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PUSKAPA
#A Fair Chance For All Children

Social Care for Children Living in Vulnerable Households in Indonesia

Understanding social care practices among families of migrant and informal workers

Center on Child Protection
and Wellbeing
University of Indonesia
(PUSKAPA)
2025

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INKLUSI seeks to increase the participation of marginalized groups in Indonesia's socio-cultural, economic and political development, and the benefits they derive from it. INKLUSI works with the Government of Indonesia and Civil Society Organizations to promote gender equality, the rights of persons with disabilities, and social inclusion. The information presented in this publication is the responsibility of the production team and does not necessarily represent the views of the Government of Indonesia and the Government of Australia.

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Foreword

This study reflects our commitment to advancing policies and fostering multi-stakeholder collaboration to ensure inclusive social care rights for vulnerable groups, especially children. It seeks to examine social care practices for children in vulnerable families in rural Indonesia by gathering insights on relevant policies, programs, and both government and community-driven initiatives. The study also explores the influence of social norms on caregiving practices.

We define social care as a set of activities and relationships to fulfill the material and emotional needs of individuals who depend on others for their wellbeing. This study found that social care remains widely regarded as a family responsibility, driven by deeply embedded social norms. Furthermore, government support for social care has not been integrated into community-based caregiving practices. As a result, social care practices place disproportionate burdens on family members, particularly women. At the same time, we see these existing practices as opportunities to strengthen community roles in providing social care.

With this context, we recommend bridging national social care policies with the needs of local communities and empowering their role in shaping a social care system that works for them. It is our hope that implementing the recommendations in this report can support the achievement of Indonesia's 2025-2045 National Long-Term Development Plan (RPJPN) and the 2025-2029 National Medium-Term Development Plan (RPJMN) in creating an inclusive social care system.

We appreciate INKLUSI's commitment to working alongside the government and civil society organizations to ensure that women and other vulnerable groups can fully participate in society and improve their quality of life. We also extend our gratitude to all study participants and informants who shared their insights and experiences. The implementation of this study at the local level was also made possible through the support of PEKKA and Migrant Care as INKLUSI's civil society organization partners.

Warm regards,
The Research Team

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Abbreviations

Abbreviation	Description
ABK	*Anak Berkebutuhan Khusus* Children with Special Needs
API	Akademi Paradigta Indonesia
Bappenas	*Kementerian Perencanaan Pembangunan Nasional* Ministry of National Development Planning
BKB	*Bina Keluarga Balita* Early Childhood Family Development Program
BKKBN	*Badan Kependudukan dan Keluarga Berencana Nasional* National Population and Family Planning Agency
BLT	*Bantuan Langsung Tunai* Direct Cash Transfer Program
BPNT	*Bantuan Pangan Non Tunai* Non-Cash Food Assistance Program
BRIN	*Badan Riset dan Inovasi Nasional* National Research and Innovation Agency
BSN	*Badan Standardisasi Nasional* National Standardization Agency
CSO	Civil Society Organization
Dapodik	*Data Pokok Pendidikan* Basic Education Database
DESBUMI	*Desa Peduli Buruh Migran* Migrant Worker-Friendly Village
Desmigratif	*Desa Migran Produktif* Productive Migrant Village
Dinsos	*Dinas Sosial* Office of Social Services
DP3AKB	*Dinas Pemberdayaan Perempuan, Perlindungan Anak, dan Keluarga Berencana* Office of Women's Empowerment, Child Protection, and Family Planning
DTKS	*Data Terpadu Kesejahteraan Sosial* Integrated Social Welfare Database
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
JKN	*Jaminan Kesehatan Nasional* National Health Insurance

Abbreviation	Description
KB	*Kelompok Bermain* Playgroup
Kemendikbud	*Kementerian Pendidikan dan Kebudayaan* Ministry of Education and Culture
Kemenkes	*Kementerian Kesehatan* Ministry of Health
Kemenko PMK	*Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan* Coordinating Ministry for Human Development and Cultural Affairs
KemenPPPA	*Kementerian Pemberdayaan Perempuan dan Perlindungan Anak* Ministry of Women's Empowerment and Child Protection
Kemensos	*Kementerian Sosial* Ministry of Social Affairs
KII	*Key Informant Interview*
KK	*Kartu Keluarga* Family Card
LKS	*Lembaga Kesejahteraan Sosial* Social Welfare Institution
LKSA	*Lembaga Kesejahteraan Sosial Anak* Child Social Welfare Institution
LLT	*Layanan Lansia Terintegrasi* Integrated Older People Care
LPKA	*Lembaga Pembinaan Khusus Anak* Juvenile Rehabilitation Center
NTB	*Nusa Tenggara Barat* Province of West Nusa Tenggara
OMS	*Organisasi Masyarakat Sipil* Civil Society Organization
OPD	*Organisasi Perangkat Daerah* Subnational Apparatus Organization
P2K2	*Pertemuan Peningkatan Kemampuan Keluarga* Family Capacity Enhancement Meeting
PATBM	*Perlindungan Anak Terpadu Berbasis Masyarakat* Community-Based Integrated Child Protection
PAUD	*Pendidikan Anak Usia Dini* Early Childhood Education
PAUD-HI	*Pengembangan Anak Usia Dini Holistik Integratif* Integrated and Holistic Early Childhood Education
Pemdes	*Pemerintah Desa* Village Government

Abbreviation	Description
PIP	*Program Indonesia Pintar* Smart Indonesia Program
PKH	*Program Keluarga Harapan* Family Hope Program
PKK	*Pemberdayaan Kesejahteraan Keluarga* Family Welfare Empowerment Program
PKP	*Pusat Kendali Penelitian* Research Control Center
PMI	*Pekerja Migran Indonesia* Indonesian Migrant Workers
PUSPAGA	*Pusat Pembelajaran Keluarga* Family Learning Center
RKP	*Rencana Kerja Pemerintah* Government Work Plan
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* National Medium-Term Development Plan
RPJPN	*Rencana Pembangunan Jangka Panjang Nasional* National Long-Term Development Plan
RT	*Rukun Tetangga* Neighborhood Association
SLB	*Sekolah Luar Biasa* Special Needs School
SMP	*Sekolah Menengah Pertama* Junior High School
SPM	*Standar Pelayanan Minimal* Minimum Service Standards
TARA	*Taman Asuh Anak Ceria* Happy Childcare Program
TK	*Taman Kanak-Kanak* Kindergarten
TPA	*Taman Penitipan Anak* Daycare Center
TPQ	*Taman Pendidikan Al-Quran* Quranic Education Centers
UPT PPA	*Unit Pelaksana Teknis Perlindungan Perempuan dan Anak* Technical Implementing Unit for Women's and Children's Protection

Glossary

Abandoned children
This study examines community perspectives on abandoned children, which is defined as children who do not receive adequate parental care and support from their parents.

