COSTING A MULTIDISCIPLINARY PACKAGE OF RESPONSE SERVICES FOR WOMEN AND GIRLS SUBJECT TO VIOLENCE: A Gender Budgeting Approach

Case Study of Indonesia

Final Report

Submitted by
Center for Population and Policy Studies
Gadjah Mada University
2012
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ABBREVIATIONS AND ACRONYMS

Bapeljamkesos  Badan Pelayanan Jaminan Kesejahteraan Sosial (Board of Social Insurance Service)
BAPPEDA  Badan Perencanaan Pembangunan Daerah (Board of the Local Level Development and Planning)
BAPPENAS  Badan Perencanaan Pembangunan Nasional (National Board of Development Planning)
Bareskrim  Badan Reserse Kriminal (Crime Investigation Unit)
BP4  Badan Penasihat Pembinaan Pelestarian Perkawinan (Board of Marriage Counseling and Advisory)
BPMPKB  Badan Pemberdayaan Masyarakat, Perempuan dan Keluarga Berencana (Board of Community and Women’s Empowerment and Family Planning)
BPPM  Badan Pemberdayaan Perempuan dan Masyarakat (Board of Women’s and Community Empowerment)
CSO  Civil Society Organization
CSI  Critical Service Initiative
DAU  Dana Alokasi Umum (General Allocation Fund)
DAK  Dana Alokasi Khusus (Specific Allocation Fund)
DKI  Daerah Khusus Ibukota (Special Capital Region)
DIY  Daerah Istimewa Yogyakarta (Special Region of Yogyakarta)
DIP  Daftar Isian Proyek ()
DIPA  Daftar Isian Pelaksanaan Anggaran (Budget Implementation Form)
Dirjen  Direktur Jenderal (General Director)
Ditjen  Direktorat Jenderal (General Directorate)
DPR  Dewan Perwakilan Rakyat (National Parliament)
DPRD  Dewan Perwakilan Rakyat Daerah (Local Parliament)
DV  Domestic Violence
GBS  Gender Budget Statement
GIZ  Deutsche Gesellschaft für Internationale Zusammenarbeit (German International Development Cooperation)
GRB  Gender Responsive Budgeting
IDR  Indonesian Rupiah
Jamkesda  Jaminan Kesehatan Daerah (Regional Health Insurance)
Jamkesos  Jaminan Kesehatan Sosial (Social Health Insurance)
Jamkesmas  Jaminan Kesehatan Masyarakat (Community Health Insurance)
Kanwil  Kantor Wilayah (Provincial or District Office of Central Government)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>Kapolri</td>
<td>Kepala Polisi Republik Indonesia (Head of the Indonesian National Police)</td>
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<tr>
<td>Kepmen</td>
<td>Keputusan Menteri (Ministrial Decree)</td>
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<td>Keppres</td>
<td>Keputusan Presiden (Presidential Decree)</td>
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<td>KIA</td>
<td>Kesehatan Ibu dan Anak (Maternal and Child Health)</td>
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<td>Komnas Perempuan</td>
<td>Komisi Nasional Anti Kekerasan terhadap Perempuan (National Commission on Violence against Women)</td>
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<td>KPMP</td>
<td>Kantor Pemberdayaan Masyarakat dan Perempuan (Community and Women’s Empowerment Office)</td>
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<tr>
<td>LBH</td>
<td>Lembaga Bantuan Hukum (Legal Aid Institution)</td>
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<tr>
<td>LBH APIK</td>
<td>Lembaga Bantuan Hukum Asosiasi Perempuan Indonesia Untuk Keadilan (Legal Aid Institution of Indonesian Women Association for Justice)</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>Mabes Polri</td>
<td>Markas Besar Kepolisian Republik Indonesia (National Police Headquarter)</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MoF</td>
<td>Ministry of Finance</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHA</td>
<td>Ministry of Home Affairs</td>
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<td>MoLHR</td>
<td>Ministry of Law and Human Rights</td>
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<td>MoRA</td>
<td>Ministry of Religious Affairs</td>
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<td>MoSA</td>
<td>Ministry of Social Affairs</td>
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<td>MoWE</td>
<td>Ministry of Women’s Empowerment and Children’s Protection</td>
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<td>MoA</td>
<td>Ministry of Agriculture</td>
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<td>MPW</td>
<td>Ministry of Public Works</td>
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<td>MoNE</td>
<td>Ministry of National Education</td>
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<td>NAP</td>
<td>National Action Plan</td>
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<td>P2TP2A</td>
<td>Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak (Integrated Service Center for Women’s Empowerment and Children)</td>
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<tr>
<td>Perda</td>
<td>Peraturan Daerah (Local regulation—Provincial or District Level)</td>
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<td>Perpu</td>
<td>Peraturan Pemerintah Pengganti Undang-Undang (Government Regulations Supersede Legislation)</td>
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<tr>
<td>Pergub</td>
<td>Peraturan Gubernur (Governor’s Regulation)</td>
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<tr>
<td>Perwal</td>
<td>Peraturan Walikota (Mayor’s Regulation)</td>
</tr>
<tr>
<td>Perbup</td>
<td>Peraturan Bupati (Regent’s Regulation)</td>
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<tr>
<td>PMKS</td>
<td>Penyandang Masalah Kesejahteraan Sosial (People with Social Welfare Problems)</td>
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<tr>
<td>Polda</td>
<td>Kepolisian Daerah (Provincial Police Office)</td>
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<td>Polres/TA</td>
<td>Kepolisian Resort/Resort Kota (District/City Police Office)</td>
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<td>Abbreviation</td>
<td>Full Name</td>
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<tr>
<td>Polri</td>
<td><em>Kepolisian Republik Indonesia</em> (National Police)</td>
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<tr>
<td>Polsek</td>
<td><em>Kepolisian Sektor</em> (Sub-District Police Office)</td>
</tr>
<tr>
<td>Puskesmas</td>
<td><em>Pusat Kesehatan Masyarakat</em> (Community Health Center)</td>
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<tr>
<td>PBB</td>
<td>Performance-Based Budgeting</td>
</tr>
<tr>
<td>PPRG</td>
<td><em>Perencanaan dan Penganggaran Responsif Gender</em> (Gender Responsive Planning and Budgeting)</td>
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<tr>
<td>PPSDMK</td>
<td><em>Pengembangan dan Pemberdayaan SDM Kesehatan</em> (Human Resource Development and Empowerment in Health)</td>
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<tr>
<td>PP&amp;PL</td>
<td><em>Pengendalian Penyakit dan Penyehatan Lingkungan</em> (Disease Control and Environmental Health)</td>
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<tr>
<td>PSAA</td>
<td><em>Panti Sosial Asuhan Anak</em> (Children’s Social Welfare Institute )</td>
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<tr>
<td>PSKW</td>
<td><em>Panti Sosial Karya Wanita</em> (Women’s Social Welfare Institution)</td>
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<tr>
<td>Renstra</td>
<td><em>Rencana Strategis</em> (Strategic Planning Document)</td>
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<tr>
<td>Renja</td>
<td><em>Rencana Kerja</em> (Annual Work Plan)</td>
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<tr>
<td>RPK</td>
<td><em>Ruang Pelayanan Khusus</em> (Police Special Desk/Room for Women Victims )</td>
</tr>
<tr>
<td>RPTC</td>
<td><em>Rumah Perlindungan dan Trauma Center</em> (Protection Shelter and Trauma Center)</td>
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<tr>
<td>RSCM</td>
<td><em>Rumah Sakit Cipto Mangunkusumo</em> (Cipto Mangunkusumo Hospital – State National Hospital)</td>
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<tr>
<td>RSUD</td>
<td><em>Rumah Sakit Umum Daerah</em> (Local Public Hospital)</td>
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<tr>
<td>RPSA</td>
<td><em>Rumah Perlindungan Sosial Anak</em> (Social Shelter for Children in Need of Special Protection)</td>
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<tr>
<td>RPSW</td>
<td><em>Rumah Perlindungan Sosial Perempuan</em> (Social Shelter for Women in Need of Special Protection)</td>
</tr>
<tr>
<td>Reskrimum</td>
<td>Reserse Kriminal Umum (General Crime Investigation Unit)</td>
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<tr>
<td>RKA</td>
<td>Government Annual Budget Work Plan</td>
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<tr>
<td>RPJMN</td>
<td><em>Rencana Pembangunan Jangka Menengah Nasional</em> (National Medium Term Development Plan)</td>
</tr>
<tr>
<td>RPJMD</td>
<td><em>Rencana Pembangunan Jangka Menengah Daerah</em> (Local Medium Term Development Plan)</td>
</tr>
<tr>
<td>SKPD</td>
<td><em>Satuan Kerja Perangkat Daerah</em> (Local government sectoral Working Unit, e.g. Health Agency, Social Agency, etc.)</td>
</tr>
<tr>
<td>TUPOKSI</td>
<td><em>Tugas Pokok dan Fungsi</em> (Task, Function and Responsibility)</td>
</tr>
<tr>
<td>UEP</td>
<td><em>Usaha Ekonomi Produktif</em> (Productive Economy Development Assistance)</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nation Children’s Fund</td>
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<tr>
<td>UN Women</td>
<td>United Nation Entity for Gender Equality and the Empowerment of Women</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>UPPA</td>
<td><em>Unit Pelayanan untuk Perempuan dan Anak</em> (Women and Children’s Service Unit)</td>
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<tr>
<td>UPT</td>
<td>Unit Pelaksana Teknis (<em>Technical Implementing Unit</em>)</td>
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<tr>
<td>WCC</td>
<td>Women’s Crisis Center</td>
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<tr>
<td>VAW</td>
<td>Violence against Women</td>
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<tr>
<td>SOP</td>
<td>Standard Operational Procedure</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>VAC</td>
<td>Violence against Children</td>
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CHAPTER 1
INTRODUCTION

1.1 General Background of the Study

Violence against women (VAW) and girls is one of the most systemic and widespread violations of human rights worldwide. It takes place in every country, in peacetime as well as in situations of conflict and crisis, and affects women and girls regardless of age, ethnicity, or socio-economic status. It takes many forms – from domestic and sexual violence, to harmful practices, trafficking, and “honor” killings and other forms of femicide. In East and Southeast Asia, many forms of violence against women have increased in recent years, with domestic violence being one of the most common but grossly under-reported forms of violence in the region. In Indonesia, VAW reported cases have been rising substantially over the years, where domestic violence consistently dominated the trend.

To respond to this increase in VAW cases, many countries have developed a National Action Plan (NAP) for prevention and prosecution of, and provision for violence against women and girls. To support the implementation of the NAP, a number of countries in East and Southeast Asia have developed systems and mechanisms for providing a multi-disciplinary package of services for VAW survivors, through integrated service centers, one-stop crisis centers, or similar institutions. Yet it is found that these Integrated Service Centers do not have sufficient budget, funding and capacity for implementation.

This study aims to inform a thorough understanding of the future administrative measures and budgetary allocations needed to implement national strategies and plans for combating violence against women and girls in Indonesia. It aims to do this by specifically looking at the services provided through the Integrated Service Center for Women and Girls. The outcome of this study will provide beneficial inputs for the UN Women East and Southeast Asia international campaign to eliminate violence against women and girls. One of the key outcomes of this campaign centers on the adoption and implementation of a comprehensive NAP on VAW, including sufficient resource allocation to translate policies and plans into transformative change on the ground.

1.2 Objectives

As a result of concerted efforts over the past decade to establish violence against women and girls (VAW) as a top global priority, including those by women activists, governments, UN Agencies and civil society, a number of key achievements have been made in recent years to end the culture of silence that has long surrounded this issue. The


crowning of all these efforts occurred with the unprecedented launch of the UN Secretary-General’s UNiTE to End Violence against Women Campaign, which calls on governments, civil society, women’s organizations, the private sector, the media and the entire UN System to join forces to end violence against women and girls. Under the overall umbrella of the UNiTE Campaign, UN Women East and Southeast Asia is implementing an AusAID-funded research project, entitled “Strengthening the Evidence Base on Violence against Women and Girls in East and Southeast Asia: 2011-2012”. The aim of the research is to improve the evidence base in key areas related to VAW where significant data gaps have been identified in the region. This aim is taken with a view to informing effective prevention and response strategies, including strategies for awareness-raising and advocacy, policy development, service delivery, and the monitoring of results. In particular, action-oriented research can serve as a powerful tool to encourage positive social change and to address the root causes of discrimination and the unequal division of power between women and men. In this way, this study will contribute to Outcome 3 of the UNiTE Campaign: All countries have in place data collection and analysis systems that support policies and programmes to end violence against women and girls.

1.3 Scope of the Study

The study limits its scope to provision of services to women victims of domestic violence (DV). The international and national commitments that provide the definition for DV that referred in this study are:

The General Assembly resolution on the Elimination of Domestic Violence against Women recognizes that DV:

“Can include violence against women and girls by an intimate partner, and by other family members, whether this violence occurs within or beyond the confines of the home, and manifested through: physical abuse, sexual abuse, psychological abuse, and economic abuse”.

The Indonesian Law No. 23/2004 on Eradication of VAW defines DV as:

“Violence in a household shall be any act against anyone, particularly a woman, bringing about physical, sexual, psychological misery or suffering, and/or neglect of the household, including threats to commit acts, forcing, or seizure of freedom in a manner against the law within the scope of the household”.

The definition of services in this study is determined based on the budget flow and referral for DV victims. Two types of services are distinguished. (1) Direct Service consists of budget expenditures directly related to the implementation of programs and activities handling women DV victims, including expenditure to pay honorariums/wages of labor, goods and services expenditures and capital expenditures. (2) Supporting Service consists of budget expenditure which is not directly related to the implementation of programs and activities handling women DV victims, but supports the quality of service delivery to DV victims. This includes, for instance, expenditure for training and socialization to service provider staff, and developing network and referral systems. The list of services has been provided by the UN
Women based on the Critical Service Initiative (CSI) with some adaptations (list of services provided in Annex 2).

This study is not a representative study of the state of services nationally, yet it does reveal patterns of inconsistencies where the policies and procedures do not match budget allocations, thus causing a gap in available services. While the current study is limited to DV and provision of services, it is possible in the future to amplify the scope of study to include other forms of VAW, and other aspects of services for DV victims, such as prevention and prosecution, using the same methodological approach.

1.4 Conceptual Framework

a. Critical Path (Itinerary) of Victims

Figure one captures the critical path or itinerary of women experiencing violence from an intimate partner. When women experience domestic violence, they show different kinds of responses. Because of the nature of the violent relationship some women do not seek help early on. There is a tendency to justify the facts and hide the aggression, and with time victims tend to withdraw from social participation. In addition violence is experienced and witnessed by others in the household, especially children. Depending on personal circumstances and the severity of the violence, but also on the effects of campaigns and sensitization as well as on the needs of the victim, there comes a moment when the victim contacts the services available in order to seek help and support.

Figure 1: Itinerary of a victim of VAW

b. Gender Responsive Budgeting (GRB) Approach

GRB involves the analysis of the government budget in terms of its impact on women and men, girls and boys.\(^4\) As a part of a mainstreaming strategy it aims to ensure that general commitments to gender equality are reflected in the way in which resources are allocated and spent within the policy processes\(^5\). More than 90 countries across the globe have engaged with GRB in the past ten years\(^6\). Across the Asia Pacific region, there are two important steps carried out by government in the implementation of GRB: organizing trainings and capacity building workshops on GRB; and the production of Gender Budget Statements in sector plans and budgets. Although it is acknowledged that Gender Budget Statements vary and depend on the budget system of the countries where they are applied, it has been acknowledged that there should be a better format with an adequate mix of qualitative and quantitative data. Meanwhile, more significant effort is still needed by practitioners, policy makers and women’s organizations to ensure that GRB is integrated into the institutional, political and policy making sphere of public policy.\(^7\) Given the commitments to combating and addressing the consequences of VAW embodied in Indonesian legislation and policy, this exercise tracks the expenditure and the sources of finance for delivering services to victims of VAW.

1.5 Methodology

a. Research Design and Analysis

The methodology for this study follows the Manual for Costing a Multidisciplinary Package of Response Services for Women and Girls Subjected to Violence provided by UN Women East and Southeast Asia. The Manual has been developed to be used in studies in Cambodia and Indonesia; the use of it in Indonesia has been adapted to the budgeting system and political context of that country. Hence, this study has also contributed to the refining of the manual, which will be useful for further study on the issue in the future.

The components of the study are:

Systematic document analysis, which involves identifying the legal, administrative and policy documentation needed to assess the present situation with regard to government efforts to address and prevent VAW, and mapping the general environment for advancing a multidisciplinary or holistic approach to preventing and combating VAW. The main government documents that are analyzed include DV Law, Civil Law, government strategic documents, including the National Medium Term Development Plan, (RPIMND) and the Local Medium Term Development Plan (RPIMND), and Action Plans. The review is presented as Environmental Scan matrix appended in Annex 3.

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\(^7\) Mishra, Y. 2011. Breaking New Frontiers for Gender Responsive Budgeting: the Kerala Model.
Annotated bibliography, which involves obtaining knowledge of the most relevant research on VAW carried out recently in the country that can be used as further input into in the previous mapping exercise. The literature review is carried out on the most recent research and reports written on the issue, and documents published by government, NGOs, as well as UN and International Conventions.

