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Reducing Inequality to Improve the Wellbeing of Children:
Learning Lessons from Indonesia for the Post-MDGs Agenda

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Summary

Context. In the past two decades, Indonesia has overcome political turmoil and transitioned into democracy. It has survived large-scale humanitarian crises in the form of natural disasters, as well as economic crises – notably the Asian financial crisis in 1997-1998. As the fourth largest country in the world by population, with more than 230 million people, Indonesia is now steady and maintains a growth rate at above 6% a year despite the global financial crisis. The country has risen to lower-middle income status, and is ranked as the fifth largest economy in Asia after Japan, China, India and Korea.[1] The Millennium Development Goals (MDG) have guided Indonesia in achieving key development priorities like tackling human rights issues and fighting extreme poverty. The latest 2011 MDG status report concluded that Indonesia is making significant progress, despite the fact that some goals have yet been fully met. While the country has managed to reduce absolute poverty, inequalities have been on the rise. Additionally, some vulnerability issues still need to be properly addressed, which makes enhancement of human capital take place at a slower-than-expected pace.

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 primary challenges in regards to poverty, first, assisting those who are currently poor and helping them out of poverty, in addition to making sure that poor people's basic survival needs are met; and second, protecting the vulnerable from falling into poverty. These issues are vital to 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 the specific risks experienced by children living in poverty. Moreover, the strategy and programs lack the ability to address vulnerabilities that would otherwise enable children to escape poverty in the future.

Income Inequality. Over 13-14% of the population still live below the national poverty line (more or less about USD 1.53 a day), and nearly half the population lives on less than USD 2 a day. The large proportion of the population grouped slightly above the national poverty line is at risk of falling into poverty. In addition to the risk of financial shocks from events in the global economy, Indonesia has experienced and is on constant alert for natural disasters. These natural disasters can hurt the economy at large, create new poor and worsen the condition of already vulnerable people. 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 below the 40th percentile in household expenditure (World Bank 2012).

Using two measures of income inequality, income ratio of between the top and bottom quintiles and the Gini Ratio, we see that Indonesia was comparable to Vietnam[2], but more inequitable than India and Lao in 2010. Despite the lower poverty and unemployment rates, Indonesia's Gini Ratio has recently been worsening. In the first quarter of 2011, the Gini Ratio has increased beyond 0.4. In terms of the percentage of population under USD 2 per day, Indonesia is comparable to Cambodia, better than India and Lao, but worse than China.

Regional Disparity. While the country 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 such as Riau and East Kalimantan stand out with high income per capita. Most provinces with low income per capita are located in the eastern part of the country, although if put in terms of poverty headcount index (HCI), the under-the-line poor are more dispersed. Some provinces in western Indonesia (including those in Java) show high HCI values. The regional disparities in poverty in Indonesia are considerable. The poverty incidence is 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 that in the remote Papua was 37.1 %. But Java/Bali is home to 57% of Indonesia's poor, while Papua has only 3% (Patunru

[1] Indonesia's Gross Domestic Products (GDP) valued at around US$695.059 billion in 2010.
[2] Comparison of Gini Ratios across countries should be taken with caution, as they might come from different methodology and measurements.

and Tarsidin 2012).

All the provinces in Indonesia experienced worsening Gini Ratios (GR) in 2011, compared to GRs from 2009 and 2007. Even the richer provinces, some of which house substantial natural resources, also suffer high, if not the highest, income inequality, notably: East Kalimantan, Jakarta, Riau, and Kepulauan Riau. All the provinces on Java Island suffer from a GR of more than 0.4. Meanwhile, relatively rich provinces in terms of GDP per capita like Papua and West Papua have both poor GRs and very high poverty incidences – implying a very skewed income distribution.

Age-related disparity. The 2009 data indicates about 79.4 million of population in Indonesia, or more than 32%, are under the age of 18 or categorized as children.[3] According to the 2008 Social Protection Program Data (PPLS), there are more than 21 million children living in poor and vulnerable households in Indonesia.

Table 1. Children Living in Poverty In Indonesia

Child's Condition	Very Poor	Poor	Near Poor	Total
Without Disability	7,427,470	9,099,332	4,595,199	21,122,001
With Disability	59,683	75,645	39,191	174,519
Total	7,487,153	9,174,977	4,634,390	21,296,520

Source: Social Protection Program Data (PPLS) 2008

Gender Disparity. Some data shows that being a female in Indonesia increases the likelihood of being deprived of education. On average, twice as many females aged 10 or above, when compared to males, cannot read, and three times as many have never been enrolled in school. Overall, the female to male literacy ratio is around 93%.

Health. Indonesia has been improving its infant and under-five mortality rates. A recent study shows that Indonesia had reduced the infant mortality rate from 71 per 1,000 live births in 1990 to 34 in 2007. The case is the same for under-five mortality, which has declined from 99 per 1,000 live births in 1990 to 44 in 2007. The infant and under-five mortality figures show an overall improvement in child survival and health, but recently this progress has been slowing down.