Community cadres
In this study, community cadres refer to community members who provide essential services such as healthcare and education. This includes Community-Based Health Service Post (Posyandu), PKK cadres, as well as PAUD, kindergarten, or Quranic teachers.

Vulnerable families
Vulnerable families are families who are at high risk of being unable to fulfill their basic needs due to social exclusion, discrimination, and limited access to essential services. This study focuses on two types of vulnerable families: families of Indonesian migrant workers (PMI) and rural families headed by women who work in the informal sector.

Frontline workers
In this study, frontline workers refer to providers of social care services from government agencies who interact directly with community members. Frontline workers include social workers, PKH facilitators, SLRT facilitators, and PUSPAGA counselors.

Caregivers
In this study, caregivers refer to individuals who provide caregiving or social care. Social care providers in this study include parents (nuclear family), extended family members (older siblings, uncles and aunts, grandparents), or other individuals who have no familial ties to the person in need of social care.

Social care
The community's understanding of social care aligns with the conceptual framework used in this study. This study employs the term care, which encompasses both caregiving and broader social support. Within the community, social care is primarily understood as caregiving that addresses both the affective (emotional) and material needs of children.

Long-term care
In this study, long-term care refers to caregiving provided over an extended period, typically spanning several years. This term is used to describe situations in which substitute caregivers assume caregiving responsibilities when parents work as Indonesian migrant workers (PMI).

Short-term care
Short-term care, as defined in this study, refers to caregiving arrangements lasting only a few hours per day. This term is used to describe caregiving practices provided by substitute caregivers while parents are at work or engaged in other activities.

Executive Summary

In 2023, PUSKAPA and INKLUSI conducted a scoping study to identify communities with unmet social care needs, such as children from low-income families, children of Indonesian migrant workers (PMI), abandoned children, and children with disabilities. The study identified potential community-based social care practices and various challenges in providing social care services, including social norms that limit women's participation in the workforce. In addition, the Indonesian government has recently begun implementing a care economy policy aimed at creating inclusive social care services while increasing women's labor force participation.

Building on the findings of the scoping study, PUSKAPA, with support from INKLUSI, conducted an in-depth examination of social care practices for children aged 0–15 in Indonesian migrant worker (PMI) families and informal worker households in rural areas within INKLUSI's Civil Society Organization (CSO) partners. This study aims to understand community perceptions of social care, explore social care arrangements within communities — including the social norms shaping caregiving practices — and identify the support communities require to provide adequate social care.

This study employed a qualitative approach, collecting data through focus group discussions and interviews conducted at both national and subnational (Jember and East Lombok) levels. Subnational data collection involved caregivers (parents and extended family), community health volunteers, local leaders, service providers, and local policymakers. At the national level, data collection included interviews with representatives from relevant ministries and agencies. Secondary data collection was also conducted through a literature review of academic journals, research reports, and policy documents to supplement primary findings.

This study defines social care as the activities and relationships involved in meeting the physical and psychological needs of individuals who depend on others for their wellbeing. Study participants understood social care as efforts to nurture, care for, educate, guide, protect, accompany, supervise, and fulfill children's needs. The community generally considers social care ideal when provided by both parents and tends to emphasize the fulfillment of children's material needs. However, parents, extended families, and communities expressed concerns about their ability to meet children's material needs, highlighting the demand for external support. Institutional childcare services such as daycare centers (TPA) and early childhood education (PAUD) remain scarce within communities.

The study found that the division of caregiving labor between men and women is closely tied to social norms. In the study locations, women—whether as mothers, grandmothers, aunts, or older sisters—bear the primary responsibility for childcare. This dominant caregiving role stems from deeply ingrained gender norms that position men as breadwinners and women as primary caregivers. These norms restrict women's participation in formal employment while discouraging men from engaging in caregiving responsibilities. However, in certain circumstances, men take on caregiving duties, particularly when the women are ill, in postpartum, or otherwise unavailable. Some men continue caregiving despite facing social stigma from their neighbors.

Community caregiving practices are predominantly carried out by parents and extended family members. When one or both parents are absent, such as when they work as migrant workers or in cases of divorce, extended family members, particularly grandmothers, aunts, or older siblings, assume caregiving responsibilities. In both study locations, extended family members provide both short-term and long-term care. Short-term care involves a few hours of caregiving every day while parents are at work. Long-term care, such as when children are left with extended family for years while parents work as migrant workers, presents a greater burden on caregivers.

Extended family members serving as substitute caregivers help ensure that children continue to receive family-based care. However, without sufficient resources, long-term caregiving responsibilities significantly strain caregivers. The study found that women in roles such as older sisters, grandmothers, or aunts who take on these caregiving responsibilities must fulfill all parental roles in the absence of parents, often while simultaneously caring for their own

children and elderly family members. In certain cases, institutions such as schools, PAUD, daycare centers (TPA), and Quranic education centers (TPQ) offer caregiving support within a certain timeframe, providing children with supervised activities.

The study identified existing government strategies for social care at the national level, local government social care programs, and community-driven initiatives. However, government policies and programs related to social care at both the national and local levels have not directly addressed families' basic caregiving needs. National strategies for providing non-familial childcare services must be aligned with community perceptions and needs. Additionally, existing local government programs aimed at strengthening caregiving capacity have yet to actively engage men as primary caregivers in social care.

A multi-stakeholder approach is necessary to develop a social care system that aligns with community resources and needs. To ensure the fulfillment of children's material needs as part of social care, social protection systems must be expanded to support children and families assuming parental caregiving roles. Existing programs could be adapted to improve access to childcare services that align with caregiving needs, such as funding community-led PAUD initiatives to provide childcare services while parents work. In community-based programs, local and village governments could offer incentives for community members who serve as caregivers. Both government and communities can also play a role in redistributing caregiving responsibilities by involving community and religious leaders in promoting changes to caregiving norms through outreach, discussions, and capacity-building efforts.