Budgetary analysis, which involve slinking the activities stipulated by the law and/or national plans/strategies on DV with government budget and work plan. Government main documents (budget circular, medium term expenditure framework, budget statement, annual work/action plan of the ministries, etc.) are analyzed to get an understanding of the macroeconomic picture and political economy of the government. The analysis also helped the developers of the interview guide to focus their questions on the different sectors providing services. The information on services and budget derived during fieldwork is then transcribed, organized, and systemized by using tools provided in the manual, with some adaptations in order to assess the capacity of entities responsible for implementation of DV programs.

b. Fieldwork

Data collection in 46 institutions was carried out during fieldwork from May to June 2012. The informants in the study are staff at the key line ministries responsible for addressing DV, Satuan Perangkat Kerja Daerah (SKPD/LocalWork Unit) at the province and district level, and NGOs. The list of institutions/organizations as the sources of the data can be seen on Annex 1.

DKI Jakarta (Jakarta Special Capital Region) and Yogyakarta (DIY - Special Region of Yogyakarta) have been selected as research locationen, because these provinces have a greater density of services for DV victims compared to other provinces. Hence they allow for the analysis on and tracking of the budgetary allocations. DIY is also selected because it had an established referral system even long before government initiated the Minimum Standard of Services on integrated services for women and children victims of violence (MSS). In DIY, Gunung Kidul District is selected to represent a rural area whereas Yogyakarta City is selected to represent an urban area. The selection of DKI Jakarta and DIY is not intended to represent the situations in all provinces in Indonesia. It is important to acknowledge that other provinces may have less capacity in terms of budget and human resources, and may have different demographic situations. This has impacted on the lesser capacity of the provinces/districts/cities to implement MSS, or to allocate resources to provide services to DV victims.

Data on services and budget are collected during interviews, which cover information in four key areas: (i) knowledge of responsibilities, assessment of the challenges and how to tackle them; (ii) identification of resources needed and their financing; (iii) knowledge of how to adequately cost services (iv) knowledge of how to prepare budget for the resources needed.
c. Preliminary and Validation Workshop

Before doing fieldwork, the research team held a workshop which was attended by government and non-government entities. The workshop aimed to obtain a global picture of the programs/activities carried out by these entities regarding their efforts to handle DV cases, the funds budgeted for the programs, and the sources of the funds. In addition, the workshop also aimed to build contact with resource persons to be interviewed during fieldwork. After the fieldwork, the research team held a workshop to validate initial findings. The workshop attended by staff/institutions interviewed during fieldwork, and also UN agencies including UN Women and UNFPA. The validation workshop allowed the research team to triangulate qualitative data, and to gather more information which had not been obtained during fieldwork.
CHAPTER 2

SITUATION OF DOMESTIC VIOLENCE AND THE SERVICES ADDRESSING THE PROBLEM

2.1 Situation Analysis of the Violence Against Women in Indonesia

There has been a steady increase in the number reported cases of VAW in Indonesia. The National Commission on Violence against Women (Komnas Perempuan) issues an Annual Note on the status of VAW. In 2010 the Note stated that reported VAW cases had quadrupled in the period 2007-2010 from 25,522 cases to 105,103 cases. The violence takes forms of sexual, physical, and psychological violence, trafficking, violence against migrant labor/workers, and female child abduction. Domestic violence dominated the trend in VAW cases, and in 2010 accounted for 96% of all VAW cases reported. Various national surveys estimated that 3 to 27% of married women have been abused by their spouses, at least once in their lifetime.

Figure 2. Trend of reported VAW cases in Indonesia

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9 UNFPA and The Ministry of Women’s Empowerment Assessment: Capacity of Service Providers for Women and Children Victims of Violence in Papua and NTT (Kapasitas Penyedia Layanan bagi Perempuan dan Anak Korban Kekerasan di Papua dan NTT).
Numbers of reported cases of VAW in several provinces including DKI Jakarta, East Java, Central Java, South Sumatera, and West Java are among the highest\(^{10}\). Meanwhile, districts/cities such as Indramayu, Karawang, Blitar, Sukabumi, Banyuwangi, Mataram, Flores, Batam, Pekanbaru, Medan, and Manado are notable as source and transit places for trafficking\(^ {11}\). Women and children also have high risk of being victims of trafficking, sexual harassment, and sexual violence in conflict and disaster areas such as in Aceh, Ambon and East Nusa Tenggara\(^ {12,13}\). In Papua, VAW cases recorded were related to natural resources and militarism issues\(^ {14}\).

The Indonesian society is dominated by a patriarchal culture which puts women in a position as submissive partners of their husbands\(^ {15}\). Unpleasant or even abusive treatment from a spouse is regarded as a family matter that should not be made public, otherwise it will bring shame to the wife/woman herself\(^ {16}\). the community often considers a woman a victim because of her own behavior that made her deserve the violence she receives. Hence,


\(^{11}\) Amiruddin, Jaorana, dan Wijaksana MB. 2005. *Mendorong Inisiatif Lokal di Era Otonomi Daerah Kekerasan terhadap Perempuan Menghapuskan, Komnas perempuan*

\(^{12}\) *Gender Based Violence in Aceh, Indonesia, a Case Study (UNFPA).*


women tend to be reluctant to report their cases for fear of stigma or a negative image from society. This circumstance not only makes VAW cases remain underreported, which make policy responses difficult, but also makes it harder for a woman to gain access to service provider institutions to get help.\(^\text{17}\)

Since the enactment of the Law on Eradication of Domestic Violence (DV Law) in 2004, the number of service providers for VAW victims of gender-based violence has increased, including government Integrated Service Centre for Women’s Empowerment and Children (P2TP2A), and Women and Children Service Unit (UPPA/). However, the increase in number has not been followed by an increase in service quality. A study\(^\text{18}\) shows that in general, service providers’ staff are not gender sensitive and have not been provided with adequate capacity building training. Many service institutions do not have sufficient and representative facilities, particularly shelters for victims. Only a few hospitals are equipped with integrated crisis centres to provide special services for women and children victims of violence, while many service providers at sub-national level do not have sufficient fund allocation. Civil Society Organizations (CSOs) still play a significant role in provision of services to violence victims, especially in cases of psychological violence, trafficking, and violence against abused migrantworkers. In terms of legal assistance and prosecution, domestic violence was most likely reported to the higher religious court,\(^\text{19}\) as the basis for filing for divorce. According to the Ministry of Law and Human Rights (MoLHR) domestic violence was often processed as a divorce case relating to civil code (perdata), and rarely processed as criminal act (pidana). Even if it was processed as a criminal act, requiring legal proceedings for prosecution the case was often dropped halfway, unsupported by the legal enforcement officials (police, attorneys, and judges) who lack gender awareness.

Regulatory framework to address VAW in Indonesia has been developed, started by the enactment of Law No. 23 on Eradication of Domestic Violence of 2004 (DV Law) and by the development of the Minimum Standard of Services (MSS) in 2010 for integrated services provided to VAW victims. MSS is an important instrument to ensure fulfillment of the rights of women victims of violence. Yet the implementation of the standard faced challenges, including the absence of a mechanism for coordination among service providers, local government institutions, and legal and judiciary institutions\(^\text{20}\). Furthermore, the mechanism


\(^\text{18}\)Rifka Annisa, the Ministry of Women Empowerment and UNFPA. 2007. Assessment Report on Providers of Services for Victims of Gender Based Abuses.


for cross sector cooperation and coordination in the referral system is informal and dependent upon certain individuals.\textsuperscript{21}

2.2 Regulatory Framework for Service Provision to Victims

Provision of services to DV victims, as mentioned briefly above, is mandated by legislations and policies. This is the basis for ministries and government service providers to develop their programmes, and later on their budget to provide services for DV victims. This section discusses the regulation and reveal the gaps existing in the regulations and action plans addressing services for DV victims. The description and analysis of the legal environment is conducted by taking into account the context of decentralization and current initiatives of Gender Responsive Budgeting under the framework of a Performance-Based Budgeting (PBB) system. This system has shaped the way macro- and micro-referral systems for addressing DV victims are arranged.

\textit{a.} Regulations Addressing Services for DV Victims

In response to the ratification of the CEDAW, the Indonesian government enacted Law No. 23/2004 on the Eradication of Domestic Violence Law (DV Law). The DV Law basically defines the scope of DV victims’ rights, and stipulates government’s obligation to provide protection, rehabilitation, and legal prosecution in order to uphold DV victims’ rights. Following the enactment of the DV Law, there has been arguably a plethora of regulations to address VAW created in Indonesia. Complete list of regulations is presented as Environmental Scan Matrix in ANNEX 3.

The most significant national regulations for realizing the mandates stipulated in the DV Law are in the Government Decree No. 4/2006 on Management and Cooperation for Recovery of DV Victims. This regulation gives mandates to the Ministry of Women’s Empowerment and Child Protection (MoWE) as the leading agency for establishing referral systems and coordinating integrated services for DV victims. In response to this, MoWE has launched regulation No. 1/2010 on the Minimum Services Standard (MSS) on Integrated Services for Women and Children Victims of Violence. This regulation sets key tasks and responsibilities of ministries and local government agencies to support provision of services. The key ministries and state agencies are MoWE, Ministry of Health (MoH), Ministry of Social Affairs (MoSA), Ministry of Religious Affairs (MoRA), Ministry of Home Affairs (MoHA), Ministry of Law and Human Rights (MoLHR), Ministry of Finance (MoF), National Police, Attorney General, and Supreme Court. At the sub-national/local level, government and state agencies responsible include Governors, Heads of District/Mayors, and Local Government Agencies (i.e. Women’s Empowerment Agencies and Health Agencies). The regulation also sets key tasks and responsibilities of Unit Pelaksana Teknis (UPT/Technical Implementer Units) such as hospitals, puskesmas (Community Health Centers), and shelters, to provide

\textsuperscript{21} Rifka Annisa, the Ministry of Women Empowerment and UNFPA. 2007. Assessment Report on Providers of Services for Victims of Gender Based Abuses.
direct services to DV victims. In addition to stipulating the responsibilities of each institution, this regulation also provides standard operational procedures (SOP) as guidance for implementing the MSS.

The MSS specifically gives a mandate to MoH, MoSA and National Police to formulate policy and strategy for handling DV victims in the areas of health, social rehabilitation, and legal enforcement respectively. It does this by designing general and technical guidelines, developing SOP and indicators for services, and carrying out coordination/facilitation, advocacy, capacity building, and monitoring/evaluation.

Various Ministerial Regulations to address VAW have also been enacted in relation to provision of services. Even before the DV Law was enacted, a joint circular signed by the Ministers of Health, Women’s Empowerment, and Social Affairs and by the Chief of National Policy on provision of integrated services for VAW victims had been issued. Subsequently, MoH issued Minister of Health Decree No. 563/2003 on Designated Officials responsible for the coordination stipulated in the joint circular. Prior to the MSS, MoH issued decree no. 1226/2009 on the Guidelines for the Management of Integrated Services for Victims of Violence in Hospital. The MoH also published a book on Guidelines for the Development of Community Health Centres (Puskesmas) to enable them to handle cases of violence against women and children. These regulations aimed to ensure the availability of health services for DV victims at the local level.

To support MSS implementation, two Ministries and National Police issued regulations to provide guidelines for the implementation of MSS, namely:

- The Ministry of Social Affairs stipulated Decree No. 80/2010 on the Guidance of Financial Planning for Achieving MSS in Social affairs at Province and District Levels. MoSA, through the General Directorate of Social Protection and Security, has also responded to the need for basic services, not only for DV victims but also for migrant workers, by stipulating several decrees. The National Police has enacted several regulations to ensure legal protection to DV victims, including the Head Police Regulation No. 10/2007 on the organization and function of the Women and Children’s Service Unit (UPPA - Unit Pelayanan untuk Perempuan dan Anak), and Regulation No. 3/2008 on the Establishment of Special Desks/Rooms for Women in Police Offices (RPK- Ruang Pelayanan Khusus) for witnesses and victims of VAW.

- The Ministry of Home Affairs issued Decree No. 100/2011 on the Acceleration of the Implementation of MSS in the Region, which include the MSS on Integrated Services for DV victims.

Other ministries and state agencies mentioned in the MSS, such as the Ministry of Religious Affairs (MoRA), Supreme Court and Attorney General, have not yet enacted regulations to respond to the DV Law.

At the local level, the Women’s Empowerment Agency is given a mandate to lead MSS implementation. Like MoWE, the Women’s Empowerment Agency is responsible for
establishing a referral system addressing DV issues and coordinating the integrated services for DV victims. Usually the Women’s Empowerment Agency encourages the enactment of local regulations issued by governors, mayors and regents (Perda, Pergub, Perwal and Perbud) on Protection of Women and Children to address DV issues. It also establishes a coordination forum of integrated services, and arranges technical guidance for handling DV victims. DIY and DKI Jakarta Province, and Yogyakarta City have had a coordination forum of integrated services for DV victims even before the enactment of the regulation on protection of women and children. Meanwhile, vertical government institutions at the Provincial and district levels, including Polda and Polres, the High Court and State Court, and High Attorney and State Attorney, do not enact regulations, but rather implement regulations that are formulated by the Head of National Police, Head of the Attorney General, and Head of the Supreme Court respectively.

b. Sectoral Action Plan on Services for DV Victims

Government’s commitment to DV issues is also reflected in government strategy documents. The government commitment on DV issues has been incorporated in National Medium-Term Development Plan 2010-2014 (RPJMN 2010-2014) that points out the third mission for strengthening equality in all sectors:

*In order to realize gender equality and equity, we should improve access for and the participation of women in development, as well as improve the quality of women’s empowerment and children protection. Such facilities as have been built during the period 2004-2009, such as Integrated Services for Protection of Women and Children, Integrated Crisis Centers, and Special Assistance in several provinces/districts, should be spread to the entire country.*

The study found that although all institutions responsible for handling DV victims have strategic plans, not all of the strategic plans address DV issues or Integrated Services for DV victims. Strategic plans of MoWE, Ministry of Law and Human Rights (MoLHR), MoH and MoSA specifically address DV issues and put them as a priority. MoWE’s strategic plan, for instance, mentioned a “zero tolerance” policy on VAW, which translates into efforts at preventing VAW, improving access to services, and empowering DV victims. Meanwhile, MoLHR’s strategic plan targets DV as a critical issue to be prioritized in legal enforcement advocacy in order to fulfill DV victims’ rights. MoH’s strategic plan discusses DV, in the context of giving access to health services to DV victims by improving the quality of *Puskesmas* and hospitals. MoSA’s strategic plan includes services to DV victims in the broader framework of services to “victims of violence and migrant workers” in addition to six other strategic issues (poverty, disability, neglect, social disability, exclusion, victims of disaster). Specific discussion on DV issues cannot be found in the strategic plans of MoHA, MoRA, Ministry of Finance, Supreme Court, Attorney General and National Police, although gender mainstreaming or gender equality issues are mentioned.
BOX 1. Gap in Legislation

DV Law has been responded by some ministries by enacting implementing regulations and policies prescribing technical guidance on provision of services for DV victims. Although the existing regulations may reflect government legal commitment to address DV issues, this study found that there are several problems existed in those regulations as can be identified below:

Inconsistency of Laws
Although DV Law is considered a breakthrough to provide legal framework for DV victims to seek justice, it has not been supported by existing Laws that are still gender biased. One example is definition of sexual violence, that has been recognized as form of gender-based violence in DV Law, while Penal Code defines it as ‘crime against morality’ This inconsistency affects the perception of legal enforcement apparatus and the way they handle DV cases. Another example is The 1974 Marriage Law stated the responsibility of women and men to uphold their marriage as the pillar of society. Hence women who file a divorce case (because she has been abused or so) are tended to be blamed for eroding family harmony and receive unfair treatment during litigation process.

Evaporation of Government commitment to DV issues in the strategic/planning document

The fact that DV issues and integrated services for DV victims are mentioned in Medium-term Development Plan (RPJ MN) is not automatically translated into the strategic plan of the ministries/government agencies. The ministry/agency has responded the DV Law by formulating regulations and policies, but the priority on DV issues and integrated services for DV victims are not reflected in the strategic plan, thus are absent in their programs/activities and budget allocation. Chapter 3 will give an explanation on this issue.

Weak Institutional Authority to Coordinate MSS Implementation

Horizontal coordination among sectoral Ministries is still a challenge. MoWE has mandate to be a leading agency to coordinate MSS implementation (MoWE Regulation No. 1/2010), yet they have no authority to push sectoral government agencies at sub-national level to implement the MSS. In fact, the responsibility to disseminate MSS implementation in the local level is on the hand of MoHA (MoHA Decree No. 100/2012), and therefore, it is MoHA who has authority to push local government to implement the MSS. Unfortunately, MoHA do not have capacity and competency on women issues hence will find difficulty to advocate the implementation of MSS to the local governments.