The 2011 data 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 2007 figures. Only slightly more than 50% of babies under 2 years old received complete basic immunizations. Moreover, a few provinces show very low percentages, for instance Papua and West Sulawesi.

In the case of diarrhea – one of the four most significant causes of infant mortality in Indonesia – the odds of infection is 3.4 times greater for children under five years old than it is for older family members. The predicted probability of having diarrhea is 8% for a child under five years old with the following characteristics: female, not immunized, living in a rural area, living in a house whose largest floor area is dirt/soil, has *no* toilet facility, and has *no* electricity for lighting. If one compares children with the *same* abovementioned characteristics, the predicted probability of getting diarrhea is higher for children in poor provinces (8%) and lower for children in non-poor provinces (6%). Immunization has been calculated to have clear impact on the diarrhea prevalence. Overall, it can reduce the odds of having diarrhea by 59%, when all are held variables constant. Those living in rural areas have higher probabilities of diarrhea than

[3] 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.

those in urban areas.

Housing and Sanitation. While some facilities can already be accessed by more than 80% of the households in their respective provinces, for instance access to electric lighting and decent floor material, access to other facilities, like decent sanitation and clean water, are still low. Most families also live in very small houses with poor waste management. Yet, there is no clear pattern regarding whether or not these conditions can be associated with location, i.e. eastern or western part of Indonesia. If there is any pattern to be mentioned, it is that the capital Jakarta stands out in almost every variable. One exception this is drinking water, it is known in fact that Jakarta has very low water quality. More broadly, access to good housing is poorer in eastern part of Indonesia.

Nutrition. The 2007 and 2010 data show that nutrition status is improving on a national level. However, the same report shows that children from the poorest households and children in rural areas are experiencing nutritional challenges. The latest study on Child Poverty done by UNICEF and SMERU (2011) shows that underweight, stunting and wasting – measures of nutritional status – are more prevalent in the lowest decile of households and in rural areas.

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[4] 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 has been an improvement on access to birth certificates from 35% of children having birth certificates and are able to show the document to 47.7%. 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).

Child Labour. The 2011 data shows that 7.6% of children aged 10 to 15 work, of which 61% are male and 39% female children. The corresponding figures for 2009 were 8.5% of the same age group work, of which 63% were male, and 37% female. Thirty percent of the working children in 2009 and in 2011 work 7 days a week. Even though there has been a reduction since 2009, an econometric assessment of factors that might affect the likelihood of a child working shows that being a male child increases the odds of working by 97% when compared with being a female child. Living in urban areas decreases the likelihood of working by 50%, suggesting that child labour is more prevalent in rural areas. Furthermore, the odds of working increases with the age of the child, decreases with increased family income, and decreases with both the increased age and education level of the head of the household.

Crime against Children. In terms of crime, children (0 to 18 years old) are less exposed to crime than adults, but there has been a slight increase in crime experienced by children. For example, the percentages of theft, robbery, and murder that occurred to children increased from 9%, 30% and 14% in 2009, respectively, to 9.8%, 33%, and 25% in 2011 (in the meantime the rates of rape and fraud/deception to children went down). The econometric exercise shows that sex and income do not significantly affect the odds of a child becoming a victim of crime. Hence, both sexes appear to have an equal chance of being victimized. Furthermore, crime can happen to a child regardless of the family income. The odds of becoming a victim increase almost 40% for children in urban areas when compared to children in rural areas.[5]

Early-Marriage and Pregnancy. There are currently households headed by children in Indonesia because the current Marriage Law allows girls to be married at the age of 16, and allows for boys or girls to be married below the legal marital age if given parental approval. While the average age at first marriage for women in Indonesia are 19 to 20 years old, under-age marriage (defined here as marriage under 16 years old) remains high, at around 11% in 2011,

[4] 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.

[5] It is however, important to note that particular questions about crime against children in the national survey the data is derived from do not employ specific indicators of abuse and exploitations experienced by children and/or maltreatments in the context of domestic violence. The enumerators were not trained on asking sensitive issues such as child abuse nor that it was designed to investigate such cases.

compared to 9.4% and 11.2% in 2007 and 2009, respectively. Such under-age marriage is more prevalent in rural areas. Interestingly, the rate of under-age marriage is higher on Java than outside Java – the former being more economically prosperous than the latter. Another data set from the Ministry of Health shows that the prevalence of marriage between ages 15 to 19 years old is 42% and almost 5% at the age of 10 to 14. The prevalence of marriage for the age group of 10 to 14 years old is 6% higher in rural areas, 10% higher among girls who are not in school, and 6% higher within the lowest decile of poverty.

