Data Collection Survey on Disability and Development in Indonesia

Final Report

September 2015

Japan International Cooperation Agency (JICA)

KRI International Corp.
Tekizaitekisho LLC

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Abbreviations and Acronyms

Abbreviation	English/Indonesian
ADB	Asian Development Bank
AHA Centre	ASEAN Coordinating Centre for Humanitarian Assistance on disaster management
AIPJ	Australia-Indonesia Partnership for Justice
APJII	Indonesian Internet Service Providers Association
ASB	Arbeiter-Samariter-Bund
ASD	Autistic Spectrum Disorders
ASEAN	Association of South-East Asian Nations
AUD	Australian Dollar
AusAID	Australian Agency for International Development
BAPPEDA	Badan Perencanaan Pembangunan Daerah (Regional Development Planning Agency)
BAPPENAS	Badan Perencanaan Pembangunan Nasional (State Ministry of National Development Planning)
BASARNAS	Badan Search And Rescue Nasional (National Search and Rescue Agency)
BBRVBD	Balai Besar Rehabilitasi Vokasional Bina Daksa (National Vocational Rehabilitation Center)
BNPB	Badan Nasional Penanggulangan Bencana (National Disaster Management Authority)
BPBD	Badan Penanggulangan Bencana Daerah (Regional Disaster Management Agency)
BPJS	Badan Penyelenggara Jaminan Sosial (Social Security Administrative Bodies)
BPS	Badan Pusat Statistik (Central Bureau of Statistics)
CBM	Christian Blind Mission
CBR	Community-Based Rehabilitation
CBRDTC	Community-Based Rehabilitation Development and Training Center
CEMIJ	Community Emergency Management Institute Japan
CIQAL	Center for Improving Qualified Activity in Life of People with Disability
CRPD	Convention on the Rights of Persons with Disabilities
CSR	Corporate Social Responsibility
DAISY	Digital Accessible Information System
DESA	Department of Economic and Social Affairs
DET	Disability Equality Training
DF/R	Draft Final Report
DFAT	Department of Foreign Affairs and Trade (Australia)
DINSOS	Dinas Sosial (Local Department of Social Welfare)
DPD	Dewan Perwakilan Daerah (Regional Representative Council)
DPOs	Disabled People’s Organizations
DPR	Dewan Perwakilan Rakyat (People’s Representative Council)
ESCAP	Economic and Social Commission for Asia and the Pacific
F/R	Final Report
FGD	Focused Group Discussion
FY	Fiscal Year (January to December in Indonesia)
GERKATIN	Gerakan untuk Kesejahteraan Tunarungu Indonesia (Movement of the Welfare of Deaf Indonesia)
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit (Germany)
HI	Handicap International
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HWDI	Himpunan Wanita Disabilitas Indonesia (Indonesian Association of Women with Disabilities)
IC/R	Inception Report
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communication Technology

Abbreviation	English/Indonesian
IDR	Indonesian Rupiah
ILO	International Labour Organization
IMF	International Monetary Fund
ISSA	International Social Security Association
JDF	Japan Disability Forum
JKN	Jaminan Kesehatan Nasional (National Health Insurance Program)
KARA	Kesehatan Anak Remaja (Child Health)
KARINA KAS	Karitas Indonesia Keuskupan Agung Semarang
KEMDIKBUD	Kementerian Pendidikan dan Kebudayaan (Ministry of Education and Culture)
KEMENAKER	Kementerian Ketenagakerjaan (Ministry of Labor)
KEMENDESA	Kementerian Desa Pembangunan Daerah Tertinggal dan Transmigrasi (Ministry of Villages/Underdeveloped Regions Development and Migration)
KEMENHUB	Kementerian Perhubungan (Ministry of Transportation)
KEMENKES	Kementerian Kesehatan (Ministry of Health)
KEMENKUMHAM	Kementerian Hukum dan Hak Asasi Manusia (Ministry of Law and Human Rights)
KEMENPPPA	Kementerian Pemberdayaan Perempuan dan Perlindungan Anak (Ministry of Women's Empowerment and Child Protection)
KEMPUPERA (PU)	Kementerian Pekerjaan Umum dan Perumahan Rakyat (Ministry of Public Works and Public Housing)
KEMSOS	Kementerian Sosial (Ministry of Social Affairs)
KESREM	Kesehatan Remaja (Youth Health)
KIA	Kesehatan Ibu dan Anak (Maternal and Child Health)
KOMINFO	Kementerian Komunikasi dan Informatika (Ministry of Communication and Informatics)
LK3	Lembaga Konsultasi Kesejahteraan Keluarga (Family Welfare Advisory Bureau)
LKS	Lembaga Kesejahteraan Sosial (Social Welfare Institution)
MCH	Maternal and Child Health
MOU	Memorandum of Understanding
MPR	Majelis Permusyawaratan Rakyat (People's Consultative Assembly)
MSBP	Modul Sosial Budaya dan Pendidikan (socio-cultural and education survey module)
NGO	Non-governmental Organization
OT	Occupational Therapist
PERTUNI	Persatuan Tunanetra Indonesia (Indonesia Blind Union)
PKH	Program Keruarga Harapan (conditional cash transfer program for households with school-age children)
PMI	Palang Merah Indonesia (Indonesia Red Cross)
PPLS	Pendataan Program Perlindungan Sosial (Data Collection of Social Protection Programs)
PSKS	Penyandang Masalah Kesejahteraan Sosial (Persons with Social Welfare Problems)
PT	Physical Therapist
PU	Pekerjaan Umum (Public Works or a shortened name of KEMPUPERA)
RISKESDAS	Riset Kesehatan Dasar (Basic Health Survey)
RRI	Radio Republik Indonesia (Radio Republic of Indonesia)
SAR	Search and Rescue
SATGANA	Satuan Penanggulangan Bencana (Disaster Management Unit)
SIBI	Sistem Isyarat Bahasa Indonesia (Indonesian sign language)
SIGAB	Sasana Integrasi dan Advokasi Difabel (Center of Integration and Advocacy for Disability) [NGO]
SME	small and medium-sized enterprises
SRC-PB	Satuan Reaksi Cepat Penanggulangan Bencana
STKS	Sekolah Tinggi Kesejahteraan Sosial (Social Welfare University, Bandung)
SUSENAS	Survei Sosial Ekonomi Nasional
T/F	Task Force

Abbreviation	English/Indonesian
TAGANA	Taruna Siaga Bencana (Yough Volunteer Group for Disaster Management)
TATTs	Technical Assistance and Training Teams
TKSM	Tenaga Kesejahteraan Sosial Masyarakat (District Social Welfare Workers)
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team to Accelerate Poverty Reduction)
TVRI	Televisi Republik Indonesia (Television Republic of Indonesia)
UNFPA	United Nations Population Fund (formerly United Nations Fund for Population Activities)
USAID	United States Agency for International Development
UUD	Undang-Undang Dasar
YAI	Yayasan Autisma Indonesia (Autism Foundation of Indonesia)
YAKKUM	Yayasan Kristen Untuk Kesejahteraan Umum
YPAC	Yayasan Pembinaan Anak Cacat (Foundation for Development of Children with Disabilities)

Data Collection Survey on Disability and Development in Indonesia

Final Report

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Chapter 1 Outline of the Survey

1.1 Background

The Republic of Indonesia (hereinafter referred to as Indonesia) is a core country, which has the largest population in the Association of Southeast Asian Nations (ASEAN). In recent years, Indonesia achieved political stability and economic growth and plays an important role in the global society. On the other hand, the rapid economic growth also brought a growing income disparity within the nation, and this is a critical issue to be addressed to secure a long-term stability.

According to the World Health Organization (WHO), it is reported that persons with disabilities comprises about 15% of the total population of Indonesia[1]. In general, persons with disabilities are likely to live in poverty compared with non-disabled people because they have limited access to education and also the need to incur medical cost related to disability. In order to rectify the income disparity, the Government of Indonesia, therefore needs to take effective measures to improve the situation of persons with disabilities.

With regard to the recent global trend of disability, Indonesia ratified the Convention on the Rights of Persons with Disabilities (CRPD) in November 2011 with the purpose of securing the rights and freedom of persons with disabilities and accelerating respect for their dignity. Also, this convention provides measures to realize the rights of persons with disabilities. Therefore, signatory countries of CRPD are required to take legislative, administrative, and other necessity measures for persons with disabilities. This survey aimed to verify the status of achievement of the goals set in CRPD.

In addition, to improve access to education, employment, and health services for persons with disabilities, it is also important to promote accessibility to public transportation and buildings. This approach is called "Disability Mainstreaming," which is applying the barrier-free concept to a wide range of projects and activities in various sectors.

In Surabaya, the city government is preparing a city planning project called "Green City Master Plan (GMP)," and it would be efficient to apply the barrier-free concept at the planning stage, improving accessibility to public services for all the people, including persons with disabilities, elderly persons, children, expectant and nursing mothers.

Another crucial issue for persons with disabilities is disaster risk reduction. Same with Japan, Indonesia is also vulnerable to natural disasters such as earthquake, tsunami, and volcanic eruption. Compared with non-disabled people, persons with disabilities are more likely to be affected by disaster, and therefore, it is necessary to involve persons with disabilities to disaster management activities.

This survey was conducted to verify the situation of persons with disabilities from a viewpoint of the recent global tides of "Disability Mainstreaming."

[1] WHO, World Report on Disability (2011).

1.2 Objectives of the Survey

There are three main objectives as mentioned below.

(1) To collect and analyze data on disability and development in Indonesia in accordance with CRPD and the Incheon Strategy;
(2) To update the country profile on disability; and
(3) To make recommendations to the Japan International Cooperation Agency (JICA) about possible assistance toward improvement of identified challenges on disability in Indonesia.
  i) To introduce barrier-free concept to GMP in Surabaya
  ii) Other possible assistance

1.3 Agenda of the Survey

To meet the objectives of the survey, disability-related information such as statistics and government policies and actions in the field of education, health, employment, social protection and accessibility were collected through interviews with relevant organizations. In the same way, information on disability-inclusive disaster management such as laws, regulations, government policies, and preparedness programs were collected. These collected information on disability were comprehensively analyzed, and then some possible assistance were derived, considering cooperation of donor agencies, activities of the Disabled People's Organizations (DPOs), and the aid policy of Japan (Figure 1-1).

With regard to the survey on the situation in Surabaya, the Survey team collected information by interviewing the East Java Provincial Government, DPOs, and other related persons as the survey was not approved by the City Government of Surabaya.

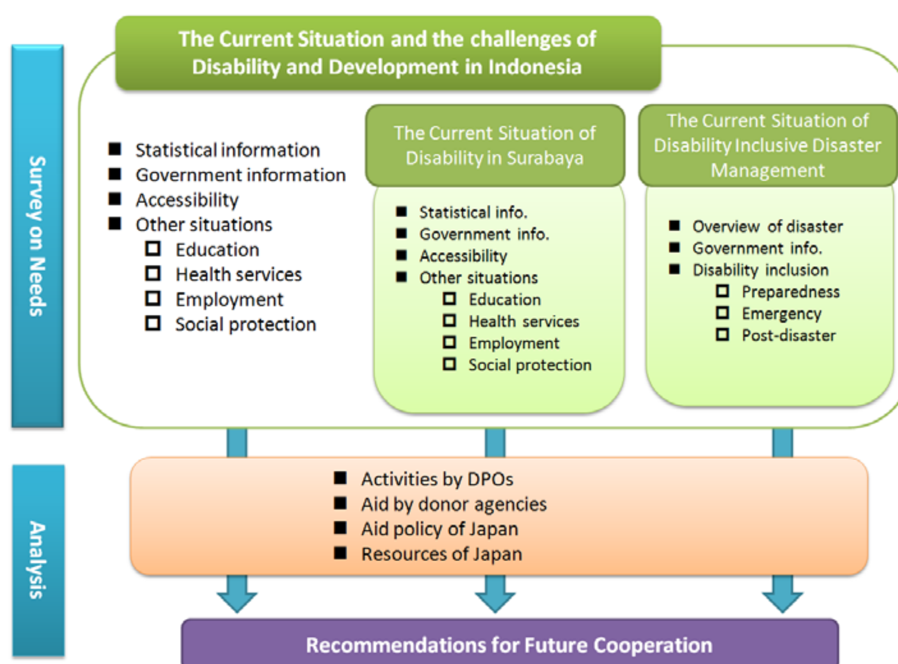


Figure 1-1 Agenda of the Survey and Data Collection/Analysis Flow

1.4 Methodology

1.4.1 Workflow and Schedule

The workflow of the survey is described in Figure 1-2, and the schedule is described in Figure 1-3.

The first field survey was conducted from 6 May to 4 June 2015 for 30 days, and the second field survey was conducted from 28 June to 11 July 2015 for 14 days. The schedule and main activities during the field survey are presented in Appendix 1. The interviewed personnel are listed in Appendix 2.

A seminar entitled "Green Buildings and Accessibility towards Smarter Green City," which has been initially intended to be held in Surabaya, was held in Jakarta, in cooperation with the Ministry of Public Works and National Residence (KEMPUPERA). It aimed to enlighten the government officials of KEMPURERA, the local government of the Department of Public Works, and the International Finance Corporation in terms of their knowledge about "green building" and "universal access" on city planning. The outline and the results of the seminar were compiled in a seminar report.

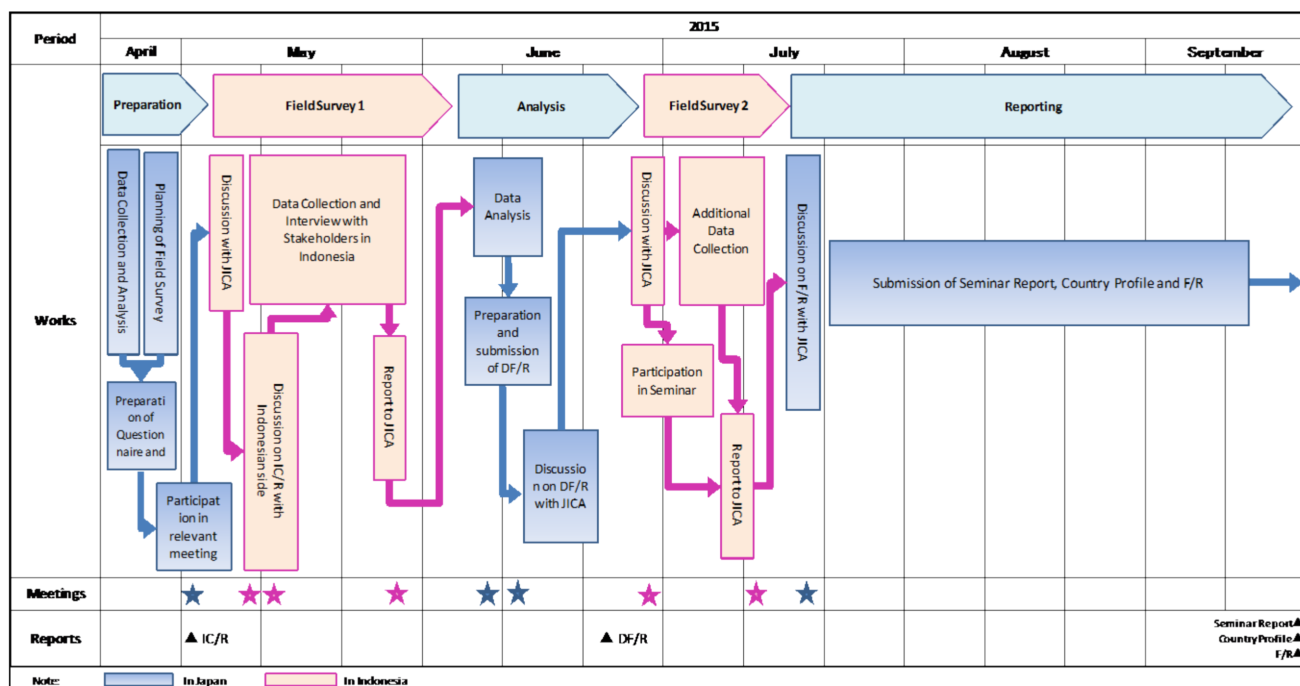


Figure 1-2 Work Flow

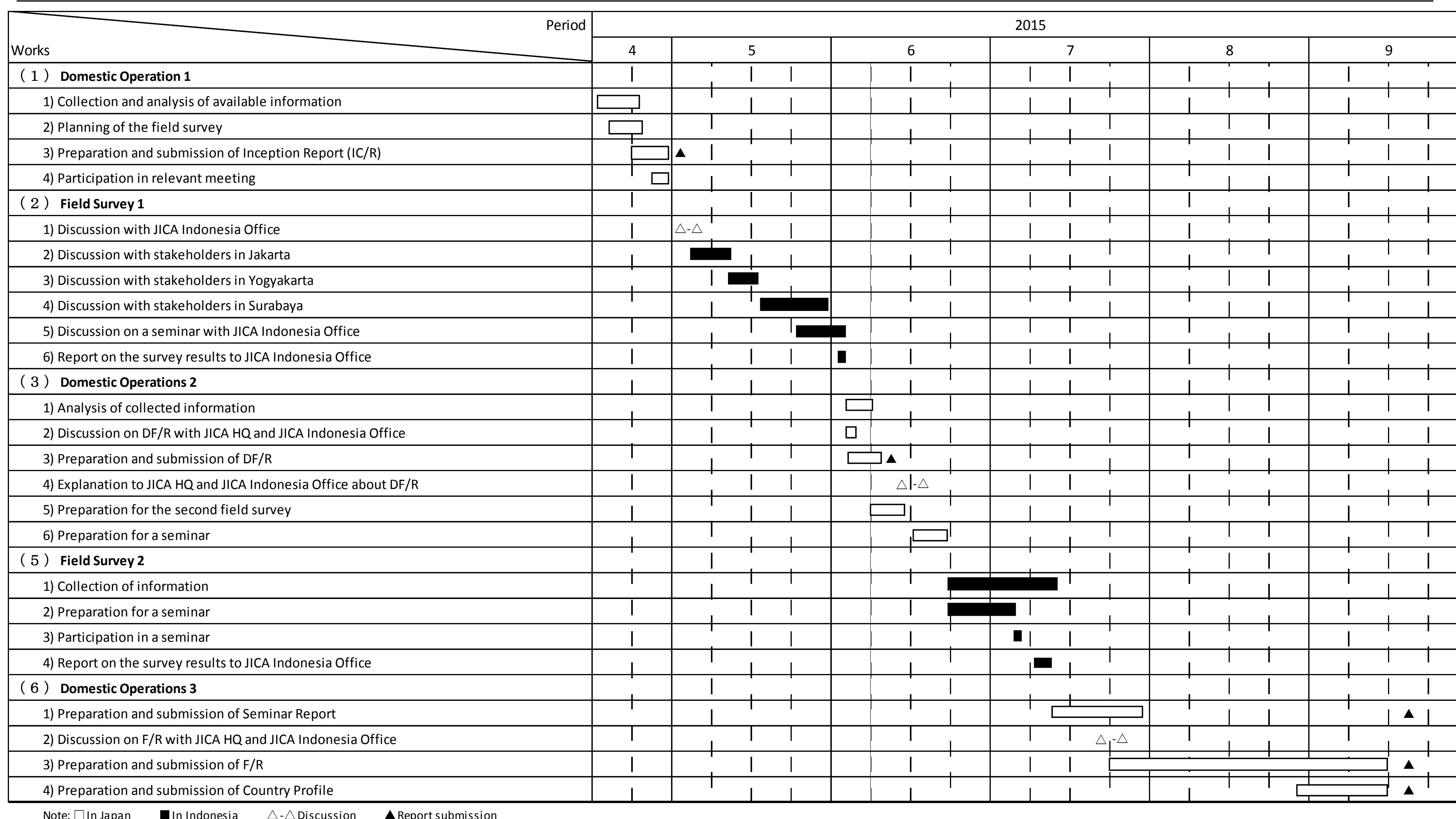


Figure 1-3 Work Schedule

1.4.2 Reports

The reports and documents submitted to JICA during the survey are listed in Table 1-1.

Table 1-1 List of Reports

Title of reports	Language	No. of Copies		Date of Submission
Inception Report (IC/R)	Japanese	2	CD-R 2	May 2015
Draft Final Report (DF/R)	Japanese	2	CD-R 2	June 2015
Seminar Report	Japanese	2	CD-R 2	September 2015
Final Report (F/R)	Japanese English	10 5	CD-R 3	September 2015
Country Profile on Disability	Japanese	1	CD-R 1	September 2015
Collected Documents	Japanese	1	CD-R 1	September 2015
Monthly Report	Japanese	1		Monthly
Record of Meetings	Japanese/English	1		-

Chapter 2 Overview of Indonesia

2.1 Socio-economic Context and Disaster Situations in Indonesia

2.1.1 Socio-economic Circumstances

Basic figures of Indonesia are presented in the following box.

Basic Figures of the Republic of Indonesia *

1. Land Area:	1,904,569 sq.km. (the world's 15th-largest)	
2. Population:	257,464,000	(estimate 2015, the world's 4th-largest)
	(as for the real number, see Table 2-6.)	
3. Life Expectancy at Birth:	71	(2013)
4. GNI per capita:	US$10,250.00	(adjusted by purchasing power parity: PPP, 2014)
5. Unemployment Rate:	6.25%	(2013)
6. Rate of Population Aging:	5.18%	(population rate, age of 65 and over, 2015)
7. Maternal Mortality Ratio:	190	(per 100,000 live births, 2013)
8. Under 5 Mortality Rate:	29	(per 1,000 live births, 2013)
9. Population per 1 Medical Unit:	20,499	(Republic of Indonesia, 2012)
(General & Special Hospitals, Clinics)	33,400	(West Java Province, 2012)
	5,393	(Papua Special Province, 2012)
10. School Attendance Rate:	98.42%	(Age 7－12, 2013)
	90.81%	(Age 13－15, 2013)
	63.84%	(Age 16－18, 2013)

(Source) Land Area: Central Intelligence Agency (CIA), *The World Factbook* (as of July 20, 2015); Population: United Nations Population Division, *World Population Prospects: The 2015 Revision*; Life Expectancy at Birth: The World Bank, *World Development Indicators*; GNI per capita: World Bank, *op. cit.*; Unemployment Rate: Badan Pusat Statistik (BPS), *Statistik Indonesia*; Rate of Population Aging: UN Population Division, *op. cit.*; Maternal Mortality Ratio: WHO, *Global Health Observatory (GHO) Data*; Under 5 Mortality Rate: World Bank, *Databank by Country*; Population per 1 Medical Unit: BPS, *Statistical Yearbook of Indonesia 2014*; School Attendance Rate: BPS, *Statistik Indonesia*; Illiteracy Rate: *Ibid.*

As mentioned in Chapter 1, Indonesia is the world's largest archipelago occupying the largest area in Southeast Asia where the ASEAN Secretariat is located in the capital city of Jakarta and showing an undisputed presence as the core country of the region.

The country's total population in 2014 reached to 250 million (the world's fourth largest after China, India, and the United States[2]) and the increasing trend has been continuing. Characteristically, 57% of the population is concentrated in Java island (127,000 sq. km., 6.6% of the national soil) where the largest city Jakarta, Surabaya, the second largest, and Jogjakarta, the ancient capital, are located. Also, the regional share of the island accounts for about 58% of the national gross domestic product (GDP)[3] and the gap between the central density and remote sparsity is significant.

Table 2-1 Growth of Indonesian Economy

	2007	2008	2009	2010	2011	2012	2013	2014
Real Economic Growth Rate (%, annual)	6.3	6.1	4.6	6.1	6.5	6.2	5.8	5.0
GNI per capita, PPP (current int'l US$)	6,410	6,870	7,150	7,640	8,190	8,750	9,270	10,250

(Source: BPS, *Statistik Indonesia*, and the World Bank, *World Development Indicators*)

The Indonesian economy suffered a blow that caused the annual growth rate of -13% because of the Asian Currency Crisis of 1997, but since then, any attempt of steady operation and voluntary structural reform supported by the International Monetary Fund (IMF) program had been successful in following years. As shown in Table 2-1, the economic growth of about 6% per year continued for six years from 2007, and Indonesia enjoys an increase of about 1.5 times growth in real income between 2007 and 2014.

Table 2-2 Transition of Poor Population Rate in Indonesia

Monthly Income/ Population Rate	2010		2011		March 2012		Sept. 2012		March 2013		Sept. 2013		March 2014		Sept. 2014	
	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)	Amt. (Rp.)	Rate (%)
Pov. Line (National)	211,726	13.33	233,740	12.49	248,707	11.96	259,520	11.66	271,626	11.37	292,951	11.47	302,735	11.25	312,328	10.96
(Urban)	232,988	9.87	253,016	9.23	267,408	8.78	277,382	8.60	289,042	8.39	308,826	8.52	318,514	8.34	326,853	8.16
(Rural)	192,354	16.56	213,395	15.72	229,226	15.12	240,441	14.70	253,273	14.32	275,779	14.42	286,097	14.17	296,681	13.76

(Source: BPS, *Statistik Indonesia*)

Considering Indonesia's endowment conditions as mentioned above (vast land area, steady economic growth, concentration in Java), the expansion of the gap between rich and poor and among the regions are the main concerns. In fact, the Gini Index, announced by the World Bank, has been increasing from 34.1 in 2008, 35.6 in 2010, and to 38.1 in 2011. It shows a trend of expansion of the gap between the rich and the poor. The proportion of the population living below the poverty line is defined by the government (Table 2-2). Nationwide Standard of September 2014 is 312,328 Indonesian Rupiah (IDR) per month, equivalent to about USD 26 at the time, less than one dollar per day) has been showing 17% to 18% reduction from 2010 to 2014 in the national, urban, and the rural areas. However, while the entire country is in the direction of poverty reduction, the gap in the poverty population ratio between the urban and rural areas still indicates 5.6 point. Although the political decentralization in this country has been steadily in effect since the early 2000s, as for the economic aspect, the fact that 60% of both population and GDP are concentrated within Java island indicates that reduction of the regional gap, as well as the one between the rich and the poor, is still considered to be one of the most urgent national development challenges.

We can see below how the effect of the gap, as part of the socio-economic background, has generally affected the livelihood of persons with disabilities and its circumstances.

[2] United Nations Population Division, World Population Prospects: The 2015 Revision. For even population trend, the country's total population is expected to continue to increase until 2070 (median estimate).

[3] BPS, *Statistics Indonesia* (http://www.bps.go.id/)

Table 2-3 and Table 2-4 are comparisons of key indicators of health and medical care among Indonesia and countries nearby. Health/medical indicators of Indonesia are fairly not at a good level compared with other countries. Even comparing it with Vietnam, which records only about a half of income per capita, and in the indicators of under-five mortality rate, maternal mortality ratio, life expectancy at birth, and the number of doctors per unit of population, Indonesia is inferior.

Table 2-3 Major Health Indicators of ASEAN Member Countries

	GNI per capita, PPP (International US$)*	Under 5 Mortality Rate (per 1,000 Live Births)	Maternal Mortality Ratio (per 100,000 Live Births)	Life Expectancy at Birth
Indonesia	10,250	29	190	71
Thailand	13,950	13	26	74
Philippines	8,300	30	120	69
Malaysia	23,850	9	29	75
Singapore	80,270	3	6	83
Vietnam	5,350	24	49	76
Cambodia	3,080	38	170	72
Laos	4,910	71	220	68
Myanmar	1,950**	52	200	66

* GNI per capita (2014), **GNI of Myanmar (2010). All other indicators are of 2013.
(Sources: World Bank, *World Development Indicators*; WHO, *World Health Statistics 2014*)

Table 2-4 Major Health Human Resource/Institution Indicators of ASEAN Member Countries

	Nr. of Medical Dr.s (per 10,000 population)	Nr. of Pshichi. Dr.s (per 10,000 population)	Nr. of Hospitals (per 100,000 population)*	Nr. of Beds at Psychi. Hospitals (per 100,000 population)
(Years)	2007-2013		2013	2014
Indonesia	2.0	0.05 or less	0.4	4.0
Thailand	3.9	0.1	1.8	0.0
Philippines	-	0.05 or less	1.8	6.1
Malaysia	12.0	0.1	0.5**	14.0
Singapore	19.5	0.3	0.5	44.3
Vietnam	11.9	0.1	-	7.9
Cambodia	1.7	0.05 or less	0.6**	0.1
Laos	1.8	0.05 or less	2.2	0.4
Myanmar	6.1	0.05 or less	0.6**	3.0

* WHO, *Baseline Country Survey on Medical Devices* (2013)、 ** Public institutions only.
(Sources: WHO, *op. cit.* and *World Health Statistics 2015*)

The causes of low standard of social development indicators of Indonesia, considering its relatively high level of economic development, are supposed to be (1) the geographic characteristics of an archipelago surrounded by the sea and occupying wide land areas, accompanied by difficult access to various social resources and services, (2) necessity destined by the width, for any social capital to be of enormous volume

to cover all the nation. For example, referring to the number of population per medical unit of institutions shown in the "Basic Figures" at the beginning of this chapter, when compared to Malaysia's 2,907, the West Java Province which has Indonesia's largest population (33,400), as well as the Papua Special Province, which is the most remote area (5,393) in Indonesia, shows a large difference. With this, considering the total population and area of West Java (43.05 million, 35,378 sq. km) and Papua (2.83 million, 319,036 sq. km) provinces[4], the fact that double constraints are existing in the field of social protection, composed of "difficulty for public services to cover vast land areas" and "absolute shortage of basic social resources such as medical doctors and/or facilities," will become apparent[5].

2.1.2 Natural Disaster

Indonesia belongs to the area of tropical rainforest and has tropical monsoonal climate being surrounded by oceans, therefore, it is vulnerable to natural disasters. There are twelve types of natural disasters in Indonesia which includes earthquake, tsunami, volcanic eruption, landslide, storm, drought and wildfire.

Table 2-5 shows the occurrence and damage of natural disasters in Indonesia from 1980 to 2014. As can be seen in the table, flood is a disaster that most frequently occurs, comprising 40% of the total number of occurrence; however, earthquake and tsunami cause the largest amount of damage in terms of the economy and number of deaths.

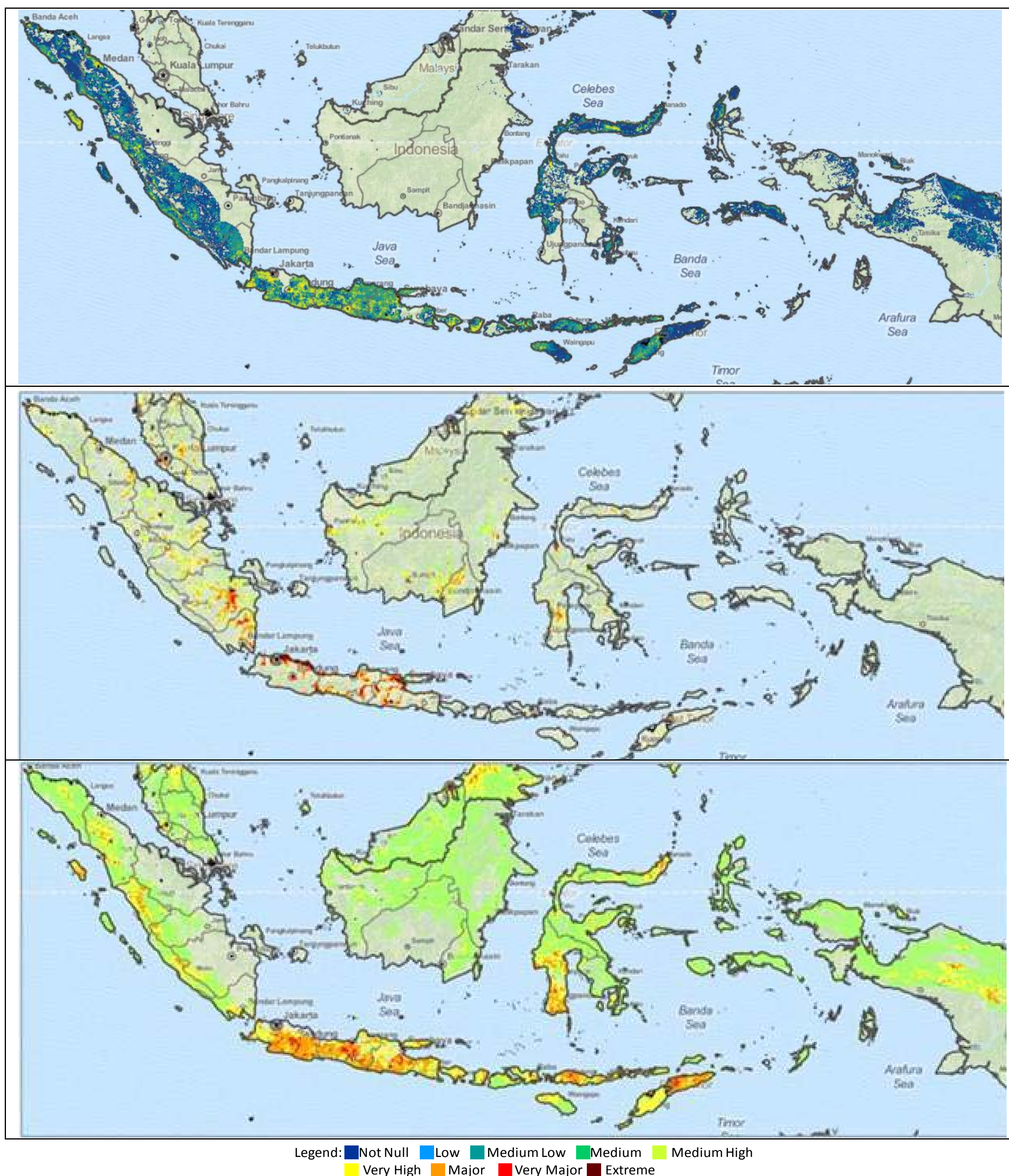
Table 2-5 Occurrence and Damage of Natural Disasters in Indonesia (1980-2014)

Type of Disaster	Number. of Occurrence	Death (Person)	Totally Affected (Person)	Economic Damage (U$'000)
Flood	154	6,408	8,357,541	6,378,016,000
Earthquake and Tsunami	85	179,441	8,505,943	11,479,576,000
Landslide	49	2,081	397,783	121,745,000
Volcanic Activity	42	729	930,153	530,190,000
Wildfire	9	300	3,034,478	9,329,000,000
Storm	6	27	15,188	1,000,000
Drought	6	1,266	1,083,000	89,000,000
Total	351	190,252	22,324,086	27,928,527,000

(Source: Centre for Research on the Epidemiology of Disasters)

Figure 2-1 presents the areas at high mortality risk for earthquake, flood, and landslide. As shown in the figure, Sumatra, Java and Sulawesi islands are more prone to be affected by earthquake than other areas. With regard to landslide, it is usually caused by heavy rain and earthquake vibration, and therefore, the areas with high mortality risk of earthquake and flood, such as Sumatra, Java, and Sulawesi islands have higher risk of landslide at the same time.

[4] Population and land areas of West Java and Papua provinces are based upon BPS, *Statistical Yearbook of Indonesia 2014.*
[5] This point is indicated by, for example, Global Health Workforce Alliance (WHO), *Country Coordination and Facilitation (CCF) – Country Case Studies: Indonesia* (2011). Also during interviews with central government offices, many public officials remarked, "Since Indonesia has vast land areas, the fact necessarily produces regional gaps and shortage of social resources. The restrictions have to be considered to be given conditions for any development programs of the nation."



(Source: Global Risk Data Platform, UNEP/UNSIDR, 2013)

Figure 2-1 Mortality Risk for Earthquake (top), Flood (middle), and Landslide (bottom)

The National Disaster Management Authority (*Badan Nasional Penanggulangan Bencana*: BNPB) mentions some prioritized locations for disaster risk reduction (Table 2-6). These priorities are defined by the number of residents, infrastructure, and the probability of occurrence for the next five years. It is considered that approximately 205 million people reside in these locations.

Table 2-6 Prioritized Locations for Disaster Risk Reduction

Type of Disaster	Locations
Earthquake	West Java, Aceh Province, West Sumatra, Central Java, Lampung Province, East Java, Bali Province, East Nusa Tenggara, Central Sulawesi, North Sulawesi
Flash Floods	East Java, West Java, West Sumatra, West Nusa Tenggara, North Sumatra, Maluku Province, Gorontalo, Central Sulawesi, North Sulawesi, South Sulawesi
Drought	East Java, West Java, North Sumatra, West Kalimantan, West Sumatra, Central Java, East Nusa Tenggara, Banten Province, South Kalimantan, West Nusa Tenggara
Forestfire	Riau Province, Central Kalimantan, West Kalimantan, South Sumatra, East Kalimantan, Jambi Province, Papua, Lampung Province, North Sumatra, South Kalimantan

(Source: Draft of Disaster Management Plan 2015-2019 (BNPB))

The Government of Indonesia considers that disaster risk would increase as a result of climate change, geological activities, and land development.

2.2 Administrative Boundaries of Indonesia

Indonesia's national territory is divided into 34 provinces (*Provinsi*) and special provinces (*Daerah Khusus*). In addition, the provincial areas are divided into prefectures (*Kabupaten*) and cities (*Kota*). These constitute the so-called second administrative districts[6]. Each province's location and population are shown in Table 2-7.

Table 2-7 Indonesia's Population by Province

Location	Province/Special Province	Population (2010)
Sumatra	Aceh Special Province	4,494,410
	North Sumatra	12,982,204
	West Sumatra	4,846,909
	Riau	5,538,367
	Jambi	3,092,265
	South Sumatra	7,450,394
	Bengkulu	1,715,518
	Lampung	7,608,405
	Kepulauan Bangka Belitung	1,223,296
	Keplauan Riau	1,679,163
Java	Jakarta Special Province of Capital (DKI)	9,607,787
	West Java	43,053,732
	Central Java	32,382,657
	Jogjakarta Special Province (DIY)	3,457,491
	East Java	37,476,757
	Banten	10,632,166
Lesser Sunda Islands	Bali	3,890,757
	West Nusa Tenggara	4,500,212
	East Nusa Tenggara	4,683,827
Kalimantan (Borneo)	West Kalimantan	4,395,983
	Central Kalimantan	2,212,089
	South Kalimantan	3,626,616
	East Kalimantan	2,930793
	North Kalimantan*	622,350

6 Paragraph 1, Article 18, Undang-Undang Dasar (UUD, 1945, 2nd amendment in August 2000). Additionally "first administrative district" and "second administrative district" are commonly used but not specified by law.

Location	Province/Special Province	Population (2010)
Sulawesi	North Sulawesi	2,270596
	Central Sulawesi	2,635,009
	South Sulawesi	8,034,776
	Southeast Sulawesi	2,232,586
	Gorontalo	1,040,164
	West Sulawesi	1,158,651
Moluccas (Maluku)	Maluku	1,533,506
	North Maluku	1,038,087
New Guinea	West Papua Special Province	760,422
	Papua Special Province	2,833,381
	Total:	**237,641,326**

(Source: BPS, *Sensus* (Population Census), 2010) * North Kalimantan Province was established by separating from East Kalimantan in 2012.

A province, prefecture, and city government have autonomies and local councils composed of elected representatives through election. They have governors and mayors, the chief of the local government, which is democratically elected by public election[7].

There is no pecking order or difference of administrative functions between prefectures and the cities. A simply prefecture is located in rural areas (or the periphery), and the city in urban areas. Under the city/prefecture, the county (*Kecamatan*) is installed and further the ward (*Kelurahan*) which is under the county. The county and the ward, as a separate administrative unit, respectively play a role to assist the administration of the prefecture and the city.

As for the village (*Desa*) located at rural areas, while playing a similar role as the ward, it has not been recognized as an official administrative unit for a long time. When the Village Law was amended for the first time in 35 years (*Undang-Undang, Nomor 6, 2014, Tentang "Desa"*) approximately 74,000 villages all over the country have attained the position of being an official administrative unit and was given its own business license, rights of budgeting, and election of head.

While the village parliament introduces a no representative system and employs "everyone-can-participate-in" conference (*Musyawarah*)[8], the head, the chief of the administration body, is elected through public election and the parliament has decision rights to plan/conduct business projects and budgeting[9].

The budget is partially financed by cash transfers from the central government (the transfer is incorporated in the village fund, with limits of not more than 10% of budgeted revenue to be shared). Although the cost of the election of head will be borne by the city or province of the upper level administration, operational

[7] *Ibid.*, Paragraph 2 to 4, Article 18. As for the autonomy, since UUD prescribes, "The regional authorities shall exercise wide-ranging autonomy, except in matters specified by law to be the affairs of the central government." (*Ibid*. Paragraph 5), the local government in Indonesia is guaranteed of broad autonomy.

[8] Paragraph 3, Article 59, Village Law (2014). Elders to chair the first Parliament, younger to assist them.

[9] *Ibid.* Paragraph 3, Article 61. Additionally, mayor has the approval rights of decisions by the parliament (*Ibid.*, Paragraph 7, Article 1 and Item 5, Paragraph 2, Article 26).

costs of the parliament (Musyawarah Desa) is based upon self-pay principle[10] and the village assets are guaranteed to be free from mortgage or seizure by other central/local administrative bodies[11].

2.3 A Matter of Local Autonomy

The evolution of the local autonomy in Indonesia since the beginning of the 2000s has been highly appreciated from the perspective, both domestic and international, regarding the civil freedom in various fields, such as politics, economy, etc., as one of the most important driving forces for the development of society. It is indicated, on the other hand, that the enhancement of discrete autonomy at the local government level undermines the state control even in case of necessities.

The large-scale slash and burn in Sumatra frequently repeated in the dry season to secure the site of the palm plantation has brought down a devastating damage in the primary forest. Also, the smoke generated by the burning has blocked the sunlight and caused serious damages on agriculture and public health not only in Sumatra, Kalimantan, and the neighboring islands, but also in Malaysia across the border.

The demand for palm oil has been rapidly growing both domestically and internationally (especially in China and India) with economic boom happening during recent years. It is literally "money trees" especially for the rural provinces with no/poor mineral resources, to abandon the primary forest that requires no small financial burden for protection but to plant palm trees that produce the cash crop instead.

In spite of the critical situations that would possibly lead to diplomatic consequences (in fact, Malaysia officially expressed the demand for correction of the present status), the existing legislation allows the central government to give "instructions" to the local authorities but with no stipulations on the necessity for local governments to obey or to implement punishment if they neglected the instructions[12].

[10] *Ibid.* Paragraph 4, Article 54.

[11] *Ibid.* Paragraph 11, Article 1. And as for the precise explanation on the Village Fund, refer to Blane Lewis, "Indonesian Village Decentralization is All Money No Plan," (*East Asia Forum*, 27 June 2015).

[12] For details of this issue, refer to Ben Bland, "Indonesian Fires Highlight Weak Governance and Corruption," (*Financial Times,* June 23, 2013) .

Chapter 3 Current Situation of Disability and Development in Indonesia

3.1 Definition of Disability and Persons with Disabilities

Indonesia has traditionally defined disabilities based upon the symptoms and functional classification. The present status of the definition will be reviewed in the following chapter in terms of both legal regulations and administrative practices.

(1) Legal Regulations

As a special law concerning disabilities in Indonesia, Law No. 4, 1997, "Law on Persons with Disabilities" exists. In the law, Paragraph 1, Article 1, defines persons with disabilities as "persons who bear disabilities to (a) body, (b) mind, or (c) body and mind.[13]"

Article 1 of the Ministerial Ordinance of Health No. 104 in 1999, "Provisions for Medical Rehabilitation," defines persons with disabilities as "Persons bearing physical or mental disability/disabilities, and, by the fact, being restricted in motions/activities for his/her daily livings." Moreover, Article 7 of the ordinance describes, "The degree of disability is determined by whether and how persons with disabilities themselves can control their own behavior on everyday life," and the degree is classified into following six grades[14]:

- Level 1: Basically possible to control their behavior themselves based upon their will, even with some difficulties;
- Level 2: Possible to control their behavior with supportive devices;
- Level 3: Necessary for others' help to control their behavior, with or without supportive devices;
- Level 4: Necessary for helper's assistance to control their behavior (supporting devices are useless);
- Level 5: Impossible to control their behavior without complete care; and
- Level 6: Impossible to control their behavior even with complete care.

(2) Administrative Practices

The Indonesian government, through the official statistical surveys, has conventionally defined disabilities by four categories: (a) visual impairment, (b) hearing impairment, (c) muteness, and (d) permanently damaged on specific parts of the body/limbs or orthopedically impaired. They recently employed, adding two more categories: (e) mental disorders and (f) difficulty/impossibility to control behavior of their own in everyday livings, six-category definition[15].

For more concrete examples, in the Census by the Central Bureau of Statistics (*Badan Pusat Statistik*: BPS; The Census is conducted every ten years. The previous one was in 2010) and Basic Health Survey (*Riset Kesehartan Dasar*: RISKESDAS; the survey is conducted every three years. The previous one was in 2013), technically designed questionnaires based upon International Classification of Functioning, Disability, and Health (ICF, adopted by the WHO General Assembly in 2001) were used.

[13] Undang-Undang Nomor 4, Tahun 1997, Tentang "Penyandang Cacat."
[14] Permenkes (Peraturan Kementerian Kesehatan) Nomor 104/Menkes/PER/II/1999, Tentang "Rehabilitasi Medik"
[15] Based upon interviews with some university professors, other intellectuals and BAPPENAS.

In actual operations and details of survey methods, however, there are differences by ministry/agency that is in charge of the research project. The fact has been the cause that produces different results of the statistical data for persons with disabilities by the research body[16].

In the provision of the National Disability Survey 2016 (tentative title), co-sponsored by BPS and the State Ministry of National Development Planning (*Badan Perencanaan Pembagunan Nasional*: BAPPENAS), coordination for the methodology of the survey has been attempted among relevant ministries, such as Ministry of Social Affairs (*Kementerian Sosial*: KEMSOS) and the Ministry of Health (*Kementerian Kesehatan:* KEMENKES), and DPOs. The national definition of (persons with) disabilities and methods of gathering disability-related data are supposed to be integrated in the near future through this kind of trials and experiences, and reliability of statistics is expected to be improved, among the central government officials[17].

In the background of these changes, there is also a ratification of the CRPD by the Indonesian government in November 2011. Some officials and intellectuals closely related to the issues of disabilities anticipate that the definition and recognition of disability in the country will possibly change to those that conform to the social model from the medical model which is based upon functional categories[18].

3.2 Situation of Persons with Disabilities - Attitudes Towards Disability-

In this chapter, the survey team will aim to introduce examples based on the information obtained through the focus group discussions (FGDs), interviews with government officials whom are responsible for disability administration, Non-profit Organizations (NPOs), non-government organizations (NGOs), support groups, and last but not the least, the persons with disabilities themselves, as well as their families,

[16] The definition of disabilities by the Ministry of Education and Culture is; (a) hearing impairment, (b) developmental disorders, (c) blind, (d) physical disability, (e) mental disorder and (f) autism, which is different from the 6-category classification by BAPPENAS (Based on the interview with KEMDIKBUD, 12 May 2015). Also, some relevant cases are reported, "While KEMSOS does not count the patient as "blind" unless he/she completely lost the sight, BPS does if there is some failure in vision," (Based on the interview with BPS, 2 July 2015) or "Children in some areas originally regarded "blind," as a result of the ratification survey, has been finally diagnosed as myopia/amblyopia (source: interview with BAPPENAS).

[17] (ditto).

[18] This is based upon interviews with government agencies, university professors, intellectuals, experts and persons with disabilities. However, "In the reality of the disability-related research, since many household persons who are to be interviewed do not know the socially-developed concept of notion on disability, inevitably the design of questionnaires have to be based on the presence or absence of symptoms" (BPS). Therefore, some officials expressed the opinion that the medical model should be practically applied to official surveys for a while. And it is to be noted that (a) the medical model regards disabilities as personal characteristics caused by illness, injury, or other health conditions. In the medical model, disability is considered to be attributed to individual problems and require medical or other treatment or intervention for its improvement; and (b) in the social model, disability is created by society, and not regarded as a personal attribution. In social model, problems concerning disabilities are considered to be products of inappropriate physical environment brought about by others' social attitudes and various social conditions and political intervention is required for the problem solving and improvement of the situation (Statistics and Information Department, Ministry of Health, Labour and Welfare, Government of Japan, "International Classification of Functioning, Disability and Health - Pediatric Youth Version (tentative name) - (Study Group for production of the Japanese version of the ICF-CY) (2nd)," Article 3 "Beginner's Guide (provisional translation) towards the common language on health: ICF International Classification of Functioning "(10 December 2008, p.8).

to obtain qualitative situation of persons with disabilities in Indonesia[19]. For the quantitative data on the situation of disability, please refer to Section 3.3 Disability Related Indicators (basic indicators).

【Poverty and Persons with Disabilities】

Generally, persons with disabilities experience difficulties in accessing education and employment. Since they lack educational background, skills, and employment experience, they fall into the vicious circle of poverty. This is a trend that is seen globally, but the impoverished situation of persons with disabilities in Indonesia is as serious as in other areas.

【Education, Health, Employment, and Social Protection】

Persons with disabilities have the same serious problem in accessing education, health, employment and social protection. In reality, only 10% of children with disabilities are registered and enrolled at schools. There is a high possibility that persons with disabilities are not registered as citizens at birth, as mandated by law, and are thus not eligible to receive education, medical, employment, care, and welfare services[20].

【Disability and Gender】

Women and girls with disabilities in Indonesia experience double discrimination, in addition to being disabled, and because they are women. For example, if a married woman becomes disabled, it is enough reason for her husband to divorce her (this is legally recognized)[21]. In addition, it is not uncommon for a woman with disability to be criticized if she becomes pregnant[22].

【Accessibility】

Daily accessibility does not come easy for persons with disability. There are cases where there are dangers because the ramps are too steep for wheelchair users to use without assistance. There are also instances where legally required wheelchair corridors and public facilities cannot be used.

【Attitude Towards Disability】

Attitude towards disability is negative in general. This is a cause of societal poverty of persons with disabilities.

This phenomenon can also be seen in the terminologies being used in Indonesia. Officially, the terminology used for disability in Bahasa Indonesian is "*disabilitas*" but the discriminatory expression is "*cacat*" (incomplete, disfigured) are still being used in official documents (such as the 1997 Disability Law by which, the official name is still *Undang-Undang, tentang "Penyandang Cacat"). "Orang gila"* (crazy, bastard) is also frequently used in daily conversations.

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[19] Due to the sensitivity of information, in most cases, it is not possible to cite sources.

[20] Based on the interview with the Ministry of Education and Culture (12 May 2015), the East Java Provincial Government Education Department (20 May), Yogyakarta City Social Affairs Department (27 May), and DPOs in Surabaya and Yogyakarta (14 to 29 May) (There were no presentation of problems based on official statistics, but there seemed to be a common awareness that the unorganized official statistics were a central problem.)

[21] *Undang-Undang, Nomor 1, Tahun 1974, tentang "Perkawinan" Article 4 No.2* of the Marriage Law. If a wife cannot bear children, this is also a reason for divorce.

[22] Based on the interview with persons with disabilities, their supporters, related government officials in Surabaya and FGDs in Jakarta. For more details on disability and gender, official activities and responsible organizations, refer to Chapter 3.4.3 (10).

When referring to persons with disability, most people assume the physically disabled. In addition, the usual way people respond to disability is to be pitiful to them and people have this stereotype that "persons with disability are those who are to be pitied". Particularly in the rural areas where local customs prevail, having a disability is considered "shameful" and "dirty". At the same time, parents have this thinking that "if my child is handicapped, he/she cannot live a normal life", and they tend to be overprotective to their child by providing the home-based care. Finally, there are cases where even professional teachers think it is impossible for children with disabilities to follow classes.

【Attitudes and Responses of Government Officials - Evaluation of Persons with Disabilities-】

According to persons with disabilities interviewed by the study mission on the general attitude and response of the Indonesian government, the general perception of civil servants and officials working in various Indonesian ministries and agencies was that, all problems associated with disability is the responsibility of KEMSOS[23]. In some cases, government officials think that disability is unrelated to government offices and that there is no need to provide reasonable accommodation on accessibility to public offices even if there are accessible facilities that are not being used or utilized[24]. This is because the participation of persons with disabilities (throughout the development program from planning, implementation, monitoring, and evaluation) is not fully understood. Opinions of persons with disabilities are only asked at the initial planning phase because government interaction with persons with disabilities is inconsistent and negotiations were discontinued. Some ministers, section heads, and officials actively promote activities for disability but there were some people that say that lower ranking officials were usually not that active.

【The Current Situation of Service Provision - Evaluation of Persons with Disabilities】

It is unclear whether the inaccuracy or the inconsistency in the use of concepts and terminologies about persons with disabilities are the main problems or whether the reality is already reflected in the use of these concepts and terminologies. Persons with disabilities continue to be treated unfairly and receive unsatisfactory services. There are increasing numbers of people who recognize the needs of persons with disabilities and try to respond to these needs with services but as seen in the case of a taxi company as presented in the box below, taking into account the opinion and requests of persons with disabilities and improving services is an issue which requires continuous follow-up.

Example of Trial and Error Service for Persons with Disability

The taxi company "Bluebird" announced its "accessible" and "life care" taxi service but a person with disability cannot board with a wheelchair and the reality is that it is not as accessible as a person with disability might hope it would be.

【Attitudes of Persons with Disabilities Themselves】

Not only families but persons with disabilities themselves tend to have low self-confidence and low self-esteem. Specific examples are despite vocational trainings, persons with disabilities do not have

[23] Based on interviews with persons with disabilities and Sri Moertiningsih Adioetomo, Daniel Mont and Irwanto, Persons with Disabilities in Indonesia - Empirical Facts and Implications for Social Protection Policies, (Jakarta: University of Indonesia/TNP2K, 2014), p126

[24] Ibid, P126.

self-confidence to look for a job or employment and they would usually rely on their families and go back to being not-employed or become withdrawn at home.

3.3 Disability Related Indicators (Basic Indicators)

In this section, the quantitative status of persons with disabilities in Indonesia based on the statistics, mainly government agencies have compiled will be introduced in a form of summarized charts and tables.

3.3.1 Number of Persons with Disabilities (by Province, Gender, Age Group, Residential Area)

As presented in Table 3-1, the rate of disability population in Indonesia is officially a little less than 4.5%, and significantly different from 15% of the WHO estimates[25].

