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PERSONS WITH DISABILITIES IN INDONESIA

Empirical Facts and Implications for Social Protection Policies

Sri Moertiningsih Adioetomo, Daniel Mont and Irwanto

LEMBAGA DEMOGRAFI
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Foreword

In 2006, the United Nations issued a Convention on the Rights of Persons with Disabilities. In this convention, disability is not limited to medical factors only but defined as the interaction between personal functioning and the environment. Causes of disability range from internal factors such as poor nutrition and poor health care and external such as violence and accidents.

The Demographic Institute, Faculty of Economics University of Indonesia (or DI-FEUI) with the National Team for Accelerating Poverty Alleviation (*Tim Nasional Percepatan Penanggulangan Kemiskinan or TNP2K*) conducted a study to look at issues on disability in Indonesia. A comprehensive method was applied and the result is a report on "Persons with Disabilities in Indonesia: Empirical Facts and Implications for Social Protection Policies".

The study was conducted using a multipronged approach to examine issues on disability in Indonesia. Secondary data analysis was done by utilizing information available on disability from the National Basic Health Research (*Riset Kesehatan Dasar* or Riskesdas) 2007 and the Indonesian Population Census 2010. A newly designed quantitative survey of people with disabilities and qualitative data drawn from in-depth interviews and focus groups on stakeholders was conducted in 11 provinces representing Jawa and non-Jawa and also western and eastern parts of Indonesia.

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Sonny Harry B. Harmadi
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In recent years, TNP2K has investigated the official measurement of disability statistics in Indonesia and the socioeconomic conditions of and poverty among persons with disabilities. This report, Persons with Disabilities in Indonesia: Empirical Facts and Implications for Social Protection Policies, provides for the first time in Indonesian history a comprehensive empirical overview on nationally representative disability statistics. Besides using Riskesdas 2007 and Census 2010 data, this report makes use of a unique household survey of 2,200 individuals with disabilities in 11 provinces that collected data in March 2012. The report also reviews the Indonesian and international legal framework related to persons with disabilities and discusses a variety of urgent policy interventions that are intended to improve the lives of persons with disabilities in Indonesia, particularly those who live in poverty.

In 2011, TNP2K commissioned the Demographic Institute (University of Indonesia) in collaboration with Professor Irwanto and Daniel Mont to compile a comprehensive research report covering the topics mentioned above. This paper, Persons with Disabilities in Indonesia: Empirical Facts and Implications for Social Protection Policies is a reproduction of the Demographic Institute's research report. The conclusions contained here do not necessarily represent the views of the Government of Indonesia or the Government of Australia.

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Acronyms and Abbreviations

APBN	National Budget (*Anggaran Pendapatan dan Belanja Negara*)
BAPPEDA	Regional Body for Planning and Development (*Badan Perencana Pembangunan Daerah*)
BKKBN	National Family Planning Coordinating Board (*Badan Koordinasi Keluarga Berencana Nasional*)
BPS	Statistics Indonesia (*Badan Pusat Statistik*)
Bulog	National Logistics Agency (*Badan Urusan Logistik*)
GDP	Gross Domestic Product
IMF	International Monetary Fund
Kemko Kesra	Ministry of People's Welfare (*Kementerian Koordinator Bidang Kesejahteraan Rakyat*)
MoF	Ministry of Finance (*Kementerian Keuangan*)
MoSA	Ministry of Social Affairs (*Kementerian Sosial*)
NTT	East Nusa Tenggara (*Nusa Tenggara Timur*)
OPK	Special Market Operation (*Operasi Pasar Khusus*)
PKK	Family Welfare (*Pembina Kesejahteraan Keluarga*)
PMT	Proxy Means Testing
PPLS	Data Collection for Social Protection Programme (*Pendataan Program Perlindungan Sosial*)
RASKIN	Subsidised Rice for the Poor (*Beras Bersubsidi bagi Masyarakat Berpenghasilan Rendah*)
RT	Neighbourhood Association (*Rukun Tetangga*)
RW	Community Association (*Rukun Warga*)
SLS	Local Community Unit (*Satuan Lingkungan Setempat*)

SUSENAS	National Socioeconomic Survey (*Survei Sosial Ekonomi Nasional*)
TNP2K	National Team for Accelerating Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*)
TPKAD	Village Budget Implementation Team (*Tim Pelaksana Kegiatan Anggaran Desa*)
UPM	Community Complaints Units (*Unit Pengaduan Masyarakat*)
WFP	World Food Programme

Executive Summary

The issue of disability is complex and wide ranging, and although much evidence exists globally about its connection to poverty, this report serves as the first truly comprehensive look at disability in Indonesia. Utilising previously collected data from the National Basic Health Research (*Riset Kesehatan Dasar* or Riskesdas) 2007 and the Indonesian Population Census 2010, this report explores the prevalence of disability and its relationship to poverty. Using a new survey of people with disabilities designed to conform to new international standards on defining and conceptualising disability, the report provides an in-depth look at the barriers that people with disabilities face in participating in Indonesian society. This quantitative information is supplemented by a broad series of qualitative interviews of people with disabiliites, government workers, and other stakeholders—as well as a desk review of the legal framework of disability in Indonesia. The report provides the basis for a series of recommendations to help improve the lives of people with disabilities by giving them access to the rights of people with disabilities acknowledged by the Government of Indonesia when it ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006.[1]

This report incorporates the bio-psycho-social model of disability, which conceives of disability as arising from the interaction between a person's functional limitations and the environment. This is captured in the definition of disability in the UNCRPD, namely that 'persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

In other words, a person might have an impairment that prevents them from moving their legs, thus making them incapable of walking, but what makes that person disabled is an inaccessible physical environment, lack of assistive devices, and negative attitudes that erect barriers for their participation in society. Therefore, disability is not synonymous with a medical diagnosis but rather emerges from an interaction between personal functioning and the environment. This approach to disability focuses on how people function—what they can do in the environment they live in—rather than any condition they have. It directs policy makers to think about what barriers exist in society that are preventing them from doing things, given their functional status.

Chapter I: Introduction. Disability is a very heterogeneous phenomenon. The age of onset, the type of disability, the degree of disability, and how it interacts with the environment vary broadly. However, much evidence from around the world suggests that people with disabilities are more likely to be poor and less likely to receive an education, be employed, and be full participants in the life of their families and communities.

Chapter II: Disability Research Activity: Approach to the Study. Disability is difficult to measure and various approaches have been taken. This study uses a multipronged approach to examining the issues, using secondary data from existing sources, a newly designed quantitative survey of people with disabilities, and qualitative data drawn from in-depth interviews and focus groups comprising a wide range of stakeholders.

[1] Adopted in General Assembly in 2006 and came into force in 2007. The convention may be retrieved from http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-jakarta/documents/presentation/wcms_160663.pdf

Chapter III: Legal Framework for Persons with Disabilities in Indonesia. The Government of Indonesia has recognised the problems people with disabilities face. Long before this new concept of functional limitation, the Government of Indonesia had been highly committed to improving the well-being of persons with disabilities (PWDs), as seen in Law No. 4 of 1997 concerning the 'handicapped', hereafter referred to as PWDs. This law claims equal rights and opportunities for PWDs in all aspects of life, including the right to obtain education, employment, a proper standard of living, equal treatment in participating in national development, accessibility, rehabilitation, including and especially children with disabilities. The law states that the government and the community shall conduct rehabilitation and social assistance and maintain social welfare standards. This was followed up by ratification of the UNCRPD, on 30 March 2007, which was strengthened through enactment of Law No. 19 of 2011 on Ratification of the UNCRPD. This new law reaffirmed that Indonesia is committed to respecting, protecting, and meeting the rights of PWDs.

Nevertheless, despite these strong commitments from the government, programmes and activities to improve the living conditions of PWDs are still minimal. As discussed in this report, existing laws are not well enforced and subscribe more to the older concept of disability as being a medical problem that a person has (and thus should be cared for) rather than a disability resulting from barriers faced by people with certain functional limitations that should be actively minimised.

Chapter IV: Disability Prevalence and General Demographic Features. Overall, this report finds that the prevalence of disability in Indonesia is between 10 and 15 percent, which is comparable to the global findings presented in the recent World Report on Disability 2011 (WHO and World Bank 2011); however, this could be a conservative estimate. According to the Riskesdas 2007 data, the prevalence rate for moderate and severe disabilities is about 11 percent. Including mild disabilities raises the prevalence rate to more than 25 percent (which is only slightly higher than reported prevalence rates in the United States and Australia). The census in Indonesia tends to underreport that rate in part because it asks less extensive questions on disability.

Disability is much more common among older people. Excluding mild disabilities, 46.6 percent of people over age 65 have a disability. Disability is also slightly more prevalent among women and people living in rural areas. The probability of being disabled depends significantly on a person's residential location by province. Unfortunately, as explained in the report, the disability questions in the Riskesdas 2007 survey were not capable of providing a clean distinction between those with mental and physical disabilities, so prevalence rates by these types of disability could not be generated.

Chapter V: Education. People with disabilities in Indonesia are less likely to attend school. In examining these data, it is important to keep in mind that most people with disabilities become disabled when they are no longer of school age. Nevertheless, people who had a disability during their school years are only 66.8 percent as likely to complete their primary education as children who were not disabled, controlling for other factors. There are barriers to both entering and completing secondary education, but they are not as large. This suggests that overcoming barriers when younger—including attitudinal barriers—could be particularly effective.

Several recommendations emerged from Chapter V. These include the following:

- Raise awareness to address misconceptions about disability
- Build an inclusive education system that includes physical access but also teacher training and curriculum development
- Improve and subsidise transportation to school

Chapter VI: Employment. People with disabilities are also less likely to be employed. According to Census 2010, having a mild disability gives a person only a 64.9 percent chance of being employed compared with a nondisabled person. For people with more serious disabilities, that percentage drops significantly to barely more than 10 percent. They are also more likely to be self-employed, even though they report difficulties in obtaining access to credit in order to establish businesses.

Some people with disabilities reported success in obtaining employment but found current laws and programmes not very helpful. There was no systematic effort to make governmental training programmes effective or to enforce Indonesia's laws on disability and employment. Many people experienced a lack of training, education, and access.

The recommendations from this chapter follow:

- Make vocational training programmes inclusive
- Align labour laws with the UNCRPD to enforce a rights-based approach to employment
- Promote employment through public awareness campaigns
- Conduct pilot tests of employment programmes to develop and demonstrate good practices
- Reduce barriers to microfinance for people with disabilities to assist in self-employment

The report also talks about building partnerships with the private sector, as has been demonstrated in the United Kingdom and Sri Lanka as an effective means of building an accessible work environment.

Chapter VII: Poverty, Social Protection, and Health. The report then looks at the extent of poverty among people with disabilities and the coverage of social protection programmes. People with disabilities were 30 to 50 percent more likely to be poor than nondisabled people, especially in urban areas. Households with disabled family members had a 12.4 percent poverty rate in urban areas and 14.0 percent in rural, compared with 8.2 percent and 11.4 percent for households with no disabled members. In addition, the relationship between consumption and disability is more pronounced for the elderly, probably because many elderly become disabled after their working years are already over.

Among low-income people, people with disabilities are concentrated near the bottom of the distribution. As the poverty line is raised from one to two times the poverty line, people with disabilities are still overrepresented but less so.

When the extra costs of living associated with having a disability are included (ranging from negligible to 14 percent, depending on the province), the poverty gap between disabled and nondisabled households increased, often noticeably. Moreover, the association of disability with lower consumption was more noticeable among families with disabled children or working age adults, as opposed to disabled elderly.

The social protection and health coverage of people with disabilities was problematic. People with disabilities complained about the difficulty of applying for and the inaccessibility of benefits. The low rate of programme participation and the large unmet need for assistive devices indicate that coverage is too low and that the mechanisms to reach the most vulnerable are not adequate. Assistive devices—such as mobility or hearing aids—can increase participation but can come at a cost that poor PWDs cannot bear. The costs of not having those devices, show up in less participation in work, employment, and community affairs and increased responsibilities given to nondisabled family members, who must care for relatives who could otherwise be more independent.

The report also briefly summarizes some of the major issues in designing a disability benefits programme, primarily eligibility determination, work disincentives, and trade-offs between cash and in-kind benefits.

Recommendations coming from this chapter follow:

- Establishing outreach programmes to inform people with disabilities about existing programmes and help in accessing them
- Expanding cash benefit programmes to a broader range of people
- Accounting for the costs of disability in programme design
- Expanding programmes to include coverage of assistive devices
- Conducting additional research to address issues raised in this report regarding the nature and extent of poverty's relationship with disability
- Tailoring programmes to provincial experiences, which vary substantially

Chapter VIII: Family and Community Life. People with disabilities also face barriers to full participation in family and community life. This includes community organisations, recreation, sports, and culture, as well as religious and political organisations. This is particularly true for people with more significant disabilities. For example, although 11 percent of men with mild disabilities felt restricted in taking part in community organisations (18 percent for women), men with more significant disabilities reported barriers to participating more than 55 percent of the time (70 percent for women).

The same pattern held for effects on family life, although the gender differences were much smaller. About half of men and women with mild disabilities reported a financial strain on their families and more than a third thought it affected family life. For those with more significant disabilities, nearly two-thirds thought it caused financial problems and more than half thought it affected family life. People with disabilities also reported the need for a significant amount of assistance through assistive devices and personal assistance.

Recommendations emerging from this chapter follow:

- Raise awareness to break down stereotypes and promote inclusion
- Make public spaces accessible
- Establish community-based rehabilitation to enable people with disabilities to be more independent

One overarching theme that emerged across all sectors examined in this report was the major differences among provinces—regarding the prevalence of disability and its relationship to poverty, education, employment, and family and community life. Clearly, policy and programmatic approaches adopted to improve the lives of people with disabilities must be designed with sufficient flexibility to adapt to local conditions and concerns.

Overall, people with disabilities in Indonesia are at a disadvantage. They are poorer, less educated, less employed, and more isolated and at times feel they are a burden on their family. To ensure full rights for all of its citizens, Indonesia needs to pursue inclusive policies in line with the goals of the UNCRPD and Ministerial Declaration on the Asian and Pacific Decade of Persons with Disabilities, 2013–22.

Chapter I
Introduction

Background of the Study

The issue of disability is complex and wide ranging. Disability can occur at any time during life—from birth to old age. It can be caused by a multitude of factors from poor nutrition to violence to poor health care. It can be mild or severe, and it could potentially affect a wide range of functional areas: mobility, vision, hearing, communication, psychosocial function limitations, etc. In addition, if people with functional difficulties live in an unaccommodating environment, they can be greatly limited in their participation in the economic and social lives of their communities: work, school, marriage, civic engagement, as well as religious and leisure activities. Growing evidence suggests that disability and poverty are intricately interlinked (Mitra, Posarac, and Wick 2011; Kelles-Viitanen 1999; Elwan 1999). But, persons with disabilities (PWDs) are not necessarily poor. They may come from wealthy families or have been able to obtain an education. Their communities may have the awareness, attitudes, and means to create an environment that minimises the barriers that prevent many PWDs from participating in higher levels of education, employment, community and/or social activities.[2] However, many PWDs are not as fortunate and face a higher risk of poverty: children with disabilities are less likely to attend school, adults with disabilities are less likely to be employed, and PWDs have less access to public transportation and must pay more for private transport. The cost of medical care is higher than for those without disabilities, and households with a disabled member are more likely to struggle to maintain food security or to secure access to better housing, safe water, and good quality health services. In turn, poverty may increase the risk of disability. Low birth weight, malnutrition, lack of safe water and adequate sanitation, or poor living and working conditions may lead to poor health, which in turn increases the risk of disability (WHO and World Bank 2011; Mitra, Posarac, and Wick 2011).

The link between disability and poverty is rooted in the barriers that prevent people with functional difficulties from having access to the same opportunities as nondisabled people. These barriers could be physical, attitudinal, laws, or policies or stem from a lack of capacity on how to make appropriate accommodations to programmes and facilities. The World Report on Disability 2011 confirms growing evidence across the world that PWDs and their families are more likely to experience economic and social disadvantages than those without disability.

Therefore, disability is a development issue; to address it properly is to make sure that economic and social development is inclusive. This is the basis of the United Nations Convention on the Rights of Persons with a Disability (UNCRPD) to which Indonesia is a signatory.

Studies by Mitra, Posarac, and Wick (2011), Groce, London, and Stein (2012), Trani and Loeb (2012), Mont and Cuong (2011), Braithwaite and Mont (2009), and Yeo (2001) found that PWDs are disproportionately amongst the poorest of the poor in all parts of the world. In the poorest countries of the world, particularly where there are no social assistance benefits available, being amongst the very poorest has more severe impacts than being amongst the poorest in richer countries with more developed social assistance and social welfare services. The basic cause of PWDs' high representation among the poorest is exclusion: exclusion from social, economic, and political life (Yeo 2001). Women, especially disabled women, are usually the most excluded from development programmes (Loeb and Grut 2005): 'Disabled women struggle with both the oppressions of being women in male-dominated societies and the oppressions of being disabled in societies dominated by the able-bodied' (p. 261).

This is true in Indonesia where a patriarchal system still prevails in most provinces and gender roles in the household lead to weaker control over resources by women.

[2] Example from Stephen Hawking in preface in World Report on Disability 2011 (WHO and World Bank 2011).

Inclusive development is the answer to reducing poverty among PWDs. Of primary importance is to change people's mindsets from the traditional way of thinking about disability (the medical concept of disability) towards a social model. That is, disability should not be seen as synonymous with impairments, such as blindness, deafness, or paralysis. Rather, it should be seen as an interaction among functional difficulties that may result from impairments and barriers that exist in society. The goal is not simply to 'fix' people's impairments or give up on them when those impairments cannot be fixed. People with functional difficulties need to be supported to function better despite any impairments (through rehabilitation, counselling, and assistive devices. Of equal importance is to transform the environment and societal attitudes so that they do not preclude people with different types and levels of functioning from being full participants in society.

Disabled people should not be seen as objects of charity, but people who have a right to live in a society that does not erect barriers to their participation based on their functional status. Current policy emphasises the need to create an environment that facilitates PWDs by removing barriers and reducing their limitation to enable them to participate in many social and economic activities that in turn prevent them from being poor. Again, when this report refers to 'access' and 'barriers,' it is referring to the full range of societal structures—physical, cultural, financial—that limit or prevent people with disabilities from having the same opportunities as others.

Indonesia is undergoing a demographic transition that is changing the age structure towards more adult and older persons. The results of the Population Census in 2010 (Census 2010) indicated the number of older persons aged 60 and older is 18.1 million people and is expected to increase to 29.05 million in 2020 and 35.96 million in 2035 (2010 Population Census; National Development Planning Board (*Badan Perencanaan Pembangunan Nasional* or Bappenas)), Statistics Indonesia (*Badan Pusat Statistik* or BPS), and United Nations Population Fund 2005). Indonesia will reach the threshold of becoming an aged population in 2018 when 10 percent of the population is aged 60 and older. This will also lead to an increase the number of people with disabilities.

Long before this new concept of functional limitation became the international standard, the Government of Indonesia made strong commitments in its laws to improve the well-being of people with disabilities, as seen in Law No. 4 of 1997 concerning the 'handicapped', now called 'persons with disabilities'. This law claims equal rights and opportunities for PWDs—including and especially children with disabilities—in all aspects of life, including the right to obtain education, employment and a proper standard of living, equal treatment to participate in national development, accessibility, and rehabilitation (see Chapter 3). Chapter 5 states that the government and the community shall conduct rehabilitation, provide social assistance, and maintain social welfare standards. On 30 March 2007, Indonesia ratified the UNCRPD and strengthened it by enacting Law No. 19 of 2011 on Ratification of the UNCRPD. This new law reaffirmed that Indonesia is committed to respecting, protecting, and fulfilling the rights of PWDs.

The difference between the 1997 and the 2011 laws on disability issues is the different concept defining disability used in each. The 1997 law follows the medical model in which disability is seen as a deficiency or deviation from the norm, located in the individual that can be fixed; whereas the 2011 law views disability as a human rights issue and recognises disability as the consequence of interactions with an environment that does not accommodate that individual's differences and limits or impedes the individual's participation in society (see the UNCRPD).[3]

[3] Available at http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-jakarta/documents/presentation/wcms_160663.pdf. See also Colbran (2010).

Despite these strong commitments from the government, programmes and activities to improve the living conditions of PWDs are still minimal. The lack of consistent and reliable data for policy making is compounded by evolving definitions and measurements of disability versus functional limitation that hampers the effort to develop reliable data for evidence-based policy making. The existing data are fragmented among national and provincial sources, which sometimes use different definitions of disability. Representative and statistically reliable disability data for the development of policy making are lacking.

Rationale of the Study

The National Team for Accelerating Poverty Alleviation (*Tim Nasional Percepatan Penanggulangan Kemiskinan* or TNP2K) Cluster 1 Social Assistance Policy Working Group focuses on overseeing the policy development of integrated social assistance and poverty reduction programmes, while consolidating, simplifying, and improving the efficiency of existing programmes. TNP2K emphasises the importance of evidence-based policy development for poverty reduction and social inclusion. However, the lack of reliable and representative data hampers the development of effective social assistance programmes for regional and population subgroups. Therefore, further research is required to improve data and collect additional information so that a more relevant and accurate assessment of needs and assistance for people with disabilities can be made.

The Indonesian government has included the improvement of accessibility to basic social and quality of life services for people with social welfare issues in the current National Mid-Term Development Plan (*Rancangan Pemerintah Jangka Menengah*) 2010–14. In 2010 the Presidential Regulation (Inpres No. 3) stipulated that the Ministry of Social Affairs (MoSA) and local governments take the following actions for 2010 and 2011: (1) data on disability shall be improved by 100 percent, (2) number of seriously disabled people receiving social assistance shall be scaled up to 17,000 people in 2010 and 19,500 people in 2011, and (3) the number of disabled receiving support in institutions, rehabilitations centres, and homes shall be scaled up to 11,000 in 2010 and 13,000 in 2011.

This study aims to collect necessary data from which it is feasible to derive prevalence rates of disabilities, both at national and provincial levels. A household survey was conducted applying the concepts of the World Health Organisation's (WHO's) International Classification of Functioning, Disability, and Health (ICF) in order to provide an evidence base for policy making. That classification system is based not on medical diagnoses but on people's functional capacity, that is, their ability to undertake activities and tasks across all functional domains (e.g., gross and fine motor mobility, vision, hearing, communication, cognition, etc.) and to participate in the social and economic life of their communities. This approach has been shown to be a much better and more reliable way of measuring disability and should be adopted in all survey and census data on disability (WHO and World Bank 2011).

Structure of the Report

The structure of the report follows:

- Chapter II (Disability Research Activity: Approach to the Study) reviews the methodology undertaken in conducting the study, including both quantitative and qualitative research.
- Chapter III (Legal Framework for Persons with Disabilities in Indonesia) provides the current legal framework regarding the rights of people with disabilities in Indonesia.
- Chapter IV (Disability Prevalence and General Demographic Features) explains the conceptual approach taken to disability in this report and lays out key demographic attributes associated with disability.
- Chapter V (Education) and Chapter VI (Employment) report on the experience of people with disabilities when it comes to education and employment: to what extent they partake in these activities and what are the main barriers preventing further participation.
- Chapter VII (Poverty, Social Protection and Health) addresses the issues of poverty and to what extent social protection programmes offer protection for people with disabilities.
- Chapter VIII (Family and Community Life) then explores family and community life: identifying existing restrictions for people with disabilities to participate in these activities and the types of assistance people with disabilities need from their families and communities.

The report then provides a brief conclusion. Throughout the report, attention is paid to the experience of people with disabilities, the barriers they face, and recommendations for improving their lives. All the recommendations contained in each of the chapters are briefly summarised in the conclusion.

Chapter II
Disability Research Activity : Approach to the Study

A comprehensive approach to data collection was undertaken in order to obtain a full picture of the impact of disabilities on people's lives. Disability is a complex phenomenon that has impacts across virtually all sectors of society. Quantitative data on the scale and scope of the issues was needed but also qualitative data on the dynamics of how having a disability affects people's lives. All this information needs to be placed within the legal and policy framework of Indonesia in order to better understand the barriers and opportunities people with disabilities face.

After conducting a legal and policy review, a three-part strategy was employed to obtain information on the lives of people with disabilities.

1. Part I consisted of a secondary data analysis from existing data sources to derive prevalence of disability and characteristics of people with disability as well as factors associated with disability.
2. Part II involved design and fielding of a quantitative survey with 2,200 PWDs as respondents in 11 selected provinces in Indonesia. The survey instrument was developed applying the bio-psycho-social model of disability of the WHO's ICF and was designed to both improve the measure of disability, and to fill the gap from secondary data on functional difficulties and barriers to participation.
3. Part III consisted of a qualitative study involving in-depth interviews with related stakeholders at the provincial level and focus group discussions (FGDs) with PWDs as participants in six selected provinces.

Part I: Secondary Data Analysis

This study benefitted from large Indonesian data sets that are representative of the general population at the national and provincial levels. However, each data set applies different concepts and measurements of disability and functional limitations, some of which are methodologically superior to others. The data sets selected for this study—the 2010 Population Census and the 2007 National Basic Health Research (*Riset Kesehatan Dasar* or Riskesdas)—applied a functional approach consistent with WHO's ICF and the United Nations (UN) Statistical Commission's Washington Group of Disability. Nevertheless, results from these two data sets reveal differences in prevalence rates. These differences stem in part from the more extensive list of functional questions in the Riskesdas but also probably from the way the instruments were implemented.

In addition, the Indonesia Family Life Survey 2007 contains a variety of questions related to activity levels, daily living, mobility, etc. that are asked of respondents aged 40 years and older. There are some questions on disability, but they ask whether the disabling condition was diagnosed by doctors and health professional/ paramedics. The concern about using data from this survey was that the survey excludes health and disability conditions for people that have not had their condition assessed by medical staff and may have limited access to health professionals and thus bias the results. Also, many conditions that can lead to disabilities do not fall into specific medical diagnostic categories. This is one of the reasons why the ICF moved away from using this approach.

The matrix in table 2.1 presents data that could be used in this study; it shows that only census and Riskesdas data are appropriate for estimating prevalence of disability.

Table 2.1. Review of Existing Data for Analysis in This Study

Existing Data	Producers	Sample / Coverage	Type of Questions Asked	Eligibility for This Study
2010 Population Census	BPS: Statistics Indonesia	Complete coverage: entire population	Modified version of Washington Group* census questions on disability	Eligible with limitation: Underreported number of PWDs compared with Riskesdas. Possible to conduct regression to present patterns of characteristics of PWD respondents. Prevalence rates probably reflect the most seriously disabled, so a lower bound on overall prevalence.
Basic Health Survey: Riskesdas 2007	Centre for Health Research and Development Ministry of Health: Puslitbangkes	Large sample survey of 258,366 households. Sample is drawn as a subset of the larger representative survey, that is, Susenas† 2007	Very comprehensive and detailed questions on functional limitations; adopted concept of ICF. Other information related to health and characteristics of respondents	Highly eligible, and can provide prevalence of disability, functional difficulties, and other characteristics of respondents, especially related to health. Information on consumption and expenditure on food and nonfood are not in Riskesdas 2007, but it is possible to merge data with Susenas† 2007 to obtain picture of poor PWDs.
Susenas†: module on sociocultural factors (2009)	BPS: Statistics Indonesia	Large sample survey of 291,888 households. Contains characteristics of respondents—individuals as well as households—information on housing characteristics, consumption, and expenditures in order to estimate poverty line.	Questions on impairment rather than functional limitation, causes of disabilities, and whether disabilities affect social functioning of respondents	Not eligible for this study, due to different concept and definition of disability
2007 Indonesia Family Life Survey	Survey Meter and Rand Corporation, USA	Longitudinal survey, following same respondents over time. Initial survey conducted in 1993 with representative sample of 7,000 households.	Very detailed and elaborate questionnaires covering many aspects of respondent livelihoods, including activities and mobility of respondents, with focus on measuring activities of daily living (Book IIIb).	Eligible with limitation-only activities, aged 40 years and older. The data set is not representative nationally as the sample was originally drawn in 1993 from 13 of 27 provinces in Indonesia. It also consists of longitudinal data, which means the sample was originally drawn based on the age structure of Indonesia's population in 1993 and the same sample is constantly re-interviewed for the next wave. By 2007 the Indonesia age structure had changed. The sample also underwent some attrition; many of the respondents are dead or have moved and cannot be traced. Thus, 2007 Indonesia Family Life Survey respondents may also not match with the 1993 picture. This has a severe impact on deriving rates or prevalence. Only displayed patterns of changes in the lives of respondents. A number of the disability questions are tied to diagnosis by a health professional, which creates a bias towards finding disabilities among populations with access to health professionals and misses disabilities not clearly linked with a particular medical diagnosis.

Table 2.1. Review of Existing Data for Analysis in This Study (continued)

Existing Data	Producers	Sample / Coverage	Type of Questions Asked	Eligibility for This Study
Survey on the Need for Social Assistance Programmes for People with Disability (SNSAP-PWD) 2012	Demographic Institute, Faculty of Economics, University of Indonesia.	2,200 respondents from 11 provinces. Purposive sample due to the challenges in finding PWDs at the grassroots level.	Contains information adopting WHO concept of ICF and detailed characteristics of respondent PWDs and information on social protection and unmet need of services. This survey was conducted to fill the gap in information that is not available from existing data.	Highly eligible for the study but 'purposive' sample.[‡] Good to see relationship between disability and factors associated with functional difficulties. Not suitable for estimating disability prevalence. Overrepresentation of people with severe disabilities.

* *Susenas* = Survei Sosial Ekonomi Nasional *(National Socioeconomic Survey).*

[†] *Washington Group = UN Statistical Commissions' Washington Group on Disability Statistics.*

[‡] *A purposive sample is not random, but designed to include respondents with a wide range of characteristics.*

Description of Census 2010 Data

Indonesia has conducted population censuses every 10 years since 1961, but only Census 2010 contains questions on functional difficulties consistent with the approach of the UN Statistical Commissions' Washington Group (WG) on Disability Statistics. A detailed discussion of these questions and their comparison to WG questions, as well as a theoretical discussion of disability measurement issues can be found in Chapter IV.

The census provides complete coverage on all Indonesian households. Thus, census data are free from sampling errors. However, non-sampling errors or content errors are unavoidable, especially when asking about functional difficulties. Errors may be the result of misunderstandings by the respondents about the questions or miscommunication between enumerators and respondents. Questions about functional difficulties may be unfamiliar to the respondents. Only with patience and knowledge and sensitivity can enumerators obtain better responses. This takes a much longer time. In the case of the Indonesian population census, asking 237.6 million people is too costly and time consuming to apply the full standards/guidance outlined in the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) guidelines for collecting data on disabilities (WHO and UNESCAP 2008). Therefore, underreporting of cases of certain functional difficulties is likely to occur.

Nevertheless, because the census has complete coverage and also contains respondents' characteristics, such as age, sex, urban, rural, province, education, and employment, a first national estimate of disability prevalence rates can be derived. (See Chapter IV).

Description of Riskesdas 2007

To provide additional data on disability prevalence, this study also explores data from Riskesdas 2007. The National Institute of Health Research and Development, Ministry of Health, Republic of Indonesia, conducted this survey in August 2007–January 2008 in 28 provinces and August– September 2008 in East Nusa Tenggara, Maluku, North Maluku, Papua, and West Irian Jaya). The aim of this survey was to support evidence-based health information systems by collecting basic data and health indicators. The survey collected detailed information related to disability and mental health.

Riskesdas 2007 is a cross-sectional survey. The sample is drawn from the population of all households in the entire Republic of Indonesia; each household has an equal probability of being included. The sample of households and household members in Riskesdas 2007 was designed identically with the household sample in the 2007 National Socioeconomic Survey (*Survei Sosial Ekonomi Nasional* or Susenas).

Riskesdas 2007 collected information from the 258,366 households sampled and the 987,205 household members sampled for measurement of several public health indicators. Detailed questions included in Riskesdas 2007 and the 2010 Population Census can be found in Chapter IV (Disability Prevalence and General Demographic Features).

Part II: Quantitative Survey: Survey on the Need for Social Assistance Programmes for People with Disability

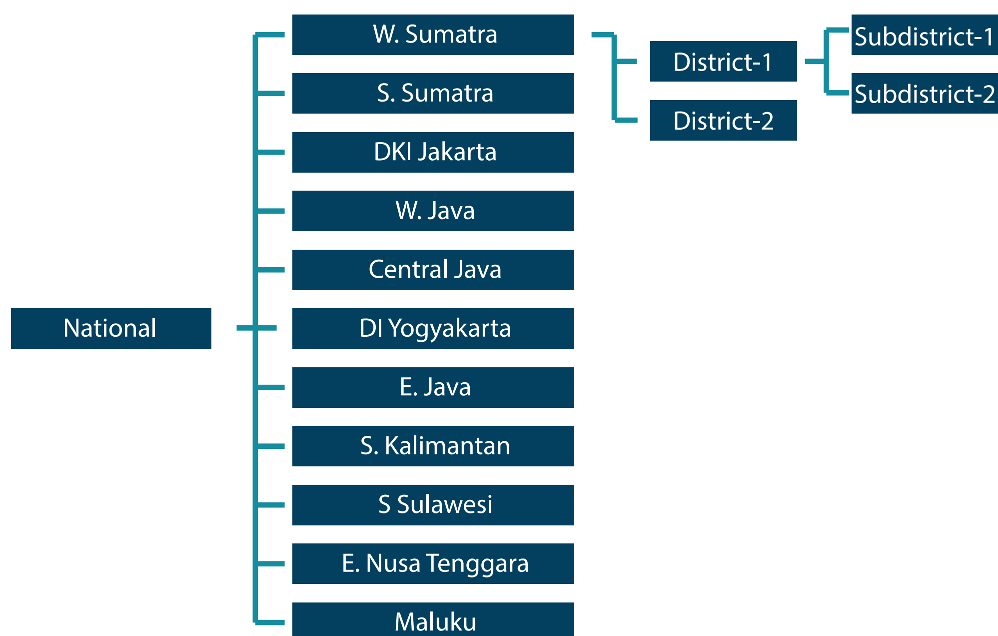
The 2012 Survey on the Need for Social Assistance Programmes for People with Disability (SNSAP-PWD) was conducted in 11 selected provinces determined by TNP2K and the Demographic Institute (Figure 2.1). The selected areas covered 3 provinces in western Indonesia (Sumatra and Kalimantan), 5 provinces in central Indonesia (Java), and 3 provinces in eastern Indonesia (Sulawesi, East Nusa Tenggara, and Maluku) for a total of 2,200 individuals with disabilities.[4]

The applied sampling procedure can be classified as purposive sampling. In each province, two districts were drawn, resulting in a total of 22 districts sampled. These districts were chosen on the basis of Census 2010 including information on the largest number of PWDs in each district and also the availability of disabled people organisations (DPOs) at the district level.[5] The existence of a DPO at the district level was important to guide the fieldworkers in finding respondents at the subdistrict level down through to the village level. Interviews were conducted at the home of PWDs. The selection of subdistrict-level samples depends on the guidance of the DPO at the district level. In cases in which the required number of 200 respondents in two districts could not be met, the deficit was sought from adjacent districts. For example, in Banjarmasin and Barito Kuala Districts in South Kalimantan Province, the total of 200 disabled respondents could not be met, so more interviews were conducted with PWDs from the adjacent Banjarbaru District. Table 2.2 presents the selected provinces and the districts in each of the provinces.

[4] From the terms of reference: implementation of surveys, focus groups, key informant questionnaires, and other data collection from administrative programs at sites approved by TNP2K.

[5] The list of district DPOs is obtained through several steps: first, DPO Headquarters provided a list of DPOs at the provincial level by name and address of the administrators. At the provincial level, lists were obtained of DPOs at the district level (*Kabupaten* and *Kota*) by name and by address. If the district or municipal had no DPO, information on the location of PWDs was obtained from the Office of Social Affairs at the district level.

Figure 2.1. Study Area



In each selected district, respondents were selected using three approaches. The first approach used a list of recipients from MoSA's Social Assistance for Disabled People (*Jaminan Sosial Penyandang Cacat* or JSPACA). JSPACA is a social security programme for people with disabilities. The name of the program changed in 2012 to Social Assistance for People with Severe Disability (ASODKB), by which it will be referred in this document. The second approach used the list of members of DPOs such as the Association of Disabled Persons Indonesia (*Persatuan Penyandang Cacat Indonesia* or PPCI), Organisation of PWDs with Visual Impairment, etc. The third approach used a snowball process (explained below) based on recommendations from the head of the village, community members, and respondents themselves. The three different approaches were used in order to obtain better variation in the data. PWDs in the ASODKB recipient list were severely disabled with no chance of being rehabilitated, whereas most PWDs who did not receive ASODKB had potential for work and self-care.

The procedure in snowball sample selection starts by obtaining a list of members from DPOs. Some provinces had no active DPOs, so interviewers talked to village office staff as alternate sources of information on PWDs' whereabouts. The names of possible respondents on the resulting list sometimes did not match the ones found at the intended addresses. This could be explained by nicknames used in day-to-day life or changes of addresses for listed PWDs. To overcome this issue, after interviewing a respondent, the interviewer would ask the PWD or his/her family members whether they were aware of other PWDs living in the area. Based on this information, the interviewers were able to find other eligible PWDs to interview.

People with disabilities who were isolated (or hidden by their families) were least likely to be found during sample selection. Also, people with nonphysical disabilities (such as mental health issues, mild cognitive delays, or developmental issues, such as autism) were less likely to be recommended. As pointed out in Chapter IV, this might explain the greater proportion of severely disabled people in the survey compared with the nationally representative Riskesdas survey.

Table 2.2. List of Provinces, Districts, and Subdistricts Selected

Province Code/BPS	Province		District		Sub-district
13	West Sumatra	1	Kab. Agam	1	Lubuk Basung
				2	Palupuh
		2	Kab. Padang Pariaman	1	Nan Sabaris
				2	VII Koto
16	South Sumatra	1	Palembang City	1	West Ilir II
				2	East Ilir I
				3	Kertapati
		2	Lahat	1	West Merapi
				2	South Merapi
31	DKI Jakarta	1	East Jakarta	1	Cakung
				2	Pulo Gadung
		2	North Jakarta	1	Cilincing
				2	Koja
32	West Java	1	Kab. Bandung	1	Ciparay
				2	Pameungpeuk
		2	Kab. Sukabumi	1	Cikidang
				2	Cisolok
33	Central Java	1	Kab. Sragen	1	Gemolong
				2	Sukodono
		2	Magelang City	1	South Magelang
				2	Central Magelang
34	DI Yogyakarta	1	Kab. GunungKidul	1	Palian
				2	Saptosari
		2	Kab. Bantul	1	Banguntapan
				2	Imogiri
35	East Java	1	Kab. Nganjuk	1	Bagor
				2	Gondang
		2	Kab. Sidoarjo	1	Candi
				2	Sidoarjo
53	East Nusa Tenggara	1	Kab. Central South Timor	1	North Molo
				2	Boking
				3	East Amanuban/Faut Molo
		2	Kupang City	1	Alak
					Oebobo

Table 2.2. List of Provinces, Districts, and Subdistricts Selected (continued)

Province Code/BPS	Province	District		Sub-district	
63	South Kalimantan	1	Banjarmasin City	1	West Banjarmasin
				2	North Banjarmasin
		2	Barito Kuala	1	Cerbon
				2	Wanaraya
				3	Marabahan
73	South Sulawesi	1	Makasar City	1	Tallo
				2	Tamalate
		2	Takalar	1	North Galesong
				2	North Polongbangkeng
81	Maluku	1	Central Maluku	1	Amahai, replaced with Leihitu
				2	Salahutu
		2	Ambon City	1	Teluk Dalem
				2	Baguala

Note: Where DPOs did not exist or were not active at the district level, the selected district had to be replaced with an adjacent district with a DPO. Access to Amahai District in Maluku by sea was severed for two weeks due to bad weather, so Amahai was replaced with Leihitu.

** DI = Daerah Istimewa (Special Area).*

Survey Instruments

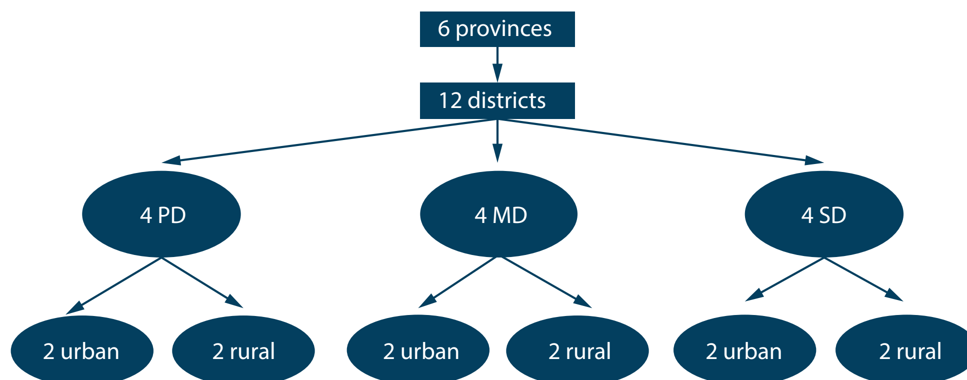
The sample for this study focused on PWDs aged 10 years and older because a survey for children with disabilities requires a different strategy as well as different instruments.[6] The WG, for example, explicitly stated that its questions were not suitable for small children and is currently testing a new set of questions for children.[7] Due to the technical difficulties and added expense, it was determined that undertaking a study of disabled children was not feasible at this time. As UNICEF rolls out their recommendations, we recommend that Indonesia participate in the next available round of data collection on disability in children.

Questionnaires and protocols were developed using measures in line with the concept and measurement of disability underlying the ICF, the WG disability question set, the UNESCAP Training Manual for Disability Surveys (WHO and UNESCAP 2008). Before these were developed, a workshop on the concept and measurement of disability/functional difficulties and UNCRPD was conducted. This was followed by another workshop on 'Sensitising Disabilities' led by Mimie Lusli and other PWDs acting as resource persons. This activity was intended to change field workers' mindsets from the medical disability concept to the bio-psycho-social model of disability, which focuses on functional limitations and environmental barriers to participation (see further explanation in Chapter VI). Disabled resource persons were asked to act as live respondents to test the survey instruments. Feedback from these respondents was highly useful in improving the survey instruments and survey protocol, as well as sensitising fieldworkers to disability issues.

[6] Decision made based on recommendation of Daniel Mont, the study's disability consultant, in line with recommendations from the Working Group on Childhood Disability of the UN Statistical Commission's Washington Group on Disability Statistics. Currently, UNICEF and the Washington Group are testing new questions and a two-stage procedure for identifying children with disabilities that will be recommended for rollout in the next round of the UNICEF's Multiple Indicator Cluster Survey.

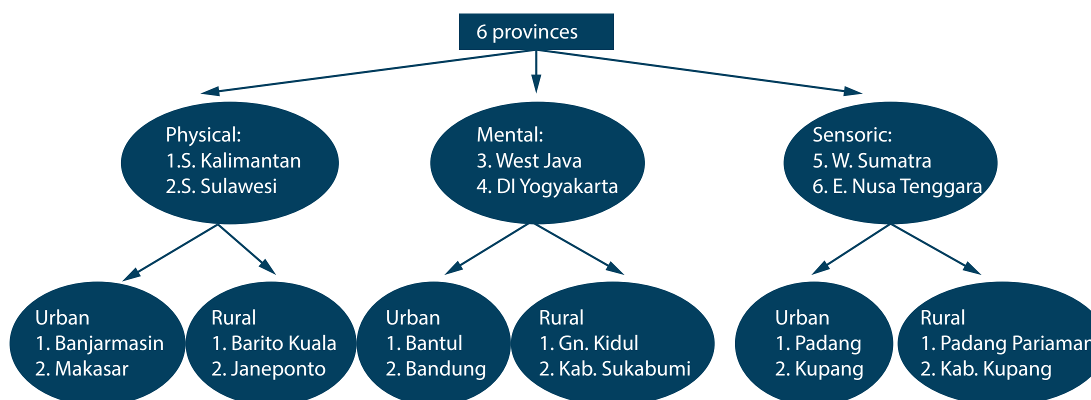
[7] There is a separate ICF for children (ICF-Children and Youth or ICF-CY) as well. Currently, UNICEF is overhauling its recommended procedures for collecting data on disability in children.

Figure 2.2. Design: FGD Implementation



Note: PD = physical difficulty; MD= motoric difficulty; SD= sensoric difficulty.

Figure 2.3. Provinces and Districts Selected for FGDs and In-Depth Interviews



Information collected in this survey included the following (see Annex 1 for the final questionnaire):

- Geographic location
- Demographic and socioeconomic background of the respondents
- Functional limitations, onset of disability, participation in education and employment, family and community activities, assistive devices, services needed and used, social protection, etc.

Table 2.3. Province, District, and Type of Difficulty

No.	Disability/Dificulty	Province	District
1	Physical	South Kalimantan	Banjarmasin (urban)
			Barito Kuala (rural)
2	Physical	South Sulawesi	Makassar (urban)
			Janeponto (rural)
3	Mental	West Java	Bandung (urban)
			Kab. Sukabumi (rural)
4	Mental	DI Yogyakarta	Bantul (urban)
			Gunung Kidul (rural)
5	Sensory	West Sumatra	Kota Padang (urban)
			Kab. Padang Pariaman (rural)
6	Sensory	East Nusa Tenggara	Kupang City (urban)
			Kab. Kupang (rural)

Part III: Qualitative Survey

The qualitative research consisted of FGDs and in-depth interviews. FGDs were conducted with PWDs, and in-depth interviews with stakeholders such as staff of the Ministries of Social Affairs, Manpower, Transportation, Education, Public Works, and Health. The qualitative research was intended to identify stakeholder perceptions on the need to expand social protection programmes for PWDs and the potential barriers for their implementation, both from the supply side and from the beneficiaries.

In each province there were two FGDs organised for PWDs and six interviews with local staff of stakeholders (figures 2.2 and 2.3). The six provinces were selected based on their representation of western, central, and eastern Indonesia and their cultural variations. The six provinces were Special Area (*Daerah Istimewa* or DI) Yogyakarta, East Nusa Tenggara, South Kalimantan, South Sulawesi, West Sumatra, and West Java. The FGD participants were determined as follows: 2 provinces conducted FGDs with participants with sensory disabilities, 2 provinces conducted FGDs with participants with motoric disabilities, and 2 provinces conducted FGDs with participants with mental disabilities (table 2.3).

Each FGD had 8 to 10 participants consisting of the following:

- Younger (15–30 years) and older (31–60 years)
- Men and women
- Members and nonmembers of DPOs

The participants were quite evenly distributed according to disability type; for example, sensory difficulties included people with vision and hearing difficulties, mental disabilities included those with cognitive difficulties (e.g., Down Syndrome) and developmental issues (e.g., autism), and motoric difficulties included people with either upper or lower body impairment, regardless of cause.

To conduct the FGDs, qualitative researchers worked with DPOs at the local level: PPCI for PWDs with motoric difficulties in South Kalimantan (Banjarmasin and Barito Kuala) and South Sulawesi (Makassar and Jeneponto); PPCI for PWDs with sensory difficulties in Padang; and PPCI and the Organisation of PWDs with Visual Impairment in Kupang. One FGD was conducted at the provincial level and another one at the district level.

In-depth interviews were conducted at national and district levels. Six in-depth interviews were carried out at the district level with two districts in each province, resulting in 12 in-depth interviews carried out in each province included government staff in the district offices of social affairs, manpower and transmigration, health, education, public works, and transportation.

In-depth interviews were conducted at the national level with ministry offices in Jakarta and several disability associations. This included representatives from the following government offices:

- Directorate on Social Protection and Directorate on Manpower at Bappenas
- Directorate on Mental Health and Directorate General of Health Development Efforts at the Ministry of Health
- Sub-Directorate on Special Employment Placement at the Ministry of Manpower and Transmigration
- Directorate on Special Education and Special Services at the Ministry of Education
- Directorate on People with Disability and Directorate on Social Rehabilitation at the Ministry of Social Affairs
- Centre on Public Communication at the Ministry of Transportation

Due to time constraints, the Ministry of Public Works was not interviewed during the study timeline. In addition, in-depth interviews were also conducted with related organisations, such as the following:

- Association of Indonesian Entrepreneurs
- Trade unions (*Serikat Pekerja*)
- PPCI

Chapter III
Legal Framework for Persons with Disabilities in Indonesia

Introduction

Before the enactment of Law No. 4 of 1997 on Persons with Disability, terminology used to label PWDs had been evolving since the early years after the Declaration of Independence in 1945. However, the concept of disability has always centred on a person with functional impairments. A person is labelled with a prefix ber-, which means 'has' or 'to own' disability(ies). A person with disability(ies) or abnormality(ies) is explicitly assumed to suffer from the consequences of impairment (to suffer: *menderita* is a person who suffers: *penderita*). The label '*tuna*', which also means 'disability' in Javanese or 'lacking of' or 'without' in Bahasa Indonesia was introduced in 1974 as a socially and politically correct term to deal with prostitutes (*tunasusila*: without manner), homeless (*tunawisma*: without home), and other '*tuna*' to label impairment (*tunarungu*: without hearing; *tunadaksa*: without physical ability, etc.).

During 1995–97 when the Law on People with Disabilities was formulated and enacted, the terminology chosen was '*Penyandang Cacat*'—a term already used in public policy. The term was initially used in Law No. 15 of 1992 on Aviation (article 42) (see summary in Table 3.1). In Law No. 4 of 1997, articles number 6, 8, 10, 11, 12, 13, 14, and 16 include statements on the right of PWDs to have access to education and work; to live according to their particular degree of disability; and to have public facility access and equal opportunity and treatment in all aspects of their lives and livelihoods. These articles also gave the government and/or community administrators the means for providing rehabilitation and social assistance and maintaining social welfare standards (see Annex 6). Law No. 4 of 1997 is implemented through Government Regulation No. 43 of 1998 on 'Efforts and Undertaking in Social Welfare for People with Disability'.

Political reform during the monetary crisis of 1998 provided a window of opportunity for adopting universal human rights principles as part of Indonesia's domestic laws. Soon after the transition of power from the New Order regime, the newly elected parliament enacted Law No. 39 of 1999 on Human Rights, which lays out the basic principles of further laws and regulations to avoid discrimination in all aspects of people's lives. This was followed by an amendment of the 1945 Constitution to include clauses on human rights.[8] Articles 28 a, b, c, d, and h clearly state the rights of every citizen to have access, to live, and defend his/her life and existence; establish a family; have access to basic needs, and obtain an education, employment, health, and social protection. However, no statement clearly and specifically includes the rights of PWDs. These laws and regulations, however, are seen as outdated and do not reflect current international concepts of disability, which view disability as a human rights issue and recognises disability as a consequence of PWDs' interaction with the environment (Colbran 2010).

A rights-based approach to disability policy has been introduced by the Bamako Millennium Framework for Action 1992–2002 and renewed in the second Biwako Millennium Framework for Action (2003–12) Plus Five in which Indonesia is a member state. During the first framework, Price and Takamine (2003) reported lessons learned from the Asian and Pacific Decade of Disabled Persons, 1993–2002; they praised Indonesia as one member country that had achieved recognisable progress in national coordination and legislation; whereas less than 25 percent of UNESCAP member countries have passed comprehensive disability legislation and only eight have antidiscrimination measures. Law No. 4 of 1997 on Persons with Disability and a number of related government regulations and ministerial decrees were products of this global movement. As noted above, the national law was available for implementation, but it was not a rights-based legal instrument.

[8] The Constitution is the foundation of the political and legal system of the government, often codified as a written document it contains the rules and principles of the political and legal entities. In this report, the term includes the structure, procedures, powers, and duties of state government, and the rights and responsibilities of its citizens ('*Konstitusi*' 2012).