Policy Highlights and Implications. Indonesia ratified the Convention on the Rights of the Child (CRC) in 1990 and has since 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 also as a signatory of several international instruments, Indonesia has incorporated a series of child-related national laws into its legislative framework. Following the abdication of Soeharto's authoritarian government in 1998, Indonesia amended its Constitution and added to Chapter 10A Section 28b (2) a stipulation on child rights ("Every child has a right to live, grow and develop and to be protected from violence and discrimination"). In 2002, Indonesia passed the Child Protection Law that guarantees a number of measures to protect the right of children to health, the right to education, cultural rights, economic, political and civil rights, the right to care, participation rights and rights of special protection. Additionally, in 2011 the Social Welfare Law was enacted. This law does not make specific reference to the protection of children's wellbeing, but the accompanying elucidation stipulates that this law is to guide the government in addressing issues of neglected children.

For the first time after decades of development, in February 2010, Indonesia incorporated child protection as one of the four national priorities (alongside important arenas of Poverty Reduction, Climate Change, and Marine Development) in its National Medium Term Development Plan (RPJMN) for 2010-2014. This milestone includes a strategic statement and plan to improve the survival and development of children, and 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 Presidential Instruction Number 1/2010 on the Acceleration of the Implementation of National Development Priorities for 2010 and Number 3/2010 on Access to Justice. Both set forth the prioritization of child protection and wellbeing programs, and categorize social assistance programs for children as one of the national priorities under the poverty reduction sector.

A commitment from the government to address poverty issues is reflected in a number of Social Assistance programs targeting very poor, poor and near poor families and for some individuals. For over more than a decade, Indonesia has been starting to implement different programs (Table 2 for some program highlights) along various timelines, with a variety of model interventions and targeting specific categories of beneficiaries. Despite the good intentions, those programs have yet to reach all of the vulnerable populations that carry risk of falling into poverty. Each program also has a different level of success or impact to the life of its beneficiaries and some are still lacking in efficacy.

Table 2. Existing Social Assistance Programs as per Actual Beneficiaries in Mid 2011

Program	Target group	Coverage	Benefit
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

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

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).

The challenges with these policies are two-fold:

First, many Indonesian laws, no matter how ground-breaking, -including the Child Protection Law and the Social Welfare Law- set forth rather ambiguous stipulations instead of clearly elaborate a mandate on who should fulfill those and how. This has an implication on the implementation of the law, including on how to articulate it into programs and interventions. When the law is otherwise clear, many details of how the law should be implemented are delegated to subsequent Government Regulations, and some of them are still work-in-progress.

Second, despite being identified side by side in the national development plan as cross-cutting priorities, the two agendas of Child Protection and Poverty Reduction did not seem to have worked as such. Each works in its respective silos, therefore missing the interlinks between the two. Poverty reduction strategies often overlook the 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 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 vulnerabilities to prevent inter-generation poverty.

Expenditure. Indonesia has the potential to leverage its resources and economy to reduce poverty and inequality. The current budget allocation and government spending for social assistance programs are much less than neighboring countries like the Philippines and Vietnam, as well as other countries like Mexico, Brazil, Argentina and India. Compared to the budget allocated to subsidies (especially for fuel), the portion that goes to social assistance is very low. 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%. This current subsidy regime is regressive because almost half of the benefit is enjoyed by the richest 20% of the country, and less than 2% reaches the poorest 20%. It is also counter-productive because it prevents additional allocation for social assistance (as part of poverty eradication program) and infrastructure development (often cited as the most problematic factor on Indonesia's supply side). In addition, it suppresses the incentives to move to cleaner energy (Patunru and Basri 2012). In 2011, the budget realization for Social Aids was less than one-fourth if that for Subsidies.

Supply and Demand. With growing assistance programs, Indonesia has the potential to reach almost all the most vulnerable people so as to enable 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 and the quality of services—the supply. Ensuring that the country has enough supply remains a matter of concern. The 2011 Child Poverty study shows that poor children in rural areas have difficulty accessing adequate basic facilities like education and health when compared to poor children in urban areas (SMERU 2011).

Discussion about supply naturally leads to the issue of resources. No matter how well designed or targeted an intervention is, it will only make a significant difference on the wellbeing children if the country has the ability to implement it over the long term. Indonesia is very committed to doubling social assistance programs' coverage over the next two years. However, supporting the goals and anticipating the challenges ahead requires careful calculation. Programs need to understand the country's income sources and how they are being spent. Policies on child wellbeing should be realistic in regard to the state of the economy, budget mechanisms, and also

clear on why making such investment in children is important.

Decentralization. Geographical richness poses one of Indonesia's greatest challenges, and decentralization has magnified this challenge. 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. There is also a shortage of technical assistance from the central government implementing its own activities and budgets across different sectors and programs.

Recommendations:

1. The post-MDG goals need to shift the focus from input to output. Indonesia is doing relatively well in meeting the 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.

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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.

Therefore, we discuss the issue of inequality in Indonesia with an emphasis on the wellbeing of 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. The report also contains an assessment of existent policies, as well as recommendations for future policy directions relevant to the post-MDG agenda.