Programme Overlap with Less Added Value

As defined by the MSS, the ministry/government agency is responsible for providing supporting services, while the UPT is responsible for carrying out direct services. In reality, there are several ministries/government agencies which also provide

2.3 Addressing the Needs of DV Victims

a. Implementation of the Referral System

The MSS has designed a referral system that integrates various services for DV victims. There are two levels of implementation that can be distinguished in this system; the macro-referral system and the micro-referral system. The macro-referral system consists of the institutional environment and structural relationships of the supporting institutions in the overall referral system. It is related to laws, policy, roles and coordination at the top level whether it be National, Provincial, District or City. On the other hand, the micro-referral system focuses on the organizational and individual capacity of institutions (such as Unit Pelaksana Teknis (UPT / the Technical ImplementerUnit)) and their key stakeholders and/or networks directly providing the services. In other words, it can be said that the macro-referral system is related to supporting services (services not directly related to the victims but supporting the good delivery of direct services), whereas the micro-referral system relates to direct services or services that can be accessed directly by victims. Figure 2 shows the mechanism of the micro-referral system.
MSS gives separate mandates to institutions that play a role in the two referral systems. The Ministries are given a mandate to operate at the macro level:

- MoWE has the responsibility to lead the National Program of Integrated Services for Women as victims of violence, to monitor and evaluate, and to report the outcome to the President.

- MoHA has the responsibility to provide general guidance and monitor the implementation of the MSS by regency/municipality governments.

- MoH is responsible for setting the norms, standards, guidelines and criteria of health service for women and children as victims of violence. It also has the responsibility to provide integrated service facilities at central and regional hospitals, and also at puskesmas that are able to deliver services in cases of violence against women and children. The Ministry must also facilitate the availability of human resources (health workers) and capacity building.

- MoSA is responsible for developing the operational guidelines of social rehabilitation services, and conducting trainings to improve the capacity of the social workers who deliver the services to DV victims.

- MoRA has the responsibility to develop the operational guidelines for spiritual counseling for VAW victims and to conduct trainings, supervising and coaching for spiritual counselors.

- The National Police is responsible for developing the operational guidelines of UPPA and setting up the UPPA at the provincial and district levels. It is also responsible for conducting trainings in capacity building for its personnel.

- The Attorney General is responsible for holding trainings for attorneys in relation to cases of violence against women and children.

- The Supreme Court is responsible for training judges in handling VAW cases with a victim-oriented perspective.

These ministries and state agencies at the national level act under the coordination of MoWE to fulfil their responsibilities and to support enabling systems that support the delivery of services for women and children victims of violence. These include buildings, equipment, regulations, budget and well-trained human resources.

On the other hand, the micro-referral system consists of institutions/agencies which deliver direct services to victims. Different from the macro-level referral system, which involves only governmental institutions, the micro-referral system includes non-governmental
organizations (NGOs). There are five types of services provided in the integrated referral system for VAW victims as stated in the MSS:23

a) Complaints and reporting of violence cases; provided by the Integrated Service Unit (P2TP2A, UPPA, Shelter and Trauma Center (RPTC)), Social Shelter for Children in Need of Special Protection RPSA - Rumah Perlindungan Sosial Anak (RPSW - Rumah Perlindungan Sosial Wanita), Puskesmas, Hospitals, Lembaga Bantuan Hukum (LBH/Legal Aid Institution), and Women’s Crisis Center (WCC).

b) Health Service, provided by Puskesmas and hospitals.

c) Social Rehabilitation Services, which consist of counseling, providing shelters, and spiritual guidance. Social Affairs Agencies, Women’s Empowerment Agencies, WCC, and NGOs have the responsibility to provide psychological counseling and shelters. The spiritual guidance is provided by Board of Marriage Counseling and Advisory (BP4 - Advisory Badan Penasihat Pembinaan Pelestarian Perkawinan the).

d) Legal Aid and Law enforcement. The Police, through UPPA, carry out investigations and examinations, and the attorneys carry out prosecutions, while courts (judges) have the responsibility to lead the litigation process in court and make court decisions.

The micro-referral system has been designed as an integrated service mechanism in which the institutions listed above provide a referral system to assess victims’ needs and (when they do not have the capacity to deliver the services needed) refer victims to the institutions which provide the needed services.

**BOX 2. Challenges on the Implementation of Referral System**

*The Services to DV victims is not institutionalised*

The services for DV victim has not been integrated in the program planning, budgeting, and human resources capacity building up to the process of evaluation in the institutions in responsible for services. The handling of DV victims is still carried out sporadically and is not reflected in the documents of the respective institutions. The programs of DV victims handling at provincial and regional level were usually coordinated by the Women Empowerment Agency. However, the Women Empowerment Agency played the role as a coordinator only once in a while whenever there was any DV case that should be handled together with other institutions. Furthermore, the coordination of the services for DV victims was often carried out based on individual commitment. While this personal commitment has been contribute to make the services are responsive to DV victim, this is not sufficient for the sustainability of the activities at the institutional level.

*Insufficient coordination among referral institutions*

Coordination is very important as this system relied on the institutional network tied under the MoU. However, some services are overlap, and some services are carried out by the institution that was not mandated to do so. In DKI Jakarta, services for DV victims is free of charge if victim are accompanied/referred by P2TP2A or by the Women Empowerment Agency. If victim come to the service providers by themselves or accompanied/referred by NGO/WCC, victim must pay for the services. In reality, most of the times, victims did not go first to P2TP2A for seeking help, rather they went directly to the institution which provide services they need, such as hospital or shelter. This situation often complained by NGOs staff who are often have to bear the cost for services, while they are currently facing budget constraint.

*Weak Organisational capacity*

Not all staff has been trained on gender issues, and in particular, on providing services to women victims. In one Puskesmas in DKI Jakarta Province, there was only one staff that had been trained on DV case handling. As consequence, the puskemas could not perform a full standard protocol as required by the MSS to DV victims as not all staff (including front desk personnel who receive complaint) had never been trained on DV case handling.

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23 This study excludes discussion on the institutions/agencies which responsible for repatriation and social reintegration because this service is more related to migrant workers.

b. Services in the Referral System

The study found an itinerary for women in accessing and receiving services as reflected in Figure 3. There has been an increasing trend of women’s reporting their cases to women’s crisis centers (run by NGOs) or P2TP2A (run by the government). This trend can be attributed to communities’ increased awareness about sexual and gender based violence. In addition, there have been more institutions giving assistance to women who become victims of violence which are trusted to maintain confidentiality. Crisis centers run by NGOs
normally have separated and private consultation rooms which make DV victims feel comfortable and not afraid that their case will be publically disclosed.

Women’s Crisis Centres (WCCs) and P2TP2A assess victims’ needs and then give service options (health, social rehabilitation, legal assistance, or social reintegration). If the victim agrees to further treatment, she will be referred to relevant service providers (i.e. hospitals, shelters, or police). In most cases, DV victims come directly to hospital/Puskesmas when they get injured. In hospitals which have an integrated crisis center, victims will be handled by staff who have been trained to provide services for VAW victims. Hospitals that have a Memorandum of Understanding (MoU) with other service providers will assess victims’ needs and refer them to relevant service providers. However, hospitals that have MoUs are few (for instance there is only one in Yogyakarta). In a hospital which does not have an MoU, victims usually only receive health treatment for their injury.

Victims sometimes go to the police, yet, despite the mandate of police to be more responsive to women victims needs and work closely with other institutions in the referral system, the police tend to tell a victim to go home to solve the problem first through family discussion. The police are willing to process a report by a victim only if they can clearly categorize the incident as a crime (for instance rape)\textsuperscript{25}.

Victims who are in danger, feel insecure, or have been abandoned by their families can stay at shelters which are provided by P2TP2A, WCCs, or Social Affairs Agency. Victims a allowed to stay at the shelter for a maximum for two weeks, because of the high operational costs of these shelters. The highest budget in this case is for staff salary/honorariums, transport and logistics outreach, living costs at the shelter, monitoring, communication, security, renting a house and management.

\textbf{Box 3. Staff Pays the Cost of Services from Their Own Pocket}

Indonesia has been applying referral system in providing service to women victims of violence, in which victim could come to either community health center/hospital, Police, WCC, or P2TP2A for reporting violence case. In these institutions, victim will be given service according to their needs. If an institution visited by client does not provide the service needed, the institution will refer them to appropriate service providers. The effectiveness of referral system in Indonesia has been varied across region and district. Some region has dense service providers and well-functioning system such as in NTT and Cirebon. In district that has been successfully applying referral system, leadership commitment and staff capacity play a critical role.

The cost borne by women who became victims of violence consists of direct and indirect cost. Direct cost consists of cost for searching information and access the services (transportation, logistic, and administrative), cost for medical care (medicine, doctor visit and laboratory), and litigation cost. Meanwhile, indirect cost is income lost during legal process, as well as during getting health care. Rifka Annisa calculated the cost (direct and indirect) of services to women who became victims of violence was minimum Rp130,000, and maximum Rp1,200,000 for a day. Generally, the highest cost was for medical care and litigation services. In Rifka Annisa for instance, the cost of counseling service (outreach, logistic, transportation, and communication) consumed 20% of the total annual budget. This cost is borne by Rifka Annisa.

The itinerary of DV victims accessing services as found in this study is quite different from the referral scheme as designed by the MSS. The comparison of Figure 4 and Figure 5 shows that victims do not access services only through the institutions that are given a mandate by the MSS to accept complaints. Instead, they go directly to any service according to their needs. The Women’s Empowerment Agency plays the role of coordinator only once in a while, whenever there is any DV case that should be handled together with other institutions. Furthermore, the coordination of services for DV victims is often based on the commitment of individuals. While this personal commitment has contributed to making the services responsive to DV victims, this is not sufficient for the sustainability of the activities at the institutional level.
Figure 5: Real Itineraries of the Victims

- **VICTIM** → P2TP2A
  - Psychological couns
  - Legal assistance
  - Shelter
  - Empowerment

- **VICTIM** → Puskesmas
  - Health treatment
  - Visum et Repertum
  - Psychological counseling (DKI) (Jogja)

- **VICTIM** → Hospital (PKT)
  - Health treatment
  - Visum et Repertum
  - Psychological couns
  - Psychiatrist
  - DNA test
  - Autopsy

- **VICTIM** → RPTC
  - Shelter
  - Counseling
  - Empowerment
  - Health

- **VICTIM** → UPPA
  - Hospital

- **VICTIM** → UPPA
  - Hospital

- **VICTIM** → P2TP2A
  - Hospital

- **VICTIM** → UPR
  - Reporting
  - Investigation
  - Referral

- **VICTIM** → NGO/WCC
  - Psychological couns
  - Legal assistance
  - Shelter
  - Empowerment

- **VICTIM** → BP4
  - Mediation

- **VICTIM** → Community Group
  - Reporting
  - Referral

- **VICTIM** → Attorney
  - Hospital
  - NGO
  - Shelter
  - Social Service

- **VICTIM** → Police
  - P2TP2A
  - NGO/WCC
  - Hospital

- **VICTIM** → UPPA
  - Hospital

- **VICTIM** → Shelter
  - P2TP2A
CHAPTER 3
BUDGETARY ANALYSIS

This chapter analyzes budgetary allocation for services for DV victims at the national and sub-national levels through the lens of multi-services packages. The first section provides an overview of the Indonesia budget system. This overview discusses the context of decentralization which currently defines the national and local government administrative structure and the current initiative of Gender Responsive Budgeting (GRB) under the Performance-Based Budgeting (PBB) system. This structure and current development have opened the space to confirm government commitment, but at the same time confine the planning and budgeting of services for DV victims at both the national and sub-national levels. The second section specifically identifies and describe how entities in charge of services for DV victims as discussed in Chapter 2 allocate budget for the services. The government of Indonesia introduced an integrated service for DV victims with the introduction of MSS in 2010. Yet, the service has not been effectively implemented, as has been discussed in Chapter 2. Hence, this section looks at budget allocation of services separately per sector tp get a picture of the way the integrated service is functioning at the moment.

3.1 Overview of the Indonesia Budget System

a. Regional Autonomy and its Implications for Budget Allocation for Provision of Services

The national-local government competency relation in Indonesia is defined by the Law No. 32/2004 on Local Government and Law No.33/2004 on Financial Balancing between National and Local Government. These laws define province and district/city as autonomous regions. The Law decentralized most of competency or function to local government, including matters pertaining to health, education, social issues, population and civil registration. These matters are stipulated as mandatory competency, that must be carried out by the local government. In addition, the local government is also given optional competency or function, pertaining to the improvement of community’s welfare, that is tailored to local conditions. Some competencies remain centralized including judicial authority, religion, security, defense, monetary and national fiscal and foreign policy.

The matters related to empowerment and protection of women and children are not explicitly mentioned either as mandatory or optional competencies. The distribution of competencies particularly related to the empowerment and protection of women and children is defined by the Government Decree No. 38/2007 on the Division of Competencies among the National, Provincial, and District governments. The Decree defines the responsibilities of each level of government as follows:

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26 The Law No.32/2004 emphasizes regional autonomy at district level, hence the provincial government has no authority over district government. Budget at both regions is still largely depends on the national budget, but its allocation is left entirely to the local government.
Table 1: The Implementation of Women’s Protection Policy in Indonesia  
(According to the Government Decree No.38/2007)

<table>
<thead>
<tr>
<th>Sub-Program</th>
<th>National Government</th>
<th>Province</th>
<th>District/City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s protection policy</td>
<td>Formulation of national policy on protection of women against violence, and of women workers, disabled and elderly women, and women in conflict and disaster affected areas.</td>
<td>Formulation of Provincial policy on protection of women against violence, and of women workers, disabled and elderly women, and women in conflict zones and disaster affected areas in the province.</td>
<td>Implementation of policy in districts/municipalities on protection of women against violence, and of women workers, disabled and elderly women, and women in conflict and disaster-affected areas in the district/municipality.</td>
</tr>
</tbody>
</table>

From Table 1, it can be seen that the responsibility for protection of women and children is equally distributed among the national, provincial and district/city levels, where the differences lie in scale or scope of activities at each level. These different scale of operation are rather ambiguous and could potentially cause confusion of authority and responsibilities between the national, provincial, and district/city governments in addressing DV issues.

The Law No.33/2004 on Regional-National Financial Balance stipulates fiscal relations between the national and sub-national level of government. The Law defines three types of budget flows from the national to province and district/city government:

- Decentralization fund consists of a balance of funds transferred by the national government to local government for implementing decentralized competency. This balance fund comes from National Budget (APBN) (the national budget) which consists of General Allocation Fund Dana Alokasi Umum (DAU - / Dana Alokasi Umum General Allocation Fund) and Specific Allocation Fund Dana Alokasi Khusus (DAK - /Dana Alokasi Khusus Specific Capital Fund). DAU is a block grant that is transferred to local government to ensure equal financial capacity among regions to carry out obligatory and optional competencies. It is observed that the largest portion of DAU has been allocated to hire local public servants (salary), and a small portion of the budget is allocated for development and delivery of public services. DAK is an earmarked fund which is transferred to regions which have little financial capacity to help them fund vital activities that are the national government’s priority, such as program related to achieving MDGs.

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27 One example is RPTC managed by the MoSA and other shelters that are managed and owned by the provinces and districts.

28 In the system of public spending in Indonesia, the difference in the budget amount for hiring employees and for construction and public services has serious political implications. The public tends to perceive the larger budget amount for hiring employees as government’s showing more concern for bureaucracy than for community development. This public perception is quite reasonable because not all government employees provide direct services to the public.
• Deconcentration fund comes from National Budget APBN (the national budget) that is transferred by the Ministry to the Heads of Province (Governors) who act as the National Government’s representatives. Deconcentration funds are earmarked for non-infrastructure programs which are pre-determined by the Ministry. Most empowerment and protection of women and children programs in the regions are financed by this fund.
• The assistance (Medebwind) fund comes from National Budget funds which are transferred to province, district, and village and earmarked for certain tasks, specifically for infrastructure programs, pre-determined by the ministry.

Beside those three kinds of funds, there are also what are called Grant (hibah) and social assistance funds (bantuan sosial). These funds generally come from foreign and domestic aid agencies. In the local government, this fund is usually used for programs that are not included in the routine planning and budgeting for programs, but have an emergency purpose, for instance disaster recovery early response. Some local governments have used these funds for empowerment and protection of women and children programs. However, with the enactment of the Government Decree No. 2/2012 on Regional Grants and MoHA Decree No. 32/2011 on Guidelines on Grant and Social Assistance Allocation, the allocation of the grant and social assistance funds has become more stringent, with the allocation of funds to NGOs prohibited.

The flow of budget from the national level to provinces and districts/cities can be seen in Figure 4. At the national level, all revenue must go through the National Budget including Grant/Aid funds from either foreign or domestic donor agencies. APBN funds from the national budget are allocated to ministries/agencies at the national level. The ministries/agencies channel some portion of these funds to districts/cities directly. The largest ministerial budget allocation is dedicated to finance national priority policies areas such as education, health, economy and infrastructure. The ministries channel the funds to province sub-national level government agencies (province and district) through the deconcentration and assistance/Medebwind funds for programs that are considered national priorities. Deconcentration funds flow to the provincial level, while the assistance fund flows to district and village. Some local government agencies have established a Technical Implementing Unit (UPT – Unit Pelaksana Teknis) UPT as a unit that is authorized to provide direct services to the public, for instance puskesmas under the Health Agency, and P2TP2A under the Women’s Empowerment Agency.