Chapter

01

Introduction

1.1. Background

In 2023, PUSKAPA and the Australia-Indonesia Partnership for an Inclusive Society (INKLUSI) conducted a scoping study to understand the context of social care and map the challenges and support required to establish inclusive social care in Indonesia. In 2024, the study titled Social Care for Children Living in Vulnerable Households in Indonesia: Understanding Social Care Practices among Families of Migrant and Informal Workers builds on the findings of the scoping study. This study is designed in alignment with the work of INKLUSI's Civil Society Organization (CSO) partners, who focus on providing access to inclusive basic services and promoting fair, safe, and productive livelihoods for women. As such, the scope of vulnerable groups in this study is limited to children in Indonesian migrant worker (PMI) families and children in households where the head of the family—primarily a woman—works in the informal sector in rural areas. More specifically, this study focuses on social care for children aged 0-15 years from these vulnerable families who continue to live with their nuclear or extended families, being cared for by one parent or another family member, in the areas where INKLUSI's CSO partners work in East Lombok, West Nusa Tenggara (NTB), and Jember, East Java.

The findings from this study are expected to support the Indonesian government's goals under the National Long-Term Development Plan (RPJPN) 2025-2045 and the National Medium-Term Development

Plan (RPJMN) 2025-2029, which aim to create a social care system that improves women's workforce participation in the country. This will be achieved through the strengthening of care regulations and infrastructure, improving access to care services, and enhancing the recognition of care work. The study's recommendations can contribute to improving access to more inclusive care services for children in migrant worker and informal worker families in rural areas, as part of the broader group of vulnerable families in Indonesia. Additionally, the results of this study will provide valuable input for INKLUSI's implementing partners to advocate for and develop community-based care models.

1.2. Social Care for Children in Vulnerable Households in Indonesia

Social care refers to activities and relationships aimed at fulfilling the physical and psychological needs of vulnerable adults and children—those who are unable to meet their own needs independently. Participants in the scoping study and relevant literature describe social care as encompassing the provision of basic needs and, subsequently, care services. Therefore, inclusive social care policies must address both efforts to meet basic needs and the provision of care services. The scoping study identified vulnerable groups requiring social care, including children from poor families, children of Indonesian migrant workers (PMI), abandoned children, and children with disabilities.

Economic and social factors contribute to the growing number of children living without proper care. Abandoned children in institutions, such as orphanages, are often separated from their families due to the family's inability to care for them. In 2020, the Ministry of Social Affairs (Kemensos) reported that at least 102,482 children were residing in around 3,575 Child Social Welfare Institutions (LKSA) throughout Indonesia. While society still tends to view orphanages positively, institutional care can increase the likelihood of children experiencing abuse and facing difficulties reintegrating into their communities when they leave these institutions (Agastya et al., 2024; PUSKAPA, 2014).

Family economic challenges also drive migration, both within Indonesia and abroad, which heightens the risk of family separation. In 2019, there were 276,553 Indonesian migrant workers, with about 65% being married or previously married (BP2MI, 2020). Based on this data, we can infer that the number of children left behind by parents working overseas is also quite high. Parental migration also affects traditional family structures, with child care and upbringing often shifting to grandparents, relatives, or older siblings (Hoang et al., 2015). Previous studies have found that there is little government regulation to support extended families,

such as grandparents or uncles and aunts, who take on the responsibility of becoming caregivers or social care providers (Butt et al., 2017).

Research on children left behind by migrant workers indicates that these children experience feelings of shame, which leads to anxiety. They also face negative stigma from society due to their parents' absence. Their needs for food and education are sometimes unmet (Beazley et al., 2018). These challenges arise not only from the physical absence of parents but also from the lack of government support, such as social assistance for children, aid for extended families acting as caregivers, and legal recognition for children of migrant workers (Butt et al., 2017).

Globally, the caregiving responsibilities traditionally shouldered by women limit their participation in the workforce, particularly in the formal sector (Schaner & Das, 2016). For working women, a World Bank study in Indonesia found that they still face a disproportionate dual burden of work and child care, due to insufficient caregiving support (World Bank, 2024). For example, caregiving services in Indonesia are mainly focused on Early Childhood Education (PAUD), which serves children aged 4-6 years for only a few hours a day, and not all of these services are accessible to women, as they are often paid. The scoping study also identified several challenges in providing social care in Indonesia and other middle-income countries, including: limited facilities and poor-quality social care services, inadequate support for caregivers, and social norms that place caregiving burdens on women.

As a result, working women, including migrant workers, often have to delegate or share the responsibility of child care—especially for children under five—with other family members (besides their spouse). This highlights the crucial role of extended family and community in supporting women's participation in the workforce, regardless of the availability of Early Childhood Education (PAUD) or daycare centers (TPA). Informal and community-based caregiving practices have become an integral part of the social care system in Indonesia (Newberry, 2010). Strong family and community bonds, within the cultural context of Indonesia, play a significant role in providing care for children and other vulnerable groups. In the case of PMI families, a study in West Nusa Tenggara (NTB) found that informal caregiving by extended families is a common practice (Butt et al., 2017). However, community-based caregiving models do not receive adequate support from the government (Chan, 2018; O'Donnel et al., 2022). For example, community health workers (cadres) are regarded by both the government and communities as volunteers, meaning they do not receive appropriate incentives. Families left behind by migrant workers also do not have access to government services such as extracurricular activities, financial aid, or entrepreneurial support (Butt et al., 2017).

Therefore, policies aimed at increasing women's labor force participation should

not only focus on expanding access to child care services but also include financial support for caregivers, workplace social care policies, and a shift in social norms surrounding caregiving responsibilities. To reduce poverty and improve social welfare, the Indonesian government has developed policies to encourage greater participation of women in the workforce, including the Social Care Roadmap. Several studies on the state of daycare centers (TPA) in Indonesia have been used by the government to continue developing TPAs, Holistic Integrative Early Childhood Development program (PAUD HI), and to encourage businesses to provide child care centers as well as maternity and paternity leave for parents. However, studies specifically addressing social care within vulnerable families are still limited.