2. Indonesia's Development: Brief Overview

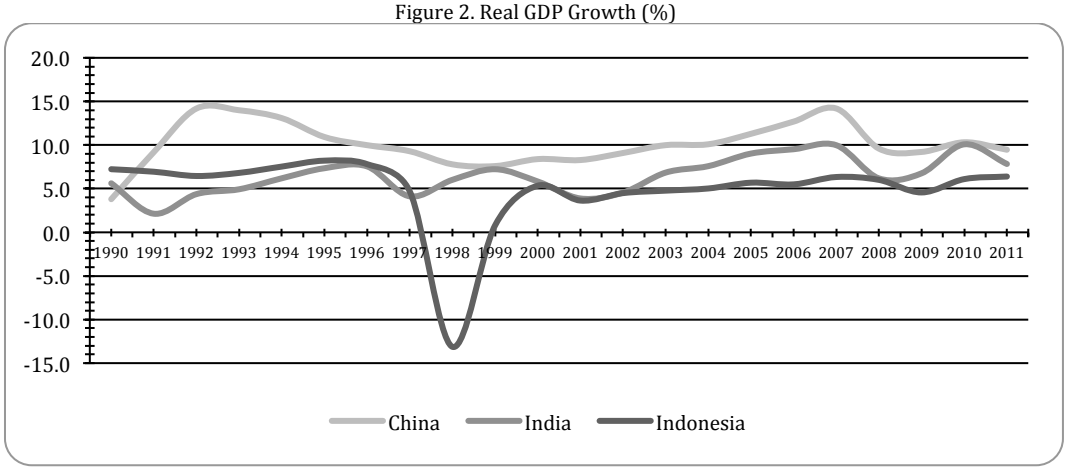
Indonesia's archipelago is not only geographically well positioned (Figure 1), but also economically and politically well positioned. After only 67 years of independence, Indonesia has caught the world's eye by overcoming political turmoil and transitioning into democracy in 1998 in a relatively peaceful 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 2). 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 3).

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.

Figure 1. Map of Indonesia

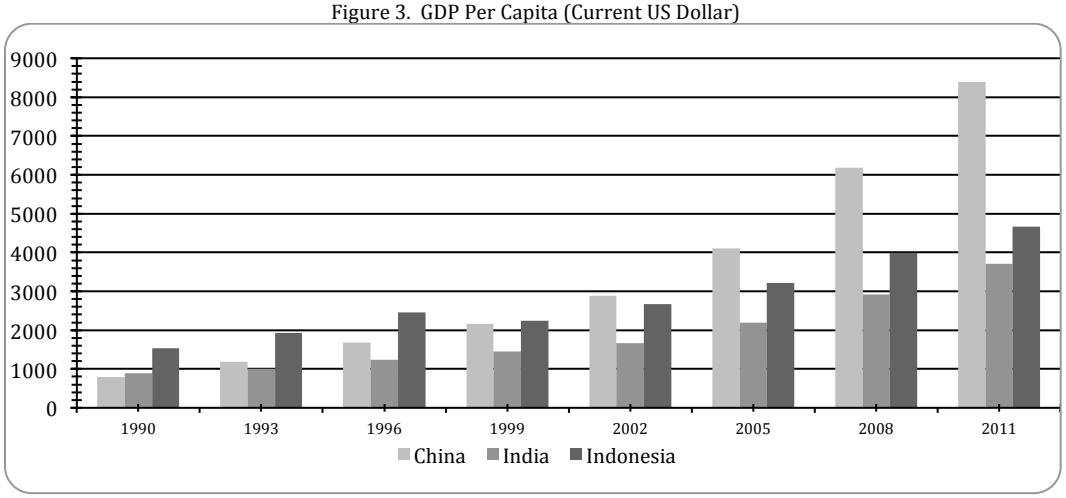
Source: Geography.about.com

Figure 2. Real GDP Growth (%)



Source: IMF, various years

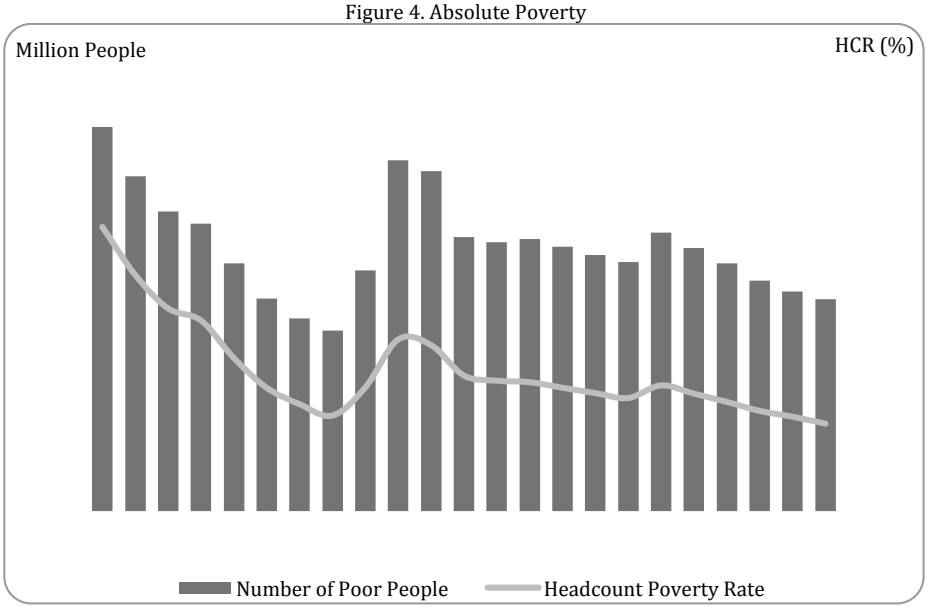
Figure 3. GDP Per Capita (Current US Dollar)