Table 3.1 Evolution of the Concept of Disability in National Legislation

Terminology	Meaning (English)	Documents	Notes
(Ber)cacat	With disability(ies)	*Undang-undang* (Law) *Nomor 33 Tahun 1947 tentang Ganti Rugi Buruh yang Kecelakaan* (on compensation for work-related accident)	Revised
		Undang-undang (Law) *Nomor 4 Tahun 1979 tentang Kesejahteraan Anak*	Revised
Orang-orang yang dalam keadaan kekurangan jasmani atau rokhaninya	Persons who have a physical or mental disability	*Undang-undang* (Law) *Nomor 12 tahun 1954 tentang dasar-dasar pendidikan dan pengajaran di sekolah untuk seluruh Indonesia* (Fundamental Principles for Teaching and Learning for All Indonesian Schools)	Revised
Tuna such as in *tunarungu* (deaf) *Orang yang terganggu atau kehilangan kemampuan untuk mempertahankan hidupnya*	Javanese: loss, disability Bahasa: without, lacking Persons who are disturbed or have lost the ability to survive	*Undang-undang* (Law) *Nomor 6 Tahun 1974 tentang Ketentuan-ketentuan Pokok Kesejahteraan Sosial* (on principal provisions in social welfare)	In effect
Penderita cacat	Persons suffering from disabilities	*Peraturan Pemerintah* (Government Regulation) *Nomor 36 Tahun 1980 tentang Usaha Kesejahteraan Sosial Bagi Penderita Cacat* (Welfare Services for Persons Suffering from Disability)	In effect
		Undang-Undang (Law) *Nomor 14 Tahun 1992 tentang Lalu Lintas Angkutan Jalan* (on ground traffic)	Revised
Penyandang kelainan	Abnormalities	Peraturan Pemerintah (Nomor 72 Tahun 1991 tentang Pendidikan Luar Biasa (on special education)	Revised
Kelainan fisik, emosional, mental, intelektual, dan/atau sosial	Physical, emotional, mental, intellectual, and/or social abnormalities	*Undang-undang* (Law) *Nomor 20 Tahun 2003 tentang Sistem Pendidikan Nasional* (on the national system of education)	In effect
Anak berkebutuhan khusus (*anak luar biasa*)	Children with special needs (special needs children)	*Surat Edaran Direktorat Jenderal Pendidikan Dasar Dan Menengah* (Circular Letter of Directorate General of Primary and Secondary Education) *Nomor 380/G.06/MN Tahun 2003 Perihal: Pendidikan Inklusi* (on inclusive education).	In effect
Penyandang cacat	Disability	First used in *Undang-Undang* (Law) *Nomor 15 Tahun 1992 tentang Penerbangan* (on aviation; see article 42).	Revised

In 2004 Indonesia developed a National Plan of Action (NPoA RENAKSI) for People with Disabilities 2004–13 (Ministry of Social Affairs, 2004). This NPoA was developed as an implementation of the consensus on a ministerial meeting in Otsu Shiga, Japan, 25–28 October 2002. It follows the seven priority areas of the first Millennium Biwako Framework, plus one issue—international collaboration and human rights—to accommodate the local situation. Thus the eight priority areas stated in the NPoA were (1) training and employment, including self-employment, (2) early detection, early intervention, and education, (3) poverty alleviation through capacity building, social security, and sustainable livelihood programmes, (4) access to built environments and public transport, (5) access to information and communications, including assistive technologies, (6) private organisation of PWDs and association of parents who have children with disabilities, (7) women with disabilities, and (8) international relations and human rights.

The expected outcomes of the NPoA include the following:

- Gaining political commitments among stakeholders, especially policy makers, nongovernmental organisations (NGOs), community and religious leaders, and disability experts to improve the welfare of PWDs
- Building and strengthening informal support from the family and community for PWDs
- Building formal support for PWDs to have access to health care and social protection
- Strengthening institutions concerning PWDs through collaboration inter- and intra-sectors, both national and international
- Strengthening PWD participation in family life, communities, the nation, and states
- Developing guidance to improve the welfare of PWDs to be implemented by all stakeholders at national, provincial, districts, and municipal levels

The 2004–13 NPoA was developed on the basis of the Biwako Millennium Framework of 2003 and has not been updated to accommodate the Biwako Millennium Framework Plus Five in 2007. It has been suggested that the NPoA be updated/expanded to include five strategies for achieving the seven priorities above by:

- reinforcing a rights-based approach to disability issues;
- strengthening comprehensive community-based approaches to disability issues;
- promoting an enabling environment and strengthening effective mechanisms for policy formulation and implementation;
- improving the availability and quality of data and other information on disabilities; and
- promoting disability inclusive development.

Achievements from the 2004–2013 NPoA have been less than satisfactory. Commitment by other sectors is still very minimal, which might be due to lack of effort in advocating with stakeholders.

The UNCRPD represents a paradigm shift in attitude and approaches to PWDs: how to promote, protect, and ensure the full enjoyment of all human rights and fundamental freedoms equally for all people with disabilities and to promote respect for their inherent dignity.

The Government of Indonesia's ratification of the UNCRPD provides an opportunity for new policy making for PWDs in Indonesia. Previous antidiscrimination clauses in the Universal Declaration of Human Rights, International Covenant on Civil and Political Rights, and International Covenant on Economic, Social, and Cultural Rights (e.g., in article 2 of the Universal Declaration of Human Rights) did not explicitly mention impairment or disability.[9] PWDs were included under the heading 'other status', which contributed to the 'invisibility' of their rights.

The UNCRPD adopts the social and human rights model (Quinn and Degener 2002). This model suggests that 'disability' is a constructed phenomenon based on cultural perceptions of human differences. That is, disability is not so much a personal characteristic as an outcome of an environment that places barriers in the way of people with functional impairments. PWDs do not make or create the disabling conditions; the powers that construct society do. Often it is ignorance, attitudes, behaviour, and other social, cultural, and political factors that perpetuate exclusion of certain people, including those with physical or mental impairments. The preamble of the convention states:

> *(e) Recognising that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.*

Human rights values and norms start with dignity, freedom, and nondiscrimination for all people, regardless of gender, ethnicity, disability, or any other attribute. All human beings have an equal right to claim their part in society as someone with a sense of self-worth and a valued member of their community. It is our moral obligation to recognise that PWDs are holders of unconditional rights and that discrimination based on disability is a violation of a person's dignity and self-worth.[10]

The UNCRPD also marks significant progress in the fulfilment of the rights of PWDs. The UNCRPD preamble section 'm' recognises that PWDs' existing and potential contribution to their society will result in an enhanced sense of belonging and in significant advances in the human, social, and economic development of society, as well as eradication of poverty.

As explained earlier, Law No. 4 of 1997 on Persons with Disability represents the current Indonesian legal framework on disability. This law defines PWDs as someone with physical or mental 'abnormalities', or 'disabilities', or 'impairment'[11] that can potentially disturb or hinder their normal daily activities (article 1[1]). As such, lack of participation or disability is caused by impairment in the person. It does not recognise that the society could be creating the conditions that cause the person to be disabled, that is, to not be able to undertake the activities necessary for being a full member of society.

The following review will look specifically on the impact of this definition on existing laws and regulations and the consequences to the rights to full participation and development of PWDs.

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[9] Article 2 of the Universal Declaration of Human Rights, granting rights 'without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'. See Schulze (2009).

[10] UNCRPD Preamble (h).

[11] The terminology used to conceptualise disability is '*kelainan*', which literally means 'different than the norm'.

Requirement to Be Physically and Mentally Sound

Article 28 of the 1945 Constitution[12] contains all the principles of human rights. Indonesia enacted its own Law No. 39 of 1999 on Human Rights, which establishes the rights of PWDs. With ratification of the UNCRPD, discrimination based on disability became illegal and unconstitutional. The reality, however, is that the notion that PWDs are not capable of performing typical daily activities prevails in many laws and regulations that require a person to be 'physically and mentally' healthy or 'sound' in order to be eligible for a programme, represent oneself in a court of law, occupy official positions, or access (monetary) services (Colbran 2010). No explicit explanations are provided. It is usually stated as 'already clear (*sudah jelas*)—no need for further explanations'. In the amendment of Law No. 3 of 1998 (see Annex 6 for other specific provisions).These legal clauses incorporate the notion that disability is lodged only within the individual. A person is deemed 'not healthy' and thus automatically seen as incapable of work—independent of the particular job and particular situation. No recognition exists that with appropriate accommodations, many people with disabilities could undertake—or at least participate in—these activities. The standard in many disability rights laws is that society has the responsibility of providing 'reasonable accommodations', if it will enable such participation.

People with physical disabilities often only need physical accommodations. Even people with mental illness (such as schizophrenia) are often perceived as living in a schizoid mental state all his/her life, but in fact, many of them, when treated properly, may have productive lives without episodes of the disease.[13]

Exclusion from Inclusive Education

The right of PWDs to obtain quality education is stated in Articles 28c and 31 of the 1945 Constitution; Article 31, paragraph 2 suggests that every citizen should complete six years of basic education paid by the government. Article 5, paragraph 1, of Law No. 20 of 2003 on the National Education System states that every citizen has the right to a quality education; paragraphs 2 and 4 suggest that PWDs and those with superior talents should have access to special education; and paragraph 5 states that all citizens have the right to improve their education in the course of their lives. However, the World Report on Disability 2011 (WHO and World Bank 2011) indicated that gaps in school enrolment of children with disabilities aged 6 to 11 and 12 to 17 years old, compared with their peers without disabilities, were 60 percent and 58 percent, respectively in Indonesia (WHO n.d., p. 207).

Access to special education has been problematic as the number of special schools is very limited. They are available only in large cities, especially in Bali, Java, and Sumatra. Children with special needs in rural areas, and in areas other than those three major islands, have no or very limited access. In addition, the number of training institutions for training teachers in special education is significantly limited and training courses are undersubscribed among prospective students applying for higher education degrees. According to the Ministry of Education and Culture, Indonesia does not have enough teachers that can teach special education programmes. Only 11 universities in the country have programmes that prepare teachers for special needs

[12] The Indonesian legal system is hierarchical; the constitution sits at the highest level. Thus, every law needs to be based on the constitution, and every government regulation (*peraturan pemerintah*) should be based on the constitution and laws. Government regulations (*peraturan pemerintah*) are developed as guidelines for implementation of any laws. The constitution, laws, and government regulations are binding on all parties. Meanwhile, ministerial regulations (or ministerial decrees) or circular letters from ministries are not binding. They are guidelines/suggestions on approaching issues.

[13] Mr. Nurhamid Karnatmaja in district of Cianjur was himself once a psychiatric patient and received proper treatment. For four years he has been reaching out to more than 800 patients who are neglected and shackled at home. He is able to mobilise treatment for them and convince the local government to provide them with state-subsidised health insurance. Sources: PBS News Hour at http://www.pbs.org/newshour/bb/health-july-dec11-mentalhealth_07-18/ ; Indopos Online: *Jelajahi Kampung, Pakai Mantan Pasien*. Accessed 11 October 2011 at http://www.indopos.co.id/2011/10/jelajahi-kampung-pakai-volunteer-mantan-pasien.html

[14] Jakarta Post, 21 March 2013

children.[14] Currently there are about 1,803 special schools from kindergarten to secondary high schools (Ministry of Education and Culture 2009–10). The majority (1,366 or 75 percent) are privately owned. In the 2009–10 school year, these schools accommodated 74,293 students with special needs and 17,217 teachers.[15] This is the reason the Ministry of Education and Culture issued consecutive Circular Letter[16] No. 6719/C/I of 1989 to extend opportunities for children with minor disabilities to be admitted to regular schools and No. 380/G.06/MN of 2003 on inclusive education (see table 3.2 for definitions). This was followed by Government Regulation No. 10 of 2010 that provides for instruction without any discrimination at all levels of education, including discrimination based on disability.[17]

Table 3.2. Definitions of Inclusive Education

Source	Original Statement	English Translation
Surat Edaran Direktorat Jenderal Pendidikan Dasar dan Menengah nomor 380/G.06/MN tahun 2003 Perihal: Pendidikan Inklusi (Circular Letter)	*Pendidikan inklusi adalah pendidikan yang mengikut-sertakan anak-anak yang memiliki kebutuhan khusus (anak luar biasa) untuk belajar bersama-sama dengan anak sebayanya di sekolah umum.*	Inclusive education is education that welcomes the participation of children with special needs (extraordinary children) to learn together with their peers in regular schools.
Prosedur Operasi Standar pendidikan inklusi Direktorat Pembinaan Sekolah Luar Biasa Direktorat Jenderal Mandikdasmen Departemen Pendidikan National tahun 2007 (Standard Operational Procedures)	*Pendidikan inklusif adalah sistem layanan pendidikan yang memberikan kesempatan kepada semua anak belajar bersama-sama di sekolah umum dengan memperhatikan keragaman dan kebutuhan individual, sehingga potensi anak dapat berkembang secara optimal.* *Semangat pendidikan inklusif adalah memberi akses yang seluas-luasnya kepada semua anak, termasuk anak berkebutuhan khusus, untuk memperoleh pendidikan yang bermutu dan memberikan layanan pendidikan yang sesuai dengan kebutuhannya.*	Inclusive education is a system of education services that provides opportunities for all children to learn together in a regular school, while accommodating variations in individual needs so that children's potential can optimally develop. The spirit of inclusive education is to provide the widest access to school to all children, including children with special needs, to obtain quality education and to provide services appropriately according to their needs.

The government's Circular Letter No. 380/G.06/MN of 2003 on inclusive education was issued following the Dakar Commitment and Agenda of Action (2000).[18] This circular later received positive responses expressed in the Bandung Declaration (2004) on inclusive education in Indonesia (*Indonesia menuju pendidikan inklusif*) and Bukit Tinggi Recommendations (2005) on quality improvement and accessible education for all. In 2007 the Ministry of Education and Culture through the Directorate on Special Education and Directorate on General of Elementary and Secondary Education issued an Standard Operating Procedure on providing inclusive education. This operational procedure defines what constitutes inclusive education institutions and provides the background philosophy and appropriate school management, which includes alternative approaches to learning needs and curriculum development; alternative measurement of students' achievement; different procedures on passing grades; requirements of teachers; and so on.

[15] http://www.psp.kemdiknas.go.id/uploads/Statistik%20Pendidikan/0910/index_plb_0910.pdf recalculated

[16] A 'circular letter' is usually a letter from the head of a government institution or department addressed to all of its members and the society. It contains an announcement, an appeal, or an explanation that is considered relevant and of interest to the public. Although not legally binding, circular letters are usually effective and followed up by action.

[17] *Surat Edaran Direktorat Jenderal Pendidikan Dasar dan Menengah nomor 6719/C/I tahun 1989 perihal Perluasan Kesempatan Belajar Bagi Anak Berkelainan di Sekolah Umum. Surat Edaran Direktorat Jenderal Pendidikan Dasar dan Menengah Nomor 380/G.06/MN Tahun 2003 Perihal:Pendidikan Inklusi. Peraturan Pemerintah Nomor 10 tahun 2010: Non-diskriminasi.*

[18] The government's circular letter is not legally binding; however, it is usually effective and followed up by an action.

In implementing the policy, however, challenges were instantly observable. First, the concept of inclusive education as defined in the standard operating procedures has not been widely socialised and practiced. Often, when referring to 'inclusive' schools, stakeholders are actually talking about integrated schools.[19] An inclusive school has a child-centred focus with a flexible curriculum and teachers trained to adapt their methods to the learning styles of all children—disabled and nondisabled alike. This may also involve special services delivered in the classroom or as pull-out services. An integrated school simply means that disabled children are present in the classroom, although they may also receive some special services. An integrated approach is less effective (see the citations in the education chapter). Even in special schools, children with certain types of disability, especially mental and intellectual disabilities, have not been appropriately accommodated. Although accessibility, assistive devices, and appointment of a special education teacher are supposed to be subsidised by the state, real investments to achieve the goal are inadequate.

Vernor Munoz (2007), a UN special rapporteur on the rights to (inclusive) education for PWDs concluded that despite all Indonesia's achievements to date, it lacks genuine political will to achieve the goals of disability legislation and policies. In the context of inclusive education, he observed a significant gap between the legal framework and resources made available to realise rights to inclusive education. Consequently, many children with special needs have been put into 'special classes' in a special room with special education teachers in so-called 'inclusive' schools (Irwanto et al. 2011 and Irwanto et al. 2010). Many parents have pulled their children out of these schools, as they saw their children were not getting optimal treatment and input. Furthermore, special education teachers have not been getting adequate support to build a career in regular schools. Many of them eventually decided to move back to special schools where their career is supported by government policy.[20]

Postsecondary Schooling

What about higher education and training? As indicated above, Law No. 10 of 2010 suggests that all levels of education should have a nondiscriminatory admission policy. The low enrolment of PWDs may be caused by a number of factors. First, almost all physical infrastructure in colleges and universities was not built with universal accessibility in mind. This in itself is intimidating for many PWDs. Second, most if not all registration and selection systems are not disability friendly. No higher institutions have a written protocol to assist prospective students with disabilities (Rofah 2010).[21] For example, when the Centre for Disability Studies was established in 2006 at the Faculty of Social and Political Sciences in the University of Indonesia, the administration was not able to provide the centre with the number of students who have disabilities. Their special needs were not considered important for registration and, therefore, not recorded. Third, it is commonly understood that disability awareness among administrative staff and lecturers is quite low. Fourth, enrolment of students with disabilities in the senior secondary school is much lower than their nondisabled peers as indicated by the World Report on Disability 2011 (WHO and World Bank 2011).

Article 19 of Law No. 13 of 2003 on Manpower stipulates that, 'Job training for workers with disabilities is conducted by considering the types of disability, the level of severity and the skills of the workers.' The labour sector, however, does not have a strong mandate to provide vocational training to PWDs. The mandate falls to MoSA. The Main Centre for Vocational Rehabilitation for Physically Disabled Persons (*Balai Besar Rehabilitasi Vokasional Bina Daksa* Cibinong) was established to accommodate this mandate. Currently, however, this facility

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[19] See Rudiyati (2011) and Firdaus (2010).

[20] Based on interviews with parents. See Irwanto et al. (2011) and HKI and Unika Atma Jaya (2009). At this time, no national policy exists to support the careers of teachers with special education background working in regular schools.

[21] A number of physical audits have been performed by Disabled Students of Universitas Negeri Jakarta (2011), Puska Disabilitas FISIP Universitas Indonesia (2012).

has a serious capacity limitation, as it can only train about 130 participants a year. Moreover, some people with disabilities are excluded from the programme, for example, people with paraplegia, epilepsy, and colour blindness; persons in need of medical rehabilitation; those with infectious disease or who have no fingers and/or hand coordination; wheelchair users; those who cannot stand for a long time; and those who only obtained junior secondary schooling. Persons with hearing and speech impairments must have a senior secondary school certificate. All of these exclusion criteria seriously limit the number of participants that can be served by the centre.

Disability as a Reason to Terminate Employment and Family Relationships

Employment of PWDs in Indonesia is statutorily guaranteed by Law No. 4 of 1997 on Persons with Disability, followed by Government Regulation No. 43 of 1998 to implement the law, which requires that one of every 100 employees should be a PWD. This stipulation, however, has been observed to be ineffective. Markus Sudibyo (2002), who reviewed the policy, indicated that the government failed to implement the quota policy in part because policy makers and prospective employers saw PWDs only as customers of rehabilitation services. The lack of urgency in implementing the law was reinforced by the lack of data and information on the magnitude of the problem and the situation of PWDs, both for policy makers (labour inspectors in the field) and prospective employers. The government failed to provide tangible incentives to compliant institutions. All of this reflects how unimportant disability issue has been in this sector.

Serious challenges in harmonisation of domestic law are apparent in the labour sector. Law No. 13 of 2003 on Manpower clearly prohibits termination of work based on disability. Article 153 paragraph 1 (j) of the law clearly states that employers cannot discharge employees when they are ill or disabled during their duty time, except when their disability has continued for more than 12 months during which time they have been unable to perform their duties (article 172). The penalties or sanctions are not specified.

In practice, the right of PWDs to employment is not guaranteed. Indonesia's domestic laws and regulations still contain provisions that give employers the right to terminate a relationship on the basis of disability. Law No. 13 of 2003 and a Joint Decree of the Ministry of State Apparatus and Ministry of Internal Affairs No. 01/SKB/M.PAN/4/2003 No. 17/2003 allows officers who recruit and terminate state employment to cancel the employment of a prospective employee if s/he is disabled. They also have the authority to terminate employment of a government staff member on the basis of permanent disability during duty. This goes on without much debate because the public and, hence, the community of PWDs are not well informed about this policy.

The labour policy also contains loopholes and inconsistencies when it comes to protection of employees. Law No. 13 of 2003 on Manpower, article 67, stipulates the following:

Paragraph (1) 'Employers who employ workers with disability have to provide protection based on his/her disability.'

Paragraph (2) 'Protection provision as told in article (1) is implemented according to the existing laws and regulations.'

What does 'protection' mean? 'Protection as it is meant under this article shall be performed in the forms of providing accessibility, provision of devices to enable the person to work, provision of devices to protect oneself that is adjusted to the type and severity of one's impairment' (*Perlindungan sebagaimana dimaksud dalam ayat ini misalnya penyediaan aksesibilitas, pemberian alat kerja, dan alat pelindung diri yang disesuaikan dengan jenis dan derajat kecacatannya*). Failure to implement this article is punishable by 1 to 12 months imprisonment or a fine of as much as Rp10–100 million (Article 187). Protection is also mentioned in Article 87, which states that every worker has the right to be protected through standards of occupational health and safety, morals, and decency and be granted dignified and respectful treatment. The right to social insurance (*jaminan sosial*) is stipulated in Article 99. Unfortunately, these articles do not protect the employee from being discharged on the basis of his/her disability.

Related to family life and disability, Law No. 1 of 1974 on Marriage, Article 4, paragraph 2, enforced through Government Regulation No. 9/1975, Section V, Article 19 (e) allows a husband to file for divorce because of his wife's inability to perform her role as a (subservient) wife because of a disability.[22] This is widely practiced and no political forces to this date are able to amend this law.

Disability as a Subpopulation with Social Problems

The 1945 Constitution (article 34) mandates the government to care for and provide social protection for poor citizens. Protection of PWDs is overseen by the Ministry of Social Affairs. Law No. 4 of 1997 on Persons with Disability provides for government assistance for PWDs living in poverty (article 1). Consistent with the law, the Ministerial Regulation of the Minister of Social Affairs No. 82/HUK/2005 concerns the duties and procedures of the Department of Social Affairs. The focal point for handling issues concerning PWDs in Indonesia is the Indonesian Ministry of Social Affairs.

This decision has far reaching consequences. Although Law No. 43 of 1998, Article 4 on Efforts and Undertaking in Social Welfare for People with Disability states that the government should provide equal opportunities, rehabilitation, social assistance, and government assistance to maintain the quality of welfare of PWDs, the status of the MoSA as the disability focal point has relegated PWDs to a subpopulation with social problems (*penyandang masalah sosial*)[23] in the realm of public policy. This is demonstrated in Ministerial Decree No. 06B/HUK/2010 concerning provision of welfare services in 50 less-developed districts and Ministerial Decree No. 80/HUK/2010 concerning budget planning guidelines to achieve a minimal standard of quality welfare services in the provinces, municipalities, and districts. Persons with disabilities are included in the same category as the homeless, beggars, prostitutes, ex-prisoners, trafficking survivors, drug users, and neglected senior citizens. The Decree of the Governor of Jakarta No. 8 of 2007 on Public Order, Article 41, also stipulates that persons who have illnesses that can disturb public order are prohibited to conduct activities on the street and in public gardens and other public spaces. The reasons behind this policy stem from a desire to exclude persons with leprosy and psychoses, although interpretations of this provision may include PWDs in a general sense.

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[22] *Bab V tata cara perceraian. Pasal 16 Pengadilan hanya memutuskan untuk mengadakan sidang pengadilan untuk menyaksikanperceraian yangdimaksud dalam Pasal 14 apabila memang terdapat alasan-alasan seperti yang dimaksud dalam Pasal 19Peraturan Pemerintah ini, dan Pengadilan berpendapat bahwa antara suami isteri yang bersangkutan tidakmungkin lagi didamaikan untuk hidup rukun lagi dalam rumah tangga. Pasal 19. (e) Salah satu pihak mendapat cacat badan atau penyakit dengan akibat tidak dapat menjalankankewajibannya sebagai suami/isteri*;

[23] *Kemensos RI–Panduan Pendataan PMKS dan PSKS Tahun 2007* (Manual for Data Collection).

In 2011 the ASEAN Senior Official Meeting on Social Welfare and Development renewed its commitment to implement its Strategic Frameworks on Social Welfare 2007–10 and 2011–15. Through this framework, member states declared the ASEAN Decade of Persons with Disabilities (2011–22) toward an Inclusive Society. This framework binds its member states to work hand in hand to improve the quality life of vulnerable and marginalised populations, including the elderly and PWDs. Promoting self-reliance of older persons and PWDs to be productive members of the community has been an important concern in the 2007–10 and earlier strategic frameworks. In the current 2011–15 framework, ensuring old-age pension schemes, mainstreaming disability, and ensuring equal access to the employment market for PWDs are included in the agenda of actions. Indonesia has been assigned in particular to provide oversight on CBR with Malaysia. How these commitments are channelled through the national development agenda has not been very clear. Although Indonesia was the ASEAN chair in 2011, very little improvements were observed in its national disability policy. DPOs and civil society organisations were more enthusiastic about the UNCRPD ratification. Information on this strategic framework was not well promoted among them and, probably, among authorities at the subnational level.

Accessibility, Mobility, and Community Participation

Accessibility and special provisions for sick people, elderly, and disabled have been addressed in earlier laws on transportation, such as Law No. 13 of 1992 on Railways, Law No. 14 of 1992 on Ground Traffic and Transportation, Law No. 15 of 1992 on Aviation, and Law No. 21 of 1992 on Sailing and Seafaring. Each of these laws lacks specific guidelines on design (see Annex 6 for more complete notes). One of the achievements during the first-decade review of the Biwako Millennium Framework for Indonesia was the enactment of the Decree of the Ministry of Transportation No. KM-71/1999 on accessibility for PWD in transportation facilities and infrastructures (8 September 1999) to support Article 8 on accessibility for the disabled in Law No. 4 of 1997 on Persons with Disability. This decree outlines in detail what universal design means, along with the correct structural measurements (Irwanto and Hendriati 2002). Following this decree, the state enacted three relevant laws that are supposed to support provision of accommodation and accessibility: Law No. 28 of 2002 on Building (with implementing regulations), Law No. 11 of 2008 on Electronic Information and Transactions (with no provisions addressing PWD needs), and Law No. 22 of 2009 on Ground Traffic (which has two articles that address accessibility for pregnant women, elderly, sick people, and people with disabilities).

Unfortunately, all these well-intentioned laws and regulations have not been seriously enforced. Observations and accessibility audits in major cities such as Bandung, Jakarta, and Solo revealed that very few public buildings, government offices, markets and malls, religious buildings, tourism facilities, and other public infrastructures constructed have complied with the law after its enactment and have not received any sanctions (Irwanto et al. 2011). This is not to say there has been no progress. New buildings have been constructed with accessibility according to the law. In Jakarta, the governor has been advised by a special task force providing oversight on physical accessibility. Generally speaking, however, their advice has not been taken seriously. People with physical or mobility challenges still find it difficult to go out on the streets or pedestrian walks in Jakarta. Barriers such as uneven walkways or dangerous cracks or holes are everywhere. Public transportation, such as buses or trains, has no accessibility accommodation. PWDs also find it difficult to participate in religious ceremonies, as only very few mosques, churches, and temples are aware of the needs of PWDs.

Latest Developments

As a consequence of UNCRPD ratification, the Indonesian government, led by MoSA, has started to engage in revision of Law No. 4 of 1997 on Persons with Disability or drafting of a new disability law. It should be noted, however, that Law No. 19 of 2011 on Ratification of the UNCRPD translated 'person with disabilities' to '*penyandang disabilitas*'. The term '*penyandang*', as indicated earlier, defined the problem in terms of the persons, contrary to the message of the convention. In addition, the government does not see the need to ratify the optional protocol of the UNCRPD, which contains a mechanism for reporting.

DPOs and national civil society organisations have also pressured the government to adopt and implement the Incheon Strategy to make the rights real for PWDs in Asia and the Pacific 2013–22 and to include a disability-inclusive framework in the post-2015 global development agenda.[24] The Incheon Strategy commits member states to achieving the following 10 disability-related goals:

- Reduce poverty and enhance work and employment prospects
- Promote participation in political processes and in decision making
- Enhance access to the physical environment, public transportation, knowledge, information, and communication
- Strengthen social protection
- Expand early intervention and education of children with disabilities
- Ensure gender equality and women's empowerment
- Ensure disability-inclusive disaster risk reduction and management
- Improve reliability and comparability of disability data
- Accelerate ratification and implementation of UNCRPD and harmonisation of national legislation with the convention
- Advance subregional, regional, and interregional cooperation. Each goal has specific targets and indicators.

Three draft proposals from the National Commission of Human Rights, DPO Indonesia Disabled People's Association (*Persatuan Penyandang Cacat Indonesia*), and the government are currently under discussion. During a meeting organised by MoSA on 27–28 March 2013 in Bogor, civil society organisations and DPOs voiced their concerns about MoSA as the focal point for disability issues. The needs of PWDs should be addressed at a multisectoral level. MoSA alone is not able to deal with the multifaceted issues of disabilities. On 23 January 2013, the government issued Presidential Decree No. 29 of 2013 on health insurance, to be fully enforced in 2014. Chapter 3, Article 7, of the decree indicates that only poor persons with permanent and 'total' disability (*cacat total tetap dan tidak mampu*) are eligible for the scheme—a potentially problematic provision. In addition, exclusion criteria for the scheme that may disadvantage PWDs include the following from Article 25:

- (e) aesthetic purposes
- (h) health problems related to alcohol and drug problems, self-inflicted trauma, or illnesses
- (j) complementary treatment
- (n) health services related to situation of emergencies.

[24] See Statements of the Indonesian Consortium on Disability Rights; 'Political Commitment on the Fulfillment and Protection of the Rights of Persons with Disabilities by World Leaders' Post 2015.

Conclusion

Analysis of the Indonesian legal framework on disability issues clearly suggests that the influence of the medical model based on impairment is very dominant. This is especially true in Law No. 4 of 1997 on Persons with Disability, which describes PWDs as those with a 'disability'. New amendments to the 1945 Constitution and enactment of Law No. 39 of 1999 on Human Rights have not been used to revise existing laws and regulations in order to adopt the rights-based approach. Consequently, there are inconsistencies and conflicting legal provisions and policies. Ratification of the UNCRPD provided a new opportunity to revise Law No. 4 of 1997, harmonise related laws, and adopt the social- and rights-based model into existing policies and programmes. Initial steps toward fulfilling state obligations have been moving forward. There are some indications, however, that policy makers will take serious steps to create significant space for the participation of PWDs. Their interests and needs should not be guessed by those who themselves have not experienced disabilities. PWDs will be best served by listening to PWD voices.

Chapter IV
Disability Prevalence and General Demographic Features

Introduction

This chapter presents an overview of the prevalence of disability in Indonesia according to basic demographic characteristics. First, it is important to define what is meant by disability and how it is measured in this report. As noted in preceding chapters and explained in more detail below, disability in this report is not tied to the idea of a personal 'disability' but rather to the interaction between human functioning and environmental barriers to participation in the community, that is, the 'social model of disability', which conceives of disability as arising from the interaction between a person's functional limitations and their environment. The UN Convention on the Rights of Persons with Disabilities (UNCRPD) states, 'Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'

In other words, a person might have an impairment that prevents them from moving their legs, thus making them incapable of walking, but what makes that person disabled is an inaccessible physical environment, lack of assistive devices, and negative attitudes that erect barriers for their participation in society. Therefore, disability is not synonymous with a medical diagnosis but rather emerges from an interaction between personal functioning and the environment. This is important, because it means that policies to help PWDs should not only focus on their impairments and functional limitations but on societal barriers that are limiting their participation in work, school, family life, etc.

This concept of disability underlies WHO's International Classification of Functioning, Disability, and Health (Figure 4.1). The ICF refers to disability as 'an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)'.

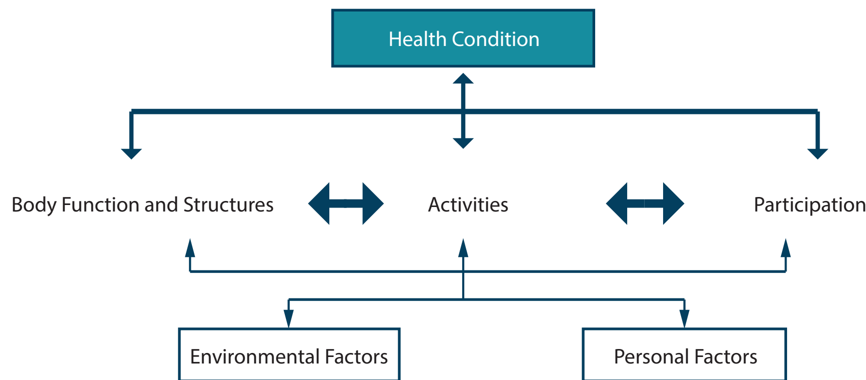
In the ICF diagram below, functional limitations are broken down into three categories: body structure and functioning, activities, and participation. An example of a limitation in 'body structure and functioning' is not being able to move one's legs. An example of an 'activity' is walking, and 'participation' refers to higher-order activities such as attending school, being employed, and participating in civic activities, that is, undertakings that involve coordination of many activities.

A health condition may lead to an impairment that limits body functioning. The extent to which that leads to a disability is affected by environmental factors. This includes not only the physical environment but also the cultural and policy environments. Personal factors—such as personal and family resources—also play a role in determining to what extent impairments lead to disability.

The ICF describes in detail the full range of human functioning at the adult levels for body function and structure, activity, and participation in terms of various functional domains, for example, vision, hearing, communication, and fine and gross motor skills.

Capturing this complicated model in a single statistic is impossible. Which box or arrow one concentrates on depends on the nature of the question being asked. As this report focuses on the barriers that prevent people from full participation, disability is defined at the basic activity level (based on a set of functional questions) and the analysis explores how the environment and personal factors influence whether those people are capable of full participation in society. In other words, this report uses 'disability' as shorthand for the presence of functional limitations in core functional domains that put a person at risk of being disabled in the social model sense.

Figure 4.1 International Classification of Functioning Model



This is also the approach taken in the Washington Group in their design of recommended census questions. Again, the approach for determining the prevalence of disability is to classify people with basic activity limitations as being disabled but then examine the association of those activity limitations with ability to participate in society.

Trying to use participation-type measures to define disability can be very difficult for analytical purposes. In the purest social model sense, a person with physical impairments who lives in an inclusive environment and does not experience any participation restrictions is not disabled. Thus they would disappear into aggregate statistics of the well-being of people with disabilities. Relying solely on body functioning (the most medical aspect of the ICF) is totally divorced from the idea of the interaction between functional impairments and the environment. Thus, the approach of the WG and other analysts has been to define people by their difficulty doing very basic activities; although this is close to the idea of impairment, it still involves the interaction of body function and the environment on a basic level (e.g., the same person can have a lot of difficulty walking in a rural mountain village but only a little in a modern city) but at a level that can be measured accurately and consistently. Nevertheless, when analysing the outcomes of people thus identified as having a disability, it is important to remain cognisant of the role of the environment in creating disability. In other words, basic activity limitations identify a group of people 'at risk' of being disabled in the social model sense, but the extent to which this risk is associated with lower participation is a function of the environment and reveals a role for policy in improving the lives of people with disabilities.

The functional limitations that underlie disability can range from minor to severe. Therefore, this report will undertake the analysis of disability using measures of mild and more severe disabilities. For some purposes—for example, determining eligibility for disability pensions—a severe cut-off might be appropriate. However, for designing accessible public transportation systems or inclusive education systems, a broader range of functional difficulties should probably be considered. Severity is determined by how much difficulty a person has undertaking basic activities in a core set of functional domains. For example, someone who has a lot of difficulty walking or is unable to do so would be severely disabled. Someone with some difficulty walking would have a mild disability.

Prevalence of Disability

Indonesia has two data sources that provide independent estimates of the prevalence of disability[25]: the 2010 national census and the 2007 Riskesdas household survey. Estimates from these sources are very different. One reason could be the different questions. This section first reviews the nature of those questions and then reports results on prevalence using both data sources.

Disability Questions in Census 2010 and Riskesdas 2007

Box 4.1 presents the disability questions from Census 2010 and Riskesdas 2007. The census questions are similar to those recommended by the Washington Group (Box 4.2) with a few distinctions. Both use a core set of functional questions targeting the basic activity level. In fact, the first three questions are identical to the WG questions, although the response categories are slightly different; the WG divides difficulties into four response levels, whereas the Indonesian census collapses them into three categories.

Box 4.1. Riskesdas 2007 and Census 2010 Disability Questions

RISKESDAS Questions
In the past month:

1. How difficult is it to see and to recognise people across the street (approximately within 20 meters), although you have used glasses/contact lenses?
2. How difficult is it to see and recognise objects at arm length/reading distance (30cm), although you have used glasses/contact lenses?
3. How difficult is it to hear people speak in a normal voice who stand on the other side of the room, although you have used hearing aids?
4. How difficult is it to hear people talking with others in a quiet room, although you have used hearing aids?
5. How bad is the feeling of pain/discomfort?
6. How bad is the feeling of shortness of breath after doing light exercise? For example climbing 12 steps of stairs?
7. How bad is the suffering from a cough or sneeze for 10 minutes or more in one attack?
8. How often are sleep disturbances (e.g. frequent drowsiness, frequent awakening at night, or waking up earlier than usual)?
9. How often are health problems that result in the emotional state of feeling sad and depressed?
10. How difficult is it to stand for 30 minutes?
11. How difficult is it to do a long distance walk of about one kilometre?
12. How difficult is it to concentrate on activities or to remember anything for ten minutes?
13. How difficult is it to clean the whole body, for example, having a shower?
14. How difficult is it to wear clothes?
15. How difficult is it to do daily activities?
16. How difficult is it to understand the speech of others?
17. How difficult is it to interact/associate with people not known before?
18. How difficult is it to maintain friendships?
19. How difficult is it to fulfil responsibilities as a member of the household?
20. How difficult is it to participate in community activities (gathering, pengajian, religious activities, or other activities)?

Response categories: None, A Little (ringan), Mild (sedang), Severe (berat), Very Severe (sangat berat).

Census Questions

1. Do you have difficulty seeing, even when wearing glasses?
2. Do you have difficulty hearing, even when using a hearing aid?
3. Do you have difficulty walking or climbing stairs?
4. Do you have difficulty remembering, concentrating, or communicating with others due to a physical or mental condition?
5. Do you have difficulty in self-care?

Response categories: None, A Little, A lot.

[25] Prevalence rates by gender, rural/urban, and age group for each province are available from TNP2K upon request

Box 4.2. Census Questions on Disability Prevalence Recommended by UN Washington Group on Disability Statistics

Introductory phrase:
The next questions ask about difficulties you may have doing certain activities because of a health problem.

1. Do you have difficulty seeing, even when wearing glasses?
2. Do you have difficulty hearing, even when using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example, understanding or being understood?

Response categories: No, no difficulty; Yes, some difficulty; Yes, a lot of difficulty; Cannot do at all.

Another difference is that in the Indonesian census the WG question on remembering and concentrating is combined with the communication question into one question. The complicated nature of this question may lead to an undercounting of mental disabilities. Cognitive testing on the WG and similar questions have revealed that combining multiple concepts into a single question produces more false negatives, as people are often confused and think they need to have all the difficulties mentioned in the question, even if the word 'or' is used (Miller et al. 2010). The final question in the census simply refers to self-care; whereas the WG questions give a couple of examples of what is meant by self-care, which may make the question more understandable to respondents and thus elicit more positive responses.

Riskesdas 2007 also contains functionally based questions, but they are more extensive. Space in censuses is very tight, which limits the number of disability questions that can be included. However, Riskesdas had the luxury of expanding the question set to contain multiple questions on seeing, hearing, mobility, and self-care and was able to ask separate questions on cognition and communication, as well as on socialising. In addition, Riskesdas contains some body function questions (coughing, pain, and shortness of breath) as well as some questions on participation level, namely, engaging in work and community activities.

Unfortunately, however, the Riskesdas questions do not allow easy separation of people by type of disability, that is, the four basic categories of disability—physical, mental/cognitive, sensory, and psychological/behavioural. The Riskesdas question on concentrating or remembering for 10 minutes can classify someone as having a mental disability; however, some people have developmental disabilities that are also 'mental' in nature, for example, difficulty maintaining friendships. But the way the friendship question is phrased, one could have difficulty maintaining friendships because one is housebound due to a physical disability, has a terrible disfigurement from burns, or one's deafness prevents speaking to people. The same can be said for the question on daily activities; a person could have trouble going to the market because of a mobility problem or because of an inability to deal with money. As a result, answers to these questions cannot generate prevalence estimates separately for mental and physical disabilities.

The exact specifications for classifying different levels of disability using the questions from these two data sources can be found in Annex 7.

Prevalence Rates

Prevalence rates for disability from Census 2010, broken down by age and gender, can be found in Table 4.1. The overall rate of disability is about 4.3 percent. This is significantly lower than in other countries using functionally based questions. According to the World Report on Disability 2011 (WHO and World Bank 2011), most countries have a roughly 15 percent rate of disability. As seen later in this chapter, when the broader array of functional questions in the Riskesdas data are used, the prevalence rates align more with those found in other countries cited in this report.

Table 4.1 also shows the degree of disability. Some 2.38 percent of people have some difficulty in a single functional domain, whereas 0.20 percent have a severe difficulty in one functional domain. Another 1.14 percent have difficulties in multiple domains but only at a lower level. In addition, 0.56 percent of people have difficulties in multiple domains with at least one severe difficulty. This leads to a total disability prevalence of 4.29 percent. Women have a 4.64 percent rate, compared with 3.94 percent for men.

Table 4.2 shows the range of disability prevalence using the Riskesdas data. **Overall, about 42 percent of the population reports at least a little difficulty in functioning** in at least one domain (100 minus the 57.59 percent with no difficulties), but this includes many people who would not be considered disabled. In fact, 16.84 percent report only a little difficulty and 14.52 percent some difficulty. A reasonable cutoff for disability suggested by the Washington Group is having a lot of difficulty in at least one functional domain. According to that definition, 11.05 percent of the population have a disability: 8.03 percent have a lot of difficulty in at least one functional domain, and 3.02 percent are unable to do one of the core activities.

Women have higher rates of disability—12.57 percent compared with 9.40 percent for men—but this is in part due to women's higher life expectancy, as older people are significantly more disabled than children, youth, or working age adults. For example, only 1.09 percent of those aged 20–24 is unable to do a core activity, 1.59 percent of those aged 40–44, but 9.75 percent of those aged 65–69. After age 70 that rate rises dramatically to beyond 40 percent for those aged 85 and older.

These rates are higher than those found in the census. Therefore, before looking at the Riskesdas data in more detail, it is worthwhile comparing those numbers more closely with the census prevalence rates. One reason for the higher rate could be that Riskesdas asked a broader range of functional questions. Table 4.3, therefore, reports the rates of disability by functional domain in the census and Riskesdas using only those Riskesdas questions that closely correspond to the census questions. Another reason could be interviewer training. In other countries, census numbers have been lower than survey numbers in part because less trained census enumerators are often reticent about asking disability questions because they are embarrassed or do not want to offend people, and so only record obvious disabilities and miss people whose disabilities are not readily apparent (Mont 2007).

As table 4.3 shows, even when limiting the functional domains to those asked about in the census, results from the Riskesdas data generally show a higher rate of disability. This could be because of the wording of the questions, different response categories, framing of questions within the broader survey, or differences in interviewer training, including sensitisation of issues pertaining to disability.

Table 4.1 Disability Prevalence (%) by Age, Gender, and Degree of Disability Using Indonesian Census, 2010

Age Group	None	Type of Disability				
		Some	Severe	Some (multiple)	Severe (multiple)	Total
Male and Female						
0–14	97.61	1.20	0.15	0.32	0.27	1.94
15–34	98.42	0.66	0.11	0.12	0.21	1.10
35–49	96.75	2.33	0.17	0.30	0.27	3.08
50–69	88.02	7.43	0.41	3.07	0.99	11.91
70+	62.18	11.69	0.96	17.77	7.35	37.78
Total	**95.71**	**2.38**	**0.20**	**1.14**	**0.56**	**4.29**
Male						
0–14	97.57	1.22	0.16	0.33	0.29	1.99
15–34	98.17	0.65	0.12	0.13	0.24	1.13
35–49	96.77	2.24	0.19	0.27	0.29	2.98
50–69	88.88	7.34	0.42	2.37	0.89	11.02
70+	65.24	12.20	1.00	15.48	6.08	34.76
Total	**96.06**	**2.32**	**0.21**	**0.91**	**0.50**	**3.94**
Female						
0–14	97.66	1.17	0.15	0.31	0.26	1.89
15–34	98.93	0.68	0.10	0.11	0.18	1.07
35–49	96.83	2.42	0.16	0.33	0.25	3.17
50–69	87.20	7.53	0.41	3.77	1.09	12.80
70+	59.92	11.32	0.93	19.50	8.32	40.08
Total	**95.36**	**2.45**	**0.20**	**1.37**	**0.62**	**4.64**

The age and gender profiles of disability prevalence can be seen more clearly in Figures 4.2a and 4.2b. Figure 4.2a shows the prevalence rates for ages by gender using a low-threshold definition of disability—that is, the sum of people with some difficulty, a lot of difficulty, or who are unable to do an activity. People who only report a little difficulty with an activity are not considered to have even a mild disability. Having that response category in the question, however, is important in order to more effectively identify people with mild disabilities. Figure 4.2b, using a high-threshold definition of disability, excludes those with some difficulty, and so only contains those people with more severe disabilities.

Using either measure, the age profiles for men and women are very similar, but women report a higher rate of disability at every age. This is especially true for the high-threshold measure of disability. Using the low-threshold measure, women have a 28 percent disability rate compared with 23 percent for men, 5 percentage points or about a 22 percent higher rate. For the high-threshold measure, they have a 12.57 percent rate of disability compared with 9.40 percent for men, a difference of about 3 percentage points or a 34 percent higher rate. From these graphs, it is clear that, as the population of Indonesia ages, the disability rate could rise significantly.