Community-based social care, which has already become part of the social care system in Indonesia, has the potential to support active women's participation in the economy and improve family and community well-being. Therefore, this study will map the social care practices within communities, as well as the challenges and support needed by communities so that informal workers and PMI families in rural areas can provide social care for their children.

1.3. Research Questions

1. What are the community-based social care practices that can meet the needs of children aged 0–15 years in migrant worker (PMI) families and informal worker families in areas supported by INKLUSI's Civil Society Organization (CSO) partners?
2. How do social norms influence social care practices within communities?
3. What government support is needed by communities and families to implement community-based social care?

1.4. Key Concepts

Below is the conceptual framework for social care that informs the design of the research questions, data collection tools, and guides the analysis of field findings and the development of recommendations.

Daly and Lewis (2000) define **social care** as activities and relationships aimed at fulfilling the physical and psychological needs of individuals who rely on others to meet those needs. Social care has three key dimensions. First, there's the dimension of care as work, which distinguishes between formal-informal or paid-unpaid work. Second, the social and relational dimension, which relates to norms surrounding social care. Social care is often seen as a responsibility arising from family or social relationships. Because it stems from social norms and personal relationships, social care is often not recognized as formal work. However, it is also a state responsibility. The third dimension is the financial and psychological burden of caregiving, which is closely tied to the social and relational dimensions. This burden is distributed differently between men and women and across the private and public spheres.

The concept of social care includes both formal and informal care, with various actors involved. Formal care services are provided by organizations and individuals without family ties, based on regulations, while informal care is provided by family members and communities (Cantor, 1989; Petrowski et al., 2017). Social care can take place in a range of settings, among people with different relationships, and is carried out through various interventions and practices (Yantzi & Skinner, 2009). Government policy interventions for social care include efforts at the community or micro level, such as changing gender norms, cultural practices, and caregiving traditions, as well as larger-scale policies and programs aimed at improving access to and the quality of social care services (Daly & Lewis, 2000). The scoping study on social care also distinguishes two levels of policy and programs integral to social care.

In addition to the concept of social care, this study also considers the concept of the **care economy.** The International Labour Organization (ILO) defines the care economy as reproductive work, including both paid and unpaid activities involving caregivers and care recipients. These activities include care within the home, such as caring for family members and performing household tasks, and care outside the home, such as caring for individuals without family relationships. Care activities are intended to meet the physical, psychological, cognitive, and mental needs, also to improve the quality of life for children, youth, adults, the elderly, people with disabilities, and the caregivers themselves.

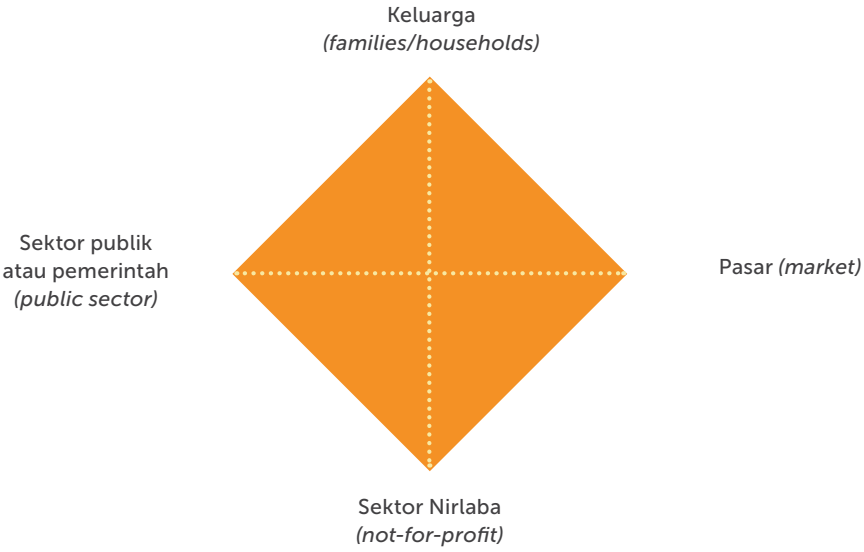


Figure 1. Care Diamond (Razavi, 2007).

The care diamond (Razavi, 2007) is a conceptual framework that maps the providers of social care, especially for vulnerable groups with intensive care needs, such as children, the elderly, individuals with chronic illnesses, and those with mental or physical disabilities. The care diamond (Figure 1) identifies four key actors: the public sector or government, the family, the market, and the non-profit sector, including voluntary care provision and community-based care, which work together to provide social care (Razavi, 2007).

Given the complexity of social care, each country needs a well-established **social care system.** A social care system includes a policy and legal framework, services, financing, social and physical infrastructure, programs, standards and training, governance and administration, and social norms that recognize, reduce, redistribute, value, and represent care work equitably between family, state, market, and community, as well as across genders (United Nations, 2024).

In communities and families, social norms play a significant role in shaping interactions and expectations regarding social care. Social norms are unwritten rules in society about attitudes and behaviors considered acceptable in specific social contexts, influencing the behavior of both care recipients and caregivers (Cislaghi & Heise, 2020; Meijer & Brabers, 2023). Social norms influence attitudes and behaviors through social consequences. Adherence to social norms leads to social acceptance, while violation results in social sanctions. These norms can vary by region

and reflect specific social expectations within particular groups, such as differing gender roles (Cookson et al., 2023) or religious practices (Azmat, 2019).

Social norms around caregiving significantly affect the provision of adequate care for children both at the community level and within programs and policies. Deep-rooted gender roles in society place the primary caregiving responsibility on women for children and other family members (Setyonaluri et al., 2021). A World Bank report shows that mothers spend an average of 13.7 hours per day on child care, compared to fathers, who spend just 3.8 hours. Meanwhile, other household family members spend an average of 4.2 hours on child care, while non-household family members and non-relatives spend 3–4 hours. This data clearly shows that women spend significantly more time than men on child care.

1.5. Social Care in the Framework of National and Regional Policies

This section outlines the findings from a review of limited regulations and literature, as well as the data collected at the national level. The policies and programs discussed here are part of the framework created by the national government. Their implementation at the regional level, particularly in the areas where the study took place, will be addressed further in the discussion of regional policies and programs.