Source: IMF, multiple years

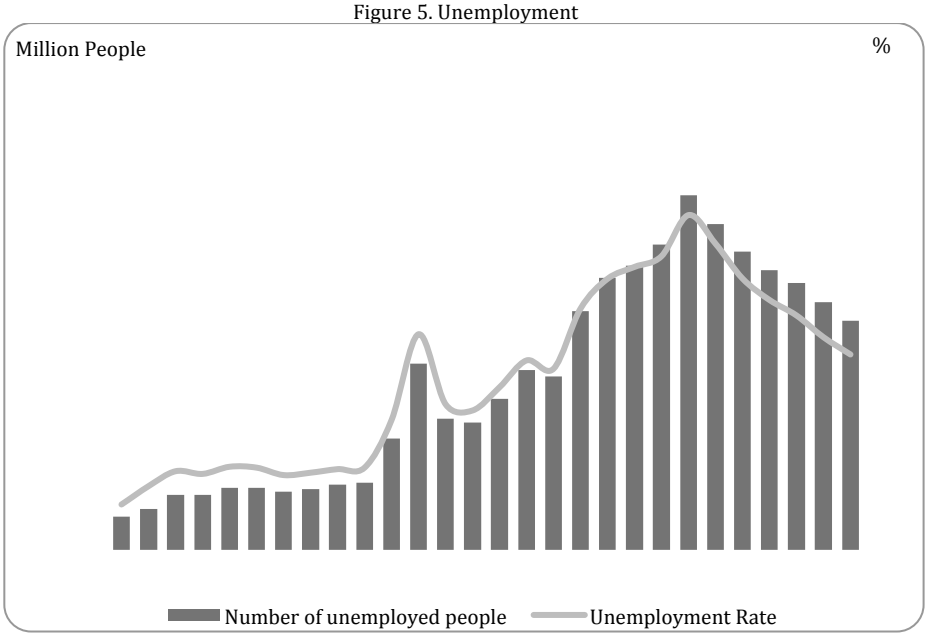
Indonesia has also experienced bad times. Higgins (1968) once called the country a case of "chronic drop out" due to the extremely bleak state of economic development under the old regime of the first president, Sukarno. Furthermore, once an oil-rich country (and hence, was a member of OPEC), Indonesia 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).

Figure 4. Absolute Poverty



Source: BPS, various years

Figure 5. Unemployment



Source: BPS, CEIC, various years

The reductions in absolute poverty and unemployment rates have also been remarkable (Figures 4 and 5). 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.

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).[6] The next sections highlight these aspects.

3. Vertical Inequality

The preceding section has elaborated on the relative success of Indonesian economic development. Ideally, this progress should be equally enjoyed by all 237 million people living on Indonesia's vast archipelago of 17,504 islands. Unfortunately, a state equality is far from the

[6] This out-of-school figure is an under/low-estimate figure since SUSENAS does not reach the population of non-residency or those who are not registered in the households list.

current reality. 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 widely dispersed. 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).[7]

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.

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

Using two measures of income inequality, income ratio between top 20% and bottom 20% and GR, we see that Indonesia is comparable to Vietnam[8], 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 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).

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

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 the 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.

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

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 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.[9] 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%

[9] 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.

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.[10] Table 7 summarizes Miranti's study.

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.

[10] 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. 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 8. 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.[11] 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.

Table 9. Children Living in Poverty In Indonesia

Child's Condition	Very Poor	Poor	Near Poor	Total
Without Disability	7,427,470	9,099,332	4,595,199	21,122,001
With Disability	59,683	75,645	39,191	174,519
Total	7,487,153	9,174,977	4,634,390	21,296,520

Source: Social Protection Program Data (PPLS) 2008

Investing in the improvement of the quality of children's wellbeing cannot be more critical. Demographic and population estimates conclude that Indonesia will enjoy its *demographic bonus*[12] 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 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

[11] 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.

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

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 10. 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 their respective provinces (such as access to electric lighting and decent floor material), access to decent sanitation and access to 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 10). Nevertheless, a simple econometric estimation shows that there might be an indication of moral hazard in regard to access to health insurance (see Box 1).