Table 4.2 Distribution of Respondents (%) by Age Group and Degree of Disability, Riskesdas 2007

Age Group	Type of Disability					
	None	A Little	Mild	Severe	Very Severe	Total
Male						
15–19	77.46	11.93	6.97	2.44	1.20	100.00
20–24	75.92	13.07	7.37	2.40	1.23	100.00
25–29	74.46	13.71	8.10	2.68	1.05	100.00
30–34	71.70	14.79	9.56	3.02	0.94	100.00
35–39	68.84	16.65	10.03	3.48	1.01	100.00
40–44	59.60	19.71	13.98	5.35	1.35	100.00
45–49	54.06	20.55	16.73	6.99	1.66	100.00
50–54	44.22	22.19	21.65	9.56	2.38	100.00
55–59	39.72	22.50	22.93	11.57	3.27	100.00
60–64	28.42	20.41	26.79	18.30	6.08	100.00
65–69	23.99	18.65	28.61	20.60	8.15	100.00
70–74	15.41	14.91	27.50	28.94	13.23	100.00
75–79	13.30	12.47	27.49	30.29	16.46	100.00
80–84	8.48	8.90	22.58	34.73	25.31	100.00
85+	6.17	6.67	17.07	34.85	35.23	100.00
Total	**60.49**	**16.53**	**13.58**	**6.83**	**2.57**	**100.00**
Female						
15–19	74.29	13.11	8.06	3.51	1.03	100.00
20–24	72.20	14.17	9.08	3.58	0.97	100.00
25–29	69.82	15.24	9.87	3.94	1.13	100.00
30–34	66.32	16.57	11.54	4.40	1.17	100.00
35–39	62.67	17.95	12.96	5.19	1.23	100.00
40–44	52.66	21.00	17.01	7.52	1.81	100.00
45–49	45.85	21.96	19.92	9.93	2.34	100.00
50–54	36.39	22.57	24.04	13.29	3.71	100.00
55–59	30.98	21.76	26.12	16.63	4.51	100.00
60–64	20.41	18.00	29.67	23.48	8.44	100.00
65–69	16.71	16.13	28.95	26.98	11.22	100.00
70–74	9.86	11.36	25.59	33.78	19.40	100.00
75–79	8.55	10.20	23.99	34.70	22.56	100.00
80–84	5.85	6.71	17.56	37.60	32.28	100.00
85+	4.64	3.65	14.09	32.57	45.04	100.00
Total	**54.92**	**17.12**	**15.40**	**9.14**	**3.43**	**100.00**

Table 4.2 Distribution of Respondents (%) by Age Group and Degree of Disability, Riskesdas 2007 (continued)

Age Group	Type of Disability					
	None	A Little	Mild	Severe	Very Severe	Total
Male and Female						
15–19	75.89	12.51	7.51	2.97	1.12	100.00
20–24	73.92	13.66	8.29	3.03	1.09	100.00
25–29	71.94	14.54	9.06	3.36	1.09	100.00
30–34	68.82	15.74	10.62	3.76	1.06	100.00
35–39	65.62	17.33	11.56	4.37	1.12	100.00
40–44	56.00	20.38	15.55	6.47	1.59	100.00
45–49	49.87	21.27	18.36	8.49	2.01	100.00
50–54	40.33	22.38	22.84	11.42	3.04	100.00
55–59	35.48	22.14	24.48	14.03	3.87	100.00
60–64	24.28	19.17	28.28	20.97	7.30	100.00
65–69	20.19	17.34	28.79	23.94	9.75	100.00
70–74	12.42	13.00	26.47	31.55	16.55	100.00
75–79	10.79	11.27	25.64	32.62	19.68	100.00
80–84	7.00	7.67	19.76	36.34	29.23	100.00
85+	5.30	4.94	15.36	33.54	40.86	100.00
Total	**57.59**	**16.84**	**14.52**	**8.03**	**3.02**	**100.00**

Source: Authors' calculations based on all provinces of Indonesia

Table 4.3 Comparison of Census 2010 and Riskesdas 2007 Prevalence Rates, Using Census Definition, Aged 15+

	Riskesdas	Census
Vision	5.5	3.4
Hearing	1.7	1.8
Walking	4.9	1.8
Cognitive plus communication	3.0	1.6
Self-care	0.9	1.1

Riskesdas questions:

Vision = seeing near plus seeing far

Hearing = hearing normal voice plus talking in a quiet room

Walking = walking one kilometre

Cognitive plus communication = concentrating plus understanding others

Self-care = clean whole body plus getting dressed

Figure 4.2a Disability Rate (%) by Age and Gender Using a Low Threshold of Disability, Riskesdas 2007

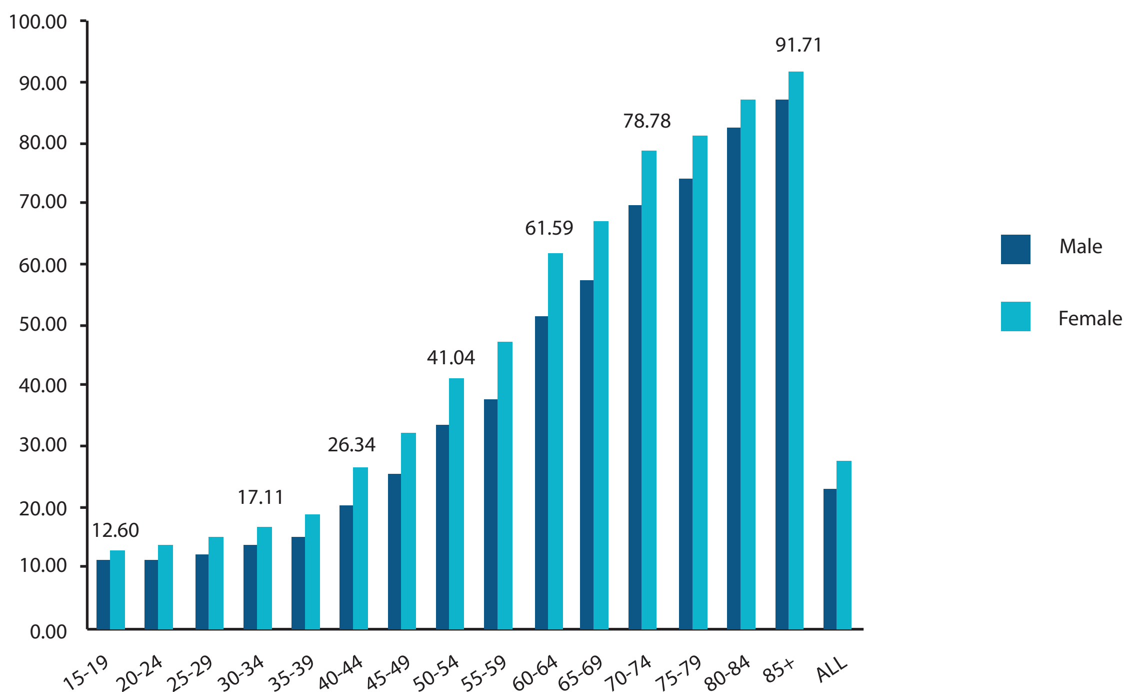


Figure 4.2b Disability Rate (%) by Age and Gender Using High Threshold of Disability, Riskesdas 2007

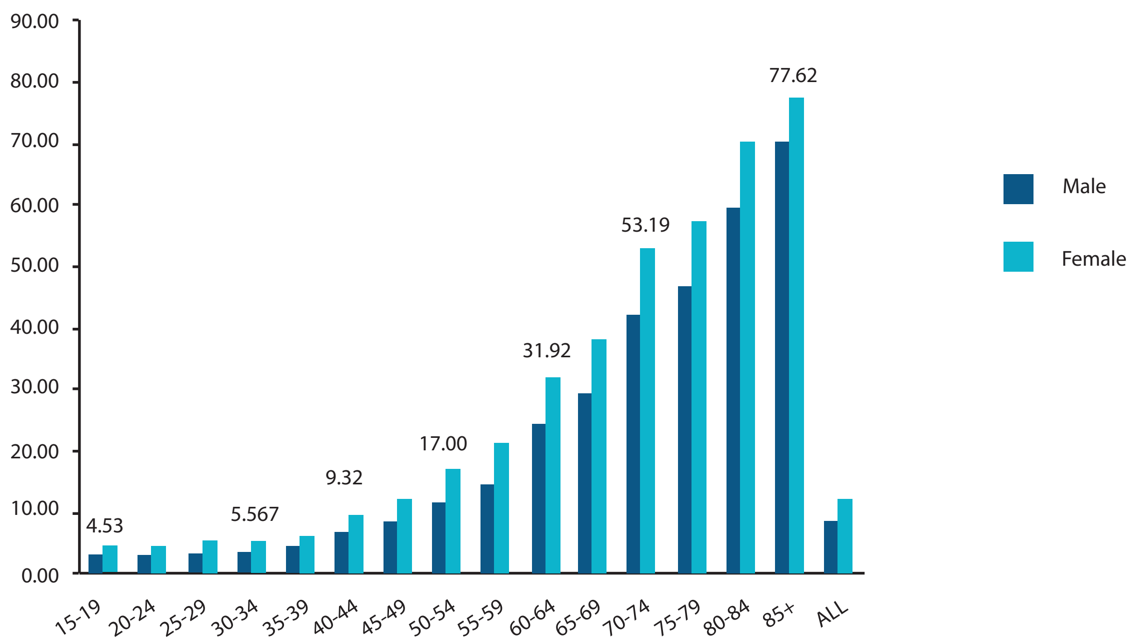


Figure 4.3a Disability Rate (%) by Area of Residence Using Low Threshold of Disability, Riskesdas 2007

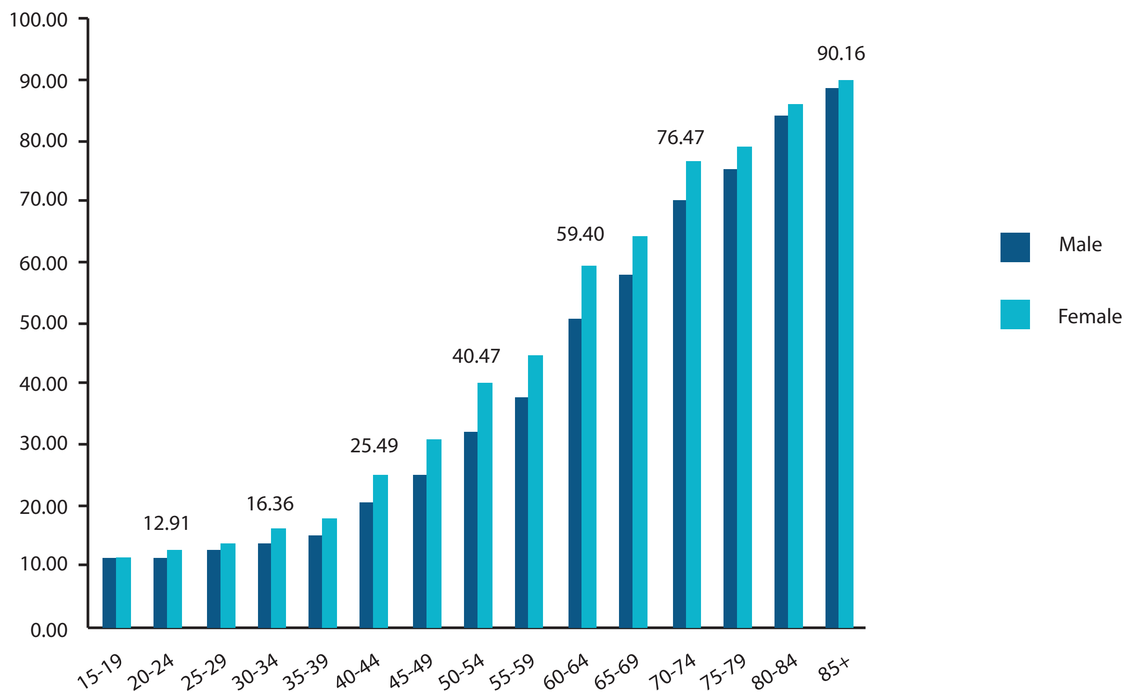
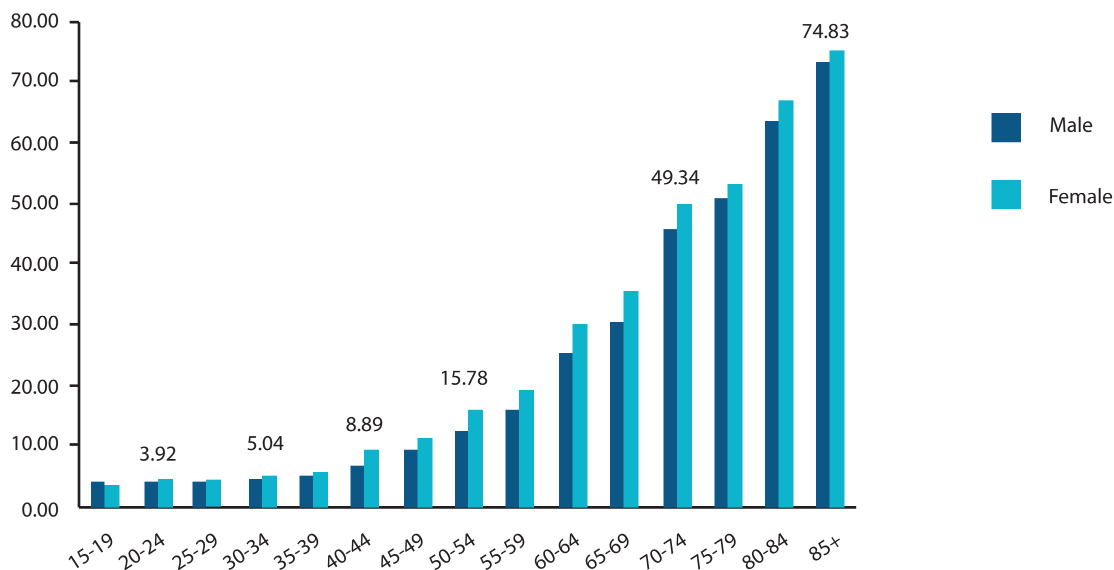


Figure 4.3b Disability Rate (%) by Area of Residence Using High Threshold of Disability, Riskesdas 2007



Figures 4.3a and 4.3b show similar age profiles by area of residence (urban/rural), again using first a low-threshold measure of disability that includes both mild and severe disabilities, and then a more restrictive, high-threshold measure that excludes mild disabilities. The age profiles in rural and urban areas using either measure are quite similar. Disability rates in the rural areas are slightly higher.

Rural/urban differences could also be driven by differences across provinces. Table 4.4 shows a breakdown of disability prevalence by gender, area of residence, and province. The difference across provinces can be quite dramatic, whether using the high- or low-threshold measure of disability. This will be a common theme in this report.

Rural rates are higher than urban rates across most of the provinces, and women's rates are higher than men's. However, the overall rate in some provinces using the high-threshold measure is nearly 20 percent in some provinces (e.g., Central Sulawesi) but significantly under 10 percent in many others (e.g., Jakarta and South Sumatra).

As these figures indicate, disability rates can be influenced by a number of factors, but of course, some of those factors—such as age and gender—are also related. And some, rooted in differences across provinces, are not directly observable. Therefore, a regression was run to examine the correlation of various explanatory variables in which disability controlled for other factors. This regression, reported in Tables 4.5a–b, uses observations from the provinces where the new disability survey (reported on in Chapters V through VIII of this report) was implemented. In addition to age, gender, and rural/urban location, a series of provincial dummy variables was included to account for regional differences. Household size was also included. Because the data are drawn from the census, the number of observations is huge (more than 17 million), so it is not surprising that all the coefficients are different from zero at the 1 percent significance level. The odds ratios in the right-hand column are more interesting in that they show the magnitude of that correlation. An odds ratio of 1 implies that having a certain characteristic does not change the chances a person has a disability, holding other variables constant at the mean level in the sample. An odds ratio of 0.5 means they are half as likely as a base category (in this case, Yogyakarta), and an odds ratio of 2.0 means they are twice as likely. So for example, people in West Sumatra—after controlling for age, gender, rural/urban, and household size—are more than twice as likely to have a disability as people in Yogyakarta. People in Central Java are only 89.5 percent as likely to be disabled as people in Yogyakarta.

The results in Tables 4.5a–b show that the impact of gender is roughly twice as large as the impact of living in a rural area. Controlling for other factors, living in a rural area only increases the chances of being disabled by 5 percent; whereas being male reduces the chance of disability by more than 10 percent.

Not surprisingly, and consistent with all national studies of disability, age is a strong correlate of disability.[26] An odds ratio of .048 for people aged 15–24 years means they have a little less than a 5 percent chance of having a disability relative to the risk of people who are age 65 or older. Adults who are 35–44 years old have about a 9 percent chance compared with the oldest age group. For people who are 45–54 years old, the chance of having a disability increases significantly, doubling compared with people aged 35–44 years. It almost doubles again for those aged 55–64 years.

[26] WHO and World Bank (2011).

Table 4.4 Disability Rates (%) by Province, Area of Residence, Sex, and Disability Threshold, Riskesdas 2007

Province	Low Threshold				High Threshold			
	Urban		Rural		Urban		Rural	
	Male	Female	Male	Female	Male	Female	Male	Female
DI Aceh	16.4	20.4	25.2	30.0	6.8	9.2	11.6	14.0
North Sumatra	15.2	18.7	22.2	26.2	4.8	7.4	7.5	10.4
West Sumatra	18.3	24.2	27.8	34.7	6.9	11.4	12.8	16.7
Riau	18.1	25.0	17.9	20.6	7.7	11.7	6.9	8.8
Jambi	18.0	17.5	29.5	31.9	5.8	7.0	8.9	11.2
South Sumatra	12.5	17.3	14.8	17.0	4.1	5.9	5.3	6.6
Bengkulu	21.6	24.2	20.6	23.9	7.9	8.8	8.5	10.5
Lampung	15.5	20.9	19.7	22.6	5.3	8.2	6.4	8.3
Bangka Belitung	31.7	36.9	34.6	39.9	12.8	15.3	12.3	16.3
Riau Island	12.7	13.2	16.9	22.5	5.2	6.2	6.2	9.6
DKI Jakarta	15.6	21.3	–	–	6.4	8.8	–	–
West Java	26.0	33.5	28.4	34.3	11.0	15.7	12.6	16.0
Central Java	22.0	28.2	25.7	29.8	8.9	12.3	11.1	13.2
DI Yogyakarta	12.3	17.2	17.9	22.7	5.6	7.4	9.0	10.6
East Java	19.2	25.4	21.7	27.8	7.7	11.2	9.3	13.0
Banten	16.9	19.8	18.7	22.8	6.9	9.4	7.6	9.1
Bali	21.9	26.4	27.0	33.1	9.6	11.0	12.8	15.6
W. Nusa Tenggara	32.0	37.7	40.1	45.1	12.0	18.0	15.4	20.3
E. Nusa Tenggara	16.8	19.8	29.7	34.5	6.0	7.2	14.1	16.3
West Kalimantan	27.4	29.1	23.0	25.4	10.3	12.7	8.4	10.2
Central Kalimantan	17.8	21.2	26.0	28.0	7.0	8.6	9.4	10.2
South Kalimantan	19.6	25.8	23.2	29.4	7.1	12.4	9.0	12.1
East Kalimantan	14.3	19.5	17.2	19.2	4.6	6.9	6.5	7.6
North Sulawesi	15.3	22.5	20.2	27.0	6.2	10.7	6.8	11.6
Central Sulawesi	35.5	46.4	33.5	40.2	15.4	25.7	16.2	20.8
South Sulawesi	23.2	28.5	33.3	40.3	8.7	13.1	15.8	22.2
Southeast Sulawesi	19.2	26.2	29.8	33.0	8.2	10.3	11.3	15.1
Gorontalo	24.3	31.3	30.6	37.4	16.9	18.9	16.9	21.1
West Sulawesi	26.3	36.0	37.4	41.5	7.9	18.3	14.8	18.3
Maluku	10.8	13.4	26.6	27.4	5.0	6.5	11.9	13.2
North Maluku	8.0	12.9	15.1	18.1	4.9	7.3	5.9	8.4
West Irian Jaya	20.6	26.6	17.8	26.7	10.6	13.2	6.7	12.3
Papua	11.6	15.8	20.9	24.1	4.1	5.4	8.8	10.5

Table 4.5b Logit Results for Presence of High Threshold Disability, All Provinces, Riskesdas 2007

Characteristics for High Threshold	B	S.E.	Sig.	Odds Ratio
Aged 15–24	-3.077.017	0.018309	0.000	0.046097
Aged 25–34	-2.963.134	0.01742	0.000	0.051657
Aged 35–44	-2.549.476	0.016088	0.000	0.078123
Aged 45–54	-1.861.401	0.014857	0.000	0.155455
Aged 55–64	-1.131.560	0.015064	0.000	0.32253
Aged 65+		**Baseline**		
DI Aceh	0.380559	0.046265	0.000	1.463.103
North Sumatra	-0.16038	0.046191	0.001	0.851821
West Sumatra	0.333953	0.045551	0.000	1.396.477
Riau	0.113748	0.051492	0.027	1.120.469
Jambi	0.10888	0.050067	0.030	1.115.028
South Sumatra	-0.52123	0.053096	0.000	0.593792
Bengkulu	0.061009	0.053579	0.255	1.062.909
Lampung	-0.35031	0.052053	0.000	0.70447
Bangka Belitung	0.694904	0.053319	0.000	2.003.517
Riau Island	-0.08262	0.073584	0.262	0.9207
DKI Jakarta		**Baseline**		
West Java	0.477819	0.042647	0.000	1.612.553
Central Java	0.036493	0.042459	0.390	1.037.167
DI Yogyakarta	-0.57347	0.061848	0.000	0.563566
East Java	-0.07102	0.042536	0.095	0.931442
Banten	0.039286	0.060459	0.516	1.040.068
Bali	0.202442	0.050397	0.000	1.224.389
West Nusa Tenggara	0.794326	0.049783	0.000	2.212.949
East Nusa Tenggara	0.364794	0.046605	0.000	1.440.217
West Kalimantan	0.162144	0.049879	0.001	1.176.029
Central Kalimantan	0.162411	0.050954	0.001	1.176.344
South Kalimantan	0.233561	0.04952	0.000	1.263.090
East Kalimantan	-0.19363	0.052053	0.000	0.823965
North Sulawesi	-0.17766	0.05831	0.002	0.837224
Central Sulawesi	1.074.404	0.047699	0.000	2.928.248
South Sulawesi	0.684549	0.043869	0.000	1.982.877
Southeast Sulawesi	0.444563	0.047854	0.000	1.559.809
Gorontalo	1.083.538	0.053749	0.000	2.955.116
West Sulawesi	0.779107	0.057842	0.000	2.179.525
Maluku	0.148428	0.061174	0.015	1.160.009
North Maluku	-0.25496	0.068081	0.000	0.774949
West Irian Jaya	0.398771	0.075551	0.000	1.489.992
Papua	0.219341	0.058195	0.000	1.245.256
Rural	0.135019	0.010765	0.000	1.144.559
Urban		**Baseline**		
Male	-0.37696	0.009755	0.000	0.685943
Female		**Baseline**		
Household Size	-0.01365	0.002662	0.000	0.986446
Constant	-0.16233	0.041745	0.000	------

The most significant finding, however, is the dramatic differences across provinces. In the estimation, Jakarta is the base province, so the odds ratios show the relative risk of having a disability in a particular province (controlling for the other variables, including living in a rural area) compared with Jakarta. Residents of Jakarta pose one of the lower risks of having a disability (i.e., most odds ratios are above one for the other provinces). Five provinces—Bangka Belitung, West Nusa Tenggara, Central Sulawesi, West Sulawesi, and Gorontalo—have more than double the risk of having a disability compared with Jakarta; Gorontalo's risk is nearly triple that of Jakarta.

Table 4.6 shows the age and gender breakdown of prevalence rates by areas of reported difficulty using the Riskesdas data. As stated earlier, however, difficulties in the social and participation areas could result from difficulties in many functional domains, so there is no clear way to separate people out into the categories of physical, intellectual, psychological, and sensory disabilities. The upper panel shows the prevalence rate if people reporting 'some' difficulties are included as well as people with severe or a lot of difficulties; that is, the definition of disability is based on a lower difficulty threshold. The bottom panel uses a higher threshold, which only includes people with 'a lot' or 'severe' difficulties. Because people can have difficulty in more than one functional domain, the sum of the percentages in any column by type of disability is greater than the overall rate.

Once again, the age profile becomes very steep starting in middle age. Using the lower threshold (i.e., including people with more minor disabilities), only 12 percent of youths have a disability, compared with 24.8 percent for those aged 25 to 64, and 72.4 percent for people 65 and older. If people with more mild difficulties are not included in the disabled population (i.e., a more restrictive definition of disability is used), those percentages drop to 4.1 percent, 9.3 percent, and 46.6 percent. Both sets of numbers are important. Although only people in the bottom panel (with more severe disabilities) may potentially qualify for special benefits, it is still important to realise how many people do report some level of functional difficulty when thinking about how many people would benefit from making public spaces and services more accessible.

For every age group, women have a higher rate of disability than men, regardless of the threshold used.[27] Moreover, the male-female gap grows larger with age. This combined with the higher life expectancies of women, means that the number of elderly disabled women will be significantly higher than the number of elderly disabled men.

Table 4.6 also shows the percentage of people with difficulties in various functional domains. As people can have difficulties in more than one functional domain, table 4.6 also reports the level of disability for communication, excluding vision and hearing problems. This is because communication issues are very different for people with sensory disabilities than for people with other impairments that lead to communication issues, such as those associated with autism and other developmental disabilities or for people experiencing a stroke.

[27] This could be from actual differences in the rate of functional limitation, or possibly differences in men's and women's perceptions of what constitutes difficulty in functioning or in their willingness to report it.

Table 4.6 Disability Prevalence Rates (%) by Gender, Age, and Functional Domain, Riskesdas 2007

	15-24			25-64			65+			Total		
	M	F	All	M	F	All	M	F	All	M	F	All
A. Lower Threshold												
Overall	10.8	13.1	12.0	22.2	27.2	24.8	67.7	76.5	72.4	23.0	28.0	25.6
Vision	1.7	2.5	2.1	12.3	15.4	13.9	54.5	62.5	58.8	13.0	16.2	14.7
Hearing	1.3	1.4	1.4	4.6	5.4	5.0	31.4	36.9	34.4	5.9	7.0	6.5
Mobility	3.3	5.7	4.5	8.9	13.9	11.5	43.0	56.6	50.3	10.2	15.4	12.9
Self-care	0.9	0.8	0.8	2.0	2.4	2.2	14.3	19.0	16.8	2.7	3.3	3.0
Social*	4.4	4.9	4.7	5.8	7.0	6.4	21.2	28.8	25.3	6.7	8.3	7.5
Participation†	6.7	6.7	6.7	9.0	9.8	9.4	32.0	41.8	37.2	10.2	11.7	11.0
Communication, no vision problem	1.2	1.2	1.2	1.3	1.5	1.4	2.6	3.1	2.8	1.4	1.5	1.5
Communication, no hearing problem	1.1	1.2	1.1	1.4	1.8	1.6	4.0	5.6	4.9	1.5	2.0	1.7
Communication (all)‡	1.7	1.7	1.7	3.3	4.2	3.7	21.2	28.3	25.0	4.3	5.5	4.9§
B. Higher Threshold												
Overall	3.6	4.5	4.1	7.9	10.7	9.3	40.9	51.6	46.6	9.4	12.6	11.1
Vision	0.4	0.6	0.5	3.7	5.0	4.4	26.5	33.0	30.0	4.6	6.3	5.5
Hearing	0.3	0.3	0.3	0.8	0.9	0.9	11.4	14.5	13.1	1.5	1.9	1.7
Mobility	0.8	1.7	1.3	2.8	5.0	3.9	23.9	36.4	30.6	3.9	6.8	5.4
Self-care	0.3	0.2	0.3	0.5	0.5	0.5	5.5	7.6	6.6	0.8	1.0	0.9
Social	1.1	1.2	1.2	1.0	1.3	1.2	7.2	11.2	9.3	1.5	2.1	1.8
Participation	2.1	2.1	2.1	2.8	3.0	2.9	16.3	23.7	20.3	3.6	4.5	4.1
Communication, no vision problem	0.4	0.2	0.3	0.3	0.4	0.4	2.1	2.3	2.2	0.5	0.5	0.5
Communication, no hearing problem	0.3	0.2	0.3	0.3	0.4	0.4	2.1	3.1	2.6	0.4	0.6	0.5
Communication (all)	0.5	0.3	0.4	0.6	0.8	0.7	7.6	10.7	9.3	1.1	1.5	1.3

** For definition of social domain using Riskesdas questions, see Annex 7.*

† For definition of participation domain using Riskesdas questions, see Annex 7.

‡ The social measure referred to in this table reflects in such things as communication and maintaining emotional stability. They are impairments in functional domains relating to social interaction. Therefore, there is no reason to be concerned about double counting.

§ Many communication problems are related to vision and hearing, but some are not (e.g., autistic people). To make it clear, it is better to separate it out. People in the vision and hearing problem rows are a subset of people in the 'all' row.

Vision and mobility problems are the most common. Using the high threshold definition, by the time people are elderly, nearly one-third have significant difficulties in these areas. Using the lower threshold, more than half have at least a little difficulty. Among working-age adults, about 5.0 percent of people have significant vision difficulties and 3.9 percent have significant mobility difficulties. Nearly 3 percent of people also report that they have significant difficulties in participating in family and community life. More than 9 percent have at least a little difficulty in this area.

As far as communication is concerned, there is not a large difference between the rate of people with communication problems including or excluding sensory difficulties for youths, but as people age that gap becomes quite significant. This means that the majority of communication problems among the elderly are associated with impairments to hearing and seeing that are part of the aging process.

The most limiting disability category is having a lot of difficulty with self-care, that is, bathing, feeding, and dressing oneself. People with these types of difficulties typically need a fair amount of personal assistance in order to get through the day. Among youth and working age adults, the rate of disability for this category was very small: 0.3–0.5 percent respectively. But for the elderly it was about 6.6 percent.

Using the lower difficulty threshold, nearly 1 percent of youths need some assistance with self-care, about 2.2 percent of working-age adults, and 16.8 percent of the oldest age group.

Characteristics of People with Disabilities

The 2012 SNSAP-PWD described in the methodology section collects information only from people with disabilities. Therefore, it cannot be used to generate prevalence rates. However, it offers a great deal of information on the characteristics and experiences of people with disabilities: the nature of their disabilities, types of assistive devices they use, extent of their participation in the social and economic life of their communities, and types of barriers that limit that participation.

This section uses 2012 SNSAP-PWD data to present a basic description of the demographic characteristics of 2012 and compares it with the nationally representative sample of the Riskesdas data. Table 4.7 shows that prevalence of people with disabilities in that data set rises steadily by age and is higher in rural areas regardless of whether a low-threshold disability measure (which includes people with mild disabilities) or a high-threshold measure (which does not include people with mild disabilities) is used. Low levels of education are also correlated with higher rates of disability, but that correlation diminishes significantly once a person has attended secondary school. This is also true using either threshold for what constitutes a disability.

The first thing that emerges from Table 4.8 is that the SNSAP-PWD sample disproportionately consists of people with more significant disabilities. In the Riskesdas data 25.58 percent had a disability according to the low threshold and 11.05 percent according to the high threshold (see table 4.7). That means that 56.6 percent of the people with disabilities ([25.6-11.1]/25.6) had mild disabilities. For the census data, the percentage of people with disabilities with only some difficulty in one domain was a similar percentage at 55.5 percent. However, in the SNSAP-PWD data, only 16.9 percent were identified as having a low level of disability. This overrepresentation of people with higher levels of disability probably stems from the sampling method, which was much more likely to identify people with more visible and significant disabilities.

This bias towards people with more significant disabilities was strongest among the elderly. This makes sense, because elderly people with more mild difficulties in functioning are often thought of as simply 'old' and not disabled. The least bias towards more significant disabilities was among those with more education, which is also expected, because people with more education tend to have higher standards for what constitutes full functioning. It is a common result in health surveys, for example, that richer and highly educated people are more likely to report mild health claims. This may account for less of a bias in urban areas, as well, because they are presumably more educated. It is unclear, however, why the bias towards the inclusion of people with more significant disabilities was stronger among women.

Table 4.7 Characteristics of Individuals by Type of Disability, Riskesdas 2007

Individual Characteristic		Type of Disability		
		Low Threshold %	High Threshold %	Total N
Sex	Male	22.98	9.41	318,486
	Female	27.96	12.57	343,537
Age of respondent	15–19	11.59	4.08	81,347
	20–24	12.42	4.13	70,794
	25–29	13.52	4.46	77,488
	30–34	15.44	4.82	74,712
	35–39	17.05	5.49	75,095
	40–44	23.62	8.07	65,135
	45–49	28.86	10.50	57,556
	50–54	37.30	14.46	47,350
	55–59	42.38	17.90	33,125
	60–64	56.56	28.28	26,570
	65–69	62.48	33.69	20,416
	70–74	74.58	48.10	15,549
	75–79	77.95	52.31	8,263
	80–84	85.33	65.57	5,091
	85+	89.77	74.41	3,532
Region	Urban	22.36	9.46	247,725
	Rural	27.60	12.06	414,298
Education	No schooling	54.11	31.42	58,247
	Unfinished primary	37.09	17.56	109,682
	Primary	25.55	10.24	184,068
	Junior high	16.86	5.72	134,332
	Senior high	15.30	5.11	139,863
	Diploma/university	17.41	5.51	35,831
Total		**25.58**	**11.05**	**662,023**

Table 4.8 Characteristics of Individuals by Type of Disability, SNSAP-PWD, 2012

Individual Characteristic		Type of Disability		
		Low Threshold %	High Threshold %	Total N
Sex	Male	18.30	81.70	1,238
	Female	15.00	85.00	973
Age of respondent	10–14	9.44	90.56	180
	15–19	14.83	85.17	209
	20–24	17.39	82.61	207
	25–29	19.57	80.43	184
	30–34	23.12	76.88	199
	35–39	22.46	77.54	187
	40–44	16.93	83.07	189
	45–49	22.30	77.70	139
	49–54	18.79	81.21	165
	55–59	24.11	75.89	141
	60–64	10.00	90.00	80
	65+	8.36	91.64	299
Region	Urban	20.00	80.00	862
	Rural	14.90	85.10	1,349
Education	No Schooling	9.17	90.83	971
	Primary Level	18.65	81.35	622
	Pesantren	27.78	72.22	18
	Junior High School	21.61	78.39	236
	Senior High School	35.04	64.96	234
	High Education	39.39	60.61	33
Total		**16.90**	**83.10**	**2,211**

Table 4.9 displays the percentages of people in the SNSAP-PWD with mild or severe disabilities by functional domain. For example, table 4.8 reveals that 83.1 percent of people within the SNSAP-PWD sample have severe disabilities. Table 4.9 shows that 22.7 percent have severe difficulties with a vision disability, and another 9.0 percent have a mild vision limitation. Notice also, that the sum of the percentages in the last column is much greater than 83.1 percent, which means that many people have difficulties in more than one functional domain. The fact that so many people have secondary disabilities is important in thinking through appropriate interventions. In Census 2010, 74 percent of people with severe disabilities in at least one domain had functional difficulties in multiple domains.[28]

Other characteristics that are very important in analysing disability issues are the age of onset and the cause of disability. These are not available in the census and Riskesdas data but are available in the SNSAP-PWD.

[28] Table 4.1 reports that 0.20 percent of people had a single severe disability; whereas 0.56 percent had multiple disabilities with at least one being severe. (0.56)/(0.56+0.20)=0.74

Table 4.9 Percentage of People with Mild and Severe Disabilities with Functional Difficulties in Various Functional Domains, SNSAP-PWD, 2012

Domain	Mild Disability	Severe Disability
Vision	9.0	22.7
Hearing	6.7	25.5
Cognitive	31.3	41.8
Communication	20.6	35.6
Mobility	19.4	28.3
Self-Care	26.2	46.6
Social	35.0	39.1
Psychological	16.0	34.2

Table 4.10 Percentage Distribution of Age of Onset of Disability by Sex and Area of Residence, SNSAP-PWD, 2012

Age	Men	Women	Urban	Rural
0	27.1	25.4	26.3	26.4
1–10	35.6	34.2	40.2	31.8
11–20	11.0	7.1	9.6	9.1
21–30	6.4	5.7	5.0	6.8
31–40	4.8	5.2	3.9	5.7
41–50	6.0	6.3	4.7	7.0
51–60	3.7	8.6	4.4	6.7
Over 60	5.4	7.6	6.0	6.6

Table 4.11 Percentage Self-Reported Cause of Disability by First Type Experienced, SNSAP-PWD, 2012

	All Types	Vision	Hearing	Cognitive	Communication	Mobility	Psycho-Social
At birth	36.32	18.86	44.62	36.92	44.33	31.03	35.10
Illness	34.64	27.58	18.78	32.33	28.12	30.43	31.66
Injury	17.73	12.52	9.79	9.69	7.78	16.69	11.57
Cursed	3.44	2.22	0.64	4.23	3.28	3.27	4.23
Aging	16.37	31.38	22.15	10.66	8.43	8.43	8.66
Do not know	1.45	0.79	0.96	0.70	0.66	0.75	0.33
Other	17.59	6.66	3.05	5.46	7.40	9.39	8.46
Total		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table 4.12 Percentage Self-Reported Cause of Disability by the One of Highest Severity, SNSAP-PWD, 2012

	All Types	Vision	Hearing	Cognitive	Communication	Mobility	Psycho-Social
At birth	37.43	19.06	45.38	33.91	44.15	30.36	33.82
Illness	36.13	29.12	18.66	28.25	27.88	29.35	29.32
Injury	15.94	12.31	9.58	10.23	7.60	13.92	10.72
Cursed	3.86	2.43	0.67	3.72	3.31	3.61	4.01
Aging	17.14	29.81	21.85	15.81	8.48	10.18	10.10
Do not know	1.41	0.69	1.01	0.64	0.58	0.76	0.28
Other	18.39	6.59	2.86	7.44	7.99	11.83	11.76
Total		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table 4.10 shows the age of onset by gender and area of residence (urban/rural). The striking result here is the large proportion of the sample with early onset. Among both males and females more than a quarter of the respondents reported having been born with a disability and more than a third of them became disabled before the age of ten. The same is nearly true for the urban/rural breakdown. This is very different than what would be predicted by the age distributions of people with disabilities seen with census and Riskesdas data, which suggests another bias in the sample. The nature of the sample selection (described in Chapter II) yielded a sample of people with disabilities who are more likely to have been disabled at younger ages and more severely, and more likely to be better connected to DPOs. This will be important to keep in mind when analysing the data. Nevertheless, as seen in later chapters, important information can be obtained from these data that can be taken to be indicative of the barriers people with disabilities face.

Table 4.11 shows the causes of disability based on the functional domain for which a person reported having difficulty. If a person is disabled in more than one functional domain, the functional domain that caused the first onset of a disability is used. That is, if a person is born without being able to see but then suffers an injury that impairs their mobility, the cause of disability is classified as 'at birth.' The first column, however, shows the distribution of all causes. It adds up to greater than 100 percent because some people report difficulties in more than one functional domain.

The causes of first disability are very different by domain. For vision, aging is the primary cause, but for hearing and communication, the primary cause is associated with birth. It is not known if these are congenital or due to birth trauma. When it comes to psychosocial and mobility issues, illnesses seem to cause as many disabilities as those that occur at birth. A small percentage of people blame supernatural causes ('cursed') for their disability, most commonly for cognition.

In analysing table 4.11, it is very important to keep in mind the skewed nature of the sample, as elderly people are underrepresented. In fact, the table is best viewed as the non-aging causes of disability; however, this makes the vision result particularly striking.

Table 4.12 shows a similar table on the causes of disability, but this time if the person has difficulties in more than one functional domain, the cause used is the one that causes the most difficulties. No significant differences exist between these results and those in table 4.11.

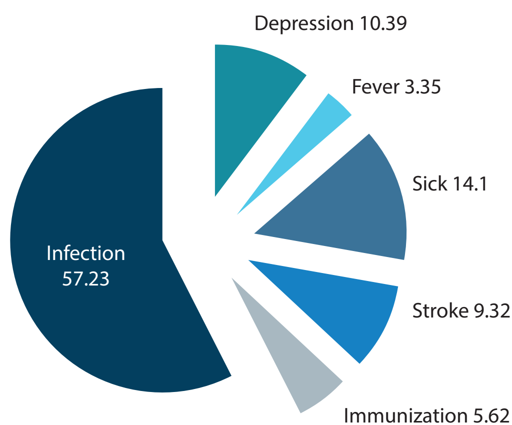
People who are unable to do self-care are those in most need of policy interventions. Table 4.13 shows the causes of the onset of their disability. These are the people for whom the ability to work is lowest and who require the most assistance in their daily lives, which could create demands on family members who could otherwise be engaged in livelihood generation or schooling. Typically, these are elderly people. However, because of the nature of the SNSAP-PWD sample, this is a younger population. Within that population, illness seems to be the primary cause of these disabling conditions, whether looking at all people with self-care issues or just those for whom self-care difficulties occurred at the onset of the disabling condition.

Table 4.13 Percentage Self-Reported Cause of Disability of People with Difficulties in Self-Care, SNSAP-PWD, 2012

	All	First Disability	Severest Disability
At birth	28.15	28.41	28.09
Illness	37.46	38.19	37.46
Injury	13.28	13.46	12.49
Cursed	3.96	3.89	4.20
Aging	9.61	9.07	10.23
Do not know	0.10	0.20	0.11
Other	7.43	6.78	7.43
Total	**100.00**	**100.00**	**100.00**

Figure 4.4 breaks down the types of illnesses that people report causing their disability. Infection is clearly the largest cause, which probably also includes those citing 'fever' and 'immunisation' as well as some of those people who responded with the more general term, 'sickness.' Most likely between two-thirds and three-fourths of disabilities caused by illness are due to infection. Strokes and mental depression are also mentioned. Again, the age distribution of the sample needs to be kept in mind.

Figure 4.4 Types of Illnesses Reported as Cause of Disability, SNSAP-PWD, 2012



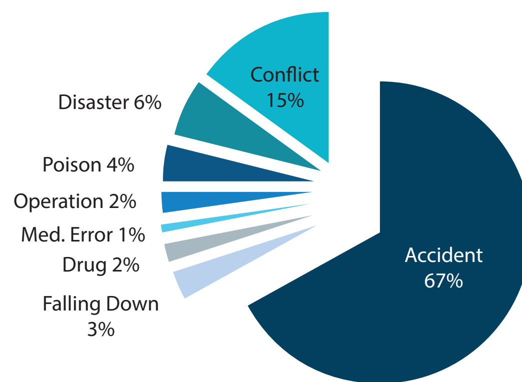
Depression played a prominent role in mental disabilities. Table 4.14 shows, among those reporting illness as the cause of their disability, the percentage of people saying that depression was that illness, broken down by functional domain. Depression was mentioned much more often in relation to cognitive and communication problems. Unfortunately, the underlying causes of the depression are not known. Also, it is not clear, in the cases of vision and hearing, what is meant by depression serving as the cause of their disability, which means that how the question is being interpreted is unclear. Depression was not one of the original response categories but emerged in re-coding the 'other' responses. Its frequency and its relation with mental disabilities suggest it is a potentially important area for future research.

Figure 4.5 shows the breakdown of the types of injuries that were aggregated into the injury cause of disability. Accident was by far the major cause (more so, if it is added to falling down), followed by conflict. Health care issues—operation plus medical error—were minimal.

Table 4.14 Percentage Reporting Depression as Illness Associated with Onset of Disability, SNSAP-PWD, 2012

	Percentages
Vision	2.8
Hearing	6.8
Cognition	16.5
Communication	17.4
Mobility	7.3
Psycho-social	16.5

Figure 4.5 Types of Injuries Reported as Cause of Disability, SNSAP-PWD, 2012



Summary

The Riskesdas 2007 data show a prevalence disability rate between 10 and 15 percent, which is consistent with results in other countries (WHO and World Bank 2011), although Census 2010 numbers are significantly less. But both data sets show that disability rises significantly with age, and is slightly more prevalent among women and people living in rural areas. Vision and mobility difficulties are the most prevalent. The data also suggest significant differences in the probability of being disabled depending on a person's province.

The sample from the SNSAP-PWD is skewed towards people who did not acquire their disabilities by aging (which is the most common cause in the general population) and who are people who, on average, have more significant disabilities. These factors must be taken into account in interpreting data from this survey. But within that population, it is clear that disability is most associated with birth (congenital issues plus birth trauma) and illnesses, primarily infections. Depression also seems to be a major issue, especially among those with mental or psychosocial disabilities.

Chapter V
Education

Education is a gateway to both economic and social participation in society; however, children with disabilities are less likely to obtain an education (WHO and World Bank 2011). The World Bank estimated that nearly one-third of primary school–aged children not enrolled in school have a disability (Peters 2004). An updated worldwide estimate of the prevalence of disabled children out of school is not available, but country-based studies have found similar results. For example, the share of children with disabilities not in school in India is five times the national rate (O'Keefe 2009). One study showed that disability was a stronger factor in explaining lack of enrolment than either gender or social class (Filmer 2008). Unfortunately, the link between disability and less access to education also exists in Indonesia. According to the Ministry of Education and Culture (MoEC), close to 70 percent of children with disabilities have no access to education and only around 116,000 children with disabilities were currently enrolled in formal schools. This number was only around 31 percent of the total number of children with disabilities in the country. Data from the ministry revealed a current total of 2,500 inclusive schools and 1,720 special schools that provide special treatment for children with disabilities.[29]

The Constitution of Indonesia mandates the provision of education services for children with disabilities.[30] Educating children with special needs is part of the state mandate to implement six years of universal education for all Indonesian citizens and improve the welfare of the community and people with disabilities. This includes programmes such as special schools, inclusive education, and scholarship programmes for students with special needs. MoEC also provides funds for sports, assistive devices, and scholarships.

Experiences in implementing these programmes vary by province. For example, in West Java and Yogyakarta, the Department of Education and Culture has been very active in building the capacities of inclusive schools and special needs teachers. West Sumatra focus group participants suggested that they currently have five fully accessible inclusive schools. Yogyakarta has a very active Special Olympics programme for intellectually and mentally challenged students. In East Nusa Tenggara, since 2009 students with disabilities in special schools have received entrepreneurship training. Special education for the gifted was also mentioned during the interviews, although no further explanation was explored.

Education of People with Disabilities

When looking at disability and education, it is important to keep in mind that the onset of disability can occur at any age. The only people for whom disability can have an influence on education are people who become disabled as children. Simply comparing the educational attainment of disabled and nondisabled people will be misleading in that it will understate the impact of disability upon acquiring an education. People who become disabled in old age have experienced no impact from disability on their schooling but at the same time grew up in an era when enrolment rates were much lower. Therefore, comparisons must be made taking into account the age of onset. In the SNSAP-PWD, controlling for age, province, and gender, people whose onset of disability occurred before age 15 were more than five times as likely not to complete primary school, compared with people whose disability began between the ages of 15 and 59.

[29] Jakarta Post, 21 March 2013

[30] The Law of 1995, Article 31; Law No. 20 of 2003 on the National System of Education; and Circular Letter of the Ministry of Education No. 70/2009 on inclusive education provision of education services for children with disabilities.

Table 5.1 Disability Prevalence by Educational Attainment and Type of Disability, Aged 15–24, Riskesdas 2007

	Disabled: Lower Threshold					Disabled: Higher Threshold				
	No Schooling	Unfinished Primary	Primary	Junior High	**All**	No Schooling	Unfinished Primary	Prima-ry	Junior High	**All**
Overall	25.1	15.8	12.8	11.2	**12.0**	14.8	6.4	4.4	3.6	**4.1**
Vision	6.3	2.9	2.0	1.9	**2.1**	3.3	0.9	0.4	0.4	**0.5**
Hearing	7.2	2.4	1.4	1.2	**1.4**	4.7	0.7	0.3	0.2	**0.3**
Mobility	9.4	5.4	4.6	4.3	**4.5**	5.0	2.0	1.4	1.1	**1.3**
Self-care	7.0	1.6	0.9	0.7	**0.8**	3.7	0.6	0.2	0.2	**0.3**
Social	14.4	7.1	5.3	4.3	**4.7**	7.6	2.1	1.3	0.9	**1.2**
Participation	17.7	9.8	7.3	6.1	**6.7**	10.3	3.7	2.3	1.7	**2.1**
Communication, no vision problems	6.7	2.3	1.5	0.9	**1.2**	4.1	0.7	0.3	0.2	**0.3**
Communication, no hearing problems	5.2	2.2	1.4	0.9	**1.1**	2.6	0.7	0.2	0.2	**0.3**

Table 5.1 uses the Riskesdas data to show the relationship between disability and the highest level of education received for youth aged 15–24 years. As can be seen in the shaded columns, 12.0 percent of the entire youth population has a disability using the lower threshold definition and 4.1 percent have a disability using a higher cut-off. Disability prevalence rates are much higher among those youth who have received no schooling—at 25.1 percent if the low-threshold measure is used (i.e., containing those with milder disabilities) and 14.8 percent if the higher threshold measure is used. For respondents aged 15–24 years with no schooling, 25.1 percent are disabled. This means that, depending on the measure of disability used, the disability rate for youth aged 15–24 years with no schooling is two or three times as high as the disability rate for all youth in that age range.

Comparing these figures with the other figures in table 5.1 reveals the extent to which disabled youths are over- or underrepresented in other educational achievement categories. Whether these youths became disabled before, during, or after their schooling years is not known, but compared with the total Riskesdas sample with all age groups, it is more likely to have occurred during school years.

Table 5.1 shows that disabled youth are less underrepresented among people with a junior high education than among people with only a primary school education. This means that disabled children completing primary school are more likely to go on to secondary school than nondisabled children. This might be because it takes a more gifted disabled child to succeed in primary school or that perceived returns to secondary education are higher for disabled children (relative to their opportunity costs). However, the fact that people with disabilities face barriers to employment—as shown in Chapter VI—makes this latter explanation less likely.

Table 5.2 Primary Education Completion Logit, Low Disability Threshold, Aged 15+, Riskesdas 2007

		Coefficient	Standard Error	Odds Ratio
Disability	Not disabled		---------------------- Baseline ----------------------	
	Disabled	-.403	.008	.668
Age group	Aged 15–24		---------------------- Baseline ----------------------	
	Aged 25–34	-.442	.013	.642
	Aged 35–44	-1.12	.013	.326
	Aged 45–54	-1.82	.013	.162
	Aged 55–64	-2.23	.015	.108
	Aged 65–74	-2.75	.017	.064
	Aged 75+	-3.21	.024	.040
Gender	Female		---------------------- Baseline ----------------------	
	Male	.448	.007	1.56
Area	Rural		---------------------- Baseline ----------------------	
	Urban	1.07	.008	2.90
Constan	(constant)	1.88	.011	--------
Pseudo R^2			0.1373	

Note: All Indonesian provinces included

Table 5.3 Primary Education Completion Logit, High Disability Threshold, Aged 15+, Riskesdas 2007

Variable		Coefficient	Standard Error	Odds Ratio
Disability	Not disabled		---------------------- Baseline ----------------------	
	Disabled	-.508	.011	.602
Age group	Aged 15–24		---------------------- Baseline ----------------------	
	Aged 25–34	-.451	.013	.637
	Aged 35–44	-1.14	.013	.320
	Aged 45–54	-1.86	.013	.155
	Aged 55–64	-2.28	.014	.102
	Aged 65–74	-2.79	.017	.061
	Aged 75+	-3.22	.024	.040
Gender	Female		---------------------- Baseline ----------------------	
	Male	.451	.007	1.57
Area	Rural		---------------------- Baseline ----------------------	
	Urban	1.07	.008	2.93
Constan	(constant)	1.85	.011	--------
Pseudo R^2			0.1832	

Table 5.4 Primary and Secondary Education Completion Logit, Aged 18+, Census 2010

Variable		Primary (aged 12+)			Secondary (aged 18+)		
		Coefficient	Standard Error	Odds Ratio	Coefficient	Standard Error	Odds Ratio
Severity of Disability	No Disability	------------------ Baseline -------------			----------------------- Baseline ----------------------		
	Low disability	-.456	.003	.634	-.126	.003	.882
	High disability	-1.42	.007	.242	-1.03	.008	.356
Age Group	0–14	---------------- Baseline -------------					
	18–24	2.35	.004	10.5	----------------------- Baseline ----------------------		
	25–34	2.34	.004	10.3	-.437	.002	.646
	35–44	1.80	.003	6.05	-.981	.002	.375
	45–54	.891	.003	2.44	-1.84	.002	.158
	55–64	.340	.003	1.40	-2.22	.003	.109
	65–74	-.386	.003	.680	-2.81	.003	.060
	75+	-.939	.004	.391	-3.68	.006	.025
Province	DKI Jakarta	--------------- Baseline -------------			----------------------- Baseline ----------------------		
	West Sumatra	-.412	.005	.663	-.177	.004	.838
	South Sumatra	-.103	.004	.902	-.294	.003	.745
	West Java	-.149	.003	.861	-1.24	.002	.288
	Central Java	-.717	.004	.488	-.443	.003	.642
	DI Yogyakarta	-.734	.004	.480	-.367	.003	.693
	East Java	-.183	.004	.833	-.270	.002	.764
	East Nusa Tenggara	-.994	.005	.370	-.666	.004	.514
	South Kalimantan	-.798	.005	.450	-.685	.003	.504
	South Sulawesi	-.662	.004	.516	-.280	.003	.756
	Maluku	.312	.006	1.37	.231	.004	1.26
Gender	Female	------------- Baseline -------------			----------------------- Baseline ----------------------		
	Male	.330	.002	1.39	.389	.001	1.48
Area	Urban	------------ Baseline -------------			----------------------- Baseline ----------------------		
	Rural	-.920	.002	.398	-1.38	.002	.252
Constant	(constant)	1.50	.003	4.48	2.25	.002	9.50

The regression results in tables 5.2 and 5.3 confirm that, when controlling for age, gender, and living in an urban area, disability has a strong negative impact on educational attainment. People with disability only had a 66.8 percent chance of completing primary education relative to their nondisabled counterparts, even using the lower disability threshold. Using the higher threshold, the chance drops to 60.2 percent.

The impact of mild or severe disabilities on educational attainment is also evident from the census data. In the regression in table 5.4, the sample size allows for enough observations to control for regional effects that may have an impact on schooling. Only data from the provinces sampled in the SNSAP-PWD were included.[31]

These results show that having a mild level of disability is associated with a 63.4 percent lower probability of completing primary school, relative to a nondisabled counterpart, but a severe level of disability reduces that relative chance to only 24.2 percent. The regression results are not reported here, but they are the basis for creating table 5.5, which shows the relative rates (compared with Jakarta) of the impact of having a disability on finishing primary school and secondary school in the selected provinces, after controlling for gender, age, and whether the person lives in a rural or urban area.

However, as also found in the Riskesdas data, the impact on receiving a secondary education is much less. For the lower level of disability, the relative chance of receiving a secondary education rises to 88.2 percent. In addition, although the odds ratio is still quite low for people with more severe disabilities at 35.6 percent, it is still significantly higher than for primary school. The barriers to a primary education seem higher than for a secondary education.

One other striking finding is the big differences in the likelihood of completing primary or secondary school by province. Because of the big differences in provincial impacts, the regressions in table 5.5 were re-estimated allowing for interactions between disability and provinces, that is, allowing for the fact that having a disability in a particular province may be more or less associated with educational achievement than in another province.

Table 5.5 Odds Ratios of School Completion by Province (Controlling for Gender, Age, and Rural/Urban), Census 2010

Variable	Primary School (aged 12+)		Secondary School (aged 18+)	
	Low Disability	High Disability	Low Disability	High Disability
Jakarta	-------- Baseline --------		-------- Baseline --------	
West Sumatra	0.77	0.35	0.71	0.34
South Sumatra	0.85	0.29	0.99	0.38
West Java	0.57	0.24	0.84	0.39
Central Java	0.34	0.16	0.50	0.25
DI Yogyakarta	0.29	0.14	0.40	0.23
East Java	0.49	0.18	0.66	0.25
East Nusa Tenggara	0.74	0.24	1.16	0.40
South Kalimantan	0.64	0.26	0.77	0.33
South Sulawesi	0.85	0.29	1.08	0.37
Maluku	0.89	0.40	0.80	0.37

[31] Due to the large size of census observation—a population of 237.6 million—a super-computer is needed to run a regression that includes all 33 provinces. This kind of computer was not available for this study.

These regression results, however, are not able to control for age of onset, so they may understate the impact of having a disability on educational attainment, for the reasons mentioned above. Data from the SNSAP-PWD do have a date of onset, but unfortunately as explained in Chapter IV, it is not a random sample. It is skewed towards people with more severe disabilities and people for whom the age of onset is younger than average and who are connected to the disability advocacy community.

Nevertheless, within this group of people it is possible to compare the relative education rates of different groups, as done in table 5.6, as well as the relationship between education and onset of disability, as in table 5.7.

Table 5.6 includes people who have become disabled at any age. Therefore, although it describes the population of people with disabilities, it does not provide insight into the possible effect of disability on obtaining an education. Table 5.7 is restricted only to people who became disabled before age 18 who had a condition that could have been a barrier to education.

Among all mildly disabled people (table 5.6), 24.04 percent did not finish primary school. In addition, there was a large gender gap—31.93 percent for women compared with only 19.17 percent for men. That gap was mostly due to age, because for people aged 19 to 40, the gap shrank to 16.07 percent for women compared with 13.08 for men. The level of educational attainment for this younger group is significantly less than the 25 percent found in the Riskesdas data, but that could well be because of the nature of the sample.

