated as deprivations. As such, any deprivations we refer to throughout this report refer to violations of children's rights and of internationally accepted standards of child wellbeing.

The Bristol approach to child poverty and its main concepts, as utilized by the country studies under the Global Study common guidelines, are presented in Box 1. As can be seen, the multidimensional deprivation approach is holistic in nature. The thresholds associated with each dimension of poverty, moreover, are adaptable so that community and contextual issues can be taken into account, and the selection of deprivation dimensions can be broadened.[6]

[4] As discussed in the introduction of a forthcoming book by Policy Press on child poverty (Minujin A, editor, forthcoming), Amartya Sen's capability theories have been integral to the formulation of such holistic conceptions of child poverty, as part of what has come to be known as the Human Rights Based Approach paradigm (Sen A, 1999). The resultant strategies start from the premise that poverty results from the deprivation of basic capabilities and thereby seek to address the broad set of inhibitors that constrain individual freedom to live a decent life (Sen A, 1999, p. 41; Minujin et al, 2006; Komarecki M, 2005). In many ways, the CRC can be regarded as the concretization of the human rights paradigm for children and adolescents as it outlines the "set of capabilities every child is entitled to achieve. The denial of these rights compromise his/her level of freedom and limits the opportunities he/she will enjoy in life" (Cappa C. 2010, p. 67).

[5] Researchers at the Townsend Center at Bristol University developed the methodological formula used for the study and as such, the indicators are often referred to as the Bristol Indicators. "The 'Bristol' method was designed to produce meaningful scientific comparisons of child poverty between countries and UNICEF regions" (Gordon D et al, forthcoming)

[6] Both Viet Nam and the Philippines chose to adapt the multivariate approach to be more responsive to local context and in the process contributed to methodological advances in measuring child poverty in the region (more information on this process can be found in Section 2.8).

Box 1: A Multidimensional Deprivation Approach to Child Poverty

i) The Bristol Deprivation Approach: The Bristol Deprivation Model was adopted by the Global Study on Child Poverty and Disparity as a method to measure child poverty that not only captures the multidimensional nature of child poverty, but also the depth of poverty. The deprivation measures of child poverty are based on internationally agreed upon dimensions of child wellbeing and the child rights enshrined in the CRC, namely: adequate nutrition, safe drinking water, decent sanitation facilities, health, shelter, education and information. The dimensions shown below were agreed upon at the 1995 World Social Summit.

ii) The Seven Dimensions of Child Poverty

Food	Water	Shelter	Sanitation	Health	Education	Information

ii) The Continuum of Deprivation along Each Dimension*

No Deprivation → Less Severe Deprivation Severe → Deprivation

iii) Thresholds for Severe and Less Severe Deprivation in Each Dimension

Dimension	Severe Deprivation	Less Severe Deprivation	Age**
Food	Children whose height and weight were more than 3 SDs below the median of the international reference population.	Children whose height and weight were more than 2 SDs below the median of the international reference population.	Under 5 yrs
Water	Children who only had access to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was more than 30 minutes round trip away.	Children using water from an unimproved source such as open wells, open springs or surface water or who it takes 30 minutes or longer to collect water	Under 18yrs
Shelter	Children in dwelling with 5 or more people per room or with no flooring material	Children living in dwellings with 3 or more people per room or living in a house with no flooring or inadequate roofing.	Under 18yrs
Sanitation	Children who had no access to a toilet of any kind in the vicinity of their dwelling. E.g., No private or communal toilets or latrines	Children using unimproved sanitation facilities. Unimproved are: pour flush latrines, covered pit latrines, open pit latrines, and buckets.	Under 18yrs
Health	Children who had not been immunized against any diseases or young children who had a recent illness and had not received any medical advice or treatment.	Children who have not been immunized by 2 yrs of age. If the child has not received eight specific vaccinations they are defined as deprived or if they did not receive treatment for a recent illness involving an acute respiratory infection or diarrhea.	Under 5yrs
Education	Children who had never been to school and were not currently attending school.	Children of schooling age not currently attending school or who did not complete their primary education	7-17yrs
Information	Children with no access to newspapers, radio, television, phones, or computers at home.	Children with no access to broadcast media (television and radio)	3-17yrs

iv) Incidence of Child Poverty Using the Deprivation Approach

Severe Deprivation (1+):	Multiple Severe Deprivation (2+):
The condition of the being severely deprived in at least one dimension	The condition of being severely deprived in two or more dimensions***

*Adapted from Gordon's (2000) theory of relative deprivation.

**Given the age cohorts under consideration, it should be noted that any mention of the incidence of deprivation in this paper refers to incidence among children only.

***This condition is referred to as Absolute Poverty in the Bristol Model, but was renamed for the purpose of this report since the Bristol terminology does not adequately capture how it relates to 'Severe Deprivation'.

Although not without its limitations,[7] the Bristol multidimensional deprivation approach is easily interpretable and was designed to maximize the ability for evidence to translate into policies and programs. As the Viet Nam report mentions, "a generally accepted and workable definition and measurement method of child poverty is an important tool for both academics and policy makers. It does not only offer the opportunity to get an insight into children's poverty status but also gives the possibility to formulate and monitor sound poverty reduction objectives, strategies and policies (UNICEF, Viet Nam, 2008, 14).

1.4 Data Sources

Each of the seven national reports on child poverty from East Asia and the Pacific are based on extensive data analysis in order to illuminate the breadth of context-specific factors that contribute to child poverty and inhibit the realization of child rights in these countries.

The present report draws heavily on the national reports as well as on data tables processed for UNICEF by the University of Bristol – both of which relied on information from two household surveys: the Multiple Indicator Cluster Survey (MICS) and the Demographic and Health Survey (DHS). The scope of the present report is highlighted by Table 3, which lists the original sources and sample sizes of country data analysed in Section II of this paper.

Table 3: Sources and Sample Size of the Countries Included in the Report

Country	Source	Sample size (All households with members aged 0-17)	Number of children under 18 in sample
Cambodia	DHS 2005	12264	33463
Lao PDR	MICS 2006	5389	16263
Mongolia	MICS 2005	5460	11576
Philippines	DHS 2006/7	9831	26768
Thailand	MICS 2006	23012	38954
Vanuatu	MICS 2007	2632	6134
Viet Nam	MICS 2006	6315	12736
TOTAL		64903	145894

Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Tables 1.1.3 and 1.1.2 unweighted, except Vanuatu).

For subregional estimations (i.e. estimations involving an aggregation of numbers from the seven countries), we processed ourselves the data available from the national reports and Bristol tables. These instances are referred to as 'own elaborations' henceforth, and the process is documented in Annex 2.

[7] The limitations include: a) the dimensions do not cover some key issues related with child rights, in particular nothing on child protection; b) it uses household surveys that do not cover (or underestimate) some of the most vulnerable groups, such as those orphaned and abandoned, living in institutions, and street children; c) the use of different age categories could bias the headcount results; and d) the equal weight of different indicators does not provide nor allows prioritization of policy actions (Roelen, K and Gassman F, 2008). Furthermore, thresholds are not always context-specific.

SECTION II: Regional Situational Analysis: More Can and Must be Done

In this section we will conduct a comparative analysis of child deprivation and poverty based upon national application of the Bristol Deprivation method. As mentioned previously, the Global Study encourages use of this method so that results are comparable across countries. In order to provide a parameter for comparative analysis, we estimated child deprivation for what will heretofore be referred to as the EAP Sub-Region (EAPSR). For the purpose of this analysis, the EAPSR represents a weighted average of the seven countries included in this report.

2.1 Trends in Child Poverty Using Deprivation Approach, ca. 2000-2006[8]

The sub-region has exhibited significant reductions in the percentage of severely deprived children and those suffering multiple severe deprivations.[9] In the sub-region, the estimated percentage of children suffering from at least one severe deprivation decreased from 56.3% in 2000 to 36% in 2006, while reductions in the rate of children suffering from two or more severe deprivations nearly halved from 26.8% in 2000 to 14.1% in 2006.[10] As shown in Table 4, the total reduction of children suffering from severe deprivation was 36% for the sub region, 32.5% in Viet Nam, 29.6% in the Philippines and 4.7% in Mongolia.

Table 4: Incidence of Child Poverty Using Deprivation Approach, ca.2000-ca.2006

Country	U18 Population (thousands)		Severe Deprivation (1 +) (%)			Multiple Severe Deprivation (2 +) (%)		
Year	2000	2006	ca. 2000	ca. 2006	Change * (%)	ca. 2000	ca. 2006	Change* (%)
Cambodia	6832	6062	91.4	90.1	- 1.4	64.4	63.5	-1.3
Lao PDR	2601	2822	76.0	75.2	- 1.1	39.8	51.1	28.4
Mongolia	1066	876	67.2	64.0	- 4.7	37.9	29.0	-23.5
Philippines	33385	36793	44.0	31.0	-29.6	16.0	8.0	-50.0
Thailand		18007		16.0			2.0	
Vanuatu		107		25.2			4.9	
Viet Nam	31139	28653	57.7	39.0	-32.5	30.7	15.0	-51.2
Subregion[11]	93756	93320	56.3	36.0	-36.0	26.8	14.1	-47.5
Subregion (thousands)	93756	93320	52815	33632	-19183	25154	13154	-12000

Sources: UNICEF Statistics (http://www.unicef.org/statistics/index.html), Bristol (2003), UNICEF Global Study (2007-2008), and own elaborations for subregion. *Note: Change is calculated as follows: (2006 estimate minus 2000 estimate) divided by 2000 estimate and then multiplied by 100 to get %.

[8] There are several methodological issues that complicate this trend analysis. Firstly, the countries of the 'sub-region' are not uniformly represented throughout the duration of the years examined. Thailand and Vanuatu data was only available after 2006. Secondly, from 2000 to 2006 there were changes in measurement standards, mainly in the shelter indicator in Cambodia, Lao PDR and Mongolia, that limit comparability and complicate sub-regional analysis. However, because the estimations consider comparable indicators, and because similar trends were reported by all countries, the observations derived from this six year analysis were deemed useful, despite the anomalies

[9] Because of comparability problems this analysis is brief and must be understood as an indication of the prevalent trends. Caution must be exercised when considering the absolute values.

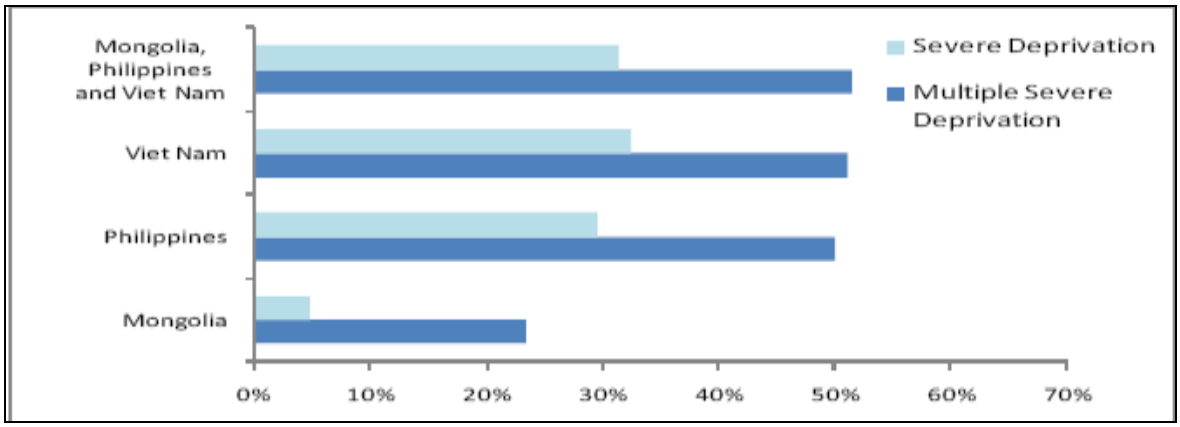
[10] See Annex 1 for the date of the DHS and MICS surveys used in these estimations. We could be overestimating the changes because of the inclusion of Thailand in 2006. However, the results without Thailand give similar trends.

[11] In this particular instance, the subregional estimations for the year 2000 include figures from Myanmar (U18 Population: 18733(thousand), Severe Deprivation: 59.8%, and Multiple Severe Deprivation: 23.5%) for more robust estimation.

12 Cambodia and Lao PDR are not included because their definitions of shelter deprivation changed from 2000 to 2006.

Figure 2 shows the relative reduction of child poverty from ca. 2000 to ca. 2006 in the three countries with fully comparable data.12 It can be observed that the reduction of multiple severe deprivations was even greater than the reduction of severe deprivation, indicating promising improvements for the most vulnerable children. In the case of Viet Nam and the Philippines, the percentage of children suffering multiple severe deprivations fell by more than 50%. In Mongolia the reduction was more than 20%. When considering deprivation in the EAPSR as a whole, it is necessary to stress that even with the improvement trends observed from 2000 to 2006, it is still estimated that 33 million children in the sub region suffer from at least one severe deprivation and nearly 13 million from two or more severe deprivations.

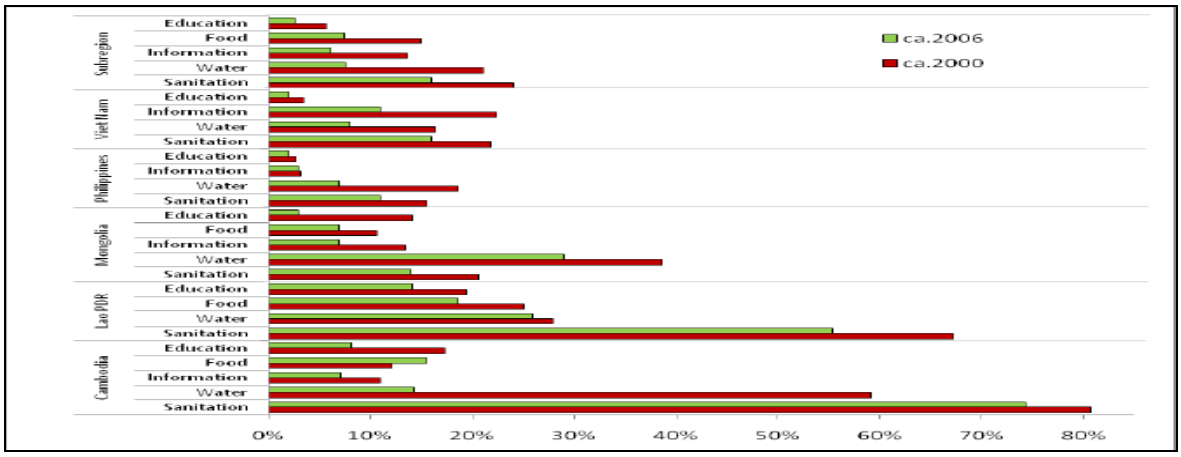
Figure 2: Relative Reduction in Incidence of Child Poverty Using Deprivation Approach, 2000–2006



Sources: Own estimation from Bristol (2003) and UNICEF Global Study (2007-2008).

Table 4 and Figure 2, however, only tell part of the story. Disaggregation by deprivation dimensions, as seen in Figure 3, can reveal more about the nature of these improvements and their impact on child wellbeing. Trend analysis of these relative improvements is a powerful tool for understanding how effective policies and programs have been, and provides evidence that can support strategic interventions.[12]

Figure 3: Severe Deprivation across Dimensions, 2000 and 2006



Note: Includes only those dimensions for which definitions/thresholds remained stable across 2000-2006.
Sources: Bristol (2003), UNICEF Global Study (2007-2008), and own elaborations for the subregion

[12] The challenge for this kind of analysis is to carefully scrutinize the comparability of data sources.

Among the dimensions it is possible to compare across 2000 and 2006 (all except health and shelter), although improvements were observed in most dimensions, the most statistically significant improvements were found in the water and sanitation. In 2000, 21% of children in the subregion suffered from severe water deprivation and 24% from severe sanitation deprivation.[13] This dropped to 7.6% and 16% respectively by 2006. It is also evident that each of the countries followed this general trend in terms of water and sanitation improvement. It should be noted, however, that such a vast improvement was in large part possible because of the very high incidence of severe deprivation in these dimensions in 2000. Furthermore, even with the improvements, water and sanitation were still among the three dimensions registering the highest incidences of severe deprivation in 2006 (which were sanitation, shelter and water).

When considering the policy and programmatic implications of this data it is important to remember that even though a relatively small proportion of children in the subregion suffers from severe deprivation in the water and sanitation dimensions (7.6% and 16% respectively), this does not imply that the remaining child population has access to safe drinking water and hygienic sanitation facilities.[14] In Viet Nam, for instance, even though only 16% of children are severely deprived of sanitation, over 40% live in dwellings without hygienic sanitation. Thus, despite impressive progress in this area, the health and wellbeing of many children in the region is still threatened by the lack of access to improved water and sanitation.

Figure 3 also highlights significant improvements in particularly child-centered indicators[15], especially regarding access to education. Severe education deprivation in Cambodia, for example, was 20% in 2000, but by 2006 this had fallen to approximately 10%. Like access to water, however, access improvements frequently belie ongoing quality concerns. This is explored further in Box 2.

Box 2: Education in East Asia and the Pacific: Access and Quality Concerns

Access Concerns, Cambodia: Despite progress, basic access to education remains a problem in Cambodia, particularly in certain regions. The Ratanakkiri province, for instance, was reported to have 27% of children out-of-school and school survival rates remain problematic. In the country as a whole, approximately 8% of school-aged children have never been to school and the national primary school dropout rate is 10.8%. Drop-out rates in secondary school are even higher, with 21% of students dropping out at the lower secondary level and 14.4% at the upper secondary level. Reflections with the Cambodian CO suggest demand concerns must also be considered, "Household poverty, low quality of education, the cost of education and remoteness could be barriers to educational demand." (UNICEF Cambodia, 2009)

Quality Concerns, Thailand: Extending compulsory education in Thailand has resulted in an increased number of children in school. Education indicators from 2007 suggest universal primary education has been achieved. The ongoing challenge, however, is to improve the quality of the education provided so as to improve academic performance indicators. Improvements in administration and management, as well as teacher training and development are believed to be critical in order to reverse the declining standards of academic institutions in the country. The Thai Government's Education Reform agenda has been making slow progress on attempts to institute student-centered learning and improved academic outcomes. The Thailand Child Poverty and Disparity report notes that the net primary school completion rate was 86.8% and secondary school attendance was around 80%. These challenges have only become more pronounced following the fallout from the global economic crisis. As part of a 2009 stimulus package, the Thai government made one-off payments to all families with school children to pay for school uniforms and books. School and system-level reforms require increased scrutiny.

[13] See Box 1 for definitions of the indicators and thresholds. Children (0 to 17 years old) considered to be suffering from severe water deprivation were those who had access only to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was a distance of more than 30 minutes round trip.

[14] Hygienic sanitation includes flush toilet, suilabh and double vault compost latrine. Toilet directly over water, other facilities or no toilet are considered unhygienic.