Table 10. 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

Box 1. Econometric estimation of factors affecting diarrhea prevalence

There are not very many variables in the 2009 SUSENAS survey that can be used as a proxy for health condition of children in a household. In this assessment we explore the prevalence of diarrhea. 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 family member 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 involved variables are as listed in Table B1-1. The results are shown in Table B1-2.

Table B1-1. Variables Used in the Estimation of Diarrhea Prevalence

n	Number of observations: In all (age 0-5): 134,485 In non-poor provinces: 101,762 In poor provinces: 32,723
diarr	Diarrhea (dummy, 1 if the family member had diarrhea in the last month; 0 otherwise)
immune	Immunization (dummy, 1 if the baby had immunization of at least 1 BCG shot, 3 DPT shots, 3 polio shots, 1 chicken-pox shot, and 3 Hep-B shots; 0 otherwise
bfed	Breastfed (dummy, 1 if the baby was exclusively breastfed for at least for 6 months – mode in the sample - in the case of babies older than a month and any number of days in the case of babies younger than a month; 0 otherwise)
sex	Dummy, 1 if male; 0 otherwise
urban	Dummy, 1 if urban; 0 otherwise
soilfl	Soil floor (dummy, 1 if the floor area in the house is mostly NOT of hardened soil a.k.a "dirt floor"; 0 otherwise)
water	Dummy, 1 if drinking water source – wells or else – is NOT located within 10 meters of defecation site; 1 otherwise
sanit	Sanitation (dummy, 1 if the house has toilet facility; 0 otherwise)
lightel	Dummy, 1 if lighting source is electricity; 0 otherwise)
Insure	Health insurance (dummy, 1 if the household has access to JPK, JPKM, JAMSOSTEK, private health insurance, company health insurance, health fund, health card, etc.; 0 otherwise)
agehead	Age of the head of household (all sample average: 46 years old; for sample associated with children of age 0-5, the average age of the HH head is 39 years old)
agehead2	agehead*agehead
eduhead	Highest level education achieved by the head of household (all sample average: "SMP" – junior high school, 7th-9th grade).
lninc	Natural log of income, proxied by average household expenditure per month (all sample average: 14.26, i.e. an income level of IDR 1,895,735/month)
Discriminant: "Poor Prov"	Poor provinces. Based on regional poverty headcount index of 2010 (2009 figures were likely more biased to the Global Financial Crises), provinces with HCI above 15% are included in "poor prov"; however, two provinces with this qualification are not included, because of their proximity to relatively un-poor provinces in Java. These are Central Java (HCI 15.76%) and Jogjakarta (HCI 16.08%). The included provinces are: Central Sulawesi, Lampung, Bengkulu, Gorontalo, Aceh, West Nusatenggara, East Nusatenggara, Papua Barat, and Papua

Notes: All data taken from SUSENAS 2009

Table B1-2. Results: Diarrhea Prevalence

	All				*Non-Poor Provinces*				*Poor Provinces*			
diarr	coeff.		p>|z|	% eff.	coeff.		p>|z|	% eff.	coeff.		p>|z|	% eff.
immune	-0.8806	***	0.000	-58.5	-0.9127	***	0.000	-59.9	-0.8263	***	0.000	-27.0
bfed	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
soilfl	-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
sanit	-0.1414		0.107	-13.2	-0.2112	***	0.000	-8.6	-0.0768		0.124	-7.4
lightel	-0.2917	***	0.000	-25.3	-0.1045	**	0.023	-3.2	-0.2941	***	0.000	-25.5
insure	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

The following are some observations based on the results:

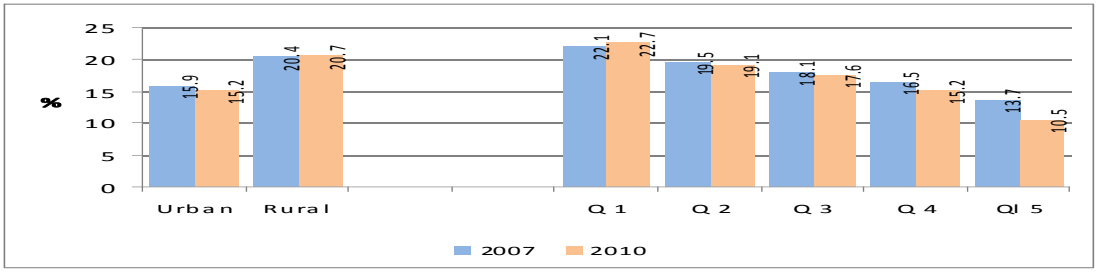
1. The actual prevalence rates of diarrhea in the sample are 5.3%, 6.9%, and 4.8%, respectively for the sample overall, poor provinces, and non-poor provinces. In the whole SUSENAS sample, the odds of having diarrhea in the case of children age 0 to 5 years old is 5.6%, while the odds in the case of family members aged 6 and above is 1.6%. That is, the odds ratio is 3.4, implying that the odds of getting diarrhea is 3.4 times greater for children up to 5 years old than the elder family members.
2. 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.
3. 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%).
4. Immunizations have a clear impact on diarrhea prevalence. Overall, it can reduce the odds of having diarrhea by 59%, holding all other variables constant.
5. 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.
6. 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.