This reduction in the gender gap, however, did not take place among those with more severe disabilities. Women's rate of not finishing primary school compared with men was, respectively, 56.82 percent and 41.69 percent. Looking only at those aged 19–40, finds a similar gap of, respectively, 54.09 percent and 41.60 percent.

Table 5.6 Highest Educational Attainment by Gender, Age, and Degree of Disability, SNSAP-PWD, 2012

Variable		Low Disability				High Disability			
Gender	Age Group	Did not finish primary	Primary	Secondary	Above secondary	Did not finish primary	Primary	Secondary	Above secondary
Male	19–40	13.08	25.23	57.94	3.74	41.60	24.31	32.08	2.01
	41–60	23.94	36.62	33.80	5.63	39.00	34.36	23.94	2.70
	61+	40.00	46.67	13.33	0.00	47.58	37.10	15.32	0.00
	All	19.17	31.09	45.60	4.15	41.69	29.67	26.73	1.92
Female	19–40	16.07	35.71	41.07	7.14	54.09	23.13	22.06	0.71
	41–60	34.69	40.82	22.45	2.04	51.44	34.13	13.46	0.96
	61+	85.71	14.29	0.00	0.00	67.84	27.49	4.09	0.58
	All	31.93	35.29	28.57	4.20	56.82	27.73	14.70	0.76
All	19–40	14.11	28.83	52.15	4.91	46.76	23.82	27.94	1.47
	41–60	28.33	38.33	29.17	4.17	44.54	34.26	19.27	1.93
	61+	62.07	31.03	6.90	0.00	59.32	31.53	8.81	0.34
	All	24.04	32.69	39.10	4.17	48.61	28.78	21.22	1.39

Table 5.7 Highest Educational Attainment by Gender, Age, and Degree of Disability, for People with Age of Onset under Age 18, SNSAP-PWD, 2012

Variable		Low Disability				High Disability			
Gender	Age Group	Did not finish primary	Primary	Secondary	Above secondary	Did not finish primary	Primary	Secondary	Above secondary
Male	19–40	16.05	23.46	56.79	3.70	48.40	24.68	25.64	1.28
	41–60	25.00	43.75	25.00	6.25	51.70	25.85	21.09	1.36
	All	20.00	28.70	46.96	4.35	49.68	25.16	23.89	1.27
Female	19–40	13.51	37.84	37.84	10.81	59.40	22.22	17.52	0.85
	41–60	47.37	36.84	15.79	0.00	66.67	23.23	10.10	0.00
	All	25.86	37.93	29.31	6.90	62.74	22.47	13.97	0.82
All	19–40	15.25	27.97	50.85	5.93	53.11	23.63	22.16	1.10
	41–60	33.33	41.18	21.57	3.92	57.72	24.80	16.67	0.81
	All	21.97	31.79	41.04	5.20	55.37	23.99	19.57	1.07

Table 5.7 shows the rates of schooling for people who became disabled as children. Care must be taken in comparing tables 5.6 and 5.7 because the mortality rates of people who become disabled in childhood are not known and the ones who survive are clearly not a random group. Also, the cell size starts becoming quite small for people at the upper age range, so results for people older than age 60 are not given separately. However, table 5.7 shows patterns across age and gender by degree of disability. Doing so yields results similar to table 5.6. Having a more significant disability, being older, and being female all reduce a person's educational attainment.

Programmes, Policies, and Barriers to Education

As stated at the beginning of this chapter, the Constitution states that all children with disabilities have a right to attend school. The Directorate for Special Education and Special Services in the Ministry of Education is the agency at the national level that is responsible for policy for children with disabilities. They provide assistance to both public schools and private schools (with permits) but with a focus on establishing special schools. In the six provinces where education officials were interviewed for this study (DI Yogyakarta, East Nusa Tenggara, South Kalimantan, South Sulawesi, West Java, and West Sumatra), officials confirmed that the main way of trying to achieve the goal of educating disabled children is through special schools.

Special schools have a number of drawbacks from special schools compared with inclusive education. One, as revealed in the qualitative interviews, is that it often imposes barriers to participation. Focus group members often complained about school fees and transportation challenges posed by special schools. These challenges existed not only for people with physical disabilities but for those with sensory and mental disabilities as well. By their very nature, there are fewer special schools than general ones, so they must draw from a wider area, making the children's commutes more difficult and expensive. This is strong justification for financial assistance for transportation or government-provided transportation.

Promoting segregation reinforces misconceptions and stereotypes of disabled people's abilities and also takes the pressure off regular schools to try to be more inclusive. Inclusive education has been shown to be a more effective way of educating children. Among disabled children, it leads to improved social interactions (Hunt et al., 1994; Fryxell and Kennedy 1995; Schnorr 1997; Fisher and Meyer 2002) as well as improved education outcomes (Hunt et al. 1994; Ryndak, Morrison, and Sommerstein 1999; Fisher and Meyer 2002; Jorgenson, McSheehan, and Sonnenmeier 2007; and Falvey 2004). Moreover, research shows that an inclusive approach to education improves outcomes for nondisabled children as well (Peltier 1997; Cole et al. 2004). These go beyond learning to social benefits (Katz and Mirenda 2001). It is important to note that an inclusive approach aligns with the UNCRPD as promoting a more inclusive society.[32]

One exception often cited is the case of deaf children because of their need to develop fluency in sign language (Stinson and Antia 1999), but even here effective models have been developed (Antia, Stinson, and Gusted 2002). Another exception is the case of children with very severe disabilities whose issues cannot be addressed by general schools. This is especially true when a school system is first becoming inclusive, but hopefully as the school system develops the ability to address the needs of a wider range of children, the population of children needing special schools will lessen (European Agency for Development in Special Needs Education 2009). The goal should be to have children attend schools in the least restrictive environment that is capable of meeting their needs and developing their full potential. This is the approach taken in many developed countries.[33]

Moving towards an inclusive schools system—or even improving the special education system—is hampered by a lack of understanding of MoEC staff in the provinces about disability issues. Participants indicated that many MoEC staff members believe that children with both mental and physical disabilities are uneducable. Some ministry officials even said as much when interviewed. When they were informed that one of the purposes of inclusive education was to reach children with disabilities who had no access to special schools, many school administrators believed that taking those children into their schools would weaken their overall academic performance (during state exams). It appears they think of the term 'inclusive school' as simply putting disabled children into the classroom, as opposed to adopting inclusive education techniques that speak to teacher training, curriculum, and integrated support services.[34]

Another issue raised by focus group participants was that accessible physical facilities are very limited, especially for newly established districts (disaggregated from one district into two or more districts). Not every inclusive school was able to provide adequate facilities for their special needs students.

Because inclusive education is a central government policy, it tends to get weak political support at the subnational level where most of the budget is controlled. Local governments prioritise their spending according to their perceived local needs and, most of the time, this does not include inclusive education. Participants also indicated that MoEC in the provinces has been suffering serious budget cuts that affect the quality and availability of services for children with special needs. Participants considered the current policy of MoEC on inclusive education to still be weak and lacks clarity in terms of the kind of education services that public schools need to provide. Complicating this is the fact that provinces lack qualified special needs teachers both in terms of quantity and quality.

[32] UNCRPD 2007

[33] For example, see New Zealand Minsitry of Education, Special Education Business Plan 2011.

[34] Including those with physical disability. Results from in-depth interview with officials from Ministry of Education.

It is also important to note that data on disability have not been provided well in the provinces, districts, and municipalities. In South Kalimantan, for example, participants also indicated that not very many children with disabilities lived in the province.

The difference in experiences across provinces, evident from the qualitative interviews, backs up the quantitative results. For example, mentally disabled people in Yogyakarta had positive reports about access to education; whereas people with motor disabilities in South Sulawesi had very different experiences. This is particularly noteworthy because people with motor disabilities are usually the most accepted at schools, because they require only physical access and not any adjustments in instruction or curricula. And although a number of the children in Yogyakarta went to special schools, they were exempt from school fees and even received financial subsidies for transportation. Children with disabilities reported that they were happy in school and had friends. As will be discussed in the next chapter, however, they face attitudinal barriers upon leaving school and seeking employment.

Some local areas do report efforts in inclusive education. In addition to special schools, West Sumatra reported that they have also established 150 inclusive schools. East Nusa Tenggara and Yogyakarta are also piloting or implementing both special and inclusive schools and can draw upon the expertise of the Directorate for Special Education and Special Services for technical support. However, stakeholders as a rule admit that the directorate's level of expertise is limited and insufficient funding hampers capacity-building efforts.

All provinces report difficulties in finding qualified teachers and other professionals with expertise given their limited budgets. But attitudinal barriers seem to be the greatest concern. People with mobility disabilities in South Sulawesi, for instance, reported that their local schools were not welcoming. Sometimes, this was because of inaccessible facilities but mainly because of the belief that the schools would lack status if they admitted disabled children or that disabled children were not capable of learning. They thought disabled children should go to special schools. In fact, children in supposedly inclusive schools were often ignored and not properly assisted; therefore, they preferred special schools. Stigma and fear associated with disability can be so high that even some students without disabilities in South Sulawesi could not make it to a higher education level than elementary because their parents were infected with leprosy. Teachers and school administrator did not understand that leprosy is not easily transmitted.

Parental attitudes also erect barriers. Focus group participants mentioned that parents often did not have confidence in their children's ability to learn or were either ashamed or overly protective of their children. Essentially, they thought their children would not benefit much from education but would be exposed to abuse and physical hardships. A few provinces suggested that awareness campaigns to change parental attitudes were essential.

Another issue raised by respondents in focus groups in several provinces was that families with disabled children were poorer than families without such children, making even regular school fees a barrier to attendance, let alone any additional costs associated with attending a special school.

Several recommendations emerge from the findings of this chapter:

- Raising awareness. National efforts should be taken to address misconceptions about disability. These should be targeted not only to educators but parents as well. Awareness campaigns should focus on the rights of all children to attend school but also the capabilities of disabled children and how, given the right circumstances, they can thrive.

- Building an inclusive education system. Consistent with the UNCRPD ratified by Indonesia, a strategic plan should be developed for a movement towards an inclusive education system in order to rectify the gaps in education documented in this report. As suggested by the UNESCO toolkit on inclusive education and other countries' experiences, this includes teacher training and curriculum development, in addition to improving physical accessibility and provision of special services within regular schools where needed (UNESCO 2009; European Agency for Development in Special Needs Education 2009; New Zealand Ministry of Education (2011); Ontario Ministry of Education 2009). Special schools should be scaled back to serve only children whose needs cannot be met even within the more inclusive schools, but some can transition into being regional resource centres that can support local schools and provide ongoing capacity-building efforts.

- Improving and subsidising transportation to school. Transportation was often cited as a barrier to education. As schools become more accessible and inclusive, this problem will lessen. But although children are going longer distances to special schools, they especially need subsidies to offset the costs of getting to school.

With all of these activities, evidence from other studies suggest that campaigns should especially focus on the early detection of disabilities so that interventions can begin at a young age when they are most effective (Bailey and Powell 2005; Blauw-Hospers and Hadders-Algra 2005; Guralnick 2004; Moeller 2000).

Chapter VI
Employment

Most studies from around the world show a negative relationship between disability and employment (WHO and World Bank 2011). According to the World Health Survey administered in 51 countries, men with disabilities have an employment rate of 52.8 percent compared with 64.9 percent for men without disabilities. For women, those percentages are respectively, 19.6 percent and 29.9 percent. These figures, of course, do not refer to the quality of that employment (WHO and World Bank 2011).

Table 6.1 Percentage of Working Individuals Aged 18–64 by Characteristics, Census 2010

Variables		Employed (%)		Total (number)
		Yes	No	
Age group	18–24 years	44.71	55.29	2,732,806
	25–34 years	66.51	33.49	3,969,479
	35–44 years	71.33	28.67	3,291,260
	45–54 years	71.83	28.17	2,376,491
	55–64 years	60.86	39.14	1,318,539
Severity of disability	None	64.11	35.89	13,195,511
	Mild	56.36	43.64	428,777
	Severe	26.42	73.58	64,287
Education	Did not finish primary school	64.95	35.05	1,049,868
	Finished primary school	65.67	34.33	3,859,363
	Finished secondary school	62.68	37.32	8,779,344
Province	West Sumatra	66.28	33.72	451,210
	South Sumatra	59.33	40.67	1,134,395
	DKI Jakarta	62.02	37.98	2,945,985
	West Java	60.74	39.26	3,249,023
	Central Java	77.03	22.97	602,555
	DI Yogyakarta	78.74	21.26	985,660
	East Java	67.83	32.17	1,906,566
	East Nusa Tenggara	66.54	33.46	438,274
	Kalimantan Selatan	64.64	35.36	572,487
	South Sulawesi	52.01	47.99	1,005,231
	Maluku	57.45	42.55	397,189
Area	Rural Areas	71.64	28.36	3,522,160
	Urban Areas	60.94	39.06	10,166,415
Gender	Male	83.35	16.65	6,861,529
	Female	43.94	56.06	6,827,046
Total		**63.69**	**36.31**	**13,688,575**

Descriptive data from the Indonesian census aligns with these results, but data from Riskesdas tell a different story. As can be seen in table 6.1, the employment rate of people with severe disabilities in the census was 26.4 percent, much lower than the 64.1 percent for nondisabled people. People with mild disabilities had an employment rate of 56.4 percent.

Raw data from the Riskesdas survey, however, does not show that disability is negatively related to employment. As seen in table 6.2, people with mild disabilities actually have a slightly higher rate of working (59.72 percent) than people without disabilities (57.93 percent). Those with severe disabilities in the Riskesdas data are about 10 percent less likely to work (47.3 percent) than people without disabilities. The rate of employment for nondisabled people, however, is lower in Riskesdas (57.93 percent) compared with the census (64.1 percent). Differences in these results may be due to problems with Riskesdas data on labour activity. Riskedas does not allow for determining employment per se but only working status, which includes even very low levels of informal work and self-employment. The qualitative interviews suggest these low levels may be the experience of many people with disabilities. It could also be because the definition of mild disability using the Riskesdas includes people with more mild disabilities than the definition of disability used with the census data.

Table 6.2 Percentage of Working Individuals Aged 15+ by Characteristics, Riskesdas 2007

Individual Characteristics		Working			Total Obs. (number)
		Male (%)	Female (%)	Total (%)	
Disability	None	77.09	38.47	57.93	377,200
	Mild	82.69	40.11	59.72	211,459
	Severe	69.59	31.99	47.34	73,364
Age group by disability	**None**				
	15–17	16.47	10.30	13.50	40,158
	18–24	57.18	32.48	44.44	72,971
	25–34	90.20	39.21	63.62	106,086
	35–44	94.74	46.62	70.97	85,111
	45–54	94.80	51.97	75.05	47,327
	55–64	86.85	49.85	71.03	18,067
	65+	73.81	39.23	58.83	7,480
	Mild				
	15–17	18.94	10.25	14.51	10,631
	18–24	58.35	29.81	42.26	22,038
	25–34	90.15	36.56	59.40	39,072
	35–44	94.82	44.07	66.73	45,793
	45–54	94.55	50.05	71.12	44,770
	55–64	87.31	45.90	66.28	28,326
	65+	70.50	35.18	52.68	20,829

Table 6.2 Percentage of Working Individuals Aged 15+ by Characteristics, Riskesdas 2007 (Continued)

Individual Characteristics		Working			Total Obs. (number)
		Male (%)	Female (%)	Total (%)	
Age group by disability	**Severe**				
	15–17	14.90	11.48	13.07	2,186
	18–24	48.38	26.49	35.48	4,157
	25–34	80.37	33.66	51.53	7,042
	35–44	89.00	40.89	59.93	9,326
	45–54	88.88	44.25	62.54	12,809
	55–64	78.86	37.56	54.95	13,302
	65+	52.98	21.06	34.07	24,542
	Total				
	15–17	16.88	10.34	13.68	52,975
	18–24	57.10	31.59	43.60	99,166
	25–34	89.81	38.22	62.01	152,200
	35–44	94.45	45.30	68.87	140,230
	45–54	94.10	50.01	71.86	104,906
	55–64	85.55	44.76	65.18	59,695
	65+	63.92	28.37	44.88	52,851
Education	Did not finish primary school	83.66	44.38	60.61	167,929
	Finished primary school	75.29	33.07	53.58	318,400
	Finished secondary school	78.46	40.76	60.80	175,694
Province	DI Aceh	75.26	34.06	53.47	27,756
	North Sumatra	76.91	41.44	58.60	44,338
	West Sumatra	76.05	35.21	54.13	28,009
	Riau	79.43	26.76	53.10	16,824
	Jambi	82.14	37.52	59.43	15,336
	South Sumatra	82.20	50.70	66.43	23,346
	Bengkulu	80.42	51.35	65.94	12,847
	Lampung	82.52	43.54	63.42	16,489
	Bangka Belitung	79.26	29.31	54.52	9,559
	Riau Island	80.87	36.66	56.57	8,556
	DKI Jakarta	71.74	30.24	49.85	12,316
	West Java	74.06	26.94	49.36	46,622
	Central Java	80.11	50.75	64.63	62,569
	DI Yogyakarta	74.20	52.61	62.97	7,860
	East Java	79.91	48.19	63.23	74,673

Table 6.2 Percentage of Working Individuals Aged 15+ by Characteristics, Riskesdas 2007 (Continued)

Individual Characteristics		Working			Total Obs. (number)
		Male (%)	Female (%)	Total (%)	
Province	Banten	74.17	27.29	49.50	11,594
	Bali	79.72	57.97	68.72	15,155
	W. Nusa Tenggara	73.22	43.18	56.97	14,380
	E. Nusa Tenggara	79.93	37.97	57.41	23,299
	W. Kalimantan	80.67	43.49	61.96	18,251
	C. Kalimantan	83.18	40.37	61.63	18,804
	South Kalimantan	81.42	44.58	62.20	17,816
	East Kalimantan	80.49	28.25	54.60	17,437
	North Sulawesi	77.69	22.04	49.48	10,395
	Central Sulawesi	80.81	27.85	53.67	13,788
	South Sulawesi	72.63	20.85	44.58	36,470
	S.E Sulawesi	73.69	26.51	48.90	16,715
	Gorontalo	77.33	18.50	46.48	7,345
	West Sulawesi	77.84	27.71	51.97	6,441
	Maluku	73.83	30.07	50.77	6,395
	North Maluku	72.91	30.15	50.53	7,093
	West Irian Jaya	75.36	22.58	47.09	4,033
	Papua	76.59	41.02	58.65	9,512
Area	Urban	73.21	33.90	52.66	247,725
	Rural	81.11	40.91	60.26	414,298
Gender	Male	–	–	78.07	318,486
	Female	–	–	38.19	343,537
Total		**78.07**	**38.19**	**57.32**	**662,023**

Logit estimations of the relationship of disability to employment, controlling for other factors, from census data show that having a mild disability gives a person only a 64.9 percent chance of being employed relative to nondisabled people (table 6.3). Having a more serious disability reduces the relative chance of being employed to only 10.2 percent.

Even with Riskesdas data, a logit showed that, when other characteristics could be controlled for, men and women with severe disabilities were significantly less likely to be working (tables 6.4 and 6.5). Interestingly, the odds ratios for women were actually better than for men. This might be because these are regressions on work behaviour, not employment, and women may have more opportunities for home-based businesses. However, men with mild disabilities were not less likely to be working than nondisabled men, although women were, even though only slightly.

Table 6.3 Working Logit, Aged 18–64, Census 2010

Variable		Coefficient	Standard Error	Odds Ratio
Severity of disability	Mild disability	-.433***	.004	.649
	Severe disability	-2.28***	.010	.102
Age Group	18–24		---------------- Baseline -------------	
	35–34	1.11***	.002	3.04
	35–44	1.36***	.002	3.89
	45–54	1.38***	.002	3.96
	55–64	.751***	.003	2.12
Education	Did not finish primary school		---------------- Baseline -------------	
	Primary school	-.002	.003	.998
	Secondary school	-.024***	.003	.976
Province	Jakarta		--------------- Baseline -------------	
	West Sumatra	-.051***	.004	.951
	South Sumatra	-.175***	.003	.839
	West Java	-.252***	.002	.777
	Central Java	.590***	.004	1.81
	Yogyakarta	.774***	.003	2.17
	East Java	.151***	.002	1.16
	East Nusa Tenggara	.085***	.004	1.09
	South Kalimantan	.041***	.003	1.04
	South Sulawesi	-.472***	.003	.624
	Maluku	-.362***	.004	.696
Gender	Female		------------- Baseline -------------	
	Male	2.04***	.001	7.69
Area	Urban		------------ Baseline -------------	
	Rural	.484***	.002	1.62
Constant	(constant)	-1.31***	.003	–

In the Riskesdas regressions, the level of disability was interacted with age categories. As can be seen in table 6.4, across all age categories, having a mild disability had a very small impact on work behaviour. Men with severe disabilities, however, were roughly half as likely as nondisabled men to work, except for those aged 18–24 years for which the odds ratio was a bit higher, at 70.

The data also showed a small negative impact of mild disability on women's work behaviour, especially for the oldest women. In general, severe disability had a larger negative impact on working, again especially for the oldest women but not as severe as for men and much less than that shown in the census data.

However, only looking at employment can mask differences in the quality of employment. For example, Chapter V showed that people with disabilities have less education, which could affect the nature of the jobs they can obtain and the level of remuneration. Even with the same level of education, disabled people's earning power might be less. For example, people with mental disabilities in Yogyakarta (and their families) report that upon graduating school, they cannot find employment but must instead start small businesses to employ themselves. Focus group participants stated that they believed they were capable of doing a number of jobs—for example, working as a server or busboy at a restaurant—but that they were discriminated against because people did not want them around. The amount of money they could make on their own was less than their expected salaries.

Table 6.4 Working Logit for Males Aged 18–64, Riskesdas 2007

Variable		Coefficient	Standard Error	Odds Ratio
Age Group	18–24		---------------- Baseline -------------	
	35–34	1.677***	5.350	0.019
	35–44	2.104***	8.200	0.023
	45–54	2.194***	8.970	0.029
	55–64	1.507***	4.510	0.034
Interaction Variables	None			
	Mild*18–24	0.014	1.010	0.027
	Mild*25–34	-0.060**	0.940	0.030
	Mild*35–44	0.065*	1.070	0.035
	Mild*45–54	-0.017	0.980	0.039
	Mild*55–64	-0.008	0.990	0.042
	Severe*18–24	-0.352***	0.700	0.058
	Severe*25–34	-0.684***	0.500	0.055
	Severe*35–44	-0.586***	0.560	0.056
	Severe*45–54	-0.623***	0.540	0.053
	Severe*55–64	-0.564***	0.570	0.048
Education	Did not finish primary school		---------------- Baseline -------------	
	Finished primary school	-0.099***	0.910	0.019
	Finished secondary school	-0.348***	0.710	0.021
Province	DI Aceh	0.006	1.010	0.048
	North Sumatra	0.311***	1.360	0.047
	West Sumatra	0.074	1.080	0.049
	Riau	0.468***	1.600	0.053
	Jambi	0.657***	1.930	0.056
	South Sumatra	0.600***	1.820	0.055
	Bengkulu	0.468***	1.600	0.059
	Lampung	0.637***	1.890	0.056

Table 6.4 Working Logit for Males Aged 18–64, Riskesdas 2007 (Continued)

Variable		Coefficient	Standard Error	Odds Ratio
	Bangka Belitung	0.584***	1.790	0.063
	Riau Island	0.647***	1.910	0.077
	DKI Jakarta		---------------- Baseline --------------	
	West Java	0.037	1.040	0.043
	Central Java	0.396***	1.490	0.043
	DI Yogyakarta	0.136**	1.150	0.062
	East Java	0.218***	1.240	0.043
	Banten	0.144**	1.150	0.061
	Bali	0.569***	1.770	0.057
	West Nusa Tenggara	0.070	1.070	0.059
	East Nusa Tenggara	0.303***	1.350	0.051
	West Kalimantan	0.562***	1.750	0.055
	Central Kalimantan	0.646***	1.910	0.058
	South Kalimantan	0.395***	1.480	0.057
	East Kalimantan	0.443***	1.560	0.053
	North Sulawesi	-0.119*	0.890	0.061
	Central Sulawesi	0.348***	1.420	0.056
	South Sulawesi	-0.224***	0.800	0.047
	Southeast Sulawesi	0.055	1.060	0.051
	Gorontalo	-0.062	0.940	0.066
	West Sulawesi	0.345***	1.410	0.075
	Maluku	-0.096	0.910	0.067
	North Maluku	-0.04	0.960	0.066
	West Irian Jaya	-0.192**	0.830	0.083
	Papua	-0.089	0.920	0.061
	Rural	0.609***	1.840	0.014
Constant	(constant)	-0.249***	–	0.044

Table 6.5 Working Logit for Females Aged 18–64, Riskesdas 2007

Variable		Coefficient	Standard Error	Odds Ratio
Age Group	18–24		---------------- Baseline -------------	
	35–34	0.355***	1.43	0.017
	35–44	0.649***	1.91	0.018
	45–54	0.854***	2.35	0.021
	55–64	0.713***	2.04	0.03
Interaction Variables	None		---------------- Baseline -------------	
	Mild*18–24	-0.069**	0.93	0.028
	Mild*25–34	-0.044**	0.96	0.020
	Mild*35–44	-0.052***	0.95	0.019
	Mild*45–54	-0.043**	0.96	0.022
	Mild*55–64	-0.136***	0.87	0.033
	Severe*18–24	-0.235***	0.79	0.06
	Severe*25–34	-0.116***	0.89	0.04
	Severe*35–44	-0.13***	0.88	0.034
	Severe*45–54	-0.204***	0.82	0.031
	Severe*55–64	-0.43***	0.65	0.038
Education	Did not finish primary school		---------------- Baseline -------------	
	Finished primary school	-0.319***	0.73	0.011
	Finished secondary school	0.067***	1.07	0.014
Province	DI Aceh	0.001	1	0.04
	North Sumatra	0.467***	1.6	0.038
	West Sumatra	0.130***	1.14	0.039
	Riau	-0.357***	0.7	0.044
	Jambi	0.240***	1.27	0.042
	South Sumatra	0.800***	2.23	0.042
	Bengkulu	0.869***	2.38	0.045
	Lampung	0.515***	1.67	0.042
	Bangka Belitung	-0.145***	0.87	0.051
	Riau Island	0.373***	1.45	0.059

Table 6.5 Working Logit for Females Aged 18–64, Riskesdas 2007 (Continued)

Variable		Coefficient	Standard Error	Odds Ratio
	DKI Jakarta		---------------- Baseline --------------	
	West Java	-0.199***	0.82	0.037
	Central Java	0.865***	2.38	0.035
	DI Yogyakarta	0.898***	2.46	0.05
	East Java	0.716***	2.05	0.035
	Banten	-0.166***	0.85	0.051
	Bali	1.244***	3.47	0.044
	West Nusa Tenggara	0.577***	1.78	0.045
	East Nusa Tenggara	0.168***	1.18	0.04
	West Kalimantan	0.496***	1.64	0.041
	Central Kalimantan	0.397***	1.49	0.042
	South Kalimantan	0.558***	1.75	0.042
	East Kalimantan	-0.174***	0.84	0.044
	North Sulawesi	-0.56***	0.57	0.055
	Central Sulawesi	-0.225***	0.8	0.045
	South Sulawesi	-0.672***	0.51	0.042
	Southeast Sulawesi	-0.299***	0.74	0.043
	Gorontalo	-0.803***	0.45	0.06
	West Sulawesi	-0.206***	0.81	0.059
	Maluku	-0.102*	0.9	0.054
	North Maluku	-0.093*	0.91	0.053
	West Irian Jaya	-0.556***	0.57	0.069
	Papua	0.265***	1.3	0.048
	Rural	0.417***	1.52	0.01
Constant	(constant)	-1.263***	–	0.037

The analysis of the interplay among education, employment, and disability needs to take into account the age of onset and the nature of the work being undertaken. It is difficult to get at these concepts with the census and Riskesdas data. The SNSAP-PWD data do have information on age of onset and type of work being done, but as stated in previous chapters, it is not a random sample of people with disabilities and so cannot be used to generalise to the full population. Nevertheless, looking at the SNSAP-PWD provides an opportunity to begin understanding the links between employment and disability within this population of people with disabilities (with earlier than usual age of onsets, higher severity, and greater attachment to the disability advocacy community) for indications of what may be important factors.

Table 6.6 shows the work behaviour of people with disabilities based on their level of disability, age, and gender in order to see if this population is very different than what is found in the census and in Riskesdas. Indeed, the overall employment rates in the SNSAP-PWD and the census are quite similar. About 55 percent of SNSAP-PWD respondents with a low level of disability were working for pay (53.12 percent working, plus 1.90 percent working and attending school) compared with 56 percent in the census. For respondents with more severe disabilities, it was less than 25 percent compared with 26 percent in the census.

Moreover, the rate of working for no pay was higher for disabled women than disabled men. If the categories of work, work and school, and working for no pay are added together, the women actually have a slightly higher rate of employment than do the men. This is consistent with the results found in the Riskesdas about the relation between disability and work behaviour, suggesting that, although the SNSAP-PWD sample is not random, it is not out of line with basic results from the random samples.

Table 6.6 Work Behaviour by Degree of Disability, Age, and Gender, SNSAP-PWD, 2012

Variable		Low Disability					High Disability				
Gender	Age Group	School	Work	Work and School	No Work and No School	Work for No Pay	School	Work	Work and School	No Work and No School	Work for No Pay
Male	10–19	75.00	0.00	4.17	20.83	0.00	42.86	2.46	1.97	52.71	0.00
	20–29	12.96	59.26	1.85	25.93	0.00	8.56	28.34	1.60	59.36	2.14
	30–39	5.36	73.21	3.57	16.07	1.79	2.27	41.48	1.70	52.84	1.70
	40–49	0.00	75.68	0.00	21.62	2.70	0.00	50.00	2.74	45.89	1.37
	50–59	2.70	56.76	2.70	32.43	5.41	0.00	38.06	1.49	57.46	2.99
	60+	0.00	64.71	0.00	35.29	0.00	4.03	12.08	0.67	79.19	4.03
	All	13.22	59.03	2.20	23.79	1.76	11.61	27.38	1.69	1.88	57.44
Female	10–19	62.50	8.33	0.00	25.00	4.17	36.03	2.94	0.74	59.56	0.74
	20–29	5.56	44.44	0.00	22.22	27.78	6.92	16.92	0.77	65.38	10.00
	30–39	0.00	62.50	0.00	21.88	15.63	0.00	33.88	0.00	57.85	8.26
	40–49	0.00	50.00	3.85	23.08	23.08	2.52	30.25	0.00	54.62	12.61
	50–59	0.00	60.71	3.57	25.00	10.71	1.87	22.43	0.93	58.88	15.89
	60+	0.00	18.75	0.00	68.75	12.50	2.04	9.69	0.00	82.14	6.12
	All	10.96	43.84	1.37	28.77	15.07	8.38	17.86	0.36	65.01	8.38
All	10–19	68.75	4.17	2.08	22.92	2.08	40.12	2.65	1.47	55.46	0.29
	20–29	11.11	55.56	1.39	25.00	6.94	7.89	23.66	1.26	61.83	5.36
	30–39	3.41	69.32	2.27	18.18	6.82	1.35	38.38	1.01	54.88	4.38
	40–49	0.00	65.08	1.59	22.22	11.11	1.13	41.13	1.51	49.81	6.42
	50–59	1.54	58.46	3.08	29.23	7.69	0.83	31.12	1.24	58.09	8.71
	60+	0.00	42.42	0.00	51.52	6.06	2.90	10.72	0.29	80.87	5.22
	All	12.20	53.12	1.90	25.75	7.05	9.98	23.23	1.11	60.86	4.82

Table 6.7 Type of Work by Degree of Disability, Gender, and Age, SNSAP-PWD, 2012

Variable		Low Disability				High Disability			
Gender	Age Group	Self Employed	Em-ployer	Em-ployee	Unpaid Family Worker	Self Employed	Em-ployer	Em-ployee	Unpaid Family Worker
Male	10–19	100.00	0.00	0.00	0.00	44.44	11.11	22.22	22.22
	20–29	62.07	6.90	27.59	3.45	43.10	0.00	44.83	12.07
	30–39	69.05	4.76	16.67	9.52	52.05	9.59	34.25	4.11
	40–49	55.56	7.41	29.63	7.41	46.91	6.17	39.51	7.41
	50–59	54.17	12.50	29.17	4.17	59.26	9.26	24.07	7.41
	60+	81.82	9.09	9.09	0.00	51.61	3.23	35.48	9.68
	All	63.70	7.41	22.96	5.93	50.00	6.45	35.48	8.06
Female	10–19	50.00	0.00	0.00	50.00	40.00	0.00	60.00	0.00
	20–29	57.14	0.00	28.57	14.29	52.17	8.70	26.09	13.04
	30–39	70.00	0.00	10.00	20.00	43.18	4.55	29.55	22.73
	40–49	50.00	14.29	28.57	7.14	50.00	2.78	30.56	16.67
	50–59	66.67	5.56	22.22	5.56	56.00	12.00	20.00	12.00
	60+	66.67	33.33	0.00	0.00	50.00	10.00	30.00	10.00
	All	63.08	6.15	18.46	12.31	48.70	6.49	29.22	15.58
All	10–19	66.67	0.00	0.00	33.33	42.86	7.14	35.71	14.29
	20–29	61.11	5.56	27.78	5.56	45.68	2.47	39.51	12.35
	30–39	69.35	3.23	14.52	12.90	48.72	7.69	32.48	11.11
	40–49	53.66	9.76	29.27	7.32	47.86	5.13	36.75	10.26
	50–59	59.52	9.52	26.19	4.76	58.23	10.13	22.78	8.86
	60+	78.57	14.29	7.14	0.00	50.98	5.88	33.33	9.8
	All	63.13	7.07	21.72	8.08	49.67	6.32	33.33	10.68

Table 6.7 shows the types of work being undertaken. Overall, the most common status for a disabled person is self-employed. Nearly two-thirds of people with mild disabilities and about one-half of those with more significant disabilities are self-employed. This is consistent with research from around the world; even in developed countries, people with disabilities are more likely to be self-employed (Mizunoya and Mitra 2012; Barnes, Thornton, and Campbell 1998; U.S. Bureau of Labor Statistics 2012). Self-employment poses fewer barriers because people can fashion their own work arrangements and are not subjected to potential discrimination from employers. Age does not seem to have a big impact.[35]

[35] Similar tables were generated only for people who became disabled as children, but there were no significant differences so they are not included

Table 6.8 Working Logit, Aged 15–64, SNSAP-PWD, 2012

Variable		Coefficient	Odds Ratio
Gender	Female	-------- Baseline --------	
	Male	.754	2.13
Area	Rural	-------- Baseline --------	
	Urban	-.059	.942
Onset of disability	Onset < 15	2.46	1.17
	Onset 15–59	1.90	6.70
	Onset 60+	-------- Baseline --------	
Age	Age	.027	1.03
Severity of disabiity	Mild disability	1.27	3.55
	Severe disability	-------- Baseline --------	
Province	West Sumatra	-1.01	.363
	South Sumatra	-.972	.378
	West Java	-.896	.408
	Central Java	-1.01	.364
	DI Yogyakarta	-1.38	.251
	East Java	-.721	.486
	East Nusa Tenggara	-.266	.766
	South Kalimantan	-1.07	.344
	South Sulawesi	-.494	.610
	Maluku	-1.70	.183
	Jakarta	-------- Baseline --------	
Constant	Cons	-39.785	–

Table 6.8 shows the impact of disability on work behaviour (employment plus self-employment) based on the age of onset, information that is not available in the census or Riskesdas. As the SNSAP-PWD is not a random sample, standard errors are not reported, but the results are indicative of the fact that the age of onset of disability has an impact on the ability to work. Becoming disabled after the age of 60 has the biggest impact on employment, maybe because the disabilities are more disabling or because people were close to the end of their working years, so deemed trying to get rehabilitated or accommodate to their new situation not as worthwhile. Of course, this could also be the nature of the people who are more inclined to belong to disability advocacy groups and therefore more likely to be in the sample.

Still, people who were disabled as children were 17 percent more likely to be employed than people acquiring a disability in old age. But people becoming disabled in their working years were the most likely by far to be employed: between six and seven times more likely than people becoming disabled either as children or when elderly.

Moreover, the degree of disability was an important factor. Having a mild disability made a person more than three and a half times likely to be working compared with someone with severe disability.

A number of focus group respondents complained about being shut out of particular jobs. In West Sumatra, even after people with disabilities receive special training in sewing, their applications to garment factories were rejected. Often people with disabilities are funnelled into particular kinds of work such as teachers in special schools. Blind people are often encouraged to be masseuses.

Yet respondents across all types of disabilities and across all provinces in the sample report success in obtaining work, even if that means self-employment when they would prefer wage employment. Occupations listed included retail, carpentry, motorcycle repair, construction, electronics, and domestic and agricultural work.

The specific mandate for employment of people with disabilities comes from Law No. 4 of 1997 on Persons with Disability, especially articles 13 and 14 and more specifically from Government Regulation No. 43 of 1998, which demands a quota of 1 percent of every 100 employees to be a person with a disability.

MoSA and the Ministry of Manpower and Transmigration (MoMP&T) also provide vocational training for people with disabilities. Participants from all provinces indicated that training in skills such as automotive, computer, sewing, electricity installation, carpentry, massage, etc. used to be available, but recently MoMP&T lacked funds to implement its own training. Its trainers now assist MoSA in its vocational training centres. The Department of Social Affairs provides vocational training through vocational training centres (*Balai Latihan Kerja* or BLK) as a form of social rehabilitation.

However, although there is a scattering of special programmes, there is no systematic effort to make governmental training programmes accessible to people with disabilities or to establish a government programme that focuses on them. This is in part due to limited funds at the national level. Most budgetary authority is at the local level where local discretion is applied. The central government reports that many local governments are not interested in spending their funds in this area or they see people with disabilities as the responsibility of the Ministry of Social Affairs. This is true even with outreach by the central government, for example, during consultation meetings to discuss the enactment of the disability rights law in 1998 and the issuing of various circulars and degrees.

The ministry does reach some people with disabilities. A monitoring report in 2008 noted that 90 companies in 10 provinces had reached 773 people employed in technical positions. Although this programme[36] may have been very worthwhile, it does not appear to be a model that local governments are scaling up or adopting.

MoSA also provides microfinance stimulants called the Joint Enterprise Group (*Kelompok Usaha Bersama* or KUBE) and Productive Economic Enterprise (*Usaha Ekonomi Produktif*) to help people with disabilities start economically gainful activities and generate opportunities for employment for other people with disabilities. Jenoponto District in South Sulawesi provides a best practice in government policy. They provide training for people with disabilities in processing seaweed in collaboration with the local office of the Department of Industry and funded by local budget. MoSA and MoMP&T also collaborated to provide instruments and tools, such as sewing machines and electric tools and computers, to enable people with disabilities to start their own gainful activities.

[36] Vocational training is implemented by the Balai Besar or Head of Training Centers owned by MoSA.

Focus group participants, however, said that lack of access to capital thwarted their desires to set up more established businesses. Many reported still relying on their parents. At times, programmes developed to help them improve their livelihoods do not reach them. For example, in Kalimantan, people with physical disabilities said that they were not capable of farming on their own without a tractor, but with a tractor, they believed they could be successful. The core plasma programme is set up to give poor people small land grants to help them start their own farms, and the provision of tractors is part of the programme. The people with disabilities said, however, that they do not get their share of tractors. There are also microcredit programmes that are technically open to them but they claim present barriers to their participation.

One key barrier is often that lenders do not believe people with disabilities are a good risk for loans. No evidence exists within Indonesia on this topic, but evidence from other countries suggests this is not the case. A microfinance programme in Andhra Pradesh helped more than 95 percent of people with disabilities successfully repay their loans, which was about the same rate as nondisabled people (Mont 2013). Similar results have been found from the ProMujer programme in Nicaragua.

Sometimes, to lessen fear that people with disabilities will default on loans, guarantees are made for them, as in Handicap International's programmes in Senegal and the Central African Republic.

Awareness on disability issues among staff of MoMP&T and related government policies is low. In the past three years, the MoMP&T in some provinces such as West Java did not receive any budget support for vocational training of people with disabilities. Their role in empowering people with disabilities is diminishing across the country. Participants indicated that MoMP&T merely sends people with disabilities to MoSA vocational centres to train them as trainers.

Regional autonomy had negative impacts for subnational programmes in both ministries. Basically MoMP&T's role is reduced to 'steering' and 'monitoring' implementation of government policies. Many vocational training centres at the subnational level have been dysfunctional, because they lacked central and local government budgetary support. In many provinces, Productive Economic Enterprise, which addresses implementation of the Law No. 4 of 1997 on Persons with Disability, offers no financial incentives such as tax breaks. It is a 'social' policy that does not interest the business sector, which deals with profit making. Moreover, this law is perceived as a MoSA or welfare-driven law and the Department of Manpower has no authority to impose any sanctions. Furthermore, many decision makers in the MoMP&T believe that strict implementation of the regulation will make the private sector less competitive. Coordination among relevant ministries such as MoMP&T, MoSA, MoEC, and Ministry of Health has not been effective.

Focus group participants believed strongly that training and education were lacking to help them meet the requirements for jobs available in the market. Many of them had to work in their own family's business. In West Sumatra, participants indicated that many families had serious concerns when letting their children go for training in government institutions. People with disabilities were also concerned with lack of accessibility generally, both in the community and the workplace.

Government Regulation No. 43/1998 is not well publicised so employers are not aware of the existing policy, according to focus group participants. There are few examples of government and privately owned companies implementing the regulation and becoming champions of inclusive industrial entities. Some success stories from Sulawesi, West Java, and Yogyakarta indicated people with disabilities at times received proper training and were able to meet job requirements. Some participants also indicated that, although they had been trained by MoSA, their skills were not acknowledged by the factories that rejected their job applications.

This chapter leads to five recommendations:

- Make vocational training programmes inclusive. Creating a parallel system of vocational training programmes within MoSA has been inefficient, creates stigma, and segregates people with disabilities into a system that is less market driven. Instead, resources should be put into making current vocational training programmes offered by MoMP&T more inclusive—by making their physical plants more accessible, training trainers on adaptive techniques, and promoting the idea that people with disabilities can be productive members of society. Some programmes currently exist, but they are small. To have any impact, funding will have to be expanded significantly.
- Align labour laws with the UNCRPD. All references in labour laws that allow for discrimination in hiring, promotion, and firing of people with disabilities should be eliminated. In addition, sanctions should be imposed for violating the disability rights law.[37]
- Conduct public awareness campaigns. Efforts should be directed to raising awareness about disability laws and about the ability of people with disabilities to work effectively and to effectively participate in microfinance programmes, drawing upon examples from around the developing world.
- Conduct pilot tests of employment programmes. There are many examples of such programmes, including many in the region (Perry 2003). These models should be explored in-depth in order to generate potential pilot projects that fit the Indonesian context. If effective, they can be used to convince local governments that it is worthwhile to pursue employment programmes for people with disabilities. These pilots should be rigorously evaluated. As of now, no good evaluations exist of such programmes that estimate their costs and benefits (WHO and World Bank 2011; Mont 2013).
- Reduce barriers to microfinance for people with disabilities. As self-employment is more common among people with disabilities and evidence from elsewhere shows that people with disabilities can be good risks as borrowers, efforts should be made to include them in microfinance programmes. This can be done by offering assistance in developing business plans, educating micro-lenders about disability, or establishing loan guarantees for people with disabilities. One possibility that has been effective elsewhere—evidenced by the way it has been embraced by the private sector—is building partnerships with businesses to establish good practices. Indonesia could draw on the expertise of employer organisations that believe in the business case for inclusive workplaces (e.g., The Business Disability Forum in the United Kingdom and the Employers Federation of Ceylon in Sri Lanka[38]). These private sector businesses have established practices that promote the employment of people with disabilities as a way of increasing productivity and can help convince Indonesian businesses that hiring people with disabilities—and marketing their products to them—need not be seen as a burden but as a business opportunity.[39]

[37] This recommendation really follows from the analysis in Chapter III on the legal framework but is included here because it directly pertains to employment.

[38] For a listing of Business Disability Forum's (formerly the Employers Forum on Disabilty) long list of publications, see http://businessdisabilityforum.org.uk/our-offer/advice-publications/publications. For more information on the Employers Federation of Ceylon, see Perry 2003.

[39] No findings from the data can be used to support this recommendation, but that is because of the absence of any attempt at partnership with businesses or of any good examples of good practices that have been shown to be cost-effective in other places, as by the two organisations mentioned here.

Chapter VII
Poverty, Social Protection, and Health

This chapter explores the relationship between disability and poverty in Indonesia and then describes the social assistance framework in place to assist people with disabilities in poverty. It also briefly describes some of the major issues involved in designing social protection programmes for people with disabilities.

The goal of inclusive development is for people with disabilities to be able to generate their livelihoods as nondisabled people do and lead independent lives. However, because of their functional limitations and the barriers they face in the physical, cultural, and policy environments they live in, people with disabilities are disproportionately poor and in greater need of social assistance in order to assure them an acceptable minimum level of well-being. Because of the extra costs associated with disability and the special barriers people with disabilities face, special programmes that target people with disabilities can be needed.

Poverty and Disability

A growing literature has begun to document the links between poverty and disability (Groce, London, and Stein 2012; WHO and World Bank 2011; Mitra, Posarac, and Wick 2011; Mont and Cuong 2011; Trani and Loeb 2012), but that correlation in Indonesia has been largely unknown. It is important to point out, however, that the causality between disability and poverty goes in both directions. Poor people have poorer nutrition, less access to health care (including maternal health care), poorer sanitation and water facilities, and generally live and work in less safe conditions than people further up the income distribution. Therefore, poverty can create disabling conditions. However, as seen in earlier chapters, people with disabilities face barriers to education and employment, which can create—or at least trap—people in poverty. This is true not only in Indonesia but across the globe (WHO and World Bank 2011). A simple correlation between poverty and disability cannot tell us which of these effects is stronger. As the data available for this report are only a snapshot in time, they cannot be used to unravel this bidirectional causality. Fortunately, however, it provides us with a detailed picture of the well-being of people with disabilities and their household members.

Other than causality, other issues emerge when dealing with the relationship between disability and poverty. The first is the definition of disability. As explained in Chapter II, the definition used here is based on functional limitations, consistent with the bio-psycho-social model of disability in WHO's International Classification of Functioning. But even using that model there is the question: at what point a functional limitation impacts an individual's participation in society to such an extent that they are considered to have a disability? Therefore, the relationship between disability and poverty presented in this chapter uses two different thresholds for what constitutes a disability.

The 'low threshold' measure sets a lower bar for the kinds of limitations that signify that a person has a disability. The 'higher threshold' measure excludes more mild limitations and looks only at people who have more significant difficulties, thus the 'higher threshold' measure identifies a subset of the people identified by the 'lower threshold' measure (see Chapter IV for a more detailed discussion of defining and measuring disability).

A second issue is the definition of poverty and its relationship to the costs of living with a disability. Poverty lines are determined to represent a minimum standard of living. But people with disabilities face extra costs that nondisabled people do not face (Tibble 2005; Zaidi and Burchardt 2005; Braithwaite and Mont 2009). These may include extra costs for medical care, transportation, personal assistants, and acquiring information, among other things. There is also the issue of the extra time it takes for people with disabilities to accomplish the same

tasks as their nondisabled peers. Therefore, a given level of consumption (or income) does not represent the same standard of living for households with and without disabled members. Households with disabled members may need more resources in order to obtain the same quality of life.

Related to this issue is the notion of equivalence scales. Not only are there differences in the costs of living for people with disabilities, but there are differences based on age as well as economies of scale that may be achieved for larger households.

Furthermore, different consumption thresholds will be used—for example, 1.5 times the poverty line—in order to get a better sense not only of people who are technically poor but people who are near poor and at particular risk of dropping below the official poverty line.

Table 7.1 begins to address the first of these issues, by reporting the poverty rates of households with and without people with disabilities using the two different thresholds for defining disability.[40] Households with disabled members are poorer, and this is more pronounced when using the high threshold (which excludes people with milder disabilities). In that instance, the poverty rate for households including people with disabilities is 13.3 percent, which is about a third greater than the poverty rate for households without people with disabilities at 10.0 percent. The difference is even greater among urban households, which with a poverty rate of 12.4 percent are about 50 percent more likely to be poor than their counterparts without disabled members.

Table 7.1 Household Poverty Rates by Presence of Disabled Members, Riskesdas 2007

	Urban (%)	Rural (%)	Total (%)
No disabled members	8.2	11.4	10.0
Low threshold	11.2	13.2	12.4
High threshold	12.4	14.0	13.3

However, as pointed out in earlier chapters, disability is a very heterogeneous phenomenon. Some people become disabled in childhood and experience its effects throughout their life. Some people acquire a disability late in life when their working years are over and they have had time to raise families and acquire assets unimpeded by the barriers that people with disabilities often face. And indeed, as this report shows, the elderly are much more likely to be disabled. Therefore, table 7.2 shows the distribution of people with disabilities across consumption deciles, depending on their age.

The percentage of households with a disabled family member when no elderly people are present in the household decreases as the households move up the consumption ladder. Using the low-threshold measure, 37.6 percent of households with the lowest 10 percent of consumption expenditures are disabled. This falls to 28.8 percent for the richest 10 percent. Using the more restrictive, 'high threshold', definition, the percentage of households with a disabled member falls from 16.7 percent for the lowest decile to 11.2 percent for the highest. Note that the percentage of people living in households with a disabled member is higher than the percentage of individuals with a disability because people with disabilities typically live with multiple nondisabled household members.

[40] The poverty lines are the official BPS provincial poverty lines, with separate lines for rural and urban areas.

Table 7.2 Percentage of Households with Disabled Members and of All Disabled Individuals by Level of Expenditures', Riskesdas 2007

Expenditure Decile	HHs without Elderly		HHs with Elderly (age 60+)		All Households		All Individuals	
	Low Threshold	High Threshold	Low Threshold	High Threshold	Low Threshold	High Threshold	Low Threshold	High Threshold
(lowest) 1	37.61	16.69	79.14	53.51	50.95	28.51	17.57	8.20
2	35.49	14.69	78.14	51.77	48.35	25.87	17.63	7.82
3	34.96	14.12	76.28	50.57	46.77	24.53	17.54	7.76
4	34.17	13.88	75.77	47.59	46.01	23.47	17.89	7.70
5	34.33	14.09	75.20	47.91	45.51	23.34	17.98	7.91
6	34.13	14.27	73.59	45.21	44.30	22.25	17.98	7.76
7	32.85	13.40	73.69	46.77	42.73	21.47	17.74	7.66
8	31.75	12.50	71.81	43.52	41.05	19.70	17.31	7.14
9	31.58	12.90	70.42	43.28	40.02	19.50	17.24	7.17
10 (highest)	28.75	11.21	66.28	39.42	35.88	16.57	16.96	6.70

Notes: HH = household. Provincial price deflator is not applied in this table. Distribution of respondents across decile can be found in Annex 8.

Not surprisingly, the presence of disability in households with elderly people is much higher than for households without elderly members. Depending on the cut-off for disability, nearly one-half to three-fourths of all households with a person aged 60 years or older contain a person with a disability. The rate of disability also falls with a rise in consumption for households with elderly people but not as much as for households with elderly members. For the high-threshold measure, households with elderly people in the highest quintile (i.e., the richest 20 percent of the population) are about three-fourths more likely to have a disabled member than households in the lowest quintile. For the households without elderly people, it is only about two-thirds as likely. So, although households with elderly people are much more likely to have disabled members and having a disabled member makes them more likely to have lower levels of consumption, the relationship between consumption and disability is actually stronger for households without elderly members. This last fact is not surprising because becoming disabled earlier in life no doubt has a bigger impact on a person's ability to generate income and acquire assets.

Another way of looking at the consumption distribution is through a cumulative density function that shows the cumulative percentage of households at various levels of consumption. This is shown in Figures 7.1a and 7.1b for households with and without disabled members using the high or low-threshold measure of disability, respectively.