[15] Of the seven dimensions of deprivation, three refer to specifically children's indicators, namely: food, health and education. As the Viet Nam report suggests, these variables can be referred to as 'child-centred' wherein measurement is based on the individual child rather than the household. The other four dimensions refer to household conditions that affect children

2.2 Differences among Countries in Incidence of Child Poverty Using the Deprivation Approach

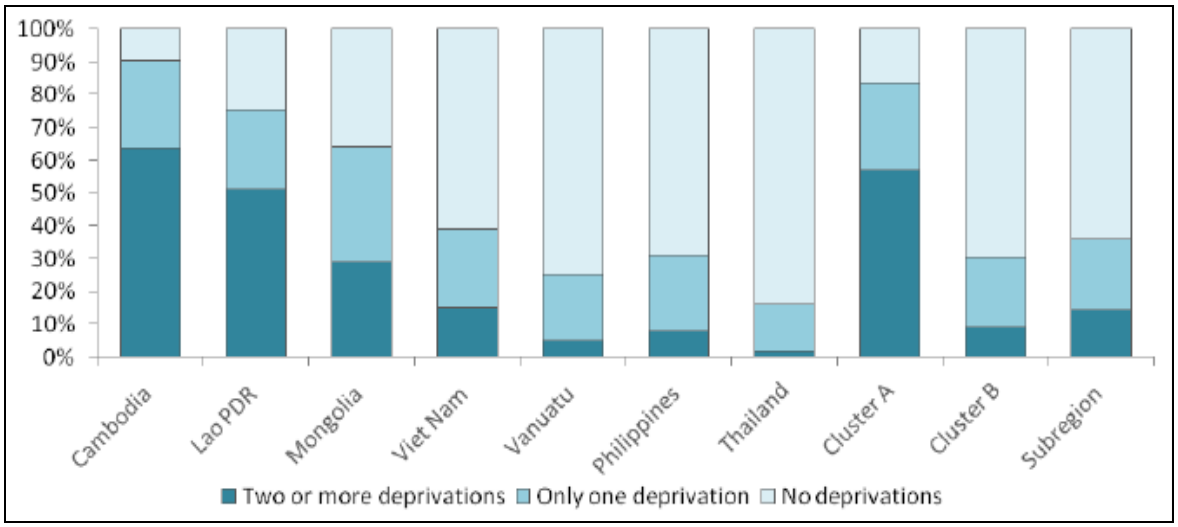
Despite observable variance in the level of deprivation and multiple deprivation, children experience severe deprivation to some extent in each of the countries, suggesting there exists significant potential for regional, horizontal cooperation to reach the region's most vulnerable. Based on our deprivation analysis, specifically the distance to the estimated sub regional averages, we clustered the seven countries into two sub-groups[16]:

1) Cluster A (Cambodia, Lao PDR and Mongolia)

2) Cluster B (Viet Nam, Vanuatu, the Philippines and Thailand)

The overall incidence of severe deprivation in countries in Cluster A (CA) was half a standard deviation (SD) above the subregional average, while the incidence in Cluster B (CB) was half a standard deviation below the subregional average. Data in the following section has been disaggregated in terms of these clusters and striking comparisons emerge that may help orient regional policies and programs. The cluster distinctions are maintained throughout this section as we examine trends, incidence of multiple deprivations, income poverty and disparity.

Figure 4: Incidence of Severe Deprivation, 2006



Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion and clusters.

Figure 4 and Table 5 highlight the incidence of severe deprivation in countries studied. Table 5 also highlights the dimensions in which countries have similar needs and where their needs diverge. In Cambodia, approximately 90% of children were severely deprived, that is, only 10% of children did not suffer from any severe deprivation. For Lao PDR, the rate of severe deprivation was 75.2%, and in Mongolia it was 64%. In Thailand, we see a dramatically different situation, where a much lower proportion of children (16%) were severely deprived. In terms of multiple

[16] These two clusters of countries happen to correspond to the country typology identified in a 2007 background report prepared for the RMT at EAPRO, which used different socio-economic indicators to identify 'progressing economies' – comparable to our Cluster A – and 'young dragons' – akin to our Cluster B (UNICEF EAPRO 2007).

severe deprivations, rates range from 63.5% in Cambodia to 2% in Thailand. The range of severe deprivation stretched from 90.1% in Cambodia to 16% in Thailand. These extremes can be contrasted to the subregional average for severe deprivation at 36%, and multiple severe deprivation at 14.1%.

The weighted average shows the incidence of severe deprivation in Cluster A was 83% while in Cluster B it was 30%. When considering these findings, one must acknowledge the larger child populations in some of the CB countries and its impact on the absolute number of children suffering from severe deprivation. For example, the absolute number of severely deprived children in the Philippines is over 10 million even though only 31% of children suffer from severe deprivation. This can be contrasted with Cambodia where the percentage of children suffering from severe deprivation is 90%, but the absolute number of children suffering severe deprivation is around half that of the Philippines at 5.4 million. As will be discussed in Section IV, the policy implications are different for each case.

Table 5: Incidence of Severe Deprivation, ca. 2006

Deprivations	Cambodia	Lao PDR	Mongolia	Viet Nam	Phili-ppines	Vanuatu	Thailand	CA	CB	EAPSR
Severe Deprivation(1+)	90.0	75.2	64.0	39.0	31.0	25.2	16.0	83.4	30.5	36.0
Multiple Severe Deprivation(2+)	63.5	51.1	29.0	15.0	8.0	4.9	2.0	56.8	9.1	14.1
Shelter	69.9	34.1	52.0	24.0	14.0	13.6	12.0	57.9	17.0	21.3
Sanitation	74.4	55.4	14.0	16.0	11.0	3.2	1.0	63.5	10.5	16.1
Water	14.3	25.9	29.0	8.0	7.0	7.5	2.0	19.0	6.3	7.6
Information	7.1	26.0	7.0	11.0	3.0	*	1.0	12.6	5.3	6.1
Food	15.6	18.6	7.0	*	*	9.9	3.0	15.7	3.0	7.5
Education	8.1	14.2	3.0	2.0	2.0	5.2	1.0	9.4	1.8	2.6
Health	21.0	46.4	8.0	7.0	17.0	17.1	7.0	27.4	11.7	13.3

* Vanuatu data about information deprivation not included due to incompatibility of indicators (severe dep. 51.0%). Philippines and Viet Nam - no data in used source.
Notes: Colors indicate position with respect to the regional average:
Green: Deprivation less than 'regional average - 1/2 SD'
Yellow: Deprivation between 'regional average -1/2 SD' and 'regional average+1/2 SD'
Red: Deprivation higher than 'regional average + 1/2 SD'
Font size indicates position among all the deprivations in the country; the larger size indicates the dimensions with the largest incidence in the country.
Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion and clusters.

It is clear from Table 5 that each of the identified deprivations follows a similar incidence pattern. Rates that are higher than the regional average are represented by the color red, and are typically found in Cambodia, Lao PDR, and Mongolia. Conversely, Thailand can be seen to consistently have lower child poverty incidence than the regional average.

When specifically child-centered variables like education are considered, the story is slightly different. Vanuatu reported that 5% of children between 7 and 17 years had never been to school and were not attending school at the time of the survey. In Cambodia, 8% of children were in the same situation. Despite the total incidence of deprivation being lower in Lao PDR than in Cambodia, the country exhibits higher instances of 'child-centered' deprivation, like lack of access to education. To further support the case for a non-aggregate analysis of the data, it is important

to highlight that Mongolia also has a high total percentage of children experiencing severe deprivation (64%), but it is in a relatively better position than Cambodia and Lao PDR when child-centered dimensions of deprivation, such as food, education and health, are emphasized.

Table 6 details the deprivations in each of the seven countries, relative to the subregional average. As can be seen in the final column, the subregional average was set at 100. Countries with numbers above 100 fare worse than the EAPSR average, while countries with numbers below 100 fare better than average. Examination of columns CA and CB highlights the distinction made earlier about the different levels of deprivation in these two groups of countries. The implications of such groupings will be discussed later in the paper.

Table 6: Relative Distance from the Subregional Average by Country, 2006

Deprivations	Cambodia	Lao PDR	Mongolia	Viet Nam	Phili-ppines	Vanuatu	Thailand	CA	CB	EAPSR
Severe Deprivation (1+)	250	209	178	108	86	70	44	232	85	100
Multiple Severe Deprivation (2+)	451	362	206	106	57	35	14	403	65	100
Shelter	328	160	244	113	66	66	56	272	80	100
Sanitation	463	344	87	99	68	19	6	395	66	100
Water	188	341	382	105	92	105	26	250	83	100
Information	117	428	115	181	49	*	16	207	88	100
Food	209	249	94	*	*	134	40	210	40	100
Education	313	549	116	77	77	193	39	363	69	100
Health	158	349	60	53	128	128	53	206	88	100

*No data. Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion and clusters.

It is important to stress that the national statistics reported in Table 6 frequently belie tremendous national disparity. For instance, even though national indicators in Thailand are among the strongest of studied here, the number of severely deprived children is 52% higher in the southern region than in the central region. Similar pockets of inequality can be found in each of the CB countries.

2.3 Less Severe Deprivation

The approach adopted by the Global Study on Child Poverty defines deprivation as a continuum. As discussed, the continuum of deprivation includes 'less severe' deprivation' as well as 'severe deprivation' While the latter reflects the most extreme situation of deprivation, 'less severe' deprivation thresholds also reflect a fairly serious situation of deprivation for children. (Refer to Box 1 for thresholds of less severe and severe deprivation along each dimension.) In Table 7 we can observe significant changes in the relative incidence of child poverty as measured by deprivation – particularly in Cluster B - when we shift our analysis to the 'less severe' threshold. For example, Vanuatu registered 69.2% of children suffering less severe deprivation, compared with 25.2% suffering severe deprivation. Thailand also shows a marked increase in the incidence of deprivation when the less severe threshold is used, especially on water and food.

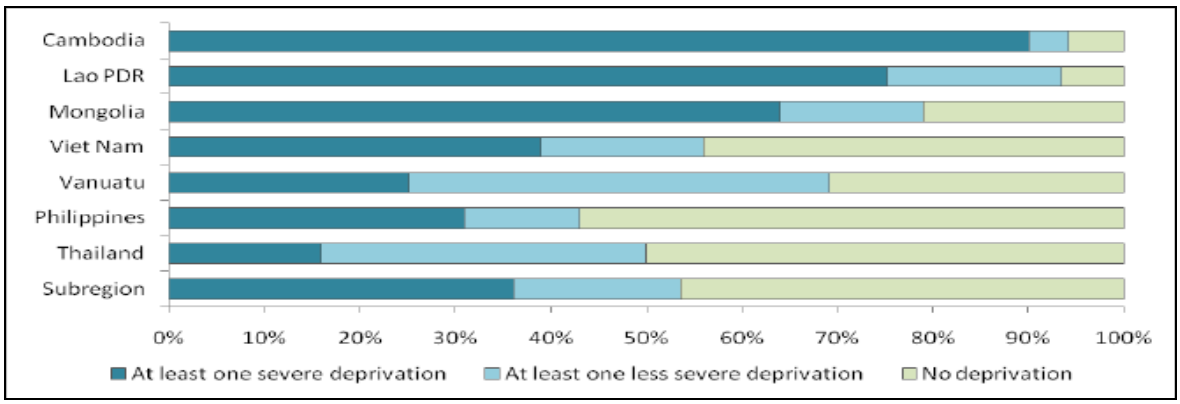
Table 7: Incidence of Less Severe Deprivation, 2006

Deprivations (Less Severe)	Cambodia	Lao PDR	Mongolia	Vanuatu	Viet Nam	Thailand	Phili-ppines	CA	CB	EAPSR
Less Severe Deprivation(1+)	94.2	93.5	79.0	69.2	56.0	50.0	43.0	92.6	49.0	53.6
Multiple 'Less Severe' Dep. (2+)	76.4	72.8	46.0	37.8	28.0	11.0	15.0	72.6	18.6	24.3
Shelter	85.5	54.1	70.0	43.9	33.0	24.0	14.0	75.0	22.7	28.1
Sanitation	74.9	59.7	24.0	37.9	27.0	1.0	16.0	65.9	16.6	21.7
Water	28.9	58.9	38.0	16.1	13.0	30.0	18.0	38.4	18.9	20.9
Information	7.5	27.4	7.0	*	11.0	2.0	4.0	13.2	6.0	6.7
Food	46.7	49.4	24.0	26.4	*	19.0	*	45.5	18.9	28.2
Education	16.5	28.3	8.0	22.8	14.0	1.0	6.0	19.1	7.7	8.9
Health	34.0	64.9	14.0	64.5	27.0	9.0	28.0	41.4	23.7	25.5

* Vanuatu data about information deprivation not included due to incompatibility of indicators (less severe dep. 54.5%). Philippines and Viet Nam - no data in used source.
Notes: Colors indicate position respect to the regional average (as indicated under Table 5).
Font size indicates position among all the deprivations in the country.
Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion and clusters.

Figure 5 captures the significant effect the change of threshold has on Cluster B. In Thailand only 16% of children suffered from at least one severe deprivation, while half of them suffered from at least one 'less severe' deprivation. In the case of Vanuatu, the percentage of children suffering one or more 'less severe' deprivations was higher than Viet Nam. The impact of shifting our analysis to less severe deprivation is not as dramatic for countries in Cluster A because of the very high incidence of severe deprivation in those countries.[17] For CB countries, consideration of less severe deprivation is extremely useful for policy design. As was clearly shown in Box 1, less severe deprivation still represents a serious inhibitor to child wellbeing and development and must not be overlooked.

Figure 5: Incidence of 'Severe' and 'Less Severe' Deprivation by Country, 2006

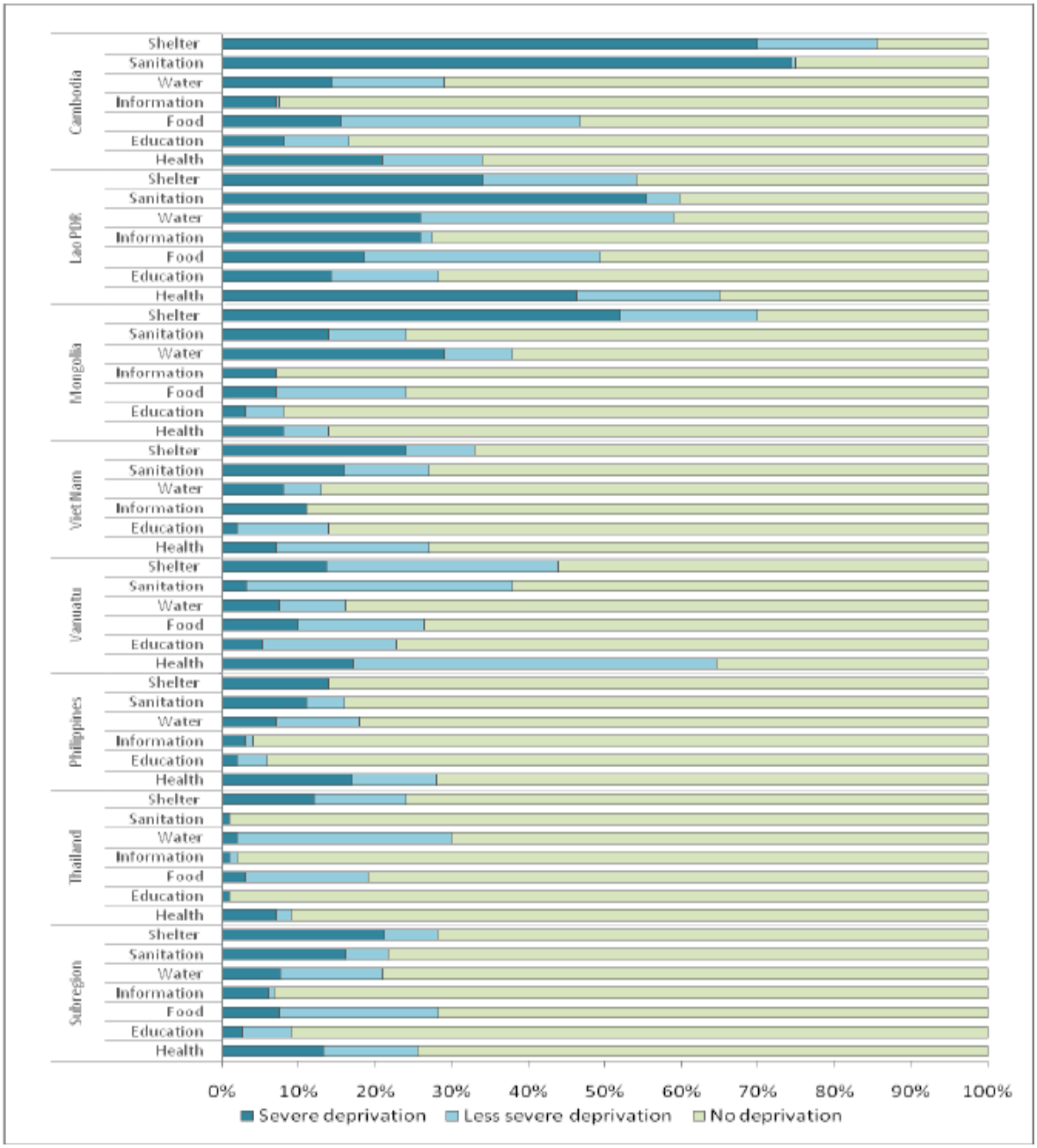


Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion.

[17] Using the methodology presented in the Viet Nam report, we estimated a Child Poverty Index for severe and less severe deprivation and a combination of both in the EAPSR. This analysis can be found in Annex 2 and highlights the relative shifts in the incidence of deprivation when the two thresholds are considered. For example, in the case of Thailand, the country had the lowest incidence of severe deprivation in the subregion, but when we consider less severe deprivation the Philippines performs better than Thailand

Figure 6 takes this analysis a step further and compares the incidence of severe deprivation and less severe deprivation among all of the seven deprivation dimensions. Less severe deprivation in shelter, water and food is widely prevalent and in most countries tends to be more extensive than severe deprivation. Where there is a high incidence of less severe deprivation these specific thresholds provide important insights for formulating policy and alert us to important threats to child wellbeing in each dimension that may be overlooked if only severe deprivation is considered.

Figure 6: Incidence of Severe and Less Severe Deprivation by Dimension, 2006



Note: no data on Vanuatu and on food deprivation in Philippines and Viet Nam.
Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaborations for subregion.

2.4 Child Poverty Indices

While the incidence of severe and less severe deprivation and of multiple severe and less severe deprivation provide a useful snapshot of the prevalence of child poverty across countries, these are somewhat incomplete as summary measures since incidence of deprivation across all dimensions is not cumulatively factored in. In order to compare across countries, a composite index score that takes into account the incidences of deprivation across all dimensions and normalizes these would be much more suitable. The Child Poverty Index for both 'severe' and 'less severe' deprivation was thus calculated for each country and the scores obtained are shown in Table 8.

Using these indices, it becomes possible to rank countries in the region by their score. Rankings are shown in Figure 7. As can be expected, Cluster A countries (Cambodia, Lao PDR and Mongolia) generally rank lower than Cluster B countries (Vanuatu, Viet Nam, Philippines and Thailand). However, if the 'less severe' deprivation index is used, Vanuatu (a CA country) actually ranks lower than Mongolia (a CB country).

Table 8: Child Poverty Index, 2006

Child Poverty Index (CPI)	Cambodia	Lao PDR	Mongolia	Viet Nam	Vanuatu	Philippines	Thailand	CA	CB	Sub-region
CPI 'Severe Deprivation'	1632	1183	559	178	114	111	30	1285	88	149
CPI 'Less Severe Deprivation'	2489	2595	1115	506	1500	269	275	2254	309	469

Source: Own elaboration from UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4).

Replicating the methodology for calculating a child poverty index used in the Viet Nam Child Poverty Report, CPI 'Severe Deprivation' and CPI 'Less Severe Deprivation' were each calculated as the sum of the squared dimension scores divided by the total number of dimensions. A 'squared dimension score' refers to the square of the incidence of deprivation in that dimension. The dimension scores for CPI 'Severe Deprivation' can be found in Table 5 and the dimension scores for CPI 'Less Severe Deprivation' can be found in Table 7. An example of the CPI calculations, based on the methodology just described, is included in Annex 2.

Even within Clusters, the ranking of countries changes across 'severe' and 'less severe' deprivation index. For instance, Cambodia ranks the lowest when the 'severe deprivation' index is used but it is replaced by Lao PDR when the 'less severe deprivation' index is used. Similarly, Thailand has the highest ranking when the 'severe' index is used but is replaced by Philippines when the 'less severe' index is used. It must also be noted that ranking countries by index gives different results than if we compared countries simply by the incidence of deprivation. For instance, while Mongolia has a higher incidence of "at least one less severe deprivation" compared to Vanuatu (79% and 69% respectively), this is mainly driven by the extremely high incidence of shelter deprivation (70%) in Mongolia. However, once all dimensions are cumulatively taken into account, as is done by the child poverty index, Vanuatu actually has greater child poverty compared to Mongolia, suggesting that addressing child poverty in Vanuatu might require much more a multi-sectoral approach than in Mongolia where addressing shelter deprivation alone would significantly reduce the incidence of child poverty.