7. 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.
8. 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.
9. 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).
10. 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.

<end of Box 1>

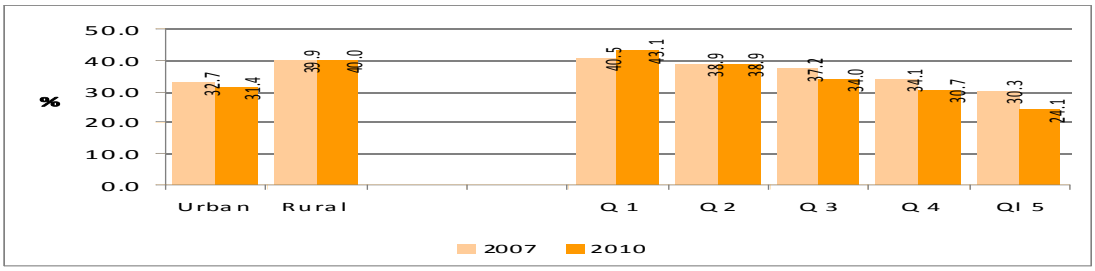
The 2007 and 2010 National Basic Health Survey (RISKESDAS) show that the nutrition status is improving on a national level. However, the same report shows that children from the poorest households and children in rural areas are experiencing nutrition challenges in regard to nutrition. Figures 6, 7 and 8 were derived from the latest study on Child Poverty done by UNICEF and SMERU, analyzing the nutritional status of children from the 2007 and 2009 RISKESDAS data in terms of underweight, stunting and wasting in each decile (SMERU 2011). The data shows that underweight, stunting and wasting are more prevalent in the lowest decile of households and in rural areas.

Figure 6. Underweight Status of Children 2007 and 2010



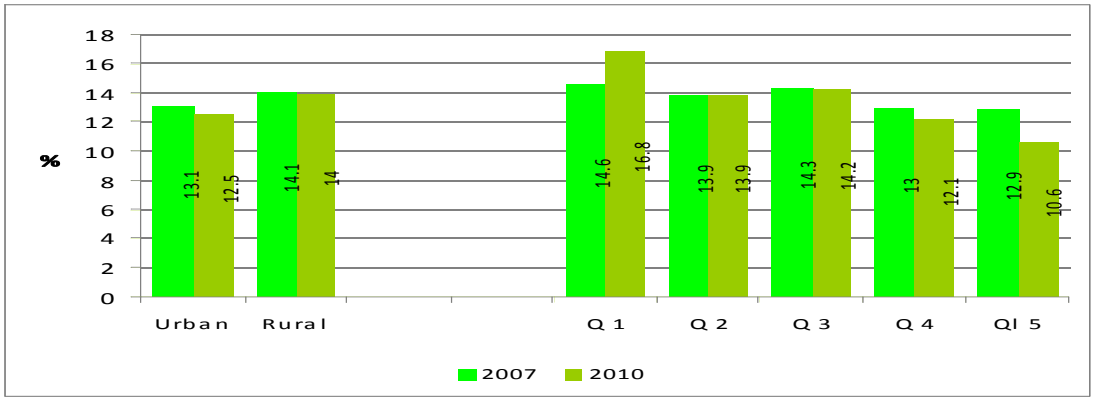
Source: National Basic Health Survey (RISKESDAS) 2007 & 2010 (graph from SMERU 2011)

Figure 7. Stunting Status of Children 2007 and 2010



Source: National Basic Health Survey (RISKESDAS) 2007 & 2010 (graph from SMERU 2011)

Figure 8. Wasting Status of Children 2007 and 2010



Source: National Basic Health Survey (RISKESDAS) 2007 & 2010 (graph from SMERU 2011)

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 11). While the school enrollment ratios of children age 7 to 12 are close to 100%, those of age 7 to 18 are less (Table 12), 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 11. 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 12. 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 13). 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 14).