For both measures, there is little difference in the distribution of consumption for the bottom half of the distribution, but because the cumulative density function is so flat, there is not that much room for a possible difference. In other words, when so many people spend so little, there is not much room for one group to have more than another. Once we move beyond the median level of consumption, there begins to be a small difference in the distribution of expenditures; there is more inequality among households with disabled members. In other words, households with disabled members are more likely to have lower consumption than their nondisabled counterparts except when they are very rich.

Figure 7.1a Cumulative Percentage of Households with and without Disability by Expenditures, Low-Threshold Definition of Disability, Riskesdas 2007

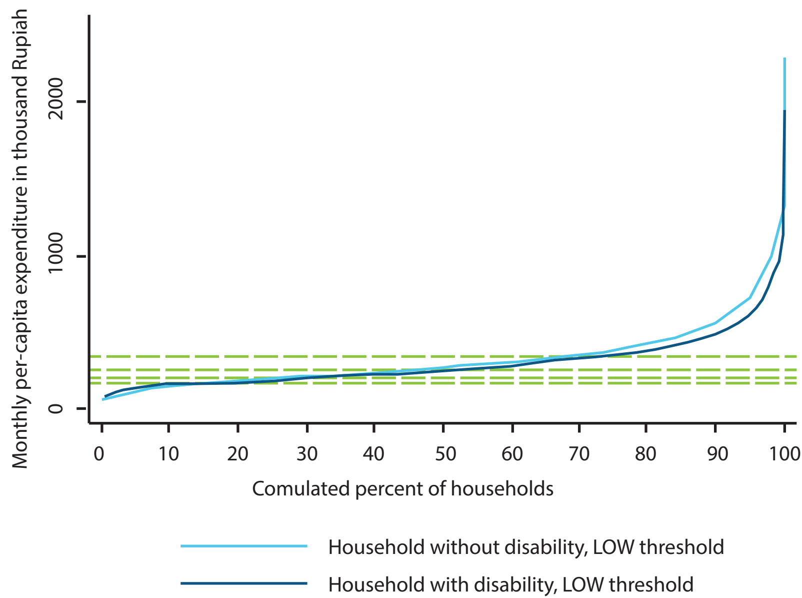
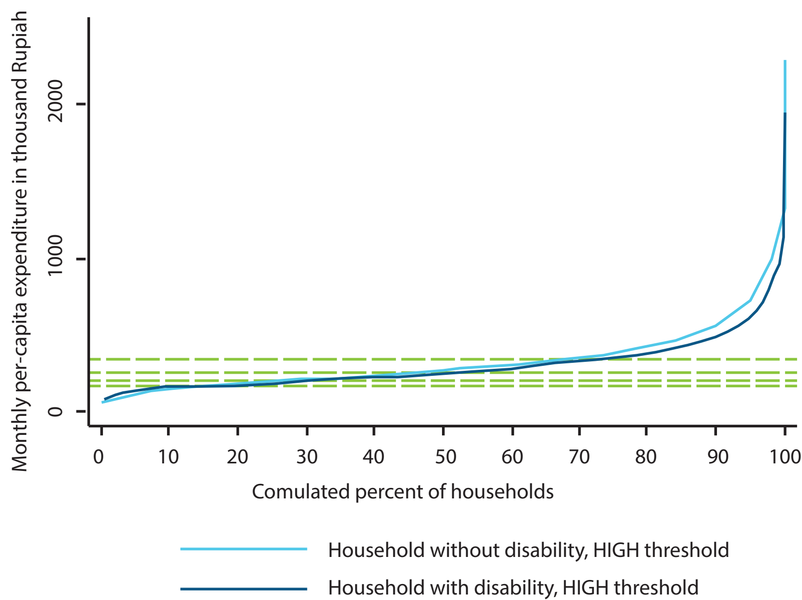


Figure 7.1b Cumulative Percentage of Households with and without Disability by Expenditures, High-Threshold Definition of Disability, Riskesdas 2007



The flat cumulative density function, however, indicates that the distribution of income is quite tight around the poverty line. If the poverty line were raised even a small amount, then the number of people under that line would expand significantly. For example, the bottom green dashed line in Figures 7.1a and 7.1b represents the poverty line. The other three dashed green lines (moving upwards) represent 1.2, 1.5, and 2.0 times the poverty line. So, small increases in the poverty line (measured in monthly per-capita expenditures) would categorise many more people as poor.

Table 7.3 Poverty Rates of Households with Disabled Members Using Different Poverty Lines, Riskesdas 2007

	Poverty Rates, Low Threshold				Poverty Rates, High Threshold			
	1xPL (%)	1.2xPL (%)	1.5xPL (%)	2xPL (%)	1xPL (%)	1.2xPL (%)	1.5xPL (%)	2xPL (%)
Urban								
No disabled members	8.23	16.01	30.19	51.00	8.70	16.77	31.10	51.99
With disabled members	11.22	20.90	36.47	57.49	12.37	22.86	39.22	60.16
Rural								
No disabled members	11.38	22.67	42.30	67.08	11.63	23.05	42.79	67.75
With disabled members	13.12	25.33	45.52	70.56	13.96	26.62	46.96	71.67
Total								
No disabled members	10.01	19.79	37.06	60.11	10.39	20.39	37.84	61.07
With disabled members	12.37	23.58	41.94	65.40	13.34	25.15	43.94	67.17

Table 7.4 Ratio of Poverty Rates of Households with Disabled Members to Households without Disabled Members Using Different Poverty Lines, Riskesdas 2007

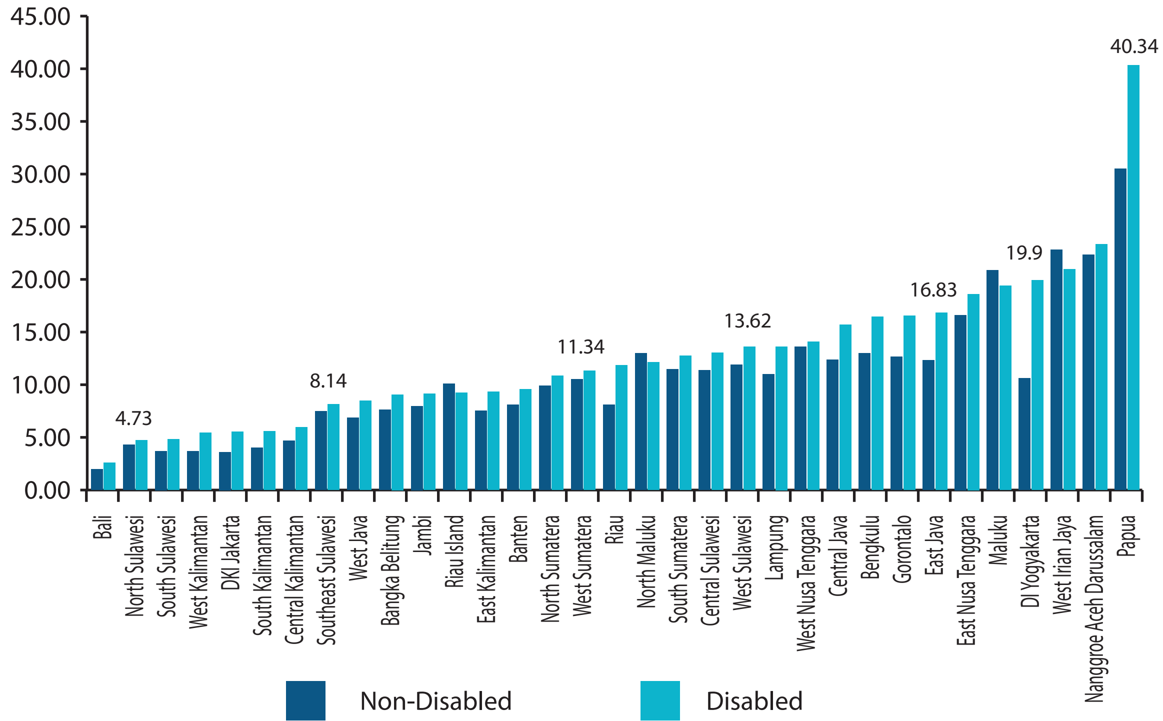
	Poverty Rates, Low Threshold				Poverty Rates, High Threshold			
	1xPL (%)	1.2xPL (%)	1.5xPL (%)	2xPL (%)	1xPL (%)	1.2xPL (%)	1.5xPL (%)	2xPL (%)
Urban	1.36	1.31	1.21	1.13	1.42	1.36	1.26	1.16
Rural	1.15	1.12	1.08	1.05	1.20	1.15	1.10	1.06
Total	**1.24**	**1.19**	**1.13**	**1.09**	**1.28**	**1.23**	**1.16**	**1.10**

Table 7.3 also shows this. Using the poverty line, 12.37 percent of households with disabled members are poor using the low-threshold measure, compared with 10.01 percent of households without disabled members. However, 41.94 percent of household with disabled members lie 1.5 times below the poverty line and 65.40 percent lie below twice the poverty line. Looking at households with only severely disabled people (the high-threshold measure), the same poverty rates are slightly higher at 13.34, 43.94, and 67.17 percent. The gap between poverty rates for disabled and nondisabled households is slightly larger in urban areas (see Table 7.4).

Table 7.4 shows the ratio of the poverty rates of households with disabled members to those without. For example, the poverty rate for households with severely disabled members is 28 percent higher for people with disabilities using the poverty line. When double the poverty line is used, their poverty rate is only 10 percent higher.

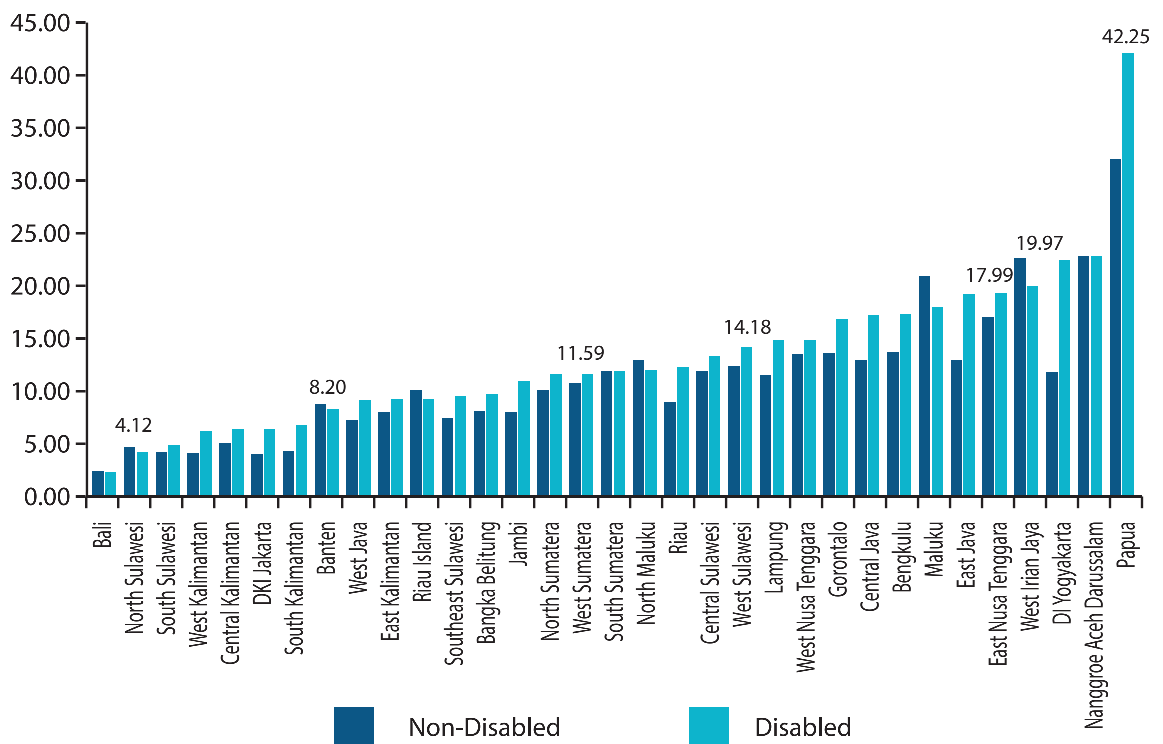
Across the board, in rural and urban areas and using either the low- or high-threshold for disability, households with disabled members are more overrepresented the lower down the consumption distribution one goes (Table 7.4).

Figure 7.2a Poverty Rates of Households by Province and the Presence of a Disabled Household Member (Low Threshold), Riskesdas 2007



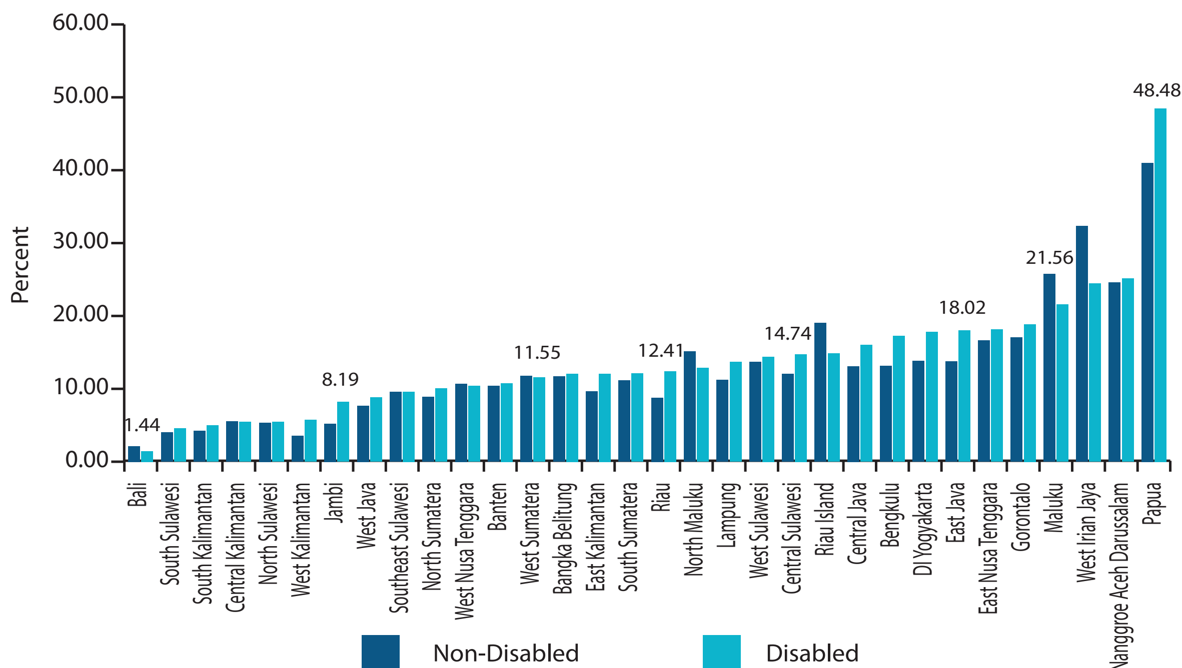
Note: See Annex 9 for a table of this chart.

Figure 7.2b Poverty Rates of Households by Province and the Presence of a Disabled Household Member (High Threshold), Riskesdas 2007



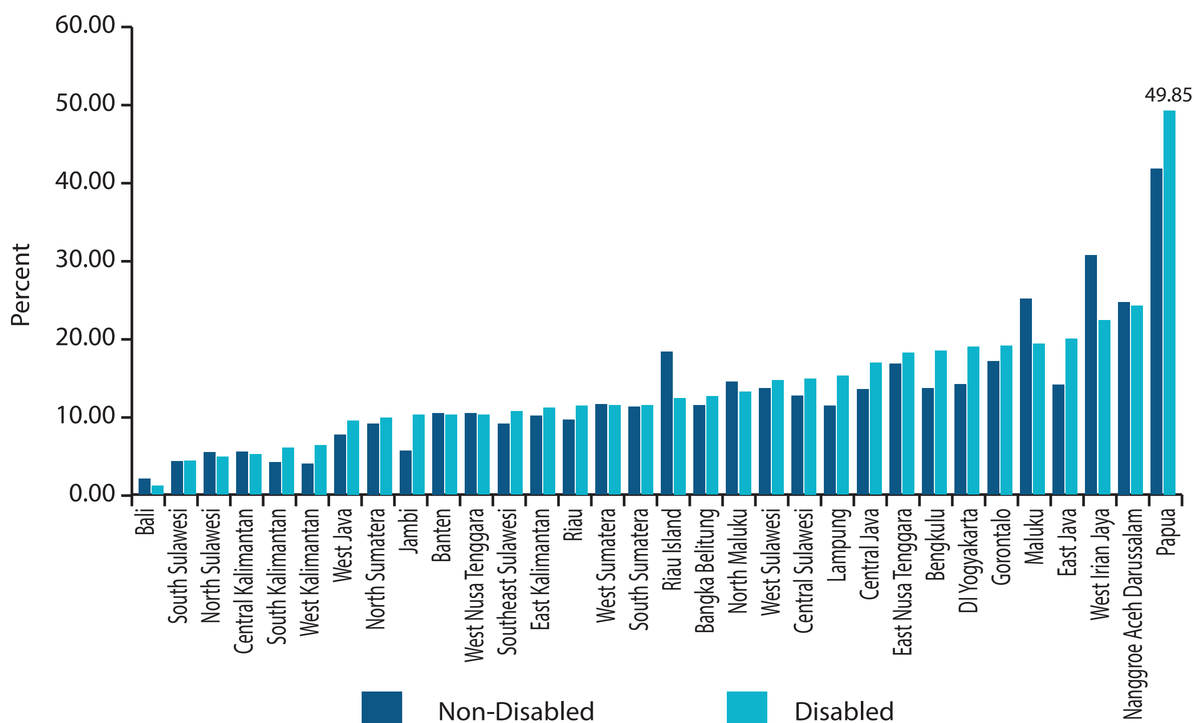
Note: See Annex 10 for a table of this chart

Figure 7.3a Rural Poverty Rates of Households by Province and the Presence of a Disabled Household Member (Low Threshold), Riskesdas 2007



Note: See Annex 9 for a table of this chart. The whole area of DKI Jakarta is urban, therefore it is not included in the graph.

Figure 7.3b Rural Poverty Rates of Households by Province and the Presence of a Disabled Household Member (High Threshold), Riskesdas 2007



Note: See Annex 10 for a table of this chart.

Table 7.4 also shows that the gap in poverty rates between households with and without disabled members is larger in urban areas and a bit more so when looking at the higher-threshold measure of disability. This gap only disappears at the regular poverty line using the low-threshold measure when poverty rates for households with disabled members are 36 percent higher in both rural and urban areas. In general, urban areas have relatively more households with disabled members in near poverty than do rural areas.

The relationship between disability and poverty also varies significantly by province. In Yogyakarta, for example, the poverty rate for households with disabled members was 19.9 percent compared with 10.6 percent for households without disabled members. Yet in four provinces—Maluku, North Maluku, Riau Island, and West Irian Jaya—the poverty rates were slightly lower for households with disabled members. The reason could be the different causes of disability in these provinces or differences in the survival rates of people with disabilities living in poor families. Figure 7.2a displays the poverty rates for households with and without disabled members by province using the low-threshold definition of disability. Figure 7.2b uses the high threshold.

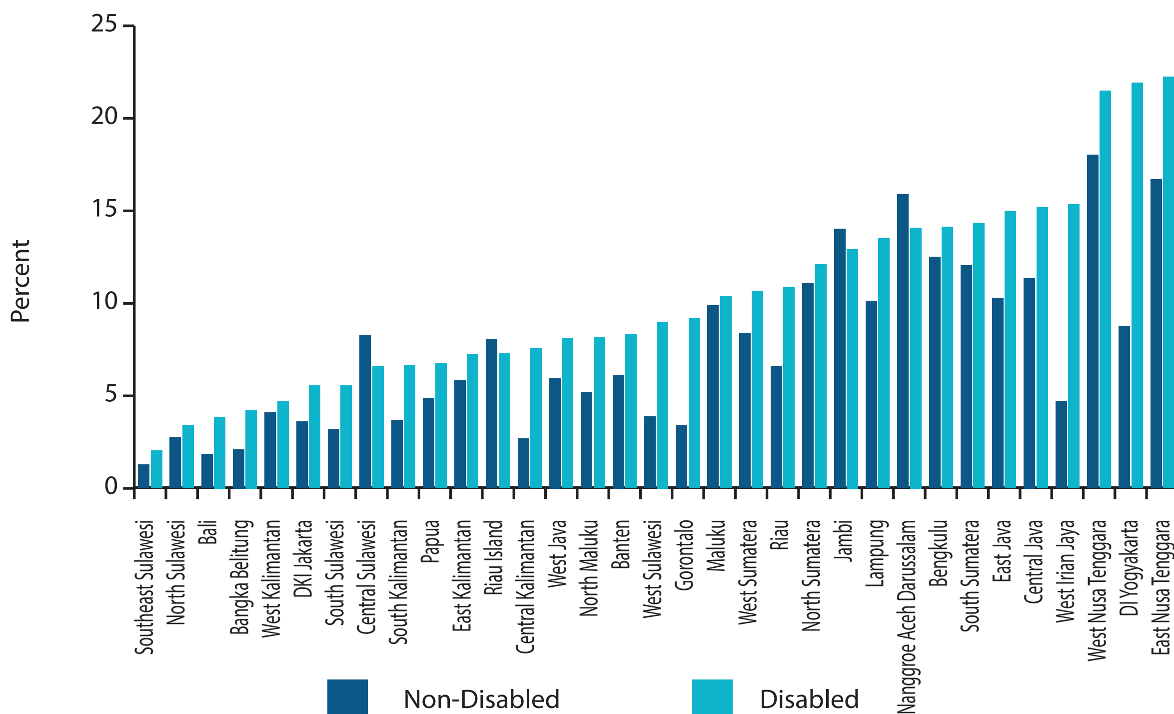
But the situation becomes even more complicated when examining the differences between urban and rural areas. Figures 7.3a and 7.3b show the differences in poverty rates in rural areas by province and disability threshold. Figures 7.4a and 7.4b do the same for urban areas. Table 7.5 shows the actual values for the low-threshold scenario.

As shown in table 7.5, in West Irian Jaya, the poverty rate for households with disabled members (using the low threshold) is lower (20.96 percent) than for households without disabled members (22.80 percent). But this masks a dramatic difference by the location of residence within the province. In urban areas, the poverty rate for households with disabled members is dramatically higher (15.36 percent compared with 4.71 percent), but in rural areas the situation is very much reversed. About 24.43 percent of rural households with disabled members are poor compared with 32.34 percent of households without disabled members.

The same pattern of higher relative rates of poverty in urban areas and lower rates in rural areas exists in the other three provinces, whose overall poverty rates for households with disabled members are slightly lower than those of households without such members. So the dynamics of the two-way relationship between disability and poverty and the impact of survival rates of people with disabilities plays out very differently depending on where the household resides. For example, it could be that the disability rates are lower in rural areas because of lower survival rates, particularly for poor households. Also, poorer, less educated people are sometimes less likely to report mild or moderate disabilities because their expectation of normal health is lower than that held by richer or more educated people.

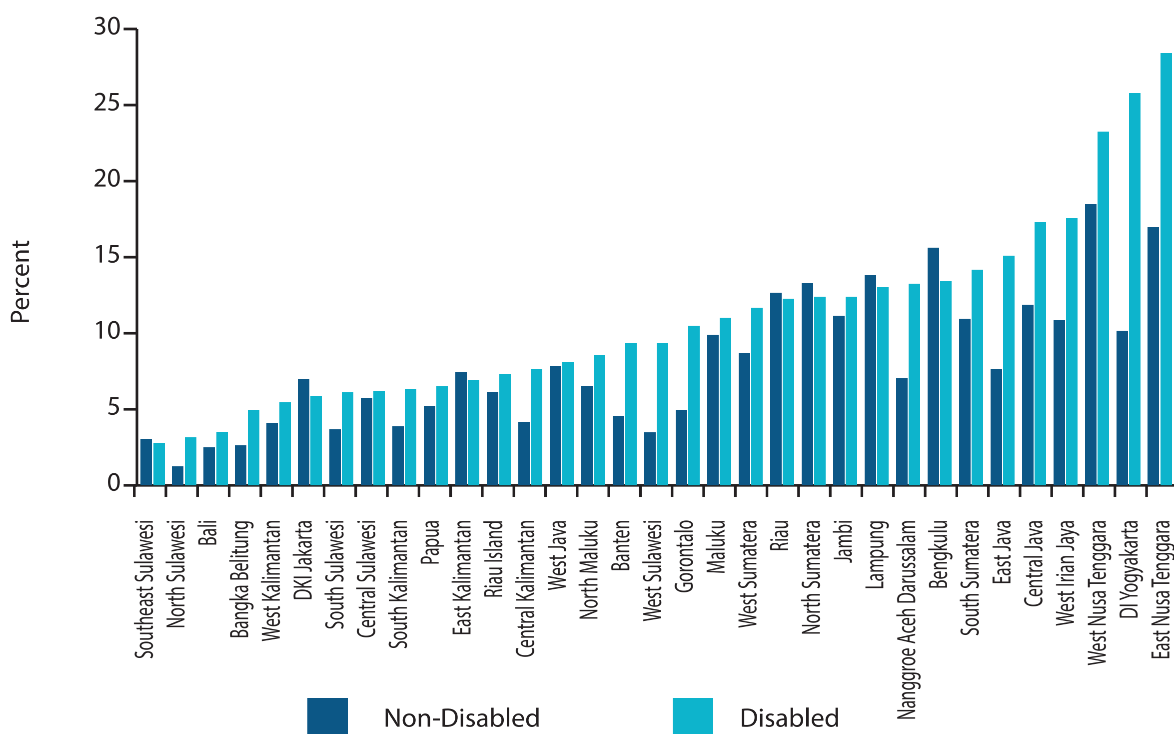
Another contributing factor to differences in disability rates by area of residence (urban/rural) could be the impact of disability on household formation. For example, if a poor elderly disabled person living alone is taken in by her child whose household did not previously have a disabled member, then two households become one. The single-person poor disabled household is gone, and the child's previous household may change status in one of three ways. If it was previously poor, it will change from a poor household without a disabled member to a poor household with a disabled member. If it were previously non-poor it may change to either a non-poor household with a disability or become a poor household with a disability. If an area has a lower correlation between disability and poverty, it may be because poor disabled people are being absorbed into non-poor households. The impact of disability on household formation and its subsequent impact on the relation between poverty and disability cannot be determined from the data available.

Figure 7.4a Urban Poverty Rates of Households by Province and the Presence of a Disabled Household Member (Low Threshold), Riskesdas 2007



Note: See Annex 9 for a table of this chart

Figure 7.4b Urban Poverty Rates of Households by Province and the Presence of a Disabled Household Member (High Threshold), Riskesdas 2007



Note: See Annex 10 for a table of this chart.

Table 7.5 Percentage of Households in Poverty by Province, Area of Residence, and Disability Status (Low Threshold), Riskesdas 2007

Province	Households without Disabled Members			Households with Disabled Members		
	Urban	Rural	Urban & Rural	Urban	Rural	Urban & Rural
Nanggroe Aceh Darussalam	15.88	24.57	22.33	14.09	25.16	23.31
North Sumatra	11.08	8.88	9.90	12.11	10.06	10.84
West Sumatra	8.39	11.80	10.53	10.66	11.55	11.34
Riau	6.61	8.78	8.10	10.86	12.41	11.85
Jambi	14.03	5.22	7.98	12.93	8.19	9.14
South Sumatra	12.06	11.15	11.46	14.31	12.12	12.77
Bengkulu	12.50	13.15	12.98	14.13	17.26	16.47
Lampung	10.13	11.24	11.01	13.52	13.66	13.63
Bangka Belitung	2.11	11.72	7.63	4.22	12.08	9.07
Riau Island	8.07	19.05	10.10	7.28	14.86	9.25
DKI Jakarta	3.61	–	3.61	5.55	–	5.55
West Java	5.98	7.68	6.85	8.11	8.84	8.48
Central Java	11.36	13.10	12.39	15.19	16.04	15.7
DI Yogyakarta	8.78	13.81	10.61	21.91	17.79	19.9
East Java	10.30	13.74	12.34	14.96	18.02	16.83
Banten	6.14	10.40	8.08	8.31	10.78	9.58
Bali	1.85	2.13	1.97	3.87	1.44	2.59
West Nusa Tenggara	18.03	10.70	13.60	21.49	10.37	14.08
East Nusa Tenggara	16.69	16.61	16.62	22.24	18.13	18.61
West Kalimantan	4.11	3.55	3.67	4.73	5.73	5.43
Central Kalimantan	2.70	5.54	4.69	7.58	5.44	5.98
South Kalimantan	3.70	4.23	4.01	6.65	5.00	5.58
East Kalimantan	5.84	9.65	7.54	7.23	12.08	9.32
North Sulawesi	2.78	5.35	4.31	3.43	5.44	4.73
Central Sulawesi	8.28	12.04	11.39	6.62	14.74	13.02
South Sulawesi	3.21	4.02	3.71	5.55	4.57	4.81
Southeast Sulawesi	1.29	9.59	7.50	2.05	9.60	8.14
Gorontalo	3.43	17.03	12.67	9.20	18.86	16.53
West Sulawesi	3.89	13.71	11.90	8.98	14.41	13.62
Maluku	9.89	25.77	20.88	10.38	21.56	19.39
North Maluku	5.17	15.13	12.98	8.19	12.85	12.14
West Irian Jaya	4.71	32.34	22.80	15.36	24.43	20.96
Papua	4.89	41.00	30.52	6.76	48.48	40.34
Total	**8.23**	**11.38**	**10.01**	**11.22**	**13.12**	**12.37**

Yet another reason could be differences in the self-reporting of functional difficulties between rural and urban areas. As explained in earlier chapters, sometimes poorer people and people who live in more disadvantaged areas are less inclined to report health problems and functional difficulties because their standards for what is expected are different. This was shown in one study in Uzbekistan where a positive correlation was found between poverty and disability using a high threshold for disability, but when looking at mild disabilities there was actually a negative correlation (Scott and Mete 2008).

Results using the higher threshold are similar in a number of ways. A great deal of variation exists across provinces. In addition, big differences exist between rural and urban poverty rates. The only surprising finding is that three additional provinces have lower poverty rates for households with disabled members—Bali, Banten, and North Sulawesi. And the gap in the four provinces with lower poverty rates for people with disabilities—Maluku, North Maluku, Riau Island, and West Irian Jaya—is if anything larger. This results from a higher rate of poverty in urban areas for the people with milder disabilities, who are excluded from the high-threshold measure of disability. Again, this could result from the difference in survival rates. People with milder disabilities in poor families may be more likely to survive, but people with more significant disabilities in poorer families do not. That is, there may be fewer severely disabled people among poor households because they do not live long. This explanation is only conjecture. Further study is warranted to figure out why in these more remote provinces there seems to be a lower rate of poverty among households with people with disabilities driven by lower rates of more severely disabled people in poor rural households. A panel study would be needed to look at the dynamic relationship among poverty, disability, and life expectancy.

But all of this discussion assumes that the poverty line for households with disabled members is the same as for the general population. As cited earlier, a number of studies make the case that this should not be so. Having a disability imposes additional costs on households so that, in order to achieve the same level of well-being, they actually need a higher level of expenditures. In Bosnia and Vietnam (two countries where these extra costs have been estimated), the cost of living for households with disabilities is more than 10 percent higher (Braithwaite and Mont 2009, Mont and Cuong 2011).

Actually adding up all the extra expenditures needed by a household with a disabled member is a very difficult task and would require a great deal of detailed data making it almost impossible. So these studies use an indirect method that works by looking at the impact of disability on an asset indicator, controlling for consumption and other factors. Intuitively, the idea is that if two families have the same level of income and other similar characteristics (e.g., household size, area of residence, age of head of household, etc.), then any gap in assets is a result of the extra costs of disability (for a technical explanation, see Zaidi and Burchardt 2005).

Zaidi and Burchardt (2005) formulate this standard of living approach as

(1) $S = \alpha Y + \beta D + \gamma X + k$

where S is an indicator of the standard of living, Y is household income, D is disability status, X is a vector of other household characteristics (household composition), and k is an intercept term representing a constant absolute minimum level for standard of living (under which the household could not survive). The extra cost of disability, E, is given by

(2) $E = dY/dD = -\beta/\alpha$

S is a latent variable that is unobservable in the data, so they substitute U, a count of consumer durables, for S and estimate (1) by using an ordered logit. The estimates of the extra cost are derived from the ratio of coefficients on disability and income as in (2) and (3).

(3) $U = \alpha Y + \beta D + \gamma X + k$

For this analysis an asset index was used for U, which was equal to the number of assets a family had from the following list: gas stove, radio or cassette player, television, video player, refrigerator, home /mobile phone, computer, motorcycle, motorised boat/canoe, car or motor boat, and disk antenna.

Table 7.6 shows the extra costs associated with living with a disabled household member in each province.

Once again, differences across provinces are significant, not only in the estimated costs of disability but what happens when a low- versus high-threshold measure is used. It is important to note, however, that these are the extra costs experienced by households, not necessarily the extra costs needed to maintain a particular quality of life. That is, a household who leaves unattended a disabled person unable to take care of themselves all day and cannot provide them with the rehabilitation services, assistive devices, or home accommodations that will make their lives better may experience no extra costs. Also, if a person receives a charitable donation—say a wheelchair or a surgical procedure provided by an NGO—those costs would also not show up using this method. The method only estimates the extra expenses that the family was actually willing to make on items available to them.

Using either threshold measure, the range in the estimated extra costs of living with a disabled household member ranges from nearly 30 percent more expensive to 15 percent less. This range is actually less than in a cross-province study in China in which the extra costs ranged from over 100 percent more to 20 percent less (Loyalka et al. 2012). The authors of that study conjectured that the wide range was due to very different sample sizes across provinces, but the estimates may also be sensitive to the asset indicator used. If the typical asset mix is very different across provinces, then it could be that a different asset index may be called for in different provinces.

Overall, however, more than two-thirds of the provinces showed an extra cost from having a disabled household member. The average extra costs across provinces (unweighted) were about 4 percent using the low threshold of disability (for both rural and urban). Using the high threshold, the average extra costs across provinces (unweighted by population) were 4 percent for urban and about 6 percent for rural. This is somewhat less than the extra costs estimated in similar studies in Bosnia and Vietnam, which were, respectively, more than 14 and 11 percent (Braithwaite and Mont 2009).

But when only the ten most populous provinces are examined (table 7.7) the rate of extra costs associated with disability is higher, averaging more than 9 percent for urban areas and nearly 8 percent for rural. It may be that the asset index (based on the most common assets nationally) was more appropriate for these provinces. This is an area warranting further study.

Table 7.6 Estimated Extra Costs of Living in a Household with a Disabled Member, by Province and Urban-Rural Areas, Riskesdas 2007

Province	Low Threshold				High Threshold			
	Urban		Rural		Urban		Rural	
	%	Rp*	%	Rp	%	Rp	%	Rp
DI Aceh	13	243,482	-5	-60,032	22	415,872	-6	-74,235
North Sumatra	10	163,772	9	106,769	8	129,946	8	90,323
West Sumatra	3	57,438	-3	-35,865	3	45,829	8	97,679
Riau	-3	-64,894	3	47,028	16	359,780	13	180,498
Jambi	-1†	-13,026	4	51,409	-3	-43,453	4	46,633
South Sumatra	9	140,626	-2	-20,402	19	305,505	5	54,765
Bengkulu	0†	-4,128	0†	1,743	-10	-150,491	-1	-10,669
Lampung	8	116,525	11	97,827	10	138,988	15	130,969
Bangka Belitung	-12	-221,373	3	48,542	-6	-110,407	0†	5,442
Riau Island	-8	-195,670	10	147,520	-5	-125,799	4	54,444
DKI Jakarta	2	55,134	–	–	3	63,747	–	–
West Java	0	6,880	7	68,801	7	113,387	7	67,730
Central Java	8	99,770	8	63,872	11	127,501	7	58,999
DI Yogyakarta	7	110,629	6	54,169	6	87,503	4	33,554
East Java	7	88,741	2	17,494	5	66,061	1	10,480
Banten	13	235,429	10	112,597	13	230,212	13	143,274
Bali	4	74,920	6	80,660	11	210,871	8	105,121
West Nusa Tenggara	8	88,312	5	44,434	6	71,007	7	56,498
East Nusa Tenggara	4	63,534	15	112,340	2	35,485	17	126,830
West Kalimantan	9	146,359	-4	-48,586	10	177,291	-3	-29,998
Central Kalimantan	-1†	-9,545	6	67,652	1†	12,294	3	36,343
South Kalimantan	3	63,693	9	94,138	14	248,964	12	132,032
East Kalimantan	3	77,617	15	217,292	-5	-120,627	14	215,757
North Sulawesi	-2	-24,505	14	146,625	2	36,357	7	69,207
Central Sulawesi	13	209,923	-2	-21,835	3	50,657	1	9,768
South Sulawesi	-3	-41,198	4	36,872	3	51,006	6	59,440
Southeast Sulawesi	8	137,364	-5	-50,897	23	418,846	0†	2,213
Gorontalo	0†	3,707	-10	-84,162	-16	-197,470	-1†	-6,232
West Sulawesi	10	132,306	2	19,068	15	202,743	-2	-16,259
Maluku	-15	-295,704	19	201,009	5	95,070	16	169,363
North Maluku	6	131,257	-15	-176,578	-2†	-46,025	-26	-310,892
West Irian Jaya	27	550,119	0†	1,564	29	587,371	12	136,083
Papua	5	111,429	16	161,115	10	232,068	1†	8,634

Note: The estimates of cost of disability are insignificant at THE 90 percent confidence interval.

**This column represents the average amount in Rupiahs that households with disabled members pay in addition (or less) to maintain the same level of assets as households without disabilities. It is the average across the sample of the extra costs of disability times household expenditures.*

Table 7.7 Percentage of Extra Costs of Living for Households with Disabled Members in the Ten Most Populous Provinces, Using High Disability Threshold, Riskesdas 2007

Province	Urban (%)	Rural (%)
Banten	13	13
Central Java	11	7
DKI Jakarta	6	4
East Java	5	1
Lampung	10	15
North Sumatra	2	7
Riau	16	13
South Sulawesi	3	6
South Sumatra	19	5
West Java	7	7
Unweighted average	9.2	7.8

Table 7.8 shows what the poverty rates for households with disabled members would be if the poverty lines in their provinces were adjusted for these additional costs using the low threshold of disability. Table 7.9 does the same using the higher threshold of disability.

The estimated impacts of the extra costs of disability vary substantially across provinces. For example, in the most populous province of West Java, with no cost adjustment, the aggregate poverty rate for households with disabled members is 8.5 percent. This increases to 10.1 percent once the costs of disability are factored in, but this comes almost entirely from extra costs in the rural areas of the province. Using the high-threshold definition of disability, the rate increases from 9.1 to 12.1 percent. In Central Java, another large province, the poverty rate increases from 15.7 to 21.2 percent using the low-threshold measure and 17.2 to 23.7 percent using the high-threshold measure—driven by extra costs in both rural and urban areas.

However, nearly one-third of the provinces (disproportionately the less populous ones) have no drop in cost-adjusted poverty or even an increase. For example, in DI Aceh, total poverty for households with disabled members dropped 2.2 or 3.3 percentage points after cost adjustments, depending on whether a low- or high-threshold measure was used. It is unclear whether this is due to the nature of the disabilities in DI Aceh, the appropriateness of the asset index, measurement error, or some other factor.

Another issue when looking at measures of poverty is that people of different ages (or possibly genders) have different consumption needs. In addition, it could be that larger households have higher economies of scale, making their per-capita consumption needs less than those for a smaller household. To account for this, analysts sometimes employ equivalence scales, an econometric method for estimating economic well-being by adjusting income or consumption for differences in need. The several methods for calculating equivalence scales—including behavioural and subjective approaches—have been found to be problematic.

The parameters used in Gasparini, Gutiérrez, and Tornarolli (2007) have served as benchmarks recently. Basically, adjustments are made arbitrarily in order to get the same poverty rate as before the equivalence scale is applied.

Table 7.8 Poverty Rates of Households with Disabled Members, with and without Adjustments for Costs of Disability (Low Threshold), by Province/Urban-Rural, Riskesdas 2007

Province	No Cost Adjustment (%)			With Cost Adjustment (%)			Difference with Cost Adjustment (%)		
	Urban	Rural	Aggre-gated	Urban	Rural	Aggre-gated	Urban	Rural	Aggre-gated
DI Aceh	14.1	25.2	23.3	22.7	21.5	21.1	8.6	-3.7	-2.2
North Sumatra	12.1	10.1	10.8	17.8	14.5	15.8	5.7	4.5	4.9
West Sumatra	10.7	11.6	11.3	12.5	10.1	10.7	1.9	-1.4	-0.6
Riau	10.9	12.4	11.9	9.3	14.2	12.5	-1.5	1.8	0.6
Jambi	12.9	8.2	9.1	12.8*	9.7	10.3*	-0.2	1.5	1.2
South Sumatra	14.3	12.1	12.8	18.4	11.1	13.2	4.1	-1.0	0.5
Bengkulu	14.1	17.3	16.5	13.7*	17.4*	16.5*	-0.4	0.2	0.0
Lampung	13.5	13.7	13.6	18.4	19.4	19.2	4.9	5.7	5.6
Bangka Belitung	4.2	12.1	9.1	1.6	13.9	9.2	-2.6	1.9	0.2
Riau Island	7.3	14.9	9.3	4.7	19.9	8.6	-2.6	5.1	-0.6
DKI Jakarta	5.6	–	–	6.0	–	6.0	0.5	–	–
West Java	8.1	8.8	8.5	8.3	12.0	10.1	0.2	3.1	1.7
Central Java	15.2	16.0	15.7	20.5	21.7	21.2	5.4	5.6	5.5
DI Yogyakarta	21.9	17.8	19.9	24.6	23.6	24.1	2.7	5.8	4.2
East Java	15.0	18.0	16.8	19.6	19.5	19.5	4.6	1.5	2.7
Banten	8.3	10.8	9.6	11.4	14.5	13.0	3.0	3.7	3.4
Bali	3.9	1.4	2.6	4.8	2.5	3.6	1.0	1.0	1.0
West Nusa Tenggara	21.5	10.4	14.1	25.8	14.6	18.3	4.4	4.2	4.3
East Nusa Tenggara	22.2	18.1	18.6	26.0	27.9	27.7	3.7	9.8	9.1
West Kalimantan	4.7	5.7	5.4	6.8	4.6	5.2	2.1	-1.2	-0.2
Central Kalimantan	7.6	5.4	6.0	7.0*	7.0	7.0*	-0.6	1.6	1.0
South Kalimantan	6.7	5.0	5.6	7.7	8.4	8.2	1.1	3.4	2.6
East Kalimantan	7.2	12.1	9.3	8.4	18.1	12.6	1.1	6.1	3.3
North Sulawesi	3.4	5.4	4.7	3.4	9.9	7.6	0.0	4.4	2.8
Central Sulawesi	6.6	14.7	13.0	11.5	13.6	13.2	4.9	-1.1	0.2
South Sulawesi	5.6	4.6	4.8	4.8	5.8	5.5	-0.8	1.2	0.7
Southeast Sulawesi	2.1	9.6	8.1	3.4	7.3	6.6	1.4	-2.3	-1.6
Gorontalo	9.2	18.9	16.5	9.2*	12.8	11.9*	0.0	-6.1	-4.6
West Sulawesi	9.0	14.4	13.6	9.9	15.5	14.7	0.9	1.1	1.1
Maluku	10.4	21.6	19.4	7.2	33.5	28.4	-3.2	11.9	9.0
North Maluku	8.2	12.9	12.1	10.2	5.9	6.6	2.1	-7.0	-5.6
West Irian Jaya	15.4	24.4	21.0	22.2	24.4*	23.6*	6.9	0.0	2.6
Papua	6.8	48.5	40.3	8.3	57.3	47.8	1.5	8.9	7.4
Total (national)	**11.2**	**13.1**	**12.4**	**13.8**	**16.0**	**15.1**	**2.6**	**2.8**	**2.7**

Notes: The estimates of cost of disability are insignificant at 90 percent confidence interval. The aggregated and national numbers are calculated based on urban and rural provincial estimates.

Table 7.9 Poverty Rates of Households with Disabled Members, with and without Adjustments for Costs of Disability (High Threshold), by Province Urban-Rural, Riskesdas 2007

Province	No Cost Adjustment (%)			With Cost Adjustment (%)			Difference with Cost Adjustment (%)		
	Urban	Rural	Aggre-gated	Urban	Rural	Aggre-gated	Urban	Rural	Aggre-gated
DI Aceh	13.41	24.51	22.8	20.91	19.19	19.46	7.5	-5.32	-3.34
North Sumatra	14.2	10.0	11.6	18.8	13.4	15.4	4.6	3.4	3.9
West Sumatra	11.7	11.6	11.6	13.5	16.1	15.5	1.9	4.5	3.9
Riau	13.2	11.6	12.2	21.3	18.7	19.7	8.1	7.2	7.5
Jambi	13.0	10.4	10.9	12.3	12.4	12.3	-0.7	2.0	1.4
South Sumatra	12.3	11.6	11.8	22.7	15.5	17.8	10.5	3.9	6.0
Bengkulu	12.4	18.7	17.3	7.3	17.6	15.3	-5.1	-1.1	-2.0
Lampung	12.4	15.4	14.8	19.0	25.2	23.9	6.6	9.7	9.1
Bangka Belitung	4.9	12.8	9.6	3.5	12.9*	9.2*	-1.5	0.2	-0.5
Riau Island	8.1	12.5	9.1	6.4	13.3	8.1	-1.7	0.8	-1.1
DKI Jakarta	6.3	–	6.3	7.2	–		0.8	–	-6.3
West Java	8.5	9.6	9.1	11.6	12.6	12.1	3.1	2.9	3.0
Central Java	17.3	17.1	17.2	25.3	22.7	23.7	8.0	5.6	6.5
DI Yogyakarta	25.8	19.2	22.4	26.0	23.6	24.8	0.2	4.5	2.4
East Java	17.6	20.2	19.2	21.9	21.2	21.5	4.3	1.0	2.3
Banten	5.9	10.4	8.2	7.6	15.6	11.7	1.7	5.2	3.5
Bali	3.5	1.1	2.2	6.4	3.3	4.7	2.9	2.2	2.5
West Nusa Tenggara	23.3	10.4	14.8	28.2	15.5	19.9	4.9	5.1	5.0
East Nusa Tenggara	28.4	18.4	19.3	31.3	30.1	30.2	2.8	11.7	10.9
West Kalimantan	5.4	6.4	6.1	7.8	5.2	6.0	2.3	-1.3	-0.2
Central Kalimantan	9.3	6.3	6.3	9.3*	6.3	7.1*	0.0	0.0	0.8
South Kalimantan	7.7	6.1	6.7	14.5	10.8	12.2	6.8	4.7	5.5
East Kalimantan	7.3	11.3	9.1	6.2	18.2	11.7	-1.1	6.9	2.5
North Sulawesi	2.8	4.9	4.1	3.7	7.8	6.3	0.9	2.9	2.1
Central Sulawesi	6.9	15.1	13.3	7.9	15.5	13.9	1.0	0.4	0.6
South Sulawesi	6.1	4.4	4.8	7.1	6.6	6.7	1.0	2.2	1.9
Southeast Sulawesi	3.1	10.8	9.4	7.7	10.9*	10.3*	4.6	0.1	0.9
Gorontalo	9.3	19.4	16.8	4.7	18.8*	15.3*	-4.6	-0.5	-1.6
West Sulawesi	10.5	14.9	14.2	14.4	14.4	14.4	3.9	-0.5	0.2
Maluku	11.0	19.6	18.0	11.0	29.1	25.7	0.0	9.5	7.7
North Maluku	6.2	13.4	12.0	6.2*	4.5	4.8*	0.0	-8.9	-7.1
West Irian Jaya	15.1	22.6	20.0	22.3	31.5	28.3	7.3	8.9	8.3
Papua	6.5	49.9	42.3	7.9	50.2*	42.8*	1.4	0.4	0.5
Total (national)	**12.4**	**14.0**	**13.3**	**16.4**	**17.2**	**16.9**	**4.0**	**3.2**	**3.5**

Notes: The estimates of cost of disability are insignificant at 90 percent confidence interval. The aggregated and national numbers are calculated based on urban and rural provincial estimates.

In this method, expenditures for an individual i living in household h is given by

$$x_{ih}=Y_h/(A_h+\alpha C_h)^{\theta}$$

Where Y_h is total household expenditure; A is number of adults (ages 15 years and older), and C is the number of children (ages 0–14 years). The parameter α allows for different weights for adults and children, which allows for children having lesser consumption needs than adults. The parameter ø regulates the degree of household economies of scale/size. When both α and ø are equal to one, the formula reduces to the conventional per-capita expenditure. Different scenarios for different values of α and ø are typically used to investigate the sensitivity of the results to different scenarios.

Unfortunately, it was not possible to undertake the equivalence scale analysis because of matching issues between the Riskesdas and Susenas data sets. Riskesdas has no poverty information, so poverty data reported in this study came from matching observations in the Riskesdas data to those in the Susenas data sets, which are drawn from the same sample. To create the weighted household size, A+α C, it is necessary to have the age of each household member, but when individual observations were matched across the two data sets, about 18 percent of individual observations could not be matched. That means that, for a significant percentage of the observations, it is not possible to create the weighted household size needed to construct the equivalence scale measurements. Moreover, these are probably not a random group of people, as a variety of factors could lead to people being absent from either the Riskesdas or Susenas data sets.

The matching of individual observations was not as important for the poverty estimates using household size (unweighted by the age of each observation). For that analysis, the decision was made to use the Susenas household size (when it did not match the Riskesdas data set); it is more reliable to do so because Susenas is the standard data set used annually to determine the national poverty rate by the Statistics Indonesia (*Badan Pusat Statistik* or BPS).

Overall, the data on disability and poverty show the following:

- Disability and poverty are positively correlated. Depending on the threshold of disability used, people with disabilities in Indonesia are 30–50 percent more likely to be poor than nondisabled people.
  The difference in poverty rates between disabled and nondisabled people is higher in urban areas. This might be the result of the different causes of disability, impact of disability on livelihood earning, survival rates of people with disabilities living in different areas, or impact of disabilities on how households are formed.
- The relationship between consumption and disability is more pronounced for the non-elderly. This is true even though the presence of a disabled household member lessens with increases in consumption, regardless of the age of the householders. Presumably this is because people becoming disabled later in life have more resources—children, assets, work experience—to draw on.
- Disability imposes extra costs on households, but these extra costs vary dramatically by province and by the degree of disability. Estimates range from an increase of nearly 30 percent to a decrease of about 15 percent, although the average cost adjustment in the ten most populous provinces is about 8–9 percent. These costs are not the costs actually paid nor an estimate of what it takes to meet disabled people's needs.

- When the extra costs of living with a disability are included, the relationship between poverty and disability becomes significantly more pronounced in the majority of provinces. Additional research is needed to explain some seemingly anomalous provinces that are more remote. It could be that the asset indicator used—based on the most common assets nationally—may not be appropriate for those provinces.
- Disabled people are more concentrated at lower ends of the consumption expenditure distribution. As one raises the poverty line from one to two times the poverty line, people with disabilities are still overrepresented but less so.

Further research would be able to answer several key questions, namely:

- To what extent does poverty lead to more disability, or does the onset of a disability drive people into poverty?
- What types of government interventions or personal and family resources prevent people with disabilities from becoming poor?
- What policies would prevent the onset of many disabling conditions: nutritional programmes, sanitation, traffic safety, etc.?
- To what extent are differences in the rates of disability and poverty in various provinces (and between rural and urban areas) due to differences in the types of disability, the survival rates of people with disabilities, differences in household formation, or differences in the barriers people with disabilities face in different areas?
- How does age affect the relationship between disability and poverty. Is it because of intra-family transfers, reliance on assets, types of restrictions people face, or some other factor?
- How can we make province-specific adjustments to measuring the extra costs of living with a disability, and is that appropriate?