Table 3-1 Number, and Ratio of Persons with Disabilities Population in Indonesia (by Province, 2 years and older)

Province	Population (2 yrs and older)	With/Without Disability		Rate of PWDs Population (%)
		With Disability	Without	
Aceh Special Province	4,280,284	219,017	4,061,267	5.12
North Sumatra	12,362,367	526,560	11,835,807	4.26
West Sumatra	4,634,445	285,647	4,348,798	6.16
Riau	5,255,195	222,175	5,033,020	4.23
Jambi	2,942,935	130,052	2,812,883	4.42
South Sumatra	7,132,445	328,943	6,803,502	4.61
Bengkulu	1,641,979	81,148	1,560,831	4.94
Lampung	7,283,319	311,273	6,972,046	4.27
Kepulauan Bangka Belitung	1,168,358	45,318	1,123,040	3.88
Keplauan Riau	1,592,385	49,641	1,542,744	3.12
Jakarta Special Province of Capital (DKI)	9,181,271	406,739	8,774,532	4.43
West Java	41,398,445	1,819,036	39,579,409	4.39
Central Java	31,207,356	1,177,261	30,030,095	3.77
Jogjakarta Special Province (DIY)	3,348,258	157,985	3,190,273	4.72
East Java	36,079,497	1,661,580	34,417,917	4.61
Banten	10,182,937	362,988	9,819,949	3.56
Bali	3,753,920	162,130	3,591,790	4.32
West Nusa Tenggara	4,304,230	195,450	4,108,780	4.54
East Nusa Tenggara	4,448,811	248,584	4,200,227	5.59
West Kalimantan	4,211,714	200,699	4,011,015	4.77
Central Kalimantan	2,119,742	97,212	2,022,530	4.59
South Kalimantan	3,471,093	149,661	3,321,432	4.31
East Kalimantan	3,381,541	151,053	3,230,488	4.47
North Kalimantan*	(n/a)	(n/a)	(n/a)	(n/a)
North Sulawesi	2,186,409	140,469	2,045,940	6.42
Central Sulawesi	2,515,726	141,419	2,374,307	5.62
South Sulawesi	7,713,797	475,066	7,238,731	6.16
Southeast Sulawesi	2,124,546	110,371	2,014,175	5.20
Gorontalo	998,455	73,791	924,664	7.39
West Sulawesi	1,106,682	54,566	1,052,116	4.93
Maluku	1,455,950	60,299	1,395,651	4.14
North Maluku	988,181	42,089	946,092	4.26
West Papua Special Province	717,182	18,359	698,823	2.56
Papua Special Province	2,681,886	44,545	2,637,341	1.66
Indonesia Total	**227,871,341**	**10,151,126**	**217,720,215**	**4.45**

(Source: BPS, *Sensus* (Population Census), 2010) * North Kalimantan Province was established by separating from East Kalimantan in 2012.

[25] WHO, op. cit.

In this regard, public officials working for the disability-related central government agencies also mentioned, "Even after the convention, superstition and bias against disabilities are still strong in some rural areas, and because of its psychological effect, interviewees tend to hide the existence of their family members with disabilities from public investigation." They assume the actual number of persons with disabilities would be much more than the statistical figures[26].

Table 3-2 Number and Rate of Persons with Disabilities (by Gender and Residential Area)

Gender	Type of Residential Areas					
	Urban		Rural		Urban+Rural	
	Population (–000–)	%	Population (–000–)	%	Population (–000–)	%
Male	**2,873**	**3.78**	**1,796**	**4.40**	**4,669**	**4.10**
Female	3,349	4.41	2,132	5.22	5,482	4.82
Male+Female	6,222	4.10	3,929	4.81	10,151	4.45

(Source: BAPPENAS document based upon *Sensus* (National Census) 2010, BPS)

As for the number of persons with disabilities by gender, female population exceeds in both urban and rural areas (about 1.2 times bigger than male as shown in Table 3-2). In this regard, there is a hypothesis that autism, with overwhelmingly high potential of appearance among males, is not so widely noticed in Indonesia that many of them are absent from the statistics[27]. But actual details are not known.

Table 3-3 Rate of Persons with Disabilities Population (by Age Group and Gender)

Age Group	Gender		
	Male	Female	M+F
2-4	3.48	3.46	3.47
5-9	2.77	2.61	2.69
10-14	1.07	0.93	1.00
15-19	0.91	0.88	0.90
20-24	1.03	0.96	1.00
25-29	1.21	1.09	1.15
30-34	1.41	1.33	1.37
35-39	1.67	1.75	1.71
40-44	2.97	3.25	3.11
45-49	4.77	4.94	4.85
50-54	7.28	7.71	7.49
55-59	9.78	10.86	10.30
60-64	14.35	16.88	15.66
65-69	19.01	22.55	20.88
70-74	28.05	32.62	30.60
75+	41.17	46.52	44.28

(Source: BAPPENAS document based upon *Sensus* (National Census) 2010, BPS)

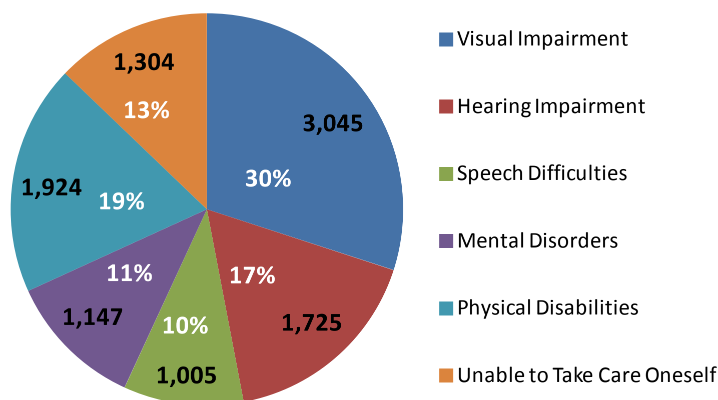
Table 3-3 shows the rate of persons with disabilities by age group and gender. The disability rate of males is slightly higher through adolescence. From middle age to the beginning of old age, however, the rate of

[26] Based on the iinterview with BPS (2 July 2015).
[27] Based on the interview with the Autism Foundation of Indonesia (8 July 8 2015). Additionally, it should be noted that in the experience of developed countries, the possibility of autism incidence among males is about four times bigger than females (ATSUMI, Yoshikata, Visiting Fellow, National Institute of Special Needs Education, "Savant Syndrome and Autism (1)," http://www.nise.go.jp/cms/6,7927,13,257.html).

women becomes higher. The increase of disability rate both in male and female, rapidly grows as persons are getting old, and it can be confirmed that aging is a strong driving factor of disabilities[28].

3.3.2 Type of Disabilities

Figure 3-1 indicates the number of persons with disabilities by type of disabilities.



(Source: BAPPENAS document based upon *Sensus* (National Census) 2010, BPS)

Figure 3-1 Number of Persons with Disabilities Population by Type of Disability (1,000 persons)

Table 3-4 is a list of causes of disabilities summarized, based upon the results of the disability survey SNSAP-PWD 2012, collecting answers from 2,200 persons with disabilities living in 11 provinces to present their actual states and opinions,[29] by the Faculty of Economics and Management, University of Indonesia.

Table 3-4 Causes of Disabilities Based on Self-reporting (%)

Causes/Types	All Types	Vision	Hearing	Cognitive	Communi-cation	Mobility	Psycho-Social
Constitutional	36.32	18.86	44.62	36.92	44.33	31.03	35.10
Disease	34.64	27.58	18.78	32.33	28.12	30.43	31.66
Injury/Accident	17.73	12.52	9.79	9.69	7.78	16.69	11.57
Aging	16.37	31.38	22.15	10.66	8.43	8.43	8.66
Cursed	3.44	2.22	0.64	4.23	3.28	3.27	4.23
Unknown	1.45	0.79	0.96	0.70	0.66	0.75	0.33
Others	17.59	6.66	3.05	5.46	7.40	9.39	8.46
Total :	(n/a)	100.00	100.00	100.00	100.00	100.00	100.00

(Source: Demographic Institute, Faculty of Economics and Management, University of Indonesia, *Survey on the Need for Social Assistance, Programs for People with Disabilities (SNSAP-PWD)* 2012)

[28] While the rate of the aging population in Japan reached 20% in 2006, the one among persons with disabilities in Japan was reported to be three times bigger (approximately 60%) [Cabinet Office, White Paper on Disabilities 2013, Section 1, Chapter 1]. As for the statistics of physical and intellectual disabilities in Japan, the numbers of males through all ages (physical disabilities: 1.95 million, intellectual disabilities: 0.35 million) exceed females (physical: 1.90 million, intellectual: 0.27 million). With respect to the mental disorders, however, female (1.85 million) largely surpasses that of males (1.35 million) [Cabinet Office, White Paper on Disabilities 2014, Section 3]. According to this figure, once recognition on mental disorders are promoted in Indonesia, the number of female with disabilities and the rate of persons with disabilities are considered to be steadily on increase.

[29] Sri Moertiningsih Adioetomo, Daniel Mont and Irwanto, Persons with Disabilities in Indonesia - Empirical Facts and Implications for Social Protection Policies, (Jakarta: University of Indonesia/TNP2K, 2014), p.10. (Since some persons have multiple disorders, once reckoned up the figures of the disability rate by type, the total will exceed 100%.)

Since it is not the survey conducted by the central government, the categorization of disability types does not correspond to the official taxonomic method of six disability groups: visual impairment, hearing impairment, speech difficulties, physical disabilities, mental disorders, and difficulty/impossibility to take care of oneself.

3.3.3 Data on Disability by Relevant Topics (School Attendance, Employment, Poverty)

(1) School Attendance Rate

Table 3-5 is a list of situations, compiled from the data of the 2010 census of children with disabilities classified by school attendance and is summarized by age group and residential area (urban/rural). It is needed to pay attention, before analyzing these figures, to the fact that some public officials stated, "Actually about 90% of school-age children with disabilities have never been to school, especially in the rural areas, and just stay at home."[30] For the planning/designing policy and development plans, with reference to this kind of official statistics, it must be noted that a particular attention should be given to the gap between the statistical numbers and realities.

Table 3-5 School Attendance Rates and Situations of Children with Disabilities (by Age Group/Residential Area)

(Unit: %)

School Attendance	Area Type		
	Urban	Rural	U+R
7-12 years old			
Not going/Never been to school	13.35	20.39	17.02
Still in school	83.82	76.30	79.89
No longer in school	2.83	3.32	3.09
Total	100.00	100.00	100.00
13-15 years old			
Not going/Never been to school	20.39	33.49	27.30
Still in school	63.50	44.48	53.47
No longer in school	16.11	22.03	19.23
Total	100.00	100.00	100.00
16-18 years old			
Not going/Never been to school	19.63	35.12	27.61
Still in school	45.28	22.31	33.45
No longer in school	35.09	42.56	38.94
Total	100.00	100.00	100.00
19-24 years old			
Not going/Never been to school	16.59	32.66	24.77
Still in school	21.06	4.92	12.85
No longer in school	62.35	62.42	62.38
Total	100.00	100.00	100.00
7-24 years old (Total)			
Not going/Never been to school	15.90	27.10	21.71
Still in school	59.54	46.98	53.03
No longer in school	24.56	25.92	25.26
Total	100.00	100.00	100.00

(Source: BAPPENAS document based upon *Sensus* (National Census) 2010, BPS)

[30] Based upon an interview with Directorate for Development of Special Education and Special Services, KEMDIKBUD (May 12, 2015)

(2) Employment

According to the collaborative research conducted by WHO and the World Bank, the comprehensive health survey of 51 countries in the world in 2011, the employment rate of male workers with disabilities was 52.8% and 12 points lower than the one without disabilities (64.9%). Employment rates of female workers with and without disabilities were 19.6% and 29.9%, respectively. The result suggests that the employment rate of female workers with disabilities was 10 points lower than the one without disabilities and the employment rate of female workers was, with or without disabilities, more than 30 points lower than the ones of the males[31].

Employment situations of persons with disabilities within Indonesia can be seen by the arrangement of data collected through the 2010 Census. Table 3-6 is a list that shows the working status of the country's working population (age 18 to 64) by degree of disabilities, educational standard, and gender.

Table 3-6 Working Status by Degree of Disabilities, Educational Standard, and Gender (Age from 18 to 64, %)

Sorting Keys	Status/Degree	Working Status	
		Employed	Unemployed
Degree of Disabilities	None	64.11	35.89
	Light/Middle	56.36	43.64
	Heavy	26.42	73.58
Educational Standard	Not Finished Primary	64.95	35.05
	Primary Graduate	65.67	34.33
	Secondary Graduate	62.68	37.32
Gender	Male	83.35	16.65
	Female	43.94	56.04

(Source: Demographic Institute, Faculty of Economics and Management, University of Indonesia, *Survey on the Need for Social Assistance Programs for People with Disabilities (SNSAP-PWD)* 2012)

There is no statistics of "unemployment rate," in a general sense, for the persons with disabilities in Indonesia. There is a result, on the other hand, of the interview survey inquiring the daily activities of persons with disabilities including employment as shown in Table 3-7.

Table 3-7 Daily Activities (including Working) of Persons with Disabilities (Age 10 and Older)

(Unit: %)

Residential Areas	Urban			Rural			Urban + Rural		
Year / Activities	2008	2009	2012	2008	2009	2012	2008	2009	2012
Working	22.06	25.38	31.93	29.48	31.52	42.54	26.78	28.83	37.85
Searching Job	6.02	0.75	0.72	4.40	0.58	0.32	4.99	0.66	0.50
Study	2.11	4.93	4.02	0.83	3.60	2.09	1.29	4.18	2.94
Housekeeping	16.14	15.21	23.47	15.00	17.54	22.88	15.41	16.52	23.14
Others	53.67	53.73	39.85	50.29	46.76	32.17	51.52	49.81	35.57
Total:	100	100	100	100	100	100	100	100	100

(Source: BPS)

31 WHO and World Bank, *World Health Survey* (2011).

The ratio shown in the "Working" column in the table is the proportion of persons with disabilities who are clearly working. The number is fairly small, compared to the country's overall employment rate of 93.75% (unemployment rate of 6.25%) listed at the top of Chapter 2, though a simple comparison is not possible because definitions and survey methods are different. Furthermore, the working environment for persons with disabilities is considered to be more oppressive in reality, taking into account the stability of their employment and continuity of their personal business.

(3) Poverty

The poverty rate of persons with disabilities in Indonesia is, as seen in Table 3-8, (i) measured as household poverty rate and the poverty level is higher compared to households without persons with disabilities; (ii) based upon the Basic Health Survey (Riskesdas) though the collected data in the year 2007 are somewhat old. In Table 2-2, the poverty rate of the national urban areas in September 2014 was at 8.16%, while in the rural areas it was at 13.76%, compared to the poverty rate of households with persons with disabilities shown in the above figures of 2007, the number of urban areas is almost at the same level and in the rural areas is even getting worse.

Table 3-8 Poverty Rate of Household (with/without Persons with Disabilities and by Residential Area)

(Unit: %)

Household Situation/Residential Area	Urban	Rural	Urban + Rural
Households with persons with disabilities	12.4	14.0	13.3
Households without persons with disabilities	8.2	11.4	10.0

(Source: Ministry of Health, *Riset Kesehatan Dasar*: Riskesdas, 2007)

3.4 Relevant Legislations and Policy Frameworks

3.4.1 Regulations

(1) Constitution

The Constitution of the Republic of Indonesia (*Undang-Undang Dasar*: UUD) was enacted at the time of independence in 1945, and it has been hitherto existing with four-time amendments.

UUD shapes the structure of the following:

Preamble (*Pancasila*[32], stating five founding principles of the nation)			
Chapter 1	Form of the State and Sovereignty (Article 1)	Chapter 2	People's Consultative Assembly (Article 2 to 3)
Chapter 3	Executive Power (Article 4 to 15)	Chapter 4	Supreme Advisory Council (Article 16)
Chapter 5	Ministers of State (Article 17)	Chapter 6	Regional Authorities (Article 18)
Chapter 7	People's Representative Council (Article 19 to 22B)	Chapter 7A	Regional Representative Council (Article 22C to 22D)
Chapter 7B	General Election (Article 22E)	Chapter 8	Finances (Article 23 to 23D)
Chapter 8A	National Audit Board (Article 23E to 23G)	Chapter 9	Jurisdiction (Article 24 to 25)

[32] 1) Belief in the one and only God, 2) Just and civilized humanity, 3) the Unity of Indonesia, 4) Democracy guided by the inner wisdom in the unanimity arising out of deliberations amongst representatives, and 5) Social justice for the whole of the people of Indonesia.

Chapter 9A	National Territory (Article 25A)	Chapter 10	Citizens and Residents (Article 26 to 28)
Chapter 10A	Human Rights (Article 28A to 28J)	Chapter 11	Religion (Article 29)
Chapter 12	State Defense and Security (Article 30)	Chapter 13	Education and Culture (Article 31 to 32)
Chapter 14	National Economy and Social Welfare (Article 33 to 34)	Chapter 15	Flag, Language and Symbols of State (Article 35 to 36)
Chapter 16	Alterations of Constitution (Article 37)	Transitional Rules (Article I to IV)	
Additional Rules		Explanation	

The UUD, as seen above, is a simplified supreme law composed of 37 articles. Therefore, the special law to be enacted in each juridical theme/issue assumes crucial roles to fulfill the precise requirements for judgment of application/coverage of the law in the legal systems of Indonesia.

The very relevant parts of the UUD to disability issues are the statements concerning people's living, social activities, and benefit of social welfare: Chapter 10 "Citizens and Residents," Chapter 10 A "Human Rights," Chapter 13 "Education and Culture," and Chapter 14 "National Economy and Social Welfare." (Specific relevance of constitutional provisions to persons with disabilities in the individual sector/issue will be summarized together with sectoral special laws in the next section.)

(2) Special Laws by Relevant Sector/Issue

Hereinafter, the contents relevant to issues of "disability and development," defined/protected by UUD and the special law, will be briefly reviewed by sector/social issue, with reference to the provisions related to the disability and persons with disabilities. (Note: The same provisions of the specific law are referred to multiple times in different sectors. Those texts are underlined.).

1) Social Protection and Poverty Reduction

- **Constitution** (UUD, 1945):
  - Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)
  - Recognition of the right to exist: "Every person shall have the right to live and to defend his/her life and existence." (Article 28A)
  - Recognition of the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment, and to obtain medical care. (Paragraph 1, Article 28H)
  - Recognition of the right of the nations to acquire "social protection in order to develop oneself fully as a dignified human being." (Paragraph 3, *Ibid.*)
  - "Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment." (Paragraph 2, Article 28I)

- **Law on Persons with Disabilities** (Law No.4, 1997):
  - Basic definition of persons with disabilities: (i) persons with physical disabilities, (ii) persons with mental disabilities, and (iii) persons with physical and mental disabilities. (Paragraph 1, Article 1)
  - Definition and categorization of rehabilitation that is "refunctionalization and development process to enable persons with disabilities to carry out their social function normally in social life": 1) medical rehabilitation, 2) education, 3) training, and 4) social rehabilitation. (Paragraph 5, *Ibid*.; Article 17; Paragraph 2, Article 18; Article 19)
  - Recognition of social assistance to make persons with disabilities: (i) to afford goods and services and (ii) to improve their healthy social lives. (Paragraph 6, Article 1)
  - Necessity to secure continuity and stability of social protection to enable persons with disabilities to live healthy social lives. (Paragraph 7, Article 1; Article 21)
  - Recognition that all citizens have the right to the benefit of social rehabilitation, various types of social assistance and social protection. (Paragraph 5, Article 6)
  - Recognition of the government and communities responsible for (i) the supply of social rehabilitation, social assistance and social protection services, (ii) the maintenance of systems for the purpose. (Article 16)
  - Recognition of the government and communities to conduct public relations and disseminate guidance of social welfare services for persons with disabilities. (Article 23)
  - Recognition of the government and communities to introduce monitoring and/or license systems into the framework of social protection services, as appropriate. (Article 24)
  - Stipulation on awarding organizations, enterprises, communities and individuals that made some contributions to the social protection for persons with disabilities. (Article 27)

- **On Social Welfare for Persons with Disabilities (Government Regulation No.36, 1980)**
  - Defined categories of persons with disabilities: a) Person with physical disability, b) Person with visual disability, c) Person with mental disorder, d) Person with hearing impairment/speech difficulty, and e) Person with disability caused by chronic disease. (Paragraph 1, Article 1)
  - Rehabilitation is a process of re-functioning and development to enable persons with disabilities to perform their social functions properly/normally in social life. (Paragraph 2, Article 1)
  - The rehabilitation institute for persons with disabilities shall be the Social Welfare Organization to supply social rehabilitation to persons with disabilities. (Paragraph 4, Article 1)
  - The medical rehabilitation covers recovering/improving the health condition of persons with disabilities, purchasing/supplying assistive instruments and/or reducing physical burdens. (Article 4)
  - The social rehabilitation for persons with disabilities covers a) social guidance, b) fulfillment of major necessities, c) provision of professional skills, d) education, e) granting

aid/fund/facility, and f) capacity development. (Article 6)

- The social guidance is given to persons with disabilities in and outside the Social Welfare Institutions. (Paragraph 1, Article 7)
- The fulfillment of major necessities for persons with disabilities includes supporting to have accesses to a) food, b) clothes, c) housing, d) health services, e) education, and f) employment. (Article 8)
- The rehabilitation institute for persons with disabilities can be established by the government or any social agency. (Paragraph 1, Article 17)
- Persons with disabilities rehabilitated or possible to fulfill conditions for working can be employed in a certain work field: a) any level of government or private enterprise, b) reemployment by the initial/former employer, or c) self-employment or returning home in accordance with their skills, levels of education, ability and job opportunities available. (Article 18)
- In case of a) or b) mentioned above, further arrangement for employment shall be done under the responsibility of the Minister of Manpower. (Article 19)
- In case of c) in the Article 18, further arrangement and assistance for implementation of working, including assistance to purchase/lend equipment for the work, shall be done under the responsibility of the Minister of Social Affairs. (Paragraph 2, Article 20)
- In case of c) in the Article 18, further arrangement and assistance for implementation of working, including assistance to purchase/lend equipment for the work, will be done under the responsibility of the Minister of Social Affairs. (Article 20)
- Any agency that operates Social Welfare services, including social rehabilitation, for persons with disabilities is eligible for subsidy. (Article 24)
- Any policy of social welfare undertaken for persons with disabilities shall be stipulated by the Minister of Social Affairs based on the grand policy outlined by the government. (Paragraph 1, Article 27)

➢ **Law on Social Protection Systems** (Law No. 40, 2004):

This law obliges the nation to build and provide comprehensive and universal systems of social protection aimed at all citizens, including persons with disabilities.

The framework of social protection systems in Indonesia is stipulated by the law. More concretely, 5 social protection modules: (i) benefit of medical support, (ii) compensation for occupational injury, (iii) assistance for the elderly, (iv) pension, and (v) death security are outlined.

- Definition of the physical disability: functional loss or restriction on the body/limbs. (Paragraph 15, Article 1)
- Stipulation on “total disability.” That is, the person who cannot control his/her activities according to one’s own will is exempted from payment of health insurance premium. (Paragraph 16, Article 1; Paragraph 3, Article 21)

- The registration procedures for the social protection systems, rates of social insurance premium and benefit, management and operations of the social pension fund, etc., will be stipulated by other special laws. (Article 33; Paragraph 4, Article 34; Paragraph 5, Article 37; Paragraph 3, Article 38; Paragraph 2, Article 42; Paragraph 3, Article 45; Paragraph 4, Article 46)

➢ **Social Welfare Law** (Law No. 5, 2009):

- Persons with disabilities as priority targets of social welfare, as well as the poor and the disaster victims. (Paragraph 2, Article 5)
- Stipulating persons with disabilities defined by the Law on Persons with Disabilities, (i) persons with physical disabilities, (ii) persons with mental disabilities, (iii) persons with physical and mental disabilities, are institutionally covered by social welfare. (Paragraph 1, Article 9)

➢ **Poor Law** (Law No. 13, 2011) :

Although there is no direct statement concerning disabilities, this law is important in terms of stipulating regulations on social benefits to be delivered to the poor persons with disabilities.

➢ **Law on Ratification of CRPD** (Law No. 19, 2011):

The keynote objectives of the law are (i) introduction of CRPD by posting all the provisions translated into Indonesian, and (ii) public announcement of ratification and observation of CRPD by the government.

2) Labor

➢ **Constitution** (UUD, 1945):

- Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)
- Recognition of the right to exist: “Every person shall have the right to live and to defend his/her life and existence.” (Article 28A)
- Recognition of equal treatments for all citizens in terms of employment, labor, compensation, and labor-management relations. (Paragraph 2, Article 28D)
- “Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment.” (Paragraph 2, Article 28I)

➢ **Law on Persons with Disabilities** (Law No.4, 1997):

- “Persons with disabilities are equally required to fulfill their obligations to society and nation. The content and extent of their contributions are changeable, however, based upon their educational background and degree of disabilities.” (Article 7)
- Securing accessibility of all persons with disabilities by construction of disability-inclusive society. This is presented in the integrated and sustainable form/manner by the government. (Article 10)

- Recognition of the persons with disabilities' rights to work and to live ordinary and peaceful lives according to their degree of disabilities and educational backgrounds. (Paragraph 2, Article 6; Paragraph 2, Article 12)
- "Every persons with disabilities has the right of equal employment opportunity, depending upon the type and degree of the one's disability." (Article 13)
- "State and private enterprises shall provide equal opportunities and treatment for persons with disabilities on occasion of hiring employees. Determination of employment is made by the employer with reference to the type and degree of disability, education, qualification and ability of the candidates." (Article 14)
- Stipulation on awarding organizations, enterprises, communities and individuals that made some contributions to the social protection for persons with disabilities. (Article 27)
- "Enterprises that employ more than 100 personnel, or the ones with total number of employees even less than 100 but related to the advanced technology, regardless of the public enterprises/ private companies, must employ persons with disabilities at least 1% of employment as long as they meet the prerequisite conditions and eligibility of the business." (Article 14, Explanation)

➢ **On Social Welfare for Persons with Disabilities** (Government Regulation No.36, 1980):

- The social rehabilitation for persons with disabilities covers a) social guidance, b) fulfillment of major necessities, c) provision of professional skills, d) education, e) granting aid/fund/facility, and f) capacity development. (Article 6)
- The fulfillment of major necessities for persons with disabilities includes supporting to have accesses to a) food, b) clothes, c) housing, d) health services, e) education, and f) employment. (Article 8)
- Persons with disabilities rehabilitated or possible to fulfill conditions for working can be employed in a certain work field: a) any level of government or private enterprise, b) reemployment by the initial/former employer, or c) self-employment or returning home in accordance with their skills, levels of education, ability and job opportunities available. (Article 18)
- In case of a) or b) mentioned above, further arrangement for employment shall be done under the responsibility of the Minister of Manpower. (Article 19)
- In case of c) in the Article 18, further arrangement and assistance for implementation of working, including assistance to purchase/lend equipment for the work, shall be done under the responsibility of the Minister of Social Affairs. (Paragraph 2, Article 20)

3) Education

➢ **Constitution** (UUD, 1945):

- Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)
- "Every child shall have the right to live, to grow and to develop, and shall have the right to protection from violence and discrimination." (Paragraph 2, Article 28B)

- "Every person shall have the right to develop him/herself through the fulfillment of his/her basic needs, the right to get education and to benefit from science and technology, arts and culture, for the purpose of improving the quality of his/her life and for the welfare of the human race." (Paragraph 1, Article 28C)
- "Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment." (Paragraph 2, Article 28I)
- "Every citizen has the right to receive education." (Paragraph 1, Article 31)
- "The state shall prioritize the budget for education to a minimum of 20% of the State Budget and of the Regional Budgets to fulfill the needs of implementation of national education." (Paragraph 4, *Ibid.*)
- "Impoverished persons and abandoned children shall be taken care of by the State." (Paragraph 1, Article 34)

➢ **Law on Persons with Disabilities** (Law No.4, 1997):

- "All persons with disabilities have the right to get education at all levels, of all kinds and via all media." (Paragraph 1, Article 6)
- Recognition of the right that children with disabilities possess to develop their talent and ability, and to improve their social lives at home and in society. (Paragraph 6, *Ibid.*)
- "Persons with disabilities are equally required to fulfill their obligations to society and nation. The content and extent of their contributions are changeable, however, based upon their educational background and degree of disabilities." (Article 7)
- Securing accessibility of all persons with disabilities by construction of disability-inclusive society. This is presented in the integrated and sustainable form/manner by the government. (Article 10)
- "Each educational institution provides equal opportunities and treatment for persons with disabilities as learners at school for any medium, kind, and level of education, according to the type and degree of their disability and ability." (Article 12)
- Recognition of the rights of persons with disabilities to work and to live ordinary and peaceful lives according to their degree of disabilities and educational backgrounds. (Paragraph 2, Article 12)

➢ **On Social Welfare for Persons with Disabilities** (Government Regulation No.36, 1980):

- Objectives of social rehabilitation to be rendered to persons with disabilities shall include (a) promotion of the social participation, (b) fulfillment of the needs of persons with disabilities needs of living, (c) professional skills, (d) provision of assistance/finance/facilities, (e) education, and (f) support for the access to the employment opportunities. (Article 6)
- Persons with disabilities who finished the rehabilitation curriculum at the officially specified institutions shall be eligible to be employed according to his/her skills, educational standard, abilities and job opportunities. (Article 18)

- **Law on National Educational Systems** (Law No. 20, 2003):
  - "Special education covers persons with (i) physical disabilities, (ii) disorders on mind/ intelligence, and/or (iii) impairment of social adjustment." (Paragraph 2, Article 5; Article 32)[33]
  - "Education administrated by the nation is categorized into (i) general education, (ii) vocational education (moderate level for commerce), (iii) academic education, (iv) professional education, (v) vocational education (advanced), (vi) religious education, and (vii) special education." (Article 15)

- **On Special Education** (Government Regulation No. 72, 1991):
  - Recognition that special education is for persons with physical or mental disabilities. (Paragraph 1, Article 1)
  - Special education institutes are composed of (i) special primary schools, (ii) special secondary schools, and (iii) special high schools. As for other institutes/organizations relevant to special education, the Minister of Education and Culture will notice particular assignment. (Article 4)
  - Special education institutes are responsible for being equipped with rehabilitation facilities as well as classrooms, textbooks, assistive educational tools for instructors. (Article 7)
  - Students have the right to receive education appropriate for their talent, interest, and degree of disabilities. (Article 18)
  - Rehabilitation is one of the necessary social skills for students at the special education institutes, as well as a part of medical practice, to live their social lives smoothly. (Article 29)

- **Child Welfare Law** (Law No. 23, 2002):
  - The government has the obligation for all children to arrange and supply compulsory education of nine years and make them receive the education. (Article 48)
  - Children with disabilities equally have the right to receive general and professional education. (Article 51)
  - The government shall support the children (i) of poor families, (ii) having some living/social difficulties, and (iii) residing in remote areas by total or partial payment for their educational costs. (Article 53)

【Reference: Regulations by the East Java Provincial Government】

- **On Protection of Persons with Disabilities and Relevant Services** (Provincial Act No.3, 2013):
  - Managers/operators of educational institutions and suppliers of educational services are obliged to (i) provide opportunities of education, at any level and on any theme, for all children with disabilities, (ii) arrange educational contents according to the type and degree of their disabilities. (Paragraphs 1 and 2, Article 10)

[33] And the "Special Education Service" stipulated in the law is not for persons with disabilities, but for "the nations residing in the remote or undeveloped areas." (Paragraph 3, Article 5)

- Education providers may launch inclusive education by their own judgment, on the occasion, however, it is necessary to deploy both specialized instructors and counselors with experience and competence adequately in the program. Also, if the number of children with disabilities who attend the class is not worth the implementation of inclusive education, education providers are responsible for coordination with other educational institutions to develop appropriate educational environment for students. (Paragraph 1 to 3, Article 11)
- Recognition of the right of freedom for students to select educational institutes, classes, and academic credits. (Article 12)

4) Health

- **Constitution** (UUD, 1945):
  - Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)
  - Recognition of the right to exist: "Every person shall have the right to live and to defend his/her life and existence." (Article 28A)
  - Recognition of the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment, and to obtain medical care. (Paragraph 1, Article 28H)
  - "Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment." (Paragraph 2, Article 28I)

- **Health Law** (Law No. 36, 2009):
  - Disability as an object for public health/medical care. (Paragraph 14, Article 1)
  - Every citizen equally has the right to have an access to information on public health and education. (Article 7)
  - Stipulation on emergency medical service as a preventive medical care of disabilities ("Regardless of private/public, any medical institution is prohibited to reject providing medical service in case of emergency"). (Paragraph 1, Article 32)
  - Recognition of the right for patients to pursue responsibility for damages caused by medical malpractice(s). As for a result of emergency medical treatment at the time of disaster, however, claim for the damage of residual disability shall be declined. (Article 58)
  - Prohibition of abortion. It is exempted, however, in case that (i) the pregnancy threats mother's life and (ii) the baby has heavy genetic disease or disability. (Paragraphs 1 and 2, Article 75)
  - The central government, local governments, and communities shall be in charge of medical treatments and provisions/arrangements of facilities necessary for the case of emergency, such as natural disasters. Emergency medical treatments include life-saving activities to avoid the risk of victim's decease and to get impaired. (Paragraph 1 to 3, Article 82)

- Persons engaged in the medical care as part of the disaster management shall assign high priority to (i) survival of victims/patients, (ii) prevention of residual disabilities to victims/ patients, and (iii) maximization of health benefit for victims/patients. (Paragraph 1, Article 83)
- At the time of disaster, all resources relevant to public health and medical care, regardless of public or private, shall be mobilized for life-saving of victims and to prevent them from residual disabilities. (Paragraph 1, Article 85)
- Stipulation on the realization of persons with disabilities' healthy and productive socio-economic life, paying sufficient attention to the dignity of persons with disabilities. (Paragraph 1, Article 139)
- Stipulation on the responsibility of the central government, local governments, and communities to provide medical institutes/facilities necessary for achieving the objective mentioned above. (Paragraph 2, *Ibid.* and Article 140)
- The first statutory law on the mental health (Article 144 to 151)
- If violating the regulations mentioned in Article 85 (obligation to mobilize all health/medical resources), the penalty of (i) imprisonment of two years or less, or (ii) fine up to IDR 2 million shall be imposed. And as a result that the victim/patient was killed or got residual disabilities, the penalty of (i) imprisonment of ten years or less, or (ii) fine up to IDR 1 billion shall be imposed. (Paragraphs 1 and 2, Article 190)

➢ **On Social Welfare for Persons with Disabilities (Government Regulation No.36, 1980)**

- Rehabilitation is a process of re-functioning and development to enable persons with disabilities to perform their social functions properly/normally in social life. (Paragraph 2, Article 1)
- The medical rehabilitation covers recovering/improving the health condition of persons with disabilities, purchasing/supplying assistive instruments and/or reducing physical burdens. (Article 4)
- The fulfillment of major necessities for persons with disabilities includes supporting to have access to a) food, b) clothes, c) housing, d) health services, e) education, and f) employment. (Article 8)

➢ **Mental Health Law** (Law No. 18, 2014):

Contents of this law has been partially inherited from the Health Law and become more comprehensive, by including concepts of and stipulation on mental disorders. Autism and Autistic Spectrum Disorders (ASD) are, however, not discussed in the provisions.

5) Public Construction and Transportation

➢ **Constitution** (UUD, 1945):

- Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)

- Recognition of the right to exist: "Every person shall have the right to live and to defend his/her life and existence." (Article 28A)
- "Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment." (Paragraph 2, Article 28I)

➢ **Law on Persons with Disabilities** (Law No.4, 1997):

- Securing accessibility of all persons with disabilities by construction of disability-inclusive society. This is presented in the integrated and sustainable form/manner by the government. (Article 10)

Since the following four transportation-oriented laws had been considered to be insufficient in terms of stipulation on the accessibility, "Law on Road Traffic and Transportation," to be described later, was enacted in 2009 in order to supplement the shortage of the four preceding laws.

➢ **Railway Law** (Law No. 13, 1992):

- Persons with disabilities and victims of disease shall be of special treatment in transit on the railway. (Paragraph 1, Article 35)

➢ **Law on Traffic and Ground Transportation** (Law No. 14, 1992)

- Persons with disabilities shall be of special treatment in the traffic and in transit on the ground transportation. (Paragraph 1, Article 49).

➢ **Aviation Law** (Law No.15, 1992):

- Persons with disabilities and victims of disease shall be of special treatment by flight service providers. (Paragraph 1, Article 15)

➢ **Law on Navigation of Vessels** (Law No.21, 1992)

- Persons with disabilities and victims of disease shall be of special treatment in transit on and under the water. (Paragraph 1, Article 83)

➢ **Building Law** (Law No. 28, 2002):

- Following high priorities shall be assigned to the construction of the building: (i) safety, (ii) health consideration, (iii) amenity, and (iv) convenience. (Article 3)
- Stipulation on the necessity of securing safe, convenient, and easy access to the building, especially for persons with disabilities and the elderly. (Paragraph 2, Article 27)
- All conditions mentioned above shall be applied to all the buildings, except for the private housing. (Article 31)

➢ **Technical Guideline of Accessibility on Building and Environment** (Government Regulation No.36, 2006)

- Stipulation on the accessibility standard of public restroom, parking, public space, public phone facility, Braille block, signs/marks, entrance/exit, slope, elevator, etc., especially for persons with disabilities and the elderly.

- **Law on Road Traffic and Transportation** (Law No. 22, 2009):
  - Accessibility to the public transportation, paying attention to the users' convenience, shall be secured at the station/stop. (Paragraph 2, Article 37)
  - The central government, local governments, and enterprises relating to public transportation/ traffic are responsible for the provision and arrangement of accessibility, relevant services, facilities and equipments, paying attention to persons with disabilities, children, pregnant women, the sick and the injured. (Paragraphs 1 and 2, Article 242)

【Reference: Regulations by the East Java Provincial Government】

- **On Protection of Persons with Disabilities and Relevant Services** (Provincial Act No.3, 2013):
  - Provision of accessibility indicates environmental arrangement for persons with disabilities to enjoy smooth and hospitable social life. (Paragraph 11, Article 1)
  - The provincial government, enterprises, and society shall be responsible for the provision of accessibility to public facilities and social infrastructure for persons with disabilities. (Paragraph 1, Article 58)
  - The public facilities and social infrastructure mentioned above include public buildings, road, park and cemetery, transportation facilities (ground, water, and air). (Article 59)

6) Gender

- **Constitution** (UUD, 1945):
  - <u>Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)</u>
  - <u>Recognition of the right to exist: "Every person shall have the right to live and to defend his/her life and existence." (Article 28A)</u>
  - <u>Recognition of the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment, and to obtain medical care. (Paragraph 1, Article 28H)</u>
  - <u>"Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment." (Paragraph 2, Article 28I)</u>

- **Persons with Disabilitiess (PWD) Law** (Law No.4, 1997):
  - <u>Securing accessibility of all persons with disabilities by construction of disability-inclusive society. This is presented in the integrated and sustainable form/manner by the government. (Article 10)</u>

- **Marriage Law** (Law No.1, 1974)

There is almost no statement to urge consideration on gender issues. In some parts, rather, discriminative ideas are codified in provisions as seen below.

- Once the wife has got a residual disability or an incurable disease, the court may give a permission to the application of divorce from the husband. (Item 2, Paragraph 2, Article 4)

- **On the Protection and Empowerment of Women and Children in Social Conflict** (Presidential Decree No.18, 2014)

Throughout the whole provisions, women and children are regarded as so-called "socially vulnerable," and the necessity of support/rescue when they are involved in the social conflict, including domestic violence and abuse are mentioned and stipulated.

  - The central government, relevant ministries, and local governments are responsible for the protection and empowerment of women and children. (Paragraph 1, Article 3)

- **On the Ministry of Women's Empowerment and Child Protection** (Presidential Decree No.59, 2015)

It is the latest regulations on the Ministry's roles, functions, organizations, etc.

  - The Ministry of Women's Empowerment and Child Protection shall control the administration relevant to the empowerment of women and children and, by so doing, operationally support national projects conducted by the Executive Office of the President. (Article 2)

7) Political Participation

- **Constitution** (UUD, 1945):
  - The People's Consultative Assembly (MPR) is composed of representatives, elected through general elections, of the People's Representative Council (DPR) and the Regional Representative Council. (DPD) (Paragraph 1, Article 2)
  - The President and Vice-President shall be elected as a pair directly by the people. (Paragraph 1, Article 6A)
  - The authorities of the provinces, regencies and municipalities shall include each Regional People's House of Representatives (DPRD) whose members shall be elected through general elections. (Paragraph 3, Article 18)
  - Members of the DPR shall be elected through a general election. (Paragraph 1, Article 19)
  - The members of the DPD shall be elected from every province through a general election. (Paragraph 1, Article 22C)
  - <u>Equality of all citizens before the law and government. (Paragraph 1, Article 27 and Paragraph 1, Article 28D)</u>
  - <u>"Every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment. (Paragraph 2, Article 28I)</u>

- **Law on Implementation of the General Election** (Law No.22, 2007)
  - Stipulation that the presence or absence of disability can never be a factor of the eligibility to be a member of the National Election Commission (KPU). (Paragraph 8, Article 11, Explanation)

- Stipulation that the presence or absence of disability can never be a factor of the eligibility to be a member of the National Election Supervisory Board (BAWASLU), the Provincial/ Municipal/Regional Election Supervisory Committee (PANWASLU). (Paragraph 8, Article 86, Explanation)

➢ **Law on Election of DPR, DPD and DPRD** (Law No.10, 2008)

- Stipulation that the presence or absence of disability can never be a factor of the eligibility to be a candidate of the DPR, DPD or Provincial/Municipal/Regional DPRD. (Paragraph 4, Article 50, Explanation)
- Of the necessary items for the election, stated at the Paragraph 2, Article 142 of the main text, "polling supporting tools/facilities" include aid devices for the persons with visual impairment. (Paragraph 2, Article 142, Explanation)
- Voters with visual impairment, quadriplegia or other physical disabilities can ask and obtain appropriate assistance from others at the polling stations. (Paragraph 1, Article 156) And the supporter shall be to follow the voter's will. (Paragraph 2)
- In case that the supporter, provided in the Article 156, betrayed and intentionally led the voter to vote for the different candidate from the one initially the voter intended to vote for, the supporter shall be imprisoned at least for three months but less than 12 months, or fined three million rupiahs or more but not exceeding 12 million rupiahs. (Article 295)

➢ **Law on General Election of President and Vice President** (Law No.42, 2008)

- Of the necessary items for the election, stated at the Paragraph 1, Article 105 of the main text, "polling supporting tools/facilities" include aid devices for the persons with visual impairment. (Paragraph 2, Article 105, Explanation)
- Voters with visual impairment or other physical disabilities that may disturb the voters' activities can ask and obtain appropriate assistance from others at the polling stations. (Paragraph 1, Article 119) And the supporter shall be to follow the voter's will. (Paragraph 2)
- In case that the supporter, provided in the Article 119, betrayed and intentionally led the voter to vote for the different candidate from the one initially the voter intended to vote for, the supporter shall be imprisoned at least for 3 months but less than 12 months, or fined three million rupiahs or more but not exceeding 12 million rupiahs. (Article 241)

3.4.2 National Development Plan

The national development plan of Indonesia is composed of "Long-term Plan (*Rencana Pembangunan Jangka Panjang Nasional*: RPJPN)" (the latest version is of 2005-2025) and "Medium-term Plan (*Rencana Pembangunan Jangka Menengah Nasional*: RPJMN)" (latest: 2015-2019) formulated by the State Ministry of National Development Planning (*Badan Perencanaan Pembangunan Nasional*: BAPPENAS). And "Annual Action Plan (*Rencana Kerja Pemerintah*: RKP)" based upon the above national development plan also exists.

Since around the time of the CRPD ratification in 2011, with the improvement of attentive consciousness for the disability within the government and the activation of educational campaign for the nations, it is eventually determined that the data collection/development goals concerning disabilities are included in the national census conducted in 2010 and the next RPJMN after 2015.

Within the "Sectoral Issues" of RPJMN 2015-2019, the planning concept targeting persons with disabilities and the elderly are brought forth in all aspects of strategic arguments relevant to, such as, social protection, priority development goals, direction of development policies, and institutional development. The following is the overview by each discussion related to disabilities within the contents of RPJMN.

[Strategic Target: Improvement of Accessibility][34]

- Persons with disabilities who do not have sufficient opportunities to participate in society at present have the right and possibility to contribute to national development.
- The improvement of persons with disabilities' financial/social accessibility extends the period of productive age in each of their lives, and it becomes an important key in creating an opportunity for each person to gain an individual livelihood.

[Priority Development Goals: The Realization of a Disability-inclusive Society][35]

- The provision of disability-inclusive public services and development of social systems/ environmental systems to make it possible.
- Increasing the number of cities/regions where the disability-inclusive development, based upon proper regulations, can be practiced.
- The establishment of an integrated social rehabilitation system that the central and local governments, communities, and citizens are all related to and able to participate in.

[Direction of Developmental Policy: Promotion of a Disability-inclusive Society] [36]

- As necessary conditions for promoting social inclusion in every aspect of the entire livelihood of persons with disabilities, the following factors are presented:
  - The improvement of advocacy through public services based upon proper regulations and policies, and the implementation of disability-inclusive programs (examining the expansion of inclusion of persons with disabilities in the process of development planning and budget compilation at the central and local government levels).
  - The improvement of the social protection for the poor persons with disabilities. Specifically, vocational training programs, increase of job opportunities, financial empowerment, and credit accommodation (providing access to financing for persons with disabilities).
  - The development of equipments/facilities, mechanisms, and human resources relevant to public services (including improvement of care technology for persons with disabilities and inclusive educational management technology) have been raised.

[34] RPJMN 2015-2019, p.2-67.
[35] *Ibid.*, p.2-88.
[36] *Ibid.*, p.2-123/124.

[Development of Regulations and Organizational Framework: Institutional Arrangements for the Improvement of Welfare for persons with disabilities][37]

i) Legislative Arrangement: (a) Revision of Law No. 4 of 1997 (Law on Persons with Disabilities) based upon Law No. 19 of 2011 (Law on Ratification of CRPD) and Law No. 13 of 1998 (Welfare Law for the Elderly); (b) Preparation of national action plan targeting persons with disabilities and the elderly; (c) Development of regulations strengthening the cooperation/coordination between ministries and government offices at all the central/local government levels with the goal of the improvement of human capacities concerning the execution of the social protection services; (d) Setting of legal provisions at the local level that propels/protects disability inclusion

ii) Development of Organizational Framework: (a) Expansion of the medical-care introduction system and the integrated service system that measures the need and situation of every region, promotes the inclusion of persons with disabilities and the elderly, and eventually contributes to the improvement/prevalence of social protection nationwide; (b) Development/expansion of institutions relevant to the social protection through the settlement of the minimum service level, expansion of facilities, qualitative improvement of social-protection field education and advancement of the qualification systems, and the diversification of each supporting activities; (c) the qualitative standard setting of social protection services and strengthening of the supervisory systems including penalties and rewards for the staff.

Furthermore, as for one of the goals of the legislative arrangement in i), the revision process of Law on Persons with Disabilities is currently underway. The draft of the provisions has been mostly completed, and discussions will be held at the assembly in September this year. It is expected to be approved and come into effect in December[38].

In addition, separate from the medium-term plan, "National Action Plan for Human Rights" (tentative title) that specializes in consideration/protection of the rights of "vulnerable people" such as not only persons with disabilities, but also the elderly, children, women, ethnic minorities, and the poor. Clerical works necessary for the administrative procedures are almost completed, and the cabinet secretariat is about to establish the law as a presidential promulgation[39].

[37] *Ibid.*, p.2-137.
[38] Based on the interview with BAPPENAS. (June 3, 2015)
[39] (ditto.)

3.4.3 Outline of the Government Organizations on Disability Issue

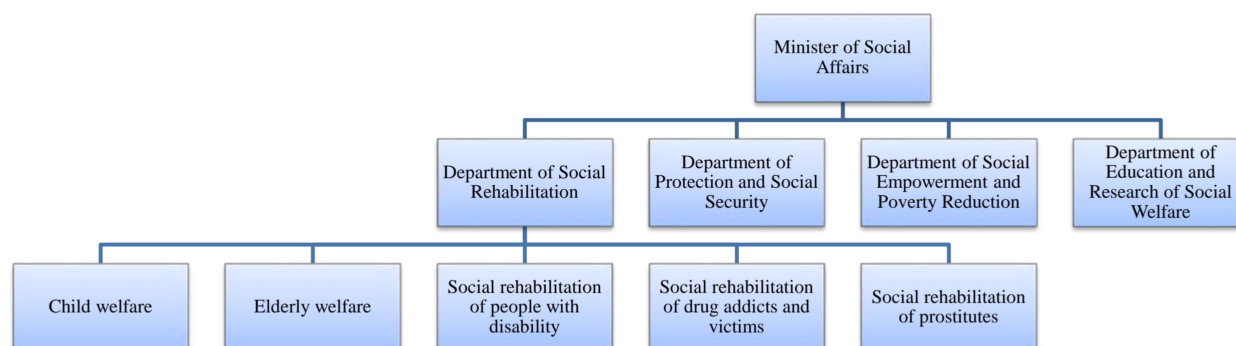
(1) Ministry of Social Affairs (*Kementerian Social*: KEMSOS))

1) Outline of the Organization

The Ministry of Social Affairs (*Kementerian Social*: KEMSOS) is responsible for the welfare of women, the elderly, street children, and social assistance as well as the social welfare of persons with disabilities. It is the focal point in the disability field in instituting the following programs:

- Policy development related to disability [40]
- Improvement and implementation of programs related to disability[41]
- Play a coordinating role between other ministries and agencies in developing/implementing programs related to disability[42]

As shown in Figure 3-2, KEMSOS has four General Directorates of which, the Directorate for Social Rehabilitation oversees the disability field. The Directorate for Social Rehabilitation has five departments (child welfare, elderly welfare, rehabilitation of persons with disabilities, rehabilitation of drug addicts and victims, and rehabilitation of prostitutes). The Department of Rehabilitation of Persons with Disabilities is directly responsible for disability issues.



(Source: the Survey team based on the material from KEMSOS)

Figure 3-2 Organizational Structure of KEMSOS (Disability Related Divisions)

Other departments within the directorate do not have personnel in-charge of disability but work closely with and coordinate with the Department of Social Rehabilitation. Reorganization is planned in August 2015, where a focal person within the Department of Social Protection will be assigned to disability issues. As of July 2015, this person is still being selected[43].

The Department of Social Rehabilitation of Persons with Disabilities focuses on the following three points in implementing its programs:

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[40] 2015 President Regulation No. 46, Regulations on the Ministry of Social Affairs, Article 10 No. 1
[41] 2015 President Regulation No. 46, Regulations on the Ministry of Social Affairs, Article 10 No.2 and the 1998 Government Regulation Article No. 43, Regulations on the Revision of Social Protection for Persons with Disabilities
[42] 2015 President Regulation No. 46, Regulations on the Ministry of Social Affairs, Article 34
[43] Based on the interview with KEMSOS (29 June 2015). An interview with the Directorate of Social Protection was not conducted; the demarcation of responsibilities between those directorates remains uncertain.

- Social Protection System (management of facilities and cash benefits for persons with disabilities) (refer to Section 3.6.4)
- Promotion of Community-based Rehabilitation (CBR) programs (refer to Section 3.6.4)
- Implementation of outreach type rehabilitation (refer to Section 3.6.2)

Other programs offered are provision of assistive devices (refer to Section 3.6.4), capacity building for families of persons with disabilities, promotion of employment of persons with disabilities, outreach for persons with disabilities in emergency situations (organization of first response team), management of the vocational training schools, as well as awareness-raising activities. Examples of awareness-raising activities are public speeches, events to celebrate the International Day of Disabled Persons (3 December) (for example a walk-together with persons with disabilities (Fun Walk) (held simultaneously in major cities all over the region)), national radio broadcasts (*Radio Republik Indonesia:* RRI), the National Solidarity Day, as well as a regular program on disability every Saturday on RRI.

2) Roles of the Central and Regional Levels and Interagency Cooperation

<Central/Region Role>
The central government is responsible for policy development at the central level. Provincial governments, if such policies at the national level have been issued, are expected to bridge the gap between the central and local governments by issuing separate provincial government rules. For example, Provincial Rule No. 3 on disability was issued in 2009 by the East Java Provincial Government. In Indonesia, decentralization started in earnest in 2001, but progress on systems and program development for disability varies between the provinces. One reason given is the Decentralization Law of 1999, Article No. 22 (Local Government Act) and the 1999 Article No. 25 (Central and Regional Level Fiscal Balance Act), which means the provincial governments are not allowed to force municipal governments to implement provincial regulations. For municipal governments to implement provincial regulations, it must issue its own set of rules. However, most municipal governments do not have a budget to issue local level rules.

<Budget>
The central government, provincial governments, and local governments all have a budget allocated for disability. In other words, a budget is allocated to the provincial and local governments by the central government. Allocation amounts are determined by the financial status of the government. Revenues differ from city to city (as consumption tax rates are set at the municipal level). If there is no budget for disability issues at the local level, the provincial government provides this budget. If there is no budget at the provincial government level, the central government supports the provincial government.

<Interagency Cooperation>
KEMSOS is the focal point for the disability field and is expected to coordinate with other associated ministries. The National Coordination Team of the Measure of Social Welfare Enhancement is responsible for interagency cooperation, coordination with other ministries and civil society, the private sector, and universities. The purpose of the National Coordination Team is to strengthen the welfare of persons with disabilities. The team was set up under KEMSOS in 2004. Regular meetings are held once a year and when

necessary. In documenting the implementation process of the CRPD, KEMSOS collects relevant information from other ministries and agencies and is responsible for reporting to the Ministry of Foreign Affairs.

3) Personnel

More than 4,000 staff works at KEMSOS but approximately 20 staffs are involved in disability issues or are assigned to the Department of Social Rehabilitation[44].

As of June 2015, there were 78 persons with disabilities working in relevant organizations of KEMSOS and the Departments of Social Affairs (*Dinas Social*: DINSOS) (In 2014, the number of staff with disabilities was at 59 people).

4) Budget

KEMSOS does not have a fixed annual budget for disability issues. The annual budget for disability issues changes according to current priorities and policies. For example, the total budget for KEMSOS in the fiscal year (FY) 2013 was IDR 6.5 billion (about 70 billion yen). In FY2014, the budget increased to IDR 7.6 billion (about 80 billion yen).