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29 Deconcentration fund is only intended to fund activities that are non-infrastructure, e.g. for capacity building. This fund belongs to the ministry, its use has been established by the ministry and the local government just implements.
Figure 6: Indonesia’s Budgeting System

Legend:
- : budget flow
- : services access
- : vertical coordination
- : horizontal coordination

Source: Primary data
Budgeting Policies and their Effect and their Implication for Provision of Services for the Empowerment and Protection of Women and Children

The Ministry of Home Affairs Regulation No.13/2006 on Financial Management Guidelines categorizes two expenditure structures:

a. **Indirect (supporting) expenditure**, budget expenditure not directly related to the implementation of programs and activities. This type of expenditure can be measured indirectly by the expected outputs and outcomes, and by credible forms of personnel expenses to pay for the salaries and allowances of civil servants, subsidy grants, social assistance expenditures, expenditures for sharing revenue, financial aid and unforeseen expenditures. The large number of civil servants in Indonesia leads to indirect (supporting) expenditure being larger than direct expenditure.

b. **Direct expenditure**, the budget expenditures directly related to the implementation of programs and activities. This type of expenditure can be measured directly by the results of programs and by credible forms of the budget, considering efficiency in the achievement of outputs and outcomes for the expenditure to pay the honorariums/wages of labor, goods and services expenditures and capital expenditures.

The Performance-based Budgeting (PBB) System (PBSPBB) policy approach was established through the enactment of the Government Decree No. 21/2004. Although the PBS was introduced eight years ago, it has not been implemented effectively by all agencies as expected. One of the causes is the difficulty government agencies face in uniting different sources of planning and budgeting (such as strategic planning) into a single performance-based budgeting concept. Another challenge to the adoption of PBSPBB is the confinement of government ministries/agencies to covering only issues within their core task, function, and responsibility (tugas pokok dan fungsi/Tupoksi) according to national priorities in the National Medium-Term Development Plan. As a result, some ministries and government agencies which do not have the specific task and function to address women and children’s issues face difficulties in integrating services for DV victims into their programs and activities. Although policies (for example Presidential Instruction No. 9/2000 on Gender Mainstreaming) have been in place to ensure that gender equality should be integrated into all programmes in government Ministries, these have not been well adapted to service provision for women victims. Indeed, in the government structure, the ministries and institutions which have the specific task and function to address women’s issues are only MoWE at the national level and Women’s Empowerment Agencies at the sub-national level.

The Government of Indonesia also initiated the implementation of Gender Responsive Planning and Budgeting *Perencanaan dan Penganggaran Responsive Gender* (PPRG - / *Perencanaan dan Penganggaran Responsive Gender* Gender Responsive Planning and Budgeting) in 2009 and piloted it in seven ministries (MoWE, MoF, Ministry of Public Works (MoPW), Ministry of Agriculture (MoA), MoH, Ministry of National Education (MoNE), and Ministry of Planning BAPPENAS). However, a BAPPENAS study (2011) conducted in seven ministries and in four provinces (Banten, DIY, Central Java and East Java) found that the initiation of Gender Responsive Planning and Budgeting (GRBP) has encountered several obstacles including uneven commitments on gender equality, low capacity of
sectoral ministries to conduct gender analysis and the ad hoc nature of GRB monitoring. PPRG has faced obstacles in the implementation of GRBP. These obstacles include the following:

1. The majority of the proposed GBS is not a national priority, areas priority, or Ministry/Agency priority; thus there is no leverage for implementation.
2. There is a lack of specific legal basis for the implementation of PPRG.
3. There is a lack of commitment among policy-makers and advocates of PPRG.
4. PPRG is still isolated from the mainstream of regional planning, as the advocacy for PPRG was carried out through an ‘ad hoc’ task force.
5. There is a lack of understanding and human resources capacity for implementing PPRG.
6. A lack of monitoring and evaluation culture across all government ministries.

Decentralization and the shift towards PBB as well as current initiative on GRBP have unintended consequences for the institutionalization of government budget for provision of services. Room for local government to deliver services is opened by the decentralization of competencies. However, DV issues are still considered minor issues by most government institutions, so that the opportunity to obtain sufficient funds tends to be small and often confined within the women’s empowerment programme.

From an overview the budgeting system in Indonesia, it can be concluded that there is still a lack of clarity in the authority relationship between national, provincial, and district levels, which raises the possibility of overlapping services for the protection of women and children. With the introduction of regional autonomy, there are actually many sources of budget revenue that could be used to finance services for DV victims. However, DV issues are still considered minor issues by most government institutions so that the opportunity to obtain sufficient funds tends to be small. In addition, government officials lack the capacity and commitment to implement the PPRG/GRBP. More efforts are needed to align the principles of PBS PBB with PPRG and GRBP objectives in order for government to be able to respond to DV effectively.

3.2 Budgeting Services for DV Victims: Examining the Flow

As discussed in Chapter 2, there are a number of entities responsible for delivering services for DV victims. This section looks at how these institutions respond to this responsibility, specifically in allocating budget for supporting and direct services for DV victims. Different services reflected in this section are a result of both the environmental scan exercise (desk review of existing policies) and interviews with various entities in charge of services to DV victims. First, the section discusses how integrated services for DV victims are advocated for, coordinated, and facilitated by MoWE through implementing the MSS. Then it discusses how entities at national and sub-national levels provide services for DV victims in the areas of health, social rehabilitation, and legal aid and law enforcement. It then carries out an analysis of how these entities obtain money to fund their services; how this money is used to fund the services; and how the services are accessed by DV victims. The previous section on the overview of the budget system in Indonesia provides a background for the cases presented in this section.

a. MoWE’s Roles and Responsibilities for Creating an Enabling Environment for MSS Implementation
• Money Flow

In general, the budget for supporting MSS implementation predominantly goes to MoWE and Women Empowerment’s Agency. As seen in Figure 5, the budget for MoWE for initiating and implementing MSS comes from the National Budget and other sources of funding such as international agencies or the private sector. UNFPA gave funds to MoWE to support the drafting of MSS, and is currently, building a database for tracking VAW cases. GIZ also gave funds to MoWE for the GRB planning program and for supporting the MSS implementation.

Institutionally MoWE’s allocated budget for VAW is mainly channelled to the Deputy of Women’s Protection, which oversees the Assistant to the Deputy responsible for responding to cases of DV, and to the Deputy of Children’s Protection, which oversees the Assistant to the Deputy responsible for responding to cases of violence against children. The budget is used to fund programs/activities relating to the development of a referral system in 33 provinces, including trainings, regular meetings, facilitation, and coordination.
Figure 7: Money Flow & Coordination in MSS Implementation by MoWE

Legend:
- : budget flow
- : services access
- : horizontal coordination
- : vertical coordination

Source: Primary data
At the sub-national level, the budget for coordinating integrated services at the Women’s Empowerment Agencies (along with P2TP2A) comes from the Local Budget Province/District/City. Aside from the Local Budget, the Women’s Empowerment Agencies in Provinces/Districts also receive funds from other sources. For instance the Women’s Empowerment Agency in DIY received donor funds from GIZ to fund advocacy on gender mainstreaming and GRB, while the Women’s Empowerment Agency of the Gunung Kidul District received money from the Satu Karsa foundation for trainings of community leaders on psychosocial support for DV victims.

In DKI Jakarta, Local Budget is allocated for the Women and Children’s Protection programme; whereas in DIY, it is allocated for Women Rights Protection. At the district level, the budget is allocated to the Sub-sector ‘Vulnerable Groups’ (in Yogyakarta City) and the Sub-sector ‘Women and Children Protection’ (in Gunung Kidul District). The budget is used to fund the referral system at the grass roots level.

In the meantime, WCCs, and Legal Aid Foundation (LBH – Lembaga Bantuan Hukum) LBH as non-state actors which provide direct services for DV victims are most often funded by international donor agencies or the private sector. In some cases, they also get funding from either national or local governments, but based on the interviews with staff of LBH APIK in Jakarta, it can be seen that before 2012 MoWE and Women’s Empowerment Agencies were rarely issued funds to support WCC and LBH activities for dealing with DV victims. Nonetheless, there is the social assistance fund scheme which is channeled by MoSA to the Social Affairs Agency, which can be accessed by local NGOs (more explanation on this issue can be found on the social rehabilitation section).

**Box 4. Source of Funding for P2TPA in DKI Jakarta and Yogyakarta City**

At the province or district level, the P2TP2A is structurally placed under the Women’s Empowerment Agency. The P2TP2A budget comes from the Local Budget Province/District which is channeled through the Women’s Empowerment Agency. In some cases, however, the P2TP2A budget comes from the Local Budget Province/District in a form of Grant (hibah) because of insufficient budget allocated to the Women’s Empowerment Agency. The study found that the P2TP2A in DKI Jakarta and in Yogyakarta City have funded their activities from grant mechanisms received from this kind of budget source. The amount of the Grant depends on the budget capacity of the Provincial or District Government. Since the budget capacity of the DKI Jakarta is higher than the capacity of Yogyakarta City, the P2TP2A DKI Jakarta Province has greater budget. In fact, the P2TP2A in DKI Jakarta has become a semi-autonomous institution. In contrast, budget for the P2TP2A in Yogyakarta City is very limited and only enough to fund operational expenses. Meanwhile, P2TP2A budget in the DIY Province is quite high and has increased from year to year.

- Link between Programs, Activities and Budget

**Supporting services**

It has to be noted first that available data on the exact amount of the budget allocation for supporting and direct services are not fully accessible since not all budget documents can be freely accessed by the public. However, the information on the services and budget available from the
related ministries and government institutions provides the pattern of budget allocation for services to DV victims.

As mandated in the MSS, MoWE and Women’s Empowerment Agencies are responsible for coordinating integrated services for DV victims. Accordingly, these institutions have programs for supporting services for DV victims, and as a consequence, the budget of the supporting services is higher than that of the direct services. In MoWE for instance, the budget for coordination/facilitation of integrated services for DV victims and for developing the database of VAW during 2011 is around Rp3 billion. In regards to the MSS implementation, MoWE has established referral systems in seven provinces: DKI Jakarta, DIY, Central Java, West Java, South Java, Bali, and Bangka-Belitung.

The budget of the Women Empowerment Agency in DKI Jakarta is also largely allocated for supporting services. In 2011, it spent IDR Rp275.750.000 to cover programs/activities related to socialization and advocacy of Regional Regulation on Women’s Empowerment and Child Protection, networking with women’s organizations concerned with women’s empowerment and child protection issues, and developing partnerships among integrated service units for handling cases of violence against women and children. In the Women’s Empowerment Agency of DIY, the budget for supporting services is more than Rp1 billion to cover various activities such as Training of Trainers (ToT) for DV victims’ counselors, facilitation of women’s and child protection, and facilitation of women’s empowerment. In the Women’s Empowerment Agency of Yogyakarta City, the budget is allocated for coordination of women’s and child protection, facilitation of networking on responding to situations of VAW, and capacity building for community counselors of DV victims. Similarly in Gunung Kidul District, the Women’s Empowerment Agency allocated the budget to coordination and capacity building for DV victims’ counselors.

Table 2. Budget for MoWE, Women’s Empowerment Agencies and P2TP2A Year 2011

<table>
<thead>
<tr>
<th>Institution</th>
<th>Direct Services (in IDR)</th>
<th>Supporting services (in IDR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoWE</td>
<td>no allocation</td>
<td>3 billion</td>
</tr>
<tr>
<td>Women’s Empowerment Agency DKI Jakarta Province</td>
<td>275.750.000</td>
<td></td>
</tr>
<tr>
<td>P2TP2A DKI Jakarta Province</td>
<td>486.382.940</td>
<td>516.694.000</td>
</tr>
<tr>
<td>Women’s Empowerment Agency/ P2TP2A DI Yogyakarta Province</td>
<td>300.000</td>
<td>1.145.111.500</td>
</tr>
<tr>
<td>Women’s Empowerment Agency/ P2TP2A Yogyakarta District</td>
<td>208.004.500</td>
<td></td>
</tr>
<tr>
<td>Women’s Empowerment Agency Gunung Kidul District</td>
<td>15 million</td>
<td>10.5 million</td>
</tr>
</tbody>
</table>

Source: Primary Data

Direct Services

Compared to supporting services, the budget for direct services is smaller. It is important to note, however, that the budget itself for both supporting and direct services is often lumped together in a single/mixed budget; much of this budget is not easily identified as budget for provision of services. In Yogyakarta City, the budget for direct services for DV victim is integrated with supporting services. In the DIY Women Empowerment Agency, the budget of facilitation for developing P2TP2A exists
under the Subsector “Institutional Strengthening for Mainstreaming Gender and Children”. In the Women's Empowerment Agency of Yogyakarta City, the budget for the P2TP2A secretariat exists under the Subsector ‘Vulnerable Groups’. It is thus important to note that even though budget is allocated to P2TP2A which is responsible for delivering direct services, in practice, the money has been spent for supporting services as well. Moreover, organizational development issues become a necessity for an autonomous institution such as P2TP2A of DKI Jakarta, and this implies the use of budget which is more prioritized towards supporting services. In the case of the Women’s Empowerment Agency in Gunung Kidul District, the budget for direct services is greater than the budget for supporting services; the agency spent most of the budget (about IDR Rp15 million) for a program for economic empowerment of DV victims.

*Budget insufficiency for P2TP2A*

The budget channeled to MoWE and Women’s Empowerment Agencies/P2TP2A for coordinating the MSS implementation is basically available at both national and local level, yet, the budget allocation tends to be insufficient. As explained previously, the budget for responding to DV issues is usually allocated to Sectors or even Sub-sectors within the MoWE/Women’s Empowerment Agency organizational structures. This means that the budget must be divided again among the many other programs/activities that are not necessarily focused on responding to DV. For example, in the Women’s Empowerment Agency in Yogyakarta City, the budget for providing services to victims of DV is very limited because the DV issue is categorized as ‘women issues’, which is only one of several other categories handled by Sub-sector ‘Vulnerable Groups’.

Another problem is that the existing institutional arrangements of the ministries/agencies usually do not put services for DV victims as a priority. This also affects the amount of budget channeled to P2TP2A. In some cases, P2TP2A DKI Jakarta and P2TP2A Yogyakarta City must prepare and submit proposals for Grant to the local government in order to finance direct services for DV victims. Since the Grant scheme is normally used to cover unpredicted activities of the local government, the amount and allocation is not certain in the budget document. As a result, the funding of the P2TP2A has become unsustainable.

*MoWE’s lack of authority to monitor and evaluate MSS implementation*

There are a number of challenges to the MSS implementation. Since the MSS was just introduced a couple years ago (in 2010), not all mandated institutions have implemented it. The implementation of the MSS requires the integration of the MSS with the national and regional budget system, which is quite a complex task. Another challenge in the implementation of MSS is MoWE’s lack of authority to force other Ministries integrating services for DV victims into their budget planning. It is important to note that even though MoWE has a mandate to coordinate the implementation of MSS, the socialization, monitoring and evaluation of the MSS implementation (as well as GRB) at the provincial level is the responsibility of MoHA. APBN the National budget also goes to the other ministries and state agencies which are in charge of implementing the MSS (MoH, MoSA, MoRA, National Police, General Attorney, Supreme Court, and Komnas Perempuan). It is important to note that even though MoWE has a mandate to coordinate the implementation of MSS, the socialization, monitoring and evaluation of the MSS implementation (as well as GRB) at the provincial level is the responsibility of
MoHA. The National Budget also goes to the other ministries which are in charge of implementing the SPM, (MoH, MoSA, MoRA, National Police, General Attorney, Supreme Court, and National Commission on the Elimination of VAW - Komnas Perempuan). It should note that Komnas Perempuan is also the key actor responsible for monitoring and evaluation of government policies and their implementation. Unfortunately, their role has not been thoroughly harmonized with MoWE’s mandate to coordinate the MSS implementation.

**Limited Access to Services for DV Victims**

After what is learned from the experiences of the government in spending money for the handling of DV victims, the question remains of how the services are effectively accessed by DV victims. The findings show that in most cases, the direct services become the burden of the staff of integrated service units, especially expenditures which cannot be reimbursed by the government i.e. transportation, meals and other personal needs of the victims. A staff of P2TP2A Yogyakarta District testified,

"I work here only as a volunteer. Based on my experiences, there was no budget available to meet the emergency needs of the victims. Sometimes I have to spend my own money to buy food, pay for transport to the district court, even accommodate the victim to stay in my house...”

The fact that the staffs of the P2TP2A are mostly volunteers becomes another critical issue in developing an integrated service for DV victims. Those volunteers, either as counselors, legal assistants, or administrative staff, usually receive a small amount of incentive. For the counselor, the incentive is counted based on the number of DV cases that the counselor responds to. For legal assistants, the incentive is given based on legal cases advanced (usually pro-bono). For administrative staff, the incentive is given per month. This issue has probably been a concern for the other integrated service units. But for P2TP2A, it becomes critical because the MSS mandated P2TP2A as the main actor in the referral system for providing services to DV victims. As long as there is no budget priority for direct services in P2TP2A, the needs of DV victims will never be fulfilled.
b. Health Services

- Money Flow

Budget for services for DV victims in the health sector comes from the national, provincial and district budget (the national budget, and provincial/district local budget respectively). Besides the government budget, donors such as WHO, UNFPA, and UNICEF also channel funds to health sector, primarily through the Ministry of Health for supporting services such as producing guidance books on early detection, records, and reporting. UNICEF is noted to have assisted the establishment of integrated service unit in Rumah Sakit Cipto Mangunkusumo (RSCM/Cipto Mangunkusumo Hospital) before it was handed on to the provincial government.