1.5.1. Policies to Strengthen the Social Care System Framework

Care economy policies are a key priority for the government, as outlined in the National Long-Term Development Plan (RPJPN) 2025-2045. These policies focus on strengthening care regulations and infrastructure, improving access to care services, and enhancing recognition of care work. This initiative comes in response to the low labor force participation rate (LFPR) of women. The aim is to increase women's labor force participation by improving care infrastructure and services, recognizing care work as formal employment, ensuring fair wages for social care workers, and providing them with social security. At the same time, the care economy within the RPJPN 2025-2045 is part of the national social protection policy, designed to meet the care needs of vulnerable groups, such as children, the elderly, and people with disabilities. This policy has been incorporated into the Care Economy Roadmap 2025–2045, focusing on seven strategic issues:

1. Child care services and programs (daycare).
2. Long-term care services for the elderly.
3. Inclusive services for people with disabilities, people living with HIV, survivors of violence, and other vulnerable groups.
4. Maternity protection.
5. Strengthening fathers' roles in child care through paternity leave.
6. Recognition and protection of care workers.
7. Social protection for the economic welfare of care work.

The national data collection process revealed that care economy policies are being implemented across several ministries, with the Coordinating Ministry for Human Development and Cultural Affairs (Kemenko PMK) and the Ministry of Women's Empowerment and Child Protection (KemenPPPA) leading the efforts. As of 2024, the Coordinating Ministry for Human Development and Cultural Affairs (Kemenko PMK) is overseeing the integration of care economy policies into the National Medium-Term Development Plan (RPJMN) 2025-2029 and the annual Government Work Plan (RKP). Meanwhile, the KemenPPPA , through Law No. 4 of 2024 on the Welfare of Mothers and Children during the First Thousand Days of Life, is advocating for maternity protection, paternity leave, and social

protection for caregivers. Additionally, the Ministry of National Development Planning through the Directorate of Poverty Reduction and Community Empowerment (PKPM), is piloting community-based Integrated Elderly Services (LLT) in two regions of Indonesia: Bali and Yogyakarta.

Another key policy in developing the social care system focuses on integrating child care and early childhood education services as temporary child care facilities. The Ministry of Education and Culture (Kemendikbud) has announced that future child care policies will focus on strengthening the integration of services, called Holistic Integrative Early Childhood Development (PAUD HI), with particular emphasis on children aged 0-3 years. Under current regulations, PAUD HI policies target children aged 0-6 through various PAUD units, including daycare centers (TPA), playgroups (KB), kindergartens (TK), and similar educational units. One national informant pointed out that while PAUD HI targets children aged 0-6, its implementation has mainly focused on children aged 4-6, prioritizing education, particularly school readiness, and often overlooking caregiving aspects.

PAUD HI policies aim to meet children's comprehensive needs in three main areas: education, health and nutrition, and caregiving. PAUD HI is implemented across sectors, with Kemenko PMK serving as the head of a task force coordinating various ministries and agencies involved, such as Kemendikbud, the Kemenkes, and the BKKBN. The task force also monitors and evaluates PAUD HI implementation in the regions. Meanwhile, Kemendikbud which oversees PAUD units, provides budgetary support to regional education offices to enhance the capacity of PAUD units, organizes technical training for PAUD facilitators in the regions, and offers guidance to PAUD units.

Daycare centers (TPA), as part of PAUD HI, are also beginning to gain more attention from national policymakers. The policy to strengthen daycare centers focuses on increasing both the quantity and standardization of TPAs, especially for women working in the formal sector, such as in offices, corporations, and plantations. The KemenPPPA through the Taman Asuh Anak Ceria (TARA) program, has developed guidelines for standardizing TPAs in collaboration with the National Standards Agency (BSN). The hope is that this program will increase parents' trust in daycare centers, encouraging them to entrust their children to these facilities.

1.5.2. Policies to Strengthen the Capacity of Social Care Providers

Policies aimed at strengthening the capacity of parents or caregivers are being implemented by multiple ministries. The Ministry of Women's Empowerment and Child Protection (KemenPPPA) runs the Family Learning Center (PUSPAGA) program, which offers education, consultation, and counseling to families. BKKBN runs the Early Childhood Family Development (BKB) program, which

focuses on nutrition and child development education for parents of children aged 0-6. Additionally, The Ministry of Social Affairs (Kemensos) has a capacity-building component for parents in the Family Hope Program (PKH) through Family Skills Enhancement Meetings (P2K2). P2K2 includes several modules on topics such as health and nutrition, education and caregiving, financial management, and child protection.

For migrant workers, the Ministry of Manpower (Kemenaker) runs the Productive Migrant Village (Desmigratif) program, which focuses on empowering PMI and their families. The program includes a community parenting component, aimed at training and building the capacity of substitute caregivers, as well as educating the community to engage in the care of PMI children. Unfortunately, the program has been inactive since 2022, and in practice, it primarily led to the creation of reading corners or children's play areas through partnerships. As of 2024, Kemenko PMK is evaluating the Desmigratif program, specifically the community parenting component, with the goal of refining its implementation to better address the needs of PMI families.

Several national policies are beginning to address social norms related to caregiving, either directly or indirectly. The P2K2 PKH program plans to increase the involvement of fathers and other family members in the P2K2 sessions, which have previously been attended only by mothers. The Ministry of Women's Empowerment and Child Protection (KemenPPPA) through its family quality improvement programs, is starting to focus on a more equitable distribution of caregiving responsibilities between men and women. In implementing this program, The Ministry of Women's Empowerment and Child Protection (KemenPPPA) has previously partnered with the Aliansi Laki-laki Baru (New Male Alliance) organization.

1.6. Study Scope and Report Structure

This study focuses on social care practices for children within PMI families and informal worker families in rural areas. The study also explores the social norms that influence social care, as well as policies and programs related to care. The focus on child care practices within migrant worker families offers insights into the long-term care provided by extended families and communities in rural areas. Meanwhile, focusing on social care practices for children in informal worker families provides a perspective on the short-term care offered by extended families and communities in rural settings.

This report consists of eight sections. The first section introduces the background, the situation of social care for children in vulnerable households in Indonesia, research questions, key concepts, and social care within the framework of national and regional policies. The second section details the methodology, including the

data collection phases at the regional and national levels, data management and analysis, and research ethics. Section three analyzes social care from a community perspective. Section four covers community-based social care practices to meet the needs of children aged 0–15 in migrant worker or informal worker families in the study areas. Section five discusses the social norms that shape and influence social care practices within communities. Section six addresses policies, regional programs, and the community's needs for social care services, as well as the challenges in implementation. Section seven presents the discussion, and section eight offers recommendations.