Another factor to consider is living arrangements. Tables 7.10a and 7.10b display the breakdown of household structure by poverty and the presence of disability. The data show that people with disabilities are less likely to live in households with children than nondisabled people (perhaps because they are elderly). Using the low-threshold measure, 54.7 percent of households with a disabled member contain a child, compared with 69.2 percent of households without a disabled member. Using the high-threshold measure, those rates are 50.6 and 66.4 percent (Lanjouw and Ravallion 1995). Regardless of whether a household has a member with a disability or the disability threshold used, however, being poor is more associated with living with children.

Table 7.10a Household Structure by Disability and Poverty (Low Threshold), Riskesdas 2007

	Low Threshold Disability					
	Non-Poor		Poor		Total	
	(%)	(n)	(%)	(n)	(%)	(n)
Household with (at least) a disabled person						
Person with disability living alone	8.60	7,745	2.07	213	7.79	7,958
Person with disability living with others in a household without children	38.81	37,455	27.98	3,433	37.47	40,888
Person with disability living with others in a household with children	52.58	52,811	69.95	10,170	54.73	62,981
All households with disabled people	100	98,011	100	13,816	100	111,827
Household with no disabled person						
Person without disability living alone	6.79	8,291	0.62	66	6.17	8,357
Person without disability living with others in a household without children	25.63	31,783	15.84	2,221	24.65	34,004
Person without disability living with others in a household with children	67.58	87,749	83.55	13,027	69.18	100,776
All households without disabled people	100.00	127,823	100.00	15,314	100.00	143,137

Note: The rate for households without a disabled member changes because, when using the high-threshold measure, some of the households that used to be in the disabled category when using the low-threshold measure shift to being in the nondisabled category.

Table 7.10b Household Structure by Disability and Poverty (High Threshold), Riskesdas 2007

	Low Threshold Disability					
	Non-Poor		Poor		Total	
	(%)	(n)	(%)	(n)	(%)	(n)
Household with (at least) a disabled person						
Person with disability living alone	9.65	4,406	2.73	156	8.73	4,562
Person with disability living with others in a household without children	42.01	20,451	32.07	2,090	40.68	22,541
Person with disability living with others in a household with children	48.34	24,374	65.20	5,140	50.59	29,514
All households with disabled people	100.00	49,231	100.00	7,386	100.00	56,617
Household with no disabled person						
Person without disability living alone	7.00	11,630	0.82	123	6.35	11,753
Person without disability living with others in a household without children	28.36	48,787	18.01	3,564	27.28	52,351
Person without disability living with others in a household with children	64.65	116,186	81.17	18,057	66.36	134,243
All households without disabled people	100.00	176,603	100.00	21,744	100.00	198,347

Social Protection Programmes in Indonesia

The Government of Indonesia is highly committed to expanding social protection for the entire population. This is shown by the enactment of the *Sistem Jaminan Sosial Nasional* or Law on National Social Security System No. 40 of 2004. This law mandates universal coverage with compulsory contribution, although those who cannot afford to pay for contributions should be paid by the government through a programme called *Penerima Bantuan Iuran* or Premium Assistance (Adioetomo 2011). The implementation of this law is to be done by the Social Insurance Agency (*Badan Penyelenggara Jaminan Sosial* or BPJS). However, it was not until 2011 that this body was established through Law No. 24 of 2011 on the state institution to provide social security. This law has two components: a health insurance carrier (BPJS Health [*Kesehatan*]) and labour-related insurance carrier (BPJS *Ketenagakerjaan*).

BPJS Health should be fully operable in 2014, therefore the Government of Indonesia (2013) has recently published the Road Map toward the Implementation of Social Health Insurance 2012–19 (*Peta Jalan Menuju Jaminan Kesehatan Nasional* 2012–19). This roadmap was developed to attain full operation of BPJS Health in 2014 to cover 121.6 million of the population as well as operationalisation of National Health Insurance (INA-CARE) in 2019 to cover 257.5 million of the population. Thus, it is expected that by 2019 the whole Indonesian people, including PWDs will be covered by National Health Insurance.

Until BPJS Health is fully operable, three ministries are providing social protection programmes for people with disabilities in Indonesia: MoSA, MOH, and MoMP&T.

Social Assistance for Severely Disabled Persons and ASLUT

MoSA is implementing various programmes intended to empower PWDs with the potential to be self-reliant, whereas people with severe disabilities are given social assistance in terms of cash transfers. Its cash transfer programme, once called JSPACA, is now called ASODKB. The aim of ASODKB is to fulfil basic needs for people with severe disabilities and maintain their health by providing additional income, so that PWDs can maintain their level of social welfare. This is implemented in the form of a cash transfer of Rp300,000 per month per person for one year, mainly for PWDs who have no employment possibilities, are bedridden, and/or depend on the help of others (severely disabled).

This programme started in 2006 with a pilot project in five provinces, namely Central Java, South Sumatra, West Java, West Sumatra, and Yogyakarta, covering 2,750 PWDs. In 2007 Bali, South Kalimantan, and South Sulawesi were included to cover 3,250 severely disabled PWDs. In 2008 East Java, East Nusa Tenggara, Jambi, North Sumatra, and West Nusa Tenggara, were added to cover 4,000 PWDs. This means that by the end of 2008, 10,000 severely disabled PWDs received cash transfers.[41] In 2009 the budget allocated for ASODKB was Rp86.6 billion or $8.3 million to cover 17,000 severely disabled people (MoSA 2009). MoSA recognised that this coverage was too low and in 2011 increased the coverage to about 19,500 recipients. However, it is much lower than the number of severely disabled people, which is estimated to be about 1.8 million by the 2010 census and about 7.2 million by the Riskesdas data.

In 2011 it was reported that 19,500 severely disabled persons in 33 provinces or 257 districts and municipalities were covered by ASODKB, involving Rp75 billion.[42] Overall, however, compared with the population of PWDs in Indonesia, this programme is almost insignificant.

[41] See http://rehsos.depsos.go.id/modules.php?name=Content&pa=showpage&pid=7; see also MoSA (2010).

[42] Information from official at the MoSA.

MoSA is also implementing a cash transfer programme directed to older persons. This programme is named ASLUT (previously, *Jaminan Sosial Lanjut Usia*), that is, social assistance for older persons who are poor and/or neglected and whose lives depend on other persons. Older persons who are bedridden have been included as beneficiaries, receiving Rp200,000 a month per person. But information is lacking on how many older persons with disabilities are covered by ASLUT.

Social Assistance for Children Program

The Social Assistance for Children Program (*Program Kesejahteraan Sosial bagi Anak* or PKSA) started in 2010 and is intended to fulfil children's basic needs and protect children against neglect, exploitation, and discrimination to ensure children's growth, survival, and participation. Six categories of children are prioritised to receive cash transfers of Rp1,800,000 per child per year. In 2010–11, the number of beneficiaries totalled 147,321 children. Organised by categories, they consisted of the following:

- Displaced children (1,405 children)
- Abandoned children (135,014 children)
- Street children (6,173 children)
- Children facing the law (430)
- Children with disabilities (2,041 children)
- Children who require special needs (2,258 children)

Assistance for children with disabilities was only 1.4 percent of the total assistance given in 2010–11 (MoSA 2009). It was planned that, during 2010–14, 263,000 children would be targeted to receive PKSA, with a budget of Rp473,400,000,000.[43]

Social Health Insurance for Informal Workers

Social Health Insurance (*Asuransi Kesehatan Sosial* or Askesos) has been managed by MoSA since 2003 and targets informal workers as a strategy for income replacement, in case the bread winner, who has not been covered by any other social insurance schemes, suffers from sickness, accident, and/or death. Participants have to pay a monthly premium of Rp5,000 to the implementing agency, which is a selected community group (i.e., NGO).[44] Although it is called social insurance, it acts as a savings plan, which means that participants will receive a sum of money equal to the premium paid, whether or not they use the benefit. The criteria set for an individual to be eligible to join Askesos are (1) the main income earner in the family (male or female) mostly undertakes informal work and earns a minimum income of Rp300,000 a month, (2) the beneficiary is between 21 and 59 years old or has never been married, and (3) the beneficiary has an identification card (KTP).

Until 2009 Askesos covered as many as 192,600 participants and partner institutions involving as many as 963 executing agencies spread across 33 provinces. However, the philosophy of the 'Law of Large Numbers' in the insurance business is challenged by the lack of awareness of the informal workers and also problems of their ability to pay the premium. Therefore, sustainability of this programme is highly questionable.

As a strategy to accelerate poverty reduction, the Government of Indonesia is implementing social assistance through various agencies to help the poor meet their basic needs. Among these are those who may be related to disabled persons and may be reported by respondents in the SNSAP-PWD survey.

[43] Official documents from Directorate of Planning, MoSA

[44] Askesos Field Officers' Handbook

Subsidised Rice for the Poor[45]

Subsidised Rice for the Poor (*Beras Bersubsidi bagi Masyarakat Berpenghasilan Rendah* or Raskin) provides rice with a subsidised price and has been operating since 2002. Targeted household recipients (RTS) are poor households. Since 2008 the eligible recipients only pay Rp1,600/kg for rice instead of the normal market price on average of around Rp5,000–5,500/kg.

Family Hope Programme

The Family Hope Programme (*Program Keluarga Harapan* or PKH) is a conditional cash transfer programme. Eligible households must be classified as very poor or chronically poor (*rumah tangga sangat miskin*) and meet one of the following conditions: has a child aged 6 to 15 years and/or a child under 18 years who has not completed primary school; has a child aged 0 to 6 years; or has a pregnant/lactating mother. MoSA is the implementing agency and uses post offices to manage the transfer of funds. The objectives of the PKH social assistance are to (1) improve socioeconomic conditions of beneficiaries, (2) improve education levels of beneficiaries, (3) improve the health and nutrition status of pregnant women, postnatal women, and children under five years of age in recipient households, and (4) improve recipients' access to and quality of education and health services (Asian Development Bank 2011). Receipt of benefits is conditional on the use of education and health services. PKH was established in 2007 in seven provinces and then rolled out to six additional provinces the following year. Locations were selected based on high rates of malnutrition, low rates of transition from primary to secondary schools, and an inadequate supply of health and education facilities. However, the programme does not specifically state whether it covers disabled children. The PKH provided assistance to more than 3.1 million people in very poor families in 2010. Receipt of benefits was conditional on the use of education and health services.

JAMKESMAS: Health Insurance for the Community

Public Health Insurance (*Jaminan Kesehatan Masyarakat* or Jamkesmas) offers a comprehensive benefits package, including inpatient and outpatient care. In terms of medication, enrolees are only entitled to coverage for drugs from specific formularies and must opt for generic drugs when filling prescriptions. The Jamkesmas scheme is funded by the central government from general tax revenue. Beneficiaries are not responsible for premium payments, nor are they charged a co-payment at the time of the visit. Membership quotas/targets for the Jamkesmas programme in 2009 included poor and underprivileged families in Indonesia, totaling 76.4 million persons.[46] Regional Health Insurance (*Jaminan Kesehatan Daerah* or Jamkesda) is similar to Jamkesmas but funded by local government. For example, in Jakarta this kind of scheme is called Social Assistance for Poor Families (*Jaminan Pemeliharaan Kesehatan Keluarga Miskin* or JPK Gakin) (Asian Development Bank 2011).

MoMP&T provides cash assistance and in-kind services, such as the vocational training programmes mentioned earlier in this report.

Figure 7.5 presents the percentage of SNSAP-PWD respondents who receive social assistance from the schemes mentioned above. These figures show that some proportion of respondents actually did receive Raskin, Jamkesmas, and ASLUT. A very small proportion of them receive ASLUT and ASODKB, although these may be overrepresented due to the sampling procedure.

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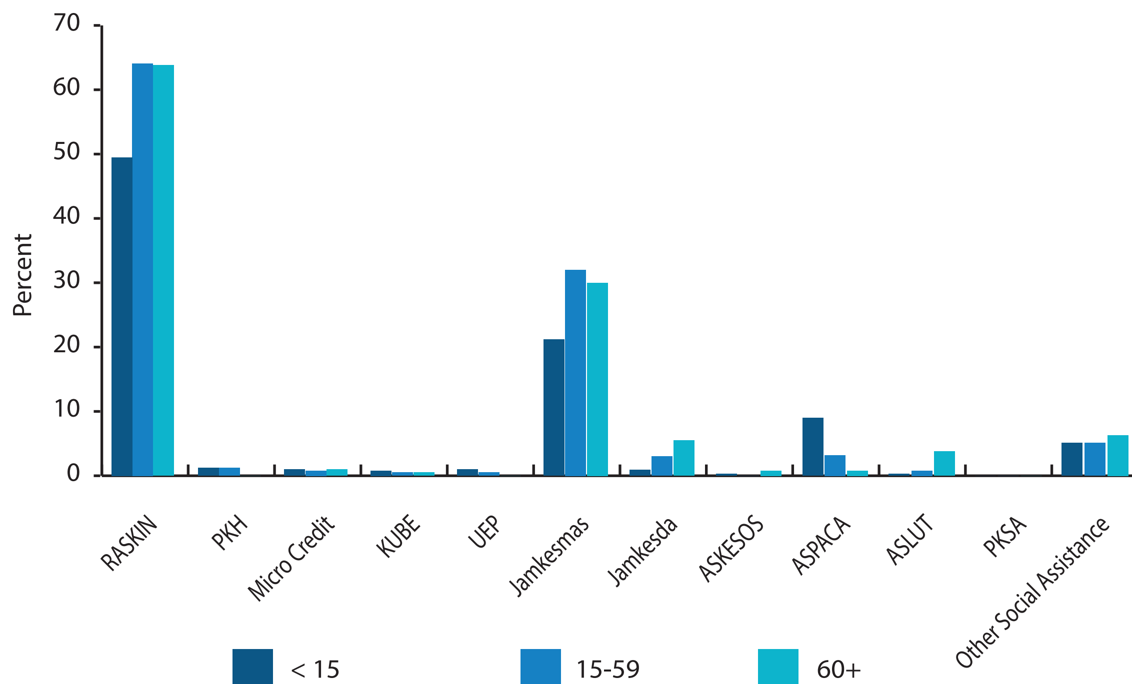
45 See http://www.bulog.co.id, '*Sekilas Raskin*' [Overview of Raskin], June, 2011.

46 See Final Report of Social Assistance Needs for the Poor and Vulnerable Older Persons, Output 2, Findings of Household Survey, Demographic Institute, HelpAge International, TNP2K, 2012.

Figure 7.5 Percentage of Respondents with Severe Disability Who Receive Social Assistance, by Age, SNSAP-PWD, 2012

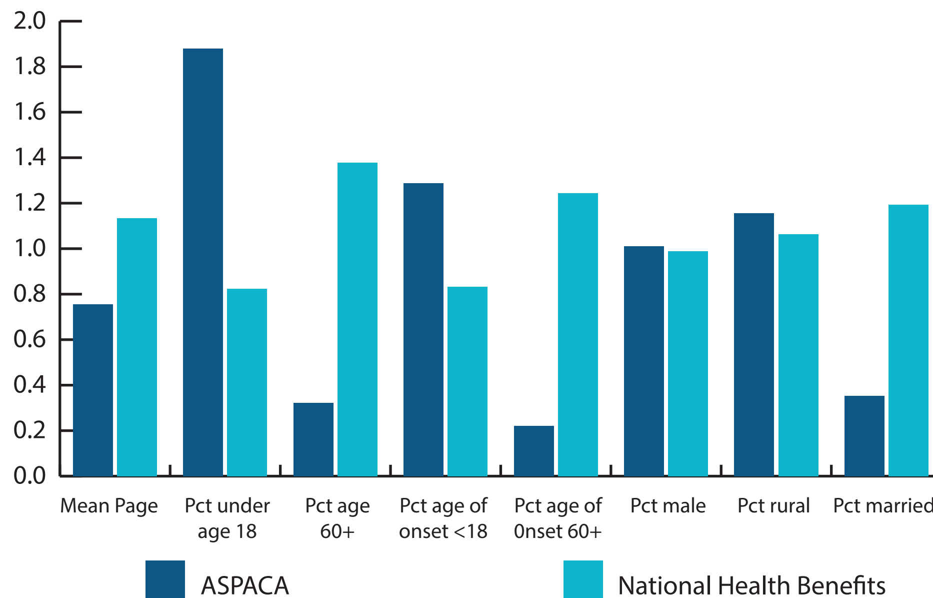


These programmes are all means tested and are meant to offset the economic difficulties of living with a disability, but they do not explicitly take into account those added costs. As mentioned earlier, at a given level of income, a household with a disabled family member is less well off than their counterparts without a disabled member, because they have additional expenses related to health care, transportation, assistive devices, personal assistance, and housing needs, among other things. They also have additional costs in terms of their time, because it can take them longer to complete tasks than people without disabilities.

Because of the way the SNSAP-PWD sample was constructed, it is not possible to estimate the percentage of people with disabilities receiving cash assistance or health benefits. In fact the rate of receipt in the sample is significantly higher than in the general population, probably because the people who made it into the sample were the people who were most networked with disabled people's organisations and so were more likely to know about the programmes and how to apply for them successfully. However, one can look to see how the people receiving national benefits differ from those who do not.

Because the average characteristics of people receiving and not receiving benefits are different from what would be measured by a random sample, Figure 7.6 shows the ratio of various characteristics for people receiving ASODKB. A value of 1 means there is no difference between people receiving and not receiving benefits. Figure 7.6, therefore, shows that ASODKB recipients are much more likely to be young, which means they are more likely to have an earlier age of onset and not be married. There is no gender gap and only a slight overrepresentation of people in rural areas.

Figure 7.6 Ratio of Programme Recipients to Non-Recipients, SNSAP-PWD, 2012



Conversely, national health benefits recipients are on average older and more likely to have acquired their disabilities as adults. There is no gender or rural/urban gap. Their marriage rate is about 20 percent higher than nonrecipients.

In addition to cash benefits, people with disabilities also desire access to services. Table 7.11 shows the percentage of people claiming they need services and what percentage of those people actually get them. The first of the four panels of the table refers to people receiving any type of benefit: ASODKB, national health benefits, or both. This is followed by panels for those receiving each benefit and the two together.

Among people receiving benefits of any type (Table 7.11, panel A), there is a somewhat greater need for certain services, (except for vocational training and social workers). This suggests that the programmes are covering people with more significant difficulties. Yet, the ratio of people getting services to those who need them is not very different for people receiving or not receiving benefits. This suggests that the programmes might not be very helpful in getting recipients services.

The exception may be ASODKB recipients' ability to obtain medical rehabilitation and assistive devices. About 68 percent of ASODKB recipients needing medical rehabilitation were able to get it, compared with only 48 percent of those not receiving ASODKB (but maybe national health benefits). For assistive devices, those rates were 50 and 27 percent, respectively. So in this one aspect of service delivery, some evidence suggests that the programme is having a positive influence. Still, across all types of services many people are not getting what they require.

Across the board, benefit recipients claim a greater need for services. This is especially true regarding medical rehabilitation and counselling. This may indicate that benefit recipients have greater needs but could also mean they are more informed of types of services and therefore have a higher demand.

In terms of getting services, recipients of ASODKB and national health care do better when it comes to medical rehabilitation and counselling, although, on the whole, counselling services are the most unavailable.

Table 7.11 Percentage Needing/Obtaining Services by Receipt of Benefits, SNSAP-PWD, 2012

A. Receiving ASODKB, national health benefits, or both

Services	Receiving Benefits			No Benefits		
	Need Service	Get Ser-vice	Getting/ Needing Ratio	Need Service	Get Ser-vice	Getting/ Needing Ratio
Medical rehabilitation	85.1	45.1	0.53	76.2	36.2	0.48
Assistive devices	74.7	22.2	0.30	68.4	19.4	0.28
Specific training	69.2	16.8	0.24	62.3	16.8	0.27
Vocational training	64.4	14.2	0.22	63.1	15.8	0.25
Counselling	75.4	15.6	0.21	66.3	11.9	0.18
Counselling for family	72.6	11.0	0.15	61.7	6.1	0.10
Social worker	58.3	4.3	0.07	56.8	5.8	0.10
Health provider	88.9	49.9	0.56	83.9	42.7	0.51
Traditional healer	64.0	41.8	0.65	61.4	40.4	0.66
Others	26.7	15.1	0.57	15.7	2.4	0.15

B. Receiving ASODKB

Services	Receiving Benefits			No Benefits		
	Need Service	Get Service	Getting/ Needing Ratio	Need Service	Get Service	Getting/ Needing Ratio
Medical rehabilitation	84.4	57.4	0.68	78.4	37.6	0.48
Assistive devices	80.2	40.4	0.50	69.5	18.9	0.27
Specific training	60.7	14.9	0.25	64.6	16.9	0.26
Vocational training	54.8	11.1	0.20	64.0	15.6	0.24
Counselling	80.0	30.4	0.38	68.2	11.8	0.17
Counselling for family	79.4	25.2	0.32	64.0	6.3	0.10
Social worker	60.0	7.4	0.12	57.1	5.2	0.09
Health provider	89.7	50.0	0.56	85.0	44.5	0.52
Traditional healer	57.0	35.6	0.62	62.6	41.2	0.66
Others	28.6	23.1	0.81	17.5	4.2	0.24

C. Receiving national health benefits

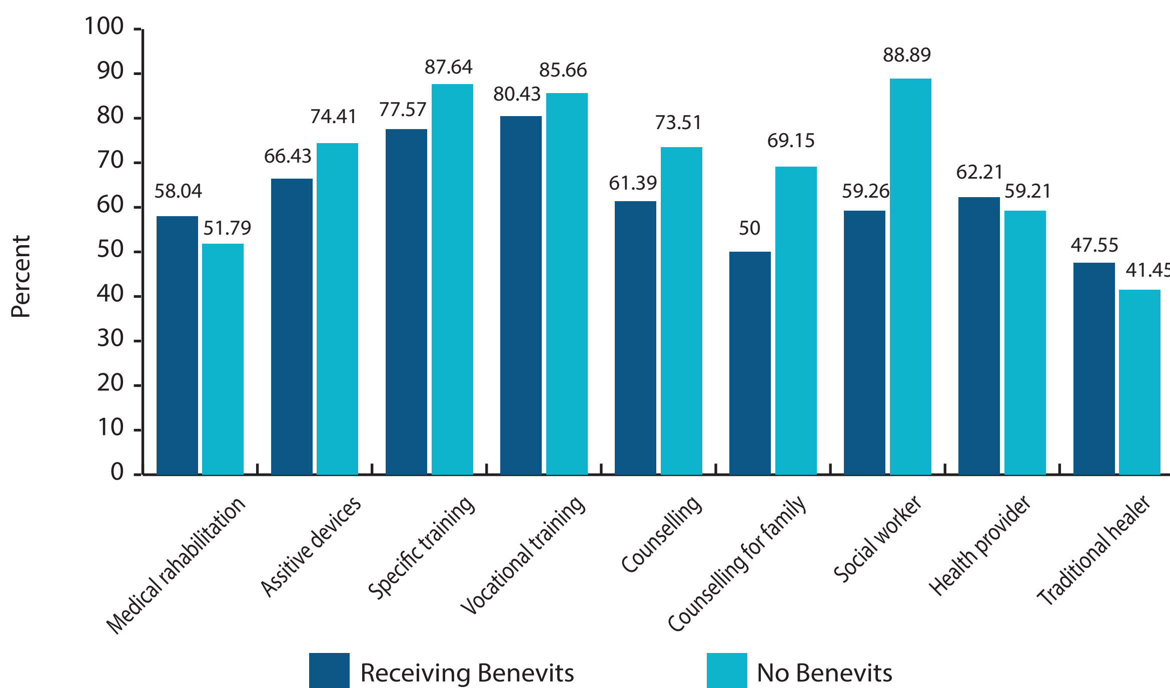
Services	Receiving Benefits			No Benefits		
	Need Service	Get Service	Getting/ Needing Ratio	Need Service	Get Service	Getting/ Needing Ratio
Medical rehabilitation	85.9	44.4	0.52	76.4	36.9	0.48
Assistive devices	74.4	19.8	0.27	68.7	20.3	0.30
Specific training	70.9	16.8	0.24	62.0	16.8	0.27
Vocational training	65.6	14.6	0.22	62.7	15.6	0.25
Counselling	74.6	13.7	0.18	67.0	12.7	0.19
Counselling for family	71.6	9.0	0.13	62.6	7.0	0.11
Social worker	57.9	3.4	0.06	57.0	6.0	0.11
Health provider	89.1	50.1	0.56	84.0	43.0	0.51
Traditional healer	66.2	44.2	0.67	60.8	39.7	0.65
Others	27.7	14.1	0.51	15.8	2.9	0.19

D. Receiving ASODKB and national health benefits

Services	Receiving Benefits			No Benefits		
	Need Service	Get Service	Getting/ Needing Ratio	Need Service	Get Service	Getting/ Needing Ratio
Medical rehabilitation	91.1	67.9	0.75	78.5	38.04	0.48
Assistive devices	85.7	42.9	0.50	69.78	19.61	0.28
Specific training	66.1	12.5	0.19	64.26	16.91	0.26
Vocational training	53.6	10.9	0.20	63.7	15.46	0.24
Counselling	78.6	32.1	0.41	68.65	12.46	0.18
Counselling for family	7867	25.0	0.32	64.52	7.04	0.11
Social worker	58.2	3.6	6.26	57.22	5.4	0.09
Health provider	92.9	51.8	0.56	85.13	44.61	0.52
Traditional healer	69.1	50.9	73.69	62.02	40.56	0.65
Others	50.0	25.0	0.50	17.51	4.64	0.26

Figure 7.7 shows the extent to which people receiving services believe they have benefitted from them. Training was thought particularly effective at improving people's situations. The biggest gap between people receiving and not receiving ASODKB or national health benefits was in counselling. Unfortunately, counselling was not always part of the available services. In vocational training, for example, career counselling should be an important part of the programme as a social rehabilitation intervention. For most occasions, however, it was not conducted. As seen in Figure 7.7, obtaining counselling services has been rare, but when it took place, it was particularly helpful to people who were not already connected to national programmes.

Figure 7.7 Percentage Reporting that Services Improved Their Situation, SNSAP-PWD, 2012



Medical rehabilitation was only helpful slightly more than half the time, whereas assistive devices were helpful roughly two-thirds of the time. This means a significant number of recipients were receiving ineffective services.

Table 7.12 displays the experience of people with hearing and vision difficulties when it comes to assistive devices. A relatively small percentage of people report using hearing aids, eyeglasses, or white canes. According to the table's data, these percentages should be at least three times as high. When people do use these devices, they are primarily purchased or self-produced; the government provides very few of them. For people with defective devices, the main barrier to repair is the expense.

Table 7.12 Experience with Hearing and Vision Assistive Devices, SNSAP-PWD, 2012

	Severe Hearing Difficulty	Severe Vision Difficulty	
	Hearing Aid (%)	Eye Glasses (%)	White Cane (%)
Using device	11.3	11.3	8.7
Device's source:			
Made by self	8.0	4.6	11.1
Buy	50.0	84.1	33.3
From Ministry of Health	12.0	–	5.6
Different Ministry	6.0	–	33.3
NGO	4.0	–	16.7
Other	20.0	11.4	–
Device's condition			
Very good	57.7	40.0	75.0
Good	23.1	37.8	13.9
Not good but still usable	5.8	15.6	11.1
Broken/bad	13.5	6.7	–
Barrier to repair			
Do not have money/expensive	80.0	81.8	75.0
Do not know the place	10.0	–	–
Too far	–	–	–
No transportation	–	–	–
No one can repair it	–	9.1	25.0
Cannot be repaired anymore	–	–	–
Other	20.0	10.0	–

Table 7.13 shows similar information for a range of mobility related devices. Again, few people use such aids, and when they do, they are self-made or bought and not provided by the government. Mobility-related devices are more prone to deteriorate than devices for hearing and seeing, but once again, cost is the main barrier to obtaining repairs. Presumably, it is also the cost that is preventing people who claim they need services from getting them. If everyone who needed assistive devices received them, more than three times as many people would have them.

Table 7.13 Experience of People with Mobility Assistive Devices, SNSAP-PWD, 2012

	Crutches	Wheelchair	Tricycle	Walking Frame	Walking Stick
% Using mobility aid	5.4	17.3	0.8	1.5	15.2
Device's source					
Made by self	14.3	3.3	25.0	14.3	73.4
Buy	17.9	33.3	50.0	71.4	16.5
From Ministry of Health	14.3	12.2	–	–	2.5
Other than Ministry of Health	7.1	15.6	–	–	–
NGO	14.3	15.6	25.0	14.3	–
Other	32.1	20.0	–	–	7.6
Device's condition					
Very good	33.3	43.9	25.0	42.9	26.9
Good	37.0	42.7	75.0	28.6	47.4
Not good but still usable	22.2	12.2	–	14.3	25.6
Broken/bad	7.4	1.2	–	14.3	–
Barrier to repair					
Do not have money/expensive	87.5	90.0	–	50.0	68.4
Do not know the place	25.0	–	–	–	5.3
Too far	12.5	–	–	–	–
No transportation	–	10.0	–	–	–
No one can repair it	–	20.0	–	50.0	10.5
Cannot be repaired anymore	–	–	–	–	21.1
Other	–	–	–	50.0	10.5

The low rate of programme participation and the large unmet need for services and assistive devices indicates that coverage is too low. In part, this has been due to a lack of funding that results from the perception that the number of people with disabilities is only 1 percent of the total population. Study interviews also revealed a prevailing perception among government officials (West Sumatra) that most people with disabilities have been able to find care and support and are financially independent and, thus do not need government assistance.

Mechanisms to reach the most vulnerable are not adequate. In Banjarmasin, many people with disabilities were living in slums and not covered by such programmes. Because most of these programmes are central government programmes, it depends on the local officials' ability and willingness to make proposals to secure the budget. For example, in 2012 Jenoponto district did not receive any Jamkesmas budget. This has been detrimental to their existing programme.

People with disabilities complained that it is difficult to apply for social assistance programmes by themselves due to lack of accessibility and public assistance. In Bandung, many people with disabilities benefited from social protection programmes due to assistance available from an NGO (Bandung Living Independent Centre). Such assistance was also available in Yogyakarta but not in other regions. MoSA social cash assistance and PKSA were provided only to severely disabled children. There were reports of misuse of funds because the cash assistance was often received by family members and not by the person with a disability.

Several recommendations emerge from this analysis:

- **Outreach programmes**. Programmes should be developed to inform people with disabilities about existing programmes and to help them access them, possibly in conjunction with currently existing disabled people organisations. These should include social workers that can help people with disabilities navigate the system and provide counselling services.
- **Expansion of cash benefit programmes**. ASODKB is reaching under 1 percent of people with disabilities, and must be expanded to be an effective tool for improving PWD well-being.
- **Accounting for the costs of disability**. Disability imposes additional costs that go beyond the typical needs accounted for in official poverty lines. These costs should be incorporated into any means testing for disability benefits.
- **Assistive devices**. Jamkesmas and other national benefit programmes should assist with obtaining and maintaining assistive devices. These devices are critical for promoting the participation of people with disabilities in the economy and within their communities.
- **Additional research**. As detailed in the first section of this paper, research is needed to answer important questions about the relationship between disability and poverty, and the causes and costs of disability.
- **Tailoring programmes to provincial experience**. Throughout this report the extent of disability, its impact on people's lives, its correlation with poverty, and its estimated costs vary significantly across provinces. Programmes should be designed with enough flexibility to adjust for local conditions.

Disability Issues in Social Protection for PWDs

Recently, there has been a broadening of social protection programmes around the world to not only serve as safety nets but increasingly implement programmes to develop people's productivity, for example, through public employment (Grosh et al. 2008; Norton, Conway, and Foster 2002). This is also the case for Indonesia with its Law on the National Social Security System that is implemented by BPJS as the insurance carrier that will operate in 2014 (see Chapter VII.2). The National Plan of Action 2004–13, which includes concern about expanding social protection for PWDs, was also developed and is expected to be fully implemented (see Chapter III.1).

But a question remains: to what extent should social protection efforts for people with disabilities be mainstreamed into general social protection programmes by removing barriers to their participation, or by designing specific programmes for people with disabilities.[47] Clearly, there is a need for both. People with mild disabilities experience barriers to participation but, given the right environment, have proven their ability to be productive. Sometimes a useful strategy is transitional supports that help people regain productivity after the onset of a disability through rehabilitation, retraining, and restructuring work environments. Studies have shown that these can often pay for themselves (Hunt 2009; Wendt et al. 2010).[48] Sometimes subsidy programmes to cover transportation costs or accommodations in the workplace are established. However, there are also times—especially for people with severe disabilities—when special disability benefits are needed to provide income replacement when work is not possible.

[47] See Mont (2010).

[48] For examples of such programs in East Asia, see Perry (2003).

The major challenge in establishing disability benefit programmes is determining and implementing eligibility criteria. Typically, these criteria are a combination of an earnings screen followed by a joint medical and functional approach linked with the ability to work. For example, in the United States if a person earns under a minimum amount each month and has certain medical conditions, they automatically qualify for disability benefits. If they do not have such a condition but present with a significant impairment, then a functional assessment determines whether the person is capable of working (Mashaw and Reno 1996). The reason for the initial medical listings is an attempt to reduce the administrative burden of the procedure because people with those conditions are seen as very likely to have great difficulties working. However, the rigidity of such listings has led both the United States and European countries to adapt their procedures to stress functionality to a greater extent (Stobo, McGeary, and Barnes 2007).

Mitra (2005) notes that even this approach is complicated by the fact that some impairments (e.g., those involving back pain) are invisible or, as in the case with some psychological conditions, episodic (Mitra 2005).

Moreover, there is the issue of how one gauges the inability to work. In any job? In a job similar to the person's last job? In the United States, the standard is to first determine whether the person has the residual functional capacity to undertake similar jobs they held in the past and, if they do not, to determine if they could successfully perform jobs in the general economy based on their residual functional capacity, age, education, and prior work experience.

Another eligibility determination approach is a social model of assessment, where eligibility is determined not through medical evaluations but through a community-based assessment of a person's ability to secure their livelihood given both their functional status and the environment they live in. This was attempted in South Africa but proved difficult to implement because without a medical baseline and without the community board being directly responsible for the social protection budget, it was difficult to prevent mistargeting and fraud at the community level (Simchowitz 2004). A similar approach is being piloted in Vietnam where a system of commune councils provides a structure more integrated with the provision of community-based programmes.

Fraud and misuse is not just an issue with community-based screening. Systems with medical screening have also been victims of fraud and misuse, sometimes dramatically so, as in Poland, the Netherlands, and elsewhere (Mont 2004; Hoopengardner 2001). Being able to document a medical condition to justify entry into the eligibility evaluation is important. A system must 'start with clearly articulated, objective medical standards to determine who is impaired but then move on to a more social needs–based assessment to help the individual receive whatever s/he needs to be fully integrated into work and society' (Marriott and Gooding 2007, p. 49).

Besides eligibility, the next big issue is work disincentives. For a programme targeting the most severely disabled people, this is less of a problem than if one pursues a programme that provides graduated benefits based on the degree of disability. However, a programme based on 'total disability'—that is, the inability to work—creates a situation in which people with disabilities who are near the poverty level have an incentive to abandon efforts to become employed and to claim to have a total inability to work in order to secure benefits, even if they have some work capacity, because they believe they will be better off with a reliable stream of benefits. Without programmes that aim to assist people with disabilities with obtaining better and sustained employment opportunities, the incentive to claim one cannot work and apply for benefits is greater. In general, once people start receiving disability benefits, their probability of returning to work is low, even when countries attempt policy measures intended to promote a return to work (Mont 2007; Organisation for Economic Co-operation

and Development 2003, Ch. 4). For example, once people make the case that they cannot work in order to receive benefits, they may be reticent about attempting any effort to work, because if they work for a while and then either lose their job or think they cannot maintain it, they are fearful they will not be able to requalify for benefits because they demonstrated some work capacity. Many countries have instituted programmes such as guaranteeing a return to benefits after a trial work period and allowing benefits to continue through this trial period, but none of these have been very successful at helping the transition to work.

Another issue is the nature of the benefits: should they be cash or in-kind? Cash benefits are usually considered more efficient, because they come with lower administrative costs and provide the greatest flexibility for recipients. However, in-kind benefits have several advantages. First, they are sometimes more politically popular because they can be used for generally agreed-on necessities, such as energy and housing. Also, they can at times be used for surplus goods, such as food or extra capacity, for example, by issuing subsidised bus passes. This is especially true with disability, for which in-kind benefits can include assistive devices, personal assistants, or rehabilitative services. This would also provide less incentive for fraud, because those items are not as valuable as cash to people who are not disabled. However, although they cover some of the extra costs associated with living with a disability, these in-kind benefits do not deal with more general needs.

Chapter VIII
Family and Community Life

People with disabilities may face barriers to full participation in family and community life. Taking part in religious or political activities, festivals, and sporting events are important parts of living a full life. But negative attitudes and inaccessible design can hinder a PWD's ability to participate.[1] In addition, sometimes having a household member with a disability can put added pressures and responsibilities on family members. This is especially true if the disabled person does not have access to the services or assistive devices that s/he needs or is made more dependent on family members because of barriers that prevent their independent participation in the economic and social life of their communities. To get at these issues the SNSAP-PWD asked a number of questions targeted to gauge community participation and the impact on families.

Law No. 4 of 1997 on Persons with Disability and its ministerial regulations provides the basis for the public sector to develop and ensure accessibility for PWDs. Recent laws such as Law No. 28 of 2002 on Building Establishments and Law No. 28 of 2009 on Traffic and Transportation support public accessibility. Most of the participants from the government sector (public works) who were interviewed for the SNSAP-PWD indicated they have been consistent with the law in provision of accessibility in public building and transportation.

Nevertheless, as Table 8.1 shows, many people with disabilities experience restrictions to their participation in community activities. Moreover, a significant difference exists in restrictions depending on the severity of the disability. For example, only 12 percent of men with mild disabilities felt restricted in participating in community organisations, but nearly 63 percent of men with more severe disabilities felt limited. Women with disabilities felt more restricted across the board.

Table 8.1 Percentage of People Reporting Restrictions in Participation in Community Activities, by Degree of Disability, Age, Gender, and Type of Residence, SNSAP-PWD, 2012

	Mild Disabilities				More Significant Disabilities			
	Comm. Organisations	Recreation, Sports, and culture	Religious	Political	Comm. Organisations	Recreation, Sports, and Culture	Religious	Political
Age								
10–19	27.08	10.42	8.33	41.86	74.85	50.74	47.65	75.16
20–29	8.33	5.63	2.78	8.33	64.44	53.94	45.14	55.27
30–39	17.05	18.18	3.41	11.36	60.94	64.86	48.82	55.25
40–49	3.17	20.63	4.76	7.94	60.31	66.29	47.17	57.74
50–59	13.85	33.85	7.69	10.77	61.67	69.29	48.96	48.33
60+	45.45	56.25	15.15	36.36	80.12	85.47	60.06	72.75
Gender								
Men	12.00	17.86	3.56	11.76	62.94	60.26	46.91	58.38
Women	23.45	27.08	9.66	22.22	73.77	70.85	53.40	65.64
Area								
Rural	15.29	16.57	7.06	16.87	62.52	57.10	43.94	61.14
Urban	17.50	25.63	5.00	15.08	71.03	69.76	53.37	62.00

[1] Chapter IV provides data on people with social disabilities, but this chapter refers to specific impairments related to social issues, such as making friends. This chapter focuses on participatory behaviour in social and community events. That lack of participation could be caused by difficulties across all functional domains. And even with 'social impairments', the impact on social behaviours will be heavily influenced by the environment.

The differences between rural and urban areas are not as uniform. Among people with mild disabilities, the only area of difference was in recreation, sports, and culture, in which rural residents felt more restricted from participating. Among people with more severe disabilities, rural residents also felt more restricted from participating in community and religious organisations but not in political activities. But, as reported in Table 8.4, the difference in impacts between rural and urban areas goes away (except for recreation, sports, and culture), once other factors are controlled.

In terms of age, elderly people with disabilities felt the most excluded. And when it came to politics and community organisations, so did disabled teenagers. There were no strong differences in experiencing exclusion by age during people's prime working years of ages 20 to 60.

Similar tabulations were made for people who became disabled before age 20. The thought was that acquiring a disability at an early age could lessen their participation in various activities, because they had no experience participating before having a disability. Conversely, acquiring a disability at a younger age could increase participation if people becoming disabled later in life have harder times adapting both physically and emotionally to their new situation (see Table 8.2).

For people with mild disabilities, onset of disability before the age of 20 years made no difference when it came to community organisations or recreational activities; however, it did seem to be associated with fewer restrictions in religious organisations. Participation in politics was more complicated. Early onset led to fewer restrictions for younger people but more for elderly. One hypothesis is that attitudes might have changed over the intervening years about disabled people's right or ability to participate.

For people with more significant disabilities, when early onset did have an effect, it was to lessen the number of people reporting restrictions, although the ages when this became apparent differed for different types of activities. Younger people faced fewer political restrictions, but the elderly face fewer when it came to recreation and religion. Community organisations were more accessible in general for people with disabilities when they acquired their disability before age 20.

In order to control for various factors, a logit was estimated to generate odds ratios that give the relative risk of participation restrictions (Table 8.3). Men with disabilities are significantly less likely to have restrictions on community participation, whether it is participation in community organisations, sports, recreation and culture, or religious or political activities. Having a mild disability also greatly reduces the chances that the disabled person feels restricted in these activities. Living in an urban area seems to reduce the chances of feeling restricted in recreation activities but not in other types.

In terms of age of onset, people who become disabled late in life (the base category) think they face the most restrictions. People becoming disabled as children report the fewest problems in participation.

By far the dominant factor is the province of residence. Interestingly, provinces do not necessarily show the same degrees of restriction in different areas. For example, in Yogyakarta, the degree of participation restriction in the areas of community organisations and recreation and cultural activities is not much different than in Jakarta (the base province). However, the restrictions on cultural and religious activities are quite high. In East Java there are much lower participation restrictions in political activity than anything else. Once again, this is evidence that programmes promoting inclusion need to adapt to situations in particular provinces.

Table 8.2 Percentage of People Reporting Restrictions in Community Activities by Degree of Disability, Age, Gender and Type of Residence, Age of Onset <20, SNSAP-PWD, 2012

	Mild Disabilities				More Significant Disabilities			
	Comm. Organisations	Recreation, Sports, and culture	Religious	Political	Comm. Organisations	Recreation, Sports, and Culture	Religious	Political
Age								
20–29	8.93	5.36	1.79	5.36	65.38	54.14	46.55	56.34
30–39	20.63	20.63	4.76	12.70	61.36	64.84	49.55	53.42
40–49	3.13	9.38	0.00	3.13	57.14	62.94	41.76	54.12
50–59	12.50	33.33	8.33	8.33	53.04	54.31	37.93	42.24
60+	42.86	57.14	0.00	57.10	73.33	70.00	55.93	63.33
Gender								
Men	11.38	13.82	1.63	7.32	55.40	54.84	42.14	50.82
Women	17.74	24.19	8.06	16.13	70.03	65.72	50.00	58.40
Area								
Rural	15.19	16.46	3.80	11.39	51.90	50.15	36.55	50.00
Urban	12.26	17.92	3.77	9.43	68.22	65.56	51.29	56.80

Table 8.3 Odds Ratios for Participation Problems by Type of Participation, SNSAP-PWD, 2012

	Comm. Organisations	Recreation, Sports, and culture	Religious	Political
Age				
20–29	8.93	5.36	1.79	5.36
30–39	20.63	20.63	4.76	12.70
40–49	3.13	9.38	0.00	3.13
50–59	12.50	33.33	8.33	8.33
60+	42.86	57.14	0.00	57.10
Gender				
Men	11.38	13.82	1.63	7.32
Women	17.74	24.19	8.06	16.13
Area				
Rural	15.19	16.46	3.80	11.39
Urban	12.26	17.92	3.77	9.43

Table 8.4 shows the perceived impact of a person's disability on their family life. People with mild disabilities are less likely to think their disability affects their household's daily life, creates financial pressures, or makes their family unhappy.

For example, 37.2 percent of women with mild disabilities think it affects their family life and nearly half say it causes financial problems. Among women with more significant disabilities, more than half say it affects family life and about two-thirds claim it causes financial difficulties. Unlike in community participation, however, there does not appear to be a gender difference.

Table 8.5 shows the odds ratios from a logit that can measure the relative risk when other independent variables are held at the sample means. In terms of age of onset, people who become disabled during their working years are more likely than those becoming disabled while a youth or when they are old to think their situation affects family life, causes financial problems, or makes their family unhappy. People with mild disabilities are only half as likely to think their disability is having a negative impact on their families as those with more significant disabilities.

Once again, there are strong provincial differences. In East Nusa Tenggara, disabled people are much more likely to report that their disability affects their family and creates financial pressures. They are also highly likely to think their family does not understand they need help, while, in Java, people with disabilities are more likely to think that their families do understand.

Table 8.4 Percentage of People Reporting Family Impacts by Degree of Disability, Age, Gender, and Rural/Urban, SNSAP-PWD, 2012

	Mild Disabilities				More Significant Disabilities			
	Affects Family Life	Financial Problems	Family Unhappy	Family Does Not Understand My Needs	Affects Family Life	Financial Problems	Family Unhappy	Family Does Not Understand My Needs
Age								
10-19	33.33	39.58	27.08	39.58	52.06	64.12	20.00	48.08
20–29	16.67	36.11	12.50	40.28	45.77	54.72	17.55	47.34
30–39	34.09	42.05	17.05	35.63	53.36	59.73	24.50	43.96
40–49	47.62	65.08	23.81	40.32	57.36	65.91	27.92	44.91
50–59	43.08	47.69	20.00	41.54	58.58	70.71	26.58	42.02
60+	60.61	63.64	21.21	57.58	63.87	78.32	28.03	51.73
Gender								
Men	36.44	47.11	20.44	78.67	54.88	65.10	25.35	74.80
Women	37.24	47.59	17.93	75.86	55.39	66.02	21.94	71.39
Area								
Rural	34.71	44.71	20.00	81.18	52.20	67.25	24.93	76.87
Urban	38.50	49.50	19.00	74.50	56.84	64.49	23.14	71.12

Table 8.6 Percentage of People with Non-Mild Disabilities Who Need Assistance, by Type of Activity and Frequency, SNSAP-PWD, 2012

Charac-teristic	Eating		Bathing		Toileting		Dressing	
	Some	A Lot	Some	A Lot	Some	A Lot	Some	A Lot
Age								
10-19	11.60	23.71	8.27	27.65	9.04	26.1	11.63	27.13
20–29	6.92	14.62	3.84	16.11	3.59	15.38	6.68	14.65
30–39	10.42	9.11	6.49	10.13	4.95	10.42	8.88	9.92
40–49	9.17	12.54	6.73	12.84	6.12	11.62	7.95	12.23
50–59	15.74	14.75	11.15	18.03	9.84	16.07	13.44	15.41
60+	19.36	22.02	15.38	29.18	15.38	27.32	17.38	24.87
Gender								
Men	13.39	18.85	8.13	21.73	7.25	20.66	10.82	20.06
Women	14.11	19.34	11.42	23.33	11.80	22.02	14.04	21.25
Area		**14.11**						
Urban	14.43	16.47	9.05	18.3	7.87	18.08	11.09	17.08
Rural	13.29	20.63	9.95	24.87	10.15	23.18	12.97	22.70

Figure 8.1 Percentage People with Non-Mild Disabilities Needing Assistance, SNSAP-PWD, 2012

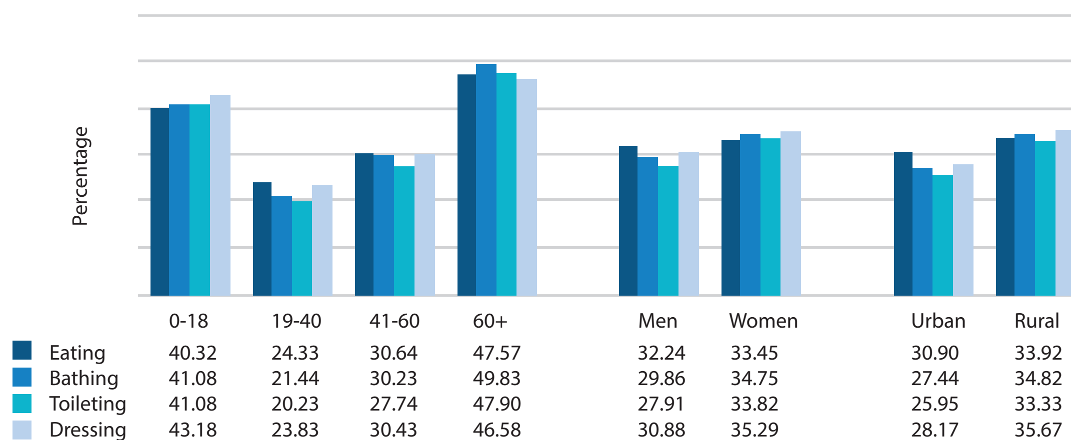
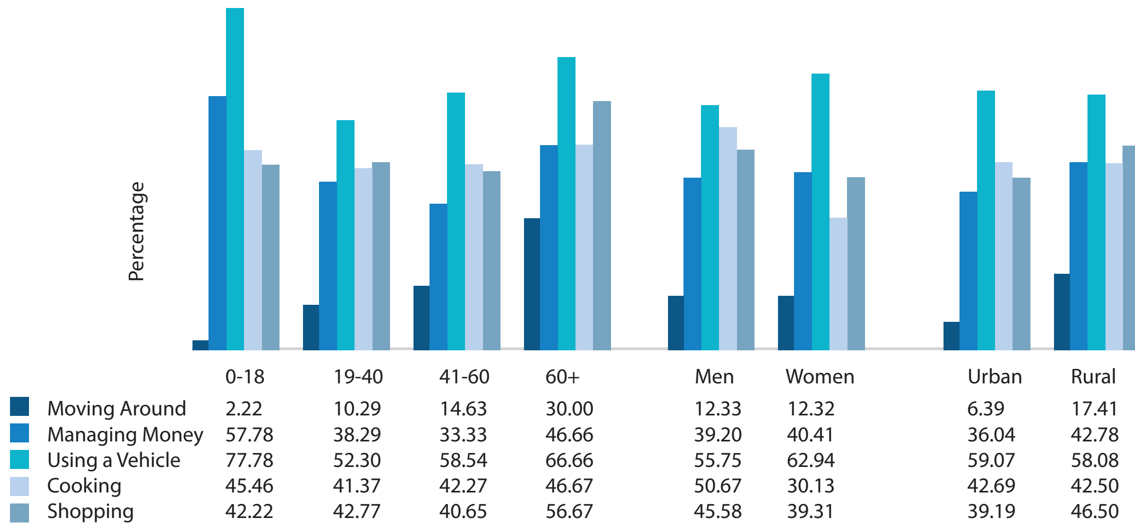
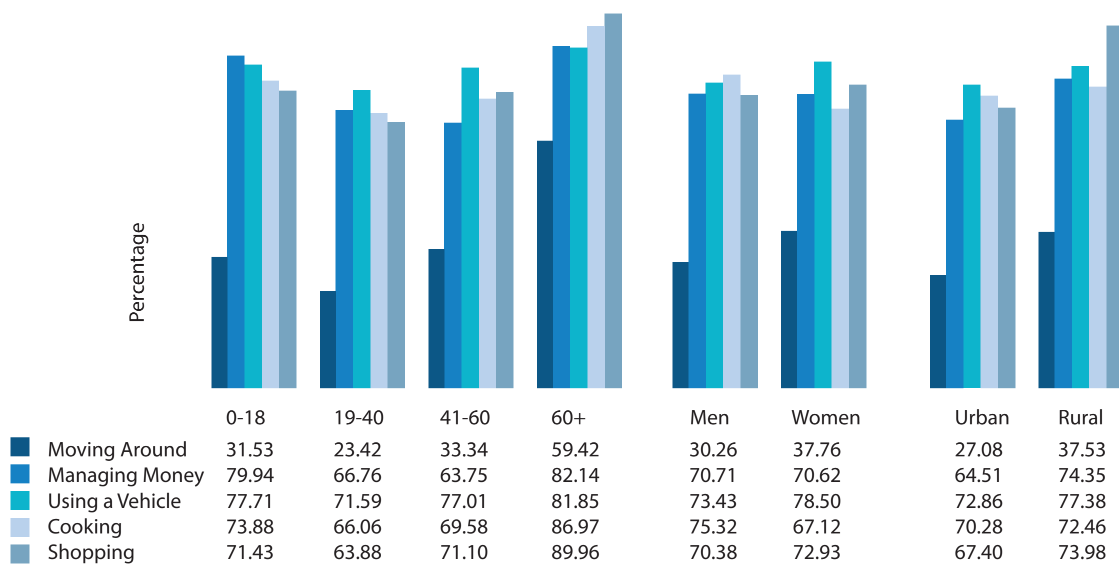


Figure 8.2 Percentage of People with Mild Disabilities Needing Assistance with Higher Order Activities, SNSAP-PWD, 2012



	0-18	19-40	41-60	60+	Men	Women	Urban	Rural
Moving Around	2.22	10.29	14.63	30.00	12.33	12.32	6.39	17.41
Managing Money	57.78	38.29	33.33	46.66	39.20	40.41	36.04	42.78
Using a Vehicle	77.78	52.30	58.54	66.66	55.75	62.94	59.07	58.08
Cooking	45.46	41.37	42.27	46.67	50.67	30.13	42.69	42.50
Shopping	42.22	42.77	40.65	56.67	45.58	39.31	39.19	46.50

Figure 8.3 Percentage of People with More Significant Disabilities Needing Assistance with Higher-Order Activities, SNSAP-PWD, 2012



	0-18	19-40	41-60	60+	Men	Women	Urban	Rural
Moving Around	31.53	23.42	33.34	59.42	30.26	37.76	27.08	37.53
Managing Money	79.94	66.76	63.75	82.14	70.71	70.62	64.51	74.35
Using a Vehicle	77.71	71.59	77.01	81.85	73.43	78.50	72.86	77.38
Cooking	73.88	66.06	69.58	86.97	75.32	67.12	70.28	72.46
Shopping	71.43	63.88	71.10	89.96	70.38	72.93	67.40	73.98

Another way of looking at the impact on families is measuring how often family members need to assist their disabled relatives in basic activities. The number of people reporting they need some of this assistance is reported in Table 8.6 (excluding people with mild disabilities). As the table shows, roughly a quarter to nearly one-half of people report needing help in some areas ('some' plus 'a lot'). Rates are highest for the lowest and oldest age category. Women and people living in rural areas need help slightly more than men, but the gender difference could well be attributable to the fact that women tend to be older. The results are also displayed in Figure 8.1 with the 'some' and 'a lot' categories added together. Other than toileting for people aged 19–40 years old, the rates at which people need help across these four basic activities of daily life are very similar.