Figure 7: Country Rankings by Child Poverty Index, 2006

Ranking by CPI	CPI 'Severe Deprivation'	CPI 'Less Severe Deprivation'
7th	Cambodia	Lao PDR
6	Lao PDR	Cambodia
5	Mongolia	Vanuatu
4	Viet Nam	Mongolia
3	Vanuatu	Viet Nam
2	Philippines	Thailand
1st	Thailand	Philippines

Cluster A Cluster B

Ranking:

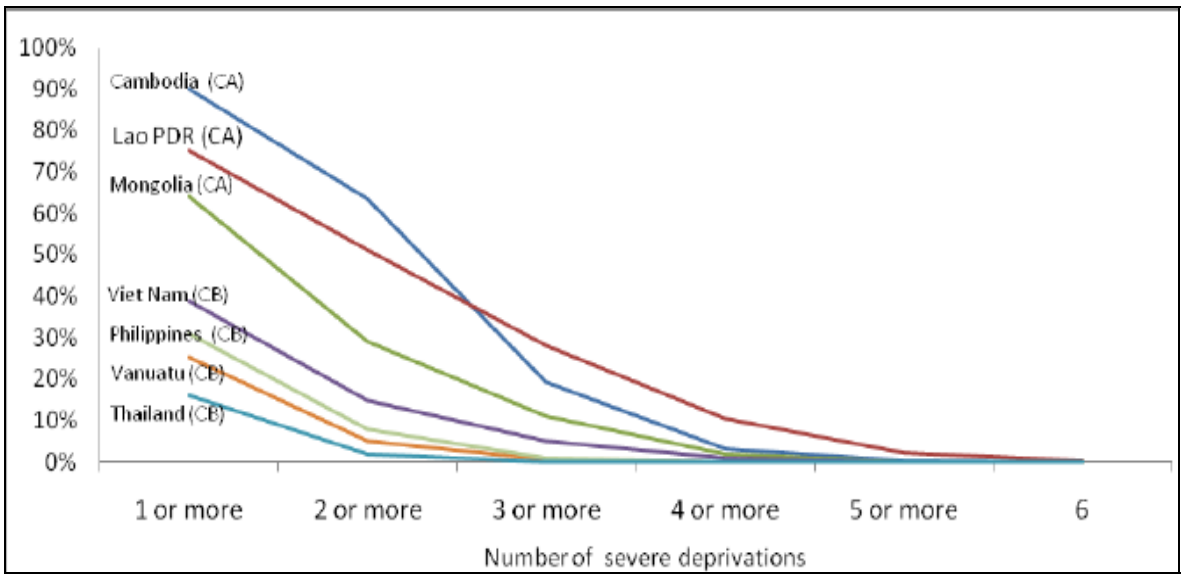
1st = lowest poverty score among countries studied; 7th = highest poverty score among countries studied

Source: Own elaboration, based on Table 8.

2.5 Multiple Deprivations and Depth of Child Poverty

Child poverty consists of multiple material and non-material deprivations. The multiple deprivation methodology does not imply each deprivation should be considered in isolation from others, but rather that the negative synergy among multiple deprivations is what contributes to the violation of child rights and contributes to stalled societal development. The approach to child poverty must be holistic and the solutions must be integrated. The deprivations that children suffer are only the visible part of an iceberg, and are usually bound to larger, non-visible, foundations that are at times difficult to measure. The analysis of the multiplicity of deprivations, specifically those disaggregated by location and population group, are key to identifying these foundations and directing targeted policy and programmatic orientation. Figure 8 shows the incidence of multiple severe deprivations in the seven countries.

Figure 8: Multiplicity of Deprivation: Cumulative Percentage of Households with Children Suffering Multiple Severe Deprivations, 2006



Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4).

Figure 8 shows that for CA countries the incidence of children with 3 or more severe deprivations is significant, while in CB countries there is a much lower incidence. In Cambodia we can see that 60% of children have 2 deprivations and 20% have 3 or more. In Lao PDR the incidence of 3 or more deprivations is the highest in the subregion. We can see that in Cluster B countries, the incidence is concentrated in 1 or 2 severe deprivations. Again, it is important to keep in mind that even in countries with low incidence of multiple severe deprivations, there are often pockets within the country where deprivation incidences are comparable with countries with high rates of multiple severe deprivations. Furthermore, based on evidence presented in Section 2.3, Cluster B countries can be expected to exhibit a much higher incidence of multiple deprivation if 'less severe' thresholds are applied, with the implication that an integrated approach which addresses multiple deprivations would be advisable in all countries.

It is also important to note the most frequent combination of deprivations. In the Philippines, for example, the most frequent deprivation combination was water and sanitation. In Vanuatu, health and shelter combined deprivations were most common, followed by nutrition and water. This information is invaluable for formulating cross-sectoral policies and programmatic interventions.

In order to analyze the extent and concentration of multiple derivations among children, depth measures are useful.[18] Depth indicators for child severe deprivation are presented in Table 9. Depth, in this case, refers to the average number of deprivations suffered by children who are severely deprived.[19] Analysis reveals that the depth of deprivation – that is the average number of deprivations experienced - ranges from 1.13 in Thailand to 2.22 in Lao PDR. These fall either side of the subregional average, which stands at 1.53.

Table 9: Depth of Severe Deprivation among Children with at Least One Severe Deprivation, 2006

Country	Lao PDR	Cambodia	Mongolia	Viet Nam	Philippines	Vanuatu	Thailand	CA	CB	EAPSR
Depth	2.22	1.96	1.66	1.54	1.29	1.22	1.13	2.01	1.38	1.53

Note: Depth is the average number of deprivations. It is calculated by dividing the sum of the product of number of deprivations and incidence (of each number of deprivations) by the incidence of at least one severe deprivation.
Sources: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4), with own elaboration for subregion and clusters.

2.6 Income Poverty and Deprivation

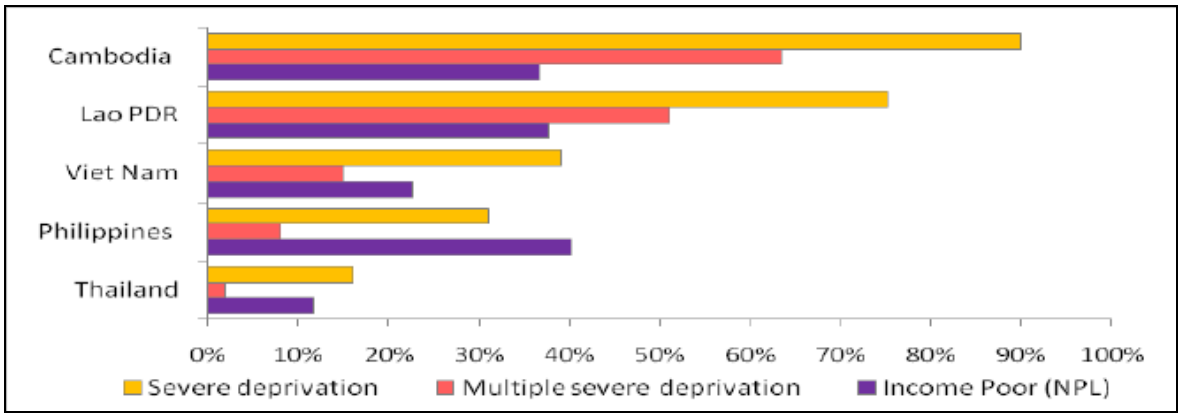
The multiple deprivation approach to child poverty and the income and consumption approach are different but complementary. Neither can alone capture the totality of child poverty. Thus, it is not an issue of deciding to use one or the other, but best to use both. Each measure has the ability to capture critical information about different populations and threats to child wellbeing. Figure 9 highlights this need by showing how income poverty can underestimate child deprivation and child poverty. This is often particularly relevant to Cluster A countries. In Lao PDR, for example, while the income approach reported 38% incidence of child poverty, 75% of children in the country suffered form one or more severe deprivation. Estimations by the two approaches are

[18] Depth and Severity are usually used in the analysis of income poverty as additional information to the headcount. The numerical method to estimate depth and severity (see Annex 1) of child deprivation used in this report are easy to interpret and follow the notion of depth of poverty as developed by Foster, Greer, and Thorbecke (1984) and Sen's axioms.

[19] Severity, defined as the standard deviation (SD) of the distribution of multiple deprivations, is presented in Annex 1

closer in the case of Thailand and Viet Nam. The Philippines is the only country of the seven to estimate a higher number of income poor children, wherein it was estimated 31% of children were severely deprived and 40.2% of children were estimated to live in income poor households.

Figure 9: Multiple Deprivations, Severe Deprivation and Income Poverty, 2006



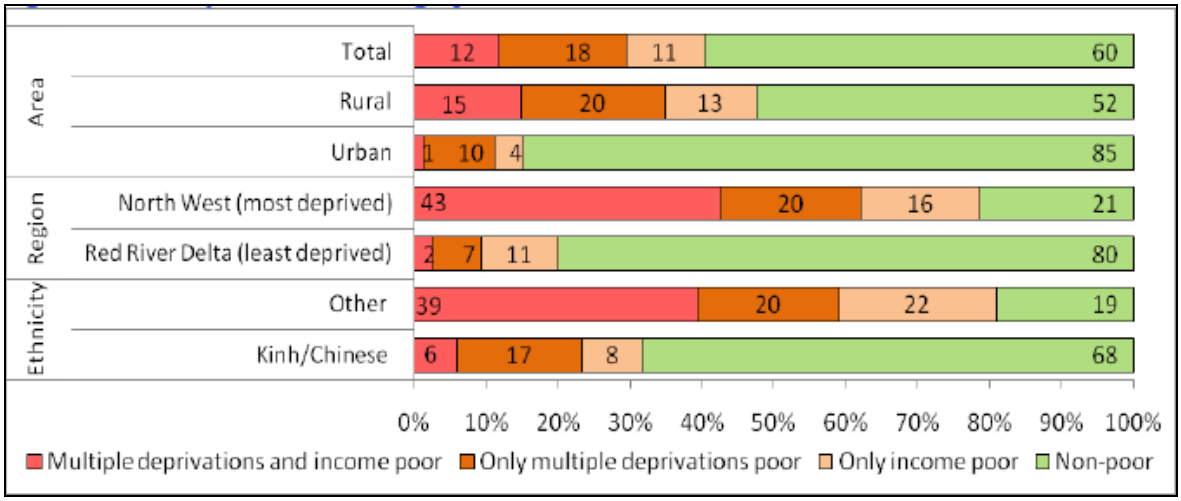
Note: NPL (National Poverty Line) data from Lao (2002/3), Philippines (2006), Thailand (2006) and Viet Nam (2006) refers to child population. Data from Cambodia (2004) refers to households with children. NPL poor in the Philippines refers to children under 15 years and in Vietnam refers to children under 16 years; in the other countries it refers to children under 18 years.
Source: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.4) and National Child Poverty Reports.

In the case of Cluster B countries, it is important to stress that even though the headcount ratios using the two approaches are similar, policies and programs need to be targeted to three distinct groups: i) those children that suffer from severe deprivation but are not income poor; ii) those that are poor according to both conditions; and iii) those that are not deprived, but are income poor. It is argued here, therefore, that the main issue is not the underestimation of child poverty by the income approach, but rather the need to capture the full picture as measured by a combination of both approaches.[20]

Figure 10 examines the said phenomenon with an in-depth look at Viet Nam. It reveals that the North West region has the highest incidence of child poverty. Out of a total of 78.6% poor children, most of them, 42.5%, were both deprived and income poor. As shown, only 16.4% were solely income poor. By contrast, in the Red River Delta, of the 20% of children who were poor, more than half (10.7%) were solely income poor. From an equity perspective, the underestimation of poverty by the income or monetary approach, as captured by the orange section of the bars in Figure 10, is greater for population subgroups that are traditionally worse-off, such as rural residents, people living in poorer regions within the country, and ethnic minorities. This suggests that using the multi-dimensional approach to measuring poverty may have greater potential to enhance equity than an income or monetary approach alone.

[20] The challenge involved with this kind of integrated and comprehensive measurement of child poverty is the incompatibility of much of the available data. This issue warrants serious attention

Figure 10: Poverty Rates and Demographic Characteristics, Viet Nam, 2006



Notes:
1. Both methods (income and deprivation) use VHLSS data (2006).
2. The monetary poverty method used is based on the combined food and non-food poverty line from World Bank Vietnam and GSO for 2006.
As monetary poverty is based on household poverty, monetary child poverty is based on the percentage of children living in household that are monetary poor.
3. It is considered that a child is poor according to the method of multiple deprivations when the child is poor in at least two domains. (In the case of Viet Nam, 'domains' was the terminology used instead of 'dimensions' but both refer to the same concept.)
VHLSS domains and thresholds are different from the MICS and DHS for EAPRO Child Poverty Study Countries indicators. In VHLSS case, the domains included are:
*Shelter (0 to 15 years): Living in improper housing or in dwellings without electricity.
*Water and sanitation (0 to15 years): In dwellings without hygienic sanitation or in dwellings without safe drinking water.
*Education (5 to 15 years): Not enrolled or not having complete primary school (12 to 15 years).
*Health (2 to 4 years): Not having visited a health facility.
*Child work (6 to 15 years): Child working.
*Social inclusion and protection (0-15 years): With caregivers that are not able to work.
Source: Own elaboration from Viet Nam Child Poverty Report (Table 11, page 75).

In summary, it is suggested that child poverty analysis based on a combination of deprivation poverty and income (and consumption) poverty is advisable. Such analysis must be used to direct policy and programs toward children suffering particular forms of poverty and ensure the solutions presented are the most relevant and effective for the circumstances. Where deprivation poverty and income poverty are prevalent, cash transfers can be of assistance, but where income poverty is much less than deprivation poverty the expansion of the supply of basic social services should be the principal focus. Such differentiated strategies require extensive disparity analysis, which is what will be discussed in Section 2.8.

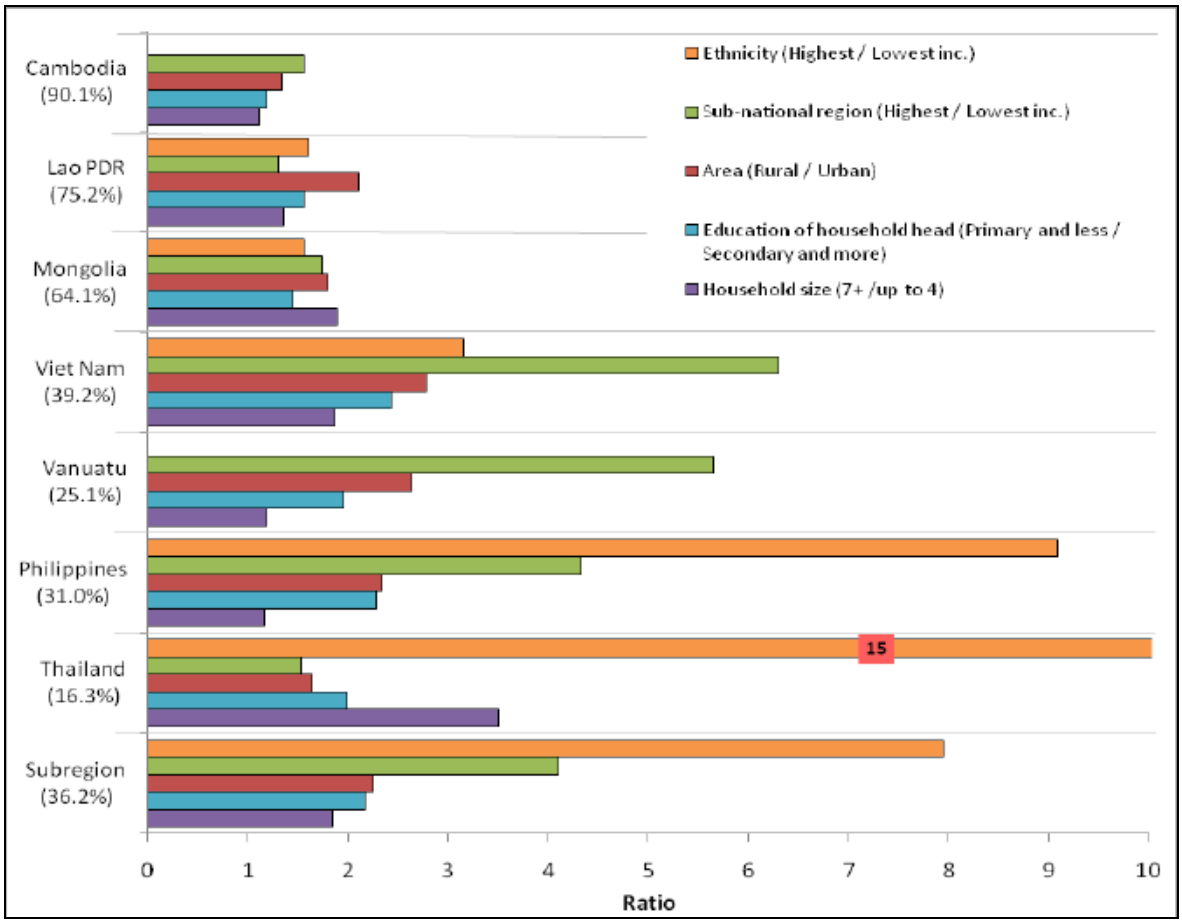
2.7 Disparity and Inequity

As mentioned in Section I, inequity is a significant obstacle to the realization of child rights. In Cluster A and Cluster B countries alike, the lack of equity presents a key challenge. Reducing poverty and achieving equity are complementary objectives in the battle to ensure child wellbeing. We will focus here on some of the most notable dimensions of inequity presented in the country reports, namely: i) the rural/urban divide; ii) sub-national regional disparity; iii) household size; iv) education of the household head; and v) ethnicity.[21] Figure 11 presents data disaggregated by these categories.[22]

[21] As mentioned in Section I, in order not to overlap with the EAPRO report on MDGs with Equity, this section will be brief and focus on disparity 'ratios'.

[22] There are different ways of expressing the distance between two categories. One is the simple difference, called

Figure 11: Disparity in Incidence of Severe Deprivation, 2006



Sources: Own elaboration from UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.6).

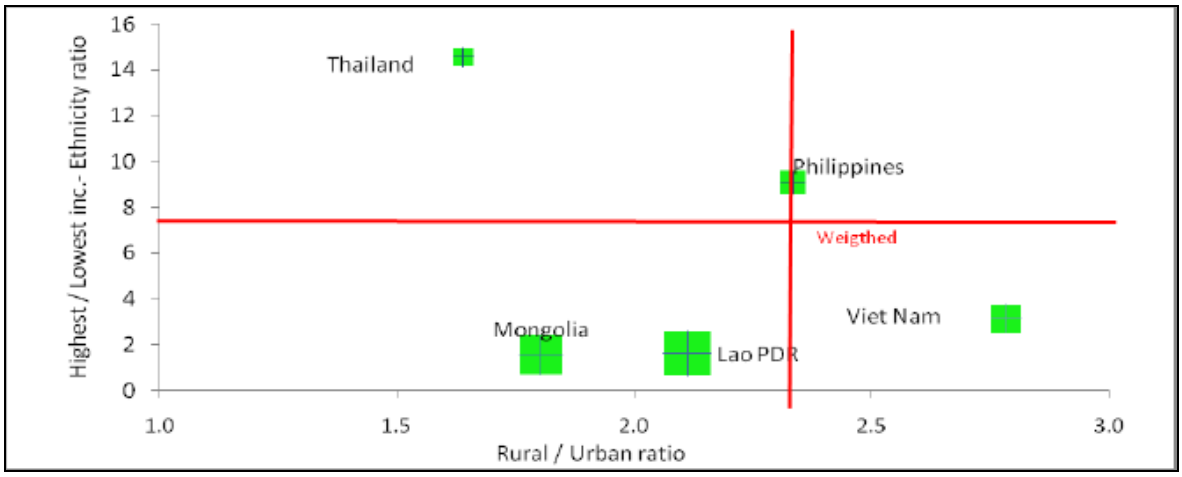
The rural concentration of deprivation is evident in countries studied. While in Cambodia the rural/urban ratio was 1.3:1, (that is to say, the incidence of child deprivation is 30% higher in rural areas compared to urban areas), in Philippines it was 2.3:1, and 2.8:1 in Viet Nam. Geographic inequities are more pronounced among regions within countries than between countries. The ratio of severe deprivation incidence between regions with the highest and lowest deprivation is 6.3:1 in the case of Viet Nam. That is to say, for every child that is severely deprived in the Red River Delta, there are 6 children severely deprived in the North West Region. Similar patterns can be observed in the Philippines. In the case of Thailand, the ratio between the South (highest deprivation) and the North (lowest) was 1.5:1, mirroring the rural-urban ratio that was 1.6:1.