The state budget goes to the MoH which allocates it to its directorate generals which have the task of addressing VAW. Some of the budget is used by the directorate general and its sub-units to deliver supporting programs, and some is transferred to the health agency at the provincial level in the form of deconcentration funds. The MoH also has a health insurance program to cover the cost of health services for poor communities and it can be used by women and children victim of DV.

Besides receiving deconcentration funds from the central government, the Health Agencies at the provincial and district level also receive budget from the provincial and district budget respectively to deliver supporting services. The Health Agencies at the provincial and district level also develop and fund their jaminan kesehatan sosial (jamkesos/health insurance) and jaminan kesehatan daerah (jamkesda/local health insurance).

Direct services for DV victims are delivered through hospitals and puskesmas. Puskesmas provide basic medical services while hospitals deliver advanced/referral services. In addition to government hospitals, some private hospitals in the provincial level also have MoUs with government to deliver services to victims of DV. Government hospitals and puskesmas receive funds from the state, provincial, and district budgets for their operational activities.

DV victims can access free services at the provincial/district government hospitals, private hospitals (which have MoUs with the health insurance providers), and puskesmas. These service providers can then claim the cost under jaminan kesehatan masyarakat (jamkesmas/community health insurance), jamkesos, or jamkesda.
Figure 9: Money Flow in Health Sector

Legend:
- : budget flow
- : services access
- : vertical coordination
- : horizontal coordination

Source: Primary data
Box 5. Social and Health Insurance (Jamkesos) in DIY

The DIY Province Health Agency had a unit which manages health insurance called Bapeljamkesos (Badan Pelayanan Jaminan Kesejahteraan Sosial). The jamkesos aims to cover health expenses of the poor, and the target group is determined based on the data of the population of poor people in DIY. Currently, DV victims can also access jamkesos, but the budget for that is not allocated specifically from the overall jamkesos budget. All costs in puskesmas and hospitals that are incurred by DV victim can be claimed under jamkesos—including visum et repertum, and visum et repertum psychiatricum— as long as the funds are used under the economic class (kelas 3) which is for inpatient treatment and generic medicines. Jamkesos does not cover autopsy or DNA tests. A respondent during our interviews said that the reason is that jamkesos only cover health services for victims who are still alive. Furthermore, DNA tests are also very expensive (IDR Rp2 million), and are required mainly for the purpose of law enforcement, not for patients’ health.

Currently, victims who want to access free health services must access them through hospitals or Puskesmas located in the district/province where the violence occurred. Panti Rapih Hospital staff said that sometimes they have patients who experienced violence outside Yogyakarta, but had come to Yogyakarta to stay with their relatives. For cases such as this, the hospital has a policy to cover the costs. But it is not known whether other service providers have the same policy as Panti Rapih Hospital. In DIY, this issue had become part of the agenda in the discussions of the local regulation (perda) draft. The local regulation was endorsed in June 2012, but the issue remains unresolved. One of the obstacles is the lack of agreement and the different levels of capacity among entities and among regions (because of decentralization districts now have become independent). However, currently MoWE has been paving the way for cooperation and networking across regions to address services for DV victims, and it is expected that it will be able to address cross regional issues such as this one.

From interviews with puskesmas and health agency staff in Gunung Kidul District, it is also found that puskesmas have difficulty to claim the cost from jamkesos for several reasons. The procedure and requirements for accessing jamkesos ve not been socialized well among the community. Patients who want to access jamkesos often do not bring required documents. This problem is coupled with poor administration in the puskesmas themselves. Claims from puskesmas were often refused by jamkesos because of puskesmas staff making administrative mistakes such as writing the wrong jamkesos card number. In Gunung Kidul District, where houses and offices located far away and where a large portion of population is poor, the process for accessing jamkesosis is perceived as time and money consuming (for transportation cost). If puskesmas staff think that the cost for health treatment is lower than the cost for processing a jamkesos claim, they would prefer just to pay the cost from their own pockets.

- Link between Program, Activities, and Budget

Supporting Services

MoH has enacted Ministry Decree No. 1226/ 2009[

30] which states that all hospital staff must be trained in services to women and children victims of violence. Meanwhile, the National Strategic Planning for Health 2010-2014 states that each district must have at least two puskesmas able to deliver reproductive services and services for women and children victims of violence. This ability is indicated by each puskesmas having at least two trained workers consisting of a doctor or dentist and

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30 On the Guidance of Provision of Integrated Services for Women and Children Victims of Violence in Hospital
a nurse or midwife, and being able to refer cases to relevant service providers. To achieve this target, the MoH has carried out capacity building program in the form of Training of Trainers (ToT) to puskesmas as a pilot project.

By 2012, training activities in provinces had reached various stages of implementation. The Health Agency in DKI province has carried out training to all 44puskesmas. In 2012, the deconcentration fund was all used, so that the agency did not conduct any more training, and instead carried out seminars or coordination workshops attended by participants from across sectors, and provided supervision (including monitoring and evaluation) to puskesmas. However, this supervision was not focused on services to DV victims, rather on all programs. Similarly, the Health Agency of Yogyakarta City currently only conducts mentoring of puskesmas. In DIY Province, the health agency carried out training for 29 puskesmas and five local government hospitals with deconcentration funds.

Direct Services

The MoH decree requires puskesmas to provide medical, medico-legal and psychosocial services. This covers health examination and treatment, health rehabilitation (physically and psychologically), counseling, and/or systems of referral to other health providers, delivering reproductive services such as family planning, keeping medical records, and an authorized staff who can produce visum et repertum and/or visum et repertum psychiatricum. However, it is found that puskesmas and hospitals have varied levels of facility and capacity and therefore varied quality of services to DV victims. Hospitals which already have an integrated service unit, such as in RSCM and Panti Rapih Hospital, have more complete services needed by women and children victims of violence. In the Gunung Kidul Government Hospital, there is no integrated service unit, and the services are not as complete as in the previously mentioned hospitals. Puskesmas generally have to deliver medical, medico-legal and psychosocial services as mandated by the minimum service standard, yet they are generally constrained by the number of staff.

Supporting services are largely funded by the Central Government

Sub-national level governments generally did not allocate budget for training for puskesmas/hospital staff, as they are largely dependent on deconcentration funds. DKI Jakarta relegated the responsibility for conducting training to city government in 2012, but little can be expected from the district government’s allocation of budget for the program as it is currently not a government priority. In DIY, budget for conducting mentoring to puskesmas was only enough to conduct one training activity in a year. Although the agency staff think that more training activities are needed to cover more puskesmas, it is difficult to increase budget allocation from what it is now because the puskesmas have many programs and activities to be funded. The absence of local government budget for training

31 The Government Regulation No.4/2006 on carrying out of and cooperation for rehabilitation of victims of DV, Article 8
of health workers will threaten training program sustainability because deconcentration funds are not intended to be allocated to the province or district indefinitely. Even so, the budget in the central government for carrying out training programs is not enough to deliver the programs as planned or targeted. The respondent in the MoH said that the budget for violence programs only covers 80% of what would be in fact needed, and they have to use a strategy to make it sufficient by reducing the volume of the trainings or the number of provinces covered by the trainings. In puskesmas, there is no specific budget allocation for training of staff. During fieldwork, it was found that some service providers such as puskesmas Tegalrejo and Panti Rapih Hospital have simultaneous training or socialization among staff for responding to VAW, but that is not a norm.

Overlap of supporting services program across units

The program to address DV at the MoH is the responsibility of many different units. It is noted that of six directorate generals, four have programs and activities related to domestic violence, namely, Nutrition, Maternal and Child Health (Gizi and KIA), Health Development Unit (BUK - Bina Usaha Kesehatan), Human Resource Development and Empowerment on Health (PPSDMK - Pengembangan dan Pemberdayaan SDM Kesehatan), and Disease Control and Environmental Health Pe (PP&PL - ngendalian Penyakit dan Penyehatan Lingkungan). These units sometimes have overlapping supporting services, for instance between the Training Center for Health Workers in the PPSDMK and Child Health Development which both have programs for training on handling of DV victims by health workers. The respondent in the PPSDMK said that actual training and need assessment are the main responsibility of the Training Center, but apparently training programs have been carried out by many of the sub-units in the MoH, although those units write ‘staff development’ in their proposal of program and budget reports.

The training program has a monitoring and evaluation component which is carried out 3-6 months after the training has been conducted. However, it is also difficult to see the impact of training programs because of high level of staff rotation. Staff rotation frequently occurs in government now, and often is done without due consideration to the skills, experience, and education of the staff. Staff who have been trained are often transferred to other units (often to institutions which do not have any relation to their skills, experience, and education) before they can apply the knowledge they gain in their workplace. To address this problem, the Training Center at the PPSDMK has required that health workers who join the trainings must not be moved to other position for two to three years after training to allow them to implement their new skills and to transfer them to their colleagues. Monitoring and evaluation show that there is difficulty in optimizing the impact of training on the quality of services because of the low level/rank of staff that join the training. Puskesmas often do not send decision makers/program planners in the unit to join the training, and therefore it is believed that most participants have little ability to improve the quality of services in their unit after they receive training.

At the Ministry level, the handling of VAW and VAC (violence against children) was carried out separately by two sub-Directorates, Maternal Health and Child Health. The two sub-directorates have different indicators: ability to deliver services for women victims of violence in the former and ability to administer services for children victims of violence in the later. As consequence, training in services
to women and children victims of DV of health workers has been carried out separately, thus creating inefficiencies of time, energy and cost. There has been a discussion currently in the MoH about merging the programs (VAW and VAC) because some of the materials are the same and the guidance book and the module had been integrated. However, there is still on-going discussion of how or at what level the coordination can be carried out.

**BOX 5: Key Findings in Health Sector**

*Donor fund is easier to be allocated/spent*
A respondent in the MoH admitted that the mechanism for proposing budget, and reporting for program funded by donor was quicker and simpler compared to programs which were funded by the MoH where the source of budget comes from National Budget. This was the case when the donor fund comes directly to the Ministry. Once a unit in the Ministry received funding from the WHO, but it then stopped in 2012 because the financial system or the budgeting for the program must go through to Daftar Isian Pelaksanaan Anggaran (DIPA/the Budget Implementation Registration Form). It has to be integrated into budgeting system in the National Budget which is make it difficult and it took a long time for allocating the money or long delays, the fund sometimes is received when activities had already finished.

*Varied capacity to deliver services to DV victim*
From the interview, it is found that puskemas has difficulty to outreach DV cases due to lack of communities’ motivation to report the cases. Puskesmas is only able to identify a DV victim when the victim comes to puskesmas and they come with physical injuries for instance because of being hit. For a DV victim who experienced psychological trauma it is more difficult to be identified. Victims who come by themselves to the hospital usually are recorded as ordinary patients. Usually victims do not convey that they are DV victim when they register, it is only when they are examined by doctors that they could be identified as victims of violence, if the doctors have the adequate training on DV case handling.

*Not all health staff had been trained on how to respond to cases of DV*
In puskesmas, not all units has been trained, equipped or given responsibility to identify and respond to women and children victim who are victims of violence. This increase the possibility for the victims of DV to go on unidentified when they come alone to the service providers for getting health treatment, and therefore victims will not get all the services needed, or not referred to relevant service providers, such as police, shelters, etc. In Puskesmas Menteng DKI Province for example, there is only one staff positioned in a response unit (unit tindakan, a unit which deals with coroner, lung and stitching) who has responsibility for DV cases.

In hospitals that have an integrated services unit, and are well known by the society, DV victims usually come directly to the integrated service unit (not through the registration at the front office/lobby). Similarly, a victim who is referred by WCC, NGO or police usually goes directly to the doctor without going through the register. In Panti Rapih, DV victims who know that the hospital provide Pusat Krisis Terpadu (PKT/Integrated Service Unit) will directly goes to the UPPA, so she does not have to go to registration (applied for general patients). In the UPK, DV victims will be referred to doctor or unit according to her needs. However, not all service providers have developed integrated services unit. RSCM and Panti Rapih Hospital has integrated crisis center and an integrated service unit called UPPA respectively. Meanwhile, Gunung Kidulpublic hospital did not have due to limited human resource and financial capacity.

*Commitment of the head of the entities influence the quality of services*
Commitment and the involvement of service providers in the NGO network greatly influence the quality of services provided. Panti Rapih Hospital had cooperated with Rifka Annisa into respond to victims of domestic violence since 1999. At that time, Panti Rapih Hospital was the only hospital which responded to Rifka Annisa and offered to build referral system with Rifka Annisa and other service providers. Since then, every year Panti Rapih Hospital conducted socialization for new staff, debriefing, and training so that all staff can provide services for victims and understand the referral procedure. The fund for this program comes from the hospital itself (foundation). A similar thing applies in Puskesmas Tegalrejo, the Puskesmas Head who had joined special training for responding to victims of violence and since 2009 has carried out socialization and training of services for victims of violence to staff. Meanwhile, RSCM is the pilot project of integrated service unit assisted by UNICEF, hence it has better quality and capacity to deliver services to victim of violence compare to other service providers.
c. Social Rehabilitation

- Money Flow

Government and NGOs have played roles in providing social rehabilitation services to DV victims. The MoSA has provided social rehabilitation to DV victims, while MoRA has responsibility to give spiritual counseling. Psychological counseling in general is provided by P2TP2A, and NGOs such as Rifka Annisa and PULIH.

MoSA receives funds from the National Budget where some funding is allocated to the Sub-directorate of social protection for the victims of violence and migrant workers, which runs a shelter named RPTC. MoSA also transfers deconcentration funds to provinces for Productive Economy Development Assistance programs (UEP - *Usaha Ekonomi Produktif*), which can be accessed by DV survivors. The Social Affairs Agencies at the provincial and district level receive deconcentration funds from MoRA and budget allocation from the Local Budget. Some provinces such as DKI and DIY also have shelters which are funded by Local Budget.

Religious affairs is one of the sectors that are not decentralized to district level. Hence MoRA has a vertical structure, with representative offices in the provincial and district levels. The budget in MoRA mainly comes from National Budget. The budget flows from MoRA at the central level to MoRA offices at provincial and district levels. This funding is used for delivering supporting activities such as coordination and facilitation. MoRA also allocates budget to Board of Marriage Counselling and Advisory (BP4). Before 2009, BP4 was integrated in the MoRA organization structure, but since 2009\(^{32}\), it has become an independent and professional institution, as the partner of MoRA whose duty is assisting the government in improving marriage quality and promoting family harmony according to Islamic values (*sakinah* family). As an independent organization, BP4 also receives money from civil society organization such as RAHIMA (Centre for Information on Islam and Women’s Rights) and Istiqlal Mosque which give funding assistance to BP4 DKI Jakarta. BP4 also has a vertical line of structure, and the flow of budget follows down this line; the budget from MoRA goes to national BP4, which then distributes the funds to provincial BP4, and further distributes them to district BP4. By 2012, BP4 are available only in 17 provinces.

\(^{32}\) Based on the BP4 National Discussion XIV conducted in 2009 in Jakarta
Figure 10: Money Flow in Social Rehabilitation and Reintegration Services

Legend:
- : budget flow
- : services access
- : vertical coordination
- : horizontal coordination

Source: Primary data
Link between Program, Activities, and Budget

MoSA has carried out supporting and direct services. The planning and budgeting for women’s protection was managed by the Sub-directorate on Social Protection of Victims of Violence and Migrant Workers. MoSA provides social rehabilitation through conducting supporting services such as socialization and advocacy, providing human resources, developing structure and infrastructure, and monitoring and evaluation. In addition to the indirect/supporting service, MoSA also delivers direct services through Shelter and Trauma Centre (RPTC). The Sub-Directorate of Social Protection from Violent Actions and Migrant Workers established RPTC in 2004 to provide social protection for VAW victims (including DV and trafficking victims). The RPTC delivers programs that consisted of: admission, acceptance, outreach, counseling, further counseling, victim monitoring, home visits, and preparation for reintegration. Figure 11 shows that the allocation of budget in the Sub-directorate has been largely spent for supporting services.

DKI Jakarta and DIY have RPTC which are run with budget from Local Budget. The Social Affairs Agency of DKI Jakarta established an RPTC named Panti Bakti Kasih which is funded by the Social Assistance fund from the Local Budget. Although the objective of this shelter was to accommodate DV victims, it also accommodates homeless people. The total number of the people staying there was 70 women out of which 52 women were the victims of domestic violence and the rest were homeless women.

DV victims who have stayed in a shelter and have been deemed by a counselor have recovered physically and mentally are reintegrated into their community. Before returning to the community, they are given training on skills such as sewing, so that they may start small business and be able to earn money and become financially independent.