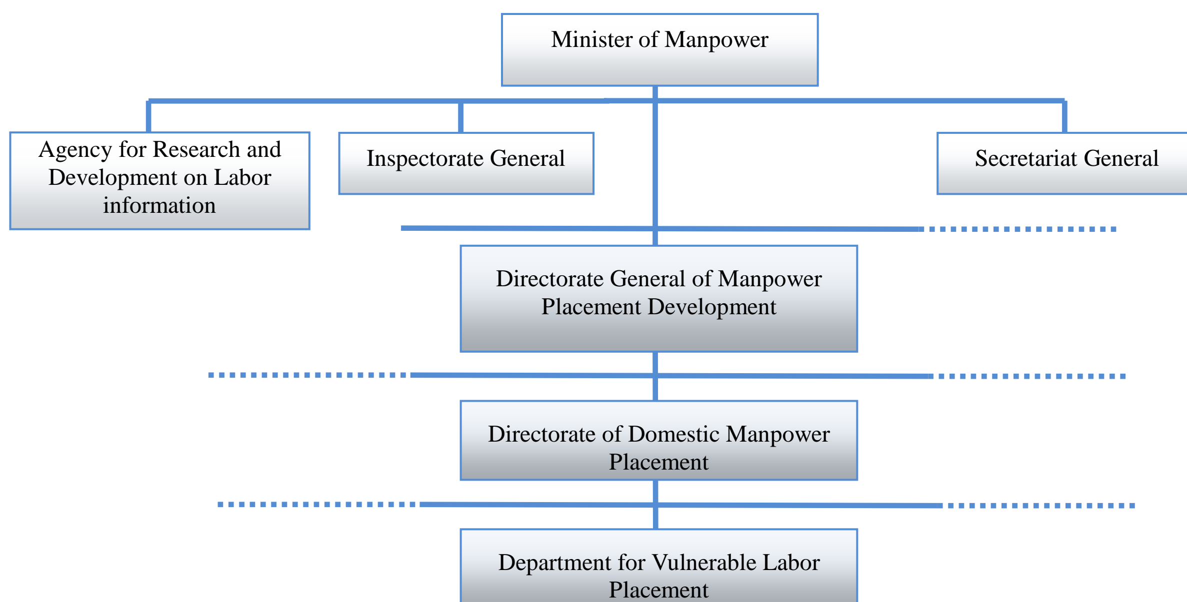
(2) Ministry of Manpower (*Kementerian Ketenagakerjaan*: KEMENAKER)

The roles and organizational missions of the Ministry of Manpower (Kementerian Ketenagakerjaan: KEMENAKER) are listed below and the organizational structure is shown in Figure 3-3[45]:

i) The establishment and implementation of labor policies (improvement of labor productivity and competitiveness, creation and stabilization of employment opportunities, and supervision and improvement of the working environment),
ii) Coordination among and management of (a) all the directorates/departments/sections within the ministry and (b) all the agencies relevant to the labor administration and services,
iii) Technical guidance and supervision related to the implementation of labor policies, and
iv) Survey, planning, and development in the field of labor administration.

Regarding employment promotion policies for persons with disabilities, the Department for Vulnerable Labor Placement, Directorate of Domestic Manpower Placement under the Directorate General of Manpower Placement is in charge.

[44] Based on interview with KEMSOS (29 June 2015)
[45] Regulations on the Ministry of Manpower (Presidential Decree No.18, 2015)



(Source: the Survey team based on the material from KEMNAKER)

Figure 3-3 Organizational Structure of KEMENAKER

(3) Ministry of Education and Culture (*Kementerian Pendidikan dan Kebudayaan*: KEMDIKBUD)

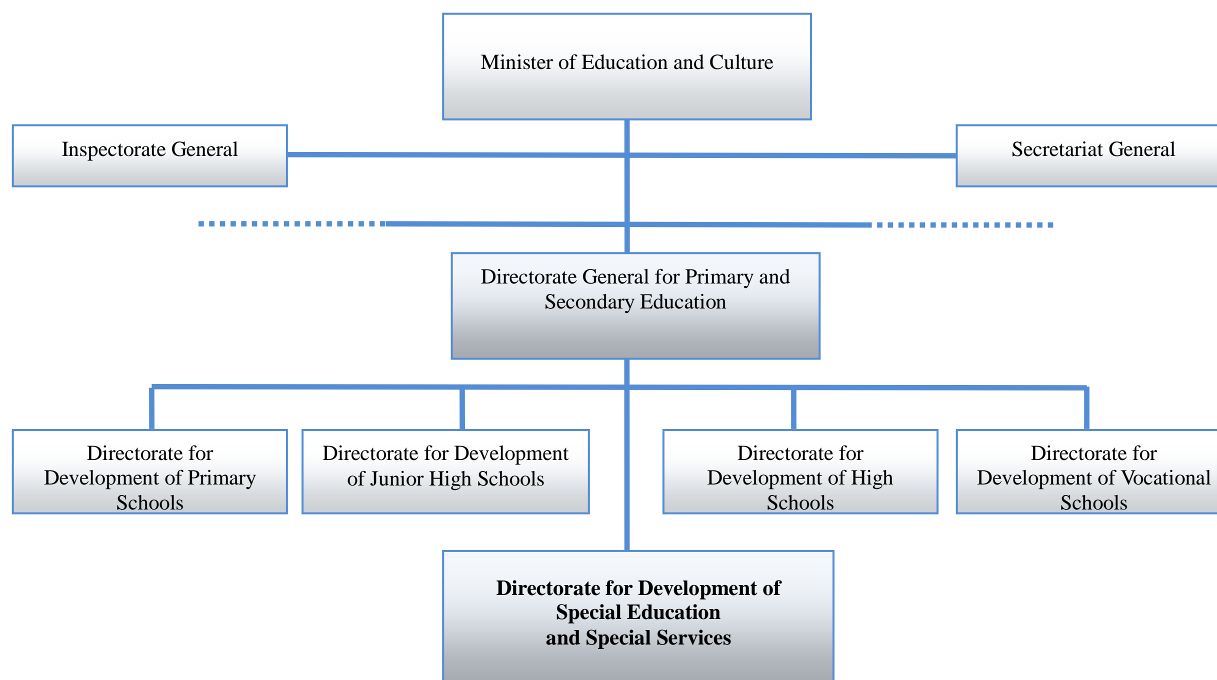
The Ministry of Education and Culture (*Kementerian Pendidikan dan Kebudayaan*: KEMDIKBUD, Figure 3-4) is a central government agency that oversees all of the administration and cultural administration related to early education (infants), primary education, secondary education, higher education, and each of the educational institutions in the country of Indonesia.

The roles and organizational missions of the ministry are as follows[46]:

i) The education of citizens and the establishment and implementation of policies related to culture
ii) Human resource development of teachers and instructors in educational institutions
iii) Making adjustments and management in the departments and all of the related institutions
iv) Technical guidance and supervision related to the implementation of educational/cultural policies
v) Development/instruction/protection related to the official language and documents

The educational system is the same as Japan, a 6-3-3-4 system, and the six years of primary school and three years of secondary school are compulsory education. The ministerial organization is basically structured according to the line of the educational system. In regard to the education for children with disabilities, it is under the Directorate for Development of Special Education and Special Services, the Directorate General for Primary and Secondary Education, which is arranged in parallel with the directorates of primary schools, secondary schools, high schools, and vocational schools.

[46] Act No. 14 of the Presidential Law of 2015, Regulations Related to KEMDIKBUD



(Source: the Survey team based on the material from KEMDIKBUD)

Figure 3-4 Organizational Structure of KEMDIKBUD

(4) Ministry of Health (*Kementerian Kesehatan*: KEMENKES)

1) Outline of the Organization

KEMENKES (Figure 3-5) is responsible for the formulation of the national health policy, its implementation, and evaluation. Departments (such as those in charge of mental health, polio, leprosy, maternal and child health, medical rehabilitation, assistive devices, prevention, etc.) have formulated guidelines concerning disabilities. KEMENKES has four General Directorates and ten departments. As for the administration concerning disability issues, the department in charge of the leprosy control functions as the focal point. The ministry has a disability working group which involves relevant departments and is supposed to hold annual meetings. However, due to budget constraints, coordination and partnering has not progressed as what was hoped for[47].

＜Medical Rehabilitation＞

Medical rehabilitation is under the control of the Division of Basic Nursing, Directorate of Nursing Care, KEMENKES.

＜Mental Health＞

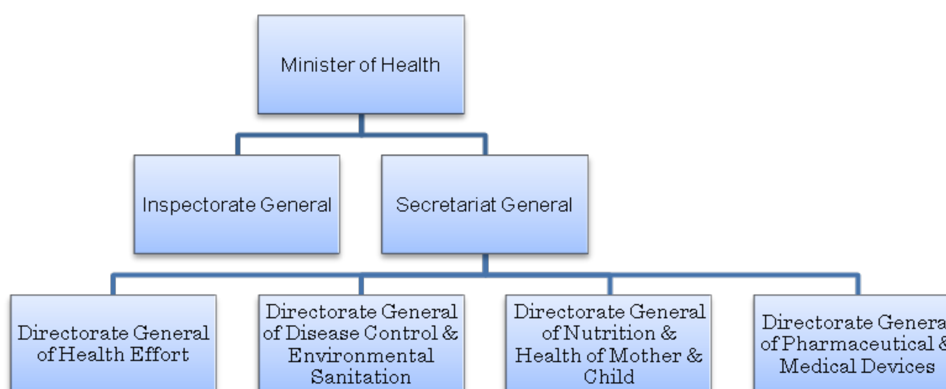
The Mental Health Department is responsible for mental health issues. Fifty personnel is spread in over five divisions working on a) drug abuse, b) mental health facilities, c) community mental health, d) mental health and high risk populations such as autistic persons, children, persons with Alzheimer's disease, women and children who have been victims of violence and minors, and e) assessment (development of

[47] Based on the interview with a WHO officer (9 July 2015)

teaching materials). There is no staff with disabilities. The FY 2014 budget for mental health was IDR 25 million which was spent on the operations of psychiatric hospitals.

＜Maternal and Child Health＞

The Division for Child Protection is responsible for children with disabilities (0 to 18 years old). It has created guidelines on how to treat children with disabilities for health centers.

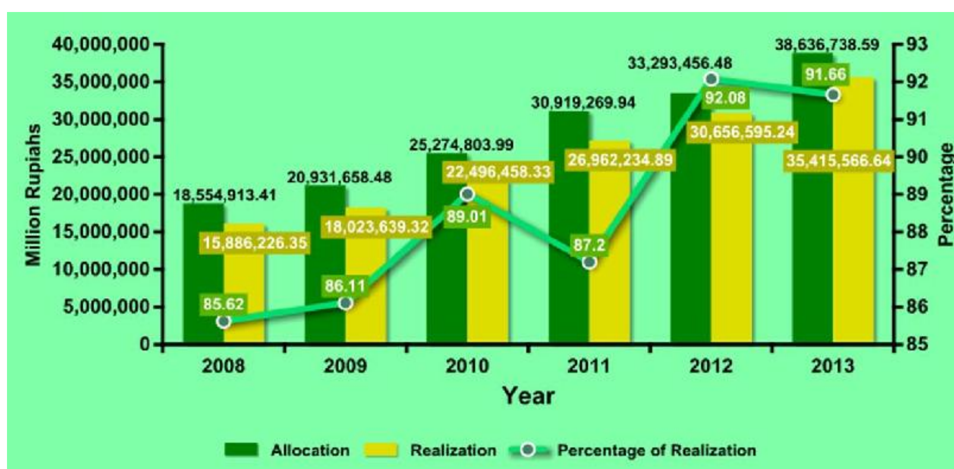


(Source: the Survey team based on the material from KEMENKES)

Figure 3-5 Organigram of KEMENKES (Disability Related Divisions)

2) Budget

The budget of KEMENKES has increased gradually from 2008. In 2013, it was 38.64 trillion Indonesians Rupiah (IDR), its actual expenditure was IDR 35.42 trillion (Figure 3-6). The largest amount allocated was IDR 25.27 trillion to the Medical Services Directorate. The amount distributed to disability issues is unknown.



(Source: Indonesia Health Profile 2013, KEMENKES)

Figure 3-6 Budget of KEMENKES and 2008-2013 Expenditure

(5) The National Team to Accelerate Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*: TNP2K)

The National Team to Accelerate Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*: TNP2K, Figure 3-7) was founded under the administration of former President Yudhoyono in February of 2010 in order to promote/enhance effectiveness of the policies relevant to the poverty reduction in Indonesia. It is a government agency under the immediate control of the vice president.

One of the most important goals of the TNP2K is resolving the inefficiencies of individual poverty reduction programs that have been implemented by each of the existing ministries. Specifically, (i) the establishment of comprehensive poverty reduction policies and programs at the national level, (ii) making adjustments with relevant ministries, (iii) the evaluation/monitoring of the effectiveness of poverty reduction programs, and (iv) the survey/analysis related to poverty reduction. A permanent staff is placed only at the office of the executive secretary, and selected officials who belong to the ministries/ government agencies relevant to specific issues concerning the poverty reduction occasionally participate in the thematic working group.

As for specific projects after 2011, ones (i) to improve the targeting of the main social protection programs and (ii) to improve the design of social protection policies as a whole, in particular, the construction of a comprehensive database of social protection programs can be listed. Furthermore, this team summarizes and organizes the laws and regulations concerning the rights of persons with disabilities, and also implements fact-finding surveys related to the social support for persons with disabilities in cooperation with the University of Indonesia[48].

Because TNP2K plays a significant part of the social protection systems (particularly the poverty database), it is an important institution for persons with disabilities. On the other hand, since it is an organization created under the previous administration and it does not fall in line with any of the other ministries, it is politically vulnerable, and there are voices that fear a decrease in future activities and influence[49].

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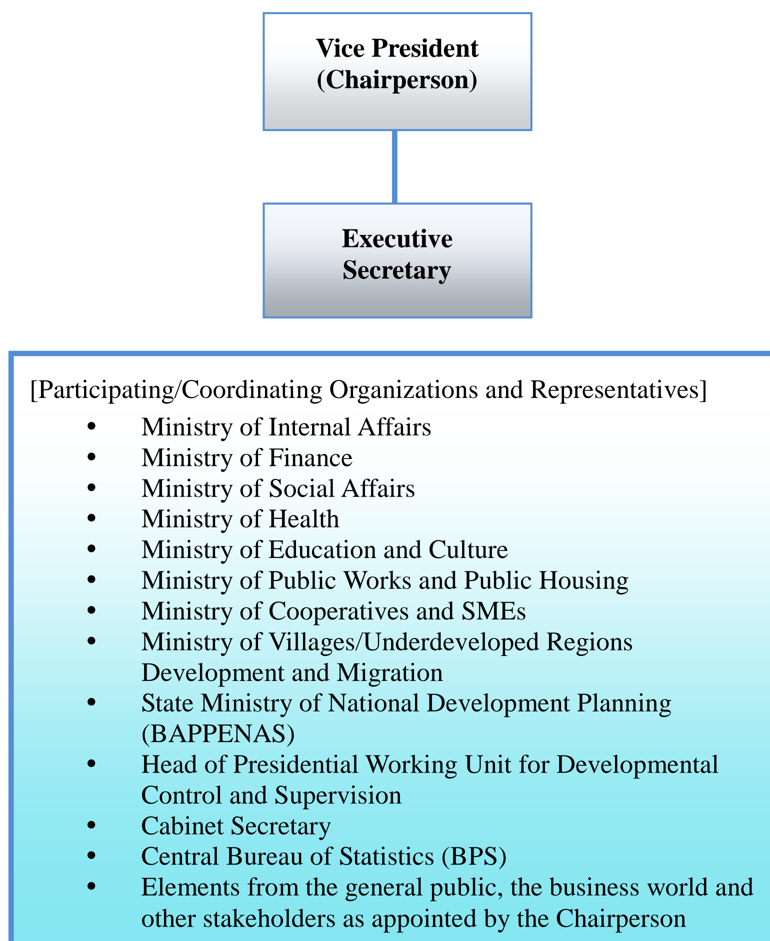
[48] The law was not created by TNP2K itself, but it is merely an organization of the related laws that exist. The document information related to disabilities created by the same team is as follows. All of the following can be downloaded from the TNP2K homepage (http://tnp2k.go.id/en): (i) A Guide to Disability Rights Laws (2014), (ii) The Life of Persons with Disabilities: An introduction to the Survey on the Need for Social Assistance Programs for Persons with Disabilities (2014), (iii) Persons with Disabilities in Indonesia – Empirical Facts and Implications for Social Protection Policies (2014). Furthermore, the results of the joint survey with the University of Indonesia is summarized in the Demographic Institute, Faculty of Economics and Management, University of Indonesia, *Survey on the Need for Social Assistance: Programs for People with Disabilities* (SNSAP-PWD) 2012 (as noted in 3.3.3 as a source material).

[49] The common opinion among both the central government and DPO (based on the interviews surveys).



(Source: the Survey team based on the material from TNP2K)

Figure 3-7 Organizational Concept of TNP2K

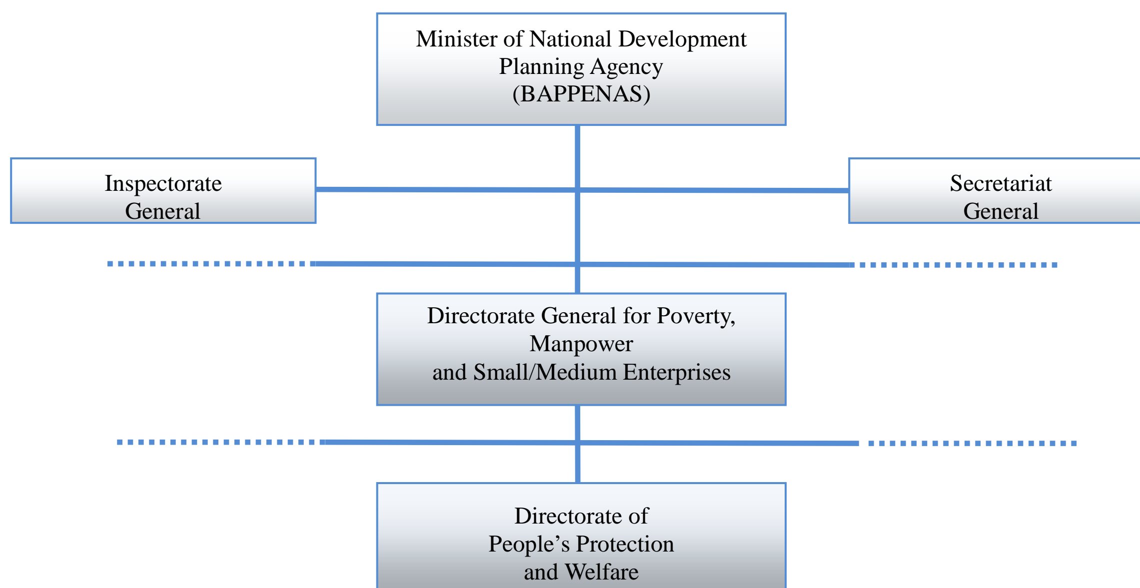
(6) The State Ministry of National Development Planning *(Badan Perencanaan Pembagunan Nasional*: BAPPENAS)

The State Ministry of National Development Planning (Badan Perencanaan Pembagunan Nasional: BAPPENAS, Figure 3-8) is in charge of the national development planning. As for the tasks of various cross-cutting development issues, BAPPENAS takes over the role of coordinator among the multiple government agencies that officially administer each field/sector. In addition, it is also a general contact window that controls the reception and guidance of the assistance and cooperative development projects from overseas.

In corresponding to its functions and roles, the organization of BAPPENAS is structured by appointing nine head offices by field/issue in line with the office of inspectorate general and secretariat general in the form of being directly beneath the minister. Furthermore, issues relevant to disabilities and development are controlled by the Directorate of People's Protection and Welfare under the Directorate General for Poverty, Manpower, and Small and Medium Enterprises.

As for the segregation of duties, relevant to "disability and development," with KEMSOS, BAPPENAS is in charge of the planning of development programs, monitoring/evaluations, review/revision of programs, and budgetary measures, while KEMSOS is in charge of implementation.

Furthermore, regarding the Special National Survey on Disabilities (tentative title) which is scheduled to be conducted next year, it is the first national survey specializing in disabilities in Indonesia. And with the technical support from the United Nations Population Fund (UNFPA), BAPPENAS will establish the survey methods while the BPS handles the budgetary measures and implementation. Through the implementation of this survey, the systematization of disability indexes and improvement in the reliability of statistics is expected.



(Source: the Survey team based on the material from BAPPENAS)

Figure 3-8 Organizational Structure of BAPPENAS

(7) Ministry of Communication and Informatics (*Kementerian Komunikasi dan Informatika*: KOMINFO)

The Ministry of Communications and Information (*Kementerian Komunikasi dan Informatika*: KOMINFO) is responsible for the development of communication infrastructure, technology development, national policy development, as well as the promotion of informal education through media. Very little has been done on disability issues at this time. A new government rule on the provision of information and communication technology infrastructure for persons with disabilities is currently being drafted. There is a need to discuss further with KEMSOS on how persons with disabilities can access information and communication technology[50].

The ministry supports KEMSOS by raising community-level awareness on disability. When KEMSOS requests for awareness programs, KOMINFO facilitates campaigns using TV advertisements, public dialogues on radio and TV, as well as puppet shows on weekends to raise awareness on accessibility of public facilities in the provinces.

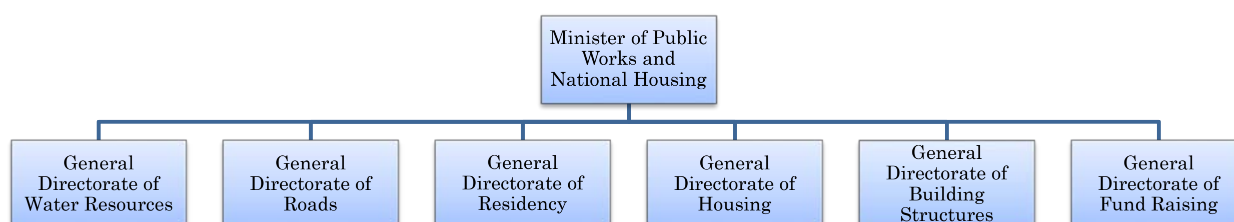
50 Based on the interview with KOMINFO (29 June 2015)

(8) Ministry of Transportation (*Kementerian Perhubungan*: KEMENHUB)

The Ministry of Transportation (*Kementerian Perhubungan*: KEMENHUB) has four General Directorates (road traffic, aviation, rail, and marine), with all departments sharing the responsibility on disability issues. Its main activities are to develop policies and institutions necessary to promote accessibility and compliance, as well as to carry out awareness-raising activities on disability-related regulations. Although operators are expected to comply with the rules and regulations in place, compliance is not an obligation. If an operator in question does not comply with the laws and systems, KEMENHUB will issue a warning up to three times. If the operator does not comply by the third warning, their license could be taken away. For the time being, there is no access audit mechanism in KEMENHUB.

(9) Ministry of Public Works and Public Housing (*Kementerian Pekerjaan Umum dan Perumahan Rakyat*: KEMPUPERA)

The Ministry of Public Works and Public Housing (*Kementerian Pekerjaan Umum dan Perumahan Rakyat*: KEMPUPERA, Figure 3-9) is in charge of Indonesia's roads and buildings. In relation to the field of disability, it is expected to formulate laws, systems, and standards for physical accessibility and promote compliance (related legal system is mentioned in Section 3.4.1 (2) 5), as well as raising awareness and dissemination of information on the related rules and regulations. The ministry works with KEMDIKBUD and KEMSOS to promote inclusive education, advising on the design of accessible schools.



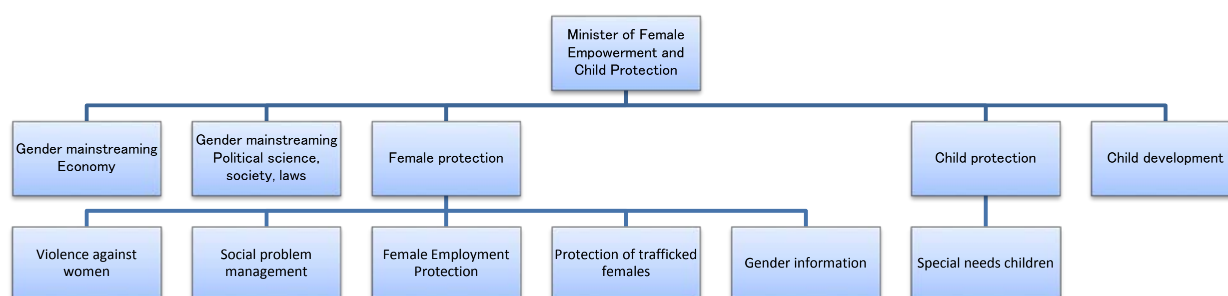
(Source: the Survey team based on the material from KEMENPUPERA)

Figure 3-9 Organigram of KEMENPUPERA (Disability Related Divisions)

KEMENPUPERA has six General Directorates, with the entry point on accessibility within the jurisdiction of the General Directorate of Housing. When the survey team interviewed the staff of the Housing Directorate, the survey team was told that there was no department nor division specialized in accessibility. However, activity reports on accessibility were issued in 2015 and were drafted by the Housing Directorate. In addition, personnel from the Housing Directorate, as well as from the Building Development Department within the Housing Directorate participated in the seminar conducted during the second half of this study.

(10) Ministry of Women's Empowerment and Child Protection (*Kementerian Pemberdayaan Perumpuan dan Perlindungan Anak*: KEMENPPPA)

There are five General Directorates within the Ministry of Women's Empowerment and Child Protection (*Kementerian Pemberdayaan Perumpuan dan Perlindungan Anak*: KEMENPPPA, Figure 3-10).



(Source: the Survey team based on the material from KEMENPPPA)

Figure 3-10 Organigram of the KEMENPPPA (Disability Related Divisions)

They are a) Gender Mainstreaming and the Economy, b) Gender Mainstreaming on Social Politics and Law, c) Women Protection, d) Child Protection, and e) Child Development. The Women's Protection and Child Protection Directorates are responsible for disability-related issues. In the Women's Protection Directorate, there are five divisions working on issues such as a) violence against women, b) management of women's social issues, c) protection of female labor, d) protection on female trafficking, and e) gender information. The Division of Management of Women's Social Issues works for women with disabilities. The foci of the Division of Management of Women's Social Issues are 1) women with disabilities, 2) elderly women, 3) women in conflict and disasters, 4) female HIV/AIDS patients, and 5) women involved in pornography. In 2006, programs for women with disabilities and elderly women were initiated by the ministry. The focus of the current program on disability that is being managed by the Division of Management of Women's Social Issues is the establishment of the Information and Consultation Center for Women with Disabilities (see 3.6.7). In addition, this division is responsible for the Progress Report on the Elimination of All Forms of Discrimination against Women for the United Nations. The division is also in-charge of the input to international and regional strategies. Under the Child Protection Department, there is a division for children with special needs[51].

KEMENPPPA publishes yearly a Female Profile, which contains data on the number of women with disabilities (number of women with disabilities/total population, type of disability, cause of disability, accessibility to assistive devices, accessibility to public facilities). The latest profile from 2013 is available for download from the website of KEMENPPPA[52]. Similarly, the Child Protection Directorate has published a children's profile every year which includes data on girls with disabilities (the number of disabled girls with respect to the total population, the type of disability, as well as the cause of disability). The latest 2013 edition profile is available from the website of KEMENPPPA[53].

(11) Central Bureau of Statistics (*Badan Pusat Statistik*: BPS)

BPS is an individual government agency and under the direct control of the Office of the President.

[51] During this study, only the interview with the Women's Social Issues Management Division was realized. The Survey team was not able to conduct an interview with the Division of Children with Special Needs on the program for girls with disabilities.

[52] Indonesia Female Profile 2013 (downloadable from the webpage of the Department of Women's Empowerment and Child Protection http://kemenpppa.go.id/index.php/daftar-buku/profil-perempuan)

[53] http://kemenpppa.go.id/index.php/daftar-buku/profil-anak

The role of this BPS is the preparation/editing of official statistics that contribute to the needs of the government/public, and they gather various statistical information of Indonesia, from the national level to the regional level, along with the compilation of data for making documents/indexes.

The data sources on disabilities are (i) the National Socio-Economic Survey (*Survei Sosial Ekonomi Nasional*: SUSENAS[54]) and (ii) the census. Both are administered by the Directorate General of Social Statistics, and the statistics related to disabilities/PWDS handled by the BPS are organized and publicized by the Social Welfare Statistics Department of the Directorate General.

The Special National Survey of Disabilities (tentative title), mentioned in the section on BAPPENAS (refer to Section 3.4.3 (6)), will be conducted in 2016 and the first disability-focused survey in Indonesia. With the technical support from UNFPA, the manual and questionnaire have already been completed. Through the implementation of this survey, the systematization of disability indexes and the reliability improvement of the statistics are expected within the central government.

(12) Ministry of Law and Human Rights (*Kementerian Hukum dan Hak Asasi Manusia*: KEMENHUKMAM)[55]

The Ministry of Law and Human Rights (*Kementerian Hukum dan Hak Asasi Manusia*: KEMENHUKMAM) is responsible for the systems of Indonesian justice and human rights, civil law, criminal law and drafting of jurisdiction laws and regulations. The ministry is also responsible for examining laws and regulations drafted by other ministries. The Correction Bureau and the Immigration Bureau are placed under the jurisdiction of this ministry. As for disability, persons with disability are grouped according to the elderly, children, women, ethnic minorities and the economically poor or as "socially vulnerable". The National Action Plan for Human Rights (working title) aims to consider and protect the rights of this socially vulnerable group and is currently being drafted in coordination with the Ministry of Law and Human Rights, BAPPENAS, and KEMSOS (refer to Section 3.4.2). In addition, KEMENHUKMAM reports on the implementation status of the CRPD.

(13) Ministry of Foreign Affairs[56]

The Ministry of Foreign Affairs, is responsible for submitting to the United Nations Committee on CRPD the status report which KEMSOS, BAPPENAS, and KEMENHUKMAM draft (For more details on the implementation status report of the CRPD, refer to Section 3.7).

(14) Employment Situation of Staff with Disabilities in the Ministries Visited in the Survey

Table 3-9 shows the employment situation of the government officials with disabilities.

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[54] Since 1963, the annual survey relevant to population, insurance, education, family planning, and household expenditure is implemented/edited. The progress is announced quarterly (http://microdata.bps.go.id/mikrodata/index.php/catalog/SUSENAS).

[55] The interview with the Ministry of Law and Human Rights and Ministry of Foreign Affairs were not realized. The information is based on the hearings with other ministries.

[56] The interviews with the Ministry of Law and Human Rights and Ministry of Foreign Affairs were not realized. The information is based on the interviews with other ministries.

Table 3-9 Employment Situation of Staff with Disabilities at the Government Organizations

Ministry	Staff with Disability Employment/Number/Notes
KEMSOS	Currently, 78 persons with disability are employed by the ministry. In 2014, 59 persons with disabilities were employed. The increase is due to the large number (300) of persons with disabilities who passed the employment assessment of which 105 persons were actually employed. 31 people were employed by the central government, 19 of the 31 people work at KEMSOS. Gender balance is unknown.
KEMENAKER	Employed. Details unknown
KEMDIKBUD	Employed. Details unknown
KEMENKES	Employed. Details unknown
TNP2K	Not employed
BAPPENAS	Not employed
KOMINFO	Three persons with physical disabilities were newly employed. Two are working as office staff (new staff) and one staff became disabled after a stroke. However, there is no toilet facility for persons with disabilities. Gender of the staff employed unknown.
KEMENHUB	Some civil servants have become disabled after being employed. Their numbers are unknown.
KEMENPUPERA	Unknown
BPS	Unknown
KEMENPPPA	Employed. One female with hearing disability.

(Source: the Survey team based on interviews with relevant ministries)

3.5 Information on Disability in Rural Areas

3.5.1 Administration on Disability in East Java

In this study, the survey team investigated the current situation of disability and development in the rural areas in East Java Province by which its capital is Surabaya City. The survey team gave an overview of the Social Affairs, Health, and Education Offices within East Java Province. More details of disability and development in East Java Province are described in Section 3.6.

(1) Department of Social Affairs in East Java Province

1) Outline of the Organization

There are five divisions which work together to implement its programs on disability.

i) Internal affairs
ii) Rehabilitation: including domestic violence
iii) Empowerment
iv) Social protection: including the safety of persons with disabilities during emergencies/disasters
v) Social development

2) Budget

The annual budget of the Social Affairs Office is about IDR 70 billion, of which, approximately IDR 500 million is allocated to the disability field. Most of the IDR 500 million is used for early detection of disability and assistive devices.

(2) Department of Health in East Java Province

1) Outline of the Organization

There are four divisions within the East Java Health Office

- Medical Services (85 persons)
  - Family Health: provision of medical services to school children including children with disabilities. 26 staff
  - Special Referral: hospital referrals. The rehabilitation division is attached to this division.
  - Basic Health: Provision of basic health services to *Puskesmas* or health centers managed by the province and municipalities[57]
- Community Health Development
- Human Resource Development
- Infection

(3) Department of Education in East Java Province

1) Outline of the Organization

The East Java Education Department's organization resembles that of the central government ministry, formed along the lines of the school system. The department has four divisions, i.e., 1) the Early Childhood Education Division responsible for education of preschool children, 2) the Primary Education Division for the 6-year elementary school, 3) the Higher Education Division in charge of the 3-year junior high school and 3-year high school, and 4) the Employment Training Division which manages the Vocational Training School for technical training and qualification before employment. The Special Education Division, which is responsible for special education, is currently under the Primary Education Section.

The Special Education Division is responsible for the 12 years of schooling from primary, middle, and high school as the Special School schooling extends over this period, despite being under the Primary Education Section. The division is also responsible for Inclusive Education and not just Special Education for children with disabilities. Since the inclusive education requires the reorganization of the current school system, the division works closely with other divisions to implement this program.

The main organizational mission of the Special Education Division is to promote the establishment of special education schools and inclusive education schools. In addition, if there are only traditional educational institutions in neighboring villages, arrangements must be made for children with disabilities to receive an appropriate education.

It should be noted that there have been no public promotion or awareness campaigns on inclusive education to date.

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[57] *Puskesmas* are provincial- or municipal-run health centers and are central to primary level health care. These facilities conduct prevention, health education, and provide curative and assist in deliveries.
http://www.mhlw.go.jp/wp/hakusyo/kaigai/12/pdf/teirei/t369-374.pdf

In 2013, East Java enacted the "Rules Concerning the Protection of Persons with Disabilities and Services" (East Java Province Ordinance No. 3, 2013). The legal framework and provisions relating to the promotion of inclusive education are found in Article 10 to Article 14.

2) Budget

Previously, the survey team described recent budget trends of the Central Government, in particular the Ministry of Education and Culture. Since 2012, Special Education School operating costs are covered by a budget allocated by the central level. Although all of the expenses are not through the ordinary budget, the allocation from the central government to local government covers the following[58]:

- Improvement of accessibility to special schools and inclusive education schools;
- Educational assistance for poor families with children with disabilities and to children who have parents with disabilities; and
- Teacher salaries.

Nevertheless, budgeting outside of the normal allocation from the central level to the provincial level and then the municipalities is complicated because of the balance transfers between levels. In addition, the financial circumstances of the municipalities and provinces differ from time to time and are never very clear.

In order to promote accessibility to social capital such as education infrastructure, there is a development policy, as well as rules for accessibility promotion at the central level, so accessibility to inclusive education schools can be financially supported.

3.5.2 City Planning in Surabaya - From the Viewpoint of “Inclusive City”

The Green City Master Plan (GMP) in the city of Surabaya, based upon an environment-friendly concept, has been deliberated and its application for the technical cooperation is now[59] being prepared by the Government of Indonesia to be submitted to Japan.

Since the city discussed some development plans, including prototypes, relevant/similar to GMP in the past to be used as reference for future cooperative projects, those plans/attempts are briefly reviewed for the following:

(1) Surabaya Vision Plan 2005-2025

The long-term development plan was conducted and designed by AECOM, an American consulting company of architecture design and construction, together with the city office and the local business consortium. Since it is based upon the consultation with a private business enterprise, it was not considered to be free of charge. The finance or budgeting of the plan is unknown; however, because there was no chance to have an interview with public officials of the Surabaya City government in-charge of the city planning through this survey.

[58] Based on the interview with the East Java Provincial DINSOS (18 May, 2015)
[59] As of the end of July 2015.

Brief explanations on the background of the plan by AECOM are the following[60]:

- At the beginning of the 2000s, while Surabaya faced an economic turndown, its population had been growing rapidly.
- Competition with cities nearby, especially in terms of trade, had also been aggravated recently.
- Under restrictive circumstances, an environmentally-conscious investment mechanism to have Surabaya City enhance regional/international competitiveness was needed. On the premise of this understanding, a resolution-oriented recommendation was presented in the plan.

(2) Green City Development Program by ISOCARP-PU

The International Society of City and Regional Planners (ISOCARP) is an international sectoral association of architecture design and civil engineering consulting composed of member companies such as AECOM, Bechtel, etc. In its 48th grand conference in 2012, the Ministry of Public Works and Public Housing (*Pekerjaan Umum*: PU) made a presentation and the contents, as a kind of an analytical paper, have been disclosed on the website[61].

It is not limited to the issues of Surabaya, but rather, covering tasks for all cities over Indonesia and includes the concept of environmentally-conscious and sustainable development.

(3) Green Cities Initiative by ADB

The Green City Development Program of (2) is considered to be based upon this initiative.

The word "green" indicates the priority of initiative that is given to the environment-friendly cities. On the other hand, since the title of “Inclusive Cities” is raised just next to the “Green Cities” in the middle of the website, the Asian Development Bank (ADB) seems to be inclusiveness-conscious in the field of city planning.

And since ADB promotes, along with the initiative, urban development projects in Indonesia, it would be useful to observe and refer to the update status[62].

(4) City Planning Laboratory (CPL) Initiative in Surabaya

The laboratory was founded in February 2014 with the support of the World Bank and Hansen Partnership (an Australian consulting group in urban planning, urban design, and landscape architecture). It is an organizational platform that provides workshops in which the city-planning bureau of the municipal government, developers, and relevant academic experts can meet and exchange ideas and discussions on the issues of introducing a tramway that would run from north to south through the city of Surabaya and the development/arrangement of the North-South Corridor along the tramway[63].

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[60] Website of the Plan: (http://www.aecom.com/vgn-ext-templating/v/index.jsp?vgnextoid=ca6e1b6a6b082210VgnVCM100000089e1bacRCRD&vgnextchannel=5815149639146310VgnVCM100000089e1bacRCRD).

[61] Djoko Kirmanto, Imam S. Ernawi, and Ruchyat Deni Djakapermana, Ministry of Public Works, Indonesia, “ Indonesia Green City Development Program: an Urban Reform” (http://www.isocarp.net/data/case_studies/2124.pdf)

[62] http://adb.org/projects/details?page=details&proj_id=46380-005

[63] http://cityform.mit.edu/projects/surabaya-cpl

It is reported that the establishment of CPL contributed to raising the fund of USD 3 million but the details are unclear. As for the city planning, CPL focuses on transportation-oriented and pedestrian- oriented comprehensive land use and zoning plans. The website of CPL also noticed the consistency with the 20-year development plan of Surabaya (probably the master plan shown in (1)) and it is highly possible that there are some suggestions for development that contain disability-inclusive aspects.

3.6 Situation Surrounding Disability - Systems and Programs

3.6.1 Education

(1) System/Program

In Indonesia, based on the Law on National Educational Systems (Law No. 20, 2003), general education, vocational education (moderate level), academic education, professional education, vocational education (higher education), religious education and special education have been implemented. Among the above, special education is specialized as the education for children with disabilities.

The schools for children with disabilities are named "Special Schools," and categorized into two types: (i) the special schools for children with disabilities (the students are only persons with disabilities) and (ii) inclusive educational schools. And there are primary, secondary, and high special schools for each. Inclusive education in Indonesia started in 2003. It does not have a long history, but since the inclusion of persons with disabilities is one of the most important goals of the national education, the number of schools for inclusive education has rapidly increased in recent years.

Under the provisions of the law, there is a duty for the government to establish at least one special school within each state and district (516 educational districts in total all over Indonesia), however, although it met the conditions for all of the 34 provinces, no special school exists in 90 districts among all the educational districts. All of the absent districts are in the remote areas, and the foundation of special schools in such districts is an urgent issue for the development of the educational infrastructure[64].

As of 2014, the total number of students under compulsory education was 184,115 (Table 3-10). In 2009, there were more than 50,000 students enrolled in the primary special schools for children with disabilities. In 2014, this number almost doubled to 97,000. However, this is due not only to the methodological improvement of the official survey, but also because of the enhancement in the awareness of disabilities/ persons with disabilities within the common people of the nation.

However, the number of children with disabilities that KEMDIKBUD supposed to actually exist is approximately 2 million, and it is assumed that 90% of children with disabilities are not attending schools[65].

[64] Based on the interview with KEMDIKBUD (12 May, 2015).
[65] Based on the interview with KEMDIKBUD (12 May, 2015) and the Department of Education, East Java provincial government (20 May, 2015).

Table 3-10 Number of Children with Disabilities in Compulsory Education in Indonesia

Year	Special School (Primary)	Inclusive School (Primary)	Special School (Junior high)	Inclusive School (Junior high)	Total
2009	50,982	3,240	10,779	20,436	90,252
2010	61,576	3,496	10,588	22,900	103,383
2011	65,789	18,476	16,324	3,519	104,108
2012	94,857	21,223	17,392	6,310	139,782
2013	97,669	43,106	17,840	14,838	173,453
2014	97,669	44,950	17,840	23,656	184,115

(Source: KEMDIKBUD)

There are 345 special schools for persons with disabilities in the East Java Province, and most of them are concentrated in the city areas centering Surabaya. Among those 345 schools, 65 schools are municipal/provincial schools, and there are two provincial schools in Sidoarjo prefecture and Malang city. In the city of Surabaya, there are currently 55 special schools for children with disabilities, and there are no special schools of the city/province and are all privately managed (Table 3-11). As for the inclusive educational schools, there were 1,282 schools in East Java as of May, 2015[66]. In 2010, there had been just 160 schools; it means, in the last five years, the number has increased by around eight times. The status of the accessibility for children with disabilities, such as placement of toilets for persons with disabilities, has yet to be developed. However, according to the department of education, East Java Province, the number of the schools that is aware of the issue is on increase.

Table 3-11 Number of Special/Inclusive Schools in East Java Province

	Special School	Inclusive School
East Java Province	345	1,282
Surabaya	55 (Private)	74 (50 primary; 20 junior high; 2 vocational; 2 secondary)[67]

Regarding children/students with developmental disorders/ASD, they attend standard schools, and attend special classes arranged within those schools. Furthermore, with the rapid increase in the number of children with autism, the Ministry of Education and Culture newly established the Autism Centers in 29 locations around the country[68].

Regarding the educational curriculum for children with disabilities, there is the “2013 National Curriculum for Children with Special Needs” that specializes in children with communication issues personally and/or socially. In addition to the increase in the number of children with autism as mentioned above, this is a result of the improvement in awareness vis-á-vis mental disorders within the urban areas and the central

[66] Based on the interview with KEMDIKBUD (12 May, 2015) and the Department of Education, East Java provincial government (20 May, 2015).
[67] PPDB Surabaya (http://9c0e96.sd.ppdbsurabaya.net/umum/pagu)
[68] According to Yayasan Autisma Indonesia (Autism Foundation of Indonesia), case reports concerning autism in the nation started increasing distinctly after 1994. However, centered in the regional areas, the concept of autism itself has not permeated, and even in the city areas, the major matter of concern for the person in question and the families is with rehabilitation, therefore, precise statistics of persons with autism have not been developed (based on the hearing survey conducted by said foundation on July 8, 2015).

government in recent years. With respect to the development of legal systems, the Mental Health Law was enacted in 2014 (as described in Section 3.4.1 (2) - 4)).

There are two types of curriculums at the inclusive educational schools. One is of an inclusive class system where students study the same curriculum as children without disabilities, and the other is of a system of the special class where students with disabilities study under the specific curriculum.

There are two ways in general, for the existing educational institutions, to become inclusive educational schools:

i.) Obtaining approval from the educational departments of the municipal government
- After obtaining approval, a written form of recognition is sent to the school from the municipal government;
- The approved school appoints teachers with training for the support of children with disabilities;
- Identification of children with disabilities to study at the school;
- Establishment of a curriculum for children with disabilities;
- Confirmation by the educational departments at the provincial level;
- Monitoring by the provincial government (visiting the school once every three months and a permanent supervisor within the city government),

ii.) Declaration by the existing schools themselves to be an inclusive educational school.

The special public schools under the provisions of the law are now from the level of primary education up to the high-school level, and any other special educational institutions particularly designated by the Ministry of Education and Culture do not exist. At the university level, however, individual programs of special education/inclusive educations by each institute have been progressing. The University of Brawijaya, the University of Gadjah Mada, and the State University of Surabaya, for instance, are all accepting students with disabilities. In order to encourage applications by persons with disabilities, those institutes set special application procedures open for prospective students with disabilities.

(2) Specialized Human Resources in the Field of Disabilities

At special schools, even the situations are different according as whether it is public/private, with high possibility, a permanent occupational therapist (OT) and physical therapist (PT) are allocated as the teaching staff in accordance with the characteristics of the disabilities of the students there. Furthermore, it is mandatory to purchase/prepare rehabilitation facilities stipulated by the law (On Special Education [Government Regulation No. 72, 1991] Article 7).

As for the training of the teaching staff working for the special schools: (i) 6,000 trainees per year attend the training programs at the 105 training institutions all over the country (in 2014), and (ii) in addition to the core centers of these 105 regions, there are 5 national training institutes directly managed by the central government where training programs are implemented for 600 trainees (the annual budget for these programs is estimated to reach IDR 60 million to 150 million in total).

Approximately 140 persons, including senior teachers with experience, university professors, and government officials, are registered at present as the lecturers of the training programs described above.

Regarding the staff training of the Ministry, they provide the support with lifelong learning, the dispatch of staff to graduate schools, etc., to be considered to be timely and appropriate.

Looking at the situations of East Java Province, they have implemented training programs targeting on teachers of special schools for children with disabilities and inclusive educational schools since 2011. Within the training, the trainee teachers learn the concept of inclusive education, ways to identify children with disabilities, assessment methods, curriculum formation methods, and performance evaluation of students with disabilities. In 2014, in cooperation with The University of Queensland (financially supported by the Australian government), 25 teachers were dispatched to the university for a month-long training course of the inclusive education. In Surabaya city, there are courses where one can learn about special education for children with disabilities and inclusive education at the State University of Surabaya, which provides a master's course for the special field.

(3) Promotion Policies for Disability Education

In the background of the rapid increase of students attending special schools and children with autism/ASD in recent years, there are various educational activities/attempts to enhance the common knowledge of the nations on the disability by the central government.

Since 2011, they have implemented the National Campaign for Children with Disabilities. A total of 60 local governments have responded to the campaign, and with the conclusion of the Minutes of Understanding (MOU) with KEMDIKBUD, house-to-house visiting activities for the announcement/ publicity concerning disabilities were deployed in each region.

A taskforce (T/F) for this campaign is set each at the national level, provincial level, and prefectural level. The T/F at the provincial levels is not obligatory and organized voluntarily by the local governments. The T/F consists of the representatives of NGOs, universities, government agencies, and local residents, etc. and the role of the chairman differs by T/F depending on the situations of the location. Basically the executive staff of the Directorate for Development of Special Education and Special Services assumes the position of the chairman and university professors are sometimes appointed for the position at the prefectural level.

As for the dissemination activities of inclusive education, the Ministry holds various festivals, such as the National Inclusive Education Olympics, and produces movies/talk show programs on television (both national and local broadcasting).

Regarding other strategic attempts, (i) the Post School Transition Program for persons with disabilities to learn the necessary skills for their employment and living social lives smoothly by attending vocational schools, (ii) the establishment of autism centers, (iii) the establishment of various resource centers, (iv) the revision of the national curriculum of special schools for children with disabilities, (v) the support for operational costs of special schools for children with disabilities, (vi) the student support through

scholarships, and (vii) awards for educational institutions and people/organizations contributing to the implementation of inclusive education can be listed.

(4) Recent Trends and Issues

Following the enactment of the Law on National Educational Systems (Law No. 20, 2003), the inclusive education was introduced, promoted, and combined with the prioritized budgetary support from the central government. And finally inclusive education spread throughout all the districts in the island of Java. For example, in East Java Province, the number of schools with inclusive education increased by eight times within five years from 2010. As a result, there is a gap where the supply (newly participating schools) exceeds the demand (number of students who wish to enroll). In addition, the current problematic status is that the number and skills of the teachers, at the inclusive educational schools, to provide sufficient service in terms of quality of education for children with disabilities are lacking. It is the issue of high priority to implement the training programs for the teachers of special schools to let them attain appropriate skills.

The progress of inclusive education is behind in remote areas such as parts of Papua or Sulawesi, and together with the establishment of educational institutions in 90 districts where special schools do not exist, these are important issues in the future.

In order to realize the ideal of “Education for All,” it must be admitted that the number of special public schools for children with disabilities are lacking due to financial reasons. However, there is no regulation, at the provincial/municipal level, that at least one special school for children with disabilities needs to be established in each city. And the establishment of special schools for children with disabilities is now totally dependent upon the willingness and judgment of each city.

Since 2012, the central government has borne the burden of all operational costs of special schools for children with disabilities. Furthermore, as for the scholarships, the central government provides the ones for all children with disabilities and children with parents who have disabilities. With the fact that number of special schools for children with disabilities is insufficient and the new supply of inclusive educational services is fulfilled almost only by the private institutions, the financial problem of public education has been quite critical. The examination of development strategies at the national level is being demanded including the possibility and concrete measures of increasing grants from the central government. Together with the current state of decentralization that has made significant progress.

In terms of the physical accessibility to the school facilities, the improvement of the facilities for securing the accessibility has not been carried out in all the schools due to budgetary constraints. In order to conduct the impediment removal in the old campuses, grants are sometimes provided by the government, but there are limits to the budget here also. Regarding new schools, if accessibility is considered from the design stage, it is possibly admitted to be improved[69].

The existence and treatment of children with disabilities who do not attend school (90% of all children with disabilities) is considered to be one of the most critical issues at the national level, but there are many cases

[69] Refer to “3.4.1 (2) - 5) “Public Construction and Transportation.” In particular, the “Building Law” (Law No. 28, 2002).

that the parents have hidden their children from birth. Those children are not even officially registered, and the current state is that any administrative intervention is difficult.

3.6.2 Health

(1) System and Program

1) Medical Rehabilitation Systems and Programs

It is said that medical rehabilitation in Indonesia started in Solo City by Dr. Soeharso in the 1940s. There is a lack of facilities and human resources which provide medical rehabilitation. In addition, most of the existing rehabilitation facilities are concentrated in Java and there is a geographical imbalance.

a. General Hospital with Medical Rehabilitation Department

In Indonesia, hospitals are classified from Class A to Class D as shown in Table 3-12. Of these, one can only receive medical rehabilitation services in Class A hospitals, which currently has 57 hospitals (Table 3-13). The National Rehabilitation Center in Solo City (Prof. Dr. Soeharso Orthopedic Hospital's Rehabilitation Centre) has an Orthopedic Specialist Department classified as Class B.

Table 3-12 Classification of Hospitals

Class	Explanation
Class A	A Class D hospital which has at least 4 departments, 5 specialty departments, 12 specialized courses, 13 sub-specialties which can provide advanced medical care. There should also be physical therapists, occupational therapists, prosthetists and orthotists, so that a comprehensive medical rehabilitation service can be provided.
Class B	A Class B hospital should have at least 4 departments, 4 specialty departments, 8 specialized courses and 2 sub-specialties to be able to provide advanced medical care.
Class C	A Class C hospital should have at least 4 departments, 4 specialty departments to provide advanced medical care.
Class D	A Class D hospital should have at least 2 departments (OB-gyn and Pediatrics) to provide continuum of care.

(Source: International Frontier Medical Support (IFMS) 2013 Field Report on the Establishment of the Joint Indonesia-Japan Center for Advanced Gastroenterology Diagnostics (Japanese, tentative title translation)[70])

Table 3-13 Number of Hospitals by Class (2013)

Class	Number of Hospitals	%
Class A Hospital	57	2.56
Class B Hospital	293	13.15
Class C Hospital	741	33.26
Class D Hospital	517	23.20
No class established hospital	620	27.83
Total	2228	100

(Source: Directorate General of Health Effort, Ministry of Health, Republic of Indonesia, 2013)
(Source: Indonesia Health Profile 2013, Ministry of Health, Republic of Indonesia, 2014)

b. Specialized Rehabilitation Centers

Section 2.1.1 describes the main health indicators and health system indicators in Indonesia. Under such circumstances, there are two rehabilitation centers which are equipped with medical staff and facilities and equipment necessary to be able to provide adequate medical rehabilitation services. One is the National

[70] http://www.meti.go.jp/policy/mono_info_service/healthcare/kokusaika/downloadfiles/fy24/outbound_19.pdf

Rehabilitation Center in Solo City, the other a private rehabilitation center is the Fatmawati Hopital in Jakarta. Medical rehabilitation in Indonesia started in Solo City by Dr. Soeharso in the 1940s.

c. Medical Rehabilitation Services at the Health Center (*Puskesmas*) Level

Health centers (*Puskesmas*) play a central role in primary health care at the municipal and district levels conducting prevention activities and health education (family planning, nutrition, etc.), providing treatment and enabling deliveries, as well as supplying medical products. There are 9,655 health centers nationwide (3,317 centers including with inpatient facilities, 6,338 centers with outpatient facilities) as of 2013. The health center has on average 1.7 doctors per facility, 8.7 nurses per facility, and 9.2 midwives per facility. The number of physical therapists working in the health centers was 652 in 2013, equivalent to one physical therapist per 15 centers. In other words, this means that not all health centers have a physical therapist. In some health centers, community health workers are called *Kader Kesehatan* (health volunteer) and provide medical rehabilitation services. *Kader Kesehatan* plays in Indonesia's health system, an important role by informing and counseling the community[71]. In 2013, there are 336,586 *Kader Kesehatan*. KEMENKES is supposed to train the *Kader Kesehatan*, but recently there has been no training due to budget constraints[72].