Table 13. 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 14. 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

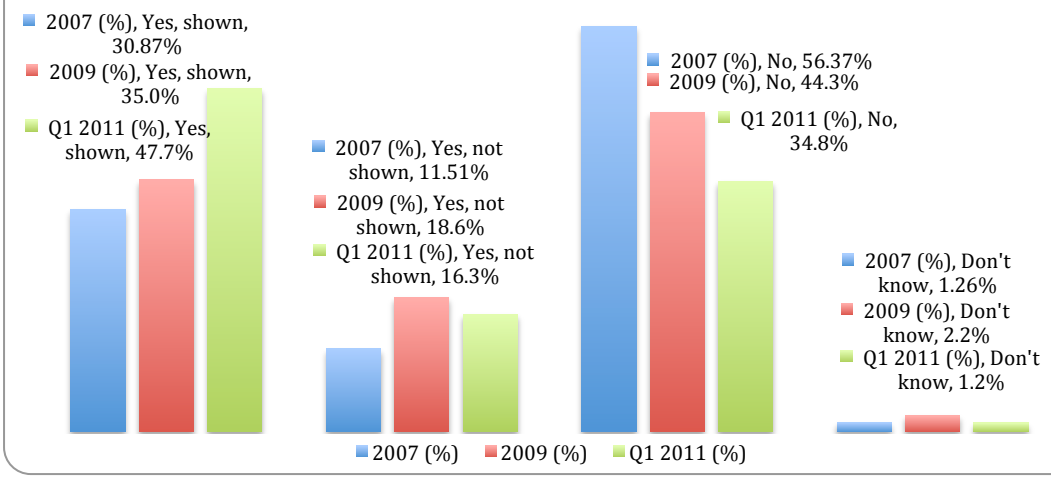
Note: all data from SUSENAS. Data for 2011 are of first quarter

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[13] 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% of children having a birth certificate and able to show it to 47.7%. 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).

[13] 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 9. Status of Birth Certificate among Children



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 10 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.

Figure 10. Absence of Birth Certificate
Age 0-6

5.4. Child Labor

The survey also shows 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. Box 2 shows a simple econometric assessment of factors that might affect the likelihood of a child working.

Box 2. Econometric estimation on the factors affecting the odds of becoming a child labor

Table B2-1. Variables Used in the Estimation of Child Labor Likelihood

N	Number of observations: In age < 18: 436,146 In age 10-18: 201,604
Work	Working (dummy, 1 if the family member works, 0 otherwise)
Sex	Dummy, 1 if male; 0 otherwise
Urban	Dummy, 1 if urban; 0 otherwise
Age	Age of the family member
agehead	Age of the head of household (in this sample of children of age 0-18, the average age of the HH head is 46 years old)
agehead2	agehead*agehead
eduhead	Highest level education experienced by the head of household (average in both sample: "SMP" – junior high school, 7th-9th grade).
lninc	Natural log of income, proxied by average household expenditure per month (average for age < 18: 14.29, i.e. an income level of IDR 1,917,582/month; and for age 10-18: 14.33, i.e. an income level of IDR 1,998,334/month)

Source: SUSENAS 2009

Table B2-1 lists the variables used in the estimation, and Table B2-2 depicts the results. Below are some observations:

1. The SUSENAS 2009 survey data indicates that 38% of the population was children of 0 to 18 years old, and 18% of that group were children of age 10 to 18 years old. About 7% of children below age 18 years worked, and about 15% of that cohort of observation is 10 to 18 years old.
2. All the variables in the estimation involving children of age 10 to 18 appear to be significant. 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.
3. 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.

Table B2-2. Results: Child Labor Likelihood

	Age < 18				Age 10-18			
work	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

<end of Box 2>

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).[14]

[14] 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,

Table 15. 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.

Box 3 below summarizes a simple econometric estimation to assess the odds of becoming a crime victim.

Box 3. Econometric estimation on the factors affecting the odds of becoming a crime victim

Table B3-1. Variables Used in the Estimation of the Odds of Becoming Crime Victim

n	Number of observations: In all (age 0-18): 436,146
crime	Crime victim (dummy, 1 if the family member had experienced theft, robbery, murder, fraud/deception, rape, or others in the last year; 0 otherwise)
sex	Dummy, 1 if male; 0 otherwise
urban	Dummy, 1 if urban; 0 otherwise
age	Age of the family member
lninc	Natural log of income, proxied by average household expenditure per month (all sample average: 14.29, i.e. an income level of IDR 1,917,582/month)

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. 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 B3-2. 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

Some observations:

1. 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. Crime can happen to a child regardless of the family income.
2. The odds of becoming a victim increase almost 40% for children in urban areas as compared to children in rural areas.
3. The odds of becoming a victim of crime increase with age.

<end of Box 3>

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 16). 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 16. 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.

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.[15] In general, there has been rapid improvement 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.

[15] 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 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.

Medium-Term Development Plan 2010-2014. In February 2010, 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) as a part of the National Medium Term Development Plan (RPJMN) for 2010-2014.[16] 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 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.

Box 4. Example of Policy Development: Birth Registration

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, post-'writing off' period, the new procedure is being enforced. According to the same 2006 law, registration of birth, and therefore issuance of birth certificate, needs to be legalized through a general court for applicants who have been born more than 60 days prior. 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.

<end of Box 4>

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

6.2. Policies on Poverty Reduction and Social Assistance

Government commitment 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 16.

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.

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

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 social workers 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 subsidies, the portion that is allocated to social assistance is very low. 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 if that for Subsidies.

Table 17. 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. Supply and Demand

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.[17] 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

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

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. 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 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 proposes the following recommendations:

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.

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