In most of the countries, severe deprivation among children more than doubled in households where the household head had a primary-level education or less, compared to households where the household head had secondary or higher education. The size of the household had almost as strong an effect in some of the countries (Mongolia, Viet Nam and Thailand), where the incidence of severe deprivation almost doubled for households with more than 7 members compared to those with 4 or fewer. Disproportionate poverty and deprivation among some ethnic minorities is an issue in almost all the countries studied. The ratio of the incidence of severe deprivation

the disparity gap, another is the relative gap, or disparity ratio. For example, children severely deprived in the rural area in Cambodia was 93.3 % and in the urban 69.3%. The disparity gap, or difference, was 23.7 and the relative gap or ratio rural/urban was 1.3:1 indicating that the incidence in rural areas was 30% higher than in urban areas. The relative gap or ratio measure is used in this report (Minujin, 2003).

among ethnic minorities to that of ethnic majority groups ranges from 1.2:1 and 1.6:1 in Lao PDR and Mongolia respectively, to 9.1:1 in the Philippines and 14.6:1 in Thailand.

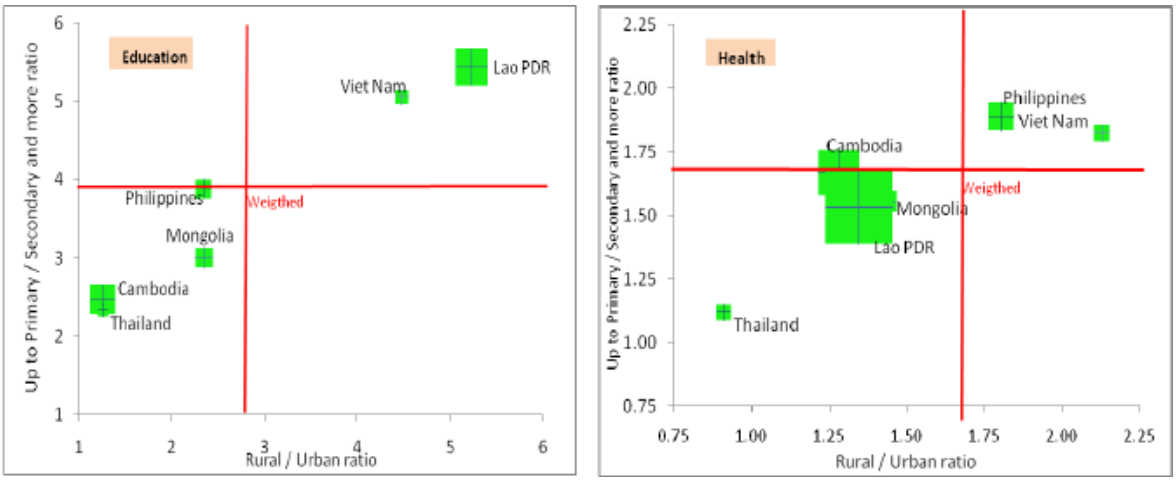
Figure 12: Severely Deprived Ratios, by Urban/Rural and Ethnicity, 2006



Note: Size indicates severe deprivation incidence (national value). No data on ethnicity was available for Vanuatu and Cambodia.
Source: Own elaboration from UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.6).

Figure 12 shows the relationship between child deprivation incidence in urban and rural residences, and also between the ethnic majority and ethnic minority. It is evident that there is not always a direct correlation in terms of child deprivation amongst these two populations. Policy formulation needs to address ethnic disparity of access as a distinct category. In Thailand, the incidence of child poverty for ethnic minorities is significant, while the rural –urban gap is relatively low. The opposite was the case in Viet Nam where the rural- urban gap is dominant and ethnic disparity is relatively low (although still higher than in Mongolia and Lao PDR). In the Philippines, there appears to be more correlation amongst these two groups. When analyzing these ratios it is important to remember multiple and overlapping inequities. As noted in the Viet Nam report, when geographical disparity overlaps with ethnic discrimination, deprivations are heavily concentrated in these areas. Such pockets of overlapping deprivation must be the target of enhanced policy and programs. These disparities will be further discussed in relation to the pillars of child wellbeing in Section III. The full tables and additional figures on disparity ratios are presented in Annex 1.

Figure 13: Severe Deprivation Disparity Ratios for Education and Health, by Rural/Urban and Education of Household Head, 2006



Note: Size indicated health/education severe deprivation incidence (national value). Vanuatu no data.
Source: Own elaboration from UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 1.1.2)

Figure 13 shows the relative gap or deprivation ratio related to the education level of the head of the household and to rural-urban location. It can be observed in the figure on the left, that the incidence of education deprivation is clearly worse for children in rural populations and for those with household heads with limited education in Lao PDR and Viet Nam.

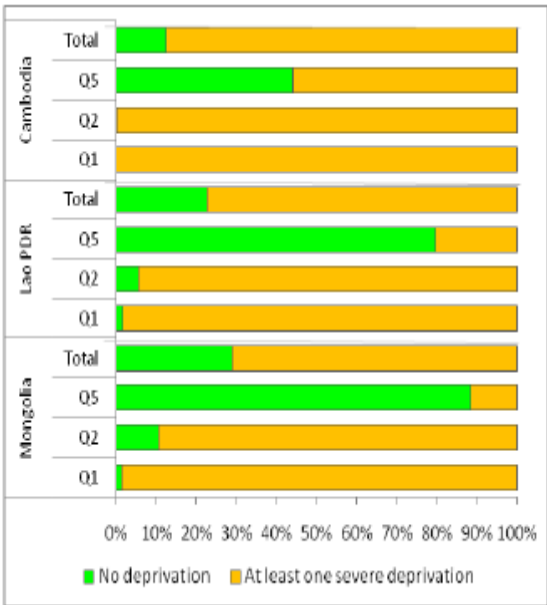
The figure on the right shows that the incidence of health deprivation was worse in the Philippines and Viet Nam for these populations. These figures highlight the pronounced lack of basic social services in rural areas in Viet Nam, health services in rural Philippines, and education services in rural Lao PDR. These indicators on sub-national disparity must be used to target equity-enhancing policies.

The Bottom Wealth Quintile[23] When discussing disparity, the range between the bottom and top wealth quintiles is often emphasized. Before moving on to Section III, we wish to touch briefly upon the specific issue of wealth poverty and examine the overlapping nature of severe deprivation and poor wealth quintiles. In so doing, it is important to remain mindful that the indicators used to formulate wealth quintiles are usually correlated to, or the same as, the household indicators used to estimate child deprivation poverty. As such, a high correlation between wealth poverty and household deprivation is to be expected. For this reason we choose to focus on the overlap with specifically child-centered dimensions.[24] Figure 14(a) and 14(b) present information on child deprivation disparity according to wealth quintile. The tables present data from Cluster A and Cluster B countries and highlight the incidence of deprivation in the various wealth quintiles. The wealthiest quintile is labeled as the fifth quintile (Q5). The second poorest quintile is referred to as Q2, and the poorest as Q1.

[23] The information on quintiles presented in this section refers to the 'wealth index' estimated by MICS and DHS

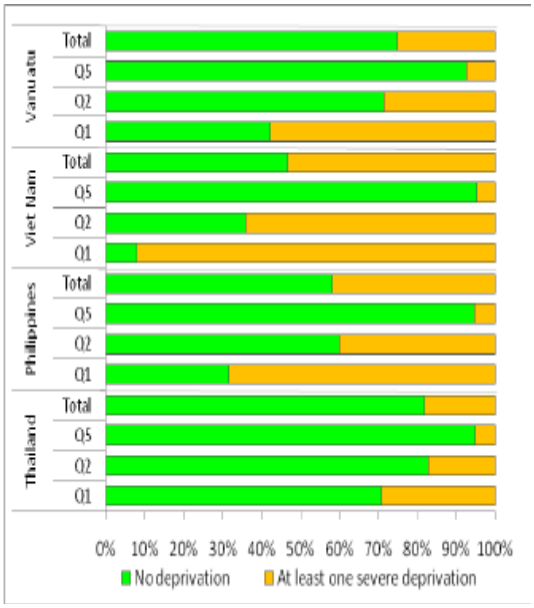
[24] It is also important to consider that the asset indicators used to estimate the wealth index are binary variables (e.g. owning a radio – 'yes' or 'no') whereas it is an assumption of Principal Component Analysis used that the variables are continuous. This issue could represent a problem for the robustness of the results (see Gordon D and Nandy S, forthcoming).

Figure 14(a): Deprivation by Wealth Quintile, Cluster A (Mongolia, Lao PDR and Cambodia), 2006



Source: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.6).

Figure 14(b): Deprivation by Wealth Quintile, Cluster B (Thailand, Philippines, Viet Nam, Vanuatu), 2006



Source: UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 2.1.6).

In Cluster B countries, 5% or fewer children in the richest quintile are severely deprived, while in Cluster A countries, severe deprivation among the richest quintile ranges from 12 to 55%. In both clusters the incidence of severe child deprivation is concentrated in the poorest quintiles. The level of overlap between the poorest quintile and severe deprivation is clearly observable in the following Venn diagram.

Figure 15: Severe Deprivation and Wealth Quintile, Lao PDR, Viet Nam, Philippines & Thailand, 2006

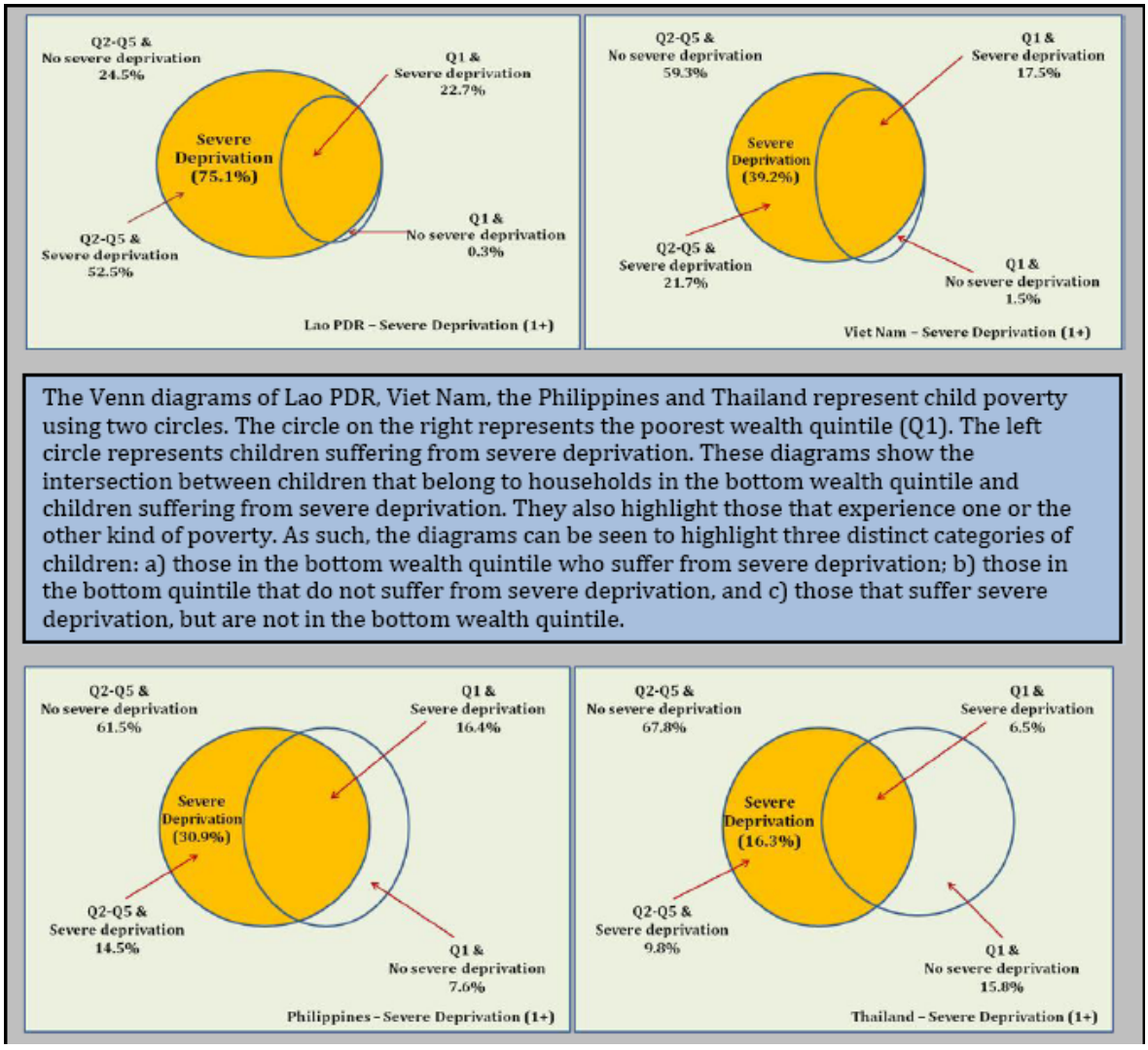


Figure 15: Severe Deprivation and Wealth Quintile, Lao PDR, Viet Nam, Philippines & Thailand, 2006
Source: Own elaborations from UNICEF Global Study on Child Poverty and Disparity (Table 2.1.6).

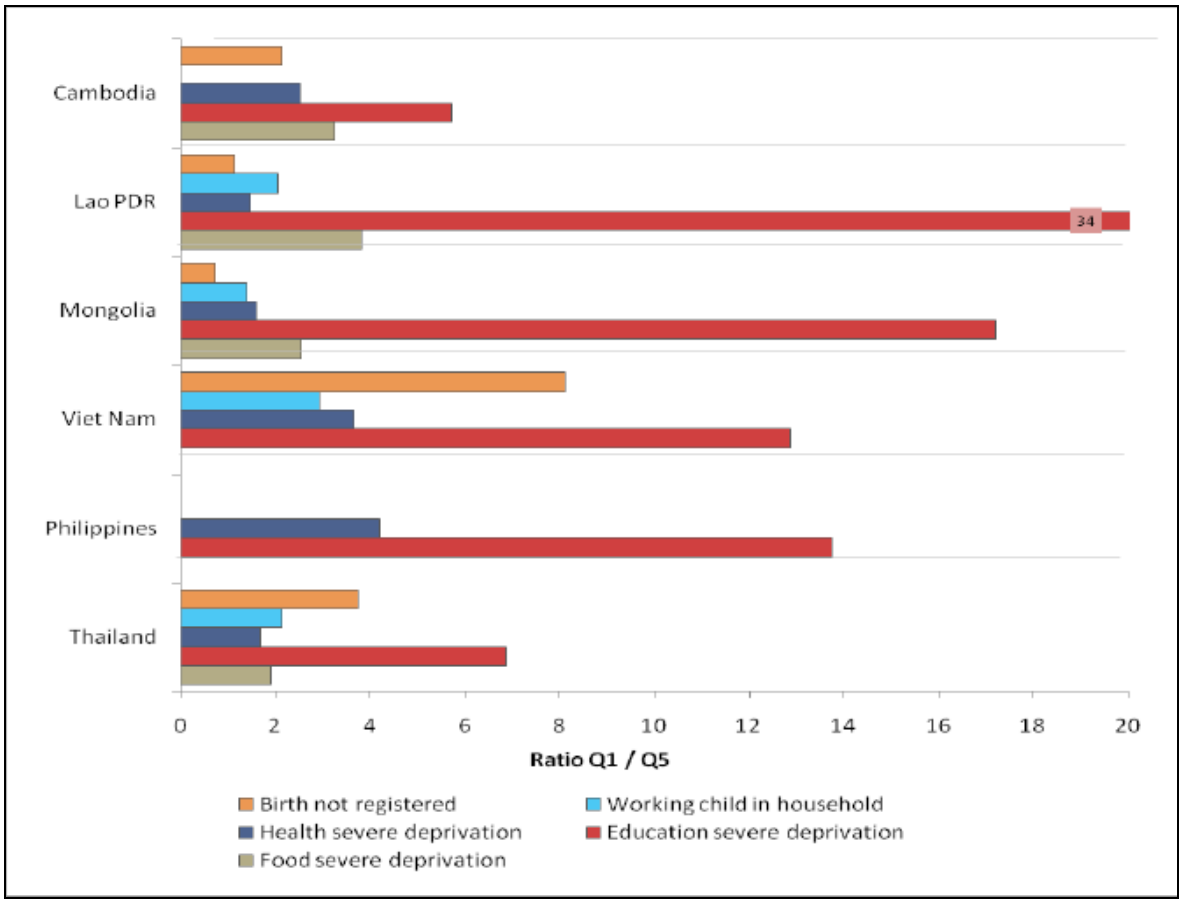
It is clear from Figure 15 that in the case of Lao PDR and Viet Nam, the poorest quintile was in practical terms included in the group suffering from severe deprivation. This was not the situation in Philippines and Thailand. In these countries there is a sizable group of children that belong to the bottom quintile, but who do not suffer from severe deprivation (7.6% in the Philippines and 15.8% in Thailand). Efficient interventions rely upon cognizance of these nuances.

Notable in Figure 16 are the deprivation ratios related to wealth quintile. The incidence of education deprivation is 34 times worse in Lao PDR for the poorest quintile and 7 times worse for the poorest quintile in Thailand. Clearly there is a worrisome lack of access to education for income-poor families.

Other dimensions of deprivation are not as responsive to wealth quintile. For example, in the case of birth registration, the ratio was 1.1:1 in Lao PDR and 3.7:1 in Thailand. [25]

[25] Figure 15 present information extracted from the report on birth registration and child labour that are not part

Figure 16: Deprivation Disparity Ratios, by Quintile, Poorest (Q1) to Richest (Q5), 2006



Source: Own elaboration from UNICEF Global Study on Child Poverty and Disparity 2007-2008 (Table 1.1.2 weighted to population).

2.8 Adapting the Multivariate Deprivation Method to be Country Specific: The Case of Viet Nam and the Philippines

As briefly mentioned in Section 1, both Viet Nam and the Philippines chose to adapt the multidimensional approach to be more responsive to local context. These processes are very informative and warrant further attention. The intention of this section is to draw some lessons from that experience. In the case of Viet Nam the research team developed a consultative process with various child development stakeholders for the specific purpose of formulating the dimensions and thresholds that would be used to define child deprivation in the country. The objective was "to ensure that the approach presented is Vietnam specific, representing areas of poverty that are defined to reflect child poverty by a wide range of stake holders"(UNICEF Viet Nam, 2008). In the case of Philippines the team decided to use a combination of different sources, one of which, the Family Income Expenditure Survey (FIES), allowed the team to utilize a combined method and develop trend analysis (UNICEF Philippines, 2009). In this case, the main objective was to utilize the experience of the national statistical office and ensure their participation and sense of ownership. The thresholds used were aligned with those typically used in the country, which facilitated the use of evidence collected by policy makers and NGOs.

of the deprivation dimensions and show relevant information.

Adapting the thresholds has been identified as a strategy for enhancing the ability of the dimensions to capture relative poverty and contextual issues.[26]

Table 10 compares the international thresholds (for deprivation)adopted by UNICEF Global Study on Child Poverty and Disparity (labeled 'Bristol Thresholds') with the country-specific thresholds adopted by Viet Nam and the Philippines. The percentage of child deprivation according to each threshold and the relative difference between the thresholds is presented. In Viet Nam, it can be observed that in all the cases the incidence of deprivation was much higher when using the adapted thresholds. For example, when considering education, 18.7% of children are deprived using the adapted indicators and 2% using the Bristol Thresholds, implying an increase of 16.7 percentage points when the new indicators are considered.