The health facilities at the village level are the village health post (*Poskesdes*), regional midwifery office (*Polindes*), and the integrated health posts (*Posyandu*). *Posyandu* is unique to Indonesia which is a simple health facility or activities operated at the village level. There are five priorities in promoting health at the village level: home visits, maternal and child health, family planning, nutrition development, vaccination and diarrhea prevention measures[73]. The child's development is monitored through the Maternal and child health Handbook[74]. If a disease is detected at the *Posyuandu* level and the midwife cannot diagnose it, the patient is referred to the county hospital. If the county hospital cannot diagnose or treat the patient, the patient is referred to the city hospital.

The health center is managed by the health center staff and volunteer. There are 280,225 *Posyandu* and 54,731 *Poskesdes* nationwide. It is not clear whether *Posyandu* provide disability related services such as medical rehabilitation.

d. Other Medical Rehabilitation Services

KEMSOS has started mobile rehabilitation where doctors and physical therapists patrol the area in a bus, providing advice or on-the-job training, referring patients to appropriate facilities. However, the area covered is limited and most rural persons with disabilities are unable to receive this service. For this reason, in Indonesia, several private organizations from the 1990s are working on disability issues in rural areas, based on the concept of CBR.

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[71] http://www.unicef.org.au/Discover/Field-Stories/September-2013/Bridging-the-gap--nutrition-in-Indonesia.aspx#sthash.M49veQKU.dpuf
[72] Based on the interview with WHO officer on 9 July 2015
[73] Australia Indonesia Partnership for Health (AIPHSS), Indonesia Health Profile 2013
[74] The JICA Maternal and child health (MCH) Handbook project was started based on a request from an Indonesian doctor. After a year of planning and development, four months of training, the MCH handbook was distributed for the first time in February 1994 in Salatiga and now distributed in all 34 provinces. (http://www.mofa.go.jp/mofaj/gaiko/oda/hanashi/story/asia/indnesia1.html)

As one of example of CBR programs, there are community rehabilitation centers in 16 provinces in Indonesia, run by the Indonesia Society for the Care of Disabled Children (*Yayasan Pembinaan Anak Cacat*: YPAC) which provide medical rehabilitation services for children with physical disabilities. YPAC was established in the early 1950s when polio prevailed. Afterwards, it served children who survived polio. Before, the YPAC was under the jurisdiction of KEMSOS, but it is now a foundation. YPAC introduced the concept of Community-based Rehabilitation (CBR) in 1978, and established the Community-based Rehabilitation Development and Training Center (CBRDTC) in Solo City. The CBRDTC is now the largest community rehabilitation center in Indonesia[75].

e. Cost of Medical Rehabilitation

The Employment Social Protection covers medical rehabilitation and prosthetics costs for industrial accidents, but does not cover medical needs such as assistive devices (wheelchairs, clutches)[76].

2) Systems and Programs for Mental Health

Table 3-14 is an overview of systems and programs for mental health.

[75] http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1436&context=gladnetcollect
[76] American Social Security Administration webpage, The World's Social Security Program 2014
http://www.ssa.gov/policy/docs/progdesc/ssptw/2014-2015/asia/indonesia.html

Table 3-14 Systems and Programs for Mental Health

Category	Overview
Mental Health Facility	There are public mental health facilities in 26 provinces. The central government runs five hospitals (of which four are mental health hospitals located in Jakarta, Bogor, Mageran and Lawan. The fifth hospital is a hospital for drug addicts) The provinces run 29 mental health hospitals.
Number of beds and patients	There are 8,850 beds in 34 public mental health hospitals, ranked A or B. The number of patients in each city is as follows: Jakarta: 200 patients Lawan: 600 patients Bogor: 700 patients Mageran: 400 patients Hospital for drug abusers (Jakarta): 100 patients Patients in the provincial mental hospitals 100-200 patients/hospital
Service contents	There are four categories of services. Primary health care: Approximately 40% of county level facilities provide mental health services. Most of the services are concentrated in Sumatra and Java Islands (West and Central Indonesia) The following three services are provided. (1) Counseling: Nurses or mental counselors provide mental counseling in 257 primary health care facilities. KEMENKES trains nurses and physicians to counsel but the quality of counseling is not adequate[77]. (2) Psycho-pharmacology (3) Methadone is provided to drug addicts (however, the institutions which can provide this drug is limited) Secondary care: normal hospitals at the provincial level (only 30% of provincial level hospitals provide mental health services. KEMENKES does not know the quality of care given) Tertiary care: At provincial level mental hospital Others: Service provision at facilities other than health centers (a non-medical approach). For example, services for the homeless with mental impairment at the social rehabilitation shelter under the jurisdiction of KEMSOS. <Services for women and children who are victims of violence> Services are provided in 68 hospitals. <Others> New rules on medical health were implemented in 2014 enabling primary health care doctors to diagnose 155 items including mental health.
Psychologist	There is only one psychologist in Yogyakarta at the primary health care level.
Data collection and research	The National Institute of Health Research and Development, under KEMENKES, conducts every five years a basic health study (Riskesdas). There are some universities conducting research on mental health, such as the University of Indonesia, but the number of universities conducting research is still small.

3) Program for Children with Disabilities

<Services at the Health Center>

Nurses provide information on how to treat children with disabilities. In some cases, home visits are conducted, but this is still rare. In addition, midwives screen newborns and children under five years of age for disabilities (such as congenital hypothyroidism[78]) and to detect developmental disability. Currently, although the target area is limited, KEMENKES plans on scaling up this early screening by 2016. Despite midwives referring children to doctors for examination, pediatricians lacked knowledge on disabilities so

[77] Based on the interview with the Mental Health Department. According to WHO (2011) Mental Health Atlas 2011-Profile of Indonesia, there has been no official training for physicians and nurses on mental health for the past five years (as of 2011).
[78] Hypothyroidism is in children could lead to a larger problem such as developmental disability.

that children cannot obtain appropriate diagnosis and treatment. This problem was pointed out in one interview in East Java.

According to the East Java Health Center interview, the newborn screening to detect hypothyroidism is insufficient. In reality, only 1 out of 3,000 newborns is examined. Although examination costs are not high at IDR 485,000 per newborn, the budget of East Java is not enough for all the children born every year. There are a large number of children with mental disorders in Surabaya and Sidoarjo cities. This is said to be due to mental stress (including chronic depression) following the industrial mud disaster (Sidoarjo Mud Flow (Lapindo Mud)[79, 80]). If a mental disorder is found, the children are referred to Bandung City (Hason Sadikin) or Jakarta (Ciptomangun Kosomo). The East Java Provincial Government is pushing to have a referral hospital in Surabaya City as it does not have one. If a child suffering from psychosis in East Java is found, the rules would be that this child be referred to Jakarta.

<Services at School>
For children attending school, screening is done at school. Special education schools also conduct screening. In East Java, out-of-school children receive information through partnership with organizations which work with families with children with disabilities. Screening is done by volunteers such as medical students.

<Provision of Health Handbooks>
For the past five years in East Java, all the municipalities have promoted the utilization of maternal and child health (MCH) handbooks. Some schools have taken the initiative to distribute handbooks like the MCH handbooks but the problem of having difficulties in communicating with children in special education schools inhibits the utilization of this type of handbook. There are three types of handbooks:

- 0-5 years old: MCH Handbook; *Buku Kesehatan Ibu dan Anak*: KIA
- Once-a-year screening for first graders: Child Health Book; *Buku Kesehatan Anak Remaja*: KARA
  Afterwards, screening is done every six months (nutrition, injuries, and vaccination)
- Teenage boys and girls 13 years and older: Youth Health Book; *Buku Kesehatan Remaja*: KESREM

<Training for Nurses and Physiotherapists>
Budget limitations have inhibited nurse and physiotherapist disability training.

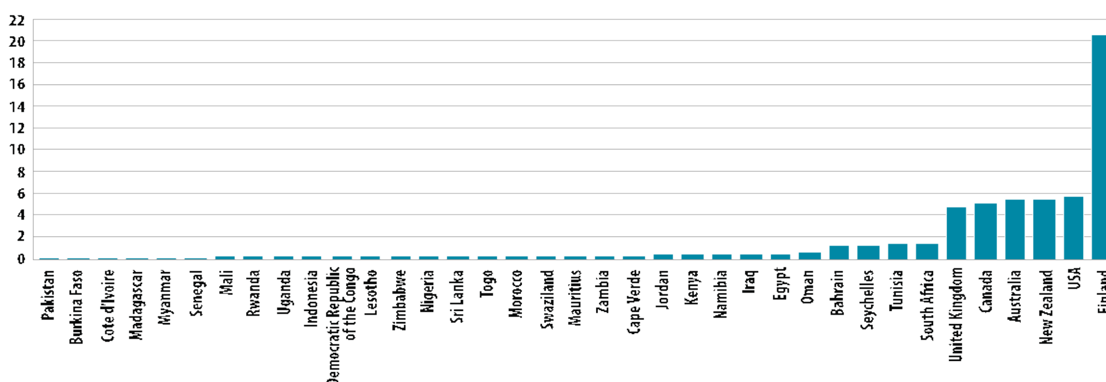
[79] On 29 May 2006, the 21st century's largest industrial mudslide disaster occurred in Sidoarjo, 30 minutes from Surabaya. Indonesia's petrol and gas company Lapindo Brantas had started drilling for new resources such as natural gas. However, while the company Lapindo Brantas drilled for natural gas at Banjar-Panji, an enormous mudslide eruption was triggered. This disaster as it is now known as the Lapindo mudslide swallowed 14 villages and tens of thousands of residents lost their homes. The surrounding ecosystem was polluted by the mud flow and infrastructure was destroyed. (Source:Titanic Made by Lapindo)

[80] The Jakarta Post 18 June 2007 article "Mental Health an issue in Sidoarjo" discusses the necessity to respond to children who are experiencing post-traumatic stress disorder after the mudslide.
http://www.thejakartapost.com/news/2007/06/18/mental-health-issue-sidoarjo.html

(2) Specialists and Workers in the Disability Field

1) Physical Therapists and Occupational Therapists

According to KEMENKES, there are currently 10,000 physical therapists. The number of physical therapists working in hospitals (out of 10,000 physical therapists) is unknown. This is a gain compared with what was reported in 1996 wherein there was a total of approximately 1,500 physical therapists, but this is still insufficient and there is very little recognition of the profession[81], [82] . This low recognition and insufficient number is partly due to the fact that the physiotherapist is not yet a national qualification[83]. Below, the survey team shows a comparison of the number of physical therapists and occupational therapists by 100 million inhabitants as reported in the WHO's Global Report (refer to Figure 3-11 and Figure 3-12).



(Source: WHO/World Bank, *World report on disability*, 2011)

Figure 3-11 Number of Physiotherapists per 100,000 inhabitants

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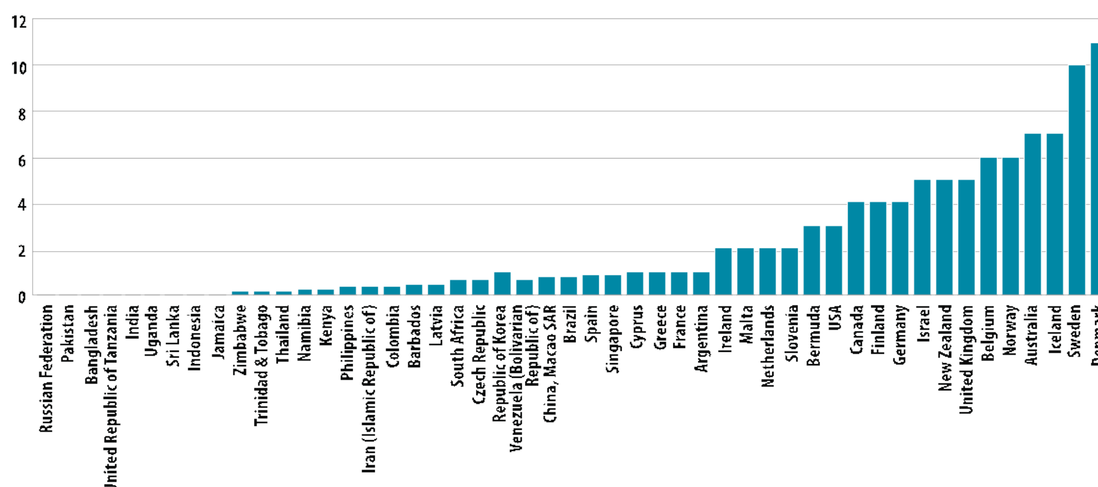
[81] Kuno *et al*.(1996) Physiotherapy in Indonesia, Physiotherapy, Japanese Volume 23 No. 5 pp. 275-284

[82] As a result, there were 110,748 registered physiotherapists and 65,929 occupational therapists in Japan as of the end of 2013. (National Institute of Population and Social Security Research (2013) http://www.ipss.go.jp/ssj-db/ssj-db-top.asp)

[83] Sawa R (2013) Training the next generation of medical and health sciences global leader in collaboration and cooperation with ASEAN countries. Report for the Initiative to Strengthen Global Expansion 2013(report in Japanese) http://www.med.kobe-u.ac.jp/asean/voice/H25%20report/kato%20add/%E3%82%A2%E3%82%AF%E3%83%86%E3%82%A3%E3%83%92_%E3%83%86%E3%82%A3%E3%83%BC%E3%83%AC%E3%83%9B_%E3%83%BC%E3%83%88%EF%BC%88%E6%BE%A4%E9%BE%8D%E4%B8%80%EF%BC%89.pdf



(Source: WHO/WB (2011) World Report on Disability)

Figure 3-12 Number of Physiotherapists per 10,000 persons

The number of graduates of physiotherapist and occupational therapist are increasing as shown in Table 3-15.

Table 3-15 Graduates from the Health Polytechnic (by type of health care 2011-2013)

	2011	2012	2013
Physiotherapist	190	123	243
Occupational therapist	50	52	99
Therapist Wicara	40	36	46
Acupuncture	-	33	42
Total	280	244	439

(Source: Indonesia Health Profile 2013)

To study the medical rehabilitation at the university level, there is the Health Polytechnic in Surabaya East Java managed by KEMENKES.

2) Prosthetist and Orthotist

There are several schools for prosthetists and orthotists represented by those in Jakarta and Solo[84]. In February 2009, the Jakarta School of Prosthetics and Orthotics (JSPO) was established as Indonesia's first international standard prosthetic training school. This school was established with the support of the Japan Foundation and Cambodia Trust (a British NGO)[85]. The course for 3rd and 4th year students (Bachelor of Applied Science for Prosthetics and Orthotics) leads to a diploma of D3 or D4 level. The curriculum follows the international P&O training guidelines of the WHO and JSPO[86]。

84 Bergsma (2011) Lower leg prosthetics in Indonesia
85 Webpage of Kobe Medical Welfare Specialized School Sanda Campus Prosthetics Department http://po.kmw.ac.jp/archives/728
86 For more information on its curriculum, see JSPO webpage http://www.jspo.ac.id/#

3) Specializations in Mental Health

Table 3-16 shows the specialization, number and qualification system in mental health. Diplomas are normally obtained through three years of schooling, but in the university it takes four years. Obtaining a diploma means attaining D3 level and to continue on to a master's course, a D4 level is necessary.

Table 3-16 Specializations in Mental Health

Specialization	Number	Qualification System
Psychiatrist	787 (every year there are 20 psychiatry graduates)	Eight medical schools in eight universities (74 medical schools for normal physicians)
Clinical Psychologist	400 (70-100 staff work in mental health hospitals)	Seven schools in Jakarta
Medical Social Workers	Insufficient number	Same curriculum as social workers. Only 2 facilities offer this curriculum - the Bandung Social Welfare University (STKS) in Bandung managed by KEMSOS and college-level vocational training WIDURI in Jakarta
Mental Disorder Specialized Nurses	Less than 100 nurses	Relatively new specialization which requires three years of nurse training and three years of additional training (one year clinical training and two year classroom)
Occupational Therapist (OT)	800	Diploma level from specialized vocational school. Two schools in Solo City. Curriculum includes social psychology, orthopedics, pediatrics, geriatrics, internal medicine, CBR, etc.
Physical therapist (PT)	10,000	Diploma level from eight institutions
Speech Therapist	Insufficient numbers	Diploma level from three institutions

(3) Awareness Raising on Disability

KEMENKES does not conduct the awareness raising on women and children with mental disabilities. This is an activity under the administration of KEMENPPPA.

(4) Recent Trends and Issues

The following issues were raised by the East Java Health Office.

- Although midwives are able to detect problems and send children with disabilities for examination to the hospital, the pediatricians lack knowledge on disability and are not able to diagnose and provide appropriate treatment. Capacity strengthening of pediatricians and midwives are necessary.
- The number of pediatricians is insufficient.
- The number of medical staff who can screen at the Special Education School is insufficient. For example, a staff who received training in Surabaya moves to Jakarta where working conditions are better. Therefore, proper screening of experts is not done. Thanks to the cooperation of the Australian government, training for screening personnel was conducted in four municipalities. However, as there are 38 municipalities in East Java, the (re)trained personnel is woefully inadequate.

<Mental Health>

According to the Mental Health Department of KEMENKES, one of the largest problems is the fact that only 10% of mentally disabled persons are able to receive appropriate curative care. Therefore, it is important to fill the gap between those who are unable to and those who are able to receive care. There is

almost no mental health care not only in the primary health care level facilities but in general. New rules and regulations on the national health insurance was announced on 1 of January, 2014 that allow doctors who work at the primary health care level to diagnose on 155 items including mental health but the capacity of these doctors needs to be strengthened.

3.6.3 Labor

(1) Policy Issues Related to Disabilities and Development Programs

As mentioned in the overview of the previous section 3.4.3 (2), the increase in the employment opportunities for citizens and the public support of acquiring occupational skills with competitiveness is the main organizational mission of the Ministry of Labor (Kementerian Ketenagakerjaan: KEMENAKER), and this also applies to the basic labor policies for persons with disabilities.

KEMENAKER assumes the population ratio of persons with disabilities at 10%, and it is seen that approximately 25 million people are settling at an employment rate lower than a general workers within Indonesia (referred to Table 3-6). Therefore, the increase in the employment of persons with disabilities is recognized as an urgent national policy issue.

However, the vocational training schools under the management of KEMENAKER currently only incorporate curriculums for workers without disabilities, and therefore vocational training programs for persons with disabilities have yet to be established. The reorganization of vocational training schools under the umbrella for the creation of employment opportunities is being examined for the future, but there has not been any specific planning[87].

KEMSOS provides the social rehabilitation for persons with disabilities as part of the social welfare benefits in order to support their job search and social participation[88].

(2) Employment Promotion for Persons with Disabilities and Challenges

1) Ministry of Labor (*Kementerian Ketenagakerjaan*: KEMENAKER)

The vocational training/job-hunting support for persons with disabilities will possibly constitute the core activities of KEMENAKER in the disability-related field. As seen in the previous section, however, KEMENAKER is still in the process of reorganization; the planning for the future programs is at the stage of examination; and specific efforts have not started yet. The plan for training/deployment of relevant human resources and the procurement/arrangement of necessary facilities are also still ambiguous.

In the Government Regulation No.36, 1980 (On Social Welfare for persons with disabilities), is found a stipulation that the persons with disabilities who finished the curriculum of social rehabilitation are eligible for the job-placement support officially implemented under the responsibility of KEMENAKER (Article 19). Through this survey, however, (i) concrete procedures of the implementation and (ii) precise

[87] "With the impact of the reorganization following the change in presidents of last year - the ministry reorganized itself from the "Ministry of Labor Force and Transmigration" to "Ministry of Labor" - the reorganizing of departments and officials in charge have yet to be decided. (Based on the interview with KEMENAKER on May 13, 2013)

[88] As for the legal framework concerning the implementation of relevant policies to this issue, see 3.4.1 (2).

coordination/cooperation with KEMSOS to be in charge of the support to prepare and lend the persons with disabilities assistive devices/equipments for working independently/at home[89] were not confirmed.

At the employment data and information center (*Pusat Data dan Informasi Ketenagakerjaan*) which is under the umbrella of KEMENAKER, in accordance with the aforementioned national employment policies for persons with disabilities, with the slogan of "Persons with Disabilities as a Work Force," statistical information and analytical reports focusing upon the importance of the capacity development of persons with disabilities has been edited and publicized[90].

2) KEMSOS

In Indonesia, the promotion of social participation of persons with disabilities concerning the aspect of working is mainly supported by KEMSOS at present. Specifically, The National Vocational Rehabilitation Center (*Balai Besar Rehabilitasi Vokasional Bina Daksa*: BBRVBD) located at Cibinong, Bogor Prefecture, West Java Province, plays the leading role to support the social rehabilitation/ participation of persons with disabilities, through the creation of job opportunities. The contents of rehabilitation programs implemented at the center and relevant issues are briefly overviewed in the following[91].

BBRVBD was established in 1996 under the mutual cooperation between the Indonesian and Japanese governments. It is under the control of KEMSOS and has been promoting the job growth for persons with disabilities by providing vocational training programs. It has been expanded and enhanced, through the assistive leverage such as the Japan's cooperative projects for strengthening functions (from 2003 to 2006), and now accepts approximately 120 trainees (age 18 to 35) per year from all over the country to let them attend the training courses of following 6 fields: (i) garment, (ii) IT/PC, (iii) graphic design, (iv) electronics, (v) metalwork and (vi) automotive industry.

Two months of the 12-month training period are devoted to the internship program designed in cooperation with the partner enterprises that will be possible employers of the trainees after graduation. The 6 fields of training courses are also designated to increase the job opportunity for trainees considering the recent situations of the job market. As a result, the employment situation of the BBRVBD graduates in general is appraised as relatively good[92]. And since lecturers are partially but directly in charge of

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[89] Paragraph 2, Article 20.

[90] For example, the *Data dan Informasi: Disabilitas Angkatan Kerja* (2014). It is an attempt at trying to connect with skill development in the future by clarifying the current situation of persons with disabilities as a potential labor resource. The existence of a social welfare training facility for persons with disabilities (*Panti Sosial Bina Laras*: PSBL) which is not under the umbrella of said ministry, but KEMSOS, is also introduced actively.

[91] Data/information on the discussion in this section are mainly based upon GIZ, *Assessment Report BBRVBD Cibinong* (November 2014), Frank Schneider, "Towards Inclusive Employment - Practice Experience from Indonesia," (GIZ Discussion Paper No.25, April 2015) and JICA Knowledge Site, "Basic Information: The Project for Strengthening Functions of the National Vocational Rehabilitation Center."
(http://gwweb.jica.go.jp/km/ProjectView.nsf/0/4d41fb98eb200bb549257655000cd938?OpenDocument)

[92] Schneider, *op. cit.*,p.3.

designing the curriculum of the training courses, this kind of "teachers' participation" is highly appreciated as a contributive factor to strengthen organizational functions of the center[93].

It is indicated, on the other hand, (i) strategy is lacking in terms of connecting the start (selection of the target group of trainees[94]) and the goal (concrete figures/variations of graduates' employment); (ii) there is the gap between the training contents, final skills to be acquired and the necessary skills to be utilized at the future workplace. Therefore, the practical appropriateness of the curriculum for the social participation/reintegration of persons with disabilities, the final goal of the social rehabilitation, should be centered at the most critical tasks to be resolved.

3) Reference in East Java Province

In East Java Province, there are private vocational training schools for persons with disabilities. Furthermore, there are two inclusive vocational training schools (at Surabaya and Malang cities). At the vocational training school for persons with disabilities, it is possible to acquire technical skills related to computers, tourism, cooking, sewing, electronics, repairing cars and motorcycles, and housework. However, after graduating the school, the ratio of the graduates who are actually able to find jobs remains at approximately 25% (in addition, the employment includes the operation of self-owned businesses).

(3) Publicity Activities Related to Disabilities

In cooperation with local governments, DPOs, employer's associations, academic societies, and the Local Development Planning Agency (*Badan Perencana Pembangunan Daerah*: BAPPEDA), an "Educational Campaign Related to Employment of Persons with Disabilities" has been launched since 2014. In 2014, it was held in five locations (three provinces and two cities: Bali, South Sulawesi, Surakarta city, South Sumatera, and Pekanbaru city). Also in 2015, it is scheduled to be implemented in five locations (Medan city, Surabaya city, Yogyakarta city, West Java, and East Nusa Tenggara) [however, the budgetary measures for this year have yet to be completed].

Furthermore, in cooperation with the local governments, events are held in celebration of the International Day of Disabled Persons (the 3rd of December).

In 2010, the National Action for Disability started (the background is the National Plan of Action on Disability [2004-2013][95] by KEMSOS), with the slogan of "Persons with Disabilities into Companies," and in terms of increase in employment, it has made some successful contributions (in Table 3-6, for example, the upward trend can be seen in the percentage of persons with disabilities being employed in recent years).

[93] GIZ, *op. cit.*, p.10.
[94] As for the strategic selection of trainees, there is no codified policy and only the general tendency, that can be seen through the past records, shows that candidates with relatively light disabilities –hearing impairments, speech difficulties, mobility impairments, etc. – passed the screening process. (*Ibid.*, p.6)
[95] The description of the activity plan can be found here: DWI Heru Sukoco, Huldaria Bako, *The Enhancement of ICT accessibility for PWD's in Indonesia* (http://unpan1.un.org/intradoc/groups/public/documents/ungc/unpan040430.pdf). However, it does not mention the content of the activity plan itself.

(4) Recent Trends, Goals of the Future, etc.

1) KEMNAKER

While there are companies like Carrefour (a major French supermarket) that actively employ persons with disabilities, most private enterprises are not so positive to employ persons with disabilities. Therefore, the one of the most significant goals of the labor administration relevant to disabilities for the future is to increase the number of companies that employ persons with disabilities[96].

In order to achieve such specific goals, KEMNAKER raises the necessary conditions. The priority issues related to "disabilities and development" in the employment field are as follows:

- After selecting a specific model district, implement an employment support project for persons with disabilities (the specific budgetary measures and planning are undecided) that communicates the best practice to all of Indonesia.
- Continuity: The action plan related to the employment of persons with disabilities is being formed. The point is how to continue this plan and its implementation.
- Regulations and systems development (although laws and various regulations exist, it is not sufficient for the achievement of the goals.)
- Infrastructure development in the working environment: Improvement of accessibility
- At the vocational training schools under the control of KEMENAKER, it is currently deliberated to accept persons with disabilities trainees, and to introduce training programs for persons with disabilities in order to implement the capacity development.
- Promotion of the cooperation with small and medium-sized enterprises (SMEs) that may employ persons with disabilities: Providing an opportunity for the productivity improvement of SMEs (the employment of persons with disabilities has relatively progressed in large companies, but it remains an issue for SMEs).
- Training of human resources in promoting the employment of persons with disabilities:
  - Training of master trainers with disabilities in the field of IT,
  - Training for the human resource departments at each of the enterprises (the government takes the lead because it is for the promotion of the employment of persons with disabilities),
  - Disability educational training for the staff of KEMNAKER, and
  - Training for the staff of local governments.
- Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ) conducted a research project on the determinant factor of employment of persons with disabilities by interviewing eight private companies located in Java island (3 in Jakarta, 2 in Yogyakarta, 1 in Sidoarjo, 1 in Surabaya, and 1 in Bogor). It is reported that the most negative factor for persons with disabilities to be employed is the necessity of alteration/arrangement of the working environment, to be borne by

[96] Based on the interview with KEMENAKER (May 13, 2013).

the employer. It is also implied that more studies for confirmation of and a countermeasure against this problem are needed for the disability-related administration[97].

2) KEMSOS

- As for the cross-cutting issues concerning disabilities, the National Coordination Team for Disability, composed of representative officials affiliated with agencies relevant to the disability issues, tries making balance of different interests and opinions. It is also applicable to the issue of employment of persons with disabilities and the confirmation of the progress and coordination between KEMNAKER and KEMSOS will be needed, especially in terms of lacking organization and arrangement of KENMAKER for the implementation of the training programs for persons with disabilities at the vocational schools under the Ministry's control.
- To respond to the suggestion for the improvement of BBRVRD, the center of social rehabilitation for persons with disabilities under the management of KEMSOS,: (i) rearrangement/redesign of the curriculum to be needed at the labor market for the promotion of the employment of graduates, (ii) in order to achieve (i), expansion of cooperation with the private sector, (iii) putting stress rather upon on-site trainings than lectures at the classroom and extending the period of internship, and (iv) trainees' participation to the stage of designing curriculums[98], KEMSOS, with close coordination with KEMENAKER, ought to examine the suggestion stated above and establish/arrange more effective systems of the vocational training for persons with disabilities nationwide.

3.6.4 Social Protection and Support Services - Including Poverty and Community-based Rehabilitation

Generally, persons with disabilities experience difficulties in accessing education and employment; thus, tend to become impoverished as a result. In Indonesia, this trend is quite evident. There is an abundant literature on the relationship between poverty and disability globally, but in Indonesia, the literature on poverty and disability is limited. Adietomo *et al.* showed there is a strong association between disability and poverty in 2014, that this varies depending on the type of disability and that the possibility in being poor was 30% to 50% higher for persons with disability compared with the non-disabled. A comparison of disparities of poverty rates of persons with disabilities and non-disabled between urban and rural areas was conducted and it was found that the poverty rate of people in urban areas was higher[99]. The additional financial burden on households caused by the disability also contributes to poverty (additional financial burden varies largely according to the degree of disability and province from 15% to 30%)[100].

(1) Systems and Programs

The National Social Security Law (Law No. 40/2004) regarding the National Social Protection System (refer to Section 3.4.2 (2) 1) mandates the extension of social protection coverage to the whole population

[97] Schneider, *op. cit.*, p.2.
[98] GIZ, *op. cit.*, p.18 and Schneider, *op. cit.*, p.3.
[99] Adietomo (2014)
[100] Adietomo (2014)

in the categories of health, work injury, old age, and death of the breadwinner. The Law on Health Social Protection Providers (No. 24/2011), elaborating the implementation of the National Social Protection System, stipulates the universal health insurance to commence in 2014, while work injury, old age, and death insurance are anticipated to start in 2015. The Social Health Insurance Provider (BPJS Kesehatan) is officially in operation since 1 January 2014[101]. The Employment Social Protection Provider (BPJS Ketenagakerjaan) is preparing to launch in 2015. BPJS Kesehatan is tasked to integrate all the health insurances, which were used to be divided by professions (the privates sector, civil servants, army, etc), and is expected to reach universal coverage with a single health care system, Jaminan Kesehatan Nasional (JKN) by 2019. There is no health insurance or pension plan for persons with disabilities.

Under the Employment Social Protection managed by the BPJS Ketenegakerjaan, if the insured person (below 55 years old) becomes disabled, disability benefits are paid. In case of permanent disability, the insured receives a one-time lump sum of 70% of 80 months of the insured's wage in the month before the disability began and IDR200,000 per month for up to 24 months. This applies to permanent disability as a result of work injury. In case of temporary disability as a result of work injury, 100% of the insured's wage in the month before the disability began is paid for the first four months, 75% for the next four months, and 50% thereafter until the determination of permanent disability. The degree of disability is based on a health examination by a medical doctor[102].

According to International Labour Organization (ILO), 41% of Indonesia's total population (according to TNP2K 70%[103]) do not have health insurance[104]. The reasons given are that non-poor informal sector laborers and their families are not covered by health insurance. This is because 1) there is a recipient-targeting problem due to the lack of accurate data to identify persons and children with disabilities, impoverished elderly, 2) there is a problem of formal sector laborers who try to avoid paying health insurance fees, and 3) there is a problem of the program being redundant (due to lack of coordination)[105]. In order to receive public medical assistance for the poor (free medical service), one must meet the criteria (this could differ between regional governments). According to a hearing with DPOs, there are cases where a person with disability was not able to meet the criteria and could not receive his/her medical assistance. For example, there is a condition which says one should not possess a motorcycle, but in many cases, persons with disabilities own a motorcycle as their access to public transportation is difficult. This means that despite being poor, they are unable to receive medical assistance.

[101] The reform of social security in Indonesia (http://www.ituc-csi.org/the-reform-of-social-security-in?lang=en)
[102] The US Social Security Program webpage, The World's Social Security programs 2014 http://www.ssa.gov/policy/docs/progdesc/ssptw/2014-2015/asia/indonesia.html
[103] Based on the interview with TNP2K on 12 May 2015
[104] ILO (2012) *Social protection assessment based national dialogue: Towards a nationally defined social protection floor in Indonesia*
[105] As above

1) The 26 Social Issues

KEMSOS, which is responsible for welfare, has 26 social categories which the country has prioritized for support. The 26 social issues are listed in Table 3-17[106]. Measures are being implemented to meet the needs of these 26 categories.

Table 3-17 26 Social Issue Categories

No.	Category	
	Indonesian	**English Translation**
1	*Anak Balita Terlantar*	Homeless toddler under 5 years old
2	*Anak terlantar*	Homeless children
3	*Perempuan Rawan Sosial Ekonomi*	Women in social and economic difficulty
4	*Lanjut Usia Terlantar*	Homeless elderly
5	*Anak Dengan Kedisabilitasan (ADK)*	Children with disabilities
6	*Penyandang Disabilitas*	Persons with disabilities
7	*Fakir Miskin*	The Poor
8	*Anak yang menjadi korban tindak kekerasan atau diperlakukan salah*	Children who are victims of violence
9	*Anak yang berhadapan dengan hukum*	Street children
10	*Anak yang memerlukan perlindungan khusus*	Children with need of special protection
11	*Anak jalanan*	Street children (homeless children living on the street)
12	*Korban Tindak Kekerasan*	Victims of violence
13	*Tuna susila*	Prostitutes
14	*Pengemis*	Beggars
15	*Gelandangan*	Vagrant
16	*Pemulung*	Scavengers
17	*Kelompok Minoritas*	Minorities
18	*Bekas Warga Binaan Lembaga Pemasyarakatan (BWBLP)*	Former sentences persons
19	*Korban penyalahgunaan napza*	Victims of drug abuse
20	*Komunitas adat terpencil*	Remote indigenous community
21	*Keluarga bermasalah sosial psikologis*	Families with social and psychological problems
22	*Korban bencana alam*	People affected by natural disasters
23	*Korban bencana sosial/pengungsi*	People affected by social conflicts
24	*Pekerja Migran Bermasalah Sosial*	Migrant workers who have social problems
25	*Orang Dengan HIV/AIDS (ODHA)*	People living with HIV/AIDS
26	*Korban* Trafficking	Victims of trafficking

(Source: Panduan Pendataan: Pusat Data dan Informasi Kesejahteraan Sosial (PMKS) (2013), Ministry of Social Affairs)

2) Social Protection System for the Poor and the Disabled

The comprehensive database obtained by the Data Collection of Social Protection Programs (*Pendataan Program Perlindungan Sosial:* PPLS) for social protection managed by TNP2K covers about 40% of the poorest of Indonesia's total population. As of September 2014, the poverty rate was 10.96%[107]. The PPLS covers not only the poor but also those who are borderline poor according to their socioeconomic situation. This is why this database was constructed based on a household survey, targeting 40% of the poorest in Indonesia.

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[106] The Social Welfare Data Information Center edits the data by province and issue

[107] BPS, *Statistics Indonesia* (http://www.bps.go.id/linkTabelStatis/view/id/1488). Based on each province's urban and rural area poverty line (monthly income per person) (see Table 2-2).

The PPLS was created and has a strong focus, even among the existing social protection programs, to assist in an accurate and efficient manner the cash transfer to the poor. The current cash benefit system for the poor targets 25% of the poor, the education support program targets also the same 25%, the national health insurance program 30% of the poor, and the rice distribution program covers 25% of the poor. Below is the Table 3-18 which describes the social welfare systems targeting the poor and the disabled.

Table 3-18 Main Social Welfare Systems for the Poor including Persons with Disabilities

Group	Benefit Type	Program Content	Organization	Ministry
Poor Households	Free Medical Care	Covers 30% of poor households. Non-contributory plan Jamkesmas was integrated with the National Health Insurance (JKN) in January 2014. JKN is managed by BPJS Kesehatan. Therefore, JAMKESMAS members and local health insurance members (*Jaminan Kesehatan Daerah*: JAMKESDA) automatically become JKN-PBI program members.	JAMKESMAS JKN-PBI	KEMENKES
	Provision of Rice	Covers 25% of poor households	Raskin (*Beras untuk Orang Miskin*)	KEMSOS
	Conditional Social Cash Transfer for Disadvantaged Children)	Started in 2007 and is called the Family Hope Program. It provides cash for households with children under five years old up to elementary and secondary school as well as pregnant women for schooling and prenatal care. Lacks an accurate database on coverage and is thought to be a small-scale program.	PKH (*Program Keluarga Harapan*), PKSA(*Program Kesejahteraan Sosial Anak*)	KEMSOS
	Social Cash Transfer for Persons with Severe Disabilities *(Assistensi Social untuk Organg dengan Kecacatan Berat* : ASODKB)	Started in 2006. Cash transfer of IDR 300,000 (equivalent to approximately JPY 2,800 as of 30 July 2015 rate) . Around 20,000 persons with disabilities received this benefit in 2014 (According to a hearing with KEMSOS). About 22,500 persons with disabilities will receive this benefit in 2015. East Java Province provided this benefit to 1,767 persons with disabilities in 2011. There are two criteria in selecting cash transfer recipients: 1) impoverished and 2) activities of daily living are hindered. There are no differences in conditions by disability. Recipients are determined by the social worker at the ward level. Based on this information, the municipal level social affairs officers prepare and give the list of candidates to the provincial level officers which in turn examine their	JSPACA (*Jaminan Sosial Penyandang Cacat Berat*)	KEMSOS

Group	Benefit Type	Program Content	Organization	Ministry
		circumstances (names and addresses). Finally, KEMSOS approves the list of recipients		
	Cash Transfer for Poor Families (Card Family Prosperous)	25% of the poor are covered. Started in 2006. Receives IDR 20,000/month	KKS (*Kartu Keluaga Sejahtera*)	KEMSOS
	Scholarship	Children of poor households are eligible. Covers approximately 25% of the poor.	BSM (*Bantuan Siswa Miskin*)	KEMDIKBUD
	Free Medical Insurance for the Poor	Poor not covered by JAMKESMAS	JAMKESDA	Regional Governments
Impoverished Communities	Social and Physical Infrastructure (country and village levels)	Community development and strengthening program. Subsidies to communities distributed through central and regional government channels. Communities decide to themselves what subsidies they will use for infrastructure, economic development, or social development.	PNPM Mandiri (*Program Nasional Pemberdayaan Masyarakat Mandiri*)	KEMSOS, Ministry of Interior, KEMPUPERA
Small and Medium Enterprises (SME)	Microcredit	Bank-managed small and medium enterprise loan insurance by the government. This allows unsecured loans to small, medium, and micro enterprises which employ the poor.	KUR (*Kredit Usaha Rakyat*)	Ministry of Economy
Elderly	Cash Transfer for the Elderly (*Assistensi Sosial Lanjut Usia* : ASLUT)	Unconditional cash transfer (social assistance) for the elderly	JSLU (*Jaminan Sosial Lanjut Usia*)	EKMSOS

(Source: Interview with TNP2K and East Java Provincial DINSOS, ILO (2012) Social protection assessment based on the national dialogue: Towards a nationally defined social protection floor in Indonesia、Table created on the basis of TNP2K webpage information)

3) Support Services and Care Service Programs Supported by the Government for Caregivers and Peer Counseling

The Incheon Strategy recognizes government-funded services and programs, including for personal assistance and peer counseling, as one of social protection programs which should be provided to persons with disabilities. There was no program for respite care or government support service program for caregivers and peer counseling according to the interviews with persons with disabilities themselves.

4) Assistive Devices

5) a. Types of Assistive Devices

The BPS has listed the following types of assistive devices: wheelchair, crutches, prosthetic legs, prosthetic arms, white cane, hearing aid, Braille templates, computer, and others. Table 3-19 shows the utilization percentage by assistive devices.

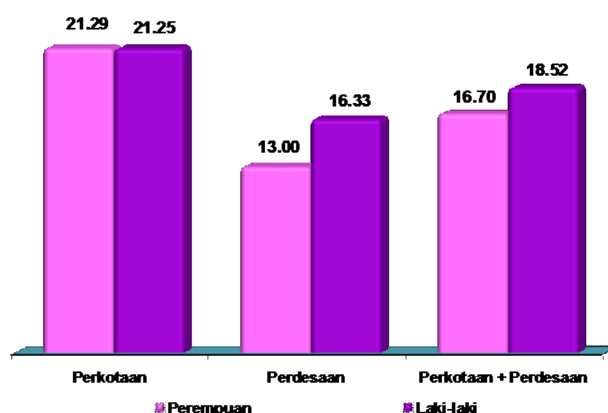
Table 3-19 Ratio of Persons with Disabilities Utilizing Assistive Devices (by type of equipment)

Type of Assistive Devices	Female			Male		
	Urban	Rural	Urban and Rural	Urban	Rural	Urban and Rural
Wheelchair	2.22	0.87	1.47	2.49	0.96	1.64
Crutches	4.00	3.62	3.79	5.01	4.74	4.86
Prosthetic (leg)	0.01	0.03	0.02	0.09	0.05	0.06
Prosthetic (arm)	-	-	-	-	-	-
White Cane	0.55	0.31	0.42	0.88	0.58	0.71
Hearing Aid	0.45	0.20	0.31	1.17	0.44	0.76
Braille Templates	-	-	-	-	-	-
Computer	-	0.10	0.06	-	-	-
Other	14.07	7.85	10.62	11.62	9.58	10.49

(Source: Indonesia Female Profile 2013, Ministry of Women Empowerment and Child Protection)
(Original source: BPS RI – Susenas, 2012)

6) b. Access to Assistive Devices

In order to receive these devices, one applies at their local office. The application is sent to the provincial government and then to the central government. KEMSOS provides free of charge for wheelchairs and canes. As shown in Figure 3-13, access to assistive devices is very limited. According to SUSENAS 2012 data collected by the BPS, only 16.7% of women with disabilities and 18.52% of men with disabilities had access to assistive devices. Regional differences were large with 21.29% of urban women with disabilities having access whilst only 13% of rural women had access (21.25% of urban men with disabilities compared with 16.33 rural men with disabilities)[108]. For example, 35.5% of men with disabilities in the Riau Islands used assistive devices compared with only 4.59% in West Sulawesi.



(Source: Indonesia female profile 2013, Ministry of Women Empowemrent and Child Protection)

Figure 3-13 Ratio of Persons with Disability using Assistive Devices by Gender and Residence

Persons with disabilities living in rural areas must travel long distances to the urban areas and transportation costs are also a burden. For persons in rural areas who have had to amputate a leg (or legs) because of a

[108] According to the Indonesia Health Status 2013, there is a large regional difference in the production and distribution of medical equipment in Indonesia. Production and distribution is limited to the west of Indonesia (Sumatra and Java) proven by a 94.4% share of production and 78.4% distribution rate. There is a large regional difference in the production and distribution of welfare equipment.

traffic accident, returned to their villages without any follow-up, there are also reported cases where they become mentally ill or depressed, isolated and in some extreme cases, do not leave their homes for years up to the end of their lives[109].

7) c. Production of Prosthetics

Only a limited number of companies are able to produce good quality, low cost prosthetics in Indonesia as there is a lack of infrastructure and technology in the country[110]. According to Handicap International (HI), there were less than 20 prosthetic manufacturing facilities, as of 2011 and is limited to urban areas[111]. In Yogyakarta, the Yakkum Rehabilitation Center manufactures a low cost module type prosthetic leg and there are facilities which can test the strength and durability of the prosthetic (legs) at the Fablab Workshop and Gadjah Mada University[112].

8) Facilities Targeting Persons with Disabilities

KEMSOS runs 20 facilities which target persons with disabilities and 500 privately managed facilities. There are also facilities run by local governments. Some facilities depend on budgetary support from KEMSOS.

(2) Experts on Disability and Social Workers

As of June 2015, the only occupation in the social welfare and support field is the social worker[113]. They are assigned to the county level and financed by a budget allocated from the central government. They work on the 26 social issues (for more details refer to Section 3.4.1) recognized by the Indonesian government, identifying and updating information on persons with social problems. Their salary is low at IDR 250,000 per month. Although there is a qualification system for social workers, the salary is too low for one to think of social work as a career. There are also social workers who work specifically on the central level-managed cash transfer program for poor households whose monthly salary is IDR 150,000. Whether one gets to receive this on top of his/her salary at the local government level, is up to the local government. Some social workers learn sign language and teach other social workers.

In order to become a social worker, training in social work or social welfare must be undertaken as shown in Table 3-20. There are two training schools that offer such courses. For prosthetists and orthotists, refer to 3.6.2 (2) 2).

[109] Bergsma (2011) lower leg prosthetics in Indonesia
[110] Bergsma (2011) lower leg prosthetics in Indonesia
[111] As above
[112] As above
[113] Based on the interview with KEMSOS (29 June, 2015) and the East Java Provincial DINSOS (18 May, 2015)

Table 3-20 Training Curriculum for Social Workers

Subject	Curriculum
Social Work	Social Welfare University (*Sekolah Tinggi Kesejahteraan Sosial*: STKS) in Bandung: Four years. Responsibility of KEMSOS. Located in Bandung. Certification of Social Workers specialized in Disability by KEMSOS. Established in 1964 and is a pioneer in the education of social workers. In addition to social work education, they provide graduate level education on poverty, child and family welfare, drug abuse, disability, medical social work. The number of undergraduate students is 1,563 and has 58 graduate students. The number of graduates is 14,224. Hosted short-term senior volunteers for one year from April 2005 and seven months from June 2006[114]. Curriculum: social welfare, medicine, community development, practical social work, disability, drugs, natural disasters, etc.
Social Welfare	Four-year university program on social welfare. Courses offered in 38 universities. Master's and Doctorate programs started in 2011.

(3) Social Insurance and Social Support Programs, Coverage Rate of Social Protection Programs for Persons with Disabilities

There is no data on the accurate coverage rate of social protection programs for persons with disabilities. TNP2K manages the coverage data of social protection related programs and is able to calculate the coverage rates of the above mentioned programs but this is only for reference and does not necessarily reflect the real situations in which persons with disabilities find themselves in. There are cases where some households do not report that there is a person with disability in their household when applying for social protection services[115]. This means that the coverage data does not necessarily include all persons with disabilities.

The University of Indonesia Center for Disability Studies, in cooperation with GIZ's social protection program and BAPPENAS's social protection and welfare department. The center has conducted a survey on persons with disabilities' social participation and access to social protection programs in Sukoharjo Province in Central Java which is reported on in "Investment in Ability[116]". According to this report, the application of social protection program is very limited. For example, the application of the program for persons with disabilities is reported as shown in Table 3-21.

The report analyzes that targeting is what inhibits the wide application of social protection programs to cover the needs of persons with disabilities. According to a field test done in 2009 to 2010 on WHO's disability identification tool, 13,918 persons were identified as disabled in Sukoharjo Province, but the data collection method of PPLS was only able to identify 5,259 persons with disabilities. If the social protection program target participants are calculated using this data, only 37.7% of persons with disabilities (identified through the WHO method) in Sukoharjo Province would be able to receive social protection benefits.

[114] Based on JICA 2015 spring overseas cooperation volunteer request study table (http://www.jocv-info.jica.go.jp/sv/index.php?m=Info&yID=SL00615C02)
[115] Based on the interview with DPOs in Surabaya City (14 to 23 May 2015) and BPS (2 July 2015).
[116] Center for Disability Studies, Investment in Ability - An Assessment of Living Conditions of Persons with Disabilities in Sukoharjo District with a Focus on Access to Social Protection Programs (Faculty of Social and Political Sciences, Universitas Indonesia: Jakarta, May 2013).

Table 3-21 Application of Social Protection Program for Persons with Disabilities

Social Welfare System	Situation
Social Insurance	Need to investigate situation of persons with disability employed by the formal sector. However, there is no data on Sukoharjo Prefecture. Overall situation on social protection of persons with disabilities is unknown.
Cash Transfer	Although unconditional cash transfers for persons with severe disabilities and poor families exist, access is limited and the coverage, as well as the cash amount is far from the actual number of persons of disabilities and their needs.
Health Insurance	Central Government led JAMKESMAS and regional government led JAMKESDA exist, but the access problem of physical distance to register and communication problem leads to limited service coverage. The needs of persons with disabilities are in theory met through health centers (*Puskesmas*) with the budget of JAMKESDA, but support for persons with disabilities who request curative care is limited.
Medical Rehabilitation System and Provision of Assistive Devices	Partnerships with NGOs exist for provision of medical rehabilitation and assistive devices, it is still minimal.

(4) Community-Based Rehabilitation Managed by the Community or the Country

According to KEMSOS, there is a CBR program in almost all of the provinces in Indonesia. In the beginning, most programs were medical rehabilitation-focused administered by KEMENKES, but recently, there is an increase of programs with a social rehabilitation component[117]. KEMSOS, in partnership with KEMENKES, KEMNAKER, and Ministry of Interior, provide financial support and capacity building to CBR volunteers. In addition, there is a national network on CBR facilitated by KEMSOS[118].

The role of the community on disability issues is large in Indonesia. Although there is a public medical insurance system for poor households in Indonesia, it only covers transport and chaperone costs. In some areas, access to medical facilities might be limited due to its proximity. Therefore, these areas would have spontaneous, self-help activities, playing an important social safety net role. Health volunteers might cooperate with the village head, the head of the settlement, the ward head, and other community leaders on day-to-day public health prevention activities. Residents might also donate or give food to maintain a minimum livelihood in case a neighbor falls ill or has to pay a high hospital bill[119]. According to a study on the reality of social participation and access to social protection programs of persons with disabilities in Sukoharjo Province in Central Java, many persons with disabilities are supported by and cared for by local citizens or local groups and in some cases, CBR is provided.

KEMSOS recognizes the following 12 individuals, families, and groups as community-level social welfare workers[120].

1. Professional Social Workers
2. Volunteer Social Workers

117 Medical rehabilitation is a treatment, after the medical intervention, at hospitals or facilities to restore the loss of one part of functions of the body that were lost. Social rehabilitation is to aim for strengthening “social skill” to live one’s own life independently by utilizing available services for persons with disabilities. Source: The concept and methods of social rehabilitation http://www.dinf.ne.jp/doc/japanese/prdl/jsrd/rehab/r089/r089_002.html

118 CBR network URL:http://www.disabilitas-jejaring-rbm-indonesia.com/

119 JICA(2012) Thematic Guidelines on “Social Protection”,p13

120 KEMSOS (2013) Panduan Pendataan: Penyandang Masalah Kesejahteraan Social (PMKS)

3. Youth Volunteer for Disaster Management (TAGANA) (for more details, refer to 4.2.1(2) 3))
4. Social Welfare Institutions (*Lembaga Kesejahteraan Sosial*: LKS)
5. Youth Organizations
6. Family Welfare Advisory Bureau (*Lembaga Konsultasi Kesejahteraan Keluarga:* LK3) : counseling services and information, awareness raising organization
7. Pioneer Families: overcome problems and become model families
8. Family Forums rooted in Local Social Welfare: a connecting system of facilities, business groups and communities
9. Female Leaders on Welfare
10. Social Instructors: social welfare officers within local governments (civil servants)
11. District Social Welfare Workers (*Tenaga Kesejahteraan Sosial Masyarakat:* TKSM): workers at district levels
12. Business: from the corporate social responsibility (CSR) perspective, entrepreneurial groups contributing to social welfare

As mentioned previously in Section 3.6.2 (1) 1), there are community rehabilitation centers managed by the *Yayasan Pembinaan Anak Cacat* (YPAC) and the Indonesia Society for the Care of Disabled Children in 16 provinces in Indonesia providing medical rehabilitation services for physically disabled children.

The Christian Blind Mission (CBM), an international NGO, implements CBR programs in partnership with local NGOs (refer to Section 6.3.1).

According to a document which studied two CBR programs in East Indonesia, local NGOs might be implementing a CBR program based on their unique definition of the CBR concept or problems occur as a result of a lack of correct knowledge on CBR or disability in general. It is pointed out that donors such as international organizations must first understand the area's problems, realities on barriers (poverty, basic health services, and community resident needs) before supporting NGOs[121].

DPOs and NGOs interviewed during this mission did not use the term "rehabilitation". This is, according to CBM due to the negative image "rehabilitation" has. In its place, the term Disability Inclusive Community Development is used to describe CBR.

3.6.5 Physical Environment, Public Transportation, Knowledge, Information and Communication on Barrier-free, Universal Design

(1) Physical Environment, Public Transportation and Barrier-free Universal Design

1) Outline

Laws and standards for accessibility have been put in place and KEMPUPERA and KEMEHUB have made efforts to diffuse information on these laws. However, based on the survey team's assessment through

[121] Integrating Disability into Development in Eastern Indonesia: A Case Study in Theory versus Reality (2011) http://hcs.pitt.edu/ojs/index.php/hcs/article/view/47/86

interviews with researchers and persons with disabilities themselves as well as the survey team's literature review and an access audit during this mission, day-to-day accessibility is not good for (average) Indonesian persons with disability due to insufficient barrier-free, universal design facilities[122]. However, as seen in the taxi company example mentioned in Section 3.2, services which are designed to keep accordance with the needs of persons with disabilities are increasing. On the other hand, there are still cases here and there where the needs of persons with disabilities are perceived incorrectly or the views of persons with disabilities are not adopted, leading to the services which cannot be appropriate for users with disabilities or where the ramp might be too steep for a wheelchair user to use by oneself[123].

There is no government access audit which requires the participation of a disability expert such as persons with disabilities themselves but some central and local level governments request the cooperation of DPOs in order to conduct this type of access audit. In Yogyakarta City, where awareness on disability is high, an access audit was conducted with persons with disabilities. In the country's capital, there is no data on the ratio of accessible government buildings, accessible international airports and ports, as well as major transport hubs, making it difficult to objectively quantify the situation. Below are the results of the access audit conducted in Surabaya City by the survey team.

2) Barrier-free, Universal Design Policy and Related Laws

The laws related to physical environment and public facilities are described in Section 3.4.1.

From 2005 to 2013, KEMPUPERA conducted accessibility improvement pilot projects in 33 provinces. As a result, physical accessibility in 271 places such as public buildings, bus terminals, airports, hospitals, mosques and schools improved. In Table 3-22, the budget and number of places improved by year are outlined. In the project sites, not only was there an improvement in physical accessibility but also improvement in attitudes of local government staff that do not see accessibility improvement as an additional burden anymore. In addition, in some private business facilities, this type of awareness has grown with an increased number of visitors.