Figures 8.2 and 8.3 show people reporting that they need at least some help in five higher-order activities—moving around, managing money, using a vehicle, cooking, and shopping. Even people with minor disabilities report needing significant levels of assistance, except when it comes to moving around. Operating a vehicle is particularly problematic. For people with more significant disabilities, the percentage of people needing assistance can exceed 75 percent.

People in the focus groups maintained that some of the reasons for restricted participation resulted from a lack of awareness by sector officials about their legal mandate. Disability affairs are seen as a mandate of MoSA, and so inclusion is not considered a priority of other agencies—such as public works and transportation. Coordination with other sectors has been difficult which results in weak monitoring and sanctioning. Many government officials also believe that people with disabilities do not have a lot of affairs that require dealing with government offices, so they make no preparation to accommodate them. Many government buildings are old, and they did not see why making adjustments in these buildings would be worthwhile.

Interestingly, focus group participants reported few barriers to community participation. They have accepted the challenges of physical, structural, and other barriers as given and think people in the community give them the opportunity to study in schools, work, and participate in organisations. Some of them indicated that they could compete with others and had different skills that other people did not have. Some of them were very proud because they were trained and supported so that they could become the backbone of family finances. They believe that the way people perceive their disability depends on how they conduct themselves.

This is somewhat at odds with the number of people reporting in the quantitative data that they experience restrictions in the community, but it may be that the people with the fewest restrictions were the ones who were able to learn about and attend the focus groups.

This chapter leads to several recommendations:

- Awareness raising. Public campaigns to promote the equality of people with disabilities should not just focus on schooling and work but on recognising that people with disabilities should be included in all community events. Communities should undertake outreach programmes to include people with disabilities and not assume they do not want to or are incapable of participating.

- Public spaces should be accessible. Public spaces and government and community buildings should be made accessible, as stipulated by Law No. 28 of 2002 on Building. Even when retrofitting such facilities might be expensive and take some time, simple things like having meetings on the first floor of buildings, and advertising meetings in more than one modality (radio for people with vision problems, print for people with hearing difficulties, etc.) can be helpful. Explicit efforts should be made to reach people with disabilities when organising community events. All new construction should be accessible that is not costly; studies show, for example, that building a fully accessible school increases costs by only 1 percent (Steinfeld 2005).

- Community-based rehabilitation. Community-based rehabilitation programmes should be developed to help people with functional issues that go beyond work and schooling, to include self-care and other daily activities. This will not only make people with disabilities more independent and improve the quality of their life but will free up the time of their family members to pursue other productive activities. Even people with mild disabilities should be included in this effort, as they also express a significant need for assistance.

Conclusions

As stated in the introduction, disability is a complex issue that has the potential to affect every aspect of a person's life. Moreover, people who have disabilities are a very diverse group—the type, extent, and age of onset of a disability vary widely. The impact of that disability is caught up in the interaction of a person's functional limitations related to some impairment with the barriers in that person's environment. Those barriers can be physical, but they can be programmatic and attitudinal, as well.

This report has attempted to review the extent of disability in Indonesia and the impact of those disabilities on people's lives. It has attempted to document the barriers that people with disabilities face, the result of facing those barriers, and policies and programmes in place that can be used to mitigate them.

The report was based on a desk review of the legal framework of disability law in Indonesia, extensive quantitative— secondary sources including Census 2010 and Riskesdas 2007, and a new national Indonesian disability survey—and qualitative analysis undertaken with a broad range of stakeholders.

The model of disability used was the psycho-biological-social model of disability, which is at the heart of the UN Convention on the Rights of Persons with Disabilities, the International Classification of Functioning of WHO, and the recent World Report on Disability 2011 (WHO and World Bank 2011). In that model, disability is not seen as a medical condition lodged in the person but as the interaction between a person's functional status (which may result from an impairment based on a health condition) and the barriers they face in the environment that limit their participation.

This is not the model generally found in Indonesian laws. Indonesia has a broad array of laws addressing the issue of disability, but they are dominated by an older medical model approach. This approach views people with disabilities as people to be protected and cared for, rather than as a group of people who need to be assured of their human rights to participate fully in society. As such, this approach is not very effective in helping people with disabilities overcome barriers to participating in the economic and social life of their communities.

Overall, this report finds that the prevalence of disability in Indonesia is between 10 and 15 percent—comparable to the global findings presented in the recent World Report on Disability 2011 (WHO and World Bank 2011)—but that Census 2010 tends to underreport that rate. Disability is much more common among older people, and slightly more prevalent among women and people living in rural areas. The probability of being disabled also depends significantly on the province.

When it comes to education, people with disabilities in Indonesia are less likely to attend school. In examining these data, however, it is important to keep in mind that most people with disabilities become disabled when they are no longer school age. People having a disability during their school years are only 66.8 percent as likely to complete their primary education, controlling for other factors. There are barriers to obtaining a secondary education, as well, but they are not as large. This suggests that overcoming barriers when younger—including attitudinal barriers—could be particularly effective.

Several recommendations emerged from the education chapter, including the following:

- Raise awareness to address misconceptions about disability
- Build an inclusive education system that includes physical access but also teacher training and curriculum development
- Improve and subsidise transportation to school

Disabled people are also less likely to be employed. Having a mild disability gives a person only a 64.9 percent chance of being employed relative to a nondisabled person. For people with more serious disabilities, that drops to barely more than 10 percent. They are also more likely to be self-employed, even though they report difficulties in obtaining access to credit in order to establish businesses.

Some people with disabilities reported success in obtaining employment but found current laws and programmes not very helpful. There was no systematic effort to make government training programmes effective or to enforce Indonesia's laws on disability and employment. Many people experienced a lack of training, education, and access.

The recommendations from this chapter follow:

- Make vocational training programmes inclusive; do not have a parallel system of training
- Align labour laws with the UNCRPD to enforce a rights-based approach to employment
- Conduct public awareness campaigns to promote employment
- Conduct pilot tests of employment programmes in order to develop and demonstrate good practices
- Reduce barriers to microfinance for people with disabilities to assist in self-employment

The report also talks about building partnerships with the private sector, as has been demonstrated in the United Kingdom and Sri Lanka as an effective means of building an accessible work environment.

People with disabilities also face barriers to full participation in family and community life. This includes community organisations; recreation, sports, and culture; as well as religious and political organisations. This is particularly true for people with more significant disabilities. For example, although 11 percent of men with mild disabilities felt restricted in taking part in community organisations (18 percent for women), men with more significant disabilities reported barriers to participating more than 55 percent of the time (70 percent for women).

The same pattern held for effects on family life, although the gender differences were much smaller. Just under half of men and women with mild disabilities reported a financial strain on their families, and more than a third thought it affected family life. For those with more significant disabilities, nearly two-thirds thought it caused financial problems and more than half thought it affected family life. People with disabilities also reported the need for significant amount of assistance in the form of assistive devices and personal assistance.

Recommendations from this chapter follow:

- Raise awareness to break down stereotypes and promote inclusion
- Make public spaces accessible
- Establish community-based rehabilitation to enable people with disabilities to be more independent

The report also looked at the extent of poverty among people with disabilities and the coverage of social protection programmes. People with disabilities were 30 to 50 percent more likely to be poor than nondisabled people, especially in urban areas. Households with disabled family members had a 12.4 percent poverty rate in urban areas and 14.0 percent in rural, compared with 8.2 percent and 11.4 percent for households with no disabled members. In addition, the relationship between consumption and disability is more pronounced for the non-elderly, probably because many elderly become disabled after their working years are already over.

Even among low-income people, people with disabilities are concentrated near the bottom of the distribution. As one raises the poverty line from one to two times the poverty line, people with disabilities are still overrepresented but less so.

When the extra costs of living that come along with disability were included (which ran anywhere from negligible to 14 percent depending on the province), the poverty gap between disabled and nondisabled households increased, often noticeably. Moreover, the association of disability with lower consumption was more noticeable among families with disabled children or working age adults, as opposed to disabled elderly.

The social protection and health coverage of people with disabilities was problematic. People with disabilities complained about the difficulty of applying for and inaccessibility of benefits. The low rate of programme participation and the large unmet need for assistive devices indicate that coverage is too low, and mechanisms to reach the most vulnerable are not adequate.

Recommendations from this chapter follow:

- Establish outreach programmes to inform people with disabilities about existing programmes and help them in accessing them
- Expand cash benefit programmes to cover a broader range of people with disabilities
- Take into account the costs of disability in determining both eligibility and benefit levels
- Encourage national programmes to provide and maintain assistive devices
- Conduct additional research to better understand the two-way nature of the disability-poverty relationship
- Tailor programmes to provincial experiences, which vary substantially

The report also briefly summarizes some of the major issues in designing a disability benefits programme, primarily eligibility determination, work disincentives, and trade-offs between cash and in-kind benefits.

One overarching theme across all sectors examined in this report was the major differences across provinces regarding the prevalence of disability and its relationship to poverty, education, employment, and family and community life. Clearly, any policy and programmatic approaches taken to improve the lives of PWDs must have enough flexibility to adapt to local conditions and concerns.

Overall, people with disabilities in Indonesia—as much as 15 percent of the population—are at a disadvantage. They are poorer, less educated, less employed, more isolated, and at times believe they are a burden on their family. Laws and programmes exist for them, but they are not well implemented and many gaps in coverage and enforcement exist. Nevertheless, the qualitative interviews in this study revealed a great deal of determination and confidence among many people with disabilities. This report urges the adoption of concrete steps towards making Indonesian society more inclusive so that people with disabilities can enjoy their full human rights and participate in and contribute to society to the best of their abilities.

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Annex

Annex 1: Questionnaires

CONFIDENTIAL	IDR:[ ][ ]. [ ].[ ][ ].[ ][ ][ ].[ ][ ][ ]-[ ][ ] Provkab kec villageresp # type disability
ENUMERATOR : ______________________[ ][ ]	PUNCHER :__________________[ ][ ]
SUPERVISOR :_________________________[ ][ ]	SUPERVISOR DATA ENTRY:________________[ ][ ]

DEMOGRAPHIC INSTITUTE FEUI
SURVEY ON THE NEED FOR SOCIAL ASSISTANCE PROGRAMMES FOR PEOPLE WITH DISABILITY, 2012

	VISIT 1	VISIT 2	VISIT3
DATE/MONTH	[ ][ ]/[ ][ ] DATE/MONTH	[ ][ ]/[ ][ ] DATE/MONTH	[ ][ ]/[ ][ ] DATE/MONTH
START INTERVIEW TIME	[ ][ ]/[ ][ ] HOUR/MINUTE	[ ][ ]/[ ][ ] HOUR/MINUTE	[ ][ ]/[ ][ ] HOUR/MINUTE
END INTERVIEW TIME	[ ][ ]/[ ][ ] HOUR/MINUTE	[ ][ ]/[ ][ ] HOUR/MINUTE	[ ][ ]/[ ][ ] HOUR/MINUTE
INTERVIEW RESULT	1. FINISH ➡ CT1 3. NOT FINISH	1. FINISH ➡ CT1 3. NOT FINISH	1. FINISH ➡ CT1 3. NOT FINISH
REASON NOT FINISH	[ ], ________________	[ ], ________________	[ ], ________________
	Respondent refuses to be interview Respondent refuses to continue interview	Respondent is ill Prohibit by family Other,_________	

CT1	Interview was conducted in language: a. Indonesia b. sign v. Other , ______________________	a b v,_________
CT2	Other language used: a. Indonesia b. sign v. Other , ______________________	a b v,_________
CT3	Did respondent answer by her/himself? 1. Yes ➡ CT5 3. No	1. Yes ➡ CT5 3. No
CT4	Who represented respondent in answering? Parent / Family member that is care giver Husband/wife / Care giver (Non-family member) Sibling / Guide Children/son/daughter in-law / Neighbour Other family member / 95. Other,________________	01 06 02 07 03 08 04 09 05 95, _______
CT5	Who was present during interview? No one / Family member that is care giver Husband/wife / Care giver (non-family member) Sibling / Guide Children/son/daughter in-law / Neighbour Other family member / v. Other,________________	a f b g c h d i e v, ________

INFORM CONSENT
Sir/Madame I am __________________________, currently assigned by the DEMOGRAPHIC INSTITUTE FACULTY ECONOMICS UNIVERSITY INDONESIA to interview you. This interview is part of 'Study of the implementation of social assistance programme for people with disability'. Purpose of this study is collecting information about people of disability in Indonesia that would be used as inputs for policy makers in designing future programmes for disable people in Indonesia.

We guarantee that your identity will be kept confidential, and this information will only be used for this study. If you do not understand aquestion, please let me know and I will repeat the question again. Do you agree to be interviewed?
1. Yes ➡ continue interview
3. No ➡ stop interview, change respondent

1. SECTIONKL: Location Information		
KL01	Province: 01.West Sumatra; 02.South Sumatra; 03.DKI Jakarta; 04.DI Yogyakarta; 05. West Java; 06. Central Java; 07. East Java; 08. South Kalimantan; 09.South Sulawesi; 10.Maluku; 11.East Nusa Tenggara	[] []*
KL02	District ___________________________	[]*
KL03	Subdistrict _______________________________	[][]*
KL04	Village_________________________________	[][]*
KL05	Area : 1.Urban 3.Rural	[]
KL06	Respondentnumber	[][]*
KL07	Name Respondent(initial only)	
KL08	Type of difficulty: (DO NOT ASK, FILLED AFTER INTERVIEW FINISH!) a. Sight; b. Hearing; c. Major motoric movement; d. Minor motoric movement; e. Intellectual; f. Communication; g. Spiritual/Emotional	[][]* ___________________
KL09	Home Address ____ ____	
KL10	Telephone number (HP/Home)____	
KL11	Name Enumerator ____	[]
KL12	Name Supervisor ____	[]
KL13	Name Field Coordinator ____	[]

2. SECTION TT: DWELLING			
TT01	Do you live by yourself or with other family members? 1.By myself 2.With other family member 3. Live in an institution/hospital /rehabilitation centre 5.Other ,______________________		 1 2 3 5, __________
OBSERVATION			
TT02	Surrounding dwelling condition: Slum/poor village/housing Simple housing Luxurious housing		 1 2 3
TT03	Floor types are mostly : Soil Concrete Tile	 Wood(Kayu) Other ,__________________	 1 4 2 5, _______ 3
TT04	Roof types are mostly : 01.Wood 02.Palm fibre 03.Cardboard/cloth 04. Bamboo	 05.Asbesto/zinc 06.Tile 95.Other,__________________	 01 05 02 06 03 95, _____ 04
TT05	Wall types are mostly : 01.Wood 02.Palm fibre 03.Cardboard/cloth 04. Bamboo	 05.Asbesto/zinc 06.Rock/Brick 95.Other,__________________	 01 05 02 06 03 95, _____ 04
TT06	Does the house have any window or ventilation system? Does not have any window or ventilation Only window	 Only ventilation Window and ventilation	 1 3 2 4
TT07	What material is the window or ventilation made from? Wood Glass Iron bars (trellis) Just a hole v,Other ____________		 a b c d v,__________

3. SECTION KD: Demographic Characteristics		
KD01	Observe or clarify respondent sex 1. Male 3. Female	1 3
KD02	What is your ethnicity? a. Minang d. Sunda g. Banjar j. Timor v, Other_____ b. Melayu e. Jawa h. Bugis k. Flores c. Betawi f. Madura i. Toraja l. Ambon	a b c def g h i jk l v,________________
KD03	Have you ever lived in another place (village, city/town, province)? Yes 3. No ➡KD05	3 ➡KD05
KD04	Did you move from another village, subdistrict, city, province or country? From another village From another province From another subdistrict From another country From another subdistrict/city	a d b e c
KD05	What is your age on your last birthday?	[ ] [ ] year
KD06	What is your marital status? Single ➡KD11 Widow ➡KD08 Separated ➡KD08 Live together ➡KD08 Divorced ➡KD08 Married	1 ➡KD11 4 ➡KD08 2 ➡KD08 5 ➡KD08 3 6
KD07	How many times have you married?	[ ][ ] times
KD08	How many children do you have?	[ ][ ] child(ren)
KD09	How many are boys and girls? Boy …………………child(ren) b. Girl………….child(ren)	a. [ ] [ ] child(ren) b. [ ] [ ] child(ren)
KD10	How many are still toddler :……………child(ren)	[][] child(ren)
KD11	What was your last education level completed No schooling 05. Senior high level Pondok Pesantren 06. Diploma 1,2 Primary level 07. Academy/BA /Diploma 3 Junior high level 08. University/master/doctoral	1 5 2 6 3 7 4 8
KD12	What is your current major activity? Schooling ➡Section 4 Work for income ➡KD 15 Work and schooling ➡KD 15 No schooling and no work Household work	1 ➡Section 4 2 ➡KD15 3 ➡KD15 4
KD13	Currently, why are you not working? Cannot do activity that provide income ➡Section 4 No one will accept me ➡Section 4 I used to work but not anymore Household work	1 ➡Section 4 2 ➡Section 4 3
KD14	Why do you stop working? 01. Pension 05. Sick/ill 02. Downsizing 06. Made a mistake 03. Lay off 07. Household work 04. Work accident 95. Other,_______________	01 05 02 06 03 07 04 95, __________
KD15	What is your current work? ____	
KD16	Are you now self-employed, an employer with fixed or non-fixed labour, a labourer or employ-ee, or an un-paid family worker? Self-employed Employee Employer with fixed labour Unpaid family worker Employer with non-fixed labour	1 4 2 5 3
KD17	Please give estimate your monthly income.Rp……………………………...	Rp. [ ][ ].[ ][ ][ ].[ ][ ][ ],-
KD18	Is your education useful forseeking work? 1. Yes 3. No	1 3

4. SECTIONSK: Source of Income		
SK01	Enumerator CheckKD12: major activity 1. Answer =2 or3 ➡SK03 3. Answer =1 or 4	3 ➡SK03 1
SK02	Who assistswith your daily living expenses?	
	a. Family b. Friend/Neighbour c. Community (institution, organisation, paguyuban etc.) d. Government (Bos, PKH, Raskin, JSLU,ASODKB, PKSA dsb) v, Other, _______________	a b c d v, _______________
SK03	Is the assistance enough to cover your daily expenses? 1.Yes 3.No	1 3

SK04	Please state two most important/biggest expenses that are covered by the assistance that you received: **(DO NOT READ ANSWER!!)**		A	B 1. Regular 3. Not regular
	A. Expenses a. Food b. Household non-food c. Rent d. Education e. Transportation f. Water/electricity g. Telephone/pulsa h. Assistance tool i. Rehabilitation and health j. Paid caregiver k. Recreation/entertainment v. Other,___________________________	B. Regular or not (incidental/temporary) 1. Regular 3. Not regular	a b c d e f g h i j k v, ______	a. 1 3 b. 1 3 c. 1 3 d. 1 3 e. 1 3 f. 1 3 g. 1 3 h. 1 3 i. 1 3 j. 1 3 k. 1 3 v. 1 3

5. SECTION BS: Social Assistance		
	BS01	BS02
Program **penanggulangan kemiskinan** yang memberi tambahan penghasilan	**During the last year**, has this household received government assistance in this programme:	How much did you receive **during the last year?**
a. Rice for the Poor (Beras Miskin)	3. No ⬇ 1. Yes ➡	a.Rice [ ] [ ][ ] kg ➡BS01b Rp.[ ][ ][ ].[ ][ ][ ] ➡BS01b
b. Conditional Cash Transfer (PKH)	3. No ⬇ 1. Yes ➡	Rp. [ ]. [ ][ ][ ].[ ][ ][ ] ➡BS01c
c. Micro Credit (KUK)	3. No ⬇ 1. Yes ➡	Rp. [ ]. [ ][ ][ ].[ ][ ][ ] ➡BS01d
d. Kelompok Usaha Bersama (KUBE)	3. No ⬇ 1. Yes ➡	Rp.[].[ ][ ][ ].[ ][ ][ ] ➡BS01e
e. Usaha Ekonomi Produktif (UEP)	3. No ⬇ 1. Yes ➡	Rp.[].[ ][ ][ ].[ ][ ][ ] ➡BS01f
f. Jamkesmas	3. No ⬇ 1. Yes ➡	Rp.[].[ ][ ][ ].[ ][ ][ ] ➡BS01g
g. Jamkesda	3. No ⬇ 1. Yes ➡	Rp.[].[ ][ ][ ].[ ][ ][ ] ➡BS01h
h. Social Welfare Insurance(Askesos)	3. No ⬇ 1. Yes ➡	Rp.[ ][ ][ ].[ ][ ][ ] ➡BS01i
i. Asistensi Sosial untuk Orang Dengan Kecacatan Berat (ASODKB)	3. No ⬇ 1. Yes ➡	Rp.[ ][ ][ ].[ ][ ][ ] ➡BS01j
j. Jaminan Sosial Lanjut Usia (JSLU)	3. No ⬇ 1. Yes ➡	Rp.[ ][ ][ ].[ ][ ][ ] ➡BS01k
k. ProgramKesejahteraan Sosial Anak (PKSA)	3. No ⬇ 1. Yes ➡	Rp.[ ][ ][ ].[ ][ ][ ] ➡BS01l
v. Other ,____________________	3. No ⬇ SECTION KA 1. Yes ➡	Rp.[ ][ ][ ].[ ][ ][ ] ➡SECTION KA

6.SECTION KA: LIMITATION IN ACTIVITY		
KA00	Do you wear glasses? 3. No 1.Yes	3. 1.

		KA01. Do you experi-ence difficulty in [..] (show card KA01)	KA02 Do you use assis-tance tools or get help from other people? Yes 3. No	KA03 How difficult do you feel it is, without using assistance tool or help from other people? (show card KA03)	KA04 Since what age did you experi-encethis difficulty [..]	KA05 What causes [….] difficulty (according to respondent) (show card KA05)
A 1	Sensory activities					
	1. Sight	1 2 3 4 🡇 KA01A1.2	3 🡆 KA04 A1.1 1 🡆 KA03 A1.1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Hearing	1 2 3 4 🡇 KA01A2.1	3 🡆 KA04 A1.2 1 🡆 KA03.A1.2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
A 2	Basic learning & apply knowledge					
	1. Learning something new	1 2 3 4 🡇 KA01A2.2	3 🡆 KA04 A2.1 1 🡆 KA03.A2.1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Remembering	1 2 3 4 🡇 KA01A2.3	3 🡆 KA04 A2.2 1 🡆 KA03.A2.2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Concentration/focus attention	1 2 3 4 🡇 KA01A3.1	3 🡆 KA04 A2.3 1 🡆 KA03 A2.3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
A 3	Slow development (problem in analysing)					
	1. Thinking/solvingproblem	1 2 3 4 🡇 KA01A3.2	3 🡆 KA04 A3.1 1 🡆 KA03 A3.1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Participatingin solving family problem	1 2 3 4 🡇 KA01A3.3	3 🡆 KA04 A3.2 1 🡆 KA03 A3.2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
B	Communication					
	1. Understand other people's conversation in national and local language?	1 2 3 4 🡇 KA01B2	3 🡆 KA04 B1 1 🡆 KA03B1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Other people canunder-stand your conversation in national and or local language	1 2 3 4 🡇 KA01B3	3 🡆 KA04 B.2 1 🡆 KA03 B2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Speak directly face to face	1 2 3 4 🡇 KA01C1	3 🡆 KA04 B3 1 🡆 KA03 B3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________

C	Mobility					
	1. Can sit and stand (by yourself)	1 2 3 4 ⬇ KA01C2	3 ➡ KA04 C1 1 ➡ KA03 C1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Change position from sit to stand, etc.	1 2 3 4 ⬇ KA01C3	3 ➡ KA04 C2 1 ➡ KA03 C2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Move from one place to another (inside home, climb stairs, outside home)	1 2 3 4 ⬇ KA01C4	3 ➡ KA04 C3 1 ➡ KA03 C3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	4. Lift two small bottles(2 litres)	1 2 3 4 ⬇ KA01C5	3 ➡ KA04 C4 1 ➡ KA03 C4	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	5. Close and open fist	1 2 3 4 ⬇ KA01C6	3 ➡ KA04 C5 1 ➡ KA03 C5	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	6. Use hand to pull, push, grab, let go	1 2 3 4 ⬇ KA01C7	3 ➡ KA04 C6 1 ➡ KA03 C6	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	7. Walk with your own two feet	1 2 3 4 ⬇ KA01C8	3 ➡ KA04 C7 1 ➡ KA03 C7	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	8. Move, spin, run, climb, jump	1 2 3 4 ⬇ KA01C9	3 ➡ KA04 C8 1 ➡ KA03 C8	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	9. Use public transpor-tation	1 2 3 4 ⬇ KA01C10	3 ➡ KA04 C9 1 ➡ KA03 C9	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	10. Drive car, ride bike, ride animal	1 2 3 4 ⬇ KA01C11	3 ➡ KA04 C10 1 ➡ KA03 C10	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
D	Self-Care					
	1. Bathe	1 234 ⬇ KA01D2	3 ➡ KA04 D1 1 ➡ KA03 D1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Brush teeth, clean nails, brush hair	1 234 ⬇ KA01D3	3 ➡ KA04 D2 1 ➡ KA03 D2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Use toilet to urinate and …… BAK, BAB di WC	1 2 3 4 ⬇ KA01D4	3 ➡ KA04 D3 1 ➡ KA03 D3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	4. Put on and takeoff clothing	1 2 3 4 ⬇ KA01D5	3 ➡ KA04 D4 1 ➡ KA03 D4	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	5. Eat and drink	1 2 3 4 ⬇ KA01D6	3 ➡ KA04 D5 1 ➡ KA03 D5	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	6. Take care of own health	1 2 3 4 ⬇ KA01E1	3 ➡ KA04 D6 1 ➡ KA03 D6	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________

E	Domestic Life					
	1. Shop in store, market, convenient store	1 2 3 4 🡇 KA01E2	3 🡆 KA04 E1 1 🡆 KA03 E1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Cook and prepare food	1 2 3 4 🡇 KA01E3	3 🡆 KA04 E2 1 🡆 KA03 E2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Do household work, washing, dusting	1 2 3 4 🡇 KA01E4	3 🡆 KA04 E3 1 🡆 KA03 E3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	4. Fix and maintain-household items	1 2 3 4 🡇 KA01E5	3 🡆 KA04 E4 1 🡆 KA03 E4	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	5. Care for other family members	1 2 3 4 🡇 KA01F1	3 🡆 KA04 E5 1 🡆 KA03 E5	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
F	Interpersonal attitude					
	1. Friendship	1 2 3 4 🡇 KA01F2	3 🡆 KA04 F1 1 🡆 KA03 F1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Relation and inter-acting with local authorities	1 2 3 4 🡇 KA01F3	3 🡆 KA04 F2 1 🡆 KA03 F2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Interacting with stranger	1 2 3 4 🡇 KA01F4	3 🡆 KA04 F3 1 🡆 KA03 F3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	4. Fabricatingand maintaining good relation among family members	1 2 3 4 🡇 KA01F5	3 🡆 KA04 F4 1 🡆 KA03 F4	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	5. Seeking and maintain-ing friendship	1 2 3 4 🡇 KA01G1	3 🡆 KA04 F1 1 🡆 KA03 F1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
G	Major Life Areas					
	1. Go to school to obtain education	1 2 3 4 🡇 KA01G2	3 🡆 KA04 G 1 🡆 KA03 G1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Seek work	1 2 3 4 🡇 KA01G3	3 🡆 KA04 G1 1 🡆 KA03 G1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Seek income and wages	1 2 3 4 🡇 KA01H1	3 🡆 KA04 G1 1 🡆 KA03 G1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________

H	Community and social life					
	1. Participate or become member to a community organisation	1 2 3 4 ⬇ KA01 H2	3 ➡ KA04 H1 1 ➡ KA03 H1	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	2. Participate in recreation/sports/culture, hobby	1 2 3 4 ⬇ KA01 H3	3 ➡ KA04 H2 1 ➡ KA03 H2	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	3. Religious activities	1 2 3 4 ⬇ KA01 H4	3 ➡ KA04 H3 1 ➡ KA03H3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	4. Political and citizen activities	1 2 3 4 ⬇ KA01 H4	3 ➡ KA04 H4 1 ➡ KA03H4	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
	5. Family gatherings	1 2 3 4 ⬇ KA01 I1	3 ➡ KA04 H5 1 ➡ KA03H5	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________
I	Mental Problems					
	1. Emotionally stable/ calmness (mental problem, abnormal attitude, depression, phobia, anger)	1 234 ⬇ KA07	3 ➡ KA04 I3 1 ➡ KA03I3	1 2 3 4	[ ] [ ] year	1 2 3 4 5 6 7 8 9 10 11 95, ________

		KA06 Is there a [..] in your home Yes, there is ➡ 3.No there is not ⬇	KA07 Can you easily go to the [...]? 1. Yes, easily 3. Not easy
A	Kitchen	3 ⬇ 1 ➡	1 3
B	Bedroom	3 ⬇ 1 ➡	1 3
C	Living room	3 ⬇ 1 ➡	1 3
D	Dining room	3 ⬇ 1 ➡	1 3
E	Bath room	3 ⬇ 1 ➡	1 3

KA08	ENUMERATOR CHECK!! KD06 Respondent's marital status 1. Answer =1, Respondent, never married ➡ KA13 3. Answer =>1, Respondent ever married	1. ➡ KA13 3
KA09	Is your partner also experiencing difficulty in doing daily activity? 1.Yes3. No	13
KA10	ENUMERATOR CHECK!! KD08number of children? 1.Answer =0 ➡ KA13 3. Answer>0	1. ➡ KA13 3
KA11	Do you have children that are experiencing difficulty in conducting daily activities? 3. No ➡ KA13 1. Yes	3. ➡ KA13 1
KA12	How many children are experiencing difficulties in conducting daily activities?	[ ][ ] child(ren)
KA13	Do you have family or sibling that are experiencing difficulty in conducting daily activity? 3. No ➡ PA01 1. Yes	3. ➡ PA01 1
KA14	How many siblings are experiencing difficulties in conducting daily activity?	[ ][ ] person

7. SECTION PA: Services and Assistive Device							
		PA01 Do you know about any assistive device/ services [...]? 1. Yes 3. No	PA02 Do you need services [...]? 1.Yes 3. No	PA03 Do you ever get services [...]? 1.Yes 3. No	PA04 Is there any improvement after you get the services [...]? 1.Yes 3. No	PA05 Did these problem occurred when you get the services [...]? (INTERVIEWER READ OPTION!) No problem Too expensive Too far Services are temporary available Problems with the service providers (not friendly, rude,etc.)	PA06 Why did you not get any services [...]? a. Nomoney to go to service provider b. Cannot afford to pay the service c. Cannot go by her/him self d.No transportation to go to the service provider v. Other, ________
a	Medical rehabilitation	3	1 3	3. ➡ PA06a 1. Yes	1 3	ab cd e PA01b	a b c d v, ______ PA01b
b	Assistive device service	1 3	1 3	3. ➡ PA06b 1. Yes	1 3	ab cd e PA01c	a b c d v, ______ PA01c
c	Special educational services, such as specific training	3	1 3	3. ➡ PA06c 1. Yes	1 3	ab cd e PA01d	a b c d v, ______ PA01d
d	Vocational training such as to work	1 3	1 3	3. ➡ PA06d 1. Yes	1 3	ab cd e PA01e	a b c d v, ______ PA01e
e	Counselling for people with disability	1 3	1 3	3. ➡ PA06e 1. Yes	1 3	ab cd e PA01f	a b c d v, ______ PA01f
f	Counselling for parent/family of people with disability	1 3	1 3	3. ➡ PA06f 1. Yes	1 3	ab cd e PA01g	a b c d v, ______ PA01g
g	Service from social worker	1 3	1 3	3. ➡ PA06g 1. Yes	1 3	ab cd e PA01h	a b c d v, ______ PA01f
h	Services from health provider	1 3	1 3	3. ➡ PA06h 1. Yes	1 3	ab cd e PA01i	a b c d v, ______ PA01h
i	Services from traditional healer	1 3	1 3	3. ➡ PA06i 1. Yes	1 3	ab cd e PA01v	a b c d v, ______ PA01v
v	Other, ________ ____________	1 3	1 3	3. ➡ PA06v 1. Yes	1 3	ab cd e PA07.1	a b c d v, ______ PA07.1

Assistive Device	PA07. Do you use any assistive device [...]	PA08 Where did you get the device [...]? (INTERVIEWER READ!) 01. Made by self 02. Buy 03. From MoH* 04.Other than MoH* 05. NGO 95. Other ________	PA09 How is the condition of the assistive device [...] that you use? 1. Very good 2. Good 3. Not good but still useable 4. Broken/bad	PA10 Problems to repair a broken device a. Do not have money/expensive b. Do not know the place c. Too far d. No transportation e. No one can fix it f. Cannot be fixed anymore v, Other ______
1. Hearing aid	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
2. Eye glasses	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
3. Crutches	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
4. Wheel chair	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
5. Tricycle	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
6. Walking frame	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
7.Walking stick	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
8.White cane	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
9.Artificial limb	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
10.Calipers	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
11. Splints	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
12.Special footwear	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
13.Neck collar	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
14.Back brace/ corset	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________
95.Other,____________	3. No ⬇ 1.Yes ➡	01 02 03 04 05 95,__________	1 2 3➡ 4➡ ⬇⬇	a b c d e f v,____________

* Ministry of Health.

8. SECTION DC: Disability effect		
DC01	Does your disability affect yourhousehold's lives?	Always 2. Sometimes 3. Never
DC02	Does your disability become a financial pressure for your household?	Always 2. Sometimes 3. Never
DC03	Does your household refuse/ is it unhappy because of your disability?	Always 2. Sometimes 3. Never
DC04	Does your family receive enough information to understand your disability?	Always 2. Sometimes 3. Never
DC05	Does your family not understand why you need more help?	Always 2. Sometimes 3. Never
DC06	Is your family happy to help you?	Always 2. Sometimes 3. Never
DC07	Did you ever get resistance from school?	Always 2. Sometimes 3. Never

9. SECTIONPK:Family help			
PK 01 In doing activity [...] do you get support/assistance from household member?	1.Always/most of the time 2. Sometime 3. Rarely/Never	PK 01 In doing activity [...] do you get support/assistance from household member?	1.Always/most of the time 2. Sometime 3. Rarely/Never
a. Dressing	1 23	g. Moving around	1 23
b. Toileting	1 23	h. Managing money	1 23
c. Bathing	1 23	i. Using vehicle	1 23
d. Eating	1 23	j. Studying	1 23
e. Cooking	1 23	k. Emotional/moral support (willing to chat, support-ing, etc.)	1 23
f. Shopping	1 23	v. Other, ________________	1 23

FINISH INTERVIEW, CHECK QUESTIONER, SAY THANK YOU AND RETREAT POLITELY

10. SECTION CP: ENUMERATOR NOTES

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Annex 2: Guidelines for FGDs with PWDs

<table>
<tr><th>Questions</th><th>Remarks</th></tr>
<tr><td colspan="2">When and how did you become disabled?

Notes:
We need to ask this question so you may get the relevant information as you go through the topics.
Do not make any assumptions when you see any functional limitations in their life.</td></tr>
<tr><td>What is life like in your community for people with your difficulties?</td><td>Find out things like:
What do they do?
How are they treated?
Do people discriminate them?
How do people think about them?
What's their place in the community?</td></tr>
<tr><td>Inside your family?</td><td>Are they involved in family decisions?
What does your family think of them?
What are their activities in the family?
Do they expect to get married/children?
Other family roles?</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Education
Do you go to school?
Do you like to go to school?
Do you want to do more?
Have you gone to school?
What was it like? Was it hard to get in the school?</td><td rowspan="5">What is your experience?
What have you done?
What do you want to do?
What do you think you can and should do?
What prevented you from doing what you want?
What are the barriers
Which would be most helpful?
Family
Community
Government
Business
NGOs
Find what they do or have done?
What they want to do?
What's preventing them?
What would be most helpful to getting to do what they want to do? Immediate circumstance, laws, policies</td></tr>
<tr><td>Employment
Have you got a job?
What is your job like?</td></tr>
<tr><td>Civic activities
Cultural events?
Social events?
Politic?
Religious events?
Neighbourhood activities?
Village meetings?
Weddings?</td></tr>
<tr><td>Health Care Services</td></tr>
<tr><td>Social Services
Pension programmes
Disability benefits
Food assistance
Sociali insurance

Notes: Find out any social assistance for people in Indonesia, not only for PWDs. Do PWDs know about those programmes? Assistance from governments and informal sectors too.</td></tr>
</table>

Annex 3: In-Depth Interview Guidelines with Related Stakeholders

- People from the Government:
  1. Ministry of Social Affairs
  2. Ministry of Manpower and Transmigration
  3. Ministry of Health
  4. Ministry of Education
  5. Ministry of Public Work
  6. Ministry of Transportation
- NGOs
- Employer Organisations
- Unions—injured on job

Stakeholder Interview Guidelines

Questions	Remarks
1. What programmes in general are they responsible for?	To what extent is PWD participation? What regulations/laws do you have to comply with? Are you complying? If not, why not? What are the barriers to participation? What are they doing about barriers? Are there any efforts or programmes to solve the barriers? Ask about programmes in general, not just programmes for PWDs. What do they think should be done? *Notes:* *It is best to ask three different levels at provincial, district, national. We want to find out whether the programmes include PWDs.*
2. What specific programmes for PWDs? Do you have any written documents to describe such programmes? Can we get any report on that?	Who are you serving? How much money do they spend on such programmes? What are they doing? When did it start? Ask about their accomplishment? What are their success stories by working with PWDs? What are the gaps and problems that they have? ex: health clinic Do you planning any new programmes? What are their recommendations at all three levels (provincial, district, national)? What do you think DPOs and NGOs can do to make the programmes successful?
3. What opportunities do they see in collaborating with other ministry?	**Example 1:** Medical rehabilitation by MOH and Vocational Training by MOL. Could the MOH assist the MOL help PWDs to explore their functional needs? What are the problems arising from cooperating between the ministry? What is the main idea of disability related with the programmes you have for PWDs? **Example 2:** Social Assistance by MoSA and PWDs who aretrying to get a job, assisted by MOL. What are the problems faced by MoSA and MOL by doing their programmes?

Questions	Remarks
4. What are the barriers faced by the employers?	What are the laws/regulations regarding employment for PWDs? How well do they know the laws? Do you have successful examples of people who have done that? What are the barriers to doing it? What could help increase jobs for PWDs? What could convince employers to hire PWDs? Information: - About how to do it profitably? - Some kind of government's assistance—subsidies? - Technical knowledge?
5. Community	What is disability? Who is the disabled person in their mind? Get them to think about different types of disabilities. What are the qualities of life of PWDs? Can they do what they want? What problems do they have? Do they participate in community events? What do you think about them? What limitations should they have? In school? Community? Work? Family? What's your responsibility for them? Do you include them? Do you take care of them? What PWDs; Family; Community; Government could do to make PWD lives better?

Annex 4: Interview Guidelines for NGOs

Questions	Remarks
What do you do or whom do you serve?	
What are PWDs' biggest problems?	Barriers PWDs face?
What are your accomplishments? How?	
What are the biggest barriers you face?	
What recommendation do you have?	What should DPOs, NGOs, local government, provincial and national governments do to make their job effective? Do you know about social assistance programmes?

Annex 5: English Translations of Names of Indonesian Provinces

Names of provinces		
No.	**Bahasa Indonesia**	**English**
1	Aceh	Aceh
2	Sumatra Utara	North Sumatra
3	Sumatra Barat	West Sumatra
4	Riau	Riau
5	Kepulauan Riau	Riau Islands
6	Jambi	Jambi
7	Sumatra Selatan	South Sumatra
8	Bangka Belitung	Bangka Belitung
9	Bengkulu	Bengkulu
10	Lampung	Lampung
11	DKI Jakarta	DKI Jakarta
12	Jawa Barat	West Java
13	Banten	Banten
14	Jawa Tengah	Central Java
15	DI Yogyakarta	DI Yogyakarta
16	Jawa Timur	East Java
17	Bali	Bali
18	Nusa Tenggara Barat	West Nusa Tenggara
19	Nusa Tenggara Timur	East Nusa Tenggara
20	Kalimantan Barat	West Kalimantan
21	Kalimantan Tengah	Central Kalimantan
22	Kalimantan Selatan	South Kalimantan
23	Kalimantan Timur	East Kalimantan
24	Sulawesi Utara	North Sulawesi
25	Gorontalo	Gorontalo
26	Sulawesi Tengah	Central Sulawesi
27	Sulawesi Selatan	South Sulawesi
28	SulawesiBarat	West Sulawesi
29	Sulawesi Tenggara	Southeast Sulawesi
30	Maluku	Maluku
31	Maluku Utara	North Maluku
32	Papua	Papua
33	Irian Jaya Barat / Papua Barat	West Irian Jaya

Annex 6: On Legal Framework

Legal and Policy Framework Related Disability and UN Convention on the Rights of Persons with Disability (Non-exhaustive compilation)

Definition of People With Disabilities

United Nations Convention on the Rights of Person with Disabilities, 2006

Preamble

(e) Recognising that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,
(i) Recognising further the diversity of persons with disabilities

Article 1, Purpose
Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments that in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2, Definitions
'**Discrimination on the basis of disability**' means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

'**Reasonable accommodation**' means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

'**Universal design**' means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. 'Universal design' shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

Article 3, General principles
The principles of the present Convention shall be:
(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
(b) Non-discrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
(e) Equality of opportunity;
(f) Accessibility;
(g) Equality between men and women;
(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159), 1990 (NOT YET SIGNED NOR RATIFIED)

Part I Article 1:
1. For the purposes of this Convention, the term disabled person means an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment.
2. For the purposes of this Convention, each Member shall consider the purpose of vocational rehabilitation as being to enable a disabled person to secure, retain and advance in suitable employment and thereby to further such person's integration or reintegration into society.
3. The provision of this Convention shall be applied by each Member through measures that are appropriate to national conditions and consistent with national practice.
4. The provisions of this Convention shall apply to all categories of disabled persons.

Laws	Articles	Sanction	Comment
Law No. 4 of 1997 on Persons with Disability	**Article 1:** (1) Person with disability is defined as any person who has a physical or intellectual disability that can disrupt their livelihoods and/or constraint him/her from performing normal activities, including the: a. physically disabled b. intellectually disabled c. physically and intellectually disabled (2) Derajat kecacatan adalah tingkat berat ringannya keadaan cacat yang disandang seseorang. (3) Equal opportunity is a condition that facilitates people with disabilities to obtain equal chances in all aspects of life and livelihood. (4) Accessibility is provided for people with disabilities in order to realise the opportunity in all aspects of life and livelihood. (5) Rehabilitation is the process of recreation and development to enable people with disabilities able to perform normal social function in society.	Not specified	This definition is based on the medical model. Impairment becomes the basis for defining and understanding disability. This way, the whole person is actually reduced into his or her impairments. This definition has been held accountable in marginalising people with disabilities (Irwanto et al. 2010a). Although Law No. 4 of 1997 provides a clause on equal opportunity, in many subsequent laws and regulations equal opportunity is not implemented due to requirements such as: 'the individual should be physically and mentally healthy'. Obviously, the definition of disability has indicated that he/she is a person who is incomplete, with handicaps or disabilities, and a person who is not going to be able to do as well as a complete or normal person.
Law No. 11 of 2009 on Social Welfare	People with disabilities are categorised as members of society who have problems and social dysfunctions.	Not specified	The definition is derived from the medical model definition of Law No. 4 of 1997. The definition in this law strengthens the current perception that persons with disabilities are subject of welfare intervention, especially because of the notion that these people are helpless.

The Right To Education

United Nations Convention on the Rights of Person with Disabilities, 2006

Article 5, Equality and nondiscrimination

1. States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures that are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 24, Education

1. States Parties recognise the right of persons with disabilities to education. With a view to realising this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:
   (a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
   (b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
   (c) Enabling persons with disabilities to participate effectively in a free society.
2. In realising this right, States Parties shall ensure that:
   (a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
   (b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
   (c) Reasonable accommodation of the individual's requirements is provided;
   (d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
   (e) Effective individualised support measures are provided in environments that maximise academic and social development, consistent with the goal of full inclusion.
3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:
   (a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;
   (b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;
   (c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deaf-blind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximise academic and socialdevelopment.
4. In order to help ensure the realisation of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.
5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

Laws	Articles	Sanction	Comment
Constitution 1945	**Article 28C** (1) Every citizen has the right to develop oneself through the fulfilment of one's basic rights, as the right for education and to benefit from knowledge and technology, arts and culture, in order to improve the quality of life and for the welfare of mankind.	Not specified	This article in the Constitution is derived from the universal declaration of human rights. It is, therefore, in line with the spirit of the UNCRPD. The lack of awareness of the government, community and the education implementer about the rights to education of people with disabilities causes the minimum services of education for people with disabilities. People with disabilities also have difficulties in accessing education. The Constitution also does not state the specific rights to education for children with disabilities (Konas Difabel 2011).
	Article 31 (1) Every citizen has the rights to get education (2) Every citizen must complete the basic education and the government must pay for it.		
Law No. 4 of 1997 on Persons with Disability	**Article 6** Every person with disability are entitled to: 1. Education in all units, lane, types, and levels of education 2. work and to live according to the type and degree of disability, education, and ability	Not specified	Although these articles provide persons with disabilities equal opportunities to obtain the highest possible education, the way the articles were stated suggests that persons with disabilities are to be put into special education programme. The statement 'according to the type and degree of disability' is restricting the rights of people with disabilities to acquire education inclusively because there is no institution that has the legal authority to determine the level of disability of the person and which type and level of education one should be admitted (see Konas Difabel 2011).
	Article 11 Every person with disability has the same rights and opportunity to get education on the unit, lane, types, and levels of education according to the type and degree of disability, education, and degree of disability		
	Article 12 Every institution provides opportunities and equal treatment to people with disabilities as learners on the unit, lane, types, and levels of education according to the type and degree of disability, and ability.		

Laws	Articles	Sanction	Comment
Law no. 20 of 2003 on the National Education System	**Article 5** (1) Every citizen has the rights to quality education. (2) Every citizen who has physical, emotional, mental, intellectual, and/or social disability has the right to obtain special education. (4) And for those citizens who have the potential of intelligence and special talents are entitled to special education. (5) Every citizen has the rights to improve one's education in a lifelong manner. **Article 15:** The types of education include general, vocational, academic, professional, religious and special education. Explanation of Article 15: Special education is an implementation of education for students with disorders or with the superior intelligence that is done inclusively or in the form of special education in primary and secondary level. **Article 32:** (1) Special education is an education for the students that have some difficulty in attending the lessons because of physical, emotional, social impairments and/or those who have potential of intelligence and special talents. (2) Special education is an education for the students who live in remote or less developed areas and community, and/or those who experience natural disaster, social disaster and low financial status. (3) The stipulation of the special education implementation and special education services as stated in point (1) and (2) will be arranged in the government regulation.	**Article 29** (1) Every persons who does not provide accessibility as defined in Article 10 or not provide opportunities and equal treatment for people with disabilities as learners in unit, lane, types, and levels of education as stated in article 12 shall be liable administrative sanction. (2) the form, type and procedures for the imposition administrative sanction,as referred to in paragraph 1, shall be further stipulated in government regulation	In Indonesia, the implementation of Inclusive Education is guaranteed by Law No. 20 of 2003 on the National Education System. It states that the imple mentation of education for children with disability or children with superior intelligence is conducted inclusively or in the form of special schools. However, the implementation of inclusive education is lacking of basic understanding about the principles and the spirit of such education. Consequently, children with special needs often find inclusive schools to be insensitive, difficult to get adjusted, and many times they experience exclusion due to lack of understanding and awareness within the system (Irwanto et al. 2011b). Law No. 20 of 2003 puts inclusive education only as an alternative (inclusivism is not served as the main principle of the national education system) (Konas Difabel 2011). These articles are derived from existing national laws that are very much influenced by Law No. 4 of 1997 on Persons with Disability. This law directs segregated education for children with disabilities. This law is a contrary to the principle of inclusivism (Konas Difabel2011).

Laws	Articles	Sanction	Comment
Law no. 23 of 2002 on Child Protection	**Article 9:** (1) Every child has the rights to get education and learning in order to develop themselves and their level of intelligence according to their interest and talents. (2) Aside from the rights of the child that is stated in point (1), especially for children with disabilities, they also have the rights to get special education, while the gifted children also has the rights to get special education.	Not specified	
Lawno.39 of 1999 on Human Rights	**Article 12:** Everyone has the right to develop and benefit from scientific knowledge and technology, arts and culture as befits human dignity, in the interest of his own welfare, and the welfare of the nation and humanity.	Not specified	This article is rarely quoted in subsequent laws.
Law no. 14 of 2005 on Teachers and Lecturers	**Article 8:** Teachers are required to have academic qualifications, competency, education certificates, physical and spiritual health, as well as having the ability to achieve national education goals. **Article 24:** The government is obligated to fulfil the needs for teachers, in terms of the quantity, academic qualification, as well their competencies equally to guarantee the sustainability of the middle school education and special education according to the authority. **Article 45:** Lecturers are required to have academic qualifications, competency, education certificates, physical and spiritual health, and meet the other qualifications required by the unit in charge of higher education institution, and to have the ability to achieve national education goals.	Not specified	This law does not specifically provide clauses on special or inclusive education. Currently teachers with special needs education have no career path within the regular school although inclusive schools need the assistance of teachers with special education training. The inclusive school requires the assistance of a special education teacher but they have no functional career path within regular school that is protected by the law.