Table 10: Dimensions and Thresholds, Global Study and as Adapted by Viet Nam and the Philippines

Dimension			Shelter	Sanitation	Water	Information	Food	Education	Health
Bristol thresholds			Children (0-17 yrs) in dwellings with 5 or more people per room or with no flooring material.	Children (0 -17 yrs) who had no access to a toilet of any kind in the vicinity of their dwelling, e.g. no private or communal toilets or latrines.	Children (0-17 yrs) who only had access to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was more than 30 minutes round trip away.	Children (3 -17 yrs) no access to newspapers, radio or television or computers or phones at home.	Severely malnourished children (0-5 yrs) whose heights and weights were more than 3 SDs below the median of the intl. reference population.	Children (7-17 yrs) who had never been to school and were not currently attending school.	Children (0- 5 yrs) who had not been immunised against any diseases or young children who had a recent illness and had not received any medical advice or treatment.
Viet Nam	Report (2006)	Thresholds	Children (0-15 yrs) in dwellings w/o electricity or in dwellings w/o proper roofing or in dwellings w/o proper flooring.	Children (0-15 yrs) in dwellings without hygienic sanitation.	Children (0-15 yrs) in dwellings without safe drinking water.	*	*	Children (5-15 yrs) not enrolled or children (11-15 yrs) not having completed primary school.	Children (2-4 yrs) not fully immunized.
		Data(%)	24.6	41.1	12.6	*	*	18.7	31.4
	Bristol data(%)		24.0	16.0	8.0	11.0	*	2.0	7.0
	Viet Nam – Bristol (pp.)		0.6	25.1	4.6	*	*	16.7	24.4
Philippines	Report (2006)	Thresholds	Children (0-14 yrs) living in wall and roof that are made of salvaged and/or makeshift materials.	Children (0-14 yrs) living in absence of any toilet facility.	Children (0-14 yrs) that obtain water from springs, rivers and streams, rain and peddlers.	Children (7-14 yrs) that do not have any of the following: radio, television, phone and computer.	Children (0- 5 yrs) whose weights were more than 2 SDs below the median of the intl. reference population.	Children (6-16 yrs) not currently attending school.	Children (12-23 months) who have not received vaccinations.
		Data(%)	14.0	11.0	7.0	3.0	26.9	2.0	17.0
	Bristol data(%)		1.1	11.8	11.6	17.1	24.6	9.8	7.3
	Philippines – Bristol (pp.)		13.0	-0.8	-4.6	-14.1	2.3	-7.8	-19.1

[26] It must be noted, however, that the dimensions adopted by the other countries, despite being defined by a global methodology, were widely accepted as representative of the countries that applied them.

*No data.
Notes:
(1) Child Poverty Report Viet Nam data and MICS and DHS for EAPRO Child Poverty Study Countries data based on MICS, 2006.
(2) Child Poverty Report Philippines data based from different sources.
Food: Food and Nutrition Research Institute (FNRI) estimate (year 2005).
Education: Based on the Annual Poverty Indicators Survey (APIS), percentage of children 6–16 years old not currently attending school (year 2004).
Health: Based on sample (1348 cases). National Demographic and Health Survey (NDHS) (year 2003).
Shelter, Sanitation, Water and Information: PIDS estimates on based from Family Income and Expenditure Survey (year 2006).
Sources: Own elaboration from MICS and DHS for EAPRO Child Poverty Study Countries (Table 2.1.4) and Child Poverty Report, Viet Nam and Philippines.

Viet Nam decided to include the following 'child-focused' domains and indicators: i) child labour, ii) leisure poverty, and iii) social inclusion and protection with the following results:

Table 11: Child Work, Leisure Poverty and Social Inclusion and Protection, Viet Nam

Domain		Child work	Leisure poverty			Social Inclusion and Protection poverty
Indicator		Children 5-14 yrs working (%)	**Toy poverty** Children 0-4 yrs not having toys (%)	**Book poverty** Children 0-4 yrs not having at least 1 book (%)	**Leisure poverty** (toy poverty and/or book poverty) (%)	Children 0-4 yrs not having birth registration (%)
Total		23.67	29.32	65.63	69.06	12.37
Area	*Urban*	10.40	10.71	40.41	*	5.73
	Rural	27.19	35.08	73.43	*	14.42
Ethnicity	*Kinh/Chinese*	21.24	20.74	61.65	*	8.44
	Other	35.81	69.35	84.29	*	30.62

* No data.
Note: "Social Inclusion and Protection" was a dimension arrived at upon multi-stakeholder consultations in Viet Nam. These stakeholders believed child birth registration is more than just a child protection issue, because it impacts social inclusion owing to the plethora of social exclusions that result from not having ones birth registered.
Source: Viet Nam Child Poverty Report (pages 42-43).

It is clear these dimensions are worth highlighting for their significant impact on children's lives. With regard to child labour, almost 24% of Viet Nam's children work, and this rate rises to 36% among ethnic minorities. Child labour, and related child trafficking is a serious issue in the region. The right to leisure and recreation is one of the most commonly denied to poor children, at serious detriment to their cognitive development and development of life skills. A lack of access to books, which is linked to decreased school readiness, affects more than 65% of children in the country (40% in urban areas and more than 70% in rural areas). Finally, birth registration is an indicator that was incorporated in the last round of MICS. It is critical to note as it is a right as defined by the CRC and its denial could be indicative of inequity and discrimination. In Box 4 we outline some of the lessons that can be gleaned from the adaptations.

Box 3: Adapting the Indicators: Lessons Learned

1. On the one hand, adapting dimensions and indicators to reflect country specificities is extremely useful for tailoring policies and programs at the national level. This is important for middle-income and low-income countries alike as country-specific thresholds give a more accurate assessment of local child wellbeing. Thresholds can be more responsive to children if they are adapted to account for cultural norms and contextual issues. A good example is that of the ger (a traditional dwelling in Mongolia) which, as a one room dwelling, can skew considerations of shelter deprivation if international standards are used.

2. On the other hand, this approach implies a loss of comparability with other countries and difficulties conducting trend analysis over time. Thus it is advisable to follow a complementary approach, adding country-specific dimensions, indicators and thresholds, while also maintaining the previous indicators and thresholds to allow for regional and international comparison.

3. At the regional and sub-regional level, adapting the method can help define more relevant and responsive development strategies and policy, and foster greater cooperation amongst local stakeholders.

4. Adapting indicators and thresholds to country-specific needs can ensure ownership and recognition from partners and policy makers. It can also be useful, as was the case in the Philippines, to align the deprivation dimensions with national statistical indicators and thresholds.

5. Sensitivity of the indicators is high in some dimensions like education. For example, in the case of Philippines health deprivation rose from 7.3% (Bristol) to 17% using the adapted indicators. The adapted thresholds may provide a more accurate picture of the local situation. It is advisable that sensitivity be analyzed carefully.

6. It is important to add 'child- focused' dimensions and indicators of poverty. The Vietnam experience shows how relevant these can be, but also the strong limitations presented by limited available sources of information on deprivation in these areas.

Regional Situational Analysis of Child Poverty: A Summary

2.1 While the percentage of children suffering from severe deprivation has decreased, 33 million children in the subregion are still severely deprived, 13 million of whom are severely deprived in two or more dimensions.

2.2 For the seven countries analysed, the incidence of child poverty (as measured by severe deprivation) varies considerably across the region, stretching from 16% in Thailand to 90% in Cambodia. A very high incidence of severe deprivation is found in three countries (Cluster A - Cambodia, Lao PDR, Mongolia), where an average of 83% of children are severely deprived. In the other four countries analysed (Cluster B - the Philippines, Thailand, Vanuatu, Viet Nam), a relatively lower incidence of severe deprivation if found, averaging at about 30%.

2.3 Child poverty in Cluster B countries is much higher if 'less severe' thresholds of deprivation are applied, averaging at about 50% for the four countries. 'Less severe' deprivation in shelter, food and water is widely spread across the subregion.

2.4 Using composite indices, CPI 'Severe' and CPI 'Less Severe', allows a ranking of countries by their composite scores. Cluster A countries generally have a higher poverty score (and a lower rank) than Cluster B countries as would be expected, except Vanuatu ranks lower than Mongolia with the application of CPI 'Less Severe'. Composite scores provide a more complete picture of the child poverty situation in the country than the incidence of at least one deprivation (or the incidence of two or more deprivations).

2.5 Multiplicity or depth of severe deprivation is higher among children in Cluster A countries compared to their counterparts in Cluster B countries. Over 10% of children in Mongolia suffer from 3 or more severe deprivations, and incidence of multiple deprivation is even higher in Cambodia and Lao PDR.

2.6 Using a combination of income and deprivation approaches for measurement provides a more complete picture of child poverty. Analysis reveals that children can be: i) income poor and not deprived; ii) deprived but not income poor; iii) both income poor and deprived.

2.7 Disparities are rampant in all seven countries analysed, with the rates of child poverty being disproportionately higher among some population subgroups in each country. These include ethnic minorities, rural residents, those in households with more members or with more educated household heads, and those living in disadvantaged provinces or regions within a country. Distinct patterns of inequity are found within each country, wherein the various factors of disadvantage are not always correlated and may interact in different ways in each country.

2.8 Using locally determined thresholds of deprivation, as done in Viet Nam and the Philippines, can be extremely useful addressing child poverty by generating more accurate assessments of local child wellbeing. However, these should complement rather than substitute international standards so that comparability is not compromised

SECTION III: A Closer Look at the Reports: The Pillars of Child Wellbeing

In this section, we will proceed to take a more in-depth look at the Child Poverty and Disparity reports prepared by the seven countries. To frame the discussion we will organize this analysis based upon the five areas of public policy identified by UNICEF to be the critical "pillars of child wellbeing" (Global Study Guide, 23). These pillars: Nutrition; Health; Child Protection; Education; and Social Protection can be seen to overlap with the seven dimensions discussed in Section II. Food, education and health deprivation directly correspond to specific pillars, while shelter, water, sanitation, information are relevant to several of the pillars.

It should be noted that the central aim of analyzing the pillars is to direct attention to specific areas of public policy and public concern (Global Study Guide, 18). Moving from analysis of the deprivation dimensions to analysis of the pillars of wellbeing enhances the comprehensiveness of each country's research and generates evidence that can influence local public policy debates and strategies. Moreover, examining the pillars highlights how pubic policy can address child poverty across multiple deprivations.

In general, as is suggested by UNICEF, policy drives outcomes. However, this is not a forgone conclusion and the country reports make it clear that policy alone cannot address child poverty and disparity. Policy can guide and drive outcomes only if backed by capable institutions and comprehensive programmatic support. While it is clear the seven countries have taken great strides toward putting national child welfare policy frameworks and strategies and in place, it also evident that the next step is to ensure these policies and strategies are adequately supported by institutions and programs. Where national policies are in place they are frequently aligned with the CRC and other internationally recognized instruments of child welfare. The realities on the ground, however, indicate there is a long way to go before these ideals are realized. The thorough analysis presented in the country reports will help countries target programmes and policies such that the most vulnerable can be reached and limited resources can be used most efficiently. It should be noted that many, if not most, of the national policies and strategies highlighted in the reports were instituted very recently and much of the data used in the analysis predates their entry into force. As such, it will be critical for the current reports to serve as a baseline from which the effects of the said policies can be evaluated and reassessed. This lag serves, at least in part, to explain the weak links between policy analysis and outcomes analysis in the reports.

At the beginning of the discussion of each pillar, a basic matrix will be presented, one constructed using information presented in each of the countries' Child Poverty and Disparity reports. This is presented to serve as a brief introduction to the pillars and highlight some of the reports' major findings. As is apparent from the information in the matrices, the indicators are not always comparable, nor are they extensive. As such, it draws attention to the difficulties inherent to conducting regional comparative studies on the five pillars and perhaps indicates the need for a refined subset of indicators that correspond to each pillar. This issue will be taken up in the conclusion to this section. At the end of the section we will identify gaps and opportunities that emerge from consideration of the country reports as well as implication for countries in the two clusters (CA and CB) identified in Section II.

3.1 Pillar One: Nutrition

Approximately one third of all under-five deaths are caused by undernutrition. Undernutrition increases children's vulnerability to infections and jeopardizes their development and cognitive function, especially when it occurs during pregnancy and the first two years of life. For these reasons, undernutrition is associated with reduced adult productivity and the intergenerational

transmission of poverty. Undernutrition results from inadequate access to the amount or quality of food needed for growth and development. It is also caused by illness, particularly diarrhea, which drains children's bodies of vital nutrients. This destructive cycle of undernutrition and illness results in chronic health problems and child mortality. For many children, nutritional deprivation begins before birth as a result of having an undernourished mother. In infancy, this is exacerbated if the child is not breastfed and especially if not exclusively breastfed during the first 6 months of life. Proper nutrition is thus an essential pillar of child wellbeing, one that must be adequately reflected by comprehensive national policies and programs.

Table 12: Nutrition Pillar: Regional Snapshot

Country	Cambodia	Lao PDR	Mongolia	Philippines	Thailand	Vanuatu	Viet Nam
	Cluster A Countries (CA)			Cluster B Countries (CB)			
Indicators	- > 49% children (18-23mths) experience stunting - 45.3% of the same age group are underweight	- 40% under 5 experience stunting - 35% children under 5 malnourished - 26% under 6mths exclusively breastfed	-6.9% children under 5 from poorest two quintiles experience severe food deprivation - Shelter deprivation affects 52% of children (in poor families 85.5% - Central and Khangai regions worst off	-27.6% of children below 5 underweight (2003) - Regional disparity range: 15.7% (NCR) to 36.1% (Bicol) -54% of infants breastfed w/in 1hr of birth -33.5% exclusively breastfed till 6mths	- 12.4% moderately stunted - 9.5% of children moderately underweight - children in the south and north-east fare much worse	- 7% of children severely stunted, 20% moderately stunted - Nationally, 16% of children are moderately underweight - Mother's education and household income are critical to outcomes	No data available at the time country report was published
Policy Framework	- National Nutrition Strategy (2008-2015) - National Vitamin A Policy (2000) - National Infant & Young Children Feeding Practice (2002)	- National Nutrition Policy - National Nutrition Plan of Action	-National Plan of Action for Food Security, Safety and Nutrition (NPAFSSN, 2001) - Health Sector Master Plan (identifies nutrition as a priority issue)	- Philippine Plan of Action for Nutrition (PPAN) - Accelerated Hunger Mitigation Plan (AHMP)	-National Food and Nutrition Plan	-Nutrition Policy - Breastfeeding Policy	*

Source: EAP Country Child Poverty and Disparity Reports (2006-2008)
* Viet Nam Policy Analysis report forthcoming

Cambodia Deprivation analysis reveals almost 50% of Cambodian children between 18-23 months suffer from stunting (i.e., low height-for-age) and 45.3% are underweight. The report suggests this is the most vulnerable age-group in terms of nutrition and notes that deprivation is worse in the poorest wealth quintiles and for children whose mothers were not educated. Government expenditure on health has been increasing since 2000 and currently stands at almost 12% (2006). Cambodia has a National Nutrition Strategy in place that specifically relates to child nutrition. The National Vitamin A Policy and National Infant and Young Children Feeding Practice support this agenda, but greater programmatic support is needed to achieve its goals. The report also suggests such support must be better coordinated.

Lao PDR In response to serious nutrition challenges in the country, comprehensive national nutrition policies and intervention strategies were recently instituted. The National Nutrition Strategy and National Plan of Action on Nutrition aim to address undernutrition rates that are among the highest in the region. The report shows 37% of children under the age of five are underweight and 40% experience stunting. It also notes that there has been little improvement in these indicators in recent years. Rural areas, households in the poorest wealth quintiles, and households headed by uneducated parents suffer disproportionately from poor nutrition. The report suggests improving nutrition is not only crucial for human rights and equity, but will be critical to improving the country's macroeconomic environment.

Mongolia Severe food deprivation in Mongolia affects 6.9% of children under 5 years of age in the poorest two wealth quintiles. The report shows that other variables significantly impact the likelihood that a child will be malnourished, namely: gender (boys' nutrition indicators were found to be much worse than girls'), parental education, access to sanitation, the number of children in the household, and geographical location (rural children have worse nutrition indicators). The policy environment is framed by both the National Plan of Action for Food Security, Safety and Nutrition (NPAFSSN, 2001) and the Health Sector Master Plan, which identifies nutrition as a priority issue

The Philippines Around 27.6% of children under five are underweight in the Philippines. Regional disparity ranges from 15.7% in National Capital Region, to 36.1% in Bicol region. The report suggests breastfeeding within in the first hour of birth must be increased from the present rate of 54% as must the number of children exclusively breastfed for the first six months. The report raised the concern that nationally collected data is not being used for policy making and that inconsistencies in certain data suggest the presently used food poor threshold many not provide an accurate assessment of undernourished children in the country. The Philippines Plan of Action for Nutrition and the Accelerated Hunger Mitigation Plan are the two primary national initiatives for promoting nutrition and combating malnutrition. Interventions ranging from the Department of Health's Food-for-School Program to the Department of Agriculture's Gulayang Masa/Barangay Food Terminal program aim to reduce the number of Filipino's suffering from food shortages. Since 2008, the government has increased attention on nutrition and the National Nutrition Council has massively increased expenditure.

Thailand Thailand's National Food and Nutrition Plan aims to guarantee the security and safety of food in the country. Despite this, 9.5% of children under 5 years of age are considered moderately underweight and 12.4% are moderately stunted (2005). Children in the south and northeast regions of the country fare much worse. The report indicates that the education of the household head, geographic location, and household income affect national child nutrition indicators. The report calls for child development monitoring systems to be revived in order to monitor local administrative organizations and combat persisting challenges to child nutrition. It also suggests continuance of school lunch and milk programs (although this is targeting older children) as well as increased emphasis on nutrition awareness among marginalized populations.

Vanuatu Indicators of malnourishment are noted in the country report to be especially troubling given the Vanuatu's good food security. Nationally, 7% of children are severely stunted, while 20% are moderately stunted. The report shows that a mother's education has a significant influence on child nutrition outcomes and that certain regional discrepancies exist. Vanuatu's Nutrition Policy and Breastfeeding Policy are the two principal national programs related to child nutrition. The National Children's Policy also makes specific mention of the need to prioritize, strengthen, and integrate food and nutrition policies and programs.

Viet Nam Unfortunately nutritional data was not available in the data sets used to compile the Viet Nam report. In addition, policy analysis was not part of the 2006 study. A recent Oxfam report, however, suggests that Viet Nam has cut hunger and reduced poverty from about 58% of the population in 1993 to just 18% today. "To put this in perspective, this means that since 1993 roughly 6,000 people per day have been pulled out of hunger poverty," Oxfam's Viet Nam country director Steve Price-Thomas said. Agricultural land reform, heavy investment in irrigation and agricultural technology, as well as the nurturing of the domestic rice industry are believed to have played a critical role.

Regional Synthesis: Nutrition

While most of the seven countries have national nutrition policies in place, the reports make it clear that programmatic support is presently inadequate, particularly in rural areas and certain geographical regions. The reports show that the education of mothers and the income of household heads both have a significant positive effect on nutrition outcomes. Educated mothers are more likely to exclusively breastfeed their children for the first six months and have a greater awareness about nutrition in general. The reports make it clear, though often not explicitly, that there is tremendous opportunity for cross-sectoral cooperation on nutrition, which is inextricably linked to the education, health, agriculture and social protection.

There is a critical window of opportunity to prevent undernutrition, which begins when the woman is pregnant and lasts until the child reaches two years of age. Undernutrition during this critical period can cause irreversible damage, impacting children's future development. Evidence gathered in the country reports, particularly as it relates to inequitable nutritional outcomes, should be combined with internationally recognized low-cost, high-impact programmatic interventions, such as promotion of exclusive breastfeeding, timely, hygienic and appropriate complementary feeding practices, appropriate micronutrient interventions and management of severe malnutrition. In this way, evidence from the international and local level can be combined to maximize the efficiency and effectiveness of interventions for child wellbeing.

3.2 Pillar Two: Health

The second pillar of child wellbeing is health. Tremendous gains in child health have been made over the years, but for these to be sustained this pillar must be supported by capable local administrative and infrastructural systems. Moreover, these gains frequently belie increased disparity. Each year, approximately 9 million children worldwide die from preventable and treatable illnesses. Five of these, pneumonia, diarrhea, malaria, measles, and AIDS, account for around half of all under five deaths. Under-nutrition, as just discussed, contributes to around a third of those deaths.