For accessibility in the education field, there are cases where the central government (KEMDIKBUD) subsidizes the rehabilitation of old school facilities of inclusive education schools and special schools so that they become barrier-free; however, budget constraints have not led to accessibility improvement for all schools. Some newer schools have improved accessibility. The standard on accessibility in special schools is set under the responsibility of KEMPUPERA.

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[122] According to an accessibility survey (*Jakarta Akses Survey*) done by multiple organizations including the HWPCI (the Indonesian Disabled Women's Association), Bina Paraplegia Foundation, Trisakti University's Civil Planning and Engineering Faculty, Jakarta branch of the Indonesian Architects Association) between 2001 and 2003,only 3% of Jakarta's buildings are physically accessible. See Inside Indonesia Article from 2008 "Disabled Megalopolitan" http://www.insideindonesia.org/disabled-megalopolitan

[123] Based upon the results of the access audit conducted in Surabaya by the survey team, it was pointed out that the involvement of PWDs themselves is weak also in Hayati and Faqih, "Disabled people's accessibility problems on public facilities within the context of Surabaya, Indonesia" (*Humanities and Social Sciences*, 2013). [http://article.sciencepublishinggroup.com/pdf/10.11648.j.hss.20130103.11.pdf

Table 3-22 Outline of Physical Accessibility Improvement Project by KEMPUPERA

No.	Year	Budget by Municipality	Number of Places	Remarks
1	2005	IDR 25,000,000-	37	Consideration for the technical accessibility in line with the 1998 Ministry Ordinance No. 468
2	2006	IDR 50,000,000-	48	Consideration for the technical accessibility in line with the 2006 Ministry Ordinance No.30
3	2007	IDR 50,000,000-	39	
4	2008	IDR 50,000,000-	46	
5	2009	IDR 100,000,000-	35	
6	2010	IDR 150,000,000-	12	
7	2011	IDR 150,000,000-	26	
8	2012	IDR 250,000,000-	26	
9	2013	IDR 250,000,000-	2	
		TOTAL	271	

(Source: Ministry of Public Works and Housing (2015) Oversight on the Provision of Facility and Accessibility in Buildings)

3) Situation in Urban Areas

There was a barrier-free toilet and escalators in the capital's international airport.

For rail transport, most stations and trains are not barrier-free. The station audited for accessibility in Surabaya did not have an entrance ramp to the station building, the walkways are narrow making it difficult for wheelchair users to use. According to users of rail transport with disabilities, the seats and aisles in the regular (second class) cars are narrow making it difficult for wheelchairs to pass so they are obliged to use first class.

There are high steps in Jakarta and Surabaya City urban walkways. This is to prevent cars from running on the sidewalk. In some cases, there are trees planted on the roadside. There are sidewalk potholes or places which are not well maintained with concrete falling apart making it difficult for even non-disabled persons to walk. For guiding blocks, there are yellow blocks and narrow grey blocks. The official guidelines promote the use of yellow blocks but in Surabaya, the narrow grey blocks are more common. Persons with disabilities use taxis and cars for daily transportation whilst persons with visual disabilities use friends-driven motorcycles or motorcycle taxis[124].

4) Barrier-free Situation in Surabaya - Access Audit Results

Access must be ensured when building an inclusive society, but in Surabaya, it is difficult for a person with disability to walk alone or use buses and other public transportation by him/herself. Surabaya City does not have an ordinance on accessibility. Children with disabilities have been refused admissions to main schools due to a stereotype that children with disabilities are not capable of learning, or because they do not have toilets for children with disabilities. As there are no disability-considerate taxis or private welfare service vehicles, persons with disabilities must move from place to place using taxis, persons with visual disabilities must use motorcycle taxis. Roads are difficult to walk for even non-disabled users and the design of walkways are far from being disability-considerate.

[124] Based on the interview with persons with disabilities.

In order to study the situation of accessibility in Surabaya, the survey team conducted a two-day access audit. The summary is presented in Table 3-23.

Date:	22 and 23 May 2015
Study area:	Parks and station, bus terminals, roads, shopping center, market. A village outside of Surabaya (Wonorejo Indah Timur No. 145)
Participants:	Petra Christian University Universal Design Lecturers, persons with disabilities (hearing, visual and physical impairment, wheelchair and crutch users), survey team members

Table 3-23 Problems Identified during the Access Audit

Area	Problems
Sidewalks	No Braille blocks before the crosswalk making it difficult to know where to cross the road.
	The width, color, and material used for the Braille blocks do not comply with standards.
	A large tree in the middle of the sidewalk. This is dangerous when persons with visual disabilities use the sidewalk.
	No ramp from the sidewalk to the crosswalk.
Railway Stations	No ramp at the entrance of the station.
	No full-time security personnel for persons with disabilities to turn to for help when necessary.
	No personnel who understand sign language at the station information center. Difficulties in obtaining information through writing on how to buy a ticket to one's destination.
	The information boards are small and hard to see
	Lack of announcements on the train making it difficult to know when the train has arrived at.
Park	The ramp is too steep for a wheelchair user to climb on it by oneself
	No Braille block making it difficult to walk in the park
	No information boards for persons with hearing disabilities, making it difficult to obtain information on the park
Bus/Bus Terminal	The bus is not barrier-free
	Lack of information on what bus to take
Surabaya Suburb Village of Wonorejo Indah Timur	Roads are not tarmacked making it difficult for wheelchair users to move from place to place
	No ramps to village administrative buildings
	No ramp to the mosque, inhibiting prayers at the mosque

The following causes and issues were discussed in the lack of physical accessibility during the post-audit meeting.

- Persons with disabilities are not involved in the process of mainstreaming a barrier-free perspective (policy development and implementation). Even if they are involved, it is just the first meeting and no invitations are issued afterwards.
- There is no access committee and rules that are necessary to establish such a committee.

- No follow-up action after the submission of the report with recommendations to the local government by a local DPO which conducted an access audit in 2006.
- Builders and construction companies do not understand the importance of a universal design.

The action point of strengthening partnership between academia and DPOs was proposed.

The reality of physical accessibility in Surabaya City can be also found in Hayati and Faqih's (2013) report125.

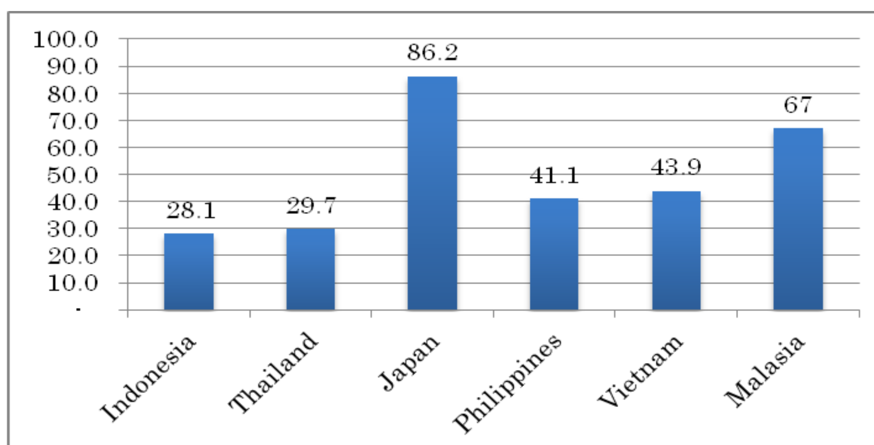
(2) Information, Communication and Barrier-free Design

In line with the Biwako Millennium Framework (1999-2002) and the ASEAN Strategic Framework on Disability, the Indonesian government set a target to improve Information and Communication Technology (ICT) utilization and access for persons with disabilities. The objectives are to improve accessibility, standardize communication, sign language, and Braille and improve its use and standardize ICT for persons with disabilities. As a result of partnership between the government and DPOs (Indonesia Braille Printing House, Mitra Netra Foundation and others), an Indonesian sign language (SIBI) was developed, digital and Braille books were published, visually and hearing impaired accessible websites were promoted[126].

Despite these efforts, activities to ensure access to information for persons with disabilities were not enough. This is said to be due to lack of government budget allocation, infrastructure, and training on ICT in the rehabilitation centers[127]. The data on ICT utilization was also scarce. For example, there is no data on the number of persons with disabilities who can use Braille, or who use mobile phones and personal computers in Indonesia making it difficult to grasp the realities of access to information for persons with disabilities and the ICT use[128]. There is no internationally-recognized accessibility standard for knowledge, information, and communication. There is also very little support for persons with disabilities to use ICT and encourage their social participation (dissemination of information and awareness raising on how ICT use can change their lives) and research and development for ICT devices designed for persons with disabilities is also not promoted.

The internet use rate in the Indonesian total population is 28.1% and is not high compared with other ASEAN countries (Figure 3-14)[129]. This could also be a reason why the promotion of ICT use amongst persons with disabilities users is behind.

[125] Hayati and Faqih (2013) Disables' accessibility problems on the public facilities within the context of Surabaya, Indonesia http://article.sciencepublishinggroup.com/pdf/10.11648.j.hss.20130103.11.pdf
[126] http://www.dcdd.nl/?wpdmact=process&did=MzYuaG90bGluaw
[127] Government achievement and challenge regarding the enhancement of ICT accessibility for PWD's in Indonesia http://unpan1.un.org/intradoc/groups/public/documents/ungc/unpan040430.pdf
[128] In Japan, under the Ministry of Internal Affairs and Communication, a research committee on IT use support for persons with disabilities has convened since 2004 with a publication in 2006 and 2007 on "Evaluation of ICT Use and Dissemination of the Elderly and Persons with Disabilities"
[129] Internet World Stats, June 2014



(Source: Internet World Stats, June 2014)

Figure 3-14 Internet Diffusion Rate in Main ASEAN Member States (Population Ratio) (2014)

1) Systems, Programs, and Services

According to KOMINFO, there is no accessibility standard for knowledge, information, and communication based on an internationally-recognized standard. KOMINFO is currently drafting new government regulations to ensure the budget for telecommunication infrastructure for persons with disabilities. Discussions need to be held on disabled access to information and telecommunication technology with KEMSOS[130].

KOMINFO supports financially the maintenance of facilities with internet access in order to promote internet use in communities. In 2013, computers designed for persons with disabilities were donated to Solo, Bogor, and South Kalimantan cities as part of a pilot project.

The situation of information services provision for persons with disabilities is as follows. The survey team was not able to confirm the situation of 1) access to information at school, 2) sound, Braille and enlarged character publications at the provincial and municipal level, and 3) the utilization of computer reading software.

【Transport】

In Jakarta Metropolitan, there were some accessible pedestrian signals (audible pedestrian traffic signals – the sound emitted by the devices) for persons with visual disabilities. There were almost no such pedestrian signals in regional cities such as Surabaya and Yogyakarta.

【Braille material】

No data exists in Indonesia on the number of Braille users amongst persons with visual disabilities or the number of persons with disabilities who use mobile phones and personal computers.

【Public Television News Programs】

There are public televisions, Televisi Republik Indonesia (TVRI), broadcasts sign language news every day from 7:00 PM in 2013.

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130 Based on the interview with KOMINFO.

【Development of ICT Devices Designed for Persons with Disabilities】

Some IT companies are involved in the development of ICT devices and software for persons with disabilities as part of their corporate social responsibility (CSR) activities. For example, the Indonesian Internet Service Providers Association (APJII) is developing software for persons with disabilities.

【Training for Persons with Disabilities】(Acquiring ICT Skills - Training of Teachers and Persons with Disabilities to Acquire Skills)

The ASEAN Foundation started the first ICT training targeting persons with disabilities in January 2012. It is a three-day course and 23 Indonesian persons with disabilities have participated to date[131].

The Indonesian government officials have participated in the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) training.

2) Situation of Sign Language Interpreters

The survey team have not obtained information on the situation of sign language interpreters during this mission therefore the survey results of sign language interpreters in Asia was referred, this is a study conducted by the National Research Association for Sign Language Interpretation in 2012. The results of the survey are shown in Table 3-24.

Table 3-24 Results of the Survey on Sign Language Interpretation (2012)

Survey	Response
Number of Sign Language Interpreters	There are only five sign language interpreters certified by Gerkatin (Indonesia hearing impaired organization) in Jakarta.
Indonesian Sign Language and the Number	Persons with hearing disabilities use only Bisindo (Indonesian sign language) to communicate. However, in educational settings, teachers are required to use SIBI (a systematic Indonesian). As Indonesia has 18,000 islands, there are many dialects in sign language too.
Law on Sign Language Interpreters	There is no law on sign language interpreters
Training of Sign Language Interpreters	Teachers for persons with hearing disabilities have been training privately as sign language interpreters until now. Since September 2010, the National University of Indonesia (Language Faculty) in cooperation with the Deaf Association started a yearlong two semester (basic) sign language course. The Deaf Association plans to open intermediate and advanced level courses for students who aim to become interpreters.
Qualification Exams or System of Sign Language	None
Rates of Sign Language Interpretation	The rate is USD 20/day/person for a self-help organization in close collaboration and USD 100-300/day/person for an international or private organization.
Sign Language Interpreter Organization	No standard exists to establish an interpreter organization or association.

(Source: National Research Association for Sign Language Interpretation "Sign Language Interpreter survey in Asian Countries (tentative translation of Japanese title), 20 May 2013[132]")

[131] http://www.aseanfoundation.org/news/asean-foundation-delivers-ict-training-for-persons-with-disabili

[132] http://www.zentsuken.net/global/pdf/questionnaire_asia_20130520.pdf

The survey team was not able to confirm whether relevant ministries such as KEMSOS provide sign language interpreters and summary scribes at meetings or distribute documents before the meetings take place.

The survey team was not able to confirm whether relevant ministries such as KEMSOS provide sign language interpreters and summary scribes at meetings or distribute documents before the meetings take place.

3) Recent Trends and Issues

According to the interview with KOMINFO, other related ministries and stakeholders, social participation through ICT which involves persons with disabilities is minimal. One reason given is that the needs of persons with disabilities are not understood. The guidelines for access to information for persons with disabilities[133] and awareness raising amongst enterprises and persons with disabilities themselves are important.

Disability-Inclusive City – Solo City

In 2013, Solo mayor declared the city a disability-inclusive city. Solo City is a unique regional city when it's transport/information/communication department set accessibility standards in 2006. These standards are epoch-making in the sense that 1) the accessibility standards are not only a public transportation standard but includes standards on information and communication, 2) various stakeholders such as persons with disabilities, regional government, and the private sector were involved, 3) local regulations on equality of persons with disabilities were developed and they strengthened law enforcement at the local level. About 60 bus shelters, 30 rapid transit buses, 3 railway stations, 54 traffic lights, and the airport are accessible.

Source: Solo City: Access to transport than can be enforced, Zero Project webpage[134]

3.6.6 Participation in Politics and Policy Decision-making Process

In Article 29 of the CRPD, "Participation in Political and Public Activities" is raised, and it states that the signatory nations guarantee the political rights of persons with disabilities. The following is the general view of the participation status in politics and the policy decision-making process of persons with disabilities from the aspect of law development and practice in Indonesia.

All citizens above the age of 17 (or under 17 but married) have the right to vote (Act No. 42/2008, "Laws Related to the Election of the President and Vice President" Chapter 5 "Right to Vote" Article 27 paragraph 1).

Regarding eligibility for elections, if he or she is a citizen (i) over the age of 21, (ii) resides inside the area of the Republic of Indonesia, (iii) is well acquainted with reading and writing of the official language, (iii) has an educational background higher than a high school graduate, (iv) and even if he or she has received a guilty conviction in the past, if it is after five years since the completion of imprisonment, candidacy for

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[133] An example from Japan - the Guidelines from Chiba Prefecture https://www.pref.chiba.lg.jp/shoufuku/shougai-kurashi/jouhouhoshou/documents/guidline.pdf

[134] http://zeroproject.org/policy/solo/

heads of the government such as a member of the congress or presidency is possible (Act No. 10/2008, "Laws Related to Election of National Assembly and Local Assembly" Chapter 3 "Candidates and Conditions" Article 12).

However, in order to run as a candidate for the president or heads of the government, "physical/mental health that makes it possible to perform the task" is required. (For example, a requirement for running as a candidate for the president/vice president: Article 6 paragraph 1, "mampu secara rohani dan jasmani." Requirement for running as a candidate for the head of a village in the Village Laws: Article 33 paragraph 11, "berbadan sehat")[135].

Furthermore, at the central government agencies participating in the creation of regulations related to persons with disabilities, the DPOs, international NGOs, or international support institutions (bilateral/multilateral) hold discussions about the draft, circulate it, and make inquiries. There is a custom of demanding comments and improvement ideas. In this way, the participation of persons with disabilities or their supporters into the process of policy forming is expected to lead to a more active process in the future, along with the progress of the social development policies of the Indonesian government that are disability-inclusive[136].

3.6.7 Women and Girls with Disabilities

Women with disabilities are subject to double discrimination as they are not only a woman but also are persons with disabilities. For example, if a woman becomes disabled, this becomes a reason for a man to divorce his wife[137]. This is an approved reason in Article 4 No. 2 of the Marriage Law allowing the husband to divorce his wife as seen in the following lines.

In the following situations, the husband is given approval to divorce his wife：

(1) When the wife does not fulfill her obligations
(2) When she becomes terminally ill or becomes disabled
(3) When she does not produce a child

According to an interview with a person with disability conducted in June 2015, even though the CRPD has been ratified, there are no plans to revise this clause Article 4 No. 2 of the Marriage Law.

It is not uncommon for women with disabilities to be criticized if they become pregnant[138]. Women also have a lower access rate to assistive devices and public facilities compared with men (refer to Section 3.6.4 (1) 4) for access to assistive devices, 3.6.3 for access to public facilities).

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[135] Former president Wahid was almost totally blind due to complications with diabetes, but has the result of becoming the first president of the Republic of Indonesia with a disability.
[136] Based on the results of interviews at multiple locations in this survey.
[137] TNP2K (2014) "A Guide to Disability Rights Laws in Indonesia", p. 7and based on FGD results done in Jakarta
[138] Same as above

(1) Systems and Programs

As mentioned in Section 3.4.3 (10), the program for women and girls with disability managed by KEMENPPPA started in 2006. More specifically, a study in two provinces (Jambi and East Java) was done in preparation for the establishment of an information and counseling center for women with disabilities. There are currently three centers located in East Java, Jambi, and East Kalimantan. Table 3-25 shows the history of this center and in Table 3-26 the outline of this center is described.

Table 3-25 History of KEMENPPPA Managed Disability Program

Year	Activity
2006	▪ Activities for persons with disabilities and the elderly started in 2006 ▪ Survey starts in the preparation of establishment of an information and counseling center for women with disabilities in Jambi and East Java Provinces
2007	▪ The concept note (draft) on the information and consultation for women with disabilities was drafted
2008	▪ Dissemination and awareness raising of survey and concept note (draft) ▪ Concept note is revised with the cooperation of the two provinces
2008-2009	▪ Dissemination and awareness raising in other provinces ▪ Decision to establish the first information and counseling center in Jambi and East Java Provinces ▪ Based on the results of meetings held in the two provinces, the provincial rules for the establishment of an information center for women with disabilities are enacted (Ministry Ordinance No. 23 of 2010)
2011	▪ Establishment and commencement of the centers in the two provinces ▪ In order to scale up the pilot projects to other provinces, awareness raising and dissemination targeting stakeholders (regional governments) starts
2012	▪ Rules on center management are put in place (Provincial Rules 2012 No.7)
2014	▪ Gender information division creates a matrix (form) as a data collection tool on violence against persons with disabilities. It is hoped that data can be collected in the future (dates unknown).
2015	▪ Information and counseling center for women with disabilities to be established in Japara and Bali provinces. The information and counseling centers will be a part of the existing Child and Woman Protection Center. The reason why these two provinces were selected is because they have rules on center management (2012 Provincial Ordinance No.7) and because they were able to select the DPO to run their facilities. ▪ KEMENPPPA held a meeting with DPOs and it was decided to provide information services on women with disabilities through all existing Child and Women Protection Centers. As of June 2015, there are Child and Women Protection Centers in all provinces totaling to 185 facilities.

Table 3-26 Outlines of Information and Counseling Center for Women with Disabilities

Role of the Center	Provide training, information on internship programs, education and employment (including job search), as an information center for the rights of the women with disabilities based on Ministerial Ordinance No. 23 in 2010. Consultation (on day-to-day issues as well as mental health, psychology, labor and education)
Number of Center Personnel and Staff	Local DPOs manage the centers. In Jambi Province, there are four staffs. However, the number depends on the budget and could be more or less.
Staff Salary	Paid by the local government. Due to budgetary constraints, situations exist where staffs have to work as volunteers (unpaid). When this happens, transport costs are provided.
Center Location	The center locations differ with some centers located outside the local government, others are located within the local government administrative building.
Number of Centers	There are currently three centers in East Java, Jambi, and from 2014, East Kalimantan.

3.7 Realizing the CRPD and Global/Regional Policy (Incheon Strategy)

Indonesia implemented the "Asia Pacific Biwako Millennium Framework (1992-2002) of Action for Persons with Disabilities for an Inclusive, Barrier-free, and Rights-based Society" (hereinafter the Biwako Millennium Framework). The Law No. 4/1997 (Disability Law) was an outcome of the commitment at this time[139]. Furthermore, Indonesia implemented actively the ASEAN Strategic Framework of Welfare and Development and the Biwako Plus 5 (2003-2012). Indonesia was also involved in the CRPD, described in detail below, and the Incheon Strategy, as well as the "ASEAN Decade for Persons with Disabilities (2011-2020).

The CRPD and Incheon Strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific (hereinafter the Incheon Strategy) and other regional policies all contributed to further improvement and awareness at the policy level. The Indonesian government ratified the CPRD in 2011 and adopted the Incheon Strategy in 2012. Subsequently, at the policy-level, laws are being revised in line with the contents of the CRPD and Incheon Strategy, while action planning, and data collection is being planned. Specific actions that were instituted are the following:

- Revision of the Disability Law (to be completed within 2015)
- Drafting of the National Action Plan on Human Rights including the rights of persons with disabilities (2015-2019)
- Planning of a National Data Survey on Disability in 2016 onwards by the Central Bureau of Statistics

3.7.1 Ratification of the CRPD, Implementation and Reporting in Indonesia

The Indonesian government was one of the first to sign the CRPD (30 March 2007) 140 and ratified the CRPD in 2011. Before the ratification, the Indonesian government made efforts to draft laws and enlarge

[139] Irwanto et al. (2015) The ratification and implementation of UNCRPD – Indonesia's experience
[140] http://www2.ohchr.org/english/issues/disability/docs/study/Indonesia.pdf The first signatory was made on 30 March 2007 by several countries where Indonesia was included. The current status of signatures and ratifications of CRPD is shown in the UN website at http://www.un.org/disabilities/countries.asp?navid=12&pid=166.

social protection programs for persons with disabilities[141]. There is an increased awareness of the importance of considering disability amongst Indonesian ministries after CRPD ratification.

There are two different country progress reports of the CPRD, which is submitted to the UN committee on CRPD: the one by government and the other is a drafted parallel report to the government by civil societies. The Ministry of Foreign Affairs is responsible for the country progress report for CRPD and the report is currently being drafted in collaboration with KEMSOS by collecting data and opinions from stakeholders through consultations with DPOs. KEMSOS collects information from other related ministries and shares this with the Ministry of Foreign Affairs. This country progress report will be submitted at the end of 2015[142].

The parallel report by civil society is being drafted by six representatives of DPOs[143, 144]. A national consultation was held on 21 June 2015 in Jakarta on the parallel report where disability activists made their final inputs. This report will be submitted to the UN committee on CRPD at the end of October 2015[145].

3.7.2 Situation of the Incheon Strategy Implementation and Progress Report

The member states of UNESCAP adopted the Incheon Strategy at the meeting held from 29 October to 2 November in 2012 in Incheon, Korea. The strategy shows the disability inclusive development goals for the first time for the Asia and Pacific region and for the world. As a result of discussions with the member states and civil society stakeholders, the strategy includes 10 goals, 27 targets, and 62 indicators. The UNESCAP secretariat reports on the Incheon Strategy implementation every three years. Indonesia reported on the first two years (2013 and 2014) of the Incheon Strategy implementation in Delhi, India in March 2015[146]. This report is written by KEMSOS and is available on UNESCAP's website[147].

According to the Incheon Strategy progress report, the Indonesian government implemented the following activities in 2013 and 2014:

- Translation of the Incheon Strategy into Bahasa Indonesian
- Diffusion of Incheon Strategy to BAPPENAS, KEMNAKER, KEMSOS, KEMDIKBUD, KEMENHUB, KEMPPPA, KEMENKES, and BPS

As of now, there is no baseline data of Incheon Strategy indicators. According to a report published in November 2013 in Bangkok, Thailand, an expert meeting on effective data collection for the Incheon Strategy was held. BPS, which conducts SUSENAS every three years, collects data on 9 out of the 62 indicators through the socio-cultural and education survey module (*Modul Sosial Budaya dan Pendidikan*:

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141 http://www.indonesiamission-ny.org/zymurgy/custom/statement.php?id=337#.VOwLO7PF840
142 Based on hearing with the Ministry of Social Affairs
143 The parallel report is an important tool for human rights civil activists. The civil society is allowed to submit a parallel report to the UN Treaty Committee which describes situations and proposes solutions perhaps differing from the government. http://www1.umn.edu/humanrts/iwraw/reports.html
144 6 DPO representatives participated in three-week training in Australia to draft the parallel report as part of AIPJ activities.
145 Based on an interview with stakeholders
146 UNESCAP (2015) Implementation of the Incheon Strategy to Make the Right Real for Persons with Disabilities by members of the Working Group (2013-2014) http://www.unescap.org/sites/default/files/ESCAP%20Summary.pdf
147 http://www.unescap.org/sites/default/files/Indonesia_11.pdf

MSBP)[148]. However, only the indicator 8.1 (ratio of disability by age, gender, and socioeconomic status according to ICF standards) was published. This mission was able to confirm 5 out of the 9 indicators as shown in Table 3-27.

Table 3-27 Achievements of the Incheon Strategy Verified in the Survey

Goal	Indicator	Data Confirmed During the Study
1. Reduce Poverty and Enhance Work and Employment Prospects	1.1 Proportion of persons with disabilities living below the USD 1.25 (PPP) per day international poverty line, as updated by the World Bank and compared with the overall population 1.2 Ratio of persons with disabilities in employment to the general population in employment 1.4 Proportion of persons with disabilities living below the national poverty line	1.2
4. Strengthen Social Protection	4.1 Proportion of persons with disabilities who use government-supported healthcare programs as compared with the general population 4.6 Availability of health insurance for persons with disabilities 4.7 A decrease in the unmet needs for assistance and support services	4.6
5. Expand Early Intervention and Education of Children with Disabilities	5.2 Primary education enrolment rate of children with disabilities 5.3 Secondary education enrolment rate of children with disabilities	5.2, 5.3
8. Expand Early Intervention and Education of Children with Disabilities	8.1 Ratio of disability by age, gender, and socioeconomic status according to the International Classification of Functioning (ICF) standards.	8.1

The Incheon Strategy goals and indicators will be integrated in the National Development Action Plan for Human Rights which is currently being drafted but the details are yet unknown (not all indicators will be adopted in the National Action Plan[149]).

This time, instead of confirming numbers, the survey team tried to find activities which would fulfill the indicators. The result is shown in Annex 3.

3.8 Activities of Major DPOs

3.8.1 Disability Movement in Indonesia

From the 1960s to 1970s, a disability movement occurred in Japan, the United States and the United Kingdom. In Japan, “the welfare oriented city planning” was born from the disability movement. The activities of DPOs had a major impact on the welfare oriented city planning movements[150]. In particular, the activities of the "Association of the National Green Turf (a cerebral palsy organization)" are famous. The "Kawasaki bus hijacking incident", which occurred in 1976 in Kawasaki City, Kanagawa Prefecture as a

148 http://www.unescap.org/sites/default/files/EGM-Breif-Indonesia.pdf
149 Based on the interview with a persons with disability, who is an adviser to the development of the National Development Action Plan for Human Rights.
150 http://www.dinf.ne.jp/doc/japanese/prdl/jsrd/rehab/r091/r091_039.html

result of an incident where a city bus driver refused a person with cerebral palsy on a wheelchair to board a city bus became a major social problem.

In Indonesia, although there was no radical disability movement as seen in Japan, persons with disabilities continue to campaign for the promotion of the rights of persons with disabilities every time there is an opportunity. According to the interviews, the following movements have been recorded in recent years:

- DPOs strongly promoted and maintained pressure on the Indonesian government to ratify the CRPD.
- Until 2013, Garuda Indonesia Airlines, the national carrier, and the airlines under its management were making persons with disabilities sign a declaration before boarding that they would not sue the airlines if something happened during flight as disability was seen as an illness. One of the persons with disabilities, whose wheelchair was damaged twice between 2011 and 2013 by airline handling, experienced various unpleasant incidents and protested against the airlines with the cooperation of the media, Jakarta Post, and the National Commission on Human Rights. As a result, the declaration was abolished and staffs were trained on how to serve persons with disabilities[151]. Nevertheless, some of the smaller airlines still require the signing of this declaration[152].
- In 2014, human rights and law networks and NGO/DPOs strongly protested that there were discriminatory private university entry standards. Persons with physical, visual, and hearing disabilities and the color blind were not allowed to apply to the university based on a paragraph which prohibited university admission if one has a disability. After this protest, KEMDIKBUD abolished this standard[153].

3.8.2 Major DPOs

Major DPOs in Indonesia is the Indonesian Disabled Persons Association (*Perhimpunan Penyandang Difabel Indonesia*: PPDI) established in 1989. They are always invited to seminars to develop policies on disability by relevant ministries. They work with all types of disabilities and all persons with disabilities in Indonesia become a member of PPDI. The organization is funded by the government.

Other main DPOs are Indonesian Women with Disabilities (*Himpunan Wanita Disabilitas Indonesia, Indonesian Association of Women with Disabilities*: HWDI), Movement of the Welfare of Deaf Indonesia (*Gerakan untuk Kesejahteraan Tunarungu Indonesia*: GERKATIN), and Indonesia Blind Union (*Persatuan Tunanetra Indonesia*: PERTUNI).

Major DPOs in Indonesia including the mentioned above are listed in Table 3-28.

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151 Jakarta Globe (May 14, 2013) “Garuda Apologizes to Passenger Who Filed Petition Over Poor Treatment” http://thejakartaglobe.beritasatu.com/business/garuda-apologizes-to-passenger-who-filed-petition-over-poor-treatment/

152 http://www.thejakartapost.com/news/2013/06/25/unpleasant-experiences-garuda-s-disabled-travelers.html http://www.thejakartapost.com/news/2013/10/23/tiger-air-turns-away-blind-man.html

153 http://www.thejakartapost.com/news/2014/03/13/disabled-people-sue-minister-over-discriminatory-regulation.html

Table 3-28 Major DPOs in Indonesia

Name or organization	HQ city	Summary
Indonesian Disabled Persons Association (*Perhimpunan Penyandang Difabel Indonesia*: PPDI)	Jakarta	▪ Established in 1989. Works with all types of disabilities. Member organization of DPI (Disabled Peoples International).
Indonesian Women with Disabilities (*Himpunan Wanita Disabilitas Indonesia, Indonesian Association of Women with Disabilities*: HWDI)	Jakarta	▪ The national organization for women with disabilities. Main activities are empowerment of women with disabilities and awareness raising. http://www.hwdi.or.id
Movement of the Welfare of Deaf Indonesia (*Gerakan untuk Kesejahteraan Tunarungu Indonesia*: GERKATIN)	Jakarta	▪ The national organization for persons with hearing disabilities ▪ http://tunarungu.net76.net/node/6
Indonesia Blind Union (*Persatuan Tunanetra Indonesia*: PERTUNI)	Jakarta	▪ The national organization for persons with visual disabilities ▪ http://pertuni.idp-europe.org/
National Federation for the Physically Handicapped (*Federasi Kesejahteraan Penyandang Cacat Tubuh Indonesia*: FKPCTI)	Jakarta	▪ Grassroots coordinating organization of rehabilitation services for the physically impaired
National Federation of the Hearing Impaired (*Federasi Nasional Kesejahteraan Tuna Rungu Indonesia*: FNKTRI)	Jakarta	▪ Grassroots coordinating organization of rehabilitation services for persons with hearing disabilities (in particular Special School Program)
Indonesian Society for the Care of Children with Disabilities (*Yayasan Pembinaan Anak Cacat*: YPAC)	Jakarta	▪ The organization for children with disabilities. Established in the early 1950s when polio prevailed. Afterwards, it served children who survived polio (see 3.6.2 (1) 1)) ypac-nasional.org
Indonesia Autism Association (*Yayasan Autisma Indonesia*: YAI)	Jakarta	▪ The first national organization for persons with autism and similar disabilities and their families.
SIGAB (*Sasana Integrasi dan Advokasi Difabel*)	Yogyakarta	▪ Established in 2003. Main activities are promotion of inclusion of persons with disability and awareness raising. ▪ Data collection and research for effective awareness raising ▪ Sharing of good practices with government (central and local levels) to promote inclusion at community level ▪ Awareness raising to change policies and skill-up through media ▪ http://www.sigab.or.id/
CIQAL (Center for Improving Qualified Activity in Life Persons with Disabilities)	Yogyakarta	▪ Main activities are economic livelihoods and awareness raising ▪ Livelihood improvement: provision of vocational training ▪ Awareness raising: education, health (promotion of adherence to medical insurance), disaster resilience ▪ http://ciqal.blogspot.ch/
OHANA (*Organisasi Handicap Nusantara*)	Yogyakarta	▪ Policy advocacy, rights of persons with disability, policy research, capacity strengthening etc ▪ https://ohanaindonesia.wordpress.com/

(Source: Created by the survey team based on interviews)

3.8.3 Other Related Information

According to the DPOs and support organizations visited during this mission, Yogyakarta is the most advanced compare with all of Indonesian cities in terms of implementation of disability-related activities. One of the reasons why Handicap International is headquartered in Yogyakarta is because DPO network is strong and it is easier to obtain their cooperation. The reason why the disability network is strong in Yogyakarta is, according to SIGAB and CIQAL, because of "cooperation" and there is a strong solidarity there. Also, according to HI, 1) one of the few rehabilitation centers is on the outskirts of Solo City and access to medical rehabilitation is easier than other cities, 2) Yogyakarta is an academic city, with many private universities centered around the Gadjah Mada University, with many researchers, and it has an active civil society movement on women's rights and other social issues. This atmosphere is said to influence the mentality of the persons with disabilities.

According to the official of Kita Kyushu City Government, Surabaya City has a very strong women's organization which is an important factor to take into account as it is important to obtain the support of women's organizations in Surabaya and other regional cities.

3.9 Disability Related Researchers and Research Institutions

The following researchers and research institutions (Table 3-29) were identified during the study mission.

Table 3-29 Researchers and Research Institutions on Disability in Indonesia

Organization	Headquarters	Field(s)	Outline and Activities
Center for Disability Studies	Jakarta, within the University of Indonesia	General (Disability)	Representative Dr. Irwanto Established in 2005. Promotion of a barrier-free campus and cooperation with disability research, provision of information.
Center for Disability Studies and Services	Melang, within the East Java Brasijaya University	General (Disability)	Publishing academic journal "Indonesian Journal of Disability Studies" from June 2014. There are publications on accessibility and inclusive education (in Indonesian except the summary).
Petra Christian University	Surabaya	Accessibility / Universal Design	Co-representatives Mr. Gunawan/Dr. Arina (architect) Classes on universal design within the Architectural Department. Awareness raising and access auditing to promote understanding on accessibility.
Center on Universal Design	Yogyakarta,within Gadja Mada University	Accessibility /Universal Design	Representative Dr. Ikapurta (architect) Classes on universal design and disability simulation within the Architectural Department.
Center on Disability Studies and Services	Yogyakarta, within the Provincial Islamic University	General (Disability)	Provision of information for students with disabilities, promotion of a barrier-free campus, Braille translation.

Chapter 4 Current Situation of Disability-Inclusive Disaster Management

4.1 Definition of Disability

According to a Regulation of Head of the BNPB No.14/2014, persons with disabilities are defined as follows.

> Persons with disabilities are those who have physical, mental, intellectual, or sensory impairments within a certain period or permanently, wherein interacting with the environment and the public can meet obstacles that make it difficult for them to participate fully and effectively.

(Source: Head of BNPB Regulation No. 14/2014)

4.2 Relevant Organizations

4.2.1 Governmental Organizations

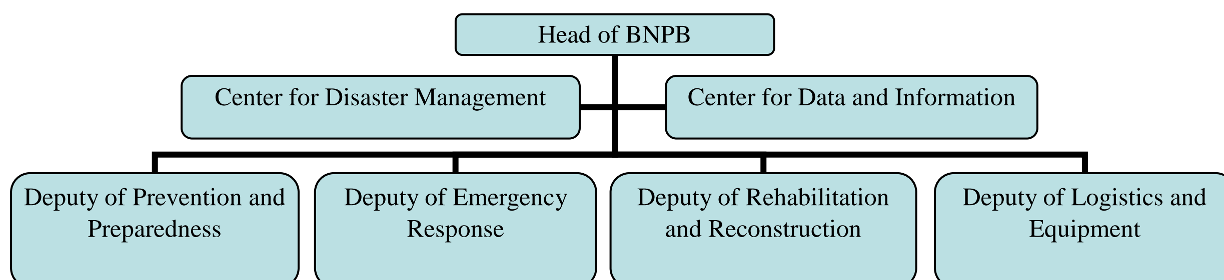
(1) BNPB/BPBD

1) Outline of the Organization

The National Agency for Disaster Management (*Badan Nasional Penanggulangan Bencana:* BNPB), and the Regional Agency for Disaster Management (*Badan Penanggulangan Bencana Daerah*: BPBD), a local disaster management agency at the provincial/city/district level were established in 2008 in accordance with Law No. 24/2007. There are 34 BPBDs at the provincial level and approximately 450 at the city/district level in Indonesia.

There are some cities and districts that have not set up BPBD[154]. This is because a Regulation of the Ministry of Home Affairs No. 46/2007 does not oblige the local government to establish BPBD at the city/district level, although its establishment is provided for in the Law No. 24/2007.

An organizational structure of BNPB is presented in Figure 4-1. There are four deputies under the head agency, 1) Prevention and Preparedness, 2) Emergency Response, 3) Rehabilitation and Reconstruction, and 4) Logistics and Equipment. Each deputy has several divisions.

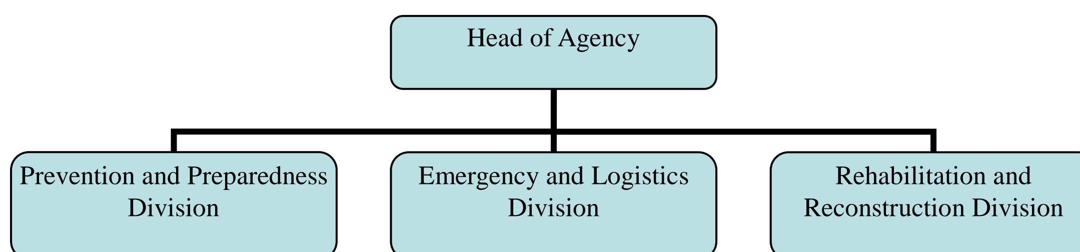


(Source: the Survey team based on BNPB documents)

Figure 4-1 Organization Structure of BNPB

[154] 35 out of 38 cities/districts have BPBD in East Java Province.

An organizational structure of BPBD at the provincial/city/district level is shown in Figure 4-2. Similar to BNPB, there are three divisions under a head agency, 1) Prevention and Preparedness, 2) Emergency and Logistics, and 3) Rehabilitation and Reconstruction.



(Source: the Survey team based on BPBD documents)

Figure 4-2 Organization Structure of BPBD (province/city/district)

The main duties of BNPB and BPBD are to coordinate the relevant organizations during preparedness, emergency, and post-disaster phases, and to give orders to the organizations during emergency. The following duties are provided for by Law No. 24/2007:

- To develop laws on disaster management and strengthen the capacity of related organizations;
- To develop disaster management plan;
- To strengthen the capacity of communities, promoting their participation in disaster management activities;
- To increase awareness of disaster and emphasize the prevention and preparedness;
- To develop warning systems for disaster;
- To conduct disaster drills;
- To lead emergency response;
- To coordinate rehabilitation and reconstruction; and
- To support victims of disaster.

2) Cooperation with Other Organizations

In accordance with the cluster approach[155] nationally applied in Indonesia, BNPB/BPBD is responsible for controlling overall the clusters when a disaster occurs. BNPB/BPBD does not have any regular meeting with other organizations during pre-disaster phases.

3) Human Resources

There are 350 staff working in BNPB. In case of the Yogyakarta Special Region, 50 staff work at the provincial BPBD and there are about 200 staff in total working in all BPBDs in the region.

These officials at BNPB/BPBD were transferred from the ministries/departments of education, health or social affairs, after BNPB/BPBD were established in 2008. Most of them, therefore, do not have any

[155] The cluster approach applied by the United Nations (UN) has ten clusters. The Indonesian government applies this approach with eight clusters: 1) refugee and protection, 2) search and rescue, 3) logistics, 4) health, 5) education, 6) facilities and infrastructure, 7) early recovery, and 8) economy. Organizations in charge of each cluster cooperate with each other under the command given by BNPB/BPBD.

educational background on disaster management. In the case of BPBD Yogyakarta Special Region, only 1 or 2 out of 50 staff has the necessary knowledge and skills on disaster management[156].

4) Disaster Response Team (SRC-PB)

The Disaster Relief Rapid Reaction Force (*Satuan Reaksi Cepat Penanggulangan Bencana*: SRC-PB) is a special team that responds to disasters managed by BNPB. It has two lodgments, one in the west and the other in the east of Indonesia, and each team comprises 550 members. When a disaster occurs, the team will be dispatched to the site within several hours and they perform the following jobs:

- Quick assessment;
- Search and rescue;
- Health services, refugee, and shelter;
- Distribution of logistics;
- Restoration of lifeline utilities; and
- Dispatching and setting of volunteers.

5) Budget

The budget allocation to disaster management programs is not shown in the Disaster Management Plan 2015-2019. The budget to establish a disability service unit at BNPB/BPBD is not adjusted as well[157].

6) Disability Inclusive Approach

In accordance with the issued Regulation of Head of BNPB No. 14/2014 regarding the handling, protection, and participation of persons with disabilities in disaster management, the legal environment to promote disability inclusion is being settled within BNPB (refer to Section 4.3.1 for the regulation). However, this regulation has not yet been informed to BPBDs; and BNPB has not yet decided on when to disseminate it. There is no specific division in charge of disability related issues, but one of the staff at the Community Empowerment Division said that the Department of Prevention and Preparedness is in charge of disability issues. Although “a disability service unit” is defined in the regulation as a unit which consists of one person or one team, the person in charge does not function as such since there is no disability-related program so far.

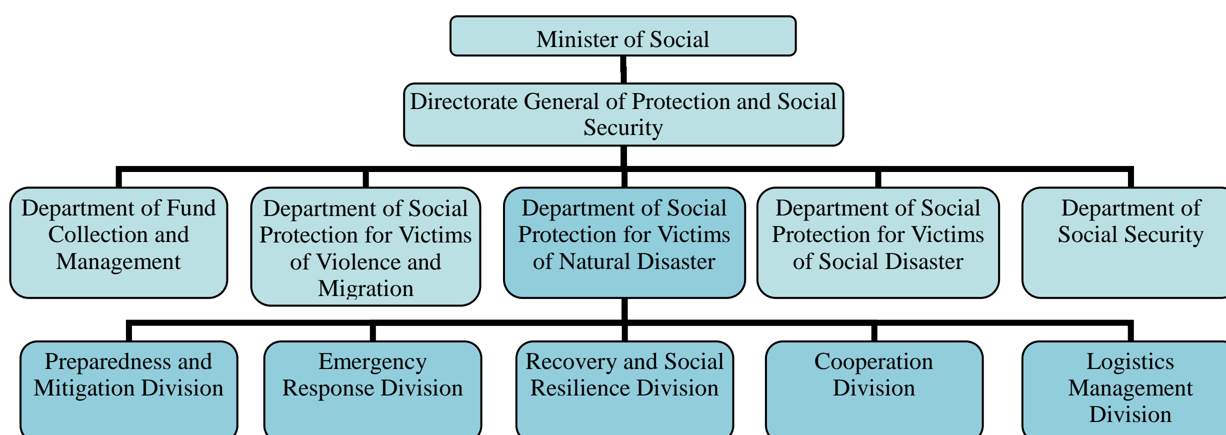
Based on this new regulation, BNPB has conducted disaster drills twice in 2014, and once in 2015, promoting the participation of persons with disabilities. According to BNPB, tsunami shelters, which are newly established by BNPB, are accessible for persons with disabilities[158]; however, the actual condition of these buildings is not verified in this survey.

[156] Based on the interview with BPBD Yogyakarta Special Region (27 May, 2015).
[157] Based on the interview with BNPB (30 June, 2015).
[158] Based on the interview with BNPB (11 May, 2015)

(2) Ministry of Social Affairs (Department of Social Protection for Victims of Natural Disaster)

1) Outline of the Organization

The Department of Social Protection for Victims of Natural Disaster, which is under the Directorate General of Protection and Social Security, is in charge of issues regarding natural disaster. As shown in Figure 4-3, the department has five divisions: 1) Preparedness and Mitigation, 2) Emergency Response, 3) Recovery and Social Resilience, 4) Cooperation, and 5) Logistics Management.



(Source: Created by the Survey team based on KEMSOS documents)

Figure 4-3 Organization Structure of KEMSOS (Department of Social Protection for Victims of Natural Disaster)

As defined in Law No. 24/2007, KEMSOS is responsible for logistics support such as shelters, food and clothes, water and sanitation, health services, and psychosocial support. In terms of the cluster approach, KEMSOS acts as a coordinator in the clusters of 1) refugee and protection, and 2) logistics. The duty of logistics on disaster management is provided in the decision of the Director General of Protection and Social Security No. 620/2014.

2) Cooperation with Other Organizations

Although KEMSOS cooperates with related organizations such as BNPB and KEMENKES to respond to emergency cases, these organizations usually do not cooperate with each other at pre-disaster phases. With regard to the Youth Volunteer Group for Disaster Management (*Taruna Siaga Bencana* :TAGANA), which is described in the next section, there is no joint training between TAGANA and other disaster response teams organized so far, but the medical team of KEMENKES sometimes plays as the lecturer in the training programs of TAGANA.

3) Youth Volunteer for Disaster Management (TAGANA)

TAGANA is a youth volunteer group for disaster management under KEMSOS, and it is organized at the provincial/city/district level. The terms of reference of TAGANA are defined in the regulations of KEMSOS No. 28 and No. 29 in 2012. According to the regulations, TAGANA was set with the purpose of increasing community participation at all disaster management stages i.e.; preparedness, emergency response, and rehabilitation.

TAGANA comprises social volunteers who have been trained and registered, or social workers in the communities. There are approximately 27,000 of TAGANA members registered to KEMSOS.

The main tasks and functions of TAGANA are summarized in Table 4-1.

Table 4-1 Roles and Functions of TAGANA

Preparedness	Emergency Response	Rehabilitation
▪ Data collection and mapping of disaster-prone areas ▪ Facilitating the establishment and development of the resilience of villages ▪ Early detection to the public about the possibility of disaster	▪ Rapid assessment and reporting of the results of identified emergency to related organizations/teams ▪ Identification of disaster victims ▪ Rescue and transferring of victims ▪ Logistics support at temporary shelters and public kitchens ▪ Psychosocial support	▪ Data collection on disaster victims ▪ Data collection on damages to homes or buildings ▪ Psychosocial support ▪ Support disaster victims to enhance social recovery ▪ Assistance in social advocacy

(Source: the Survey team based on the regulations of KEMSOS No. 28 and No. 29 year 2012)

4) Budget

There is no specific budget allocated to disability-inclusive disaster management programs. As for the whole social protection programs managed by the Directorate General of Protection and Social Security, about IDR 110,221.25 billion is allocated for five years from 2015 to 2019[159]. With regard to the training program of TAGANA, IDR 1.5 billion of the annual budget is allocated.

5) Disability Inclusive Approach

On the basis of Law No. 11/2009 on social welfare, KEMSOS acknowledges the importance of social protection of vulnerable people including persons with disabilities and it is their responsibility to introduce legislation and conduct social support and social advocacy for the case of disaster management as well. According to KEMSOS, there are some progress in introducing legislation and social support; however, social advocacy for the vulnerable is necessary to be strengthened (refer to Section 4.4.2 for social advocacy).

Although there is no special unit or personnel in charge of disability in the Department of Social Protection for Victims of Natural Disaster at KEMSOS; and in the Social Protection Division at DINSOS, KEMSOS/DINSOS can cooperate with the Department of Social Rehabilitation, which deals with disability issues.

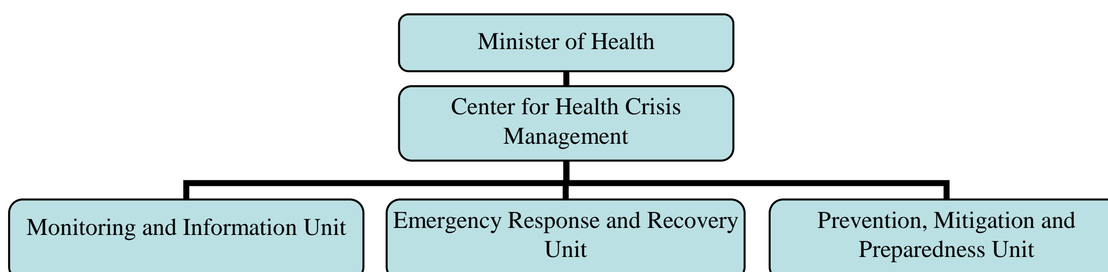
With regard to the national program “TAGANA Goes To School” (refer to Section 4.4.2 for the details), DINSOS Yogyakarta provincial government conducts it at special schools as well as in general schools.

[159] Total amount of the allocated budget from KEMSOS Strategic Plan 2015-2019 and National Development Plan 2015-2019.

(3) Ministry of Health (Center for Health Crisis Management)

1) Outline of the Organization

The Center for Health Crisis Management (*Pusat Penanggulangan Krisis Kesehatan*: PPKK) is responsible for medical services in case of a disaster. As shown in Figure 4-4, there are three units of services: 1) Monitoring and Information, 2) Emergency Response and Recovery, and 3) Prevention, Mitigation and Preparedness.



(Source: the Survey team based on KEMENKES documents)

Figure 4-4 Organization Structure of PPKK

The role of KEMENKES on disaster management is to formulate policies, establish standards, and respond to health crisis in all disaster management phases. To execute these duties, KEMENKES cooperated with other government organizations, non-government organizations (NGOs), international organizations, and academic institutions.

At the regional level, there are nine regional centers for health crisis that rapidly respond to disaster situation[160]. The functions of the regional center are mentioned below[161].

- To act as command post and information center for disaster management.
- To coordinate the logistics on medical services.
- To mobilize the Rapid Action Team and other necessary human resources.
- To act as a networking center to cooperate with health offices, health facilities, and academic institutions.

2) Cooperation with Other Organizations

PPKK does not have any regular meeting on disaster management with other organizations. It cooperates with BNPB, the National Agency for Search and Rescue (*Badan Search and Rescue Nasional*: BASARNAS), and KEMSOS in developing disaster management plan, or in the case of emergency.

[160] The regional centers are in 1) Medan, North Sumatera, 2) Palembang, South Sumatera, 3) Jakarta, 4) Semarang, Central Java, 5) Surabaya, East Java, 6) Banjarmasin, South Kalimantan, 7) Denpasar, Bali, 8) Manado, North Sulawesi, and 9) Makasar, South Sulawesi. In addition, Padan in West Sumatera and Banjarmasin in Papua Special Region have a quasi-regional center.

[161] KEMENKES, Technical Guidelines For Health Crisis Responses on Disaster (2011)

3) Disaster Response Team

PPKK mobilizes medical action teams comprising doctors, nurses, pharmacists, and other medical professions when disaster occurs. Table 4-2 summarizes the functions of three medical action teams: 1) Rapid Action Team, 2) Rapid Health Assessment Team, and 3) Health Assistance Team.

Table 4-2 Disaster Response Team of KEMENKES

Team	Function
1) Rapid Action Team	The team is to be mobilized within 24 hours after PPKK is informed of the occurrence of disaster to provide health services.
2) Rapid Health Assessment Team	The team is to be mobilized within 24 hours at the same time as 1) the Rapid Action Team. Their tasks are to conduct an assessment and identify the health needs.
3) Health Assistance Team	The team is to be mobilized on the request of 1) the Rapid Action Team to provide health services with more appropriate instruments and medical supplies.

(Source: Technical Guidelines for Health Crisis Responses on Disaster, 2011)

4) Disability Inclusive Approach

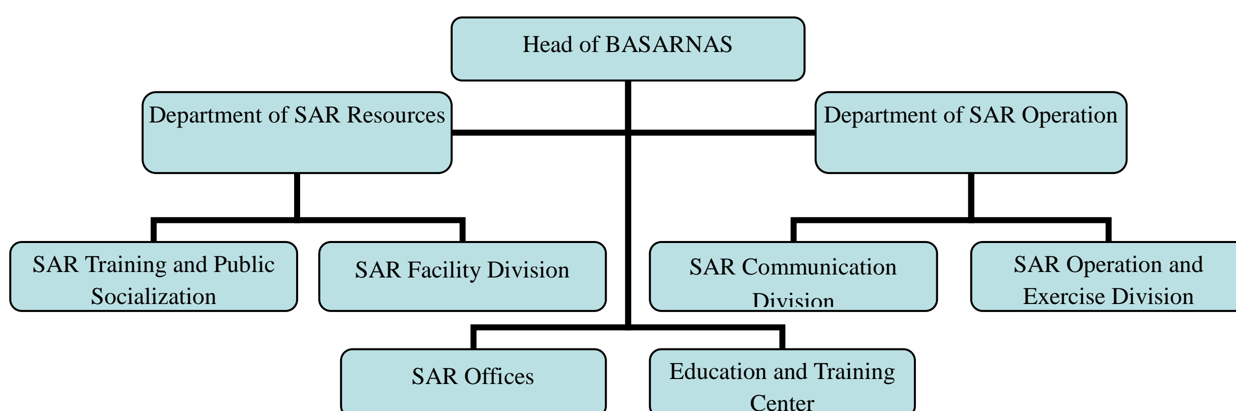
PPKK does not have special unit or personnel to manage disability related issues. There are no regulations regarding disability-inclusive disaster management and also there is no disaster management program for persons with disabilities.