Chapter

02

Methodology

Figure 2. Data Collection Methods and Research Questions.

This study used a qualitative approach through two phases of primary data collection (Figure 2): the first phase at the regional level was conducted in two districts (kabupaten), and the second phase at the national level. A non-systematic literature review was also conducted to identify relevant concepts that informed research tool development and data analysis and to strengthen the analytical depth of the study.

2.1. Data Collection Methods

In the first phase, regional-level data collection was conducted through focus group discussions (FGD), key informant interviews (KII), and community observation. Data collection at the regional level took place in two districts: Jember Regency in East Java Province and East Lombok Regency in West Nusa Tenggara Province (Nusa Tenggara Barat, NTB). These regions were selected in consultation with two civil society organization (CSO) partners involved in this study, Migrant Care[1] and the Foundation for Women-Headed Family Empowerment (Pemberdayaan Perempuan Kepala Keluarga, PEKKA)[2]. The two districts were

[1] A Civil Society Organization (CSO) in Indonesia that focuses on advocacy for migrant worker issues (Migrant Care, 2023).

[2] A Civil Society Organization (CSO) in Indonesia that focuses on the empowerment of women heads of households (Pekka, 2022).

selected due to the presence of pockets of migrant workers and informal workers. Within each district, two villages were selected based on recommendations from the CSO partners of this study. In Jember Regency, community-level data collection was conducted in Dukuh Dempok and Balung Lor villages, while in East Lombok Regency, it was conducted in Jenggik and Sukamulia villages.

The community-level instruments developed in this study used a participatory method that emphasizes collaboration between researchers and study participants and enables direct involvement of participants in problem identification and the formulation of recommendations (Duea et al., 2022). To ensure the suitability of the instruments, particularly the FGD, with the characteristics of the target participants, we conducted a pilot data collection in Cianjur Regency in July 2024, ensuring that the participants' characteristics were comparable to those of the study's target participants.

In the second phase, national-level data collection was carried out through KIIs and national consultations. KIIs were conducted to map policy priorities/ government programs related to social care in Indonesia, targeting relevant ministries and government agencies, while national consultations aimed to gather feedback on the findings from the primary data collection.

Below is a detailed explanation of the data collection methods used in this study:

1. The regional-level FGDs consisted of initial and follow-up FGDs.

   The initial FGDs aimed to explore care needs and care practices for children in the communities, as well as the impact of social norms on these practices. Various visual tools were used to encourage participant engagement.

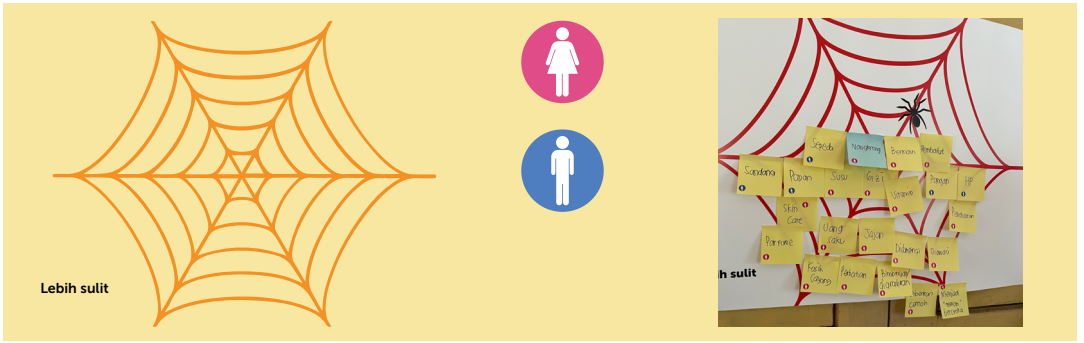


Figure 3. Discussion tools: a spider web and gender stickers.

This session used a spider web visual tool to map care needs and gender stickers to identify social norms related to care practices (Figure 3).

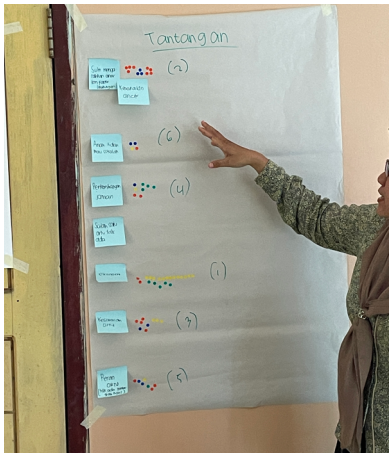


Figure 4. Example of participatory ranking method results.

The initial FGDs also applied the participatory ranking method to certain topics such as care needs and challenges (Figure 4).

Target participants for the initial FGDs:

- Primary and substitute caregivers: this group is comprised of adults who spend the most time caring for children aged 0 to 15 years. Data collection for this group was categorized by gender and age group of the children, distinguishing between toddlers and school-aged children;
- Community-based care service providers (cadres): this group included Posyandu cadres, Family Welfare and Empowerment Organization (PKK) cadres, and early childhood education (PAUD) teachers. Given these participant criteria, the group discussions were mainly attended by women; and
- Community leaders: this group included heads of the Neighborhood Association (RT) or hamlet, and religious leaders. Given these participant criteria, the group discussions were mainly attended by men.

The follow-up FGDs aimed to map available support resources, identify community expectations, and formulate recommendations to address social care needs at the community level. These sessions involved all or some of the participants from the initial FGDs. During this session, researchers engaged participants in mapping key stakeholders, facilities, and other resources that could support childcare in the village. Participants were also encouraged to share their expectations or recommendations based on the needs and challenges identified in the initial FGDs.

The district-level FGDs aimed to map existing services and programs at the district level and identify future policy and program priorities related to social care. These FGDs started with a presentation of preliminary findings from the community-level data collection, followed by discussions to map responses and identify relevant local policies, programs, and services related to social care. The district-level FGDs participants include:

- Policymakers: representatives from local government agencies responsible for social care, including the Office

of Social Services (Dinas Sosial), the Office of Women's Empowerment and Child Protection Services (Dinas Pemberdayaan Perempuan dan Perlindungan Anak), the Office of Education Services (Dinas Pendidikan), the Office of Health Services (Dinas Kesehatan), the Office of Village Community Empowerment (Dinas Pemberdayaan Masyarakat Desa), and the Regional Development Planning Agency (Badan Perencanaan Pembangunan Daerah).