Laws	Articles	Sanction	Comment
Government Regulation No. 10 of 2010	Every level of education must accept students without discrimination, including discrimination based on physical and mental condition.	Not specified	Although it looks inclusive, in the implementation there are a number of structural barriers that needs to be acknowledged. Not all children with physical or mental impairment can be admitted into inclusive school. In fact those with rather severe impairment are mostly referred to special schools. It is also important to note that the implementation of inclusive education does not adhere to the principles in inclusive school management as described in the operational standard procedure issued by Ministry of National Education in 2007. Issues of competitiveness (ranking system), unpreparedness of the school system and parents, and other reasons have prevented children with special needs to be admitted to regular schools.
Ministerial Regulation of MoEC no. 70 of 2009 on Inclusive Education for Students with Disabilities and Students with Superior Intelligence and/or Special Talents	This Ministerial Regulation mentions about: 1. The definition of inclusive education, the purpose and criteria of students those are eligible for inclusion. 2. The rules of the number of inclusive school that must be available in each district / city. 3. The curriculum used in inclusive education. 4. The teachers for inclusive education. 5. The assistance that is entitled to be received by inclusive schools from the government.	**Article 14** Inclusive education administrators who are found to be violating the provisions as stipulated in this regulation will be given administrative sanctions in accordance with the rules and regulations.	Sanction never been enforced. The mandate of Ministerial Regulation of MoEC No. 70 of 2009 seems to be too difficult to achieve. The greater Jakarta province for example that has the provincial regulation is struggling to achieve the mandate.

The Right To Employment

United Nations Convention on the Rights of Person with Disabilities, 2006

Article 27, Work and employment

1. States Parties recognise the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realisation of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, *inter alia*:
   (a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
   (b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;
   (c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;
   (d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;
   (e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;
   (f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;
   (g) Employ persons with disabilities in the public sector;
   (h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
   (i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
   (j) Promote the acquisition by persons with disabilities of work experience in the open labour market;
   (k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.
2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159), 1990 (NOT YET SIGNED NOR RATIFIED)

Article 2: Each Member shall, in accordance with national conditions, practice and possibilities, formulate, implement and periodically review a national policy on vocational rehabilitation and employment of disabled persons.

Article 3: The said policy shall aim at ensuring that appropriate vocational rehabilitation measures are made available to all categories of disabled persons, and at promoting employment opportunities for disabled persons in the open labour market.

Article 4: The said policy shall be based on the principle of equal opportunity between disabled workers and workersgenerally. Equality of opportunity and treatment for disabled men and women workers shall be respected. Special positive measures aimed at effective equality of opportunity and treatment between disabled workers and other workers shall not be regarded as discriminating against other workers.

Article 5: The representative organisations of employers and workers shall be consulted on the implementation of the said policy, including the measures to be taken to promote co-operation and co-ordination between the public and private bodies engaged in vocational rehabilitation activities. The representative organisations of and for disabled persons shall also be consulted.

Article 6: Each Member shall, by laws or regulations or by any other method consistent with national conditions and practice, take such steps as may be necessary to give effect to Articles 2, 3, 4 and 5 of this Convention.

Article 7: The competent authorities shall take measures with a view to providing and evaluating vocational guidance, vocational training, placement, employment and other related services to enable disabled persons to secure, retain and advance in employment; existing services for workers generally shall, wherever possible and appropriate, be used with necessary adaptations.

Article 8: Measures shall be taken to promote the establishment and development of vocational rehabilitation and employment services for disabled persons in rural areas and remote communities.

Article 9: Each Member shall aim at ensuring the training and availability of rehabilitation counsellors and other suitably qualified staff responsible for the vocational guidance, vocational training, placement and employment of disabled persons.

Laws	Articles	Sanction	Comment
Constitution1945	**Article 27** Every citizen has the right to decent employment and livelihood for humanitarian. **Article 28 D** (2) Every person shall have the right to work and to receive fairand proper remuneration and treatment in employment.	Not specified Not specified	The amendment of the Constitution aligns with the spirit of the UNCRPD and ILO Convention 159. The problem however, is legal provisions of domestic laws and regulations are not always consistent with the Constitution nor with existing conventions. Harmonisation among domestic laws and regulations remains a serious challenge.
Law No. 4 of 1997 on Persons with Disability	**Article 13:** Every person with disability has the same opportunity to be employed according to his or her level of disabilities. **Article 14:** State and private owned companies should provide equal opportunity for employment for people with disability by employing them in their companies according to the level of disabilities, education, and skills, which the number of people will be adjusted with the number of employees and/or company qualification.	Not specified	The opportunity of people with disability to work has not received full support from the government and society. There are policies and regulations that are conflicting with the Constitution as well as the labour law.
The Law No. 13 of 2003 on Manpower	**Article 67** (1) Employers who employ workers with disability have to provide protection based on his/her disability. (2) Protection provision as told in paragraph (1) is implemented according to the law and regulations **Article 19** Job training for workers with disability is organised by considering the types of disability, the level of severity and the skills of the workers. **Article 153** (1) Employers are prohibited to terminate employment on the basis of the following conditions such as: (point j) Workers with permanent disability, diseases because of working accidents, or illnesses because of employment reasons that according to the medical letter the duration of the recovery cannot be predicted.	**Article 67** Employers who employ workers with disability but do not provide protection based on their disabilities will get imprisonment with the minimum of 1 month and the maximum of 12 months, and/or fine at least ten million rupiahs and maximum one hundred million rupiahs.	Unfortunately, this provision does not have an implementing regulation. Related regulations (No. 98/2001 and No. 9/2003) provide stipulation, which permits termination of employment,a recruitment process on the basis of disability. Vocational training for persons with disabilities is not yet inclusive as the requirements exclude persons on wheel chairs and persons, colour blindness, with mental disability. It is also common in recruitment processes to impose physical criteria that will prevent persons with disabilities to qualify in the first instance. See, for example, Government Regulation No. 16/2007 on Sport that stipulates that a coach must be physically and mentally sound.

Laws	Articles	Sanction	Comment
	Article 172 Employees who have chronic illness, disability because of work, and cannot work after 12 months period, can ask for termination of employment and get two times incentive from the stipulation in article 156 paragraph 2, Working Cash Award 2 times from the stipulation in Article 156 Paragraph 3, and substitution money 1 time as the stipulation in Article 156 Paragraph 4.		
Law No. 3 of 1992 on Labourers Social Security	**Article 3** 1. The labour social security programme was coordinated in order to give protection to employees, whilst its management can be executed with an insurance mechanism. 2. Every employee has a right to have manpower social security.		1. Insurance scheme is not universally applied to all employees. State employees, military personnel do have social security protection from the state. Private company employees, especially outsourced labour, are not always protected. 2. If an employee has an existing disability while recruited to a certain job, s/he is considered not eligible for (private) insurance. 3. The lack of access to adequate housing for people with disabilities. Due to their disabilities, it is not easy access to bank credit mortgage because they are considered to be unable to pay the monthly repayment. 4. People with disabilities have to pay higher transportation cost because of lack of accessibility in the public infrastructures but this added costs have never been accounted in the existing benefits/ support. 5. There is no guarantee of safety and the provision of accessible workplaces for people with disabilities. 6. There is a clause in a workplace accident insurance that discriminates people with disabilities, because in case of an accident, people with disabilities are unable to claim the insurance. 7. Workers with disabilities tend to get lower wages (Konas Difabel 2011).
	Article 6 The scope of the manpower social security programme in this Law consists of: 1. Occupational accident security; 2. Death security; 3. Old age security; 4. Health Care security. The development of the labour social security programme as mentioned in paragraph (1) will be further arranged with the Government Regulation.		
Law No. 39 of 1999 on Human Rights	**Article 38** (1) All citizens have the right to work as befits a human being, in line with his or her ability and capacity. (2) Everyone has the right to free choice of employment and the right to just conditions of work. (3) Everyone, both men and women, who works has the right to equal pay for equal work, and the right to equal work conditions. (4) Everyone, both men and women, who works has the right to fair and adequate remuneration, ensuring for himself and his family an existence worthy of human dignity.	Not specified	

Laws	Articles	Sanction	Comment
Government Regulation No. 9 of 2003 on The Authority, Promotion, Mutation and Termination of Government Civil Workers	**Chapter II, Article 2, 3,4** These articles regulate recruitment, mutation, and promotion of civil servants. Disability prevents a candidate for being recruited and promoted.	Not specified	According to this article, a person with disability cannot be promoted as a central government civil worker.
	Chapter VII, Article 22 The government civil workers are terminated with respect and given pension fees, as well with the termination are mentioned about the provision of pension fees or their widows/widowers pension fees. The termination that is meant in this stipulation is the termination with respect or without respect, with some conditions as said below: (Point i). become disabled because of duty;	Not specified	According to this Article, someone can be terminated because of disability and given pension fees—see article 153 and 172 of the Law No. 13 of 2003 on Manpower.
Government Regulation No. 98 of 2000 on Recruitment of Civil Employees that has been replaced by Government Regulation No. 11 of 2002	**Article 3** Every citizen of Republic of Indonesia has the same rights to apply to become Civil Governmental workers after fulfilling the conditions that have been made in this regulation. **Article 6** (the conditions that have to be met by the each applicant) Point h: physically and mentally sound	Not specified	According to this Article, a person with disability is considered as not healthy. Disability is not identical with not physically and mentally sound, disability is an abnormality, not a disease. Because of that, people with disability that are healthy should be given the equal rights and opportunity to join the recruitment process of CPNS admission.
GovernmentRegulation No. 43 of 1998 on The Efforts and Undertaking in Social Welfare for PWDs	**Article 4 Paragraph 28:** Labour participation of People with Disability and the responsibility of the private and public institutions to provide employment opportunity, which is one in every 100 employees, should involve People with Disability.	Not specified	However, the provision is rarely been implemented, even in the government sector. There are many cases of discrimination against PWD in employment (Irwanto et al. 2010).

Laws	Articles	Sanction	Comment
Ministerial decree No. : KEP-205/MEN/1999 on vocational training and placement of workers with disabilities	**Article 8** (1) Workers with disabilities are entitled to the vocational rehabilitation after receiving medical, social or educational rehabilitation. (2) Vocational rehabilitation as referred to in paragraph (1) includes job guidance counselling, job training and selective placement. (3) To obtain vocational rehabilitation as referred in paragraph (1) labour with disabilities must register to the employment administrators.		- Vocational rehabilitation as currently implemented by the government has not been able to seriously assist trainees for job placement. - Vocational rehabilitation is only conducted in limitedly fashion to job training only. Actually vocational rehabilitation should also include vocational therapy, as well with the placement and protection of the product and its marketing. - Livelihood training is stigmatising (for example, massage for the blind, sewing for the quadriplegic, etc.) - Inadequate access to sources of capital, such as the requirements cannot accommodate people with disabilities, the lack of confidence of the private sector. This is one reason that some areas have not had a commitment and perspectives on pro-disabilities budget (Konas Difabel 2011).
Local ordinance No. 10 of 2006 (Bandung and Sukoharjo)	Regulates the quota for workers with disability Chapter 3, Article 10, Paragraph 2: Local government must employ at least one employee with disabilities, who meet the requirements and qualification of the job as an employee at the government agency for every one hundred employee.	Not specified	But in practice the governor of the province acknowledges that it has not yet been implemented well. The implementation of local ordinances is highly dependent on the goodwill of the local government, which has resulted in difficulties in standardising the realisation of rights to employment and in an increased likelihood of neglect (Irwanto et al. 2011) In the practice, West Java Governor **(H. Ahmad Heryawan)** admitted that the implementation had not been running well (Kompas, 26 Feb 2009). The implementation of the policy is depending on the goodwill of the local government. This makes it hard to standardise the realisation of the rights of employment and PWDs are so likely to be neglected.

Accesibility, Public Facility, and Transportation

Article 9—Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, *inter alia*:
   (a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
   (b) Information, communications and other services, including electronic services and emergency services.
2. States Parties shall also take appropriate measures to:
   (a) Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
   (b) Ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
   (c) Provide training for stakeholders on accessibility issues facing persons with disabilities;
   (d) Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
   (e) Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
   (f) Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
   (g) Promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
   (h) Promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Laws	Articles	Sanction	Comment
Law No. 4 of 1997 on Persons with Disability	**Article 8** States that all public facilities and infrastructure must provide for equal accessibility **Article 10:** (1) Equal opportunity for person with disability in all aspect people's live and livelihood implemented through the provision of accessibility. (2) Provision of accessibility intended to create conditions and environment that could support person with disability in order to fully live in a society. (3) Provision of accessibility as defined in paragraph (1) and paragraph (2), held (4) The provision of accessibility, as defined in paragraph (1) and (2), is done by the government and/or community and is done globally, is integrated and continuous.	**Article 10:** Any person who does not provide accessibility as defined in article 10 or do not provide opportunities and equal treatment for disabled persons as learners on the unit, track, type, and level of education as defined in section 12 subject to administrative sanctions.	The amendment of the Constitution aligns with the spirit of the UNCRPD and ILO Convention 159. The problem however, is legal provisions of domestic laws and regulations are not always consistent with the Constitution nor with existing conventions. Harmonisation among domestic laws and regulations remains a serious challenge.
Law No. 28 of 2002 on Building	**Article 27** (2) The accessibility inside a building as defined in paragraph (1) includes the facility and accessibility that is easy, safe and convenient for people with disability and elderly		

Laws	Articles	Sanction	Comment
Government regulation No. 36 of 2005 on The Implementation of Law No. 28 of 2002 onBuilding	**Article 55** (1) Facility of connection to, from, and in the building referred to in Article 54 includes the availability of facilities and accessibility is easy, safe, and convenient including for the disabled and elderly. (2) Provision of facilities and accessibility should consider the availability of horizontal and vertical relationship between room in the building, access to evacuation, including for persons disabled and elderly.		
Government Regulation No. 36 of 2005 on the provision of public facilities/building	**Article 31** (2) Facilities for People with Disabilities and elderly as defined in paragraph (1) includes the provision of accessibility and other facilities inside a building and its surroundings.		
Ministerial Decree of the Public Work Ministry No. 468/ KPTS/1998 on technical specifications and requirements for universal accessibility in public building and other environment	**Article 18** There is information and measurements for buildings in public area that allows access for people with disabilities.		
Law No. 11 of 2008 on Electronic Information and Transaction	Have no provisions that guarantee accessibility of person with disabilities on electronic information.		
Law No. 22 of 2009 on (ground) Traffic	Accessibility is mentioned in Article 37(2) on terminal arrangement; Article 93(2) d. on partition and traffic flow; Article 242(2) on special treatment for pregnant women, elderly, sick people, and people with disabilities.	Administrative sanctions such as: written reminder, administrative fine, freezing and revocation of licence. The implementation of the sanction will be enforced through an implementing regulation.	Not being observed and enforced.
Law No. 11 of 2008 on Electronic Information and Transaction	Have no provisions that guarantee accessibility of person with disabilities on electronic information.		
Law No. 22 of 2009 on (ground) Traffic	Accessibility is mentioned in Article 37(2) on terminal arrangement; Article 93(2) d. on partition and traffic flow; Article 242(2) on special treatment for pregnant women, elderly, sick people, and people with disabilities.	Administrative sanctions such as: written reminder, administrative fine, freezing and revocation of licence. The implementation of the sanction will be enforced through an implementing regulation.	Not being observed and enforced.

Laws	Articles	Sanction	Comment
TRANSPORTATION			
UN Convention on the Rights of Person with Disabilities, 2006 Article 20, Personal mobility States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by: (a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost; (b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost; (c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities; (d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.			General Mobility: - Public transportation by land, sea, air and their supporting facilities (such as airports, terminals, ports and stop) still cannot be accessed or is discriminatory, both physical and non-physical means by all people with disabilities. - Discrimination in the services and policies of the public transportation to people with disabilities. - People with disabilities cannot reach so many places yet. - The options of accessible transportation are very limited. Traffic and Transportation: - There is no protection for the people with disabilities who use private vehicle. - Crossing the road is still hard for the people with disabilities to do. - Modified vehicles should not only be promoted for its usage but also must be certified for its safety. - Most the public transportation's terminals and shelters are not yet designed to be accessible or to be equipped with accessibility, such as a high counter, emplacement that is not parallel to the floor bus, floor difference without ram, etc. - Buses or land transportation still have not provided special space for wheelchairs and preferred seating for the people with disabilities. - The traffic signs, markers, and information still cannot be accepted and understood by everyone. - Not all of the staff in the bus is aware of and able to serve users with disabilities well and properly.
Law No. 14 of 1992 on Ground Traffic and Transportation Government Regulation No. 41 of 1993 on Ground transportation	**Article 49** (1) People with disabilities reserve the right to special treatment in the form of service in the traffic and road transport field.		

Laws	Articles	Sanction	Comment
	Article 53 Any public transport authorities must provide special treatment for people with disabilities. This article is further enforced through a number of Ministerial decrees as follows: - No. 6 of 1994 on special signs for the visually and hearing impaired - No. 31 of 1995 on terminals and ground facilities - No. 71 of 1999 on accessibility for people who are sick on transportation facilities.		
Law No. 13 of 1992 on Railways	**Article 35** (1) People with disabilities and/or sick people reserve the right to special treatment in the form of service in the railway transport.		- Most of train stations have not been designed or equipped with accessibility, such as a high counter, emplacement that is not parallel to the floor of the car, floor difference without ramp, etc. - Most of the trains have not been providing special space for wheelchairs and preferred seating for the people with disabilities, as well as accessible toilets. - The signs, markers, and information still cannot be accepted and understood by everyone. - Not all of the staff in the train is aware of and able to serve users with disabilities well and properly.
Law No. 13 of 1992 on Railways	**Article 35** (1) People with disabilities and/or sick people reserve the right to special treatment in the form of service in the railway transport.		- Most of train stations have not been designed or equipped with accessibility, such as a high counter, emplacement that is not parallel to the floor of the

Laws	Articles	Sanction	Comment
Law No. 15 of 1992 on Aviation	**Article 42** (1) People with disabilities and sick people reserve the right to special treatment in the service of commercial air transport.		car, floor difference without ramp, etc. - Most of trains do not provide special space for wheelchairs, preferred seating for people with disabilities, and accessible toilets. - Signs, markers, and information still cannot be accepted and understood by everyone. - Not all of the train staff isaware of and able to serve users with disabilities well and properly. - Most of the airports have been designed to be accessible or equipped with accessibility, but it is not intended for independent passengers with disabilities. - The treatment to passengers with disabilities is often equated with the sick people, so that the standard of service at the same time becomes exaggerated and is not appropriate. - Signs, markers, and information still cannot be accepted and understood by everyone.
Government regulation No. 40 of 1995 on Aviation	**Article 46** (1) Commercial air transport company shall provide necessary facilities and provide services especially for passengers with disabilities or sick people. (2) facilities and special services referred to in paragraph (1), include: a. convenience facilities up and down or to and from aircraft b. provision of places for wheelchairs in the aircraft c. finding aids for the sick who require transportation in a sleeping position d. provision of additional priority seats.		- Most of the ports has not been designed or equipped with accessibility, such as a high counter, emplacement that is not parallel to the floor of the car, floor difference without ram, etc. - The design of the ship complicates the entry access of people with disabilities to go into the ship or their mobility inside the ship. - The signs, markers, and information still cannot be accepted and understood by everyone. - Not all of the staff in the ship is aware of and able to serve users with disabilities well and properly (Konas Difabel).

Laws	Articles	Sanction	Comment
Law No. 21 of 1992 on Sail and seafaring	**Article 83** People with disability and sick people reserve the right to special treatment in the service of transport in the waters.		- Most of the ports has not been designed or equipped with accessibility, such as a high counter, emplacement that is not parallel to the floor of the car, floor difference without ram, etc. - The design of the ship complicates the entry access of people with disabilities to go into the ship or their mobility inside the ship. - The signs, markers, and information still cannot be accepted and understood by everyone. - Not all of the staff in the ship is aware of and able to serve users with disabilities well and properly (Konas Difabel).
Government Regulation No.82 of 1999 on Water Transportation	**Article 86** (1) Transport companies in the waters must provide facilities and special services for passengers with disabilities or the sick people. (2) The provision of facilities and special services as referred to paragraph (1) are: a. Giving priority to obtain transportation tickets b. Providing services to facilitate going up and down from ship c. Providing facilities for people with disabilities during the ship d. Providing a place for sick people who require appointed in a sleeping position as well with the place and facilities for passengers with infectious diseases.		

Social Protection

UNCRPD

Article 28: Adequate standard of living and social protection

1. States Parties recognise the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realisation of this right without discrimination on the basis of disability.
2. States Parties recognise the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realisation of this right, including measures:
   (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
   (b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
   (c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;
   (d) To ensure access by persons with disabilities to public housing programmes;
   (e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

Laws	Articles	Sanction	Comment
Constitution 1945	**Article 28H** (3) every person has the rights for social protection to enable dignified self-development		
Law No. 4 of 1997 on Persons with Disability	**Article 16** The government and/or community administering the means of: 1. rehabilitation; 2. social assistance; 3. Social welfare standard maintenance.	Not specified	JSPCA, PKSA, KUBE, PKH, JLSU are examples of social welfare programmes that can be accessed by PWDs. Most of these social protection programmes lack elements of empowerment, education, and training. Investment in inadequateand coverage of each programme is very low. An added cost because of disability is not considered.
This law is implemented through Government Regulation No. 43 of 1998 on Efforts and Undertaking in Social Welfare for People with Disability.	**Article 1 paragraph 4:** Efforts and undertaking in social welfare for People with Disability are actualised through: a. Equal opportunity in all b. aspects of basic rights b. Care and rehabilitation c. Social assistance d. Maintenance of quality of social welfare status	Not specified	
Law No. 11 of 2009	**Article 4** The State is responsible to provide social welfare scheme. **Article 5** (1) provision of social welfare scheme is targeted for—(2.c. persons with disabilities)		

Laws	Articles	Sanction	Comment
The Law No. 39 of 1999 on Human Rights	**Article 41** (2) Any People with Disabilities, elderly, pregnant women, and children, are entitled to obtain facilities and special treatment. **Article 42** In the event of old age, physical and/or mental disability, every citizen has the right to special care, education, training and assistance at the expense of the state, ensuring an existence worthy of human dignity, and building his self-confidence and capacity to participate in the life of nation, state, and society.		1. Insurance scheme is not universally applied to all employees. State employees, military personnel do have social security protection from the state. Private company employees, especially outsourced contract labour, are not always protected. 2. If an employee has an existing disability while recruited to a certain job, s/he is considered not eligible for (private) insurance 3. The lack of access to adequate housing for people with disabilities. Due to their disabilities, it is not easy access to bank credit mortgage because they are considered to be unable to pay the monthly repayment. 4. People with disabilities have to pay higher transportation cost because of lack of accessibility in the public infrastructures but this added costs have never been accounted in the existing benefits/support. 5. There is no guarantee of safety and the provision of accessible workplaces for people with disabilities. 6. There is a clause in a workplace accident insurance that discriminates people with disabilities, because in case of an accident, people with disabilities are unable to claim the insurance. Workers with disabilities tend to get lower wages (Konas Difabel 2011).
Law No. 3 of 1992 onSocial Security for Labourers	This law provides workers with social protection programmes in the forms of security for accidents, death, old age and health. Compensation related to disability is provided for accident and old age (article 9 and 14)		
Law No. 40 of 2004 on the National Security System	Aborted by the Constitutional Court and replaced by Law No. 24 of 2011 on the State Institution to provide social security.	The word disability was not in the body of the law but in the explanation to Article 57(e) to explain that PT ASABRI is responsible to provide disability compensation to member of the Indonesian Army.	Access to insurance scheme or programmes depends on leadership of DPOs.

The Right To Health

UNCRPD

Article 25: Health

States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive,including health-related rehabilitation. In particular, States Parties shall::

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Laws	Articles/Provisions	Sanction	Comment
Law No. 36 of 2009 on Health	**Chapter I article 4:** every person has the rights to health. **Chapter VII Part 3 article 138 to 140** provides availability and accessibility of health services for the elderly and persons with disabilities **Chapter IX on Mental Health articles 144 -151** Provision of accessible mental health services, including community-based programmes.	No specified Sanctioned only for patient safety	Many health services for the disabled are expensive specialised services not affordable by the poor. Early detection and early intervention has not been a priority in the national health system.
Law No. 40 of 2004 on the National Security System	Aborted by the Constitutional Court and replaced by **Law No. 24 of 2011** on the State Institution to provide social security		DPOs are struggling to help their constituents to get access to important health services and Jamkesmas
Law No. 24 of 2011 on the State Institution to provide social security.	**Article 57** point 'e' on compensation provided through Program Asuransi Sosial Angkatan Bersenjata Republik Indonesia for military personnel who are disabled during or off duty.		

The Right to Political Participation

United Nations Convention on the Rights of Persons with Disabilities, 2006

Article 29, Participation in political and public life
States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake:

(a) To ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:
- (i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
- (ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;
- (iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice;

(b) To promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:
- (i) Participation in non-governmental organisations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;
- (ii) Forming and joining organisations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

Laws	Articles/Provisions	Sanction	Comment
Law no. 10 of 2008 on Election	Stipulates that, for a person to be eligible to be elected, that person must be able to speak, write and read in the Indonesian language.	Not specified	Insensitive to the situation and conditions of persons with disabilities and can be used to prevent their participation.
Law no. 12 of 2003 on General Election	Voters with disability are to be facilitated in exercising their political rights to elect and to be elected, has failed in its implementation.	Not specified	Those requirements narrow down the opportunity of PWD who can only communicate in sign language or braille. No Indonesian political party has devised a concrete plan for the protection of PWD (Irwanto).
Law No. 3 of 1999 on General Election	**Article 29** (1) Someone must be mentally and physically healthy to obtain the right to vote	Not specified	In the 2009 general election, PWDs were confronted with number of problems. This means Law No. 12 of 2003 has failed in its implementation.
Law No. 4 of 2000 on the Amendment of General Election Law	**Article 9** Those who can be promoted as General Election Commission members as defined in paragraph (3) are Indonesian citizens with conditions as said below: Point 'a'physically and mentally sound	Not specified	These laws do not provide sufficient explanation of those articles (definition or criteria of being 'physically or mentally sound'). The irony of such legislation is that the votes of persons with disability are sought but at the same time their chances of being elected to public office are denied (Irwanto, Eva Kasim, and Asmin Fransiska).
Law No. 31 of 2002 on Political Party	**Article 10** (1) Indonesian citizens can become political party members if they are 17 (seventeen) years old or married/have ever been married. (2) The membership of political party is voluntary, open and non-discriminative for every Indonesian citizen that agrees with the bylaw budget of the related party.	Not specified	

Access To Justice

United Nations Convention on the Rights of Persons with Disabilities, 2006

Article 13, Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 14, Liberty and security of person

States Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;
(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

Article 5, Equality and nondiscrimination

1. States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures that are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Laws	Articles/Provisions	Sanction	Comment
Constitution 1945	**Article 27(1)**—equal status before the law **Article 28D (2)**—equal treatment before the law	Not specified	Limitations may be put in place by law in order to satisfy just demands based upon considerations of morality, religious values, security, and public order in a democratic society (Colbran, 2010)
Law No. 39 of 1999 on Human Rights	**Article 17** Every person, without discrimination, has the right to get access to justice by applying petition, complaints and lawsuits, in criminal, civilas or administration case as well to a hearing by and independent and impartial tribunal, according to the legal procedure that guarantees the objective inspection by the fair and honest judge to reach the right and fair verdict.	Not specified	PWDs generally have poor knowledge of their rights and the ability and willingness of PWDs to access the formal justice sector is low. Grievance handling does not tend to be effective as the knowledge of and sensitivity towards the rights of PWDs among law enforcement agencies is limited. PWDs experience difficulties in accessing free legal aid and information, and they cannot physically access government buildings such as courtrooms and police stations without substantial assistance. PWDs have, however, shown a willingness to use semi-formal mechanisms such as the complaints mechanism offered by Komnas HAM and the Ombudsman, and court supported mediation. However, awareness of the role of these mechanisms is limited (Colbran 2010). People who have physical impairment cannot access governmental building (court room, police station) without any help. Many of the PWDs also are not aware of their rights and they have difficulties in accessing justice for free. The handling of complaints of PWDs is not effective because of the knowledge and the awareness of the law officers on PWDs is still limited.

Participation in Cultural Life, Recreation, Leisure and Sport

United Nations Convention on the Rights of Persons with Disabilities, 2006

Article 30, Participation in cultural life, recreation, leisure and sport

1. States Parties recognise the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:
   (a) Enjoy access to cultural materials in accessible formats;
   (b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
   (c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance..
2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilise their creative, artistic and intellectual potential, not only for their own benefit but also for the enrichment of society.
3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.
4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture
5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:
   (a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
   (b) To ensure that persons with disabilities have an opportunity to organise, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
   (c) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
   (d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
   (e) To ensure that persons with disabilities have access to services from those involved in the organisation of recreational, tourism, leisure and sporting activities.

Laws	Articles/Provisions	Sanction	Comment
Law No. 3 of 2005 on National Sport System	**Part VII on the Arrangement and Development of sport for the disabled** **Article 30** This article suggests that sport for the disabled is important to be organised and developed to improve health, build self-esteem, and achievement in sport. The provision and organisation of sport for the disabled should be held by an institution that receive mandate from community or state to conduct training and competition at all level. Government at the central and district level is obliged to form centres and /or institution to attend to the organisation and development of sports for the disabled.	Not specified	- The sports facilities for people with disabilities are still inadequate - The significant difference between the appreciation or award for the athletes with disabilities and the artists with disabilities is still existed. - The absence of the regular budget from the government to the development of achievement for people with disabilities. - The lack of news about sports of people with disabilities - Outdoor sports are not accessible for people with disabilities - The development of athletes with disabilities is still considering their type of disabilities (Konas Difabel 2011).

Laws	Articles	Sanction	Comment
Law No. 10 of 2009 on Tourism	**Article 1.6** Accessibility should be considered in the development of a tourist facilities. **Article 21** Tourists who have physical limitations, children and elderly are entitled to a special facility according to their needs.	Not specified	- Art campus buildings, museums and touristic places are not yet accessible for people with disabilities. - Certain art majors in art educational institution do not accept people with disabilities. - The unavailability of inventory mobility aids in public places. - The culture of mutual help and sensitivity are fading. - The unavailability of the assistive facilities and accommodation for arts and cultural ambassadors with disabilities. - The unavailability of the language assistant or translator. - Some people are still forcing other people with speech and hearing disability to speak. - The unavailability of accessible transportation to and within the destination. - The appreciation and exhibition for people with disabilities are only held in special moments or charities (Konas Difabel. 2011)

Natural Disaster and Emergency

United Nations Convention on the Rights of Persons with Disabilities, 2006

Article 11, Situations of risk and humanitarian emergencies
States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters..

Laws	Articles/Provisions	Sanction	Comment
Law No. 24 of 2007 on Disaster Management	**Article 55** (1) Protection for vulnerable group as referred to in Article 48 letter 'e' shall give priority to the vulnerable group in the forms of rescue, evacuation, protection, healthcare, and psychosocial services. (2) Vulnerable group as referred to in paragraph (1) shall comprise: a. infants, pre-schoolers, and children; b. pregnant women or nursing mothers; c. **the disabled**; and d. the elderly. **Article 69** (1) The Government and Regional governments shall provide grief and disability compensation money to disaster victims. (2) Disaster victims who have lost their livelihood can obtain soft loan for productive businesses. (3) The Government and Regional governments shall bear responsibility for providing grief and disability compensation money as referred to in paragraph (1) and soft loan for productive businesses as referred to in paragraph (2). (4) Procedures and amount of aid as referred to in paragraph (1) and paragraph (2) shall be regulated further by a Government Regulation. (5) Community elements may participate in provision of aid.	Not specified	**Before a disaster** - There are lacks of disaster preparedness programmes that are sensitive to the people with disabilities. - The existing programme, such as disaster risk reduction education programme, often does not involve people with disabilities (person with disability are mostlyseen as an object in the programme, not as the subject, for example in evacuation simulation programme) - Lack of accessibility of information and educational teaching materials related to disaster risk reduction (the available information is hardlyaccessible by people with disabilities with certain criteria, such as people with sight and hearing disability) - Lack of accessible early warning system for the people with disabilities. **During a disaster** Due to the unpreparedness of the people with disabilities in the pre-disaster period, (or disengagement in disaster mitigation), they are often left behind when disaster strikes. **After a disaster** - Lack of specific data collection on the condition of the people with disabilities (usually it is only about minor injuries, severe and dead). - Lack of physical and non-physical accessibility (information and services) for people with disabilities in refugee camps. - Lack of special needs identification for the people with disabilities after the disaster (Konas Difabel).

The Right to Marriage

United Nations Convention on the Rights of Persons with Disabilities, 2006
Article 23
Respect for and the family

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
   (a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognised;
   (b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided;
   (c) Persons with disabilities, including children, retain their fertility on an equal basis with others.
2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, ward ship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.
3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realising these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.
4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.
5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Laws	Articles/Provisions	Sanction	Comment
Law No. 1 of 1974 on Marriage	**Chapter 1 Article 4 (paragraph 2)**: Grant permission to a husband who will have more than one wife if the wife: a. is unable to perform his duty as a wife b. gets disability or disease that is incurable c. is unable to produce off-spring	Not specified	
Government Regulation No. 9 of 1975 on The Implementation of Law No. 1 of 1974 on Divorce Acts	**Article 19** Granting permission to divorce a wife if such elements are met in article 4 (paragraph 2) above.	Not specified	The prevailing notion that a disable spouse is lacking the ability to contribute to their family does not comply as well with the Indonesian Constitution

Annex 7: Specifications for Defining Disability using the Census and Riskesdas Data

Census 2010

There are five census questions on disability as shown in Chapter IV, Table 4.1(Disability Prevalence [%] by Age, Gender, and Degree of Disability Using Indonesian Census, 2010).These ask about difficulties in five functional domains.The questions follow:

1. Do you have difficulty in seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing stairs?
4. Do you have difficulty remembering, concentrating or communicating with others due to a physical or mental condition?
5. Do you have difficulty in self-care?

The response categories are 'None', 'A Little'or 'A Lot'.

A person was classified as having a mild disability if they had a little difficulty in one or more domains but did not have a lot of difficulty in any domain.If a person had a lot of difficulty in at least one domain, they were classified as having a severe disability.A person was considered to have multiple disabilities if they had difficulties in more than one domain, regardless of the level of severity. Table A1 Classification of Hypothetical Respondents to Census Questions gives examples of how five hypothetical respondents would be classified.

Table A1 Classification of Hypothetical Respondents to Census Questions

Respondent	Vision	Hearing	Mobility	Remembering	Self-Care	Mild	Severe	Multiple
1	A little					XXX		
2		A lot					XXX	
3	A little	A little				XXX		XXX
4			A lot		A lot		XXX	XXX
5				A lot	A little		XXX	XXX

Riskesdas 2007

The first step was to group the 20 Riskesdas questions into functional domains—vision, hearing, mobility, communication, cognition, self-care, social, and participation.The questions appear in Chapter IV, Table 4.1 (Disability Prevalence [%] by Age, Gender, and Degree of Disability Using Indonesian Census, 2010)but are repeated below.They are followed by Table A2 (Functional Domains Using RiskesdasQuestions),which shows how the questions are grouped into functional domains.

In the last one month:

1. How difficult is it to see and to recognise people across the street (approximately within 20 meters) although you have used glasses/contact lenses?

2. How difficult is it to see and recognise objects in arm long/reading distance (30cm) although you have used glasses/contact lenses?
3. How difficult is it to hear people speak in a normal voice who stand on the other side of the room, although you have used hearing aids?
4. How difficult is it to hear people talking with others in a quiet room, although you have used hearing aids?
5. How bad is the feeling of pain / discomfort?
6. How bad is the feeling of short of breath after doing light exercise? For example climbing 12 steps of stairs?
7. How bad is the suffering from a cough or sneeze for 10 minutes or more in one attack?
8. How often is it to experience sleep disturbances (e.g., easy sleepiness, frequent awakening at night or wake up earlier than usual)
9. How often is it to experience health problems that affect the emotional state of feeling sad and depressed?
10. How difficult is it to stand within 30 minutes?
11. How difficult is it to do long distance walk, about one kilometre?
12. How difficult is it to concentrate on activities or to remember anything for 10 minutes?
13. How difficult is it to clean the whole body like having a shower?
14. How difficult is it to wear clothes?
15. How difficult is it to do daily activity?
16. How difficult is it to understand the speech of others?
17. How difficult is it to interact / associate with people who have not known before?
18. How difficult is it to maintain friendships?
19. How difficult is it to do the job that becomes responsibilities as a member of the household?
20. How difficult is it to participate in community activities (gathering, pengajian, religious activities, or other activities)?

Response categories:None, A little (ringan), Mild (sedang), Severe (berat), Very Severe (sangat berat).

Table A2 Functional Domains Using Riskesdas Questions

Respondent	Riskesdas Questions
Vision	1, 2
Hearing	3, 4
Mobility	6, 10, 11
Communication	16

Respondent	Riskesdas Questions
Cognition	12
Self-Care	13, 14, 15
Social	9, 17, 18
Participation	19, 20

When using the Riskesdas data two different methods of disability classification were used.The first mirrored the method used with the census data. Having a little difficulty (response categories 2 or 3) in at least one of the functional domains but never having a lot of difficultymeant the person had a mild disability.If they had a lot of difficulty in at least one domain (response categories 4 or 5) then they were considered to have a severe disability.

The second did not divide people intomild and severe but rather classified all people with disabilities the same but using two different thresholds. People considered to have a disability using the low threshold had either mild or severe disabilities. People considered to have a disability using the high threshold were only those who had severe disabilities. This method was used because countries quite often only report one prevalence rate for disability, so the analysis was meant to show what the results would be if the threshold were drawn such that only people with severe disabilities were included, or whether a broader definition was used the encompassed people with more mild disabilities.

Annex 8: Distribution of Households with Disabled Persons and Disabled Individuals across Deciles, Riskesdas 2007

Expenditure Decile	HH without Elderly		HH with Elderly (age 60+)		All Households	Disabled Individuals		All Individuals
	Low Threshold	High Threshold	Low Threshold	High Threshold		Low Threshold	High Threshold	
1 (lowest)	9.06	10.02	9.93	10.55	10.00	10.09	10.81	10.00
2	9.11	9.26	10.25	10.67	10.00	10.08	10.29	10.00
3	9.37	9.35	10.06	10.50	10.00	10.06	10.17	10.00
4	9.65	9.49	10.34	10.35	10.00	10.21	10.21	10.00
5	9.80	9.89	10.41	10.56	10.00	10.20	10.41	10.00
6	10.20	10.45	10.36	10.19	10.00	10.28	10.27	10.00
7	10.43	10.26	10.23	10.14	10.00	10.25	10.10	10.00
8	10.34	9.95	9.94	9.54	10.00	9.90	9.55	10.00
9	10.82	10.55	9.55	9.11	10.00	9.74	9.42	10.00
10 (highest)	11.23	10.78	8.93	8.40	10.00	9.20	8.76	10.00
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Annex 9: Poverty Rates of Households by Province and the Presence of a Disabled Household Member (Low Threshold), Riskesdas 2007

Province	Household without disabled members						Household with disabled members					
	Urban		Rural		Urban + Rural		Urban		Rural		Urban + Rural	
	%	N	%	N	%	N	%	N	%	N	%	N
NanggroeAceh-Darussalam	15.88	115,970	24.57	333,341	22.33	449,311	14.09	67,667	25.16	337,506	23.31	405,173
North Sumatra	11.08	788,944	8.88	925,676	9.90	1,714,620	12.11	392,454	10.06	638,763	10.84	1,031,217
West Sumatra	8.39	205,465	11.80	346,604	10.53	552,069	10.66	129,989	11.55	404,063	11.34	534,052
Riau	6.61	220,114	8.78	488,068	8.10	708,182	10.86	136,074	12.41	240,937	11.85	377,011
Jambi	14.03	116,464	5.22	255,324	7.98	371,788	12.93	53,283	8.19	212,186	9.14	265,469
South Sumatra	12.06	384,741	11.15	738,488	11.46	1,123,229	14.31	125,653	12.12	299,956	12.77	425,609
Bengkulu	12.50	55,585	13.15	160,789	12.98	216,374	14.13	33,841	17.26	100,119	16.47	133,960
Lampung	10.13	221,505	11.24	838,941	11.01	1,060,446	13.52	118,436	13.66	487,015	13.63	605,451
Bangka Belitung	2.11	45,313	11.72	61,079	7.63	106,392	4.22	58,393	12.08	94,429	9.07	152,822
Riau Island	8.07	199,353	19.05	45,225	10.10	244,578	7.28	66,959	14.86	23,465	9.25	90,424
DKI Jakarta	3.61	1,035,990	-	-	3.61	1,035,990	5.55	519,520	-	-	5.55	519,520
West Java	5.98	2,390,183	7.68	2,482,554	6.85	4,872,737	8.11	2,363,437	8.84	2,365,064	8.48	4,728,501
Central Java	11.36	1,799,156	13.10	2,631,424	12.39	4,430,580	15.19	1,514,855	16.04	2,293,102	15.7	3,807,957
DI Yogyakarta	8.78	409,613	13.81	234,455	10.61	644,068	21.91	150,732	17.79	143,154	19.9	293,886
East Java	10.30	2,205,601	13.74	3,213,335	12.34	5,418,936	14.96	1,599,351	18.02	2,521,199	16.83	4,120,550
Banten	6.14	717,139	10.40	597,530	8.08	1,314,669	8.31	334,208	10.78	354,689	9.58	688,897
Bali	1.85	244,517	2.13	196,631	1.97	441,148	3.87	180,559	1.44	201,618	2.59	382,177
West Nusa Tenggara	18.03	181,624	10.70	276,519	13.60	458,143	21.49	213,517	10.37	425,966	14.08	639,483
East Nusa Teng-gara	16.69	82,840	16.61	325,424	16.62	408,264	22.24	44,486	18.13	340,060	18.61	384,546
West Kalimantan	4.11	108,343	3.55	382,959	3.67	491,302	4.73	107,236	5.73	251,024	5.43	358,260
Central Kaliman-tan	2.70	82,232	5.54	190,530	4.69	272,762	7.58	45,583	5.44	134,762	5.98	180,345
South Kaliman-tan	3.70	184,437	4.23	258,110	4.01	442,547	6.65	134,814	5.00	247,455	5.58	382,269
East Kalimantan	5.84	239,891	9.65	193,937	7.54	433,828	7.23	113,316	12.08	86,144	9.32	199,460
North Sulawesi	2.78	96,480	5.35	143,224	4.31	239,704	3.43	51,250	5.44	92,135	4.73	143,385
Central Sulawesi	8.28	34,915	12.04	167,889	11.39	202,804	6.62	61,727	14.74	230,741	13.02	292,468
South Sulawesi	3.21	264,305	4.02	428,281	3.71	692,586	5.55	219,000	4.57	675,789	4.81	894,789
Southeast Sulawesi	1.29	53,425	9.59	158,670	7.50	212,095	2.05	37,853	9.60	157,951	8.14	195,804

Province	Household without disabled members						Household with disabled members					
	Urban		Rural		Urban + Rural		Urban		Rural		Urban + Rural	
	%	N	%	N	%	N	%	N	%	N	%	N
Gorontalo	3.43	29,752	17.03	63,159	12.67	92,911	9.20	24,108	18.86	75,642	16.53	99,750
West Sulawesi	3.89	12,875	13.71	56,899	11.90	69,774	8.98	14,921	14.41	88,482	13.62	103,403
Maluku	9.89	47,870	25.77	107,754	20.88	155,624	10.38	15,015	21.56	62,280	19.39	77,295
North Maluku	5.17	26,511	15.13	96,438	12.98	122,949	8.19	6,800	12.85	37,410	12.14	44,210
West Irian Jaya	4.71	27,372	32.34	51,921	22.80	79,293	15.36	18,415	24.43	29,788	20.96	48,203
Papua	4.89	63,516	41.00	155,366	30.52	218,882	6.76	18,826	48.48	77,660	40.34	96,486
Total	**8.23**	**12,692,041**	**11.38**	**16,606,544**	**10.01**	**29,298,585**	**11.22**	**8,972,278**	**13.12**	**13,730,554**	**12.37**	**22,702,832**

Annex 10: Poverty Rates of Households by Province and the Presence of a Disabled Household Member (High Threshold), Riskesdas 2007

Province	Household without disabled members						Household with disabled members					
	Urban		Rural		Urban + Rural		Urban		Rural		Urban + Rural	
	%	N	%	N	%	N	%	N	%	N	%	N
Nanggroe Aceh-Darussalam	15.62	150,296	25.00	488,431	22.79	638,727	13.41	33,341	24.51	182,416	22.8	215,757
North Sumatra	10.95	1,006,745	9.22	1,278,041	9.98	2,284,786	14.16	174,653	10.01	286,398	11.6	461,051
West Sumatra	8.68	268,902	11.71	525,147	10.68	794,049	11.65	66,552	11.57	225,520	11.6	292,072
Riau	7.01	286,086	9.70	620,066	8.85	906,152	13.24	70,102	11.56	108,939	12.2	179,041
Jambi	13.79	145,914	5.69	379,256	7.94	525,170	13.01	23,833	10.35	88,254	10.9	112,087
South Sumatra	12.66	450,248	11.40	910,935	11.82	1,361,183	12.26	60,146	11.61	127,509	11.8	187,655
Bengkulu	13.26	74,761	13.79	210,977	13.65	285,738	12.38	14,665	18.69	49,931	17.3	64,596
Lampung	11.12	288,247	11.54	1,126,290	11.46	1,414,537	12.40	51,694	15.43	199,666	14.8	251,360
Bangka Belitung	2.60	72,790	11.58	108,702	7.98	181,492	4.94	30,916	12.75	46,806	9.64	77,722
Riau Island	7.85	232,657	18.56	58,011	9.98	290,668	8.06	33,655	12.53	10,679	9.14	44,334
DKI Jakarta	3.87	1,310,901	–	–	3.87	1,310,901	6.33	244,609	–	–	6.33	244,609
West Java	6.52	3,517,320	7.78	3,614,391	7.16	7,131,711	8.52	1,236,300	9.62	1,233,227	9.07	2,469,527
Central Java	11.87	2,556,781	13.65	3,756,782	12.93	6,313,563	17.30	757,230	17.10	1,167,744	17.2	1,924,974
DI Yogyakarta	10.16	482,928	14.30	298,713	11.74	781,641	25.76	77,417	19.18	78,896	22.4	156,313
East Java	10.84	3,003,155	14.23	4,408,906	12.86	7,412,061	17.56	801,797	20.23	1,325,628	19.2	2,127,425
Banten	7.00	893,790	10.59	782,051	8.67	1,675,841	5.87	157,557	10.36	170,168	8.2	327,725
Bali	2.49	334,666	2.04	285,596	2.28	620,262	3.51	90,410	1.13	112,653	2.19	203,063
West Nusa Tenggara	18.46	276,512	10.56	477,162	13.46	753,674	23.25	118,629	10.36	225,323	14.8	343,952
East Nusa Teng-gara	16.95	108,696	17.00	482,005	16.99	590,701	28.42	18,630	18.41	183,479	19.3	202,109
West Kalimantan	4.10	165,518	3.98	523,952	4.01	689,470	5.44	50,061	6.44	110,031	6.13	160,092
Central Kaliman-tan	3.48	106,734	5.56	265,384	4.96	372,118	9.33	21,081	5.23	59,908	6.3	80,989
South Kaliman-tan	4.17	248,114	4.17	391,814	4.17	639,928	7.66	71,137	6.10	113,751	6.7	184,888
East Kalimantan	6.13	306,641	10.25	240,816	7.94	547,457	7.32	46,566	11.27	39,265	9.13	85,831
North Sulawesi	3.05	123,362	5.49	194,400	4.54	317,762	2.77	24,368	4.92	40,959	4.12	65,327
Central Sulawesi	7.41	59,056	12.85	264,149	11.86	323,205	6.93	37,586	15.07	134,481	13.3	172,067
South Sulawesi	3.68	366,028	4.33	690,446	4.11	1,056,474	6.11	117,277	4.40	413,624	4.78	530,901
Southeast Sulawesi	1.24	73,850	9.20	239,149	7.32	312,999	3.14	17,428	10.83	77,472	9.42	94,900

Province	Household without disabled members						Household with disabled members					
	Urban		Rural		Urban + Rural		Urban		Rural		Urban + Rural	
	%	N	%	N	%	N	%	N	%	N	%	N
Gorontalo	4.57	37,467	17.31	90,064	13.57	127,531	9.31	16,393	19.35	48,737	16.8	65,130
West Sulawesi	4.94	19,359	13.79	98,436	12.34	117,795	10.48	8,437	14.85	46,945	14.2	55,382
Maluku	9.87	54,923	25.40	135,431	20.92	190,354	10.99	7,962	19.60	34,603	18	42,565
North Maluku	5.73	28,967	14.66	116,393	12.88	145,360	6.19	4,344	13.38	17,455	12	21,799
West Irian Jaya	7.62	37,345	31.06	66,177	22.60	103,522	15.07	8,442	22.63	15,532	20	23,974
Papua	5.20	74,502	42.29	196,148	32.08	270,650	6.49	7,840	49.85	36,878	42.3	44,718
Total	**8.70**	**17,163,261**	**11.63**	**23,324,221**	**10.39**	**40,487,482**	**12.37**	**4,501,058**	**13.96**	**7,012,877**	**13.3**	**11,513,935**

Annex 11: Logit Results for Presence of Any Disability, Selected Provinces, 2010 Census

	B	S.E.	Wald	Sig.	Odds Ratio
Aged 0–17	-2.969	0.003	815207.278	0.000	0.051
Aged 18–40	-3.390	0.004	920911.156	0.000	0.034
Aged 41–60	-1.655	0.003	385043.067	0.000	0.191
Aged 61+	-- Baseline --				
West Sumatra	0.206	0.005	1406.620	0.000	1.229
South Sumatra	0.053	0.004	143.446	0.000	1.055
West Java	-0.148	0.004	1776.122	0.000	0.863
Central Java	-0.628	0.006	10395.060	0.000	0.534
DI Yogyakarta	-0.518	0.005	11233.469	0.000	0.596
East Java	-0.457	0.004	11822.675	0.000	0.633
East Nusa Tenggara	0.092	0.006	212.755	0.000	1.096
South Kalimantan	-0.391	0.007	3331.535	0.000	0.676
South Sulawesi	0.154	0.005	1115.998	0.000	1.166
Maluku	0.010	0.007	2.157	0.142	1.010
DKI Jakarta	-- Baseline --				
Rural	0.049	0.003	335.988	0.000	1.050
Urban	-- Baseline --				
Male	-0.111	0.002	2574.750	0.000	0.895
Female	-- Baseline --				
Household Size	-0.004	0.000	221.856	0.000	0.996
Constant	-0.729	0.003	44889.312	0.000	0.482

Note: Due to the limited capacity of the computer to run regression for 33 provinces with 237.6 million of observations, this above census regression is based on the SNSAP-PWD sample only.

Persons with Disabilities in Indonesia: Empirical Facts and Implications for Social Protection Policies

In Indonesia as in many other countries of the world, persons with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than persons without disabilities. This is partly because people with disabilities experience barriers in accessing services that many of us have long taken for granted, including health, education, employment, and transport as well as information.These difficulties are exacerbated in less advantaged communities.

In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer, and mental health disorders.

Persons with Disabilities in Indonesia: Empirical Facts and Implications for Social Protections Policies provides for the first time in Indonesian history a comprehensive empirical overview on nationally representative disability statistics. Besides the use of Riskesdas 2007 and Census 2010 data, this report makes use of a unique household survey of 2,000 individuals with disabilities in 11 provinces that was conducted in March 2012. The report further includes a review of the Indonesian and international legal framework related to persons with disabilities and discusses a variety of urgent policy interventions that aim at improving the life of persons with disabilities in Indonesia, particular those who live in poverty.

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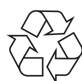

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