(4) National Agency for Search and Rescue (BASARNAS)

1) Outline of the Organization

BASARNAS is a national agency for search and rescue in case of natural disasters and flight and maritime accident. Although it initially belonged to KEMENHUB, it became an independent agency under the President in 2007.

As a regional agency, there are 34 Search and Rescue (SAR) offices at the provincial level and 63 SAR stations at the local level. The organizational structure of BASARNAS is shown in Figure 4-5.



(Source: the Survey team based on BASARNAS documents)

Figure 4-5 Organization Structure of BASARNAS

BASARNAS was originally responsible only for accident cases. After its separation from the Ministry of Transport in 2007, it has expanded its role to natural disaster cases. In addition to its duty of search and

rescue for emergency response, SAR offices and SAR stations conduct preparedness program entitled "SAR Goes To School."

2) Cooperation with Other Organizations

In case of a natural disaster, BASARNAS engages in search and rescue under the command of BNPB. SAR offices and SAR stations are also to be engaged in their duty under BPBD in case of a natural disaster, but they are to be in operation under BASARNAS in case of an accident. Except for emergency responses, BASARNAS does not have any collaboration with other government organizations.

3) Human Resources

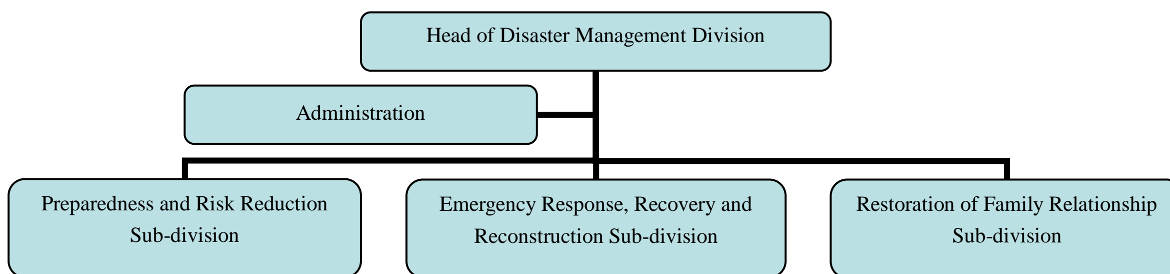
There are around 500-600 staff working at BASARNAS and it is estimated that there are 4,000-5,000 staff in total including SAR offices and SAR stations. The staff usually does not have educational background on search and rescue as there is no such technical school in Indonesia that offers such training. They will be trained to acquire necessary skills after they are employed.

4.2.2 Other Organizations

(1) Indonesia Red Cross (PMI)

1) Outline of the Organization

The Indonesia Red Cross (*Palang Merah Indonesia*: PMI) has a Disaster Management Division and Figure 4-6 shows the organizational structure of it. There are three subdivisions: 1) Preparedness and Risk Reduction, 2) Emergency Response, Recovery and Reconstruction, and 3) Restoration of Family Relationship.



(Source: the Survey team based on PMI documents)

Figure 4-6 Organization Structure of PMI

Table 4-3 describes the major tasks of PMI regarding disaster management.

Table 4-3 Tasks of PMI on Disaster Management

Preparedness	Emergency Response	Rehabilitation and Reconstruction
▪ Development of materials for disaster management ▪ Strengthening the capacity of a disaster response team (SATGANA) ▪ Development of a guideline for the disaster information system ▪ Implementation of disaster management program for the community	▪ To dispatch SATGANA ▪ Mobilizing vehicle such as helicopters, ambulances, and water tankers. ▪ Evacuation of disaster victims ▪ Provision of shelters and public kitchen ▪ Provision of first-aid ▪ Distribution of food supplies and commodities ▪ Securing water and sanitation	▪ Psychosocial support ▪ Temporary housing ▪ Recovery of family relations

(Source: the Survey team based on PMI documents)

2) Disaster Response Team

A disaster response team (*Satuan Penanggulangan Bencana*: SATGANA) is mobilized by PMI. It comprises a commander and members in charge of search and rescue, refugees, social support, and health services. The roles and functions of SATGANA are summarized in Table 4-4.

Table 4-4 Roles and Functions of SATGANA

Preparedness	Emergency Response	Rehabilitation and Reconstruction
▪ To implement educational activities to increase awareness about disaster ▪ To collect data on disaster ▪ To make a list of necessary equipment for disaster management	▪ To conduct rapid assessment ▪ To assess the needs of disaster victims (food, commodities, and health services) ▪ To support disaster victims ▪ To report to PMI	▪ To conduct counseling for disaster victims ▪ To analyze the issues for rehabilitation ▪ To conduct assessment of activities on reconstruction

(Source: the Survey team based on PMI documents)

The mobilization of SATGANA is ordered by PMI, not by the Indonesian government. SATGANA usually arrives at the disaster site to conduct rapid assessment and the results are to be informed to governmental organizations. At the site of a disaster, SATGANA cooperates with other disaster response teams sent by the government such as SRC-PB, TAGANA, and SAR. These teams operate at different sites but they share information to each other.

3) Disability Inclusive Approach

PMI announced an initiative on disability inclusion in January 2015 promoting disability-inclusive approach in disaster management. To be more specific, it prioritizes persons with disabilities in search and rescue activities and also psychosocial support program for persons with disabilities since it was provided after the Yogyakarta Earthquake in 2006.

With regard to training of PMI staff, SATGANA, and community volunteers, there is no program dealing with disability issues. PMI currently does not have educational materials on disability-inclusive disaster management and assistive devices for persons with disabilities at the time of emergency. Formulation of a guideline for psychosocial support for persons with disabilities is in process, and as the above mentioned initiative, PMI shows the attitude toward disability inclusion on other programs as well.

(2) AHA Centre

1) Outline of the Organization

The ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management (AHA Centre) is a center responsible to monitor occurrence of natural disaster in ASEAN countries, conduct disaster risk assessment, coordinate emergency responses, and share disaster-related information. In Indonesia, it also conducts disaster-preparedness drills, logistics support, disaster risk assessment, and information sharing in response to the request of the Indonesian government[162].

2) Disability Inclusive Approach

The AHA Centre considers persons with disabilities as one of the socially vulnerable people such as women, children, elderly people, and ethnic minorities, however, there are no programs specifically for persons with disabilities. In an assessment tool utilized by the rapid assessment team, there is a questionnaire item asking to identify the needs of psychosocial support of vulnerable people, and persons with disabilities is listed in the answer to be checked.

4.3 Laws/Regulations, Policies, and Strategies

4.3.1 Laws and Regulations

(1) Law

The Law No. 24/2007 stipulates roles of BNPB and BPBD, rights and responsibilities of communities, roles of the business sector and international organizations, tasks at all the disaster phases (preparedness, emergency response, rehabilitation and reconstruction), and relief measures after a disaster.

In this law, persons with disabilities are considered as one of vulnerable people, which include infants, children, pregnant mothers and the elderly, to be prioritized in rescue, evacuation, protection, and provision of medical services.

(2) Regulation of Head of BNPB

On a Regulation of Head of BNPB No. 14/2014, BNPB stipulates the handling, protection, and participation of persons with disabilities in disaster management process. The outline of the regulation is presented in Table 4-5.

The details of the roles and tasks of Disability Service Units referred to in Chapter 2 are provided below.

- To provide recommendations for the disaster management policy for persons with disabilities;
- To plan and budget programs and activities to handle and protect persons with disabilities;
- To coordinate with the ministries, institutions, regional work unit, and stakeholders in terms of policies, programs, and activities;
- To identify and facilitate the fulfillment of the rights and needs of persons with disabilities in disaster management;

[162] Based on the interview with PMI (2 July, 2015).

- To maintain and evaluate the realization of policies, programs, and activities; and
- To facilitate cooperation of the parties in order to fulfill the rights and needs of persons with disabilities in disaster relief.

Table 4-5 Regulation of Head of BNPB No. 14/2014

<table>
<tr><td>Chapter 1</td><td>General Provisions</td></tr>
<tr><td colspan="2">・Definition of persons with disabilities
・Definition of terms related to disability (accessibility, rehabilitation, habilitation, social assistance)
・Definition of terms related to disaster management (disaster, disaster mitigation, disaster victim)
・Definition of organizations for disaster management (BNPB, BPBD, forum on disaster risk reduction)</td></tr>
<tr><td>Chapter 2</td><td>Handling and Protection of Persons with Disabilities</td></tr>
<tr><td colspan="2">The regulation stipulates:
・BNPB and BPBD establish Disability Service Units which consist of one person or one team in relevant work unit;
・Roles and tasks of Disability Service Units;
・Policies, programs, and activities to handle and protect persons with disabilities in disaster management are set out in the strategic plans of BNPB and BPBD; and
・Produce budget to handle and protect persons with disabilities.</td></tr>
<tr><td>Chapter 3</td><td>Fulfillment of the Rights and Needs of Persons with Disabilities</td></tr>
<tr><td colspan="2">The regulation stipulates handling persons with disabilities at each phase of disaster management as mentioned below.
<Preparedness>
・Early warning system shall extend to persons with disabilities in a timely manner and through media considering the type and degree of disability.
・Each of the household members with disabilities should have a preparedness plan.
<Emergency Response>
・Fulfillment of basic needs of food and non-food, clothing, shelter, clean water, sanitation, health services, and special needs implemented in accordance with the minimum service standards.
・Shelters and temporary housing facilities take into account the convenience of persons with disabilities in performing livelihood activities of major households.
・The provision of food aid must be carried out in a timely manner and feasible to minimize risk and improve nutritional status, health, and survival of persons with disabilities.
・Fulfillment of the needs of water supply and sanitation shall meet the special needs of persons with disabilities.
・Providing education in disaster situations is obligated to ensure the education of learners with disabilities and should persists in a safe condition, sheltered, and attention to psychosocial aspects.
・Psychosocial assistance for persons with disabilities is provided according to the type and degree of disability.
・The tools and specific assistance for persons with disabilities are provided according to the type and degree of disability.
・In a disaster situation, disaster affected persons with disabilities are protected from violence and coercion to avoid the urge to act beyond the will and fear.
<Post Disaster>
・Implementation of rehabilitation and reconstruction must be oriented to disaster risk reduction and the fulfillment of the specific needs of persons with disabilities.</td></tr>
<tr><td>Chapter 4</td><td>Transitional Provisions</td></tr>
<tr><td colspan="2">The other regulations governing the implementation of disaster management and disaster risk reduction are required to adjust to this regulation.</td></tr>
<tr><td>Chapter 5</td><td>Closing Provisions</td></tr>
</table>

(Source: Regulation of Head of BNPB No. 14/2014)

In addition, the Disability Service Units are responsible for identifying, collecting, analyzing, documenting, updating, and disseminating data and information related to persons with disabilities. These

data and information are to be disaggregated according to gender, age, type of disability, degree of disability, and region.

4.3.2 Policies and Strategies

(1) Disaster Management Plan 2015-2019 (Draft)

The Disaster Management Plan 2015-2019, which is to be officially issued in October 2015, describes a five-year Disaster Management Policy and Disaster Management Program from 2015 to 2019.

Table 4-6 shows the outline of the Disaster Management Policy 2015-2019. The disability-inclusive approach cannot be found in this policy; however, it provides the vulnerable to be the target to be prioritized in case of emergency.

Table 4-6 Outline of the Disaster Management Policy 2015-2019

Strategic Issues/ Common Goals	▪ Optimization of national commitment; ▪ Strengthening the capacity of organizations in disaster management; ▪ Strengthening preparedness for emergency response operation; ▪ Strengthening the resilience of community; ▪ Optimization of partnership on disaster management; and ▪ Development of international cooperation.
Direction of Policy	To improve the effectiveness of disaster management of Indonesia through 1) strengthening the governance of disaster management, and 2) improvement of resilience in facing a disaster.
Disaster Management Implementation Strategy	1) To strengthen the legal framework of disaster management. 2) To mainstream disaster management into development. 3) To increase multi-sectoral partnership on disaster management. 4) To fulfill good governance on disaster management. 5) To enhance the capacity and effectiveness of disaster prevention and mitigation. 6) To enhance the capacity and effectiveness of emergency response. 7) To enhance the capacity and effectiveness of recovery from a disaster.
Specific strategies	**<Preparedness: to reduce the risk>** ▪ To stabilize coordination for prevention and preparedness; ▪ To develop the integrated system of risk reduction and preparedness; ▪ To utilize and allocate resources based on risk assessment and contingency plan; ▪ To provide facilities and infrastructure of integrated early warning system; ▪ To enhance the capacity of people through education and training; and ▪ To provide adequate logistics and equipment. **<Emergency response: to save more lives>** ▪ To enhance the capacity of community for self-managed disaster response; ▪ To utilize resources of private sector; ▪ To accelerate arrival time of rapid response teams to disaster sites; ▪ To enhance agility to determine emergency status and organizational system; ▪ To prioritize the management of vulnerable groups; and ▪ To restore damaged vital facilities and infrastructure. **<Rehabilitation and reconstruction: to build back better and safer>** ▪ To recover for disaster risk reduction.

(Source: Disaster Management Plan 2015-2019 (Draft))

The outline of Disaster Management Program 2015-2019 is described in Table 4-7. The seven priorities provided in this program correspond to the implementation strategy given in the policy.

Table 4-7 Outline of Disaster Management Program 2015-2019

<table>
<tr><th>Priority Focus</th><th colspan="2">Target</th></tr>
<tr><td>1. Strengthening the legal framework of disaster management</td><td colspan="2">Availability of legal instruments that support effective and independent disaster management at the national and local level.</td></tr>
<tr><td>2. Mainstreaming disaster management into development</td><td colspan="2">Integration of disaster management into development activities by both government and non-government organizations to guarantee sustainable development.</td></tr>
<tr><td rowspan="3">3. Increasing multi-sectoral partnership on disaster management</td><td colspan="2">Applied strategies that guarantee synergized community empowerment with orientation to disaster risk reduction and independence.</td></tr>
<tr><td>Action Plan</td><td>Developing strategies of community empowerment to achieve disaster resilience adapts to climate change issues, gender, and vulnerable issues.</td></tr>
<tr><td colspan="2">Increased multi-sectoral partnership (government, private, and civil society) on disaster management activities.</td></tr>
<tr><td>4. Fulfillment of good governance on disaster management</td><td colspan="2">Capacity enhancement of human resources and government and non-governmental organizations on disaster management.</td></tr>
<tr><td rowspan="2">5. Enhancement of the capacity and effectiveness of disaster prevention and mitigation</td><td colspan="2">Enhanced prevention and mitigation efforts to reduce potential number of victims, economic loss, and environmental degradation of a disaster.</td></tr>
<tr><td>Action Plan</td><td>Disaster mitigation management which is synergized with climate change adaptation, and considering the vulnerable groups and local wisdom.</td></tr>
<tr><td>6. Enhancement of the capacity and effectiveness of emergency response</td><td colspan="2">Enhanced independent and proactive preparedness and emergency response to face disaster.</td></tr>
<tr><td rowspan="2">7. Enhancement of the capacity and effectiveness of recovery from a disaster</td><td colspan="2">Provision of independent, effective, and prestigious support mechanism to guarantee a better and more secured disaster recovery.</td></tr>
<tr><td colspan="2">Cross-sectoral disaster recovery based on the Action Plan of Post Disaster Rehabilitation and Reconstruction.</td></tr>
</table>

(Source: Disaster Management Plan 2015-2019 (Draft))

The issues of gender and the vulnerable groups are paid some attention in the action plan of the Disaster Management Program. It can be said that the program considers women and the vulnerable as a group to be prioritized in the activities to strengthen the capacity of disaster management.

(2) KEMSOS Strategic Plan 2015-2019 (Draft)

In the draft of the Strategic Plan of KEMSOS from 2015 to 2019, the issue of disaster management was not mentioned in the development targets or strategic objectives; however, it generally aims to fulfill the rights and the needs of the vulnerable, including persons with disabilities.

4.4 Disability-Inclusive Disaster Management Programs

4.4.1 Programs of BNPB/BPBD

(1) Resilient Village Program

The Resilient Village Program is a national program to increase the resilience of community formulated by BNPB. The implementation guideline is defined in a regulation of Head of BNPB No. 1/2012, and the local governments and other implementing organizations follow this guideline.

According to the regulation, the objectives of the program are defined as below.

1) To protect the people who live in disaster-prone areas;
2) To strengthen the role of society (especially the vulnerable groups) in managing the resources to reduce the risk of disasters;
3) To strengthen the capacity of public organizations in managing and maintaining the resources and local knowledge for disaster risk reduction;
4) To strengthen the capacity of government organizations to provide technical supports for disaster risk reduction; and
5) To strengthen the partnership among the stakeholders in disaster management, such as local governments, private sector, universities, NGOs, and other community organizations.

The regulation also provides for strategies, principles, and activities in developing resilient villages. With regard to the inclusion of persons with disabilities, it is mentioned in the first item of the strategy, emphasizing the involvement of the whole society. In addition, the alignment on vulnerable group is stated in the 10th item of the 15 principles, explaining that the vulnerable, including persons with disabilities, children, the elderly, pregnant mothers, and the sick, are to be prioritized in disaster management.

The BPBD of the Yogyakarta City government and Arbeiter-Samariter-Bund (ASB), an international NGO, also conduct this program. The BPBD of the Yogyakarta City government has already developed three resilient villages through this program. The activities of the program include conducting risk assessment, developing disaster management plan, establishing DRR Forum, strengthening the capacity of government officials and the residents, and conducting monitoring and evaluation. According to BPBD Yogyakarta City government, the budget to implement the program is allocated from the provincial government. The budget to develop one resilient village is approximately from IDR 70 million to IDR 100 million.

(2) Disaster-resistant Sub-village Program

The Disaster-resistant Sub-village is a program conducted by BPBD of the Yogyakarta City government. The target of this program is for all the community members, including the vulnerable, to aim for the development of a community where the people understand risks of disasters and help each other to reduce the risks.

Through this ten-month program, BPBD conducts training on risk analysis, mapping of disaster risk, and simulation training to respond to emergencies and develops a village profile. In addition to these activities, BPBD also provides each village with disaster management tools such as a chain saw, water pump, a torch, a motorbike, and a three-wheeled vehicle.

The BPBD of the Yogyakarta City government has implemented this program in ten sub-villages in 2013 and 25 sub-villages in 2014, and also it targets 20 sub-villages in 2015. The budget allocated from the city government to conduct the program is approximately IDR 100 million per sub-village[163].

[163] Based on the interview with BPBD of Yogyakarta city government (1 July, 2015).

4.4.2 Programs of KEMSOS/DINSOS

(1) TAGANA Goes To School

The TAGANA Goes To School is a national program formulated by KEMSOS in 2010. In this program, the members of TAGANA visit kindergarten, primary, junior-high, and high schools to provide disaster management training. The targets of this program are both students and teachers and there are two different programs for each target. The activities of the program are different from each province; for example, TAGANA of Yogyakarta Special Region utilizes visual items such as video and pictures and folk songs singing "no making noise, no pushing, and no rushing" that is a basic rule for emergency situation so that school children would easily understand how to reduce the risk.

Although KEMSOS does not stipulate in inclusion of special schools in this national program, DINSOS of Yogyakarta Special Region has started to conduct the program at special schools as well since 2012. Meanwhile, DINSOS of East Java Province has never targeted at special schools.

Regarding the budget to conduct the program, DINSOS of Yogyakarta Special Region secures approximately IDR 150 million to IDR 200 million for 20 schools per year. This budget includes the allocations from the national budget[164].

(2) Social Advocacy

As referred to in Section 4.2.1 (2), social advocacy for the vulnerable, including persons with disabilities, is the recent focus of KEMSOS. In order to increase the understanding of its purposes and the implementing procedure, KEMSOS issued a guideline of social advocacy for the government officials and members of TAGANA in 2014.

The guideline defines the targets and the procedure of social advocacy as summarized in Table 4-8. In performing social advocacy tasks, the Social Advocacy Officers are to be selected from the members of TAGANA.

In this guideline, persons with disabilities are considered as a vulnerable group in disaster situation that may have more severe impacts. To fulfill their needs, the guideline gives the procedure on how to identify the needs, how to analyze the issues to meet the needs, and how to provide services for persons with disabilities. However, the needs and process for advocacy described in this guideline do not fully reflect the needs of persons with disabilities. For example, the accessibility of shelters and toilets, assistive devices, and information tools for persons with disabilities are not mentioned in the list of needs to be identified in this process. The types of the needs shown in the guideline such as foods, clothes, shelters, health services, comfort, and education, may indicate the needs of women and children. Furthermore, a tool or information to identify the whereabouts of persons with disabilities, such as a list of persons with special needs, does not exist at this moment and it is therefore difficult to approach all the vulnerable groups.

[164] Based on the interview with TAGANA at Yogyakarta Special Region (1 July, 2015).

Table 4-8 Outline of a Guideline of Social Advocacy

Main Target	▪ Infants and children ▪ Pregnant and lactating mothers ▪ Persons with disabilities ▪ Elderly people
General Target	▪ Groups or people such as women's groups, youth groups, religious groups, people live in poverty, and adopted families ▪ Policy maker and implementer such as field coordinator and local government administrators ▪ Related stakeholders in community such as health teams, evacuation teams, psychosocial teams, academic organizations, army, and PMI ▪ NGOs and Civil Society Organizations ▪ Local leaders such as religious leaders and youth leaders ▪ Central/local government organizations ▪ Children's Forum such as child care organization and child advocacy office
Procedure	1) Identification of disaster victims 2) Identification and categorization of issues into three types: 1) fulfillment of basic needs, 2) case, and 3) management 3) Collection of data and information on disaster victims (general information such as age and sex) 4) Diagnose the situation of issues 5) Setting a goal to be achieved 6) Formulation of a plan to achieve the goal (a plan includes the schedule, resources, and stakeholders) 7) Implementing the activities as planned 8) Monitoring and evaluation 9) Making recommendations as necessary

(Source: A Guideline of Social Advocacy 2014)

4.5 Assistance by Donor Agencies

4.5.1 Arbeiter-Samariter-Bund (ASB)

(1) Outline of Organization

The Arbeiter-Samariter-Bund (ASB) is an organization for social welfare that began in 1888 in Germany. Since its foundation, it provides various services such as rescue works, medical care, and social services around the world.

In Indonesia, ASB started their activities firstly to respond to the Yogyakarta Earthquake in 2006. Now it expands their activity area to the Special Administrative Province of Yogyakarta, Klaten District (Central Java Province), Ciamis District (West Java Province), and the Mentawai Islands (West Sumatra Province)[165]. The main fields of their activities are 1) disaster risk reduction, 2) livelihoods, and 3) inclusive education, and they are pursuing the inclusion of persons with disabilities in all of these activities.

[165] ASB has also conducted several programs of emergency response, medical services, and disaster risk reduction in North and South Nias districts of North Sumatra Province, Padang District of West Sumatra Province and Jakarta.

(2) Disability Inclusive Approach on Disaster Management

There are three programs on disaster risk reduction conducted by ASB: the "Resilient Village Program" and the joint research program with the University of Sydney are in practice, and another project will be started in the latter half of the year 2015. The details of these programs are described in from Table 4-9 to Table 4-11.

Table 4-9 Resilient Village Program in the Mentawai Islands (Phase II)

Period	2014 – 2015
Target Area	Four villages in the Mentawai Islands
Purpose	▪ To contribute to the development of the Resilient Village Program in disaster-prone communities in remote area. ▪ To establish and equip communities to be better prepared for, and to respond to, natural disasters.
Output	▪ Establishment of disaster risk reduction forum at the village level. ▪ Provision of training programs and equipping with the skills on emergency shelters, logistics, first aid, and search and rescue. ▪ Establishment of outreach teams for disaster risk reduction in the communities which has a particular focus on highly at-risk groups. ▪ Establishment of disaster risk reduction teams at the sub-village level. ▪ Establishment of integrated disaster management plans, regulations, and contingency plans for earthquakes and tsunami at the village level.
Cooperation Agency/Institution	BPBD at the city/district level
Notes	▪ The Phase I of this program was conducted in the villages of Mentawai Islands in 2013. Phase II targets at the further remote areas in the islands. ▪ This program pays particular attention to the inclusion of vulnerable groups such as persons with disabilities, the elderly, women, and children.

Table 4-10 Collaborative Project Including Persons with Disabilities in Disaster Risk Reduction Activities

Period	Two years
Target Area	Four provinces
Overview of the Project	▪ The project developed a disaster risk resilience tool. This tool was used in the survey, interviewing more than 200 persons with disabilities or their family members, and caregivers in the four targeted provinces. ▪ The results of this project will be utilized for planning and implementing disaster management policies at the national and local level.
Cooperation Agency/Institution	The Centre for Disability Research and Policy at the University of Sydney

Table 4-11 Technical Assistance and Training Teams (TATTs) Project

Period	October 2015-October 2016 (Tentative)
Target Area	Six provinces including Central Java and Papua
Target	TATT teams, BPBD and other related government organizations, and the University Disaster Risk Reduction (DRR) Forum
Purpose	▪ To provide key stakeholders with understanding of inclusion and relevant regulations and frameworks. ▪ To provide technical assistance on inclusion to tackle the identified issues in the provinces. ▪ To support TATT teams and BPBD, ensuring the inclusion is to be integrated into their work plans and activities. ▪ To support the establishment and trial of a model of Disability Service Unit within BPBD in Central Java as a key initiative under the new regulation of the Head of BNPB on disability.
Fund	USAID

4.5.2 Handicap International (HI)

(1) Outline of the Organization

Handicap International (HI) is an international NGO founded in 1982, providing various projects to support persons with disabilities, their family members and their communities in 61 countries.

The major working areas of HI Indonesia are 1) emergency and 2) development. The development program includes activities on inclusive education, accessibility, disaster prevention and preparedness, and human rights and advocacy. As the new Regional Program Framework in Indonesia and Timor-Leste for the year 2013 to 2015 has been laid out, HI shows the following goal and objectives:

Goal: To ensure that persons with disabilities and the vulnerable groups have better access to services and increase their participation to political and public life in emergency and development settings.

Objectives:
- To promote persons with disabilities and vulnerable groups in becoming actors to address the development issues.
- To promote disability-inclusive and disability-specific services in increasing the accessibility of persons with disabilities.
- To promote decision-makers' awareness of disability-related issues to increase accessibility to services and participation in public life.
- To promote emergency responses that adequately include persons with disabilities and vulnerable groups.

(2) Disability Inclusive Approach on Disaster Management

HI conducts several training programs on disability-inclusive assessment, planning, evacuation, and first aid for PMI that conducts rapid assessment and TAGANA that is in-charge of logistics in case of emergencies. The projects on disability-inclusive disaster management conducted by HI are listed in from Table 4-12 to Table 4-14.

Table 4-12 Project on Disaster Risk Management

Period	March-December 2015
Target Area	Kupang City, Malaka District in East Nusa Tenggara (*Nusa Tenggara Timur*: NTT) Province
Target	PMI Central staff, PMI staff of NTT Province, PMI volunteers
Output	▪ The participation of persons with disabilities and the integration of disability related issues into the training programs and activities conducted by central PMI. ▪ The participation of persons with disabilities and the integration of disability related issues into the project activities conducted by regional PMI of NTT Province.
Cooperation Agency/Institution	PMI Central, PMI of NTT Province

Table 4-13 Inclusive Disaster Risk Reduction Project in NTT Province

Target Area	Kupang City, Timor Tengah Selatan District, Belu District
Purpose	To reduce the vulnerability of persons with disabilities to natural disasters through their increased participation in activities on disaster management.
Objective	To support sustainable disability-inclusion on the school-based disaster management programs at 34 schools in NTT Province.
Output	▪ A disaster management network of 34 schools is acting in targeted area (two districts and one municipality). ▪ A disaster management network of 34 schools actively cooperates with BPBD at provincial and district level, and the capacity of DRR Forum and the government officials is developed. ▪ With the support from PMI, a school-based and disability-inclusive program on disaster management is established in 12 schools in three districts. ▪ The disability-inclusive activities on disaster management are integrated into the curriculum of primary schools.
Cooperation Agency/Institution	DINSOS (TAGANA), BPBD of NTT Province, DINSOS of Kupang City, DINSOS of Timor Tengah Selatan District (TAGANA), BPBD of Timor Tengah Selatan District, PMI of NTT Province

Table 4-14 Inclusive Early Response of Mt. Merapi Eruption

Period	November 2010-April 2011
Purpose	To bring an urgent response based on the needs of vulnerable population who were affected by the eruption of Mt. Merapi.
Objective	To respond to the needs of the affected vulnerable people in the region of Sleman District (Yogyakarta Special Region) and Klaten District (Central Java).
Output	▪ Total number of people receiving services that respond to their needs (specific impairment, disease, or disability): 8,155 (direct), 40,755 (indirect) ▪ Total number of people receiving services to prevent disability: 4,258 (direct), 21,290 (indirect) ▪ Total number of people benefited by actions not related to disability or prevention of disability: 3,408 (direct), 17,040 (indirect)
Cooperation Agency/Institution	Puskesmas in Sleman District, Puskesmas in Klaten District, TAGANA, SAPDA, CIQAL, Samsara

Table 4-15 School Disaster Risk Reduction Project, NTT Province

Period	October 2010-December 2011
Target Area	One special school and three inclusive schools in Kupang City One special school and three inclusive schools in Kupang District One special school and three inclusive schools in Belu District
Purpose	To strengthen the capacity of disaster management among non-disabled and disabled children.
Objective	▪ A group of non-disabled and disabled children organizes a task force at each school and the task force disseminates disaster related information, tools, and activities within their class. ▪ The inclusion of disability in evacuation plans and emergency response is improved through the disability-inclusive contingency plans and the peer to peer activities. ▪ The community volunteers consisting of members of TAGANA, parents, and Forum of Parents of Children with Disabilities commit the activities on disaster management.
Output	▪ A total of 4,705 (423 are disabled children) students in three special schools and nine inclusive schools were impacted by the project. ▪ A total of 405 (135 are disabled children) students cooperates with the school-based DRR program as task force members. ▪ A total of 20 volunteers supported the project activities.
Cooperation Agency/Institution	DINSOS of NTT Province, DINSOS of Kupang City, DINSOS of Kupang District, DINSOS of Belu District, Department of Education and Sports of NTT Province, Department of Education and Sports of Kupang City, Department of Education and Sports of Kupang District, Department of Education and Sports of Belu District, TAGANA of Kupang District, TAGANA of Belu District, Forum of Parents of Children with Disabilities

4.6 Activities Conducted by DPOs

There are two DPOs which address the issues of disability-inclusive disaster management namely: 1) *Karitas Indonesia Keuskupan Agung Semarang* (KARINA KAS), and 2) *Yayasan Kristen Untuk Kesejahteraan Umum* (YAKKUM). The outline of the organizations and their major activities are described as follows:

4.6.1 KARINA KAS (*Karitas Indonesia Keuskupan Agung Semarang*)

KARINA KAS was founded in 2006 to respond to the Yogyakarta Earthquake. Now it works on the activities related to the three programs as below.

1) Community-based Rehabilitation (CBR)
2) Community Management Disaster Risk Reduction
3) Development (support to increase household revenue and education for the poor)

KARINA KAS targets not only persons with disabilities but all the people in need. For example, the CBR program targets the persons with disabilities; the disaster management program targets the people in the communities; and the development program targets the people who live in poverty. With regard to the program of 2) Community Management Disaster Risk Reduction, Table 4-16 shows their major activities.[166]

[166] Based on the website: http://karinakas.org/

Table 4-16 Activities on Disaster Management

Year	Activities
2010	To respond to the needs of victims of the volcanic eruption of Mt. Merapi, KARINA KAS provided the following assistance: ▪ Dispatch of medical teams ▪ Distribution of sanitation kits ▪ Provision of massage services by the visually impaired persons trained by the CBR program ▪ Provision of psychosocial support
2011	In cooperation with SAR team and PMI, KARINA KAS conducted simulation training on early warning, evacuation, and first aid, to respond to emergency situations in case of flood.
2012	Conducted a training program on "Disaster Risk Reduction" and "Participative Disaster Risk Analysis" for the volunteers in two communities in Yogyakarta Special Region.

(Source: KARINAKAS documents)

4.6.2 YAKKUM (*Yayasan Kristen Untuk Kesejahteraan Umum*)

YAKKUM is a rehabilitation center established in Yogyakarta in 1982. Being supported by the Presbyterian and Methodist Church Alliance in New Zealand, it provides various programs such as CBR, medical check-up, physiotherapy, surgery, assistive devices, community empowerment, and inclusive disaster risk reduction. With regard to the program of inclusive disaster risk reduction, YAKKUM focuses on education of communities and persons with disabilities to reduce the disaster risk[167].

4.7 Trends of Cooperation on Disaster Management from Japan

4.7.1 Assistance from JICA

Same with Japan, Indonesia is a disaster-prone country and the Government of Japan considers disaster management as one of the prioritized fields of development assistance and has provided various assistances on this field until today. For example, JICA had implemented several projects such as developing early warning systems and strengthening buildings specifically focusing on prevention and risk reduction of disasters. In addition, it had also provided emergency assistance and programs of rehabilitation and reconstruction after the disaster. In recent years, the focus of the assistance has extended to capacity building of the government organizations, the officials, and people who live in the community. However, there is no record to verify whether those projects include the vulnerable or not.

The projects regarding disaster management conducted by the Japanese government are listed in Table 4-17.

Table 4-17 Projects for Disaster Management

Year	Name of Project
Integrated Disaster Management	
2001 – 2006	Integrated Sediment Disaster Management Project for Volcanic Area
2006 – 2007	Central Java and DIY Earthquake Reconstruction Program Advisory Team
2009 – 2012	Multi-disciplinary Hazard Reduction from Earthquakes and Volcanoes in Indonesia
2010 – 2016	Comprehensive Disaster Management Policy Advisor
2011 – 2015	The Project on Enhancing the Disaster Management Capacity of National Agency for Disaster Management (BNPB) and Regional Agency for Disaster Management (BPBD)
2012 – 2016	Enhancing Abilities of Community-based Disaster Management of Several Villages

[167] Based on the website: http://yakkum-rehabilitation.org/

Year	Name of Project
	around Merapi Volcano in Central Java
2014 - 2019	Project for Integrated Study on Mitigation of Multimodal Disasters Caused by Ejection of Volcanic Products
Earthquake and Tsunami Management	
2007 – 2009	Project on Capacity Development for National Center of Indonesian Tsunami Early Warning System
2009 – 2011	Reconstruction of Schools Considering Quake-resistant and Community-based Disaster Reduction
2011 – 2014	Project on Building Administration and Enforcement Capacity Development for Seismic Resilience Phase 2
2013 – 2014	Project for Improvement of Equipment for Disaster Risk Management
Flood Management	
2007 – 2010	Institutional Revitalization Project for Flood Management in JABODETABEK
2009 – 2014	Flood Control Sector Loan
2011 – 2015	Project for Construction of Rusumo International Bridge and One Stop Border Post Facilities
2013 – 2018	Upper Citarum Basin Flood Management Sector Loan
Sediment Disaster Management	
2009 – 2012	Promoting Project for Geotechnical Disaster Prevention Technology in Hilly and Mountainous Areas in Indonesia
2008 – 2012	Integrated Disaster Mitigation Management for "Banjir Bandang"
2014 – 2017	Urgent Disaster Reduction Project for Mount Merapi II

(Source: the Survey team based on JICA knowledge site: http://gwweb.jica.go.jp/)

4.7.2 Assistance by Private Organizations

(1) Non-Profit Organization Japan Heart

Japan Heart is a non-profit organization that provides medical support, health activities, support on nursery school, support for persons with visual impairment, and emergency medical relief in developing countries in Asia. In Indonesia, Japan Heart concludes an agreement of training programs on emergency response with KEMSOS in June 2014. Since then, it has provided the following assistances as described in Table 4-18[168].

Table 4-18 Activities Implemented by Japan Heart

Month/Year	Activities
August 2014	Implemented a four-day training for TAGANA Bogor District. Implemented a two-day training for TAGANA in South Sumatra.
September 2014	Implemented a five-day training for 60 of TAGANA members in Bogor. The training includes lectures about disaster risk management and first aid and the simulation exercise on emergency response.
October 2014	Conducted a rapid assessment on medical needs to respond to volcanic eruption of Mt. Sinabung in North Sumatra.
February 2015	Implemented a joint training on disaster management among five countries, namely; Cambodia, Lao, Myanmar, Indonesia, and Japan. The training included lectures about disaster management, risk management, information systems, disaster medical care, and regulations on disaster management of Indonesia.

[168] Based on the website of Japan Heart: http://www.japanheart.org/rescue/report/cat/

(2) Community Emergency Management Institute Japan

The Community Emergency Management Institute Japan (CEMIJ) is a general incorporated foundation to conduct technical assistance and academic activities on disaster management for Japan or other Asian countries. In Indonesia, it cooperates with KEMSOS to support their disaster management activities[169]. Table 4-19 shows the major activities implemented by CEMIJ.

Table 4-19 Activities Implemented by CEMIJ

Month/Year	Activities
March 2014	Conducted a workshop on incident command system for 11 representatives from relevant organizations. This workshop was held in collaboration with Japan Heart.
April 2014	Conducted a workshop for TAGANA in collaboration with Japan Heart. The workshop included lectures on triage, first aid skills, incident command system, and emergency communications.
March 2015	Conducted an assessment on training needs of disaster management in Garut, West Java. Based on the needs assessed, the training program will be developed.
April 2015	Implemented a training program for TAGANA. The emphasis of the training was on "social advocacy" for the vulnerable.

4.8 Practices and Experiences of Japan

4.8.1 Approach by the Government

(1) List of People in Need of Special Assistance

Article No. 49 of the Disaster Countermeasure Basic Act obliges a mayor of the municipality to prepare a list of people in need of special assistance who are not able to evacuate by themselves. A list of people in need of special assistance includes the necessary information to confirm their safety such as name, date of birth, sex, address, contact number, reason for assistance, and others identified by each municipality. In case of disasters that would threaten their lives and would need to be protected, the mayor of the municipality has the authority to disclose the information to others for assistance without their agreement.

At the time of the Great East Japan Earthquake in 2011, most of the mayors of the affected municipality did not disclose the information to others, complying with the law on protection of personal information. This situation has led to difficulty in identifying the listed people who needs assistance; as a result, the necessary services were not delivered to them. After that, the government revised the condition of the law in terms of information disclosure in 2013.

(2) Shelters for Welfare Services

In accordance with the Disaster Relief Act, the mayor of the municipality is required to provide a shelter for persons with special needs, such as persons with disabilities (physical, intellectual, and mental disabilities), the elderly, home-care patients with intractable diseases, pregnant women, and infants. To designate a welfare shelter, the mayor of the municipality figures out the numbers of persons with special needs and the facilities which can be used as shelter and prepares the necessary equipment and the management system.

[169] Based on the website of CEMIJ: http://cemij.doorblog.jp/

There are several conditions for the welfare shelters. For example, the facilities are supposed to be resistant to earthquake and fire and to be accessible for users. Although the facility for a welfare shelter is different among each municipality, schools, community centers, welfare facilities for the elderly, health centers, and public/private accommodation facilities are commonly designated as the shelters for welfare services.

(3) Support Team for Persons with Special Needs

Under the law on disaster relief, the mayor of the municipality is also required to establish a support team for persons with special needs. The team comprises the staff of municipalities centering on the welfare department, community organizations for disaster management, welfare service workers, health-care providers, and volunteers. For disaster preparedness, the team shares information on people who need special assistance, conducts emergency drills involving these people, and formulates a support plan for emergency. When a disaster occurs, the team conveys information about the disaster, assists the people to evacuate, and confirms their safety.

4.8.2 Approach by Non-government Organizations

(1) Establishment of Support Center

In the case of the Great East Japan Earthquake in 2011, the Japan Disability Forum established a support center for persons with disabilities in Iwate, Miyagi, and Fukushima prefectures as it was expected that long-term and continuing assistance would be necessary for rehabilitation. In cooperation with the government and non-government organizations, the centers supported the confirmation of the safety of persons with disabilities, provided livelihood support, and still continue their livelihood and job assistance to them.

(2) Dispatch of a Sign Language Interpreter

Based on the experiences from the Great Hanshin-Awaji Earthquake in 1997, All Japan and the Deaf Association requested information security (broadcasting with sign language or subtitles) for the deaf to the relevant ministries and the media to respond to the disaster in 2011. It also requested the Ministry of Health, Labor, and Welfare to officially dispatch sign language interpreters to the disaster sites as the persons with hearing impairment need interpreting assistance for communication. After the acceptance of their request, the association coordinated the dispatch of 76 registered interpreters from 21 prefectures.

Chapter 5 Policies and Trends of Cooperation of Japan

5.1 Aid Policies for Indonesia

Japan understands Indonesia as a core country of ASEAN with the largest population, and raises "assistance for further development that is well-balanced, and enhancement of capacity to address issues of the Asian region and international society" as a basic policy. With the focus on the further economic growth of Indonesia, as a strategic partner for Japan which Japan has long cherished a friendship, to offer assistance for well-balanced development and enhancement of capacity to address issues of the Asian region and international society, the Government of Japan set the following three priority areas for assistance to Indonesia[170] (Table 5-1).

Table 5-1 Important Points in Providing Support for Indonesia (Medium-term goal)

(1) Assistance for further economic growth: In order to accelerate economic growth led by the private sector, efforts will be made to improve the business and investment environment by providing assistance for infrastructure development especially in the Jakarta metropolitan area and for the improvement of various regulations and systems in alignment with enhanced economic partnership within the Asian region. At the same time, assistance is also provided for professional human resource development.

(2) Assistance for correction of inequality and establishment of a safe society: In order to correct domestic inequality, and contribute to well-balanced development and the establishment of a safe society, Japan will offer assistance for enhancement of internal connectivity such as development of major transport and distribution networks, as well as development of regional core areas. Japan will also offer assistance for Indonesia to improve systems and organizations, which are intended for rural development, and take disaster preventive measures.

(3) Assistance for the enhancement of capacity to address issues of Asian region and international society: Provision of assistance to contribute to the enhancement of capacity required for responding to issues of Asian region such as marine safety, measures against terrorism and infectious diseases and other global issues such as environmental conservation and climate change, while offering assistance that will help increase the capacity as a donor country.

(Source: Ministry of Foreign Affairs Support Policies by Country for the Republic of Indonesia 2012)

5.2 JICA's Aid Policy on Disability and Development

JICA has revised a thematic guideline of "Disability and Development" in February of 2015. Its purpose for cooperation is "respecting the human rights of all persons with disabilities, and the materialization of an equal and inclusive society," and JICA gives the following three areas of priority.

1. Enactment of disability-inclusive policies/regulations
    a. Promotion of CRPD ratification and related policies and regulations

[170] The source of this paragraph is basically based on "Support Policies by Country for the Republic of Indonesia" by the Ministry of Foreign Affairs (April 2012). Furthermore, on the website of the Ministry of Foreign Affairs, it is stated at the beginning section of support policies of Indonesia (http://www.mofa.go.jp/mofaj/gaiko/oda/seisaku/kuni_enjyo_kakkoku.html).

b. Development of disability-related statistics and data collection

2. Practice of disability-inclusive programs/projects
3. Empowerment of persons with disabilities

5.3 Japan's Comparative Advantages on Disability and Development

The cooperation of JICA related to disability and development has started in the 1970s. Since the early 1980s, they have accepted trainees, provided grant aid, and implemented technical cooperation projects[25].Considering the Japan's past experiences and knowledge on the related fields such as accessibility, disaster management, and social protection, it can be said that Japan has relatively a high comparative advantages in the five sectors; accessibility, medical rehabilitation, the empowerment of persons with disabilities, disaster management, and social protection. The rational behind for the comparative advantage are explained in Table 5-2.

Table 5-2 Japan's Comparative Advantages in the Assistance in Disability

Field	Japan's Experience/Knowledge
Accessibility	With the background of low birth rate and an aging population, Japan has the experiences of striving to promote barrier-free and universal design in terms of impediment removal. JICA adopts the principles of universal design in its transportation infrastructure development projects on roads, railways, ports and airports, especially in constructing urban transports such as airports or subways and schools or hospitals[171].
Medical Rehabilitation	Japan has worked to address regional disparity of medical rehabilitation in developing countries in the past, and has abundant experience in professional training, the improvement of service quality, and transition to community-participatory comprehensive rehabilitation from medical rehabilitation. Japan has sufficient knowledge/experience in this field.
Empowerment of Persons with Disabilities	In order to empower persons with disabilities, Japan dispatches persons with disabilities to developing countries as specialists in peer counseling, leadership trainings, Disability Equality Training (DET) where persons with disabilities themselves serve as lecturers, independent living and barrier-free. Japan has sufficient experience and knowledge in this field. A person with disability was dispatched as the first long-term expert with disability to "Project for Social Inclusion of Conflict Victims with Disabilities (2015-2020)" of Columbia.
Disaster Countermeasures	Japan has experienced two massive earthquakes in the last quarter-century (the Hanshin Awaji Earthquake and the Great East Japan Earthquake), and has accumulated lessons/preparations/solutions for persons with disabilities. The third UN World Conference on Disaster Risk Reduction was held in Sendai in April 2015, with active participation of persons with disabilities. Japan supported the conference where many persons with disabilities spoke up leading to the realization of persons with disabilities-centered conference.
Social Protection	Japan has achieved universal health coverage in 1961, and has sufficient knowledge and experience in expansion of the coverage. Regarding assistive devices, the spread of the devices is promoted with the background of an aging population, and has sufficient knowledge/experience.

(Source: the Survey team using the Thematic Guidelines on "Disability and Development" and "Social Security.")

[171] JICA "Thematic Guidelines 'Disability and Development'" (2015), p44

5.4 Assistances Provided for Indonesia

5.4.1 Disability and Development

Table 5-3 shows the assistances in disability and development which were provided for Indonesia.

Table 5-3 Assistances in Disability and Development to Indonesia

Period	Title of Projects	JICA's Scheme
1987	Vocational Rehabilitation	Dispatch of individual expert
1988	Vocational Rehabilitation	Dispatch of individual expert
1990	Vocational Rehabilitation (Seminar Program)	Dispatch of individual expert
1991	Vocational Rehabilitation (Seminar Program)	Dispatch of individual expert
1993	The Project for Equipment Renovation of Vocational Training Center	Grant Aid
1994-1997	Solo Center for Physically Disabled People	Technical assistance
1994-97/2006-11	The Project to Support Participation of persons with disabilities	Technical assistance
1995	Vocational Training	Dispatch of individual expert
1997-2002	The Project for National Vocational Rehabilitation Center for Disabled People	Technical assistance
2000-2006	Vocational Rehabilitation	Dispatch of individual expert
2003-2006	The Project for Networking to Support People with Hearing Impairment in Indonesia	JICA Partnership Program
2003-2006	The Project for Improvement of National Vocational Rehabilitation Center for Disabled People	Technical assistance

In addition, disability consideration was made in the loan projects listed in Table 5-4.

Table 5-4 Loan Projects with Consideration for Persons with Disabilities

Period	Title of Project
1996-2014	Railway Double Tracking on Java South Line Project Phase 4
2009	JABODETABEK Railway Capacity Enhancement Phase 1
2009-2012	Technical Cooperation Project for the Development of the Engineering Faculty of the Hasanudin University (UNHAS), South Sulawesi
2008	Project for Improvement of University of Indonesia

5.4.2 Others

The section below summarizes the JICA's assistance experience in the area of health and infrastructure development, which intervention is not disability specific though.

(1) Health

Compared with the situation in developed countries, developing countries have low consultation rate of medical examination of pregnant mothers and infants and it therefore results in delayed detection of disability. The MCH Handbook that was introduced by JICA includes items to help detect health problems that would lead to disability. Table 5-5 summarizes the history of cooperation on development of the MCH Handbook in Indonesia.

Table 5-5 History of the MCH Handbook Projects in Indonesia

Year	Name of Project
1993-1994	Phase 0 “Project for Family Planning and Maternal and Child Health” (Extended Cooperation) The project developed an MCH Handbook and made a trial practice in the pilot area of Salatiga City in the Central Java Province
1994-1996	Dissemination within the Central Java Province
1996	Expansion of dissemination to additional five provinces
1998-2003	Phase 1 “Technical Cooperation Project for Ensuring the Quality of MCH Services through MCH Handbook” In 2003, the Project expanded the target area to 23 provinces to quantitatively disseminate the handbook. In 2004, KEMENKES issued a ministerial order on MCH Handbook.
2006-2009	Phase 2, “Project on Ensuring Maternal and Child Health Service with MCH Handbook Phase 2” The Project aimed to improve the quality of the handbook and secure its sustainability[172].

(2) Infrastructure Development

In order to improve the business and investment environment by providing assistance for infrastructure development especially in the Jakarta metropolitan area, there are ongoing 17 projects in Jakarta (as of August 2015) in the area of 1) planning and regulation improvement/capacity building, 2) capacity enhancement of mass transportation, and 3) improvement of road traffic environment and capacity expansion of airports. Those 17 projects are listed in the Table 5-6 as JICA already adopts the principles of universal design in its transportation infrastructure development projects on roads, railways, ports and airports.

Table 5-6 Ongoing Projects on Development of Transportation and Traffic to Improve the Business and Investment Environment in the Jakarta Metropolitan Area

	Period	Title of Project
Planning and regulation improvement/capacity building	2014-2017	JABODETABEK Urban Transportation Policy Integration Phase 2
	-2016	Project on Capacity Building for Public Private Partnership (PPP) Network
	2013-2016	Advisor for Development Policy in West Java Province
	-2015	Japan-ASEAN Action Plan on Environment in the Field of Transportation
	2014-2018	MPA Support Facility
	2013-2018	Loan for Infrastructure Development and Development Policy on Strengthening Partnership
Capacity enhancement of mass transportation	2013-2016	Jakarta MRT Project Advisor
	2009-2016	JABODETABEK Railway Capacity Enhancement Phase 1
	2013-2017	The Detailed Design Study of Railway Electrification and Double-Double Tracking of Java Main Line Project in Indonesia Phase 1
	2013-2018	Railway Double Tracking on Java South Line Project Phase 4
	2014-2020	JABODETABEK Railway Capacity Enhancement Phase 1
	2013-2014	Jakarta MRT Development Project
Improvement of road traffic environment	2013-2016	Road Policy Advisor
	2013-2015	Project for Development of Road for Pelabuhan Tanjung Priok Phase 1
	2013-2016	Project for Development of Road for Pelabuhan Tanjung Priok Phase 2
	2013-2014	ITS Project to Improve Traffic Jam in Jakarta
Capacity expansion of airports	2013-2016	Advisor of Airport Development

(Source: the Survey team based on Development Plan for Indonesia acquired from JICA Indonesia Office)

[172] http://www2.jica.go.jp/ja/evaluation/pdf/2012_0600435_4_f.pdf

In addition to the projects listed above, the request for the technical cooperation of "Green City Master Plan (GMP)[173] in Surabaya" to the Japanese government has been in preparation within the government of Indonesia. In the process of drafting the proposal, the discussion to include the perspective enhancing the accessibility of citizens to the public goods and services has been included.

Rural Areas Infrastructure Development Project for Poverty Reduction Phase 2 (2013) intends to improve accessibility to social services as well as to generate economic opportunity for the poor and to enhance the capacity of the local government through developing small-scale infrastructure.

The Project on Development of Facilities to Support Wheelchair Users for their Independence in North Jakarta and Bekasi (2013), Development of Children's Institution in Depok, West Java (2013), and The Project for Water Supply to the Schools for persons with disabilities in Garut, West Java (2009) also aim to develop the disability-related infrastructure.

[173] See also 3.5.2 "City Planning at Surabaya."

Chapter 6 Trends of Other Donors in Indonesia

6.1 Outline

Currently (from May to August 2015), the following main donors are implementing activities on disability and development in Indonesia as shown in Table 6-1.

Table 6-1 Other Major Donors Supporting Indonesia

Category	Institution
Bilateral Organization	GIZ DFAT
International Organization	ILO UNESCO
International NGO	Christian Blind Mission (CBM) Handicap International (HI) ASB (refer to Section 4.5.1)

The above mentioned donors take turn in hosting donor coordination meetings every three months. The objectives of these donor meetings are to 1) build partnership, 2) avoid replication, and 3) network and share information. According to the disability officer at BAPPENAS, the DFAT, GIZ, CBM, and HI are the main donors supporting disability and development in Indonesia. Therefore, the survey team will examine the activities of the above mentioned organizations. Table 6-8 in Section 6.4 summarizes activities of other supportive organizations.

6.2 Bilateral Organizations

6.2.1 Australian Department of Foreign Affairs and Trade (DFAT)

The Australian government takes a disability inclusive development approach promoting disability in all of its development projects[174]. A new strategy on disability inclusive development “Development for All 2015-2020: Strategy for Strengthening Disability-Inclusive Development in Australia’s Aid Program” was launched in March 2015[175]. Assistance to Indonesia will be programmed according to this new strategy.

The budget for disability inclusive development in Indonesia is USD 540 million (672 billion yen) in 2014 and USD 320 million (397 billion yen) in 2015.

The DFAT supports mainly 7 areas; 1) economic and democratic governance, 2) education, 3) health, 4) infrastructure, 5) social development, 6) rural development, and 7) disaster risk reduction.

The following are some recent projects on disability and development:

- Implement projects to improve accessibility to schools by supporting toilets, ramps, and handrails for children with disabilities[176]

[174] http://dfat.gov.au/geo/indonesia/development-assistance/pages/development-assistance-in-indonesia.aspx
[175] http://dfat.gov.au/about-us/publications/Pages/development-for-all-2015-2020.aspx
[176] http://www.inclusivewash.org.au/Literature/Case%20Study%2008_Inclusive%20WASH%20facilities%20and%20the%20Indonesian%20education%20system.pdf

- Support for trainings in 2010, 2012, 2013 of KEMENPPPA staffs and persons with disabilities at Flinders University in Adelaide
- Support for trainings for relevant staffs on schooling for children with disabilities
- Support for trainings for social workers (at La Trobe University in Brisbane)
- Support for the drafting of the disability sub-plan of the National Plan for Human Rights[177]

The following is the detail of the Australia-Indonesia Partnership for Justice (AIPJ), which is financially supported by DFAT.