DIY Social Affairs Agency received deconcentration funds which were used for UEP training programs and gender socialization for religious and community leaders in 2012. Starting in 2012, the DIY Social Affairs Agency also allocated budget from Local Budget for UEP programs as a counterpart to budget from the MoSA. The UEP program was mostly distributed to DV survivors in Gunung Kidul District,

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34 Based on Governor Decree No. 67/2006
and violence against migrant workers survivors in Bantul District. Meanwhile, in DKI Jakarta, budget for UEP programs is allocated for training on cooking and beauty parlour operation and for VAW stimulant fundd given to victims (each victims receives IDR 3.000.000). The budget for UEP programs in Jakarta comes from the national budget and local budget.

MoRA allocated budget for staff capacity building, including training for Judges of Religious Courts all over Indonesia dealing with divorce cases. MoRA at the provincial and district level also receive budget from MoRA at the central level for coordination and facilitation.

BP4 mainly delivers mediation for couples who have problems in their marriage, including legal aid facilitation at the Religious Courts, and training to BP4 counselors at the provincial level. In every Religious Court in every province there is mediation service from BP4 for the victims. Usually, DV victims go to BP4 because they would like to file a divorce case, though there were some who came to just ask for spiritual counseling. If the couple continues the process of divorcing after getting a session with BP4, the case continues in the Religious Court.

**Government and NGO’s shelter**

Staff at RPTC said that the existence of RPTC at the National level is needed because at the provincial level, shelters run by NGOs usually only receive victims proven by their identity cards to be from the province itself. Meanwhile, the RPTC receives victims from any region regardless of their residentce. If a victim has been healed they will return her to her original place. The majority of VAW victims given service in RPTC were victims of trafficking (in 2011, of 19 people who stayed at the RPTC, only one was a domestic violence victim).

**Table 3: The Expenditure for social Rehabilitation (executed Budget of RPTC Service of the Ministry of Social Affairs of Indonesia) 2011**

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of Service</th>
<th>IDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recruitment</td>
<td>39.000.000</td>
</tr>
<tr>
<td>2</td>
<td>Client Acceptance</td>
<td>27.000.000</td>
</tr>
<tr>
<td>3</td>
<td>Psychosocial Assessment</td>
<td>17.000.000</td>
</tr>
<tr>
<td>4</td>
<td>Basic need fulfillment</td>
<td>270.000.000</td>
</tr>
<tr>
<td>5</td>
<td>Psychosocial Intervention (Salary for Social Workers)</td>
<td>670.000.000</td>
</tr>
<tr>
<td>6</td>
<td>Home visit (Transport/per diem, etc)</td>
<td>70.000.000</td>
</tr>
<tr>
<td>7</td>
<td>Final Evaluation and Referral</td>
<td>200.000.000</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1.336.882.000</td>
</tr>
</tbody>
</table>

Source: Budget document of MoSA RI, 2012

Geographical barriers also become a challenge for victims accessing shelter. There is also complaint from district governments that they face difficulty in bringing victims to shelter at the provincial level. In response to these challenges. MoRA since 2011 has initiated the establishment of shelters at district level. Until now, there are 6 districts which have been assisted by MoRA to build shelter. These
shelters are provided not only for women and children victims of domestic violence, but also for victims of trafficking.

Several NGOs also provided shelter for DV victims, such as PULIH (Jakarta) and Rifka Annisa (Yogyakarta). Although the provincial government has provided shelter, DV victims still go to NGOs’ shelters. Shelters run by NGOs are simpler to access and do not require the victims to go through bureaucratic procedures. For instance, a shelter maintained by Social Affairs Agency of DKI Jakarta Province could be accessed only by victims with a Jakarta ID Card and only if the crime site was in Jakarta. On the contrary, there was no such requirement and limitations at NGOs’ shelters. However, NGOs have limited capacity to run shelters; they do not have budget for shelter managers, so that victims sometimes feel afraid and lonely if the stay alone in the shelters. Furthermore victims are allowed to stay in the shelters for about two weeks because of limited operational cost; after two weeks the DV victims are usually referred to the government’s shelter.

Budget constraint in BP4

The National BP4 said that they have limited budget which has to be allocated to 17 provinces, while the budget in each of the 17 provinces is largely absorbed by worker salaries. Hence direct operational service for clients/victims becomes very little. The staff member interviewed at BP4 DKI Jakarta observed a similar thing. He said that that the funds from the National BP4 are so very low that often they could not cover the operational expenses. There were many occasions on which BP4 staff had to give their own money to victims from poor families as they could not pay the consultation fee. (In the National BP4 the consultation fee is IDR100,000. For facilitation at the Religious Court at the provincial level the fee is IDR 150,000. In the year 2011, BP4 DKI Jakarta received funds of IDR 1 billion (IDR 700 million for training and IDR 300 million for supporting activities such as networking); however in 2012 the budget decreased to IDR 250 millions.

Limited effectiveness of UEP program

The UEP program lacks effectiveness for several reasons. First, MoSA transfers deconsentation fund for UEP program to the provincial governments. However, provincial government does not actually have authority to deliver direct services to communities (see the discussion about autonomy in the Chapter 1). It is possible that the provincial government transfers the money to the district government so that the district government can manage the UEP program themselves. But in some cases, provincial government runs the UEP program directly. The provincial Social Affairs Agency will ask for a list of DV survivors from the Social Affairs Agency at the district level. The district agency then will select DV survivors whom they think appropriate to receive UEP funds. The district social agency then gives the list to the provincial social agency. The provincial agency will then distribute UEP fund to DV survivors, IDR 3,000,000 for one person. This process creates a long chain of procedures and makes for unclear responsibilities among the central, provincial, and district agencies in managing the UEP program. A second challenge is the lack of capacity of facilitators. The facilitators are recruited by the national government staff. Their number is insufficient to match the number of UEP fund receivers. The beneficiaries of the UEP funds were spread out in some regions, so that
monitoring and facilitating the businesses of the women who received UEP funds could not be done effectively.

**Box 6. Cooperation between Social Affairs Agency and P2TP2A for Handling DV Victims**
The DKI Jakarta Social Affairs Agency had a program for handling DV victims funded by the deconcentration fund but did not have data regarding DV survivors who were the program target, because they have never had direct contact with DV victims. The institutions which have contact and network with DV survivors are those giving direct services such as P2TP2A and LBH APIK. The Social Affairs Agency therefore cooperated with P2TP2A DKI Jakarta and LBH APIK Jakarta to deliver the UEP program to DV survivors who were handled by these institutions. This inter-institution cooperation in empowering DV victims shows that effective cooperation between government and NGOs can be pursued by integrating each institution’s strength and capacity.

d. Legal Assistance

- Money Flow

The Supreme Court, Attorney General and National Police are government institutions which have the mandate to provide legal aid and law enforcement for DV victims. Meanwhile, P2TP2A, WCC and LBH are NGOs that provide legal assistance, mediation and litigation for DV victims. As in the MoRA, defense and security matters are not decentralized to local government. In the National Police, budget flows from Mabes Polri down to Provincial Police Office (Polda), to District/City Police Office (Polres/Poltabes), and to Sub-district Police Office (Polsek). The budgetary allocation and structure follows the policy of the National Police. The police at the regional level do not receive budget allocations from the local budget.

The same pattern also occurs in non-ministerial government agencies such as the Attorney General. Budget from the National level is also channeled to the regions through the agencies under the provincial High Court and District Courts. The state budget for higher state institutions like the Supreme Court is fully managed by the Supreme Court office in Jakarta, and its allocation earmarked according to the sub-national levels. The budget in the police at the national, provincial, and district level for handling DV goes to *Badan Reserse Kriminal (Bareskrim)/Crime Investigation Unit* which has an Special Unit for Women and Children Victims (UPPA). UPPA is responsible for providing services to women and children victims of violence during case reporting and investigation, and for enforcing the laws for prosecution of perpetrators.
Figure 12: Money Flow in Legal Assistance and Law Enforcement Services

Legend:
- : budget flow
- : services access
- : vertical coordination
- : horizontal coordination

Source: Primary data
• Link of program, budget, and activities

In 2011, the National Commission of Violence against Women, Supreme Court, General Attorney, National Police, MoWE and Indonesia Lawyers’ Association signed a MoU\(^{34}\), which defines each key actor’s responsibilities in addressing VAW issues, including DV. The key responsibilities of each institution are:

- The National Police has responsibility for education and training of police personnel, providing special service rooms for women and children, developing an SOP for handling women and children, disseminating internal and external information together with other institutions, and engaging in referral systems. Attorney General has responsibilities for education and trainings of attorneys, coordination with police and civil servant investigators, developing standard guidance, internal information dissemination together with other institutions, and engaging in referral systems.
- Supreme Court has responsibilities for education and trainings of Judges and other legal staff, and conducting internal socialization together with other related institution.

**Direct services provided through Women and Children Special Service Unit (UPPA)**

The average number of criminal cases handled in General Crime Investigating Unit (Reskrimum) in Indonesia was between 300 and 400 cases per year. Meanwhile based on the data at UPPA Polri, from 2007 to 2011 there were 928 cases handled by UPPA in police offices from provinces down to the sub-districts in Indonesia. This number is not representative of the real situation since DV cases are often unreported. Reluctance of victims to make a report to the police was not only caused by their feeling of shame but also by their fear that the police will devictimize them. Interviews with the MoLHR staff reveal that there are not many prosecutors who are aware of and understand the DV Law, and refer to it when handling DV case.

NGOs or Legal Aid Institutions have minimum support from the government to provide legal assistance for victims. In general, the expense of assisting the victims during the investigation process at the police level, and for attorneys and higher courts, are borne by the NGO or LBH itself. Rifka Annisa has several lawyers who can assist DV victims who are able to pay. If a victim was not able to pay the lawyer, normally WCC would find a pro-bono lawyer who was paid by the WCC only for expenses such as transportation and meals. Similarly, all the expense was borne by LBH by cross-

\(^{34}\) The objectives of this MoU are: (a) to achieve common understanding on the handling of victims of violence among the service providers; (b) to strengthen the institution responsible for providing the services to victims; (c) capacity improvement of law enforcement officers for giving protection and law assistance to victims of violence; (d) ordination and cooperation of all stakeholders to make services fast, affordable and transparent.
subsidy from other cases where the victim was able to pay for the service. Transportation, refreshment, accommodation and communication were expenses that were in general came out of a counselor’s own pocket.

**Difficulty in processing Violence cases**

Many cases of DV against women reported to the police could not be followed up to court level. Out of 928 cases handled by UPPA all over Indonesia, only 459 cases were processed, and 109 cases were submitted to attorneys. The investigation of most of those cases was halted due to lack of evidence, especially physical evidence and witnesses to stand before the trial. Other cases were dropped because the victims took back the report. Interviews with Polda DIY revealed that many violence cases can not be categorized as criminal cases and hence could not be taken to Court. In general, it is only physical violence cases that are processed to court, whereas processing for cases of psychological violence and negligence are often aborted. During case hearings (gelar perkara), psychological violence cases were often treated as light cases and deemed unnecessary to be taken to court.

**Box 7. Criteria of Case Types Budget**

In 2012, the budget of Bareskrim of Polres in Gunung Kidul was IDR 500 million per year. This amount is utilized and sometimes insufficient. The cases are categorized as light, medium and heavy, and the budget to conduct an investigation is based on these criteria:

Heavy: if the investigation is difficult to undertake, for example it is necessary to look for the offender, go to remote areas, and conduct DNA testing, or if there is need of expert witness. The limit for heavy cases is IDR 14 million. Medium: if the investigation is less difficult. DV is often in this category as most of the cases are not complicated. The visum is usually conducted at Dr. Sarjito Hospital near the Police Office. The budget at UPPA was used for stationery, coordination, sending official letters to the hospital, getting advice from experts, etc. The budget ceiling for investigation of a medium case is IDR 9 million.

Light: if the offender and the evidence are apparent, like gambling and alcohol trafficking. Light cases are delegated to the Police General Affairs Unit (Sabhara). The ceiling is IDR 600,000.

The budget went to provincial, district and sub-district police offices. The authority of to utilize the money was with the Chief of Provincial Police and was given to Bareskrim at the middle of every month. The submission of budget planning for Bareskrim was done at the beginning of each month based on the claim from UPPA. Normally, this claim was based on the number of each type of case, heavy, middle, or light. This proposal was then used by Bareskrim to make budget planning for that month.
3.3 Conclusions of the Budgetary Analysis: Is the Money Enough?

The MSS lays out a minimum standard of services that each ministry is responsible for providing to victims of violence. It has also provided the costing of activities needed to deliver the services, both direct and supporting. The matrix on the Annex IV is an example of the costing to implement various programmes and services. But the example has many limitations; it may not reflect the actual budget, and budget for services to DV victims is often lumped together with services for trafficking victims, services in the case of violence against children and migrant workers, services for victims of natural disasters and services for disabled persons. It is also difficult to get specific information on how much the budget is for delivering service to DV victims. The box 7: No Specific Budget for Addressing VAW illustrates the difficulty.

a. Health Services

The total budget or expenditure at the MoH was largely allocated for supporting programs for DV victims as opposed to other ministries where the majority of the budget was for support services. These programs included capacity building of health workers at the local level to be able to handle VAW and VAC victim. This program was funded by deconcentration fundc from the national government. In the previous section it is mentioned the program target for the period of 2012-2014 is that all districts have a minimum of two health centres per district capable of administering service for VAW and VAC victims; thus budget is allocated to meet this minimum target. However, normally a district actually has ten or more health centres. This shows that there is a big gap in the available budget and the actual needs in the field.

The effectiveness of capacity building training is often in question because of staff rotation. The expectation of the training program is that trained health centre staff will share knowledge with other staff. However, this situation is hard to obtain. Examples from the interviews reveal that more often, a well-trained staff of one health centre was moved to another institution not long after the training. The evaluation to assess the training program could not be done as the staff had already moved and was replaced by a new staff who were never given any training.

Ministry of Health has budget for health insurance for the poor and people with special needs, including victims of violence against women and children. Provincial government has also allocated funds for health insurance. The fund managed by the Provincial Health Agency is predicted to cover all the insurance beneficiaries. For example, the Health Agency at DKI Jakarta in fiscal year 2010 received health insurance claims for the victims of domestic violence in six hospitals in DKI Jakarta of IDR 195.021.012 for 1,331 patients. For DIY, the expenditure of health insurance for the victims of domestic violence in fiscal year 2010 was IDR 30,713,196. However, in many regions, this kind of health insurance has not yet been made accessible to the poor and those with special needs like DV victims. Hence, health insurance funds were available but could not yet be accessed maximally by DV victims.
However the scheme is not commonly used. Because of the following, information about the health insurance scheme is not well disseminated; many people still don’t know that they are entitled to access the scheme. Another problem is the administrative process that is deemed troublesome. To seek an easy way, patients are often asked to pay for the services. Third is the lack of operational funds at regional level to support this program. For instance, there is no budget for transportation and communication for staff who often have to go back and forth from puskesmas to health agency to claim health insurance. Often, the staff have to use their own money. In this case, there should be an improvement in terms of fund reimbursement so that it would not be a burden for the staff and the program could run more effectively.

In general, the most frequently accessed service for victims was health care for physical violence that needed medical treatment. The service for non-physical violence was not normally accessed. For example, number of female population in DKI Jakarta in 2010 is 4,736,849. If it was assumed that 10% of these women experienced violence, the number of female violence victims was 473,684. In reality, in 2010 there were only 1,331 patients recorded as DV victims from the total number of health care receivers in all hospitals all over DKI Jakarta, omitting the patients in the community health centres because the data could not be obtained. The number of victims could be higher because many victims do not report, or victims could not be identified as victims by untrained health personnel.

b. Social Rehabilitation

MoSA and Social Affairs Agency at the provincial level have direct services for DV victims which are provided through shelters (RPTC). At the RPTC, DV victims can get psychological counseling, health service, spiritual guidance, and legal assistance if necessary. All of these services can be accessed free of charge. The existence of RPTC run by MoSA actually creates a risk of conflict of interest with sub-national level of government or NGOs which provide shelter, and make the allocation of budget for services become ineffective.

MoSA also channels funds to empower DV victims economically through deconcentration funds to the Provincial Social Affairs Agency. This funding is called UEP and is given to DV survivors who have been trained in skills and entrepreneurship such as beauty salon operation, sewing, and culinary arts. Although the amount of UEP funding is small and cannot cover all DV survivors, it has resulted in a

Box 7. No Specific Budget for Addressing VAW

The amount of budget that was specifically addressed to handle DV could not be obtained as this program was not prioritized and included in any planning document of state and institution though it was one of the missions in RPJMN. For example, in MoH, the training program on how to handle DV was attached to the training program of “overcoming violence against children at provincial level. This program covered the program for children on the streets, children with special needs, disabled children and children in prison. At Social Affairs Agency in DIY, the deconcentration fund was used, among others, for the program “improving the capacity of the staff in handling referred cases of VAW/VAC”, including DV.

At Regional Health Insurance DIY Province, the budget to handle DV victims went to the post “funding program for health care insurance” for the activity "the providence of community healthcare insurance", and sub-activity "health treatment expenses to detect good growth of children, toddlers, different ability, people with HIV/AIDS, TB, elder people, gender violence victims, and the victims of disasters and riots".
mixed record; some have successfully started small businesses and become financially independent while others have failed. One of the reasons for the program’s ineffectiveness is the limited number of facilitators who monitor and evaluate survivors’ economic activities. Therefore, the budget for the UEP program must also include monitoring and evaluation by facilitators so that the achievement of the DV survivors in benefiting the UEP fund can be tracked.