UNICEF recently announced several new policies related to child health, which bear particular relevance to the countries studied here as they pertain to increasing access to the most marginalized. These strategies and policies include training and deploying more community

healthcare workers to deliver basic health services to marginalized populations, using mass communication to encourage the poor to seek care, and building maternal 'waiting homes' near urban hospitals so that rural women can receive care before delivery.

Table 13: Health Pillar: Regional Snapshot

Country	Cambodia	Lao PDR	Mongolia	Philippines	Thailand	Vanuatu	Viet Nam
	Cluster A Countries (CA)			Cluster B Countries (CB)			
Indicators	- IMR 95 per 1,000 live births - U5MR 124 per 1,000 live births	- IMR 70 per 1,000 - U5MR 98 per 1,000 - Only 27% of children fully immunized - 19 medical physicians/ health specialists per 100,000	- IMR 19.1 per 1000 live births (2006) - U5MR 23.2 per 1000 live births (2006) - severe health deprivation affects 8.1% of children (higher in poorer, rural households)	-IMR 29/1000 (2003) - U5MR 40/1000 (2003) -CMR 12/1000 (2003) - Number of children being immunized has decreased since 2004 -0.04% of government's budget was spent on child health programs (2007)	-U5MR 10.5 (2006) - 83.3% children 12-23mths recommended vaccines - 99.2% of households have improved sanitation facilities and 94% to improved water sources	- 10% of the national budget spent of health - 20% of the population do not have access to health services (2005) - rural children have worst access	- 31% of Vietnamese children have not received full set of vaccinations - Regional disparity stark, 60% in North West are not fully immunized - access to safe drinking water only 12%
Policy Framework	- Cambodia Child Survival Strategy - Health Strategic Plan	- National Health Sector Development Plan - National Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services	-Health Sector Development Program - National Housing Strategy of Mongolia -Family Housing Program	- Philippine Plan of Action for Nutrition (PPAN) - Accelerated Hunger Mitigation Plan (AHMP)	- National Health Promotion Plan - Universal Health Insurance Policy	- Health Sector Policy - Master Health Services Plan - Government's PLAS Strategy	*

Source: EAP Country Child Poverty and Disparity Reports (2006-2008)
* Viet Nam Policy Analysis report forthcoming

Cambodia Cambodia's public expenditure has continuously increased since 2000 in an effort to achieve the goals of the Cambodia Child Survival Strategy. This strategy aims to reduce under-five and infant mortality rates from 124 and 95 per 1000 live births to 65 and 50, respectively, by 2015. Regional and gender disparity is pronounced in terms of U5MR and IMR, with girls and children from Ratanakkiri and Mondolkiri provinces suffering disproportionately. High out-of-pocket expenses, which account for 79.3 percent of health expenditure, are seen as a major inhibitor of universal access to health services.

Lao PDR The report shows that public health spending in Lao PDR as a percentage of GDP is 2-3 times lower than neighboring countries and low-income countries in general. This lack of budgetary commitment is reflected in troublesome health indicators such as an IMR of 70 and U5MR of 98 per 1,000 live births (2005). Tremendous regional disparities exist, with rural health indicators starkly worse due to disproportionately low access to: health services, improved water sources, and improved sanitation. Founded on the premise of universal access to primary healthcare, the National Health Sector Development Plan is the overarching policy framework for promoting child health. Within this plan, the National Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services can be seen as the principal guiders of policies and programs to combat child health inequalities. These frameworks, however, are not supported by sufficient government budgetary commitments.

Mongolia Since the transition was made to a market economy, Mongolia's health system has experienced massive budget cuts and massive restructuring. Since 1998 the country has embarked upon the Health Sector Development Program in an effort to improve access, ensure the sector is sustainable, and improve the quality of services provided. The report attributes falling infant mortality rates and under-5 mortality rates to government policy and initiatives. In 2006, U5MR was 23.2 and IMR was 19.1 per 1,000 live births. Although the medical examinations, immunization and hospitalization of children aged 0-16 are free, many poor households cannot afford prescribed medicines. The report focused on the effects of housing deprivations and water supply deprivations as areas of key concern for child health. Limited government finances were cited as the principal challenge.

The Philippines Infant mortality currently stands at 29 per 1,000 live births and while the rate has been decreasing slowly in recent years, the report notes that it has not kept pace with neighboring countries. Wealth quintile, geographic location, and education of the mother have significant effects on health outcomes. The report suggests improving data collection, increasing the healthcare workforce, mobilizing communities, enhancing sustainable financing, identifying the most vulnerable, and investing in infrastructure and management of the healthcare system will be critical to improving child health outcomes. The country's Medium Term Philippine Development Plan (MTPDP) includes health-related goals such as reducing the cost of drugs, expanding health coverage, and improving healthcare management systems. The Department of Health's National Objectives for Health supports these aims and promotes increased responsiveness and equity in the health sector. A plethora of programs have been implemented nationally to support the aforementioned policy frameworks. The Philippine government has declared public health to be its "main priority," but the country report suggests budgetary allocations in the national government budget and the Department of Health do not support this claim (111).

Thailand The introduction of universal health insurance has increased access to free basic health services. The report cites increased access to services as contributing to the falling U5MR, which stood at 10.5 in 2006. While the ratio of doctors to population has improved, infrastructure for delivering health services remain inadequate, particularly in remote, rural areas. Access to improved sanitation and safe drinking water has increased tremendously, but children in the northeast and south suffer disproportionately when it comes to poor health outcomes.

Vanuatu The country's geographic characteristics make healthcare provision difficult and 20% of the population is believed not to have access to health services. Geographic spread has significant implications for the cost of sending health practitioners to dispersed communities and the associated transportation and human resource costs. The Ministry of Health's Health Sector Policy prioritizes primary healthcare and the Government's high-level strategy, PLAS, aims to increase

access to healthcare, eradicate malaria, strengthen the Ministry of Health and invest in health training. The study draws attention to wide discrepancies in certain health-related data (particular focus is given to immunization indicators) collected by different agencies.

Viet Nam The report indicates 31% of Vietnamese children have not received the full set of vaccinations and that rural areas suffer disproportionately. Regional differences are also stark, with children in the North East and North West exhibiting non-immunization rates of 53% and 60% respectively. Poor infrastructure and awareness of the benefits of full immunization are suggested as reasons for this disparity. Visits to professional health facilities are also much lower in these areas. The report also shows that almost half of Vietnam's children live in dwellings without a hygienic sanitation facility and that access to safe drinking water is only around 12%. Again, rural and regional disparities are pronounced.

Regional Synthesis: Health

The seven countries under examination have implemented national health development policies and strategies. All reports, however, point to the inequitable coverage of the programs that seek to support these policies. Those in rural, remote areas and those in the poorest wealth quintiles suffer disproportionately from health poverty, with many families unable to meet the necessary out-of-pocket costs associated with healthcare. These findings, logically, reflect the disparities noted in nutrition. The reports frequently cite budgetary limitations as a key inhibitor of policy success, limiting the scope and quality of health services provided. This can also be said of access to water and sanitation, which despite rising tremendously in recent years, still excludes many of the region's poorest children, contributing to diarrheal diseases, high intestinal worm infestation, and high under-five mortality in the poorest wealth quintiles. It should be noted that water and sanitation challenges in remote areas are now being accompanied by challenges in the rapidly growing impoverished urban areas in many of the countries.

3.3 Pillar Three: Child Protection

Child Protection, the third pillar, refers to child rights violations and deficits related to violence, abuse, neglect, exploitation, and crime. Such violations occur across all segments of society (regardless of wealth quintile etc.) and can result in lifelong developmental consequences and inequities. The nature and scale of child protection issues are diverse, multifaceted and interconnected. Statistical data on child protection remains sparse. Therefore, this section is based primarily on two aspects of child protection: child labour and birth registration.

Table 14: Child Protection Pillar: Regional Snapshot

Country	Cambodia	Lao PDR	Mongolia	Philippines	Thailand	Vanuatu	Viet Nam
	Cluster A Countries (CA)			Cluster B Countries (CB)			
Indicators	- 53% of children work (2001) - high levels of injury sustained by child laborers - Birth registration of 2-4yr olds was approximately 74%	- Almost 80% of children report being hit or smacked at home	- 22% of children involved in child labor (2005) - 98% of children under five have been registered	- 1 out of 6 children work to support their family (60% in hazardous environments) - 2.6 million unregistered children (2007) - 50% disabilities acquired -3% 0-17yr old live on streets	- 9.5% of children (5-14yrs) work (highest in north-east, 11%) - 1.2% children under 5 not registered - 2.3% of woman married before 15yrs	- Just over 25% of child births are registered - much variation between regions and wealth quintiles - 7% of girls marry before 15, but in some regions up to 12%	- between 9-24% of children believed to be engaged in some form of child labor - 12% of children do not have their births registered
Policy Framework	- National Plan on Trafficking in Persons and Sexual Exploitation - National Plan of Action on the Worst Forms of Child Labour - Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children	- National Plan for Action on Commercial Sexual Exploitation of Children - Labour and Social Welfare Masterplan 2007-2020	- National Program of Action for the Development and Protection of Children	-National Strategic Framework for Plan Development for Children (PNSFPDC – Child 21) -National Plan of Action for Children (NPAC)	- National Policy and Strategy on Family Development	- National Children's Policy	*

Source: EAP Country Child Poverty and Disparity Reports (2006-2008)
* Viet Nam Policy Analysis report forthcoming

Cambodia The report states that 53% (2001) of children work (mostly in agriculture, forestry, fisheries and hunting), and that this is worse for boys, particularly in rural areas. It also draws attention to high levels of injury sustained by child labourers and suggests a need to focus on the most intolerable forms of child labour and address these immediately. Birth registration of 2-4 year olds stands at approximately 74%, but is much lower in rural areas.[27] The report suggests

[27] The right to birth registration, which can be seen as a cross-cutting right that affects all other sectors, is essential to ensuring that children have an official record of their age, birthplace, name and family ties. As such, it can help to secure citizenship for children and thereby facilitate access to health, education, protection and social

increased data collection on child protection is critical, especially as it relates to trafficking and juvenile crime. Child protection in Cambodia is mainly supported by the following policy frameworks: the National Plan on Trafficking in Persons and Sexual Exploitation, the National Plan of Action on the Worst Forms of Child Labour, the National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia, the Policy on Alternative Care of Children, and the Minimum Standards on Alternative Care for Children. Despite these frameworks and their constitute programs, child protection outcomes require continued attention.

Lao PDR The legal framework for child protection is in place in Lao PDR, but the policy framework is in a nascent stage. The National Plan for Action on Commercial Sexual Exploitation of Children was approved in 2008 in an attempt to address child prostitution, child pornography and the trafficking of children for sexual purposes. The report identifies Lao-Tai, from the lowlands of the country, as the main victims of child trafficking. Increasing numbers of children are being implicated in drug-related offences, which has led to increasing rates of child detention. Like Thailand, the Lao PDR report contends rapid social changes and cultural traditions have presented challenges to the child protection agenda and the country is yet to formulate a national policy to support this pillar. As such, the institutional support systems necessary to promote child protection are not in place.

Mongolia The country report argues there is no "integrated structure of child protection services and common understanding on the subject." Nevertheless, the country has a high rate of birth registration (98%) and efforts to reduce the number of street children have shown promising results. Child labour remains a concern as the report states 22% of children are engaged in child labor and there are still many children working as domestic servants. The report argues that there is insufficient data on child protection issues and as such, many issues remain unregulated by the government.

The Philippines The country hosts some 2.6 million unregistered children, the majority of whom are Muslim and indigenous peoples (2007). Recent programming has targeted these vulnerable populations and the numbers are reducing significantly. The report notes that over 50% of childhood disabilities are acquired and that malnutrition and poor sanitation associated with extreme poverty are the leading causes. Those in poor remote areas and densely populated urban poor communities are disproportionately affected. Child labour affects 1 out of 6 Filipino children, 60% of whom work in hazardous environments. Generally, the incidence of child abuse has decreased. The country's Child 21 plan provides the overarching framework for child protection in the Philippines. The National Plan of Action for Children was formulated to help realize its vision, as was the Child Friendly Movement (CFM). The report urges greater inter-agency data sharing and collection.

Thailand The report cites the rapidly changing socio-economic landscape for many of the country's child protection challenges. Economic pressures on parents and high rates of domestic migration may lead to greater vulnerabilities in terms of neglect and exploitation. Children involved in migration, moreover, are particularly at risk of being trafficked and exploited. While the vast majority of children have their birth registered, 98.8%, there are indications that disaggregated measurements would reveal particularly low rates of birth registration in remote parts of the country, often where ethnic minority groups reside. The report indicates that 9.5% of children work and that this percentage is higher in the northeast (11%). In terms of child marriage, 2.3% of Thai women marry before the age of 15 years.

services throughout their lives.

Vanuatu Country-wide 7% of children marry before the age of 15, and 23.6% before the age of 18. These figures vary according to region and wealth quintile. The report notes that just over 25% of children in the country have their births registered and that child labour, in the context of family-based and community-based work, is customarily accepted in many parts of the country. This highlights the challenges Vanuatu has experienced in passing child protection laws which are perceived by many to be in conflict with customary laws and practices.

Viet Nam Due to variable survey techniques, data on child protection as measured by child labor varies significantly (9-24%) depending on the data source. The report suggests the "true" figure is probably somewhere in the middle. Regardless of the source, rural children engage in child work (mostly in agriculture and fishery) far more often than their urban counterparts. Regional disparity in child labour outcomes reflects that of health and education. In terms of birth registration, the report states that 12% of children aged 0-4 do not have their birth registered. The country report does not address the threat to child protection posed by child trafficking and this indicator was not included in the country-specific multivariate methodology.

Regional Synopsis: Child Protection

In general, information related to child protection, including the range of complex, inter-connected, and often compounding, forms of child protection violations (such as sexual exploitation and abuse, neglect, criminalization of children in need of care and protection, detention as a first response, child labour, trafficking, corporal punishment, unnecessary institutionalization, abandonment, abduction, exploitation for child pornography, illegal adoption and violence in homes, schools and the community) is poorly represented in national data. Often the data simply is not available, while at other times it varies tremendously depending upon the source. At times, this results in country reports that focus on birth registration and child labour as the primary components of child protection. Regionally, cooperation to combat child trafficking and sexual exploitation has increased, but the country reports show that many marginalized populations are still highly vulnerable. In general, child protection interventions have largely been issue-based and ad hoc, rarely addressing the underlying causes of child protection challenges. Comprehensive and integrated laws, policies, structures, and capacities to effectively protect children are just beginning to be put into place.

3.4 Pillar Four: Education

The fourth pillar of child wellbeing, education, is a fundamental entitlement of all children. Education is essential for individual and societal development. The positive externalities associated with investment in education include better health, increased macroeconomic growth, greater equality, as well as the potential to stop the intergenerational transfer of poverty. UNICEF places particular emphasis on the 'multiplier effect' of educating girls and on the centrality of education to achieving the MDG targets. UNICEF research shows that educated girls are more productive at home, better paid in the workplace, and better equipped to participate in social, economic and political decision-making. They are more likely to marry later, have fewer children, and have children more likely to survive, be better nourished, and better educated. Each of the country reports reviewed here point to the better child outcomes – in multiple dimensions of poverty – achieved by children whose mothers were educated

Table 15: Education Pillar: Regional Snapshot

Country	Cambodia	Lao PDR	Mongolia	Philippines	Thailand	Vanuatu	Viet Nam
	Cluster A Countries (CA)			Cluster B Countries (CB)			
Indicators	- 10.8% primary school dropout rate - 21% lower secondary school dropout rate - primary school students to teacher ration approx. 54:1	- Primary enrollment rate 91.6% (2009) - 59% of children from the poorest quintiles attend school - 65% of children entering 1st grade complete 5th	- Primary education enrollment fell from 96.6%(2002) to 91.4% (2006) - 6.1 % of children living in poor families are deprived of education (2005) - enrollment influenced by number of children in household and income	- Between 2002 and 2006 elementary participation rates decreased (2007 level is the same as 1990) - 3 out of 5 youths attend secondary school - Literacy (10-14yrs) 95% - 9.6% of GDP allocated to basic education	- Universal primary education achieved - 86.8% completion rate - 79.9% attend secondary school	- Basic education not compulsory -attendance lowest among lowest in Pacific - Literacy rate 74% (rural 69%) - 21.08% of governmen t budget spent on education (2008)	-Approx. 1 out of 10 children don't complete primary school - education poverty twice as high in rural areas - significan t regional disparity
Policy Framewor k	- Child Friendly School Policy - Education for All National Plan (2003–2015) - Education Strategic Plan - Education Sector Support Programm e	- Education Sector Developmen t Framework - Inclusive Education Policy - Early Childhood Developmen t Policy	- Government Policy on Education - Basic Guidelines for Education Sector Reform - National Program for Pre-school Education Developmen t -Informal Education Developmen t	- Philippine Education for All Plan - Medium-Term Philippine Developmen t Plan	- National Education Plan - Master Plan for Early Childhood Developmen t	- Vanuatu Education Sector Strategy - Vanuatu Education Support Action Plan - Vanuatu Education Road Map	*

Source: EAP Country Child Poverty and Disparity Reports (2006-2008)
* Viet Nam Policy Analysis report forthcoming

Cambodia. The Cambodian government provides free education in public schools for at least nine years. Despite this policy, education poverty rates differ significantly for children in the lowest and highest wealth quintiles. The report highlights school dropout rates (10.8% primary, and 21% lower secondary school) and a very high primary student to teacher ratio of approximately 54:1. Cambodia's Education for All National Plan (2003–2015), Education Strategic Plan 2006–2010, Education Sector Support Programme (2006–2010), and Child Friendly School Policy (2007) are the key policy instruments for addressing education poverty and disparities. Their effectiveness can be enhanced by ensuring ongoing sectoral inequity analysis informs targeted implementation.

Lao PDR Lao PDR's Education Sector Development Framework (2009) was instituted following a collaborative effort to identify the country's poorest and most educationally deprived districts. In an effort to achieve Education for All, this policy framework specifically targets the country's most vulnerable and has led to the drafting of the Inclusive Education Policy and Early Childhood Development Policy. As with the health sector, Lao's public expenditure on education is limited and has actually decreased in recent years (2005-2008). Though access to education facilities has increased dramatically, rural children still suffer from a low village-to-school ratio (up to 20:1). Only 65% of children who enter first grade complete fifth grade and this rate is worse for poor, rural girls.

Mongolia Deprivation analysis using data from 2005 indicates 6.1% of poor children are deprived of education. Disparity analysis, moreover, suggests rural children are less likely to attend primary school and much less likely to attend secondary school than their urban counterparts. Like the country's health sector, the education sector has had difficulty transitioning to a market-based economy, suffering from large funding cuts. Privatization of the animal husbandry sector is believed to have played a large role in high school drop-out rates amongst males. Recent reforms have not been thoroughly evaluated, the report contends, due to a lack of surveys and assessments on impacts. The report contends the quality and responsiveness of education must be improved to combat poor academic performance indicators

The Philippines Participation rates for elementary school are troubling. Between 2002 and 2006 rates decreased and the 2007 participation rate is reported to be the same as that of 1990. In terms of secondary education, only 3 out of 5 youths participate. Male youths, moreover, have a 20% lower participation in secondary school than females, who also display higher completion rates and performance indicators than males. Aside from gender, household income, education of mother, household size, and geographical location impact participation and completion rates. The report suggests additional resources must be made available for the education sector and the efficacy and relevance of the education provided in the nation's schools must improve. The education provisions in the Medium-Term Philippine Development Plan are routed in the Education for All program and the MDGs. The Philippine Education for All Plan is the long-term guiding strategy for improving education outcomes and achieving the country's goal of functional literacy for all. To do this, the Department of Education is undertaking a package of reforms called Basic Education Sector Reform Agenda (BESRA) and implementing Alternative Learning System programs. Though government budget allocations have been climbing in recent years, the percentage of GDP spent on basic education in 2008 was only a little higher than it was in 2002. In addition, the Department of Education's budget has only grown by 0.39% (in real terms) annually since 2000.