The Phase 1 of AIJP's five-year project started in 2011, financially supported by the Australian government (AUD 50 million), and will be finished in June 2016, but the Phase 2 is already being planned. AIJP has offices not only in Jakarta but also in Nusa Tenggara Timur, Nusa Tenggara Barat, and South Sulawesi. This project is managed by BAPPENAS. AIPJ works hand-in-hand with the Supreme Court, law offices, KEMNKUMHAM, BAPPENAS, judiciary committees, the Corruption Eradication Commission, civil society, and DPOs to carry out its activities.

AIPJ's goal is to ensure legal justice not only for persons with disabilities but also for the impoverished women and children and to improve service provision and link this to poverty reduction. It uses a twin track approach encouraging both persons with disabilities and impoverished women to participate in all processes of the project and programs specializing in disability work on capacity building of DPOs. For programs not specializing in disability, there is the capacity building of legal assistants. AIPJ believes that through these capacity building activities, people who provide legal services will learn how to provide services to women with disabilities and persons with visual disabilities which in turn will improve customer relations with persons with disabilities. Other activities include co-hosting of a meeting on disability and religion with the Australia Catholic University, Islamic University and AIPJ in June 2015. AIPJ is also planning to check with the Corruption Eradication Commission whether persons with severe disabilities are receiving the IDR 300,000/month for one year (a cash transfer benefit) which they are entitled to.

6.2.2 Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

GIZ sees disability as part of social protection and is currently strengthening its involvement in disability inclusion focusing on employment creation and rights protection of persons with disabilities. A long-term disability inclusion expert is dispatched as part of a social protection program (composed of five experts) that started 2.5 years ago which has facilitated the implementation of projects from a long-term perspective. It is trying to promote better coordination by increasing dialogues among KEMSOS, BAPPENAS, and KEMNAKER. The GIZ social protection program is composed of the following three components:

(1) Social Health Protection

This is related to the new national social insurance system (BPJS) where GIZ has been supporting the reform process (from law enactment) over a period of 5-6 years.

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[177] http://mspgh.unimelb.edu.au/research/implementing-the-convention-on-the-rights-of-persons-with-disabilities-in-indonesia

(2) Social Assistance (such as cash benefits)

GIZ is working with KEMSOS to establish and promote the Program Keruarga Harapan (PKH), which is the Indonesia's largest conditional cash transfer program for households with school-age children. The PKH is currently supporting approximately IDR3.2 million mainly poor households to improve access to education and health.

(3) Inclusion of Persons with Disabilities

This component was first developed in early 2014 and is implemented mainly with BAPPENAS, KEMSOS, and KEMNAKER. The component has three themes:

1) Support for the National Vocational Training School for Persons with Disabilities (in Cibinong in southern Jakarta, under the jurisdiction of KEMSOS)

Based on a request from KEMSOS, GIZ is working on revising the curriculum and training manual. The existing curriculum and manual are needed to be improved as a good and piloting example for other vocational training institutes in the future, as well as to be updated so that the training programs will be able to meet the needs of the labor market. In addition, GIZ supports to organize workshops which target employers and Indonesian company managers in order to increase the number of managers to further understand disability and that the employment of persons with disabilities is not just about being compassionate to them. The content of the workshops are, for example, the disability inclusion in the labor market, as companies are required to employ persons with disabilities to fulfill their quota of 1% of their total employees according to the 1997 Disability Act. A study of eight companies which employ persons with disabilities and the benefits of their employment have also been conducted.

2) Support for Disability-Related Planning and Laws

GIZ has supported BAPPENAS in drafting the National Action Plan 2015-2019.

3) "Return to Work" Program Design Support[178]

BPJS Ketenagakerjaan[179], Indonesia's social insurance agency, requested German experts to train case managers[180] on four main social risks (cure, medical rehabilitation, assistive devices, and back to work system). There are many cases in Indonesia where people become disabled as a result of work-related injuries with at least 300 incidents per day. The number is expected to be more than 300 as many incidents are not reported. Two case managers were sent from Germany in 2014 and people whom became disabled as a result of work-related injuries received trainings so that they could return to work. Currently, there are 35 case managers (in regional offices such as Sulawesi and Sumatra). Germany will continue to support the training of case managers by sending them to Germany and working with experts from the International Social Security Association (ISSA) headquartered in Geneva.

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178 This system officially started in July 2015. (Jakarta Post, "Return-to-work plan set to launch," April 17, 2015) (http://www.thejakartapost.com/news/2015/04/17/return-work-plan-set-launch.html)

179 In January 2014, the social welfare system was renewed changing from JAMSOSTEK to BPJS. BPJS has two institutions under its jurisdiction: BPJS Kesehatan for health insurance and BPJS Ketenagakerjaan for social insurance.

180 Supports service recipients to set goals and benchmarks to enhance employability (ISSA 2012)

6.3 International Non-government Organization (NGO)

6.3.1 Christian Blind Mission (CBM)

(1) Outline of the Organization

CBM is an international NGO headquartered in Germany carrying out 672 projects in 65 countries around the world in 2014 with the aim of improving the lives of persons with disabilities in the poorest countries. Its main activities were CBR (207 projects in 2014), education and rehabilitation (388 projects in 2014), livelihood support activities (102 projects in 2014), and awareness raising (at regional/national policy level 441, community level 488 projects)[181].

(2) Project Overview

Currently, CBM is developing a new five-year plan. There are three pillars of activities in the plan as follows.

1. Prevention of Blindness: The objective is to provide high quality but low cost cataract surgeries and at the same time, promote a healthy eye service and system (e.g., early identification screening and access to quality affordable services to other avoidable eye health conditions) for persons with disabilities. Fifty percent of blindness in Indonesia is because of cataracts[182] and it is said that 80% of blindness can be avoided.
2. Community Mental Health: to improve the quality of livelihoods of persons with intellectual and mental disabilities
3. CBR: The difference between the previous plan and the new plan is the comprehensiveness of CBR. More specifically, instead of just aiming for eye health, access to referral services will be improved.

The current main programs in Indonesia are as summarized in Table 6-2 to Table 6-4. In 2014, CBM was working with 24 partners in 14 provinces[183].

Table 6-2 Aceh Psychosocial Rehabilitation Program

Sector	Health
Objective	Further family and community understanding on mental health
Period	After the tsunami in December 2014
Target Area	Aceh (targeting 5 villages: the details unknown)
Target Participants	Nurses, psychologists, persons with mental disabilities
Activities	▪ Provide trainings on mental health to nurses in communities ▪ Support mental health services ▪ Donate 14 motorcycles to each local health center and conduct home visits by nurses ▪ Provide referral services

181 CBM webpage http://www.cbm.org/CBM-in-numbers-310903.php
182 CBM (2013), Prevention of Blindness Program
183 CBM (2014), CBM Indonesia, Ver2

Table 6-3 Bhakti Luhur Community-Based Rehabilitation Development Center (East Java)

Sector and Objective	• Improvement of Community Based Rehabilitation • Promotion of inclusive education • Provision of low vision services and devices • Establishment of self-help groups
Objective	To support Bhakti Luhur's development and training center and their low vision unit
Period	Unknown
Target Area	East Java Province, Melang City
Target Participants	CBR staff
Activities	▪ To upgrade CBR workers on inclusive education, advocacy, and on how to form self-help groups ▪ To conduct screening, assessment, and referral services ▪ To improve access to rehabilitation services and provides low vision devices

Table 6-4 Addressing Child Blindness, Low Vision, and Visual Impairment in Indonesia

Sector	Health
Objectives	All children with visual impairment or other avoidable eye health conditions are identified early and have access to quality affordable services in order to improve their quality of life.
Period	Unknown
Target Area	South Sulawesi and Jakarta
Target Participants	Ophthalmologists, staff at schools and health centers
Activities	▪ Early identification of children with visual impairments ▪ Access to quality affordable services ▪ Referrals and follow-ups ▪ Provision of comprehensive low vision care
Partners	▪ Ophthalmology centre at a tertiary level hospital ▪ Schools ▪ Health centers

Regarding CBR, CBM also supports the CBR Development and Training Centre Solo (CBR-DTC) to promote the rights of women and children with disabilities. Also, in Yogyakarta, there is a program on economic and social empowerment of persons with disabilities financed by the New Zealand government[184] (the details are unknown).

<Literature>
CBM has recently published the following documents:

- Inclusive made easy[185] - Indonesian-translated version: It was launched in 2012 to further promote Disability Inclusive Development. The part one explains the principles of disability inclusive development and the part two provides practical tips and examples of program implementations by sector.

[184] Based on the interview with CBM
[185] http://www.cbm.org/Inclusion-Made-Easy-329091.php

- The Future is Inclusive – how to make international development disability-inclusive (2014)[186]: It provides examples of CBM's disability inclusive development programs, challenges and barriers of disability inclusive development and its solutions, and possible practices.
- Inclusion made easy in eye health programs (2013)[187]: It is the Guidelines to strengthen a comprehensive eye care services, explaining the principles of disability inclusive development on eye health program, and providing inclusive practices and practical tips and examples on the curriculum and training development.

6.3.2 Handicap International (HI)

HI's organizational overview and projects on disaster measures are described in 4.5.2. Other fields, in which HI is active in, are as follows:

HI works on not only on general disability issues but also supports the most vulnerable such as the elderly, pregnant women, and children under five years old. The Indonesia office supports civil society, inclusive regional development, medical rehabilitation, inclusive education, and community accessibility. The reason why HI Indonesia is headquartered in Yogyakarta is because of its geographical advantage in accessing East Timor compared with Jakarta and because there is a stronger DPO network there compared with other cities. As accessibility is a cross-sectoral issue, HI promotes accessibility in all of its projects especially on the importance of the use of local resources which results in the low-cost accessibility consideration. Current projects are as shown in from Table 6-5 to Table 6-7.

Table 6-5 Aceh Medical Rehabilitation Project

Sector	Health and Social Protection
Objective	▪ To cover the cost of medical rehabilitation of persons with disabilities by the provincial medical insurance. ▪ To identify how communities can compensate costs shouldered by persons with disabilities.
Period	Unknown
Target Area	Kota Banda Aceh, Aceh Besar, Aceh Tengah, Bener Meriah, Bireuen
Target Participants	Aceh parliamentary members, medical personnel, and policy makers
Expected Results	▪ Persons with disabilities are identified and the referral system functions. ▪ Medical rehabilitation services are provided in the entire target area in all health centers, counties, and provincial hospitals. ▪ Twice a year advocacy targeting Aceh parliamentary members, medical personnel, and policy makers to include medical rehabilitation services in medical insurance. ▪ Improve access to medical rehabilitation services (two pilot projects).
Partners	Health district office, health centers, and DPOs
Financial Support	Luxembourg Ministry of Foreign Affairs

[186] http://www.cbm.org/The-Future-is-Inclusive-how-to-make-international-development-disability-inclusive- 483295.php
[187] http://www.worldblindunion.org/English/resources/Documents/CBM%20Inclusion_Made_Easy_in_Eye Health_Programs.pdf

Table 6-6 Inclusive Education Project in Nusa Tenggara Province

Sector	Education
Objective	To promote access to education and provide a positive school environment for children with disabilities.
Period	Unknown
Target Area	West Nusa Tenggara Province
Target Participants	Families with children with disabilities, school personnel
Expected Results	▪ Identify out-of-school children with disabilities and encourage them to go to school. ▪ Children with disabilities are able to stay in school with the support of their parents and inclusive education teachers. ▪ The leadership and participation capacities of girls with disabilities are being promoted and strengthened in order to ensure their chances of achievement at school.
Partners	DPO, educational institutions
Financial Support	Girls Canadian Foundation

Table 6-7 Project Advocating for Changes

Sector	Capacity Building of DPOs
Objective	DPOs in the target area reinforce the action of the disability movement by developing coordinated and concerted actions to promote the implementation of the UNCRPD into governmental bodies and non-state agencies.
Period	Unknown
Target Area	Aceh Province, Yogyakarta Province, and east Nusa Tenggara Province
Target Participants	DPO
Results	▪ DPO improves the planning and implementation of health, education, and social protection for effective awareness raising. ▪ DPOs promote disability inclusion at the provincial level planning, budgeting, and systems implementation. ▪ Good practices are shared with the stakeholders at the central and provincial levels.
Partners	DPO
Financial Support	German Economic Development Cooperation Ministry (*Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung:* BMZ)

6.4 Activities of Other Major Organizations

Activities of other major organizations are organized in Table 6-8.

Table 6-8 List of Other Major Organizations for Disabilities in Indonesia

Organization	Sector	Project Name	Project Period	Project Summary
ILO	Labor	PROPEL Indonesia	Active	Promotion of rights of and opportunities for persons with disabilities through systems and awareness raising in labor[188]
		Better Work Indonesia	Finished	The project goal was to promote employment of persons with disabilities in the clothing sector[189]. Budgetary support by Australia, the Netherlands, and Switzerland.
World Bank	Capacity building of persons with disabilities	DPO Window	Finished (2012- 2014)	Budgetary support for DPOs for 1) East Indonesia DPO mapping, 2) multi-stakeholder forum, and 3) DPO organizational management strengthening[190]
UNPRPD (UNESCO, ILO, WHO, UNFPA)	Capacity building of persons of disabilities	Social Inclusion of Persons Living with Disabilities in Indonesia	Finished (2013-2014)	Budgetary support by UN Multi-donor Trust Fund. Activities include: 1)DPOs, national and provincial level governmental staff capacity building training on budgeting, reporting, monitoring, and evaluation, negotiation and presentation, awareness raising, leadership, data collection; and 2) community on inclusive city network including Yogyakarta, Banda Aceh, Metro Leampung, Ambon Banajarmasin, Denpasar.[191]
Netherlands Leprosy Relief: NLR	Health		Active	The goal is to prevent leprosy and reduce stigma. Specific activities are the integration of rehabilitation in the Leprosy Management Program. NLR has supported Indonesia since 1967. The Jakarta office was established in 1988[192].

188 http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-jakarta/documents/publication/wcms_233427.pdf
189 http://betterwork.org/indonesia/?page_id=134
190 http://pnpm-support.org/sites/default/files/DPO-Q1.2014-F.pdf
191 http://www.unesco.or.id/publication/shs/support_national_law_disability.pdf
192 http://leprosyrelief.org/offices/indonesia

Chapter 7 Challenges on Disability and Development in Indonesia

In the previous chapters, current situation of disability and development in Indonesia, persons with disabilities, concerned institutional arrangements and policies, development assistance of donor agencies and DPOs on disability, and other relevant sectors (education, health, labor, social protection, accessibility, gender, and disaster prevention) were described. Among the relevant development sectors, in the field of disaster management, the current situation of disability-inclusion in each phase was described in detail. This chapter summarizes the information on disability and development described in the previous chapters and clarifies the issues/challenges of disability and development that are to be the most important in Indonesia.

Figure 7-1 shows the concept of issue analysis of the findings and information collected in the survey. The issues and challenges in each development sectors (refer to Chapter 3) are analyzed and prioritized in Section 7.1. Those issues and challenges were carefully analyzed considering cross-sectoral aspects in Section 2. The disability-inclusion (refer to Chapter 4) issues are analyzed in Section 7.3.

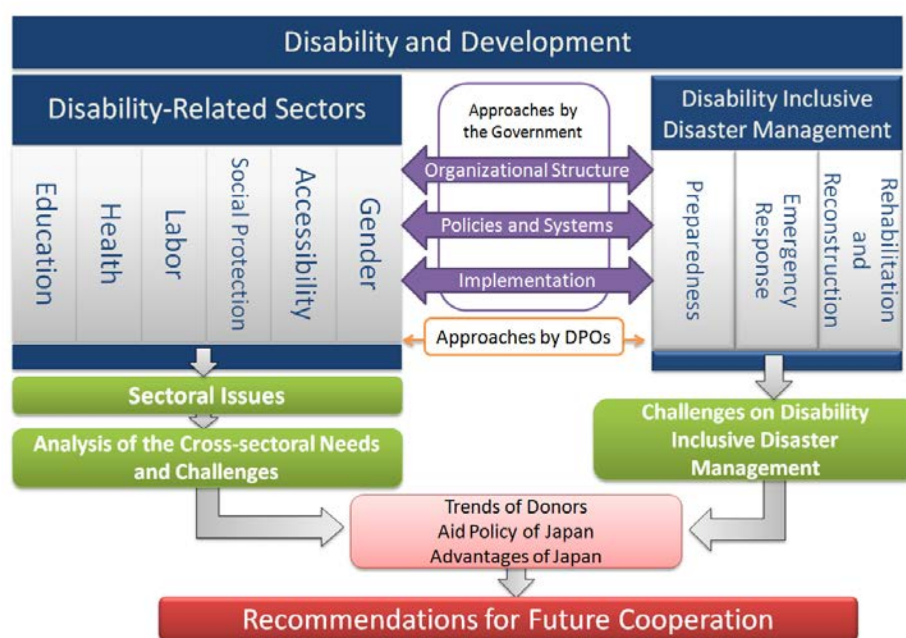

Figure 7-1 Framework of the Issue Analysis in this Survey

7.1 Sectoral Challenges and the Priorities

7.1.1 Challenges in Each Sector

(1) Education

Firstly, support for children with disabilities who are not attending school is the most important issue. There are some causes for many children with disabilities not being able to attend school; 1) the identification of children with disabilities is not processed properly at the stage of birth; 2) the number of

provinces where there are special schools is limited; 3) although inclusive education started in 2003 and schools with inclusive education increased in a short period, the supply (newly participating schools) exceeds the demand (number of students who wish to enroll), and as a result, quality and quantity of teachers have not been sufficiently ensured to provide quality education in such schools. Regarding inclusive education, human resource development including training of teachers to obtain should be prioritized. As for challenges about quality of education, the providing of assistive devises adapted for persons with visual/hearing/learning disabilities, and development of a proper curriculum and learning materials are important. Regarding the physical accessibility of school facilities, all of the school facilities have not improved due to the limited budget.

(2) Health

The access to basic health services for persons with disabilities is extremely limited. The programs of KEMENKES and health centers in the local areas focus on disability prevention measures, and medical rehabilitation for persons with disabilities, assistive devices, access to mental health services, and provision of other services which are supposed to be disability inclusive, such as HIV/AIDS programs, are not sufficiently provided.

For example, regarding mental health services, only 10% of the persons with a mental disorder are able to receive appropriate treatment because the service providers (facilities and human resources) are quite limited both in quality and quantity. Furthermore, most of the facilities that provide the service are concentrated in Java Island.

Assistive devices and medical rehabilitation are necessary for persons with disabilities to live an independent life and to participate in society. It is important to increase the access to health and medical services, including rehabilitation for persons with disabilities. Regarding human resource development of specialists, although there are training systems for specialists, such as physical therapists, occupational therapists, and prosthetists, the number of other specialists, such as speech therapists and medical social workers, still remains low. As for other causes, the health insurance does not cover medical rehabilitation services.

(3) Labor

Although KEMENAKER has set a goal of increasing the number of companies that employ persons with disabilities, a curriculum that corresponds to persons with disabilities is yet to be provided at vocational training schools for the non-disabled under KEMENAKER. A reorganization of the curriculum to create employment opportunities for persons with disabilities is being examined, but there has not been any specific planning. With this, the formulation of activity plans, development of curriculums and supporting system for persons with disabilities in vocational training schools, and strengthening of the relevant skills of the teaching staff are important. In other aspects, awareness raising, strengthening of cooperation with the private sector, and training on inclusion of persons with disabilities for personnel departments of companies should also be considered.

(4) Social Protection

A social protection system for the poor, including persons with disabilities, exists; however, the current insurance covers costs for medical rehabilitation and prosthetics caused by occupational accidents, but not for the others including assistive devices, such as wheelchairs and canes[193]. Furthermore, transportation costs and fees for care providers are not covered. Therefore, access to necessary services could be difficult especially for persons with disabilities living in remote areas. In addition, because the current targeting system could not properly identify persons with disabilities, the coverage of social protection programs among persons with disabilities is limited. In particular, in rural areas, there are even cases where people with disabilities are not registered nationally, and one may not be covered by social protection programs. It is vital to develop a comprehensive database of persons with disabilities, to expand types of benefits of health insurance, and increase the access to all social protection programs, including access to rehabilitation, care providers, peer counseling, and assistive devices.

(5) Accessibility

Laws and standards on accessibility are established but those are not properly complied. It is difficult for persons with disabilities to walk outside on their own or to use buses and other public transportation. There are cities where the cooperation mechanism between the DPOs and persons with disabilities is structured, but the number of cities is still limited, and the process to understand the needs of persons with disabilities is not developed. In terms of information support, it is particularly behind. At KOMINFO, Digital Accessible Information System (DAISY) that is an accessible information system[194] and guidelines related to accessibility on the website, as well as standards and activity plans related to ICT accessibility have not been established. Also, there are not many sign language interpreters, and the provision of related services is extremely limited.

(6) Gender

Women with disabilities in Indonesia have been experiencing twofold discrimination, in other words, having a disability and being a female. Regarding support for women with disabilities by KEMENPPPA, it has started building information and counseling centers for women with disabilities nationwide in 2006. Currently, there are only built three centers. The nationwide expansion of the centers should be prioritized. As the awareness on discrimination of women with disabilities is still minimal, the active implementation of awareness raising on disability and gender is important.

7.1.2 Priority Sectors Related to Disabilities and Development

Considering relevant activities to and achievements of the Incheon Strategy (refer to Section 3.7.2) in Indonesia, the following sectors should be prioritized among the above mentioned sectors. Also, development assistances have been less provided in these sectors.

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[193] Homepage of U.S. Social Security Administration, Social Security Programs Throughout the World 2014 http://www.ssa.gov/policy/docs/progdesc/ssptw/2014-2015/asia/indonesia.html

[194] Digital books for people with visual disabilities or people who have difficulty in reading standard printed material. The book can be played on the specialized equipment or by installing software on the computer.

- Accessibility
- Health
- Social protection
- Disaster management
- Gender

7.2 Cross-sectoral Challenges on Disability and Development

As described in Section 7.1, this report focuses on the discussion of cross-sectoral challenges. One of the most critical points of the situations on disability in Indonesia is, as frequently indicated in this paper, that while disability-inclusive policies and regulations have been developed, the roadmap to the implementation of the public services that enable realization of the disability-mainstreaming society has not been clarified yet. Through all the interviews with relevant ministries/agencies and DPOs of this survey, the capacity building of disability-related human resources, such as the officers of the concerned ministries/agencies and persons with disabilities, has been particularly emphasized as important issues.

These findings have been centered in the conceptual framework of the most critical challenges for the current situation on disability in Indonesia. The survey team has also analyzed direct factors of the issues and extracted challenges have been sorted into three categories: (a) policies/regulations, (b) implementation of services and programs, and (c) empowerment of persons with disabilities.

After the problem analysis, the team recapitulated the cross-sectoral challenges on disability in Indonesia and classified into the following six cross-sectoral challenges (Table 7-1), and its details (Table 7-2) that need to be addressed for the advancement of disability inclusion.

Table 7-1 Cross-Sectoral Challenges on Disability and Development in Indonesia

1) Appropriate design of policies and regulations
2) Expansion of cooperation and coordination among concerned persons/organizations (diverse cooperation and coordination among various sectors/parties: central-local governments, inter-/intra-ministries, government agencies-private sector-academia, etc.)
3) Increase of awareness and correct understanding of disability
4) Human resource development for persons with disabilities
5) Improvement of human resource capacity for people working in the disability-related fields
6) Narrowing the gap between the urban and the rural

Table 7-2 Analysis of Cross-sectoral Challenges on Disability and Development

Category	Problem 1	Problem 2	Challenges
Policy/ Regulation	Penal regulations are almost non-existent.	For example, with few penal regulations that exist, such as the "Duty to Employ 1% of Persons with Disabilities vis-à-vis total employees" (Explanation No. 14 of the Law on Persons with Disabilities), the penalties are cheaper than the employment cost, and it lacks effectiveness	1)
	Arbitrary operations are possible.	In the provisions of the laws related to disabilities, at the end of articles under educational administration services persons with disabilities can receive "Equal Treatment", it states, "corresponding to the degree of the disability the person has and his or her abilities." It is possible that expressions like this can be interpreted widely on-site.	1)
	Even when new laws/ regulations are enforced, the dissemination of these new laws/regulations to local governments and the fields are not thorough.	Decentralization is progressing, and even new laws and regulations are enforced at the central level, but the legal enforcement against local governments is rather weak. The disability-inclusion at the implementation phase will depend on the awareness and structure of local governments.	2)
		The training for the staff within the ministries and the local government is not being implemented.	5)
	Understanding of disability and the needs of persons with disabilities are incorrect.	A negative understanding of disabilities persists. The correct understanding of disabilities permeates the person with disabilities and government staff working on disability well, however, the general public and many government staff working unrelated to disability lack understanding.)	3)
		The definitions and use of words in the law are inappropriate (discriminatory expressions such as cacat [deformity] and kelainan [abnormality] are left unsolved).	
		Lack of data on the needs of persons with disabilities.	1)
		Persons with disabilities are not well involved in the development process of policies and regulations.	1) 2) 3) 5)
Implementation (Service and program)	The types of disabilities that are to be covered by policies/regulations are limited.	Physical disabilities are what most people think about when they hear the term "disability".	3)
	Concrete ideas to achieve disability-inclusion are lacking.	Disability trainings for staff working at ministries and local governments are not sufficiently conducted.	5)
	The level of awareness among staff at relevant ministries is low. (they tend to think that KEMSOS is only ministry responsible on disability and other ministries are irrelevant).	The demarcation of responsibilities between relevant ministries is unclear. Actions to be taken are not clearly defined.	3)
		The national cooperation team can be functioning better. The number of meetings to be held is minimal (once a year).	3)
	The participation of the private sector and academic institutions is poor.	The good examples have not spread to rural areas or all of Indonesia.	3)

Category	Problem 1	Problem 2	Challenges
	There is a shortage of trained workers on disability.	Imperfection/lack of the qualification system.	1)
		The salary is cheap.	1)
		Training is not sufficiently conducted.	5)
	The needs of the disability or persons with disabilities are not understood correctly.	There are misunderstandings and prejudices against disabilities/persons with disabilities.	3)
		Bureaucrats of the minister and director class are active towards disability programs; however, the personnel below the director class do not have the correct understanding of disabilities and they are not active in providing service for persons with disabilities.	
		Lack of data on the needs of persons with disabilities.	1)
		Persons with disabilities are not well involved in the development process of policies and regulations.	4)
	Many services are available only in Java	Regional disparity (economically in particular)	6)
		The difference in the awareness of residents per region	3)
	Budgetary measures are insufficient	The needs are not properly understood.	3)
	Particularly in rural areas, persons with disabilities are not covered by programs to receive necessary services.	People are not nationally registered.	
		Targeting method is not appropriate.	1) 3)
Empowerment of persons with disabilities	There is not much input particularly from persons with disabilities in rural areas.	The persons with disabilities do not have confidence.	4)
		Influential DPOs are disproportionately represented at the specific areas such as Yogyakarta.	

More detailed explanation on each challenge, from 3) to 6) in the Table 7-1, is as follows.

1) Appropriate design of policies and regulations

It is important to promote disability-mainstreaming into the existing services, such as covering persons with disabilities in social protection programs; disability-specific services for persons with disabilities, such as support services, rehabilitation and providing assistive devices, are also indispensable. Currently support services for persons with disabilities are insufficient.

In order to realize the appropriate design of policies/regulations, sufficient and appropriate data collection and research are necessary. In Indonesia, a national survey on disability is scheduled in or after 2016. Although the questionnaire is completed, some actions are needed to conduct an effective survey, such as giving training opportunities to the staff directly in charge of data collection. Not only improving disability data collection, but strengthening relationship with the academia and research on such as the environment of disability policy, the current situations of people's awareness of disability, and the effectiveness of the services are also important.

2) Expansion of cooperation and coordination among relevant persons/organizations (diverse cooperation and coordination among various sectors/parties: central-local governments, inter-/intra- ministries, government agencies-private sector-academia, etc.)

Disability is a cross-cutting issue that should be addressed by all sectors and organizations. In order to promote disability mainstreaming, it is significant to involve various stakeholders such as relevant governments, donor agencies, private sector organizations, academic institutions, and NGOs covering various sectors, persons with disabilities, and their families, at all levels from the home to the communities, local government, and business enterprises.

As one of the reasons why the roadmap to the implementation of services for the disability mainstreaming in Indonesia is unclear, it can be particularized that the concerned personnel in the ministries/agencies are aware that the disability is an important field/issue of administration, however, they are unsure of their own roles and actions to be taken for the mainstreaming of disability. Furthermore, the coordination among ministries/agencies is also insufficient.

Regarding the cooperation between the central and local governments, as mentioned in Section 2.3, the local autonomy is advanced in Indonesia. According to the interviews in the survey, there were many cases that the new laws were enforced at the central level, yet the officers of the local government are completely unaware. The fact indicates the legislative force of the central government has been getting weaker vis-á-vis local governments. In other words, it takes long time since the policy making until the time of realization/implementation. The future strengthening of cooperation/coordination among the central and local governments is quite important.

Although there are some cities where the cooperation mechanisms between the central/local governments and persons with disabilities are developed, from persons with disabilities, voices such as “the participation policy is not consistent” and “We are only involved at the beginning of the project, and our involvement becomes minimal from midway into the project” can be heard.

3) Increase of awareness and correct understanding of disability

As stated in detail regarding the current situation of persons with disabilities described in Section 3.2, because the people involved in business and the general public have a misunderstanding or prejudice against persons with disabilities in Indonesia, it causes the current circumstances that the supply of educational services, the administrative support, and/or job opportunities for persons with disabilities are insufficient. It is important to involve people in a wide range, including business persons, community people including the families of persons with disabilities, and persons with disabilities themselves in publicity and educational activities. As for the way of awareness raising, it will be necessary to select the appropriate means keeping accordance with the socio-cultural context and implementation circumstances of each area, such as introduction of the training programs, events and utilization of the media.

4) Human resource development for persons with disabilities

Currently persons with disabilities are not involved in the processes of forming, practicing and evaluating the related systems, policies and services. In order for persons with disabilities to participate in

programs/projects/business, efficiently and effectively, the strengthening of skills among persons with disabilities and DPO is important. Furthermore, the activities of DPOs are concentrated in Yogyakarta and Jakarta, and DPOs in other regions are not much active. Although other donors implement the programs for strengthening skills of the DPOs, it is on a small scale. More support on a bigger scale is needed.

5) Improvement of human resource capacity for people working in the disability-related fields

Currently, the education and training for the human resource working in disability-related fields are insufficient. The relevant human resources mentioned here include staff of the ministries/agencies. For example, in the field of health, as trainings for human resources for primary level are not provided, persons with disabilities cannot sufficiently receive basic health services. If the skills and knowledge of such human resources are improved, it will lead to the improvement of access to health services for persons with disabilities. Starting from the evaluation of the initial skills of the concerned personnel, it is important to implement the proper and necessary skill development programs for them. The development of training guidelines of different sectors, such as rehabilitation and education, and on the human resource level is also required.

6) Narrowing the gap between the urban and the rural

Indonesia is the largest archipelago nation in the world, and it is difficult to cover such a wide range by standardized public services with sufficient quality. As mentioned in Section 2.1.1, there is considerable gap in quality and quantity of health services between urban and rural areas. How to fill this gap between the urban and the rural is a major task to be resolved.

7.3 Challenges toward Disability Inclusion on Disaster Management

The situation and challenges to promote disability-inclusive approach on disaster management were analyzed as shown in Table 7-3, and three challenges were figured out as the result; 1) Strengthening capacity and a partnership among relevant organizations, 2) Increasing decision makers' and implementers' awareness and understanding of disability inclusion, and 3) Establishment of a system to support persons with disabilities.

Table 7-3 Situation Analysis of Disability Inclusion on Disaster Management

		Current Situation	Cause	Challenge
Preparedness	Laws and Policies	Although a regulation of Head of BNPB No. 14/2014 provides for disability inclusion, no specific action has been taken yet.	The new regulation was introduced by international donor agencies, and BNPB therefore does not have the practical know-how to implement.	1), 2)
		The consideration of the vulnerable was shown in the Disaster Management Plan 2015-2019 and the Strategic Plan 2015-2019, but the implementation of disability inclusion is dependent on local government.	Decision makers have little understanding of disability inclusion.	2)
	Programs	The provincial and city government of Yogyakarta involve persons with disabilities into the disaster management activities.	International NGOs and DPOs promote disability inclusion.	-

		Current Situation	Cause	Challenge
		The government of East Java Province does not involve persons with disabilities in the programs.	The government does not recognize persons with disabilities as a considerable target on disaster management.	2)
Emergency Response	Search and Rescue	There is no priority of the vulnerable.	The priority of the vulnerable is not described in the regulations, the mission and the tasks.	1)
	Protection of Refugees	Shelters and other facilities such as toilets are not accessible.	It is difficult to make the existing building accessible.	-
			The conditions of accessibility are not recognized.	2)
	Logistics	Although a guideline to support vulnerable groups was developed, it is insufficient on practical aspect.	The needs of persons with disabilities are not fully understood.	2)
			There is no system to identify persons with disabilities.	3)
			Lack of collaboration among relevant organizations.	1)
	Health Services	There is no specific approach for disability inclusion.	Decision makers have little understanding of disability inclusion.	2)
			The new regulation of BNPB has not yet disseminated to other government organizations.	1)
Rehabilitation	The reconstruction sites were not verified in this survey.			

7.3.1 Strengthening Capacity and a Partnership among Relevant Organizations

In accordance with a regulation of Head of BNPB No. 14/2014, the Indonesian government made an initiation step toward disability inclusion on disaster management, which would improve the legal system and strengthen a partnership among disaster-related organizations. However, the regulation does not provide for the procedure to fulfill the rights and needs of persons with disabilities, and even BNPB does not recognize which organizations are to take what kind of tasks for disability inclusion. This is because that the “disability inclusion” was advocated by the international organization, ASB, and it is therefore an entirely-new idea for BNPB. To bring it into practice, a technical guideline that provides the detailed procedure to take disability inclusive approach would be necessary for the government officials.

In addition to the capacity development of BNPB/BPBD, a strong partnership among relevant organizations is needed as various organizations/teams are to cope with disaster under the command of BNPB/BPBD. Those organizations cooperate to formulate the policies and guidelines, however, their roles on disaster management are demarcated, and therefore no joint training programs or regular meetings have been organized so far. To manage a disaster, it is necessary to establish an organizational system which equips a strong partnership with common understanding of disability under the supervision of BNPB/BPBD.

7.3.2 Increasing Awareness and Understanding of Disability Inclusion

To achieve disability inclusion, all the stakeholders are required to equip with an adequate understanding of disability. However, there are some government officials who consider that the issues of disability are

not their disaster-management duties. With regard to the programs implemented by local governments, the survey also figured out a gap in the inclusive approach between the governments. For example, the provincial governments of Yogyakarta promote the inclusion of persons with disabilities in the programs, however, the governments of East Java Province, both BPBD and DINSOS, do not provide the programs to persons with disabilities. This situation indicates that disability inclusion would be largely dependent on decision makers' and implementers' recognition. The government officials who were interviewed however do not purposely exclude persons with disabilities, and so they may not have disability-inclusive mindset to understand the needs of persons with disabilities.

In addition to recognizing of persons with disabilities, it is also important to understand the needs of persons with disabilities. The consideration of persons with disabilities is described in the new regulation of BNPB, the Disaster Management Plan and other disaster management guidelines, however, the needs of persons with disabilities are not specified in these documents. For example, the means for transmitting information, the necessary supplies, and the conditions of accessibility are not demonstrated in any guidelines/materials. Besides, the staff and members of disaster management teams are also not equipped with the knowledge and the skills to manage disability inclusion. To strengthen the organizational capacity mentioned in Section 7.3.1, it is necessary that all the stakeholders firstly recognize persons with disabilities as a considerable target of disaster management, and then adequately understand the needs of persons with disabilities.

7.3.3 Establishment of a System to Support Persons with Disabilities

As previously mentioned, the legislation toward disability inclusion has been developing, and the policies and strategies also pay more attention to vulnerable groups. However, the needs of persons with disabilities cannot be met because of the absence of a guideline and the institutional fragility. For example, although KEMSOS developed a social advocacy guideline that provides the procedure to protect the vulnerable, it practically does not function to reach all the vulnerable groups as there no exists the individual data of the people to be reached, and the relationship between the relevant organizations/departments is not strong enough. In most cases, shelters are not accessible for persons with disabilities, and they are therefore likely to take refuge at their own houses or other places. To follow up and support those people, a tool to identify their location and a reporting system is to be developed, and then assistances based on their needs should be provided. Thus, an identification system should be developed as a first step of the social advocacy procedure along with enhancement of a partnership of relevant organizations and increasing of their understanding of the needs of persons with disabilities.

Chapter 8 Recommendations for Japan's Future Cooperation

In suggesting on strategy of future cooperation for sectors relevant to disabilities in Indonesia, the following points were carefully considered.

(1) The most important issues on disability and development in Indonesia (refer to Sections 7.1 and 7.2)
(2) Among the targets of Incheon Strategy, targets and fields hardly covered or not covered by domestic social services and external development assistances (refer to Section 7.2)
(3) Priority areas of Japan's cooperation for Indonesia (refer to Sections 5.1 and 5.2)
(4) Advantages and cooperation resources relevant to the issue of disability and development in Japan (refer to Section 5.3)

8.1 JICA's Targets and Aims for the Cooperation with Indonesia Concerning Disability Issues

As mentioned in Section 5.2, "JICA Thematic Guidelines: Disability and Development (2015)" states the aim of JICA's cooperation on disability and development is to ensure that persons with disabilities are accorded their human rights, and able to participate fully and equally in an inclusive society. In the guidelines, the following three actions are prioritized: 1) Setting up disability-inclusive policies and regulations (encompassing social and environmental changes); 2) Implementing disability-inclusive programs/projects (encompassing social and environmental changes); and 3) Empowering persons with disabilities (focusing on the development of individual abilities)[195]. Those seem to comply with relevant policies in Indonesia including RPJMN 2015-2019 (improvement of accessibility in social protection sector), prioritized development target (realization of inclusive society) and development strategy (promotion of inclusive society) (refer to Section 3.4.2)[196].

(1) Policy and Institutional Reform to be Disability-inclusive

Indonesia has already ratified CRPD and pushed forward the amendment of relevant laws along with the contents of CRPD. The national action plan and laws under the review are reported to be including concept of disability inclusion with a special attention. On the other hand, existing systems in relevant sectors such as education and employment including regulations and customary practices e should be also reviewed and altered in accordance with duties of the nation stipulated in CRPD.

As for the arrangement of statistics/information on disabilities, concerned personnel in government agencies seem to be highly conscious of CRPD and the target indicators of Incheon Strategy. There is possibility, as described in Sections 3.4.3 (6) and 3.4.3 (11), that data collection system and method on disabilities, based on (i) the social model of disability and (ii) CRPD and Incheon Strategy, will be established to conduct coming "Special National Survey on Disabilities" (tentative title) in 2016. To introduce such method with the latest concept, understanding on the concept of CPRD and social model of disability inclusion should be promoted among concerned personnel including the field staff of the concerned agencies, surveyors, and persons with disabilities, who are involved in the data collection

[195] For details, refer to JICA, *Thematic Guideline: Disability and Development* (February 2015: Japanese version), p.12.
[196] For details, refer to 3.4.2 "National Development Plan."

activities. Because, at the operational level, they commonly think that the distribution of welfare benefit is more important for persons with disabilities than any other social supports.

(2) Practice of Disability-Inclusive Programs/Projects

As discussed in Chapter 7, while disability-related policies and legislations have been developed in Indonesia, implementation of disability-inclusive programs/projects has not been enough, especially in rural areas. After the amendment/establishment of relevant laws and action plans, it is necessary for donors to support effective and efficient application/implementation of the laws/plans. Furthermore, there are many examples that accessibility is not enough at the sites/facilities, both in the fields of education (e.g. schools) and health (e.g. health centers). It is indispensable for the implementation of disability-inclusive programs/ projects to secure accessibility to the relevant facilities/sites. The administration and donors should pay adequate attention to arrange, establish and maintain, in both urban and rural areas, sufficient facilities and infrastructure of transportation, communication, and various kinds of services to be smoothly accressed by persons with disabilities[197].

(3) Empowerment of Persons with Disabilities

Although several foreign donors have already launched assistance programs/projects on the issue. But, because the most influential DPOs are active mainly in the cities of Jakarta and Yogyakarta, relevant activities could not efficiently expanded to other areas. Taking into account of the situations, it is necessary to conduct cooperative programs with DPOs in other areas throughout the country, in order to (i) develop human resources of DPOs to be in charge of the future programs and (ii) reduce regional gaps of development concerning disability issues

Table 8-1 summarizes suggested JICA's priorities and programs in Indonesia mentioned above with brief explanation of its breakdown.

Table 8-1 Suggested JICA's Priorities and Programs in Indonesia

<table>
<tr><th colspan="2">Priority Activities</th><th>Remarks/Procedures</th></tr>
<tr><td rowspan="2">1. Policy and institutional reform to be disability-inclusive</td><td>1) Promotion of policy and insti- tution based upon the CRPD frame- work</td><td>Reviewing whether existing laws/institutions by relevant sector (e.g. education, labor) are in accordance with obligations under CRPD
Promotion to implement the improvement based upon the result of the review mentioned above</td></tr>
<tr><td>2) Improvement of systems of statistics/data concerning disabilities</td><td>Capacity building for persons to be charge of statistical processing/ investigation in terms of data collection/analysis</td></tr>
<tr><td colspan="2">2. Practice of disability-inclusive programs/projects</td><td>• To arrange, establish and maintain, in both urban and rural areas, sufficient facilities and infrastructure of transportation, communication, and various kinds of services to be used by persons with disabilities.</td></tr>
<tr><td colspan="2">3. Empowerment of persons with disabilities</td><td>• Organization of DPOs, especially in rural areas, and its capacity building
• Building relationship between DPOs and governments
• Leadership training regarding independent living, peer counseling, and disability equality training</td></tr>
</table>

[197] JICA, Thematic Guideline: Disability and Development (February 2015), p52.

8.2 Remarks for Implementation of Cooperative Program/Project

(1) Progress of Decentralization

As for the practice of disability inclusion in Indonesia, the operational control is more important at the provincial/municipal level than that at central level. As discussed in Chapter 7, the gap in the public services between the urban and the rural is one of the most critical administrative issues, ,and local governments are therefore to be targeted for the awareness-raising activities on disability inclusion. In conducting cooperation programs/projects in the rural, the effort should be taken to involve the provincial/municipal governments since the provincial/municipal assembly (*Perakitan Provinsi/Kota*) has final approval for budgeting, and the Governor/Mayor makes a final decision of the implementation. Furthermore, it is also important to be aware of the necessity of strengthening coordination between the central and local authorities[198].

(2) Geographical Circumstances of Indonesia

Indonesia is the world's largest archipelago nation, and its hemisphere is horizontally 5,110km wide from the east to the west, consisting of more than 10,000 islands across the equator. In Java island, where has almost 60% of the total population of Indonesia, the regional disparities can be found within the island. For example, East Java province has high poverty ratio, and West Java province has high population density. Under such circumstances, social needs are different by region, and cooperation programs/projects should be designed in concert with the regional needs[199].

(3) Ensuring Sustainability

Local autonomy: As described in (1) above and Section 2.3, since the decentralization largely enhanced, the method to scale up a program/project in a certain area to other areas may not to be easily duplicated. Necessary conditions for ensuring the success in dissemination and sustainability of the program/project are (i) to promote relevant public officials' understanding of the model project at the central government level, (ii) to arrange/establish appropriate legislation, (iii) to take provisional actions for budgeting as early as possible (It does not mean the central government must incur all the costs, but does that it is important to build consensus among different authorities beforehand. The matter of budgeting will be precisely discussed later in this section). In case that the program/project is directly related to the national policy/development plan and is supported by the central government, the model project in a certain area could be scaled up nationwide.

Participation of persons with disabilities: In Indonesia, the participation of persons with disabilities to the development program/project is not enough yet. It is recommended, in order to ensure the sustainability and effectiveness of the program/project, to recognize persons with disabilities as important stakeholder and for persons with disabilities to play a leading role at every process of the program/project as much as possible[200]. For instance, if the project team employs persons with disabilities as project staff for data

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198 As for the matter of local autonomy, refer to 2.3.

199 As for the Indonesia's geographical features and regional gaps, refer to 2.1.1.

200 JICA, Pakistan: Evaluation Report upon Termination of the Project on the Promotion of Social Participation of Persons with Disabilities (2008-2011).

collection, it could lead not only to develop capacity of persons with disabilities in data collection, delivering messages, etc., but also to play a role model of social participation for other persons with disabilities[201]. In addition, if a person with disabilities is an interviewer, it could make the interview more effective with sharing his/her honest feeling/thought[202]. It is also necessary to be kept in mind that many DPOs are disproportionally concentrating within Jakarta and Yogyakarta. It is important to promote capacity development of DPOs in other areas for project design and planning, as well as implementation and management such as selecting of appropriate pilot site and training targets.

Personnel rotation of the government: It is found through the survey that the frequent personnel rotation of the government agency may have negative effects on the sustainability of the development program/project, as indicated by the lesson learned from JICA's previous project in Indonesia[203]. To cope with this problem, (i) the transition method that secures the handover of knowledge and experience from the predecessor to the successor should be provided before; (ii) the business network that enables the reserve of professional knowledge and experience by the organization, not depending on the individuals, should be structured before the start of the program/project.

Budgeting: Lacking consistency in the allocation of the budget between the central and the local governments is also indicated as one of the most negative factors for the sustainability of the program/project [204]. In some cases, necessary budget was not secured even though the plan of program/project had been prepared[205]. For the successful budgeting, it is necessary to discuss and negotiate the budget and cash flow (from planning, allocation, disbursement, and implementation) of the main project cost, as well as the scale-up cost of a pilot project, before the start of its implementation. The discussion should be taken place not just at the central government but also at the local government administrating the pilot project site.

8.3 Proposal for Framework of Cooperation

In Figure 8-1, the whole concept of suggested JICA's cooperation on disability to Indonesia is summarized based on its targets and priority actions (refer to Section 8.1) and Indonesia's cross-sectoral challanges (refer to Section 7.2).

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[201] JICA, Rwanda: Interim Evaluation Report of the Skills Training for the Reintegration of Demobilised Soldiers with Disabilities (2005-2008).
[202] JICA, Pakistan: Evaluation Report upon Termination of the Project on the Promotion of Social Participation of Persons with Disabilities (2008-2011).
[203] JICA, Indonesia: Evaluation Report upon Termination of the Project for Ensuring Maternal and Child Health Service with MCH Handbook (2006-2009).
[204] Ibid.
[205] "Special National Survey on Disabilities" (Tentative Title) , for example, is planned to be conducted by BPS in 2016. While the operation manual and the forms of questionnaires are completed, the implementation schedule is not fixed yet because the budget is not secured. As for the detailed information, refer to 3.4.3 (6) and (11).

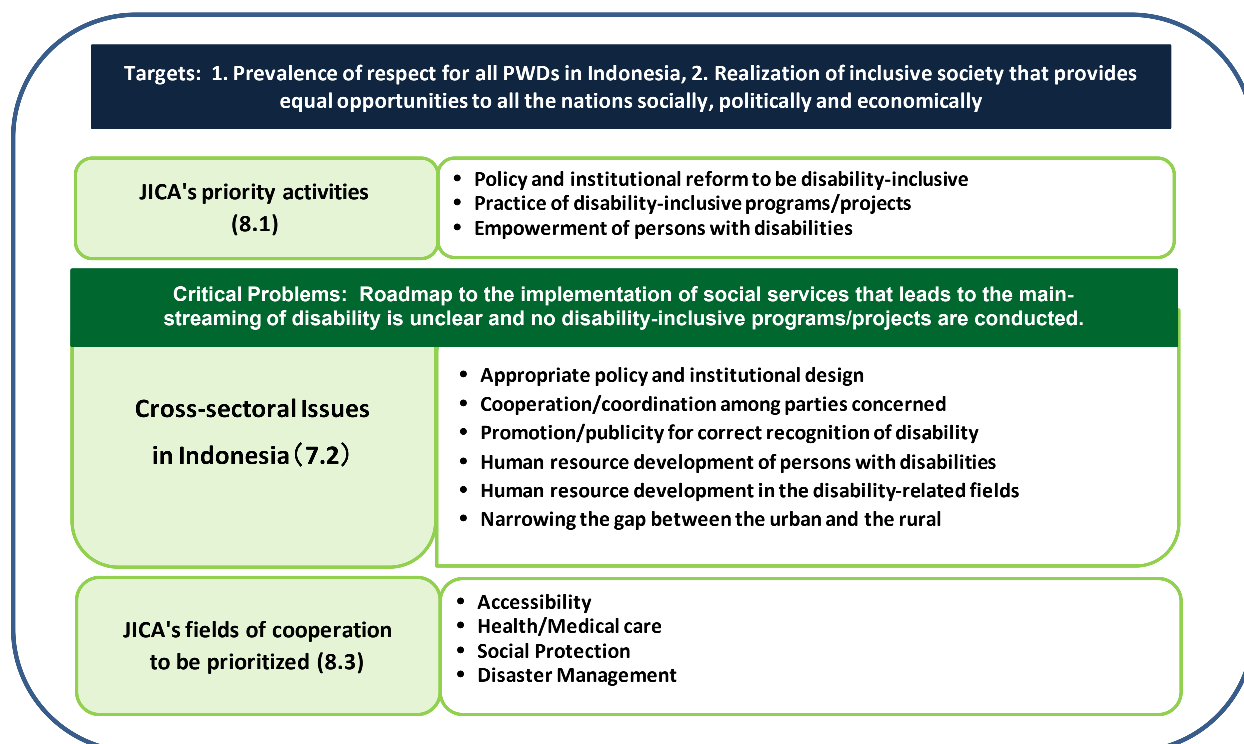

Figure 8-1 Suggested Direction of JICA's Cooperation in Indonesia (by the Survey Team)

Four sectors could be suggested to be focused out of five priority sectors mentioned in Section 7.1.2 (accessibility, health, social protection, disaster management and gender), with considering the following criteria: 1) Indonesia's needs for cooperation concerning disability and development; 2) targets and fields of Incheon Strategy which are not/almost not covered by domestic social services and external assistances; 3) Priority areas of Japan's cooperation for Indonesia; and 4) Japan's comparative advantages and cooperation resources: accessibility, health, social protection, and disaster management can be suggested as the JICA's priority fields of cooperation[206].

However, it should be emphasized that focusing upon the four sectors above does never mean prospective cooperation in other fields is unnecessary[207].

8.3.1 Disability Inclusion in General

(1) Strengthening Systems of the Central Government for Implementation of Disability-inclusive Programs/Projects

It is suggested to discuss a cooperation plan on strengthening systems of the central government, especially KEMSOS, the focal point of disability-related development, and of inter-ministerial coordination in order to effectively implement/apply new action plans and laws presently in process (Table 8-2).

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[206] As for the gender, considered not only to be of comparative advantage of Japan, but information is not enough for the analyses and making any suggestion for cooperation.

[207] The educational sector, for example, cannot be neglected with the fact that 90% of children with disabilities do not receive primary education.

Table 8-2 Outline of the Assistance to Strengthen the Capacity of Central Government for Disability Inclusion

Issues to be solved/ Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities (vi) Minimizing the disparity between cities and local areas
Other impacts	Clarification of roles of the related government organizations Formulation of possible assistances in the future
Counterpart	KEMSOS
Beneficiaries	Staff of KEMSOS/DINSOS and other relevant government organizations at central and local level, persons with disabilities
Cooperation scheme	Dispatch of individual expert Training program in Japan
Trends of donors	GIZ and DFAT attach a personnel in charge of disability in Indonesia to promote inclusive approach
Related projects	Dispatch of individual expert "Disability Mainstreaming Advisor (2012-2015) Dispatch of individual expert "Advisor on the Promotion of Social Participation of Persons with Disabilities (2012-2015)
Resources from Indonesia	Researchers at Center for Disability Studies, University of Indonesia DPOs in Jakarta and Yogyakarta
Resources from Japan	Experts in Disability and Development with experiences of organizational coordination/ project formulation Lecturer of Disability-Equality Training (DET)

For example, it can be suggested to dispatch a technical advisor for disability issues working at KEMSOS. It will contribute to the institutional strengthening of the ministry as well as the capacity development of other relevant ministries, and the clarification of the role of individual ministry/agency, by and through the National Coordination Team for Disability and the training courses of disability inclusion for public officials in charge of the disability-related administration. In order to eliminate/reduce the gap of social services between the urban and the rural, additionally, the training courses of disability inclusion should be held for the department of social affairs at the local government level. It is also important to keep close linkage by frequent and accurate communication with the ministry for the purpose of fostering mutual trust for a long time that enables honest discussions on the future plan of development cooperation.

Main roles of the technical advisor on disability issues can be listed as follows:

- Clarification and documentation of the roles of relevant ministries/agencies for the implementation of the development action plan concerning disability issues,
- Introduction and implementation of the training for the public officials and experts to be in charge of disability-related programs/projects, both of the central government and the local,
- Improvement of the coordination among stakeholders (inter-ministry, between the public and DPOs, etc.)
- Discussion on the future options for the cooperation through, for example, the workshop in which DPOs and relevant ministries/agencies are involved.

(2) Systematization and Dissemination of Good Practices from the Rural Disability-inclusive Villages to All over the Nation

It is suggested to establish "Inclusive Villages", setting KEMSOS as the national counterpart, that can be (i) the pilot sites of the community-based development project(s), and (ii) the hubs for the dissemination of good practices throughout the country under the scheme of the technical cooperation (Table 8-3).

Background: SIGAB (Sasana Integrasi dan Advokasi Difabel), a Yogyakarta-based DPO, has a plan to start conducting the research for baseline-data collection at the village level from 2015, for the eventual realization of the "Inclusive Villages." It is considered to be a powerful drive, by supporting this kind of landmark event with the central and local governments, to systematize good practices extracted from the disability-inclusive projects generated by the community-based body (bottom-up type) and finally to disseminate into other villages.