- Frontline Workers: representatives of local workers involved in social care, including staff from the Technical Implementation Unit for Women and Child Protection (UPT PPA), social workers, facilitators of the Family Hope Program (PKH), counselors from the Family Learning Center (PUSPAGA), and facilitators of the Community-Based Integrated Child Protection Program (PATBM).
- Civil Society Organizations (CSOs): representatives from CSO partners involved in this study: Migrant Care (in Jember) and PEKKA (in East Lombok).

2. Community observations were conducted, with participation from caregivers and service providers/cadres, to assess childcare arrangements and map childcare facilities within the community. The activity began with a community mapping exercise, in which participants created a simple map identifying key locations associated with childcare services. Below is an example:

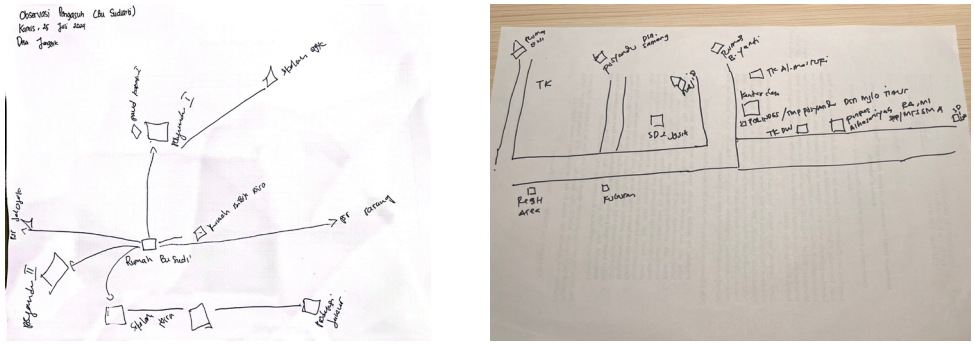


Figure 5. Example of community mapping during observation with caregivers (left) and cadres (right).

After mapping the locations, participants and researchers conducted site visits and interviews to observe the identified facilities and gather insights into their quality. Interviews with caregivers also explored child care transitions within the community.

3. Key informant interviews (KIIs) were conducted at both the regional and national levels, individually or in groups. At the regional level, KIIs aimed to further explore the insights gained from the FGD sessions. At the national level, KIIs were conducted to

map government policy and program priorities related to social care (for more details, see Appendix Table 2).

4. A limited national consultation was conducted following the completion of the regional and national data collection. The consultation gathered feedback on the primary data findings and discussed how these findings align with the programs and advocacy agendas of each organization. The national consultation was held twice, involving representatives from CSOs and development partners (see Appendix Table 3 for details).

2.2. Number of participants and activities in the study

A total of 126 participants were involved in the regional data collection, with 58 from Jember Regency and 68 from East Lombok Regency. The regional data collection included 58 research activities, comprising 30 FGDs, 16 KIIs, and 12 observations. A breakdown of the number of activities and participants in each regency is provided in Appendix Table 4.

2.3. Data Management and Analysis

Field Data Management

The primary data collection resulted in three types of field data used for analysis: (1) audio recordings, (2) field notes, and (3) documentation of discussion tools. Audio recordings from each data collection activity were transcribed using the Cockatoo application and then manually reviewed by a transcriber. The transcripts and discussion documentation were later used by the research team to supplement the information recorded in the field notes. All field notes underwent a review process conducted by the Research Control Center (Pusat Kendali Penelitian, PKP) team, which included the team leader and the principal investigators of the study. To ensure data completeness, the research team held weekly debriefing sessions throughout the fieldwork period.

This study implemented a data storage protocol. Documents or literature used for the non-systematic literature review, along with field data, were securely stored digitally on Google drive. Access was strictly limited to research team members who signed a non-disclosure agreement (NDA).

Data Analysis

The analysis of primary data was conducted using thematic analysis, as introduced by Braun & Clarke (2006, 2021). This approach allows for the systematic identification, analysis, and reporting of themes and patterns of the data while maintaining flexibility in the process.

The first stage of analysis involved coding, conducted deductively by developing a codebook with a predefined set of codes. These codes enabled the research team to systematically categorize the data from the field. The next step, diagramming, involved identifying, reviewing, and defining emerging themes. Following this, the researchers compiled the analyzed data into a report and conducted cross-reviews among team members to ensure accuracy and consistency. Regional data underwent all these analytical stages.

The national consultation activities were treated as supplementary data and were not subjected to the coding and diagramming processes. Instead, they were incorporated during the report-writing step. Field notes collected during the national data collection were directly integrated into the diagramming process. In the literature review, key findings from each document were transferred into a matrix based on predefined themes.

2.4. Research Ethics

This study has undergone an ethical review by the Social Humanities Ethics Commission of the National Research and Innovation Agency (BRIN) under reference number 452/KE.01/SK/05/2024. The researchers ensured that all participants complied with key ethical research principles, including voluntary participation, confidentiality of identities and data, respect for participation, and prioritization of their safety and well-being. These key principles were realized through the following measures:

1. **Participant's consent was obtained through informed consent form.** Participation in this study was voluntary. Before taking part in interviews, discussions, or observations, participants received a clear explanation of the study's objectives, details of their participation, and other relevant considerations. All the information gathered was written onto an informed consent form, which was signed by participants to confirm their voluntary agreement to participate.

2. **Restricting access to research data and maintaining participant confidentiality through the use of initials.** Before each interview, researchers would inform participants that their information will be used solely for research purposes, and that it will be securely in the online storage, namely Google Drive folder that

is accessible only to the research team. To protect their privacy, all field notes and research reports used participant pseudonyms. Moreover, all parties outside PUSKAPA who assisted with data collection must sign an NDA to ensure that no information is shared beyond the study's research purposes.

3. **Providing reimbursement for FGD participants to cover travel expenses and a clear explanation of the benefits of their participation.** FGD participants received compensation for their travel expenses to the study location. Additionally, the research team confirmed that while participants did not receive material benefits from their participation in this study, they did contribute to the study's informed recommendations for improving Indonesia's social care system.