Thailand Extending compulsory education in Thailand has resulted in an increased number of children in school and 2007 education indicators suggest universal primary education has been achieved and remains stable. The ongoing challenge, however, is to improve the quality of the education provided so as to improve academic performance indicators and, the report suggests, improve social responsibility. The report suggests a need to emphasize teacher-training and investment in up-to-date teaching materials and techniques. Other areas in need of improvement are dropout rates (23.2%) and secondary school attendance, which currently stands at 79.9%.

Vanuatu Education outcomes are disturbing at present as dropout rates are high and the country has the highest proportion of children who have never been to school in East Asia. Significant differences in education outcomes exist between geographical regions, wealth quintile, and depending on whether on not a child's mother was educated. Education is not compulsory in Vanuatu and participation rates have been among the lowest in the Pacific despite almost a quarter of the national budget being spent on education. This, however, is potentially on the

verge of transforming with the introduction of the Educational Roadmap, which aims to ensure access to quality education. In 2010, the government announced that school fees would be abolished for primary school, which is expected to increase attendance and national education outcomes.

Viet Nam Universal gross primary enrollment has virtually been achieved in Viet Nam, but the report shows that approximately 1 in 5 children are not in the appropriate grade and approximately 1 in 10 do not complete primary school. Education indicators are typically two times worse in rural areas, and the North West and Mekong River Delta regions have consistently higher education poverty.

Regional Synopsis: Education

Most countries in the region have embraced the goal of universal primary education. Vanuatu remains the only country where education is not compulsory, but the government recently abolished primary school fee. A great many challenges remain in all countries, however, in terms of the quality of education, completion rates, secondary enrollment, and equitable access. Lao PDR and Cambodia presently face the most dire education poverty, but have taken decisive steps toward improving the policy environment. These efforts must now be met by increased mobilization of resources to devote to the support programs and institutions responsible for carrying out that policy. Targeted and well-monitored public expenditure in this area has a high rate of return and can help break intergenerational poverty cycles.

3.5 Pillar Five: Social Protection

The final pillar is social protection. UNICEF believes that governments have an obligation to provide social protection to the most vulnerable segments of their population. UNICEF's definition of child-sensitive social protection encompasses social assistance and economic support directed at the family or at the individual child, as well as social services including family and community support and alternative care (Kamerman and Gateino-Gabel 2006). It involves a set of public and private measures that protect society from social and economic distress, such as social assistance, income support in the form of cash transfers, childcare grants, tax benefits, social pensions, and improved accessibility of social services. As such, indicators for this pillar comprise of the proportion of people in need of these measures. Social protection policies and programs are designed to reduce poverty, protect the rights of the vulnerable, and increase social equity. According to Kamerman and Gatieno-Gabel, "Children constitute the largest vulnerable group in most countries yet social protection for children remains far less developed than for the elderly everywhere" (p. 30).

Table 16: Social Protection: Regional Snapshot

Country	Cambodia	Lao PDR	Mongolia	Philippines	Thailand	Vanuatu	Viet Nam
	Cluster A Countries (CA)				Cluster B Countries (CB)		
Indicators	- 901,733 households live below the national poverty line (NIS 2004)	- share of expenditure by the poorest 20 percent was only 8 percent - Increasing consumption shares are noted only in the highest quintile over the past 15 years	- 99% of children in the poorest wealth quintile suffer from at least one severe deprivations - multiple deprivations are far more common on poorer wealth quintiles	- ARMM, Bicol, Western Visayas, MIMAROPA, and SOCCSKSARGEN have disproportionately low child welfare indicators - households in the lowest wealth quintile display disproportionately low health and education outcomes	- 19.4% of children orphan - 1.85 million children have disabilities, over 40% of these live in the northeast	- Households in the poorest wealth quintile have 8 times the incidence of severe deprivation of those in the wealthiest - Rural households and those with an uneducated mother suffer disproportionately	- 8% of children (0-15) live in a household of which the head caregiver is unable to work
Policy Framework	- Law on Social Security (2004) – not supported by policy and programs - National Social Protection Strategy	- Not in place	- National Program of Action for the Development and Protection of Children - Child Money Program - Community-based Welfare Service	- Food-for-School Program (FSP) - Pantawid Pamilyang Pilipino Program (4Ps)	- Universal Health Insurance Policy	- Country Program Action Plan - National Disability Policy	*

Source: EAP Country Child Poverty and Disparity Reports (2006-2008)
* Vie Nam Policy Analysis report forthcoming

Cambodia Cambodia's 2004 Law on Social Security had not, at the time the country report was authored, been adequately supported by plans, policies or programs. To date, the principal forms of social protection involve exemption from user fees in public health facilities and social health insurance. The report suggests access to such social protection was limited and that price continues to constitute a major barrier to access to health services. The report notes that cash transfer schemes and child support grants are under investigation and three pilot sites being prepared. It also notes that the government relies on donor support for many of its social support initiatives, which raises sustainably concerns.

Lao PDR Social protection was not discussed as a separate pillar in the Lao PDR report. It should be noted, however, that the Lao PDR government has identified 47 priority districts, which it is targeting as part of its overarching strategy for poverty reduction. In addition, as part of the Ministry of Health's National Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services (2009-15), various measures to address disparities in health outcomes were identified that can be seen to constitute social protection measures,

including conditional cash and food transfers. While the report does not provide information on whether these measures have been implemented, it does suggest that development of child-sensitive social protection mechanisms are critical for protecting children from chronic poverty.

Mongolia The country report shows that state funding for social welfare services has increased dramatically in recent years, yet it also states "social welfare allowances are not flexible enough to meet the needs and demands of vulnerable families and children" and that their impact on poverty is hard to determine. Part of the problem, the report contends, is that social welfare policy inadequately targets the poorest families. The Child Money Program, for instance, allocates assistance to children irrespective of their family background. The report shows that the effect on poverty and disparity was far greater when the program targeted income-poor households. The recently launched Community-based Welfare Service aims to address this. It is suggested by the authors that the criteria for evaluating social welfare services be better defined.

The Philippines The country report documents two principal social assistance programs that impact Filipino children. The first, the Food-for-School Program (FSP), is a conditional in-kind transfer program that aims to address hunger and improve school dropout rates by providing families with rice if they keep their children in school. Preliminary evaluation suggests the program has improved education and nutrition outcomes. The Pantawid Pamilyang Pilipino Program (4Ps) is also a conditional cash transfer program. It provides educational grants to families whose children are enrolled in and attend school at least 85% of the time and health grants to families who comply with various health-related conditionalities (such as immunizing children, and ensuring young children attend regular preventative check ups). This social safety net program is yet to be comprehensively evaluated and it is not clear the data will be available to do so. The report makes concrete suggestions for improving SSN programs and suggests targeting accuracy will need to improve.

Thailand The shortage of qualified and trained staff and a lack of interagency cooperation are suggested to be the principal challenges to social protection services in Thailand. The report reviews a number of social protection initiatives and concludes that successful interventions are implemented and evaluated over an extended period and encourage community participation and networking to ensure sustainability. Innovative financing of children's social welfare programs, such as scholarships funded by the government lottery, are promising.

Vanuatu Social Protection is an emerging focus in Vanuatu. UNDP is assisting the Government to strengthen planning and management systems related to equitable poverty reduction and implement social protection services. Targeting social protection policies will need to address the impact that region, education of the mother, and household income have on child wellbeing indicators.

Viet Nam Social protection was not discussed as a separate pillar and was included in an analytical domain entitled "Social inclusion and protection," which included aspects of child protection and social protection. Relevant data presented include the finding that 8% of all children aged 0-15 live in a household in which the head caregiver is unable to work. This indicator of disparity is, contrary to most in Viet Nam, worse in urban areas and the report suggests this may be due to the old age and/or disability of many urban household heads.

Regional Synopsis: Social Protection

Social protection is an emerging, if not fully understood, concept in the region. Many of the reports confuse child protection with social protection and it is clear the policy and institutional frameworks for social protection are in nascent stages at best. The impact of the global financial

crisis and natural disasters (see Box 4) can be seen to have strengthened the need for social protection as a means of ensuring basic human dignity, as well as promoting social and economic security. For children, social protection is especially critical as a tool for promoting equity. Some of the reports detail experiments with social protection policy, but these recently implemented policies and programmes cannot, in many cases, be evaluated yet. If found to be successful in increasing social protection outcomes for children, these policies and programmes will need to be dramatically scaled up and coordinated within comprehensive national strategies. As the Mongolia report points out, targeting such policies to the most vulnerable is absolutely critical if full benefits are to be realized.

Box 4: Natural Disasters and the Need for Social Protection

The readiness of the countries to cope with the impact of natural disasters is particularly relevant for poor children and women. Studies show that children and women belonging to the poorest segments of society are the ones most affected by natural disasters.

"Women and children appear to be more vulnerable to the impacts of natural disasters. They find it harder than men to escape from a catastrophic event due to their smaller average size and physical strength. Pregnant and nursing women, and those with small children, are particularly vulnerable. Women may also be subject to cultural restrictions on their mobility, including dress codes and seclusion practices" (UNICEF UK, 2008). From 1975 to 2004, over a million people in East Asia lost their lives because of natural disasters mostly from earthquakes and related tsunamis. In 2004 alone, over 62 million people were affected in East Asia by disasters, most of them children and women from vulnerable groups (UNICEF, 2005). In 2005, of the 90,000 people killed by natural disasters, 90% lived in Asia.

Poverty and lack of development exacerbate people's vulnerability to all extreme weather hazards. People in low-income countries are four times more likely to die in natural disasters than people in high-income countries (UNICEF UK, 2008). It is important to call attention to this issue and the threat it poses to child wellbeing in the region.

3.6 Pillars of Child Wellbeing: Gaps and Opportunities

Gaps: Analysis of the pillars of child wellbeing reveal that lack of programmatic support of child wellbeing policies is one of the primary obstacles to child welfare in the region. In general, the policy environment is guided by internationally agreed upon priorities and principles. In order for these policies to be effective, however, the programmatic support mechanisms need to be in place and be adequately supported by the necessary resources. This, of course, is an ongoing struggle for each of the countries analyzed here.

Tight resources and limited public finance necessitate targeted policies and programmes in order to maximize efficiency. The reports have gone a long way towards mobilizing the evidence and capacity required to monitor and evaluate, in a targeted way, policies and programs for child wellbeing. However, each of the countries report challenges in obtaining accurate and consistent data. Not only do different agencies use different definitions and criteria to determine their indicators, but these criteria often change over time, which makes trend analysis problematic. Advocating for enhanced data collection and management mechanisms will therefore be critical to eliminating irregularities and increasing policy and programmatic efficiency.

Another related challenge is the lag between policy implementation and policy outcomes, as well as the difficulty in measuring the isolated effects of particular policies and programs on outcomes. This lag explains, at least in part, the difficulty some of the reports had conducting evidence-based policy analysis. Many of the policy frameworks highlighted in the reports have been instituted

quite recently and their impacts are therefore not captured by the indicators presented. However, given the cyclical nature of the policy process, available indicators can inform ongoing policy formulation and design.

Opportunities: Many opportunities have arisen from embarking upon the Child Poverty and Disparity studies. The countries involved have remarked upon the consultative, partnership-building, and capacity-building nature of the work involved. The following assessment was provided by the Viet Nam CO:

> The knowledge transfer or learning process has taken place in various ways: 1) on-the-job training for the General Statistics Office (firstly on data verification for the calculation of child poverty rates/indices based on 2006 data, and subsequently through the application, by GSO staff, of the model and the calculation of the child poverty rates/indices using 2008 data - with distant support from the international experts); and 2) provision of technical training on how to use micro simulation methods in cost analysis for child benefits (scheduled November 2010). Ownership of the child poverty approach by GSO is reflected in the inclusion of child poverty calculations in the report of the 2008 household living standards survey as well as in the inclusion of additional child poverty indicators in the 2010 questionnaire of the same survey (UNICEF Viet Nam).

Such ownership is significant and should be expected to enhance the sustainability of monitoring and evaluation efforts using the multidimensional child poverty method. Furthermore, the partnerships forged during the study are helping to push child-sensitive poverty reduction strategies forward at the national level (Thailand, Viet Nam) Promising steps have been taken to take the results of the studies to sectoral ministries and key program and policy informants. Country offices should be encouraged to share their successes and challenges on this front with other COs in the region and develop strategic plans and best practices for these activities.

The preceding analysis shows that opportunities for cross-cutting policies and programs involving the health, education, and social protection sectors are also emerging. This is a key aim of the Global Study and one that is in reach if the participating countries continue to use the gathered evidence, and, as suggested by the Cambodia CO, take a step back and try to identify cross-sectoral opportunities (Reflection Interview). Cross-sectoral cooperation can increase the mobilization of resources and enhance the comprehensiveness and compatibility of data collected. These opportunities can, in many cases, be low-cost and produce very high returns. Policies such as Philippines Rooming-In and Breastfeeding Act of 1992 – which required that public and private hospitals promote exclusively breastfeeding in the first six months – produce benefits to the child nutrition, child health, and education sector. A supporting program (Pantawid Pamilyang Pilipino Program) provides cash grants to pregnant women who attend breastfeeding counseling. These kinds of cost-effective, cross-sectoral actions must be vigorously pursued.

Cluster A and Cluster B If we return to the country groupings suggested in Section II, i.e. CA and CB, we see that in terms of the policy environment, there is very little difference in terms of the guiding policy frameworks. This reinforces the idea presented earlier that the overarching goals are the same, but the strategies for achieving them need to be different. The policy frameworks for the most part reflect internationally recognized standards, in line with the CRC. Implementation of these plans and policies and their outcomes, however, is what differs. While both clusters exhibit problems with equity and concentration of poverty and deprivation in certain populations, Cluster A countries have a greater segment of their population in this situation and suffer from greater infrastructural challenges when it comes to widespread service provision. The capacity of these governments to invest in such infrastructure was undoubtedly

impeded by the global financial crisis and the resultant reduction in demand for exports and GDP growth.

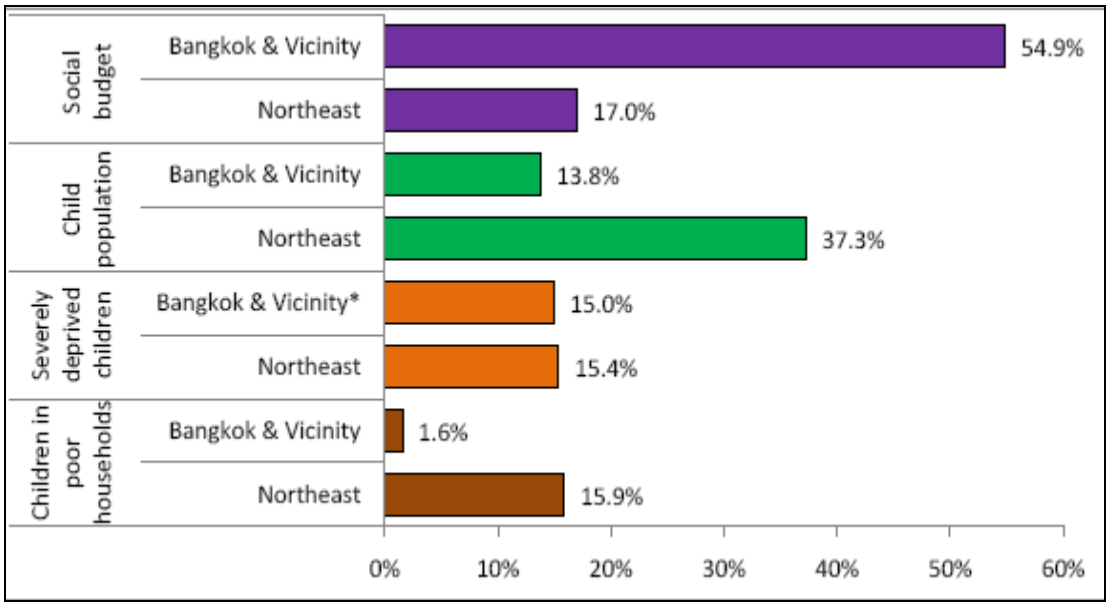
Because the pillars were identified for their centrality to child wellbeing, they provide a deeper understanding of the situation of children in the seven countries. The challenge, however, is for deprivation indicators to be better linked to these pillars so progress can be better monitored and regional comparisons made more effectively.

For Cluster B countries, the comprehensive disaggregated analysis of these pillars that was conducted as part of the Global Study is of critical strategic importance to achieving national policy aims and the MDG targets. For Cluster A countries, a key challenge is that "the study is … rather descriptive [in] nature. It informs where the problems are, but does not necessarily inform what needs to be done, how, by whom and what implementation modalities need to be utilized" (conversation with Mongolia CO). The Mongolia team notes the infrastructural challenges mentioned earlier and the difficulties these present for UNICEF which has limited involvement in the water, sanitation, and housing infrastructure sectors.

Finding ways for the evidence gathered as part of the Global Study to influence and inform strategies in these sectors will be an important next step. It is critically important, for example, that deprivation evidence inform budgetary allocations, which is why the Global Study recommends such analysis. Budget analysis was a weakness in many of the country reports, but as the following box shows, this kind of analysis can make a strong case for reforming budgets in favor of child equity.

Box 5: Social Budget Analysis in Thailand

The following figure shows a portion of the social budget analysis conducted in Thailand. It reveals a clear imbalance in favor of the Bangkok area, which received 54.9% of the social budget despite hosting only 13.8% of the country's children. By contrast, the Northeast region of the country, which hosts 37.3% of the child population, received 17.0% of the social budget[28].



Sources: Social budget, Child population: National Economic and Social Development Board (NESDB); Severely deprived children: MICS 2006; Children in poor households: Socio-Economic Survey, National Statistics Office. Figures have been rounded to 1 decimal place.

These disparate investments exists despite the fact that the incidence of children living in income-poor households was nearly zero in Bangkok and more than 15% in the Northeast region. In Cluster A and Cluster B countries alike, such evidence must be used in advocacy efforts aimed at providing for the most vulnerable children.

[28] Although the social budget allocation figures are reflective of the existing inequity in the country, it is important to note that data on budget disbursement, had it been readily available, would have provided a more complete picture, and also that some of the skewing of the budget in favor of Bangkok & Vicinity may be explained by allocations toward tertiary education (concentrated in greater Bangkok) which is not directly relevant in the context of addressing child poverty.

SECTION IV: Conclusions and Recommendations

The situation facing children who suffer severe deprivation and absolute poverty in the seven countries shows marked improvement in recent years. However, as discussed:

a) Millions of children still suffer from severe deprivation, less severe deprivation, and multiple severe deprivations.

b) Inequity is rampant, with demonstrably high levels of disparity along social indicators. Child poverty, as measured by severe deprivation in food, education, and health, disproportionately affects children living in rural areas, those belonging to families in the bottom wealth quintile, and those who belong to ethnic minorities. Gini coefficient analysis reveals income inequality to have remained stagnant or increased in all seven countries in recent years despite steady GDP growth.

Much more can and must be done in all countries to reduce inequities faced by children and adolescents in the region. This report aims to assist the UNICEF in East Asia and the Pacific to identify and implement strategies to do just that. Of course, there is no single recipe or magic bullet that addresses the complexity of multidimensional child poverty and inequity. It is neither the objective of this report, nor a desirable goal, to issue specific recommendations in terms of country policies and programs. Country Offices and their partners have, and should continue, to take that role.

Instead, this report intends to promote discussion, debate, and collaboration amongst UNICEF Country Offices, the Regional Office, and partners in the region, based on evidence collected as part of the Global Study on child Poverty and Disparity. Such conversations can generate the positive energy and momentum required to holistically address child poverty and disparity and can constitute a powerful tool to open windows of opportunities at the policy and programmatic level.

This final list of comments and recommendations is not exhaustive. Rather, it highlights issues that are emphasized in the reports and that the analysis suggests are particularly relevant for moving the agenda on child poverty and disparity reduction forward. Each point in this final section is relevant for each of the countries studied, but clearly the relative relevance of each point will vary by country. Where countries are found to be more advanced in a particular dimension, valuable horizontal cooperation opportunities could be explored. The hope is that the list of issues presented here, and the recommendations suggested, are comprehensive enough to spark discussion and action in the region.