Objectives: Prospective effects as the objectives of the development project can be listed in the following: (i) improvement of the coordination between the central and local governments, (ii) establishing/strengthening strong linkage between the DPOs and the central/local governments, (iii) foundation/structurization of influential and community-based DPOs such as SIGAB also in other regions, (iv) promotion of the cooperation among domestic DPOs, (v) reduction of the regional gaps by focusing upon the countryside, (vi) systematization of the local administrative body and DPOs for the dissemination of the good practice of "Inclusive Villages."

The Social Rehabilitation Department, KEMSOS, setting the promotion of the CBR programs as one of the pivotal targets of its official activities, has been in charge of; 1) the coordination among KEMENKES, KEMNAKER, and the Ministry of Home Affairs, 2) financial support for the communities, and 3) capacity building of the CBR volunteers, etc. It could be possible, taking leading roles of the project by the Department, to improve the capacity of community volunteers working on site of the project and to realize smooth and effective dissemination in other regions. Community plays important roles in Indonesia concerning disability-related issues, as mentioned in Section 3.6.4 (4), and KEMSOS officially recognized 12 sorts of individuals, family members, and groups in the community as the providers of social welfare. The project is also considered to be able to improve the capacity of such individuals and groups. Furthermore, since the Department, as the facilitator, has organized the National Network for CBR (refer to Section 3.6.4 (5)), the "Inclusive Village" project has a potential to be fostered and enhanced through this kind of network.

Remarks: As discussed in Section 8.2, since decentralization has been progressing in Indonesia, when any kind of pilot projects are conducted in a certain region(s), it should have been confirmed whether or not the official mechanism for the central government to smoothly and effectively support the projects is arranged before the implementation. If necessary, provisional legislation and coordination between the central and local governments have to be done, following the promotion of understanding the contents and purpose of the pilot project within the central government.

Table 8-3 Outline of the Assistance to Disseminate "Inclusive Village"

Issues to be solved/ Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities (vi) Minimizing the disparity between cities and local areas
Other impacts	Increase in people's awareness and understanding of disability inclusion Strengthened CBR network
Counterpart	KEMSOS, Other relevant government organizations in the targeted area
Beneficiaries	Staff of KEMSOS, Other government officials, persons with disabilities, Community residents in the targeted area
Cooperation scheme	Technical Cooperation Project Dispatch of individual expert Training program in Japan
Trends of donors	DFAT provides assistances in capacity building of DPOs
Related projects	Technical Cooperation Project "Creation of Non-handicapping Environment for Filipinos with Disabilities in the Rural Areas (2008-2012)"
Resources from Indonesia	DPOs in Yogyakarta (SIGAB and CIQAL) Researchers at Center for Disability Studies, University of Indonesia
Resources from Japan	Experts in Disability and Development with experiences of disability inclusion/ networking of DPOs Lecturer of DET

(3) Promotion of Disability Inclusion in all the JICA's Project in Indonesia

In order to promote disability mainstreaming in Indonesia, it would be effective to set up a new working position of an official for disability inclusion at JICA Indonesia Office. The officer will be able to increase opportunities of the new projects and steady implementation of the existing projects by observing all the development assistance programs/projects conducted by JICA in Indonesia. Some bilateral donors, such as GIZ and DFAT, has regularly stationed the disability inclusion official in Indonesia and with all the development projects of GIZ and DFAT, as a result, the disability-inclusive perspective has been impressed.

8.3.2 Disability-inclusive Healthcare

(1) Capacity Building of KEMENKES to Provide Disability-inclusive Basic Healthcare Service

It is suggested to provide support for strengthening the capacity of KEMENKES (Table 8-4). There are some programs for persons with disabilities, however, KEMENKES have not coordinated these related programs, and therefore they are fragmented and lack the efficiency. In the health sector, most of the departments are directly related to disabilities (HIV/AIDS, polio, leprosy, mental health, etc.) and it is important to provide assistance to strengthen the inter-departmental cooperation/adjustment within KEMENKES before providing support for the expansion of services to other provinces.

Specifically, the program dispatches a disability adviser (disability-inclusion official) to KEMENKES and carries out the following tasks:

- Collect/organize the information on the activities in the field of disability, which is fragmented within KEMENKES
- Strengthen the cooperation within KEMENKES
- Verify the prioritized issues on disabilities in the health sector upon implementing the above-mentioned two activities and examine the possible assistances
- Strengthen the capabilities of staff members at KEMENKES (Such as DET training, etc.) (Including the staff members at DINKES in order to eliminate the gap between local regions and cities)
- Implementation of inclusive training to Japanese experts who are engaged in the existing projects in the health sector

The WHO Jakarta office has been established within KEMENKES. If the future cooperations are to be examined toward realizing the provision of basic healthcare services to persons with disabilities, it can be effective to cooperate with WHO in implementation. The WHO Global Disability Action Plan 2014–2021, which was launched in 2014, has three objectives; 1) to remove barriers and improve access to health services and programs, 2) to strengthen and extend CBR, assistive technology, and rehabilitation services, and 3) to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services. It also emphasizes the importance of disability inclusion.

Table 8-4 Outline of the Assistance to Strengthen the Capacity of KEMENKES for Provision of Disability-Inclusive Health Services

Issues to be solved/ Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities (vi) Minimizing the disparity between cities and local areas
Other impacts	Enhancement of aid coordination Formulation of possible assistance in Disability and Health
Counterpart	KEMENKES
Beneficiaries	Staff of KEMENKES/DINKES, persons with disabilities
Cooperation scheme	Dispatch of individual expert Training program in Japan
Trends of donors	WHO provides assistances in data collection, in collaboration with ILO and other UN agencies
Related projects	N/A
Resources from Indonesia	Researchers at Center for Disability Studies, University of Indonesia
Resources from Japan	Experts in Disability and Health (Staff of Ministry of Health, Labour and Welfare) Japanese Society for Rehabilitation of Persons with Disabilities Lecturers of DET

8.3.3 Disability-inclusive Social Protection

Indonesia is positioned as high middle-income country, and in regard to social protection, the county is in the stage where the enrichment of the types of services and the improvement of the coverage of services come into view[208]. Actually, the country has been promoting an initiative of the universal health coverage:

[208] Policy according to issues "Social Security" by JICA (2012)

BPJS Kesehatan, a health insurance agency, was established and a new system was founded in January 1, 2014. The Indonesian government aims at transferring those who are currently covered by the public health insurance (public servants and military personnel, private company employees, and the indigent) to the new system as the first step, gradually expanding the scope of the mandatory application afterwards, and covering the entire population by January 1, 2019. It is important to promote the inclusion of persons with disabilities who have been placed at a disadvantage in regard to accessing the social protection system in such initiatives.

With the goal of strengthening the capabilities of the administrative officials concerned toward the smooth application/operation of the social protection systems, such as the public health insurance, which was newly introduced in Indonesia, JICA is currently implementing the Project for Strengthening Social Security System (2014–2017). Dispatch of experts in a short period, training in Japan, and holding of local seminars are the key schemes. First of all, it is suggested to add some activities that related to the social protection system for persons with disabilities in future.

The following contents can be considered as the issues in expanding the social protection system to persons with disabilities. With regard to the presence or absence of other issues and prioritized issues, it is necessary to further collect and examine the information.

(1) Development of Policies and Systems to Expand the Payment of Health Insurance

While the health insurance system covers the treatment cost for the medical rehabilitation in the case of a work accident and the cost to make a prosthetic limb, it does not cover the treatment cost for other medical rehabilitation and the cost for assistive devices such as a wheelchair and cane for persons with disabilities. It is suggested that the project aims for expanding the coverage of the social protection system to persons with disabilities with a purpose of development of the policies and systems to guarantee their access to the medical rehabilitation and assistive devices. The targets of the related training programs will be not only the staff members of KEMENKES and BPJS, but also the members of the councils, policymakers, and medical personnel in the regions, strengthening their capabilities to lead to the development of the policies and systems to guarantee the access to medical rehabilitation and assistive devices for persons with disabilities (for example, the proposed construction of the community-based social protection scheme, proposed construction of the system framework that corresponds to them, etc.).

(2) Examination of the Possibilities to Increase the Amount of Cash Payment to Persons with Severe Disabilities and Expansion of the Eligible Persons

The amount of the cash transfer program currently paid to persons with severe disabilities is small as it is IDR 300,000 per month, and the payment has not been made to all of them. There is no comprehensive database of persons with disabilities, and there is also a problem in targeting persons with disabilities who receive the social protection program. Therefore, it should be considered to examine the possibility of increasing the payment amount and developing a comprehensive database of persons with disabilities to target the eligible persons who benefit from the social protection program (Table 8-5).

Table 8-5 Outline of the Assistance to Increase the Amount of Cash Benefit for Persons with Disabilities

Issues to be solved[209]/ Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities
Other Impact	Provision of comprehensive social protection system
Counterpart	Directorate of Social Protection and Welfare, BAPPENAS Directorate of Social Protection, KEMSOS
Beneficiaries	Staff of BAPPENAS, TNP2K, KEMSOS, KEMENKES, BPJS Health, Local governments, other related organizations, persons with disabilities
Cooperation scheme	Dispatch of individual expert to the "Project for Strengthening Social Security System" Training program in Japan
Trends of donors	GIZ provides assistance to increase the coverage of social insurance. HI provided assistance to improve medical rehabilitation service, and to cover medical rehabilitation services within health insurance system (refer to Chapter 6. 6.3.2)
Related projects	Technical Cooperation Project "Project for Strengthening Social Security System (2014-2017)" Technical Cooperation Project "Project for implementation of the unified registration of the handicapped person in LPZ (2006-2007)," "Project for the program of the unified registration of the person with disability Phase 2 (2009-2012)"
Resources from Indonesia	DPOs
Resources from Japan	Staff of Ministry of Health, Labour and Welfare Experts in targeting of social protection Lecturer of DET

8.3.4 Accessibility

(1) Introduction of the Disability Inclusion in the Urban Planning

The cost of the barrier-free/universal design is said to be around 1% of the total construction cost[210]. If revamping will be made after the construction, the cost is said to be several to several tens of times larger[211]. The introduction of barrier-free/universal design in the early phase of urban planning will reduce the cost and generate economic effects, enhancing improvement of the quality of life of persons with disabilities and their social involvement, which will lead to compliance with the laws and regulations in Indonesia (Table 8-6).

Specific Contents of Assistance: There is a disability inclusion in the currently projected Surabaya City's Green City Master Plan (GMP) development project. Currently, the GMP's pilot project is underway in KEMPUPERA. Although the government officials recognize the viewpoint of accessibility in the GMP, it is hard to say that the perspective viewpoint of accessibility is surely introduced when the GMP is developed in regions or when buildings are actually constructed. It is important to have the viewpoint of accessibility introduced in all the phases from planning to implementation and to evaluation. Currently, there is no system/mechanism streamlined to implement an access audit together with persons with

[209] Refer to Section 7.2
[210] http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172606907476/DisabilityIssuesMetts.pdf
[211] Ratzka (1995) http://www.independentliving.org/cib/cibrio94access.html

disabilities. Streamlining of such a system/mechanism should be included in the contents of assistance. As GMP includes the development of public spaces and public buildings, it is also necessary to enlighten the people concerned in schools and hospitals. Promotion of development of the means of transportation for persons with disabilities (such as welfare vehicle service) will also come into view.

Specifically, a short-term expert in the disability inclusion should be dispatched to the technical cooperation project with the following initiatives:

- Strengthening of the inter-ministry cooperation at the central and regional levels (Such as the KEMENHUB, KOMINFO, KEMDIKBUD, KEMENKES, etc.)
- Bringing enlightenment to and strengthening of the capabilities of the local staff such as builders.
- Dissemination of persons-with-disabilities-centered approaches
- Cooperation of and strengthening the capabilities of DPOs (such as peer counseling, etc.)
- Introduction of DET

Table 8-6 Outline of the Assistance to Introduce Disability-inclusion into City Planning

Issues to be solved/[212] Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities (vi) Minimizing the disparity between cities and local areas
Other impacts	Enhancement of participation of persons with disabilities in education, employment, social protection and political activities through improved accessibility
Counterpart	KEMPUPERA KOMINFO KEMENHUB
Beneficiaries	Staff of the relevant government organizations at central and local level, persons with disabilities
Cooperation scheme	Dispatch of expert to technical cooperation projects to be implemented Training program in Japan
Trends of donors	There is no assistance in accessibility from donor agencies. DFAT provided assistance in improvement of accessibility of school buildings.
Related projects	Technical Cooperation Project “Creation of Non-handicapping Environment for Filipinos with Disabilities in the Rural Areas (2008-2012)” Dispatch of expert “Advisor for Improving Accessibility for Persons with Disabilities in Jordan (2014-2016)”
Resources from Indonesia	Petra Christian University (Surabaya), Center of Accessibility (University of Gadjah Madah,Yogyakarta) Alumni and alumnae of “Training program on disability-friendly urban development” organized by APCD
Resources from Japan	Researchers and experts who belong to Japanese Association for an Inclusive Society JICA experts engaged in the project of “Creation of Non-handicapping Environment for Filipinos with Disabilities in the Rural Areas” and “Advisor for Improving Accessibility for Persons with Disabilities in Jordan” Lecturer of DET Volunteers with experiences of peer counseling

[212] Refer to Section 7.2

Remarks: As accessibility should be considered in terms of not only the physical aspect but also the aspect of information, it is necessary to involve not only KEMPUPERA but also KOMINFO, KEMENHUB in the future.

(2) Development of Standard on Utilizing ICT to Improve the Life of Persons with Visual/hearing Disabilities

Although some delay in the progress of the entire accessibility can be observed, it has been particularly delayed in terms of the information support for persons with visual/hearing disabilities. KOMINFO has not developed the standard and the activity plan on ICT accessibility such as the guideline for accessibility to DAISY and web pages. Supporting the utilization of ICT will lead not only to improve the daily life of persons with disabilities but also to increase the opportunities for persons with disabilities to work in the ICT industry that will contribute to social involvement (Table 8-7).

Specifically, it can be suggested to assign disability advisors in KOMINFO, which is to be a counterpart, and provide support for the promotion of communication standards, use of communication tools, such as sign language and Braille, and standardization of ICT for persons with disabilities in order to secure their access to information. The key tasks of disability advisor could be suggested as follows:

- Comprehension of the actual condition in utilizing ICT and needs of users;
- Examination of the points to be improved and development of products based on the needs of users;
- Development of accessibility standard for knowledge, information and communication based on an internationally-recognized standard;
- Promotion/enlightenment activities for people to understand the effects of utilizing ICT: Support for the implementation of enlightenment events by persons with disabilities who play active roles in society by using ICT;
- Promotion of research and development of the ICT equipment designed for persons with disabilities: Implementation of seminars to train the engineers/developers of a software for persons with visual impairment;
- Strengthening the cooperation with KEMSOS, KEMPUPERA, KEMDIKBUD, and KEMENAKER; and
- Dissemination of persons-with-disability-centered approaches.

Remarks: As mentioned in Section 3.6.5 (2), the penetration rate of internet in Indonesia is not high as compared with other ASEAN countries. Therefore, it is important to concurrently implement the initiatives to spread the internet use to the entire population. For example, JICA has conducted the project for strengthening the capacity of the Ministry of ICT to develop IT strategy in Thailand from 2009 to 2011, aiming at establishing the knowledge-driven economy/knowledge-driven society[213]. If the similar project will be implemented in Indonesia in the future, it is important to aim for developing the disability-inclusive IT strategy. In addition, it is also important to cooperate with stakeholders in other fields. For example,

[213] Name of the case: ICT Policy Development and Planning Advisor (Individual case (Expert))
http://gwweb.jica.go.jp/km/ProjectView.nsf/8c8ff19faf91b01549256f9e0022f9ee/ba009e3a375caea4492577ec0079f5b2?OpenDocument

cooperation with KEMDIKBUD to secure the access to information for children with disabilities, cooperation with KEMENAKER to promote social involvement, such as job assistance for persons with disabilities by using ICT, and cooperation with KEMENHUB and KEMPUPERA in the traffic sites in terms of accessibility would be more effective to improve the life of persons with disabilities.

Table 8-7 Outline of the Assistance to Develop the Standard of Utilization of ICT for Persons with Disabilities

Issues to be solved/ Expected outcomes	(i) Designing of proper policies/systems (ii) Expansion of cooperation and coordination between the people/organizations involved (iii) Proper promotion/education of disability recognition (iv) Development of human resources of persons with disabilities (v) Training of human resources/skill development of people related to disabilities (vi) Minimizing the disparity between cities and local areas
Other impacts	Economic effect of research and development of ICT equipment in collaboration with private sector[214]
Counterpart	KOMINFO
Beneficiaries	Staff of KOMINFO, persons with disabilities
Cooperation scheme	Dispatch of individual expert Technical Cooperation Project Training program in Japan
Trends of donors	There is no specific assistance in accessibility of information
Related projects	Training program on ICT in the Technical Cooperation Project "Asia-Pacific Development Center on Disability (2002-2007)"
Resources from Indonesia	Alumni and alumnae of "Training program of trainers of ICT for persons with visual impairment" organized by APCD DPO
Resources from Japan	Microsoft Japan (experienced in implementing ICT project in Hiroshima) KDDI (experienced in implementing ICT project for persons with disabilities in Vietnam)[215] Local government, such as Hiroshima city, which experienced in implementing ICT project for persons with disabilities and the elderly Waseda University (experienced in implementing ICT project for persons with disabilities in Vietnam) Lecturer of DET

(3) Other Necessary Approaches/supports

1) Acceleration of Improvement of ICT Literacy of Persons with Disabilities

The improvement of the ICT literacy of persons with disabilities is important since the accessibility would be more effectively promoted if persons with disabilities acquire specialized knowledge and information on ICT. In order to improve their ICT literacy, it is also important to implement upskilling courses for volunteer trainers to train persons with disabilities to use ICT (conduct activities to disseminate the acquired knowledge to other volunteers) and also upskilling courses for instructors of a computer school for persons with disabilities. It is possible to provide support for developing a program of human resource development,, dispatching instructors, and developing educational materials such as textbooks.

[214] In cooperation with Microsoft Japan, the city government of Hiroshima implemented ICT project for PWD and the elderly from 2010 to 2011. (http://www.microsoft.com/ja-jp/presspass/detail.aspx?newsid=3810)

[215] The project examined the necessary equipment, services, and policies for persons with visual impairment to utilize ICT and acquire information. (http://www.kddi-foundation.or.jp/project/digital_divide/intro7/)

2) Promotion of Disability Inclusion in JICA's Projects in the Field of Infrastructure and ICT

In addition to the project mentioned above, the initiatives aimed to assuredly introduce disability inclusion in JICA's existing projects in the field of infrastructure and ICT is important. Expansion of infrastructure-related projects is upheld as the prioritized field by the Indonesian government and Japanese government as well. With regard to the infrastructure projects for Indonesia, about 17 projects have been currently implemented since 2013 (refer to Chapter 5). These projects have been implemented as the program for improvement of transportation and traffic environment to facilitate investment in the areas around Jakarta, and the focus of the program includes; 1) planning, improvement of the system, and capacity building, 2) increasing the transportation capacity of mass transportation, and 3) improvement of road traffic and upgrading and expanding of the airport facilities/capacity. By taking the Jakarta Mass Rapid Transit (I) as an example, "Station facilities are intended to be barrier-free" is stated in the section of Environmental and Social Consideration/Poverty Reduction/Social Development in the Preliminary Evaluation of the Project[216]. It is important to conduct monitoring in order to ensure such consideration in actual projects. As is the case with enlightenment of the consideration for disabilities to the relevant personnel in Indonesia, it is necessary to raise awareness of disabilities among Japanese experts who are engaged in the infrastructure and information and communication-related projects.

8.3.5 Disability-inclusive Disaster Management

Japan has learned important lessons about disability-inclusive disaster management from the experiences of large-scale natural disasters; the Great Hanshin-Awaji Earthquake in 1995, and the Great East Japan Earthquake in 2011. To address the issues described in Chapter 7, some possible assistances are suggested as follows.

(1) Establishment of Disability Service Unit for Community-based Disaster Management System

A regulation of Head of BNPB No. 14/2014 provides for the establishment of a disability service unit in BNPB/BPBD. Although BNPB deployed one personnel in the role of disability inclusion, it does not function as the disability service unit and any related action has not been taken yet. In respect to the policy of KEMSOS, it also has not made any specific efforts on social advocacy despite the newly developed guideline of social advocacy. With these aspects considered, establishment of a disability service unit at BPBD that collaborates with social advocacy team of DINSOS could be suggested as one of the possible assistances toward disability-inclusive disaster management (Table 8-8).

According to the regulation, a disability service unit is supposed to take a role of coordinating with ministries, institutions, regional work unit and stakeholders in terms of policies, programs and activities. If the unit functions as described, it would contribute to developing a community-based system to support persons with special needs.

To be more specific, personnel of BPBD, DINSOS and DINKES can be co-coordinators of a disability service unit, which comprises members of TAGANA, community social workers, health workers,

[216] JICA (2009) Preliminary Evaluation of the Project "Jakarta Mass Rapid Transit Project in Indonesia (I)" JICA（2009）http://www2.jica.go.jp/ja/evaluation/pdf/2008_IP-554_1_s.pdf

volunteers, and DPOs. The unit can work as a community support team to conduct activities including confirmation of the residences of persons with special needs, checking shelters, announcement of the location of shelters, confirmation of emergency information/communication system, and provision of disaster preparedness training programs. With these inclusive activities, a strong partnership between and within the departments, a good relationship between the government organizations and community members, and a community network to support persons with disabilities would be established. Furthermore, the enhanced community network will also increase community people's awareness and understanding of disability inclusion.

Table 8-8 Outline of the Assistance to Establish Disability Service Unit

Issues to be solved[217]/Expected Outcome	(i) Strengthening Capacity and a Partnership among Relevant Organizations (ii) Increasing Awareness and Understanding of Disability Inclusion (iii) Establishment of a System to Support Persons with Disabilities
Beneficiaries	▪ Staff at BNPB/BPBD, KEMSOS/DINSOS, KEMENKES/DINKES ▪ persons with disabilities, people in communities, DPOs
Other impacts	▪ Enhancement of people's awareness and understanding of disability inclusion ▪ Contribution to an increase of enrolment rate of children with disabilities
Cooperation scheme	▪ Technical Cooperation Project ▪ Training programs in Japan ▪ JOCV (Community disaster management, Social work)
Counterpart	▪ BNPB/BPBD, KEMSOS/DINSOS, KEMENKES/DINKES
Trend of donors	▪ ASB is planning to conduct a project in Central Java for 1 year from October 2015, which supports to establish a disability service unit at BPBD.
Resources from Japan	▪ Expert in Community Development, Local Administration ▪ JOCV: Experiences of volunteer work on disaster management ▪ Personnel with experiences of the activities of "Bethel"
Resources from Indonesia	▪ Researchers at Center for Disability Studies at University of Indonesia, Researchers at Disaster Management Course at University of Gadjah Madah

(2) Establishment of a Following-up System with a List of People in Need of Special Assistance

With the increasing emphasis on social advocacy which aims to protect vulnerable groups, KEMSOS has developed the social advocacy guideline in 2014. However, as mentioned in Chapter 7, it may be still difficult to reach all the vulnerable groups as a list of people to be followed up does not exist. Therefore, development of a list, which functions as the one used in local government of Japan, can be suggested. Once the list developed, it helps to identify the location of the people in need, and also helps to establish a following-up system of them (Table 8-9).

However, there is a concern about their privacy. There may be some persons with disabilities who refuse to register on the list. With consideration of this situation, the list should be developed under the activities of the program suggested in Section 8.3.5 (1), with the cooperation of disability-related stakeholders such as DPOs and Community Social Workers. As a result, the list would be an effective tool for strengthening the community network for disaster management.

Table 8-9 Outline of the Assistance to Establish a Following-up System with a List of People in Need of Special Assistance

Issues to be	(i) Strengthening Capacity and a Partnership among Relevant Organizations

[217] Refer to 7.3, Chapter 7 for the challenges on disability-inclusive disaster management.

solved/Expected Outcome	(ii) Establishment of a System to Support persons with disabilities
Beneficiaries	▪ Staff at KEMSOS/DINSOS ▪ persons with disabilities, DPOs, Community Social Workers
Other impacts	▪ The list can be used for the national statistical data on disability. ▪ A network of community will be strengthened.
Cooperation scheme	▪ Technical Cooperation Project ▪ Dispatch of Expert (long term)
Counterpart	▪ KEMSOS/DINSOS
Trend of donors	▪ No assistance from donors
Resources from Japan	▪ Expert in Local Administration, Social Welfare
Resources from Indonesia	▪ DPOs, Community Social Workers

(3) Other Necessary Assistances

In addition to the cooperation programs suggested in Sections 8.3.5 (1) and (2), there is some necessary assistance as below.

1) DPO's Lodgment as a Support Center for persons with disabilities

Along with improving the accessibility of shelters, it is necessary to establish a support system for those who have not access to shelters. To support the livelihood of people who need assistance at shelters or outside of shelters, it can be suggested to make a DPO's lodgment perform as a support center for persons with special needs, which is a focal point of providing relief supplies and counseling services. Some DINSOS use a social rehabilitation center as a shelter for persons with disabilities, however, the availability of the rehabilitation center is insecure because of its limited number. Additionally, there is a concern about an increase of discriminative sense against disability if the rehabilitation center is arranged only for persons with disabilities. The role of DPO's lodgment should be defined in the disaster management plan of each local government, and it would also contribute to building a good relationship between DPOs and local governments.

2) Participation of persons with disabilities in Disaster Management Activities

To establish a disability-inclusive disaster management system, it is necessary to develop the relevant legislative systems and policies, and to enhance public awareness and understanding of disability. In addition, it is also important to encourage persons with disabilities to participate in the related activities. Some persons with disabilities who were interviewed in this survey show a negative attitude toward evacuation, not asking for a help but giving up to escape a disaster. However, if they participate in the related activities with other community members, and prepare necessary equipments and supplies, their vulnerability to a disaster can be mitigated.

3) Provision of Training Programs on Disability Inclusion

To promote disability-mainstreaming approach, it is important to increase all the relevant personnel's understanding of disability issue. Some international NGOs, such as ASB and HI, and Japanese NGOs already provides training programs on disability inclusion for disaster management teams in several areas. The followings are the points to be commonly understood among the relevant personnel.

- Reporting system in case that emergency response teams identified persons with special needs
- Method of communication with persons with disabilities
- Provision of accessibility at shelters
- Dispatch of caregivers at shelters
- Needs of persons with disabilities, such as commodities, medical equipments and medical supplies
- Provision of supports for those who take refuge at the place apart from registered shelters

4) Disability Mainstreaming on Other Related Projects

The disability-mainstreaming approach should be integrated into other disaster-related projects. For example, contingency plan is supposed to consider disability inclusion, and early warning system should be accessible for persons with disabilities, and post-disaster reconstruction projects should promote accessibility.

Appendix 1

Schedule of the Field Survey

Appendix 1: Schedule of the Field Survey

Schedule of the First Field Survey

Date		Activities	City
6-May	Wed	Arrival in Jakarta	Jakarta
7-May	Thu	Attending at Donor Coordinating Meeting	
		Focused Group Discussion (FGD) in Jakarta	
8-May	Fri	Meeting with JICA Indonesia Office	
9-May	Sat	Team meeting	
10-May	Sun	Meeting with JICA Expert for Disaster Management	
11-May	Mon	Meeting with BNPB	
		Meeting with AHA Centre	
12-May	Tue	Meeting with Ministry of Education and Culture	
		Meeting with TNP2K	
13-May	Wed	Meeting with Ministry of Manpower and Transmigration	
14-May	Thu	Jakarta -> Surabaya	Surabaya
		Meeting with Interpreters/Coordinators	
15-May	Fri	Meeting with International Cooperation Bureau, East Java Provincial Government	
		Meeting for Mr. Gunawan Tanuwidjaja, Petra Christian University	
16-May	Sat	Team meeting	
17-May	Sun	Team meeting	
18-May	Mon	Meeting with Municipal Government of Surabaya City	
		Meeting with Department of Social Affairs, East Java Provincial Government	
19-May	Tue	Meeting with Resource Center, Sidoarjo Regency Government	
20-May	Wed	Meeting with Department of Education, East Java Provincial Government	
		Meeting with BPBD, East Java Provincial Government	
		Meeting with Kitakyushu City Government staff	
		Meeting with Teachers at Special School for Students with Disabilities	
21-May	Thu	Meeting with Department of Health, East Java Provincial Government	
		Focused Group Discussion (FGD) in Surabaya	
22-May	Fri	Access Audit in Surabaya	
23-May	Sat	Access Audit & Meeting with PWDs in urban-area village	
24-May	Sun	Surabaya -> Jakarta -> Yogyakarta	Yogyakarta
25-May	Mon	Team meeting	
26-May	Tue	Meeting with Dr. Ikaputra, University of Gadjah Mada	
		Meeting with Handicap International	
		Meeting with an Interpreter	
27-May	Wed	Meeting with BPBD, Yogyakarta Provincial Government	
		Meeting with Department of Social Affairs, Yogyakarta City Government	
28-May	Thu	Meeting with ASB	
		Meeting with SIGAB and CIQAL	
29-May	Fri	Team meeting	
30-May	Sat	Yogyakarta -> Jakarta	Jakarta
31-May	Sun	Team meeting	
1-Jun	Mon	Meeting with Ministry of Transportation	
		Meeting with BASARNAS	
		Meeting with Ministry of Public Works and National Residence	
2-Jun	Tue	Team meeting	

Appendix 1: Schedule of the Field Survey

Date		Activities	City
3-Jun	Wed	Meeting with BAPPENAS	
		Meeting with Ministry of Health	
		Meeting with JICA Indonesia Office	
		Jakarta -> Haneda/Tokyo (GA874)	
4-Jun	Thu	Arrival in Japan	Tokyo

Schedule of the Second Field Survey

Date		Activities	City
28-Jun	Sun	Arrival in Jakarta	Jakarta
29-Jun	Mon	Meeting with Ministry of Social Affairs (Directorate of Social Rehabilitation)	
		Meeting with Ministry of Social Affairs (Directorate of Social Protection)	
		Meeting with Ministry of Social Affairs (Functional Development Center of Social Workers and Social Instructor)	
30-Jun	Tue	Meeting with Ministry of Communications and Information Technology	
		Meeting with ILO/UNESCO	
		Meeting with BNPB	
		Meeting with JICA Indonesia Office	
1-Jul	Wed	Jakarta -> Yogyakarta	Yogyakarta
		Meeting with BPBD, Yogyakarta City Government	
		Meeting with TAGANA, under the Department of Social Affairs, Yogyakarta Provincial Government	
		Yogyakarta -> Jakarta	
2-Jul	Thu	Meeting with BPS	Jakarta
		Meeting with Indonesia Red Cross	
3-Jul	Fri	Meeting with Ministry of Health (Directorate of Mental Health)	
		Meeting with Ministry of Health (Directorate of Child Health)	
		DFAT Jakarta [Saito]	
		Meeting with Ms. Cucu (a person with disability)	
		Jakarta -> Surabaya	Surabaya
		Meeting with TAGANA, under the Department of Social Affairs, East Java Provincial Government	
4-Jul	Sat	Meeting with Mr. Gunawan, Petra Christian University	
		Meeting with Dr. Timoticin Kwanda, Petra Christian University	
		Surabaya -> Jakarta (Yonezawa / Nishimagi)	
5-Jul	Sun	Team meeting	Jakarta
6-Jul	Mon	Meeting with Ministry of Health (Center of Health Crisis Management)	
		Seminar "Green Building and Accessibility: Towards Smarter Green City"	
7-Jul	Tue	Meeting with Spatial Planning Bureau, Makassar City Government	
		Meeting with Dr. Irwanto, University of Indonesia	
8-Jul	Wed	Meeting with Ministry of Home Affairs	
		Meeting with Autism Foundation of Indonesia	
		Meeting with Ministry of Women Empowerment and Child Protection	
9-Jul	Thu	Meeting with WHO	
10-Jul	Fri	Meeting with JICA Indonesia Office	
		Jakarta -> Haneda/Tokyo	
11-Jul	Sat	Arrival in Japan	Tokyo

Appendix 2

List of Interviewees

Appendix 2: List of Interviewee

(1) Central Government

Ministry of Social Affairs		
1.	Ms. Eva Rahni Kasim	Directorate for Social Rehabilitation for PWDs
2.	Mr. Nahar	Director of Social Rehabilitation for PWDs
3.	Ms. Mahdacenah	Staff, Division of Social Rehabilitation for PWDs
4.	Ms. Aris Miarti	Staff, Division of Social Rehabilitation for PWDs
5.	Mr. Toto	Functional Development Center of Social Workers and Social Instructor
6.	Mr. Dian Purwasantama	Functional Development Center of Social Workers and Social Instructor
7.	Mr. Iyan Kusmadiana	Head of Emergency Response Sub-Directorate
8.	Mr. Yadi Muchter	Head of Social Advocacy Section

Ministry of Health		
9.	Dr. Eko	Directorate of Health Effort
10.	Ms. Upik Rukmini	Directorate of Health Effort
11.	Dr. Eka Viora	Director of Mental Health
12.	Dr. Edward Idul Riyadi	Head of Sub-Directorate of Mental Health for High Risk
13.	Dr. Jane Soepardi	Director of Child Health
14.	Ms. Puh An Merry Antarina	Directorate of Child Health
15.	Dr. Yenai Yuuana	Directorate of Child Health
16.	Dr. Stefani Chirstanti	Directorate of Child Health
17.	Dr. Florentine M.	Directorate of Child Health
18.	Dr. Edi Priyono	Sub-Directorate of Reproductive Health Protection, Directorate of Maternal Health
19.	Drg. Zaman	Center for Health Crisis Management
20.	Ms. Lita	Center for Health Crisis Management

Ministry of Education and Culture		
21.	Dr. Harizal	Head of Programming and Evaluation
22.	Dr. Praptono, M. Ed	Deputy Director of Learning
23.	Mr. Aswin Windiyanto	Head of Planning Program
24.	Ms. Tita Srihayati	Curriculum Implementation Section
25.	Ms. S. M. Fadhilah	Programming and Evaluation Section

Ministry of Public Works and National Residence		
26.	Ms. Dian Prasenjawati	Head of Arrangement, Department of PBL
27.	Mr. Wahyu Imam S.	Department of PBL
28.	Ms. Amanda Erika	Staff, Department of PBL

Ministry of Manpower and Transmigration		
29.	Mr. Abudul W. Bangkona	Secretary General
30.	Ms. Roostiawati	Head of International Cooperation Center
31.	Mr. Wisnu Pramone	Director
32.	Mr. Sapto Purnomo	Deputy Director for Vulnerable Labour Placement

Ministry of Transportation		
33.	Mr. Saptandri Widiyanto	Deputy Director for International Cooperation
34.	Ms. Susanty Pertiwi	Chief for Bilateral Cooperation
35.	Mr. Ami Ruddin	
36.	Mr. Aznac	

Ministry of Communication and Informatics		
37.	Drs. Freddy H. Tulung	Director General, Public Information and Communication
38.	Ms. Henni Prastiwi	Head of Section, International Information Services
39.	Ms. Mediodecci Lustarini	Head of Cooperation Section
40.	Ms. Dewi Rahmarini	Staff

Ministry of Women Empowerment and Child Protection		
41.	Ms. Dessy Oktarina	Advocacy Sub-Division

Ministry of Home Affairs		
42.	Drs. Sugiyono M. Si	Directorate General for Regional Development

TNP2K		
43.	Dr. Elan Satriawan	Chief of Policy Working Groups
44.	Ms. Fiona Howell	Social Assistance Policy Advisor

National Development Planning Board (BAPPENAS)		
45.	Dr. Vivi Yulaswati	Director, Directorate of People's Protection and Welfare

Central Bureau of Statistics		
46.	Dr. Kecuk Suhariyanto	Deputy Chief Statistician for National Accounts and Statistical Analysis
47.	Mr. Teguh Pramoto	Director of Social Welfare Statistics

National Disaster Management Agency (BNPB)		
48.	Dra. Anny Isgrati	Director of Community Empowerment
49.	Mr. Pangarso	Head, Section of Community Preparedness Promotion
50.	Mr. Melissa	Head, Section of Community Awareness Promotion
51.	Mr. Irawan	UNDP Expert
52.	Mr. Takafumi Shinya	JICA Expert on Comprehensive Disaster Management Policy

National Search and Rescue Agency (BASARNAS)		
53.	Mr. Zulfikar S.	Planning and International Technical Cooperation Bureau
54.	Ms. Annie Sloman	Planning and International Technical Cooperation Bureau
55.	Ms. Melina Margaretha	Planning and International Technical Cooperation Bureau

(2) The Government of East Java Province

Cooperation Affairs Bureau		
56.	Mr. Benny Sampir Wanto	Director
57.	Mr. Adji Arwowo.	Head, Sub-Division of International Cooperation

Department of Social Affairs		
58.	Mr. Budi Yuwono	Social Rehabilitation Division
59.	Mr. Teguh Setyanian	Social Rehabilitation Division
60.	Mr. P. Adi Kiidodo	Social Protection Division
61.	Mr. M. Gunawan	TAGANA
62.	Mr. Ivan	TAGANA
63.	Mr. Waryv Riski	TAGANA

Department of Education		
64.	Ms. Puji Hastuti	Special Education Sub-division

Regional Agency for Disaster Management		
65.	Drs. Bambang Munarto	Program and Reporting Sub-section
66.	Ms. Puji	Secretary

(3) The Government of Surabaya City

67.	Mr. Yunar Hermawan	Department of International Cooperation
68.	Ms. Rahmasari	Department of International Cooperation
69.	Ms. Putri P.	City Development Planning Agency
70.	Mr. Dhoni C.	City Development Planning Agency
71.	Ms. Ehdahs S.	Department of Social Affairs
72.	Ms. Yumita E.	Department of Health

(4) The Government of Yogyakarta Special Region

Department of Social Affairs		
73.	Mr. Sigit Alifianto	TAGANA

Regional Agency for Disaster Management		
74.	Mr. Gatot Saptadi	Head of Agency
75.	Mr. Heru Suroso	Secretary
76.	Mr. Heri Siswanto	Head of Prevention and Preparedness

(5) The Government of Yogyakarta City

Department of Social Affairs		
77.	Octo N. Arafat	Head of Division, Rehabilitation and Service
78.	Sri. Mulyatininqesh	Rehabilitation and Service Division
79.	B.Nanik Trisnajayanh	Rehabilitation and Service Division
80.	Anita Anggraini	Secretary, Rehabilitation and Service Division

Regional Agency for Disaster Management		
81.	Mr. Heky	Head Section of Emergency and Logistics
82.	Mr. Djoko Tbiamo	Head Section of Rehabilitation and Construction
83.	Ms. Retno Rahayu	Staff of the Prevention Section
84.	Ms. Siti Miftahussaadah	Staff
85.	Ms. Dewa Aivuerah	Staff of Protocol Division
86.	Mr. Septirian Praditya	Staff of Protocol Division

(6) Donor/International Agencies

Bilateral Agencies			
87.	Ms. Andini Mulyawati	Program Manager	DFAT
88.	Mr. Frank Schneider	Team Leader, Inclusion of PWDs	GIZ
89.	Mr. Naoki Motoshima	Section Chief in Charge of Commercialization, Asian De-carbonization Center	Kitakyushu City (Japan)

Multilateral Agencies			
90.	Mr. Tolhas Damanik	Private Sector Support and Disability Specialist	ILO Jakarta Office
91.	Mr. Gde Yulian Yogakhita	Emergency Field Program Officer and Injury Prevention	WHO Indonesia Office
92.	Ms Ailsa Amila	Programme Assistant	UNESCO
93.	Ms Risya Ariyani Kori	National Programme Officer – Gender Equality	UNFPA

International Agencies			
94.	Ms. Agustina Tnunany	Preparedness and Response Officer	AHA Centre
95.	Mr. Yos Malole	Preparedness and Response Officer	AHA Centre
96.	Dr. Ritola Tasmaya	Secretary General	Indonesian Red Cross
97.	Ms. Istianasari	Staff	Indonesian Red Cross

International NGO			
98.	Mr. Matthew R. A. Hanning	Country Director	CBM
99.	Dr. Alex Robinson	Country Director Indonesia	ASB
100.	Ms. Annie Sloman	Programme Development Manager	ASB
101.	Ms. Melina Margaretha	Project Manager	ASB
102.	Ms. Julie Nuttens	Regional Program Director	Handicap International

103.	Ms. Belly Lesmana	Advocating for Changes Project Manager	Handicap International
104.	Mr. Dwi Ariyani	Inclusion Programme Thematic Advisor	Handicap International

(7) Disability-Related Institutions/Centers

Resource Center in Sidoarjo City

105.	Ms. Endang	Head section of the center
106.	Ms. Rina	Clinical Psychologist
107.	Aries	Autistic therapist
108.	Andy	Autistic therapist
109.	Santi	Autistic therapist
110.	Dini	Deaf therapist
111.	Windi	Deaf therapist
112.	Nuhul	Administrative staff
113.	Agung	Support staff

Autism Foundation of Indonesia

114.	Dr. Melly Budhiman	Chairman

Special school

115.	Mr. Atung	Teacher at special school for people with visual impairment
116.	Mr. Abdul Syakur	Teacher at special school

(8) Academic Institutions

University of Indonesia

117.	Dr. Irwanto	Co-Director, Center of Child Protection
118.	Mr. Bahrul Fuad	Research Associate, Center for Disability Studies
119.	Mr. Eriando Rizky Septian, S.	Administrative Coordinator of SARI Project

Petra Christian University

120.	Mr. Gunawan Tanuwidjaja	Team Leader of University Network of Digital (Local) Knowledge
121.	Dr. Tomoticin Kwanda	Dean of Faculty of Civil Engineering and Planning

University of Gadjah Madah

122.	Dr. Ikaputra	Associate Professor/ Chairman

(9) DPOs

123.	Mr. Joni Yulianto	Executive Director	SIGAB
124.	Mr. Haris	Vice Director	SIGAB
125.	Ms. Nuning Suryatiningsih	Director	CIQAL
126.	Ms. Wuri Handayani	Director	D-Care
127.	Ms. Cucu Saidah	Technical Coordinator for Disabilities	AIPJ

(10) PWDs and Other Relevant Persons

No.	Name	Organization	Remarks
128.	Ms. Rachmita MH	SEHJIRA Deaf Foundation	PWD
129.	Ms. Welin Hargati	HWDI	PWD
130.	Ms. Ratripuspita NJ	PLJ	PWD
131.	Ms. Juniati Effendi	Gerwatin Pusat	PWD
132.	Ms. Nabressa	PENWMI	PWD
133.	Ms. Siswanti	PENWMI	PWD
134.	Ms. Ridwan S.	JRFT	PWD
135.	Ms. Frida		PWD (Wheelchair user)
136.	Mr. Tutus	YPAB	PWD (visual impairment)
137.	Ms. Feny	Gergatin Surabaya	PWD (hearing impairment)
138.	Ms. Umaroh	Gergatin Jatim	PWD (hearing impairment)
139.	Mr. Eka Prastama	Social Worker	
140.	Ms. Ana Rafika		

Appendix 3

Current Status to the Indicators of Incheon Strategy

Incheon Strategy: Goals, Targets and Indicators

NA=Not Available

As of 8 September 2015

Goals		Targets		Core Indicators		Current Status	Supplementary Indicators		Current Status
1	Reduce poverty and enhance work and employment prospects	1A	Eliminate extreme poverty among persons with disabilities	1.1	Proportion of persons with disabilities living below the US$ 1.25 (PPP) per day international poverty line, as updated by the World Bank and compared to the overall population	NA	1.4	Proportion of persons with disabilities living below the national poverty line	NA
		1B	Increase work and employment for persons of working age with disabilities who can and want to work	1.2	Ratio of persons with disabilities in employment to the general population in employment	Census provides a proportion of the employed persons with disabilities among the total population of Indonesia. Refer to F/R, Table 3-6 "Working Status by Degree of Disabilities, Level of Education, and Gender"			
		1C	Increase the participation of persons with disabilities in vocational training and other employment-support programmes funded by governments	1.3	Proportion of persons with disabilities who participate in government-funded vocational training and other employment-support programmes as a proportion of all people trained	NA As of July 2014, 197 people with disabilities have participated in the vocational training program organized by the provincial government in East Java (ILO, 2014*). Besides, only one out of 16 vocational centers does not have a trainee with disabilities.			
2	Promote participation in political processes and in decision-making	2A	Ensure that persons with disabilities are represented in government decision-making bodies	2.1	Proportion of seats held by persons with disabilities in the parliament or equivalent national legislative body	unknown	2.5	Proportion of cabinet positions held by persons with disabilities at the national level	Except for dead president Abdurrahman Wahid who had a visual impairment, there is no cabinet member with disabilities.
		2B	Provide reasonable accommodation to enhance the participation of persons with disabilities in the political process	2.2	Proportion of members of the national coordination mechanism on disability who represent diverse disability groups	Various DPOs have participated in policy planning.	2.6	Proportion of supreme court judges who are persons with disabilities	NA
				2.3	Proportion of those represented in the national machinery for gender equality and women's empowerment who are persons with disabilities	NA Ministry of Women's Empowerment and Child Protection has an employee with disabilities.	2.7	Availability of legislation that requires the national election authority to conduct the election process in a manner that makes it accessible for persons with diverse disabilities	Provision of assistive devices at voting place for persons with visual impairment is provided for by Law No. 10/2008 and No. 42/2008. Besides, the Government Regulation No. 36/2006 provides for a standard of accessibility to public building.
				2.4	Proportion of polling stations in the national capital that are accessible with processes in place that ensure confidentiality of voters with disabilities	NA			
3	Enhance access to the physical environment, public transportation, knowledge, information and communication	3A	Increase the accessibility of the physical environment in the national capital that is open to the public	3.1	Proportion of accessible government buildings in the national capital	NA	3.6	Availability of a government access audit programme that requires the participation of experts with disabilities	Yogyakarta City Government conducts an access audit in cooperation with people with disabilities. Ministry of Transportation does not have procedure for access audit.
		3B	Enhance the accessibility and usability of public transportation	3.2	Proportion of accessible international airports	NA	3.7	Availability of mandatory technical standards for barrier-free access that govern the approval of all designs for buildings that could be used by members of the public, taking into consideration internationally recognized standards, such as those of the International Organization for Standardization (ISO)	Ministry of Public Works and Public Housing formulated a regulation on accessibility.
		3C	Enhance the accessibility and usability of information and communications services	3.3	Proportion of daily captioning and sign-language interpretation of public television news programmes	Indonesia Republic Television provides one news program with sign language interpretation.	3.8	Number of sign language interpreters	There are five sign language interpreters in Jakarta who were certified by the Movement of the Welfare of Deaf Indonesia (Gerakan untuk Kesejahteraan Tunarungu Indonesia: GERKATIN)
		3D	Halve the proportion of persons with disabilities who need but do not have appropriate assistive devices or products	3.4	Proportion of accessible and usable public documents and websites that meet internationally recognized accessibility standards	NA (The government does not have an internationally recognized standard.)	3.9	Availability of mandatory technical standards for barrier-free access that govern the approval of all ICT-related services, such as websites for the public, taking into consideration internationally recognized standards, such as those of the ISO	There is no technical standard.
				3.5	Proportion of persons with disabilities who need assistive devices or products and have them	NA			

Goals		Targets		Core Indicators		Current Status	Supplementary Indicators		Current Status
4	Strengthen social protection	4A	Increase access to all health services, including rehabilitation, for all persons with disabilities	4.1	Proportion of persons with disabilities who use government-supported health-care programmes, as compared to the general populatior	NA	4.4	Number of government-supported programmes for care services, including for respite care	There is no program.
		4B	Increase coverage of persons with disabilities within socia protection programmes	4.2	Coverage of persons with disabilities within social protection programmes, including social insurance and social assistance programmes	The data was not obtained in this survey. (Although TNP2K has the related data, it does not cover all the people with disabilities since there may be some people with disabilities or family members with PWD who do not declare his/her disabilities.)	4.5	Availability of national community-based rehabilitation programmes	Abailable.
		4C	Enhance services and programmes, including for persona assistance and peer counselling, that support persons with disabilities, especially those with multiple, extensive and diverse disabilities, in living independently in the community	4.3	Availability of government-funded services and programmes, including for personal assistance and peer counselling, that enable persons with disabilities to live independently in the community	There is no program for personal assistance and peer counseling that support persons with disabilities.	4.6	Availability of health insurance for persons with disabilities	There is no health insurance specialized for persons with disabilities.
							4.7	A decrease in the unmet need for assistance and support services	NA
5	Expand early intervention and education of children with disabilities	5A	Enhance measures for early detection of, and intervention for, children with disabilities from birth to pre-school age	5.1	Number of children with disabilities receiving early childhood intervention	Although the government provides early childhood intervention, the related data is not available.	5.4	Proportion of pre- and antenatal care facilities that provide information and services regarding early detection of disability in children and protection of the rights of children with disabilities	The proportion is unknown. The pre-natal care is not available, but the government provides information about early detection of disability in children.
		5B	Halve the gap between children with disabilities and children without disabilities in enrolment rates for primary and secondary education	5.2	Primary education enrolment rate of children with disabilities	79.89% (Not include the information of undeclared household) Refer to F/R, Table 3-5 "School Attendance Rates and Situations of Children with Disabilities)	5.5	Proportion of children who are deaf that receive instruction in sign language	NA
				5.3	Secondary education enrolment rate of children with disabilities	53.47% (Not include the information of undeclared household) Refer to F/R, Table 3-5 "School Attendance Rates and Situations of Children with Disabilities"	5.6	Proportion of students with visual impairments that have educational materials in formats that are readily accessible	NA
							5.7	Proportion of students with intellectual disabilities, developmental disabilities, deafblindness, autism and other disabilities who have assistive devices, adapted curricula and appropriate learning materials	NA
6	Ensure gender equality and women's empowerment	6A	Enable girls and women with disabilities to have equitable access to mainstream development opportunities	6.1	Number of countries that include the promotion of the participation of women and girls with disabilities in their national action plans on gender equality and empowerment of women	Ministry of Women's Empowerment and Child Protection promotes the program for women with disabilities.			
		6B	Ensure representation of women with disabilities in government decision-making bodies	6.2	Proportion of seats held by women with disabilities in the parliament or equivalent national legislative body	NA			
		6C	Ensure that all girls and women with disabilities have access to sexual and reproductive health services on an equitable basis with girls and women without disabilities	6.3	Proportion of girls and women with disabilities who access sexual and reproductive health services of government and civil society, compared to women and girls without disabilities	NA			
		6D	Increase measures to protect girls and women with disabilities from all forms of violence and abuse	6.4	Number of programmes initiated by government and relevant agencies aimed at eliminating violence, including sexual abuse and exploitation, perpetrated against girls and women with disabilities	Ministry of Health provides the program. (The detail is unknown.)			
				6.5	Number of programmes initiated by government and relevant agencies that provide care and support, including rehabilitation, for women and girls with disabilities who are victims of any form of violence and abuse	Ministry of Health provides the program. (The detail is unknown.)			

Goals		Targets		Core Indicators		Current Status	Supplementary Indicators		Current Status
7	Ensure disabilityinclusive disaster risk reduction and management	7A	Strengthen disability-inclusive disaster risk reduction planning	7.1	Availability of disability-inclusive disaster risk reduction plans	Disaster Management Plan (2015-2019) that considers persons with disabilities will be issued by BNPB.	7.4	Number of persons with disabilities who died or were seriously injured in disasters	NA
		7B	Strengthen implementation of measures on providing timely and appropriate support to persons with disabilities in responding to disasters	7.2	Availability of disability-inclusive training for all relevant service personnel	Yogyakarta provincial BPBD and DINSOS, and Yogyakarta city BPBD conduct disability-inclusive training.	7.5	Availability of psychosocial support service personnel that have the capacity to assist persons with disabilities affected by disasters	Ministry of Social Affairs provides phycho-social support.
				7.3	Proportion of accessible emergency shelters and disaster relief sites	According to BNPB, newly established shelters are all accessible for PWDs. There is no data on the total number of shelters (inluding the non-accessible) and accessible shelters.	7.6	Availability of assistive devices and technologies for persons with disabilities in preparing for and responding to disasters	Assistive devices or other special equipments are not prepared for PWDs.
8	Improve the reliability and comparability of disability data	8A	Produce and disseminate reliable and internationally comparable disability statistics in formats that are accessible by persons with disabilities	8.1	Disability prevalence based on the International Classification of Functioning, Disability and Health (ICF) by age, sex, race and socioeconomic status	The census conducted in 2010 shows a proportion of PWDs by age, sex and residential area. Refer to F/R, Table 3-1, 3-2 and 3-3.			
		8B	Establish reliable disability statistics by the midpoint of the Decade, 2017, as the source for tracking progress towards the achievement of the goals and targets in the Incheon Strategy	8.2	Number of Governments in the Asia-Pacific region that have established, by 2017, baseline data for tracking progress towards achievement of the Incheon goals and targets	Special National Survey on Disabilities will be conducted by BPS in 2016.			
				8.3	Availability of disaggregated data on women and girls with disabilities in mainstream development programmes and government services, including health, and sexual and reproductive health, programmes	NA			
9	Accelerate the ratification and implementation of the Convention on the Rights of Persons with Disabilities and harmonization of national legislation with the Convention	9A	By the midpoint of the Decade (2017), 10 more Asia-Pacific Governments will have ratified or acceded to the Convention on the Rights of Persons with Disabilities, and by the end of the Decade (2022) another 10 Asia-Pacific Governments will have ratified or acceded to the Convention	9.1	Number of Governments that have ratified or acceded to the Convention	The government of Indonesia ratified the Convention in 2011.	9.3	Number of Asia-Pacific Governments that have ratified the Optional Protocol to the Convention on the Rights of Persons with Disabilities	Not yet ratified.
		9B	Enact national laws which include anti-discrimination provisions, technical standards and other measures to uphold and protect the rights of persons with disabilities and amend or nullify national laws that directly or indirectly discriminate against persons with disabilities, with a view to harmonizing national legislation with the Convention	9.2	Availability of national anti-discrimination legislation to uphold and protect the rights of persons with disabilities	There is no legislation on anti-discrimination.	9.4	Number of amended or nullified laws that directly or indirectly discriminate against persons with disabilities	Law No. 1/1974 (Marriage Law) that stipulates the acceptance of a request of divorce from the husband if the wife has got a residual disability or an incurable disease is not planned to be amended.

* ILO (2014) Baseline Survey - Access of Persons with Disabilities to Vocational Training in Technical Implementation Units in East Java, Indonesia, ILO Propel Project