The budget from National Budget and Local Budget to protect DV victims is still lacking if seen from the victims’ side (money/service received by victims). Though at the national level the budget seems to be big, this funding was used more for supporting programs. Up to the province and district/city level, the budget to handle and protect victims often has to be taken from other budget allocations or other activities. It is also often true that the government staff have to make material and immaterial sacrifices in order to keep the program running although the budget is insufficient. For instance, in Gunung Kidul District, the Women’s Empowerment Agency’s staff conduct home visits to DV survivors at their own expense. In addition, in order to make psychological counseling services available, a staff member who happens to have graduated from a psychology faculty is assigned to give the services while she also holds other responsibilities, because the institution does not have budget to hire a professional psychologist.

Other institutions that provide direct service to DV victims are NGOs such as Rifka Annisa (WCC), PULIH (an NGO that provides psychological counseling), and LBH APIK (an NGO that provides legal assistance). In general, the financial support to NGOs which deliver services to DV victims has been decreasing. As interviews revealed, donor money has been diminishing significantly throughout the year, while government does not allocate budget to the NGOs. As a result, these NGOs have difficulty in covering the operational cost and providing services for victims. To overcome budget constraints, some NGOs also deliver paid services, in addition to its free services to DV victims. This effort has helped their financial condition although only a little. Yet, on the flip side, this activity creates a negative perception among community that NGOs have now been commercialized and are asking...
money from patients. As Rifka Annisa staff state, they often have to emphasize that they only charge those who are able to pay, and the money is used to cross-subsidy activities for DV victims who are unable to pay.

c. Legal Assistance

Since 2010, UPPA has been put under the directorate of General Crime Investigation Unit, Sub-Directorate III for Teenagers, Children and Women in the police institution structure. This has an impact on the amount of budget allocated to UPPA. For instance, the UPPA Polres Gunung Kidul in 2011 handled 9 cases of violence against women and 24 cases of violence against children. The ceiling budget per case is IDR 9 million for DV case investigation. Based on research team calculation of the total spent and the total cases, it is assumed that the cost to handle those 33 cases is IDR297 millions. However, as stated by the staff, in reality, not all DV cases are funded IDR 9 millions, so that the total expense may have been less than IDR297 million. This shows that UPPA must compete with other units for budget allocation.

Almost all network organizations that are part of the integrated services voiced issues of budgetary constraints. However, they admitted that the budget would be managed so as to be ‘enough’ though it did not meet the minimum standard of service as stipulated by the government. The National Police, Attorney General and Supreme Court have not been supported by sufficient budgeting. Based on Head of Police Regulation No. 10 year 2007, the National Police stipulate the establishment of Special Service Rooms to give women and children victims of violence special investigation room and shelter. These rooms should be private, comfortable and friendly. However, not all UPPA have met this criteria; generally the room is only an empty room with a desk and typewriter.
CHAPTER 4

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATION

4.1 Key Findings Legislative and Policy gaps

Even though the DV Law has been widely implemented in handling DV cases, the spirit of the DV Law to protect DV victims is often inconsistent with the Criminal Code and Marriage Law, which tend to be gender biased. The result is double victimization of the victims and an ineffective legal system to prosecute the perpetrators.

- There is conflict of responsibility between MoWE, which is mandated to be the leading agency of Integrated Services for DV victims, and MoHA, which is mandated to socialize, monitor and evaluate MSS implementation at the local level. This has had an impact on the complexities in coordination for implementation of the MSS. In addition it also affects the amount of budget and the inefficient use of budget for addressing VAW. This in turn affects the delivery of services at the micro level.

Budget Gaps

Gender Responsive Budgeting has been integrated into the Performance Based Budgeting System. However, there needs to be more effort to technically integrate the two, because ministries’ planning and budgeting staff are still grappling to implement both. Furthermore, there is no institutional arrangement that ensures budget allocation for direct services needed by DV victims.

- The budgeting system is perceived to have difficulty accommodating the program designed for addressing DV, which demands emergency responses. In many other cases, Donor funds are considered easier to be allocated or spent by government institutions dealing with VAW because the mechanisms for proposing a budget and reporting the programs are perceived to be quicker and simpler than those funded by the government (National and Local Budget). Commitments to deliver services to DV victims are uneven, as well as the capacity of government officials to deliver services. It is observed that unclear authority and overlapping mandates/services between departments within a ministry/agency or between ministries/agencies exist, so that inefficiency of budget allocation for both supporting and direct services is unavoidable.

- The budgets for supporting services, which were largely funded by National/Local Budget, are unable to meet the needs of DV victims. There is no budget allocation available for direct services, especially at the P2TP2A. It is because as a service unit, P2TP2A has just been established by the stipulation of MSS in 2010. Facing this situation, Women’s Empowerment Agencies submit a budget proposal to the local governments through a hibah scheme in order to fund direct services in P2TP2A. On the other hand, there is budget allocation for the other service units, i.e. UPPA, RPTC, and Community Health Centres/Hospitals, but it remains
insufficient because of the lack of priorities on DV issues. Both situations might challenge to the sustainability of budget for DV victims.

- In some regions, services for DV victims are free, if victim is referred by an integrated service centre for women and children’s empowerment (P2TP2A) or Women’s Empowerment Agency. However, in many cases, victims do not come to those institutions but go instead to NGOs. Unfortunately, these NGOs are currently confronted with insufficient budgets and resources to fund the cost of services since donor funding has been reduced in Indonesia. This results in victims having to start procedures again through the government channels, with the risk of double victimization and unavailable services.

**Service Delivery Gaps**

- **Health Services**: The most significant supporting service of MoH and Health Agencies is to provide trained health workers in Crisis Centre in community health centres (puskesmas) and hospital. But coverage is still a problem; trained health workers are not available at district level, hence victims cannot get appropriate services.

- **Social Rehabilitation Services**: According to the mandate of MSS, ministry institutions are responsible for supporting services. However, it is a fact that MoSA also delivers direct services (by running RPTC). The budget allocation is thus unavoidably divided to fund both supporting services (in MoSA) and direct services (in RPTC).

- **Legal Services**: There is no transparency in delivering information pertaining budget allocation for DV victims. However, interviews, indicate that there is no priority for budgeting capacity building of legal enforcement apparatuses in handling DV victims.

- The referral system has been established by Women’s Empowerment Agencies in partnership with other government/non-government agencies and service units at the provincial and district levels by stipulating the local regulation on the Forum of Integrated Services for DV victims. Usually, the implementation of a referral system among agencies/service units is formally legitimated by MOUs to ensure additional funds for assistance and services to DV victims. Nonetheless, this ‘formal’ referral system is less flexible and unresponsive to the needs of victims. As a result, in many cases, an informal referral system is considered more effective to meet the needs of DV victims as it relies on voluntary behaviors of key persons in the Forum. While this voluntary behavior is a good indication of high commitment of staff, this tendency is not good for program and institutional sustainability.

- The commitment of key persons in the Forum to the sustainability of referral systems continues to face challenges, especially in regard to mutation/rotation of the workforce and comprehension/capacity of staffs. Often, staff have been trained and then rotated, and replaced by new staff who do not necessarily have the commitment, understanding and capacity of previous staff.
4.2 Conclusion

1. The Indonesian Government nationally has put forth the policy on women and children’s protection as a national priority. However, this policy still faces challenges in its implementation, including the availability of the enforcement mechanism and its supporting infrastructure, specifically the consistency and the harmony between legislation and regulations. At the level of implementation, there is unclear authority among government institutions both vertically (national, province, and district/city) and horizontally.

2. There are an increasing number of entities that provide services, along with an increasing number of cases of DV. However, the numbers still do not make results meet the minimum standards because of lack of well-trained staff, lack of coordination among service providers and under-budgeting. Cost of services for most service providers is also far higher than their budget. Furthermore it is difficult to calculate the unit cost of services, since DV cases tend to be under-reported and services for DV victims are lumped together with the overall program or activities.

3. The integrated services as designed in the MSS have not been implemented effectively in practice. This is because the forum of integrated services established by Women’s Empowerment Agencies—as the leading agencies in the protection of women—has not developed a clear referral mechanism among service units. As a result, many service units have not built better service systems to fulfill the needs of DV victims. To some extent personal commitment of government institution leaders has contributed to the drive for better services for DV victims.

4. The flow of services in the referral system has not been thoroughly supported by the flow of budget. This is because the referral system, as designed in the MSS, has involved both government and non-governmental agencies, while the budget for developing the referral system has mainly been channeled to government institutions. On the other hand, such programs/activities as are planned to sustain the referral system are often not accommodated in the current system of performance-based budgeting. The other challenges, such as overlapping mandates/services, unclear authority, lack of political will and lack of staff capacity, also affect inefficiency in budget allocation. This is evident from most of the budget’s being allocated for supporting services. As a result, almost no budget is allocated for direct services, and ultimately the government has failed to meet the needs of DV victims.

5. There is evidence to support the idea that the government funded activities are channeled for the most part to support services rather than to direct services to victims. This is in part due to the administrative structure of the government in Indonesia, whereby the decentralisation legislation leaves implementation of such services to the lower levels of government and policy making to the higher ones. However, there needs to be a revision of the expenditure in support services as, for example, the findings show that the efforts fall short in the area of
training for delivery of services because of mutation and rotation of staff. On the other hand, the funding for direct services at the lower levels of government seems to be insufficient.

6. Budget allocation for the DV services does not sufficiently fulfill the needs of the victims. In regard to this, there are at least three categories of budget allocated for the services. First, the budget was allocated for the services but quality was negatively affected because of insufficient resource allocation. Secondly, there was no budget allocated for concrete services so that the services are not provided. Thirdly, the services are not properly budgeted, so that the cost is assumed by another agent who can be the service provider or even the victim accessing the services.

4.3 Recommendations

a. Macro Level

The general recommendation that needs to be taken into account at the macro level referral system is to provide an enabling environment for the development of integrated services for DV victims. This can be done by undertaking a legislation reform to ensure that current laws and policies for VAW are aligned with services offered and accessible on the ground. In the meantime, VAW should be prioritized within GRB initiatives as the funds needed to support VAW-related services are currently insufficient and/or there are a number of inefficiencies and duplicated efforts.

- Referral System

1. Policy change to ensure harmonization between and amongst Law, Decree, and national and local government competencies that help to implement good women’s protection services.

2. Develop regulations and policies on women’s protection to delineate and clarify roles and responsibilities of actors for seamless non-duplication of mandates.

3. Ensure that DV and other gender-based violence issues become a policy and program priority in Rencana Strategis(Renstra/the strategic mid-term) and Rencana Kerja(Renja/annual work plan) of the mandated institutions.

4. Ensure that the handling of DV victims is explicitly included in the program activities of the government entities which are mandated to address DV.

5. Develop regulations that provide strong authority for MoWE at the national level, and Women’s Empowerment Agencies at provincial/district levels, to lead the other government institutions which are mandated to deal with DV.

- Budget System
1. Translate Laws/Decrees which discuss budget for DV very generally into technical regulations that regulate in detail budget allocation for the services of DV victims.

2. Ensure that the budget for DV victim services is a priority in annual budget documents of governmental agencies (RKA) providing the mandated institutions.

3. Develop regulations that provide clear and specific mandates for Women’s Empowerment Agencies at the provincial/district levels to be the leading agencies to implement GRB in partnership with BAPPEDA and other relevant agencies.

4. Encourage National, Provincial, and District Governments to share commitment to financing direct services for DV victims, especially in P2TP2A.

b. Micro Level

Some practical recommendations at the micro levels should be considered in order to provide better services for DV victims. The recommendations need to address all entities of either government or non-government institutions which are mandated to handle DV victims. This can be done by engaging NGOs more fully as partners in advising government on NAPs, particularly on services design and implementation issues, and coordinating the implementation process given governments’ budgetary constraints. Moreover, it is important to advocate for stronger inclusion of NGOs into formal VAW referral systems, along with additional funding particularly for logistics surrounding VAW-related services.

- Referral System

1. More socialization of MSS and the other laws, decrees and policies related to DV up to the district and community levels.

2. Evaluate different models of integrated services, from exercises of either government or non-government institutions to understand their effectiveness, and adopt the models which are proved effective.

3. Review the roles and responsibilities, and acknowledge the strengths and capacities of key actors (both government and non-government institutions), in delivering services for DV victims, in order to decide in which area each key actor can effectively play a role.

4. Improve coordination among the institutions mandated to handle DV victims, and develop networking among service units to create a better mechanism for the referral system.

5. Share good practices and learn from failures in delivering services for DV victims in order to find strategies to overcome unclear authority, overlapping services, and conflicting roles of each institution mandated to handle DV victims.
6. Conduct trainings on the handling DV victims which are more sustainable, by targeting higher officials as decision makers, program and budget planners in government agencies, and staff who deliver services to DV victims.

7. Optimize the role of Komnas Perempuan as an institution mandated to conduct monitoring and evaluation of the integrated services for DV victims, and involve independent evaluators to audit the performance of programming and budgeting at each level of ministries mandated to carry out Gender Mainstreaming, GRB and services for DV victims.

- **Budget System**

1. Evaluate objectives, scopes and targets of supporting services for handling DV victims to ensure that budget allocation is more effective.

2. Encourage the government to expand funding sources, not only from *hibah* and *bantuan sosial*, but from other sources of budget, to ensure the sustainability of direct services for DV victims.

3. Provide budget allocation in MoWE at the national level and Women’s Empowerment Agencies at the provincial/district levels to fund operational needs of P2TP2A, including the needs of DV victims.

4. Open more opportunities for NGOs dealing with DV victims to be able to access government funds with certain criteria taken into consideration.

5. Take variable costs into account (i.e. transportation, accommodation, meals, communication) for DV victims in service units (P2TP2A, UPPA, RPTC, *puskesmas*/hospital).

6. Consider MSS’s indicators as the indicators of outputs-outcomes in the budgeting system to make it as an integral part of GRB implementation.
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Indonesia Nomor 18/MPP-PA/D.II/05/2011 tentang Peningkatan Efektivitas Pengarusutamaan Gender dan Pemenuhan Hak Anak. Jakarta.


Rifka Annisa Women’s Crisis Center (WCC). *Kekerasan terhadap Perempuan Berbasis Gender*. Yogyakarta.


## ANNEX

### I. List of Informants

#### A. DKI Jakarta Province

<table>
<thead>
<tr>
<th>No</th>
<th>Institution</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Ministry of Women Empowerment and Child Protection</td>
<td>Deputy of Handling Violence Against Women</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health</td>
<td>Directorate General of Nutrition and Maternal and Child Health: Sub Directorate of Child Health and Sub Directorate of Maternal Health</td>
</tr>
<tr>
<td></td>
<td>Ministry of Social Affairs</td>
<td>Head of Sub Directorate of Social Protection for Victims of Violence</td>
</tr>
<tr>
<td></td>
<td>Cipto Mangunkusumo Hospital (RSCM)</td>
<td>Integrated Crisis Center</td>
</tr>
<tr>
<td>5</td>
<td>Attorney General</td>
<td>Prosecutors on Terrorism Crime Task Force and Cross Country</td>
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<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>National Police</td>
<td>Directorate of General Crimes</td>
</tr>
<tr>
<td>LBH APIK</td>
<td>Chairman of LBH APIK</td>
</tr>
<tr>
<td>Social Affairs Agency DKI Jakarta Province</td>
<td>Division of Social Security Assistance and Protection of Displaced People</td>
</tr>
<tr>
<td>Komnas Perempuan</td>
<td>Chairman of Komnas Perempuan</td>
</tr>
<tr>
<td>P2TP2A DKI Jakarta Province</td>
<td>Assistance and Advocacy Division</td>
</tr>
<tr>
<td>PULIH Foundation</td>
<td>Chairman of PULIH Foundation</td>
</tr>
<tr>
<td>Board of Marriage Counseling Advisory (BP4)</td>
<td>Chairman of the National BP4</td>
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<tr>
<td>BAPPENAS</td>
<td>Director of Population, Women.s Empowerment and Child Protection</td>
</tr>
<tr>
<td>Ministry of Law and Human Rights</td>
<td>Head of Sub Directorate General for Dissemination of Research and Chief of Human Rights for Special Groups</td>
</tr>
<tr>
<td>Institution</td>
<td>Position</td>
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<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UPPA Polda DKI Jakarta Province</td>
<td>Head of UPPA Polda DKI Jakarta</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>Staff of Directorate of Budgeting System</td>
</tr>
<tr>
<td>Supreme Court</td>
<td>Head of Program Planning and Organization</td>
</tr>
<tr>
<td>BAPPEDA DKI Jakarta Province</td>
<td>Division of Public Welfare</td>
</tr>
<tr>
<td>Office of Health Services DKI Jakarta Province</td>
<td>Section of the Health Resources and Head of the Health Insurance</td>
</tr>
<tr>
<td>UPPA Polres East Jakarta</td>
<td>Head of UPPA Polres East Jakarta</td>
</tr>
<tr>
<td>BPMPKB DKI Jakarta Province</td>
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**B. DI Yogyakarta Province**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>BAPPEDA</td>
<td>Chairman of BAPPEDA Yogyakarta City and Division of Planning and Budgeting</td>
</tr>
<tr>
<td>BPMPKB</td>
<td>Head of PHP</td>
</tr>
<tr>
<td>Office of Health Services DI Yogyakarta Province</td>
<td>Head of Public and Family Health</td>
</tr>
<tr>
<td>Social Affairs Agency DI Yogyakarta Province</td>
<td>Head of Victims of Violence, Migrant Workers and Social Assistance</td>
</tr>
<tr>
<td>P2TP2A</td>
<td>Manager of P2TP2A</td>
</tr>
<tr>
<td>UPPA Polda DI Yogyakarta Province</td>
<td>Head of UPPA Polda DI Yogyakarta Province</td>
</tr>
<tr>
<td>Rifka Annisa Women’s Crisis Center</td>
<td>Chairman of Rifka Annisa</td>
</tr>
<tr>
<td>Bapeljamkesos</td>
<td>Supervisor of Health Maintenance Section</td>
</tr>
</tbody>
</table>