One Shared Vision but Different Strategies: Cluster-Specific Recommendations

The analysis shows that countries in the region have a clear, shared vision when it comes to child poverty. This can be synthesized as follows:

i) Policies to reduce poverty must start with children;

ii) Child poverty is multidimensional and goes far beyond income poverty;

iii) Inequity is a critical obstacle to reducing child poverty and fulfilling child rights.

Under this common, clear vision, different strategies should be applied to achieve the overarching goal of eliminating child poverty and fulfilling child rights. This will necessitate balancing policy and programmatic action on two fronts: On the one hand, universality of access to basic consumption and social services, encapsulated in the seven dimensions and five pillars, must be

pursued. Simultaneously, the quality and scope of these public goods and services must be enhanced.

Universal access to quality services will require different strategies from country to country according to their political, economic and social dynamics. Historical, cultural, economic, social and geopolitical contexts and forces vary greatly across countries. In spite of these differences and their implications for policymaking, it may still be a potentially useful analytical exercise to cluster the seven countries into two groups: Cluster A and Cluster B. The main findings and strategy implications for each cluster are presented below.

Cluster A	Cluster B
Main Findings • Incidence of Severe Deprivation: 83.4% • Incidence of 'Less Severe' Deprivation: 92.6% • Depth (Multiplicity) of Severe Deprivation: 2.01 • Income and Deprivation: More overlap – almost all children who are income poor are also severely deprived • Disparities in child poverty are rampant	Main Findings • Incidence of Severe Deprivation: 30.5% • Incidence of 'Less Severe' Deprivation: 49.0% • Depth (Multiplicity) of Severe Deprivation: 1.38 • Income and Deprivation: Less overlap – many children who are income poor are not severely deprived • Disparities in child poverty are rampant
Strategy Implications In Cluster A countries (Cambodia, Lao PDR and Mongolia), most children suffer from at least one severe deprivation and, on average, one out of every two children suffer two or more deprivations. This suggests that the vast majority of the populations in these countries do not have access to basic services. Lack of supply of those basic services is a central issue, as are the inhibiting demand side forces associated with insufficient income. It is necessary for these countries to examine relevant user fees and their impact on access. In addition, hidden costs must also be carefully scrutinized. Free healthcare access is frequently undermined by transport costs and the high out-of-pocket expenses associated with medicines and specialized care. As mentioned earlier, the desired impact of free education on universal access can be undermined by required expenditures on uniforms, transport, and books. Given that Cluster A countries are also the ones that face severe resource limitations, ensuring universal access to a *basic* package of quality services, essentially the pursuit of a minimum social floor, is strongly recommended.	Strategy Implications In Cluster B countries (Philippines, Thailand, Vanuatu and Viet Nam), severe deprivation is less prevalent, while 'less severe' deprivation is more widespread. Lack of access to basic services is concentrated in certain geographical areas and amongst excluded groups. Issues such as the quality and scope of services, and disparities therein, usually affect a much greater share of the population. Under these circumstances, a two-pronged approach is strongly recommended for these countries: a) Addressing access to basic services among those in remote areas and those belonging to marginalized groups; b) Expanding the frontiers of services in order to enrich their capacity to enhance child wellbeing. Frontiers in the education sector, for example, can be expanded by increasing the compulsory years of education, and including preschool. Social service frontiers can also be expanded by enhancing training, increasing the number and quality of healthcare providers, and strengthening the quality of social service infrastructure. Essentially, both quality and scope of services merits attention in these countries.

Note: The conclusions presented in each cluster are merely suggested guidelines for conceptualizing and prioritizing development strategies in the subregion. Clearly, each country will have unique contextual issues that need to be considered when formulating targeted policies and programs.

Final Comments and General Recommendations

- **Enhance equity through policies to reduce child poverty:** Any equity and disparity reduction policy must start with child poverty reduction at its center. It is recommended that this be clear on regional and country poverty reduction agendas.

- **Promote the multidimensional deprivation approach:** The multidimensional deprivation approach to child poverty can be considered a stand-alone component of the poverty agenda, one that is well established in the region. The multidimensional and child-focused approach to child poverty provides important and holistic evidence about child wellbeing based on disaggregated data analysis. The approach has the potential to be a very valuable supplement to typical sectoral situation analysis, and should therefore be actively promoted.

- **Emphasize the complementarities of monetary and deprivation approaches to poverty:** The multiple-deprivation approach to child poverty and the monetary approach to child poverty are complementary ways of gathering information about the situation of children and their families. As stressed in some of the reports and discussed in Section II, each method identifies different groups of children, for whom development interventions need to be different. "Only using the monetary approach as input into the policy process would result in the exclusion of children that are only captured by the child poverty approach but are not poor according to the monetary method"(UNICEF Viet Nam, 2008).

- **Increase awareness through research:** The process of producing national Child Poverty and Disparity Reports raises awareness about child poverty and opens the possibility of influencing the policy agenda. Two comments by countries bear mentioning: the Thailand report concluded that "The partnership around the poverty study provided an entry point to discuss ways of exploring [child poverty] issues, including the possible role for entitlement-based social transfers." The Viet Nam report concluded: "The participatory approach to the study design has created awareness among development players on the multidimensional nature of poverty and particularly poverty among children." Based on these experiences, other countries could be encouraged to conduct child poverty studies.

- **Maintain momentum:** It is important to maintain the momentum created in the countries from having developed and launched the study on child poverty and disparity. It is recommended that strategic communication and advocacy pieces be developed and utilized to influence policy. The country network created for the study should be maintained and nurtured.

- **Develop advocacy and communications strategies:** Influencing the policy agenda requires the strategic allocation and investment of resources in an advocacy, communications and dissemination plans. Advocacy is key to influencing policy and program development. The country reports should be used to emphasize the efficiency and effectiveness of evidence-based policy. Network development, capacity building, workshops and high-level presentations also play an important role in building a multilevel communications strategy. UNICEF Philippines, in partnership with PIDS, offers a good example. A series of policy briefs entitled "The Filipino Child" present acute problems and key intervention results related to children living in poverty. For instance, Policy Brief No. 3 emphasizes the multiple dimensions of child poverty and Policy Brief No. 6 focuses on schooling disparities.[29] These hort and clear notes are specifically geared toward influencing policy. Countries in the region are encouraged to develop explicit, strategically-oriented communications materials that target

[29] www.unicef.org/philippines/brief03_fnl.pdf

particular audiences such as policy makers, media, private sector, academia and NGOs. Participation by children and adolescents should be considered as part of this strategy.

- **Enhance links between policy and evidence:** Moving forward, as suggested in Section III, the links between the evidence provided by the studies and policy analysis must be strengthened. To progress strategically requires: a) continued commitment to evidence-based policy, and b) providing more concrete recommendations based on the study results. The CO should specify clearly the implications of the evidence presented in the child poverty report and generate strategies for influencing relevant policies and programmes.

  The strength of the deprivation approach is that it allows analysts to assess various deprivations and identify specific and concrete measures to improve the lives of children. To promote enhanced action, it is recommended that a selection of the most significant deprivations and disparities be identified by each country office, based upon evidence presented in their reports. This will allow countries to prioritize issues and link these to the current policy agenda. Such prioritization can yield powerful policy recommendations, streamline opportunities and communication between partners and stakeholders, and influence national political priorities. These policy-oriented activities should form part of the strategic orientation to promote poverty reduction and enhance equity in the region. The Regional Office should promote horizontal cooperation on relevant best practices in this area.[30]

- **Promote inter-sectoral advocacy:** Policies and programs for child poverty reduction generally lack an integrated strategic vision. The sectoral approach prevails. As stated by UNICEF Pacific, "In this respect, UNICEF's work with government to raise awareness and understanding on poverty and deprivation of children… is fundamentally important as it provides the evidence that yields the entry point to bring children's issues in the mainstream development and poverty alleviation agenda, rather than remaining as sectoral issues limited to the domain of Ministry of Education, Health and Social Welfare/Justice." This approach is particularly necessary for the child protection and social protection pillars of child well-being. Ad-hoc and fragmented measures currently in place have not been effective in ensuring adequate protection and fulfillment of child rights. Inter-sectoral advocacy and collaboration with governments to develop comprehensive, integrated national child protection systems and social protection systems should continue to be pursued. The evidence gathered on deprivations and the pillars of child wellbeing in the country reports will be invaluable for such efforts.

- **Promote social protection for holistic poverty reduction:** Social protection tools such as universal child benefits and targeted cash transfers tend to be very effective in improving the living conditions of children in poor families. Countries such as Viet Nam and Thailand, reported that the child poverty study encouraged them to move in the direction of promoting such policy measures. Mongolia has already been implementing such a program. The main effectiveness of child benefits and cash transfers lies in reducing child income poverty and positively influencing nutrition, health and education. However, child benefits and cash transfers are not the only social protection tools for addressing child poverty. Other social protection measures such as health insurance for the poor, education stipends for girls, and employment guarantees for parents can also be effective. UNICEF should develop a

[30] In fact all the UNICEF COs interviewed for this report mention this as the central task to which they are or will be committed.

sound and doable social protection strategy for the region, taking into account the lessons learned in countries already implementing social protection policies and programs.

- **Examine budgetary initiatives and fiscal space**: Public resource allocation plays a central role in promoting, fulfilling and protecting child rights. Budget analysis, monitoring and lobbying in support of child rights could be a powerful tool to promote equity and increase programmatic support for child wellbeing policies. It can open dialogue with finance ministries and influence macroeconomic policy. In some cases, the child poverty reports cite a lack of reliable and useful budget information. In most, the need for strengthening budgetary assessment is acknowledged. It is highly recommended that EAPRO promote and develop child-sensitive budgetary assessment.

- **Improve child-sensitivity of household surveys:** To generate stronger evidence on child poverty it is recommended that UNICEF continue to advocate for additional child wellbeing indicators to be incorporated in national household surveys.

- **Promote trend analysis**: As stressed in the reports, analyzing trends on child poverty and disparity can be a powerful tool for evaluating policy. It is recommended that UNICEF promotes this kind of research.

The preceding comments and recommendations are based upon the findings of the country studies and the Bristol indicator analysis conducted in Section II. It is clear countries have gathered a tremendous amount of information from conducting the studies and it is hoped the recommendations can assist them in their efforts to move the agenda forward and maximize the utility of the information collected. In the following box, we will mention a few outstanding issues that were not sufficiently addressed by the reports nor captured by the Bristol Indicator analysis. These issues may need to be addressed in the next round of country studies and incorporated in future deprivation indicator sets

Box 6: Issues in Need of Additional Research

1. Migration, remittances and children left behind: Internal and external migrations constitute an increasingly important phenomenon in each of the countries studied. Migration affects children in a variety of important ways. In the case of external migration, remittances from overseas workers constitute an important source of country and family wealth and income. In the Philippines, for example, remittances have risen sharply, from $6 billon in 2000 to over $12 billion (constituting 12.5% of GDP) in 2006[31]. Studies show that families frequently invest this additional income in their children, leading to a positive impact on child wellbeing. While overseas workers' remittances help drive economic growth, the social costs and benefits, especially as they relate to children, remain largely unmeasured.

The Thailand study shows that 20.9% of children in rural areas do not live with their parents. This relates to an internal rural to urban migration or to an international migration. Most of the countries report a negative impact on family structure and children because of migration, especially among poor families. Low school achievement and high drop-out rates, child labor, abuse and child neglect may result from high migration rates. Migration is also linked to exploitation and trafficking, especially in the case of adolescents girls. Young people who migrate are said to be vulnerable to exploitation by traffickers (NGO Group, 2005). It is recommended that collaborative, multi-country research efforts be promoted by the RO that involve all affected countries in the region. The RO should develop and disseminate research on migration issues in an effort to generate evidence for actions that reduce child poverty and disparities associated with the phenomenon. Regional strategies, programs and agreements should be promoted that address shared international migration concerns.

2. Urban poverty: The studies analyzed in this report and the analysis presented in Section II show that child poverty is more acute in rural areas. However, urban data often masks huge inequalities between rich and poor areas (Barlett S, 2003). The analysis of wealth quintiles shows this to some extent. It is recommended that further research be undertaken to acquire more evidence about children living in urban poor settlements. This is highly relevant for EAPR given the important rural to urban migration process and the high density of urban populations in many of the countries.

3. Adolescents and adolescent girls: Given the demographic transitions in EAPR, adolescents represent a major proportion of the child population and can be seen to suffer from several simultaneous discriminations and invisibilities. International research is conclusive when it comes to the efficiency and effectiveness of investing in adolescent girls due to the plethora of positive externalities it spawns. Despite having the capacity to constitute a productive and positive social force, adolescents are frequently perceived by society in negative terms. This group's relevance to child poverty was not emphasized sufficiently in the reports. It is recommended that the information provided in the reports be reviewed with this lens.

4. The voice of children and adolescents: When children and adolescents express their own points of view related to how they experience poverty, perspectives emerge that are fresh and enlightening. In the case of Mongolia, for example, the report cites instances when children and adolescents were consulted. Children and adolescents expressed that "dressing and belongings create disparities" for them. Also, they report that their parents do not pay attention to them. Such qualitative analysis provides valuable insights. International experience shows that participatory approach methodology is a useful tool, especially for adolescents. It is recommended that giving a voice to children and adolescents on the issue of child poverty will enhance a basic understanding of the issue. While we frequently speak about the issue of child participation, planning for such inclusion rarely constitutes part of the basic report strategy. This should change. The quantitative information in the Global Study would be enhanced and complemented by qualitative and participatory research that gives voice to the perspective of children on their problems and possible solutions.

5. Other: There are other several issues that warrant examination in future conversations on child development and poverty reduction in the region. These range from the catastrophic impact of natural disasters on children in the region and the increasing prevalence of obesity among children living in poverty.

[31] Bangko Sentral Pilipinas (BSP), as cited in the January 2008 issue Of Asia Focus published by the Federal Reserve Bank of San Francisco, (http://www.frbsf.org/publications/banking/asiafocus/2008/Asia_Focus_Jan_08.pdf).

Bibliography

Bartlett, S (2003) 'Water, sanitation and urban children: the need to go beyond "improved" provision', London, UK: International Institute for Environment and Development, Environment & Urbanization, Vol 15 No 2.

Bartlett, S and Minujin, A (2009) 'The Everyday Environments of Children's Poverty', Colorado, USA: Children, Youth and Environments 19(2): 1-11.

Boyden, J Hardgrove, A and Knowles, C (forthcoming) 'Continuity and Change in Poor Children's Lives: Evidence from Young Lives', Bristol, UK: Minujin A Ed. *Child Poverty: A Global Perspective*, Policy Press.

Buchanan, A (2009) 'Evidence based social policy and practice: A new ideology or a Human Rights imperative? ', Santiago de Chile, Chile: http://www.uc.cl/trabajosocial/site/artic/20090910/asocfile/20090910165848/rev_trabajo_social_76.pdf.

Cappa, C (2010) 'Application of a Multidimensional Approach to the Assessment of Child Deprivation in India', Geneva, Italy: Ph. D Thesis Graduate Institute of International and Development Studies.

CCF (2004) 'Understanding how children experience and respond to poverty', New York, USA: Christian Children Fund, presentation in UNICEF.

Chang Ha- Joon (2008) 'Bad Samaritans', New York, USA: Bloomsbury Press.

Court, J and Young, J (2006) 'Development in Practice', London, UK: *Bridging research and policy in international development: an analytical and practical framework,* Volume 16, Number 1, pg. 89.

Ferraz, O (2008) 'Poverty and Human Rights', Oxford, UK: Oxford Journal of Legal Studies, Vol.28, No. 3, pg. 585-603.

Gordon, D. (2002) 'The international measurement of poverty and anti-poverty policy' Bristol, UK: In Townsend, P. and Gordon, D. (Eds) *World Poverty: New Policies to Defeat an Old Enemy*, Policy Press.

Gordon, D and Shailen N (forthcoming) 'Measuring Child Poverty and Deprivation', Bristol, UK: Minujin A Ed. *Child Poverty: A Global Perspective*, Policy Press.

Government of Vanuatu (2009) 'Education Road Map', Vanuatu.

Kamerman Sheila and Gateino-Gabel Shirley (2006), "Social Protection for Children and their Families: a Global Overview" in Minujin A and Delamonica E. Ed *Social Protection for Children, Women and Families*, The New School, New York.

Minujin, A and Bang, J, H (2002) 'Indicadores de Inequidad Social. Acerca del uso del ''índice de bienes'' para la distribución de hogares', Buenos Aires, Argentina: Desarrollo Economico, 42(165), pp. 129–146.

Minujin, A and Delamonica, E (2003) 'Mind the Gap! Widening Child Mortality Disparities', UK: Journal of Human Development, Vol. 4, No. 3

Minujin, A, Delamonica, E, Davidziuk, A and Gonzalez, E (2006) 'The definition of child poverty: A discussion of concepts and measurements', UK: Environment & Urbanization.

Minujin, A, Delamonica, E, Davidziuk, A and Gonzalez, E (2003) 'Children Living in Poverty: Overview of Definitions, Measurements and Policies', New York, USA: UNICEF DPP Working Paper.

NGO Group for the convention of the rights of the child, Subgroup Against the Sexual Exploitation of Children (2005) 'Semantics or substance: towards a share understanding of terminology', ECPAT, Bangkok: NGO Group for the convention of the rights of the child, Subgroup Against the Sexual Exploitation of Children.

Pemberton S, Gordon D and Nandy S (forthcoming) 'Child Rights, Child Survival and Child Poverty: The Debate', Bristol, UK: Minujin Ed, Policy Press.

Sen, A (1999) 'Development as Freedom', Oxford, UK: Oxford University Press.

Stiglitz, J (2003), 'The Roaring Nineties', New York, USA: Norton Co.

UNICEF (2005) 'Emergencies Refugees, IDPs and Child Soldiers

Natural Disasters', UNICEF East Asia and Pacific Regional Office.

UNICEF (2007) 'Global Study on Child Poverty and Disparities 2007-2008', New York, USA: Manual, DPP.

UNICEF (2010) Lake, A 'Important News from UNICEF', New York, USA: UNICEF, Email.

UNICEF (2010): 'Narrowing the Gaps to Meet the Goals,' UNICEF New York.

UNICEF UK (2008) 'Our climate, our children, our responsibility. The implications of climate change for the world's children', UK: UNICEF UK.

UNICEF EAPR (2007): 'East Asia & Pacific in 2015: Implications for future UNICEF advocacy and action for children', UNICEF EAPR: Draft report.

UNICEF Cambodia (2009) 'Study on Child Poverty and Disparities in Cambodia', Cambodia: UNICEF Cambodia, Draft.

UNICEF Lao (2010) 'Child Well-being and Disparities in Lao PDR', Lao: UNICEF Lao Draft.

UNICEF Mongolia (2009) 'Child Well Being and Equity in Mongolia', Mongolia: UNICEF Mongolia, Draft.

UNICEF Philippines (2009) 'Global Study on Child Poverty and Disparities: The Case of the Philippines', Philippines: Philippine Institute for Development Studies and UNICEF Philippines.

UNICEF Thailand (2009)'Global Study on Child Poverty and Disparities: National Report, Thailand', Thailand: UNICEF Thailand.

UNICEF Vanuatu (2010) 'Global Study on Child Poverty and Disparities: National Report, Vanuatu', Vanuatu: UNICEF Vanuatu, Draft

UNICEF Viet Nam (2008) 'Children in Viet Nam: who and where are the poor? ', Viet Nam: MLISA**,** UMGS and UNICEF Viet Nam.

United Nations (1995) '*The Copenhagen Declaration and Programme of Action*: World Summit for Social Development 6-12 March 1995', New York, USA: United Nations.

Vandermoortele, J (2000) 'Poverty Reduction Begins with Children', New York, USA: UNICEF.

Wilkinson R and Pickett K (2010) 'The Spirit Level. Why Greater Equality Makes Societies Stronger', New York, USA: Bloomsbury Press.