**C. Yogyakarta City**

<table>
<thead>
<tr>
<th>Institution</th>
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</thead>
<tbody>
<tr>
<td>KPMPMP</td>
<td>Head of Vulnerable Groups and Volunteers of KPMP</td>
</tr>
<tr>
<td>Office of Health Services Yogyakarta City</td>
<td>Staff of Nutrition and Family Health</td>
</tr>
</tbody>
</table>
Social Affairs Agency Yogyakarta City | Section of Social Rehabilitation Issues
---|---
Jamkesda | Technical Implementer Unit
Panti Rapih Hospital | Senior Nurses
Polresta Yogyakarta City | Head of UPPA Polresta Yogyakarta City
Puskesmas Tegalrejo | Paramedics and General Doctors

D. Gunung Kidul Regency

<table>
<thead>
<tr>
<th>Institution</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>BAPPEDA</td>
<td>Head of Governance and Social Culture and Head of Statistics and Planning</td>
</tr>
<tr>
<td>BPMPKB</td>
<td>Head of Women’s Empowerment</td>
</tr>
<tr>
<td>Office of Health Services Gunung Kidul Regency</td>
<td>Head of Health Services</td>
</tr>
<tr>
<td>Social Affairs Agency Gunung Kidul Regency</td>
<td>Head of Labor Utilization</td>
</tr>
<tr>
<td>Ministry of Religious Affairs in District</td>
<td>Head of Ministry of Religious Affairs in Regency</td>
</tr>
<tr>
<td>RSUD</td>
<td>General Doctors</td>
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<tr>
<td>Legal Assistance of UPPA</td>
<td>Lawyers</td>
</tr>
<tr>
<td>Public Health Centers</td>
<td>Midwives</td>
</tr>
<tr>
<td>Police Resort</td>
<td>Personnel UPPA</td>
</tr>
<tr>
<td>Playen Community</td>
<td>Social Officers</td>
</tr>
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</table>

II. List of Services
<table>
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<tr>
<th>LIST OF SERVICES</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Immediate Safety</strong></td>
</tr>
<tr>
<td>• Immediate safety and protection through police response and emergency legal measures (protection orders)</td>
</tr>
<tr>
<td>• Emergency help lines and information about these help lines</td>
</tr>
<tr>
<td>• Training of persons responding to help line calls</td>
</tr>
<tr>
<td>• Training of nurses and doctors to identify signs of VAW</td>
</tr>
<tr>
<td>• Training of police on assisting and responding to VAW victims</td>
</tr>
<tr>
<td>• Providing referrals and safe transport to victims/survivors</td>
</tr>
<tr>
<td><strong>2. Emergency Physical &amp; Mental Care</strong></td>
</tr>
<tr>
<td>• Emergency Treatment of physical injuries for women and affected children</td>
</tr>
<tr>
<td>• Post-rape care: rapid testing for pregnancy, including emergency contraception to avoid unwanted pregnancy, post-exposure prophylaxis to prevent HIV infection, treatment for other sexually transmitted infections</td>
</tr>
<tr>
<td>• Psychological treatment for victims/survivors and affected children</td>
</tr>
<tr>
<td>• Referrals to available support services</td>
</tr>
<tr>
<td><strong>3. Safe Accommodation</strong></td>
</tr>
<tr>
<td>• Shelters or other alternatives, with access to basic necessities (e.g. food, sanitary supplies, clothing, room spaces, etc.) and with provisions and protection services for women and affected children</td>
</tr>
<tr>
<td>• Safe transportation to court (or other services e.g. health care)</td>
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<tr>
<td>• Training for shelter staff in responding to cases of VAW</td>
</tr>
<tr>
<td>• Education for affected children</td>
</tr>
<tr>
<td><strong>4. Counseling and Support Services</strong></td>
</tr>
<tr>
<td>• Counseling and referrals for continued psycho/social/health based support and family counseling for women and their children</td>
</tr>
<tr>
<td>• Training for social workers on responding to cases of VAW</td>
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<tr>
<td><strong>5. Ongoing Protection and Police Intervention</strong></td>
</tr>
<tr>
<td>• Police enforcement of protection orders</td>
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<tr>
<td>• Witness protection before, during and after trial</td>
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<tr>
<td>6. Advocacy and Legal Services</td>
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<td>7. Legal Processes</td>
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<tr>
<td>8. Longer/term empowerment of victims /survivors</td>
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<tr>
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<tr>
<td>9. Shared Practice Standards, Guidelines and Codes</td>
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<tr>
<td>10. Risk Assessment and Management</td>
</tr>
<tr>
<td>11. Case Data Systems and Record Keeping</td>
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<td>12. Engaging the Community in the Response</td>
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III. Environmental Scan Matrix

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<td></td>
<td>Regulation of Government 4-2006: Implementation &amp; Cooperation for Rehabilitation of DV Victim Instruction of President 9-2000: GM in Social Development</td>
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<td>Regulation of MoWE 1-2007: Forum of Coordination for Organizing Prevention &amp; Rehabilitation of Victims of DV</td>
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<td>Regulation of MoWE 1-2010: Minimum Services Standard on Integrated Services for Women &amp; Children Victims of Violence</td>
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<td>MoU between Komnas Perempuan, Supreme Court, Attorney, National Police, Lawyer Association MoWE (2011): Access to Justice for Women Victims of Violence</td>
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<td></td>
<td>Decrease of MoH 1226-2009: Guidelines for Management of Integrated Services for Victims of Violence Against Women &amp; Children in Hospital</td>
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<td>Guidelines for Development of Pukenmas Cases of Violence Against Women and Children</td>
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<td></td>
<td>Decrease of MoH 80-2013: Social Protection, Technical Standards for Violence Victims</td>
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<td>Decrease of MoSA 80-2013: Social Protection, Technical Standards for Violence Victims and Migrant Workers</td>
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<td>Regulation of MoSA 102-2007: Establishment and Operation of RPTC</td>
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<td></td>
<td>Decrease of MoSA 31-2012: Comparator Guidelines Productive Economic Business Assistance (UAP) for Victims of Violence and Migrant Workers</td>
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<tr>
<td>MoWe</td>
<td>MoH</td>
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<tr>
<td>MoSA</td>
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<tr>
<td>MoRA</td>
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<tr>
<td>MoU</td>
<td></td>
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<tr>
<td>National Police</td>
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<tr>
<td>General Attorney</td>
<td></td>
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<tr>
<td>Supreme Court</td>
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<tr>
<td>MoLHR</td>
<td></td>
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<tr>
<td>MoF</td>
<td></td>
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<tr>
<td>MoF</td>
<td></td>
</tr>
<tr>
<td>BAPPENAS: National Planning and Development Board</td>
<td></td>
</tr>
<tr>
<td>Komnas: National Commission of Violence Perempuan Against Women</td>
<td></td>
</tr>
</tbody>
</table>

Glossary:
- DV: Domestic Violence
- GM: Gender Mainstreaming
- MoWE: Ministry of Women Empowerment and Child Protection
- MoH: Ministry of Health
- MoSA: Ministry of Social Affairs
- MoRA: Ministry of Religious Affairs
- GA: General Attorney
- MoLHR: Ministry of Law and Human Rights
- MoHA: Ministry of Home Affairs
- MoF: Ministry of Finance
- BAPPENAS: National Planning and Development Board
- Komnas: National Commission of Violence Against Women


Regulation of MoH 15-2008: Guidelines for Implementation of GM in Local Level
Decree of MoH 15-2008: Guidelines for Implementation of GM in Local Level
Decree of MoH 15-2008: Guidelines for Implementation of GM in Local Level
Decree of MoH 15-2008: Change in Regulation of MoH 15-2008 on the Guidelines for Implementation of GM in Local Level

The National Medium Term Development Plan 2010-2014

Policy of Women’s Protection 2011-2014
National Strategic Plan of Gender Mainstreaming
Strategic Plan 2011-2014
Strategic Plan 2011-2014
National Action Plan 2010-2014
Strategic Plan 2011-2014
Strategic Plan 2011-2014
Strategic Program Plan 2010-2014
IV. Budget of Supporting and Direct Services

A. Health Services

<table>
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<tr>
<th>INSTITUTION</th>
<th>PROGRAM/ACTIVITY (DIRECT SERVICES FOR THE VICTIMS)</th>
<th>FISCAL YEAR</th>
<th>BUDGET/EXPENDITURE</th>
<th>FUND SOURCE</th>
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<tbody>
<tr>
<td>The Ministry of Health (Direktorat Bina Kesehatan Anak)</td>
<td>Providing Health Services</td>
<td>2011</td>
<td>No special budget Total expenditure for service for 533 patients who were DV victims was Rp53,227,346.00</td>
<td>Local Government DKI Jakarta Province</td>
</tr>
<tr>
<td>Hospital (PKT) (RSCM)</td>
<td>2012</td>
<td>-</td>
<td>Rp4,379,000.00</td>
<td></td>
</tr>
<tr>
<td>Office of Health Services (Yogyakarta City)</td>
<td>Financing Health Insurance</td>
<td>2012</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Jamkesda (Yogyakarta City)</td>
<td>2010</td>
<td>-</td>
<td>Rp8,177,630.00</td>
<td></td>
</tr>
<tr>
<td>Office of Health Services (Gunung Kidul Regency)</td>
<td>Providing operational and maintenance funds including first aid and medicine ransom</td>
<td>2011</td>
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<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>PROGRAM/ACTIVITY (DIRECT SERVICES FOR THE VICTIMS)</th>
<th>FISCAL YEAR</th>
<th>BUDGET/EXPENDITURE</th>
<th>FUND SOURCE</th>
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<tbody>
<tr>
<td>The Ministry of Health (Direktorat Bina Kesehatan Anak)</td>
<td>Providing Health Services</td>
<td>2011</td>
<td>No special budget Total expenditure for service for 533 patients who were DV victims was Rp53,227,346.00</td>
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<td>Office of Health Services (Yogyakarta City)</td>
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<tr>
<td>Jamkesda (Yogyakarta City)</td>
<td>2010</td>
<td>-</td>
<td>Rp8,177,630.00</td>
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<tr>
<td>Office of Health Services (Gunung Kidul Regency)</td>
<td>Providing operational and maintenance funds including first aid and medicine ransom</td>
<td>2011</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
### Supporting Program/Activity (Non-Direct Services)

<table>
<thead>
<tr>
<th>Supporting Program/Activity (Non-Direct Services)</th>
<th>Training, coordination meeting, monitoring, and developing manual</th>
<th>Monitoring <em>puskesmas</em> capable of violence against women case administration (including coordination)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Budget/Expenditure</th>
<th>Rp1,996,680,000.00</th>
<th>Rp350,000.00</th>
<th>-</th>
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</table>

<table>
<thead>
<tr>
<th>Fund Source</th>
<th>National Budget</th>
<th>Local Budget of Yogyakarta City</th>
<th>-</th>
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</thead>
</table>

### Social Rehabilitation

<table>
<thead>
<tr>
<th>Institution</th>
<th>RPTC The Ministry of Social Affairs</th>
<th>MoWE The Ministry of Religious Affairs (BP4)</th>
<th>Office of Social Affairs (DKI Jakarta Province)</th>
<th>P2TP2A (DKI Jakarta Province)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FISCAL YEAR</td>
<td>2011</td>
<td>2011</td>
<td>2011</td>
<td>2011</td>
</tr>
<tr>
<td>-------------</td>
<td>------</td>
<td>------</td>
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</tr>
<tr>
<td>PROGRAM/ACTIVITY (DIRECT SERVICES FOR THE VICTIMS)</td>
<td>Providing social rehabilitation services</td>
<td>-</td>
<td>-</td>
<td>Training for victims (troublesome migrant workers as well as the victims of women and children trafficking)</td>
</tr>
<tr>
<td>BUDGET/EXPENDITURE</td>
<td>Rp1,336,882,000.00</td>
<td>-</td>
<td>-</td>
<td>Rp210,000,000.00</td>
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<tr>
<td>FUND SOURCE</td>
<td>National Budget</td>
<td>-</td>
<td>-</td>
<td>Regional and National Budget</td>
</tr>
<tr>
<td>SUPPORTING PROGRAM/ACTIVITY (NON-DIRECT SERVICES)</td>
<td>Coordination and facilitation (APBN)</td>
<td>Mediator training in Higher Religious Courts in 17 provinces in cooperation with Supreme Court</td>
<td>Service network reinforcement, training for &quot;PIK&quot; workers, police, mass organization, etc.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>BUDGET/EXPENDITURE</td>
<td>Rp3,000,000.00</td>
<td>Rp700,000,000.00</td>
<td>Rp509,686,000.00</td>
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</tr>
<tr>
<td>FUND SOURCE</td>
<td>National Budget</td>
<td>Aids from Government, unbinding funds from national and international institutions, <em>infaq</em>, <em>sodaqoh</em>, and donation; other legal and unbinding effort</td>
<td>Pro vincial Budget of DKI Jakarta Province</td>
<td></td>
</tr>
<tr>
<td>INSTITUTION</td>
<td>BPMPKB or Office of Women Empowerment (DKI Jakarta Province)</td>
<td>Office of Social Affairs (DI Yogyakarta Province)</td>
<td>Office of Social Affairs (Yogyakarta City)</td>
<td>Office of Women Empowerment (Gunung Kidul District)</td>
</tr>
<tr>
<td>PROGRAM/ACTIVITY (DIRECT SERVICES FOR THE VICTIMS)</td>
<td>Social Welfare Rehabilitation and Service (Psychosocial Service for PMKS at Trauma Center); Social Protection for violence victims and migrant workers</td>
<td>-</td>
<td>-</td>
<td>Direct aid to victims</td>
</tr>
<tr>
<td>BUDGET/EXPENDITURE</td>
<td>-</td>
<td>Rp736,595,000.00</td>
<td>-</td>
<td>-</td>
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<tr>
<td>FUND SOURCE</td>
<td>-</td>
<td>Local and National Budget</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>SUPPORTING PROGRAM/ACTIVITY (NON-DIRECT SERVICES)</td>
<td>Socialization, advocacy, coordination meeting, improving UPT cooperation in handling VAW</td>
<td>-</td>
<td>Institutional reinforcement on gender and children mainstreaming</td>
<td>Social counseling training</td>
</tr>
<tr>
<td>BUDGET/EXPENDITURE</td>
<td>Rp275,750,000.00</td>
<td>-</td>
<td>Rp508,586,500.00</td>
<td>Rp98,000,000.00</td>
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<tr>
<td>FUND SOURCE</td>
<td>Regional Budget</td>
<td>-</td>
<td>Board of Marriage Counseling Advisory</td>
<td>Board of Marriage Counseling Advisory</td>
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</table>
C. Legal Assistance

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>FISCAL YEAR</th>
<th>PROGRAM/ACTIVITY (DIRECT SERVICES FOR THE VICTIMS)</th>
<th>BUDGET/EXPENDITURE</th>
<th>FUND SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ministry of Law and Human Right</td>
<td>2011</td>
<td>-</td>
<td>-</td>
<td>Police Headquarters</td>
</tr>
<tr>
<td>Supreme Court</td>
<td>2011</td>
<td>-</td>
<td>-</td>
<td>National Budget</td>
</tr>
<tr>
<td>Police Resort (UPPA or Unit of Women and Children Services)</td>
<td>2012</td>
<td>Funding of heavy cases, middle cases and light cases in one year of case handling</td>
<td>Rp500,000,000.00</td>
<td>Donor Agencies</td>
</tr>
<tr>
<td>NGO: LBH APIK Jakarta</td>
<td>2010</td>
<td>Handling women seeking justice who experience sexual violence and reproductive health problems</td>
<td>Rp15,000,000.00</td>
<td>-</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORTING PROGRAM/ACTIVITY (NON-DIRECT SERVICES)</th>
<th>BUDGET/EXPENDITURE</th>
<th>FUND SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissemination, coordination meeting</td>
<td>Rp652,217,900.00</td>
<td>National Budget</td>
</tr>
<tr>
<td>Conducting Institutional Reinforcement in Mainstreaming Gender and Children year 2011</td>
<td>Rp1,609,160,000.00</td>
<td>National Budget</td>
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<tr>
<td>-</td>
<td>-</td>
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</table>