4. **Adjusting the location and schedule of research activities to prioritize the safety and comfort of participants.** All activities took place in secure locations to prevent any discomfort caused by third-party interventions and to avoid disrupting participants' primary activities. The research team was supported by local facilitators who provide insights into the customs and culture of the research location. The team also developed a response mechanism as a mitigation measure in case participants feel uncomfortable during the interview activities.

2.5. Study Limitations

This study focuses on social care practices for children in vulnerable migrant worker and informal worker families in rural Indonesia. It does not provide a complete picture of social care practices across the country, social care practices for children in families of other vulnerable groups, or other vulnerable population groups such as the elderly or people with disabilities. The study focuses only on care practices within household settings and does not account for children in institutional care, such as children living in orphanages, Islamic boarding schools (pesantren), or juvenile rehabilitation (Lembaga Pembinaan Khusus Anak, LPKA). As the study was carried out in rural areas, the findings might not reflect the realities of social care practices for children in urban areas. Furthermore, the design of the study did not specifically include children in the data collection process. Therefore, the study's findings and conclusions primarily represent the perspective of adults, which may not align with the insights gained from involving children as participants.

Chapter

03

Social Care from a Community Perspective

This section provides an overview of how participants in the regional study (caregivers, service providers, local government officials, and community leaders) define social care, along with their assumptions about it. Their understanding and assumptions shape their perceptions of the challenges and support needed to deliver effective social care, which is also one of the key focuses of this study.

There is variability in the way social care is understood within the community. For caregivers, social care is understood as the act of nurturing and fulfilling a child's needs. For community leaders, health workers, and local government agencies, social care is viewed as a set of policies or programs aimed at assisting parents and families in providing care. In both cases, there is a shared recognition that children's care needs remain unmet. Furthermore, children raised without both parents are often considered to be deprived of adequate care, and thus categorized as neglected. This assumption also extends to children with disabilities and those affected by stunting, who are regarded as having specific and distinct care needs.

3.1. Definitions and Groups of Children in Need of Social Care

Caregivers conceptualize social care as the efforts involved in raising, caring for, educating, guiding, protecting, accompanying, supervising, and fulfilling a child's needs. As participants equate social care with meeting children's needs, they often conflate the concept of care with a child's basic requirements. Some caregivers consider the objective of child-rearing to be the development of an independent child who can bring pride to their parents and grow into a person of good character.

> "It's like caring for my own child—looking after their health, education, and other needs. I want them to understand how to be independent and active in the future." —Female Caregiver, Focus Group Discussion, Jember.

In contrast, community leaders, health workers, and OPD understand social care as a tool to improve welfare and empower vulnerable families and groups. This includes providing economic support to low-income families, capacity-building through educational programs on child-rearing, and offering social care services such as child education and health services through community-based health service post (Posyandu).

> "Social care is about improving the family's economic situation to raise their social status or welfare, either through material support or providing guidance to help them improve." —Health Worker, Focus Group Discussion, Jember.

Participants in the study identified several groups of children whom they believed were not receiving adequate social care. These included neglected children, children raised by grandparents, children with disabilities, and children experiencing stunting. Participants regarded neglected children as those not cared for by their parents, including children of migrant workers or children of single parents. The ideal caregiving arrangement, as perceived by participants, is one where both biological parents are involved, and that children not directly cared for by both parents are therefore categorized as neglected. For instance, informants observed that children raised by grandparents often do not receive the necessary supervision and care. They perceived that grandparents are unable to provide adequate caregiving.

> "...There are children whose parents are absent and are only cared for by their grandparents or great-grandparents. In the mornings, their grandparents can take them to school, but by the afternoon, they are busy and can't pick them up. Sometimes, they wear mismatched uniforms—one child wears yellow while another wears green. We just accept it because, well, there are no parents around. They also bring very little for lunch compared to kids whose parents are around. The quality of their lunch and other things is very different." —Health Worker, Jember.

3.2. Addressing the Social Care Needs of Children in the Community

In general, the social care needs of children can be classified into material and emotional needs. Material needs include those related to education (such as uniforms, stationery, and school fees), hygiene, nutrition, clothing, and other health-related necessities. Caregivers also mentioned daily allowance and gadgets as material needs for children.

Emotional needs, on the other hand, encompass guidance, supervision, attention, and affection. Guidance and supervision were the most frequently mentioned needs by caregivers. Caregivers provide guidance and supervision by setting a positive example, offering assistance when children face problems, and monitoring them to protect them from negative influences such as overuse of tech gadgets or harmful peer relationships.

Caregivers differentiate care needs based on gender and age. For example, girls are considered to require clothing, cosmetics, and reproductive health care due to menstruation. Girls are also perceived to need closer supervision in their daily interactions. In terms of age, younger children (toddlers) are seen as needing more attention to their nutritional needs, physical care, and direct supervision.

Furthermore, participants in the study identified children with specific health conditions as requiring more intensive social care. Children with disabilities and those suffering from stunting were seen as needing more specialized and intensive care. In both Jember and East Lombok, participants indicated that children with specific health conditions require tailored care, such as additional nutritional support for those affected by stunting. Children with special needs (ABK) also require appropriate social care services, including special education schools (SLB) for children with mental disabilities, and communication aids for daily living.

Informants involved directly or indirectly in child care noted that families' material needs are often not being fully met. Both parents and substitute caregivers feel they are unable to adequately fulfill children's basic needs. They attributed this to the unstable employment conditions of parents and caregivers. For example, informal jobs such as farm labor do not provide parents and families with sufficient income to meet the needs of children.

Chapter

04

Community-Based Social Care Practices to Meet the Needs of Children Aged 0–15 in Migrant Worker (PMI) Families or Informal Worker Families in the Study Areas

This section describes the social care practices found within the communities. In both study areas, the majority of social care for children of informal workers and children of migrant workers is provided by parents and extended families. This section further highlights the short- and long-term care provided by extended families.

This section also presents data regarding the challenges faced by caregivers within families and communities in providing social care. For instance, extended families acting as substitute caregivers experience economic and emotional burdens, which prevent them from fully meeting a child's basic needs. We also identify facilities and support systems that can assist in providing social care for children beyond the extended family and neighbors, such as daycare centers (TPA), Quranic Education Centers (TPQ), and schools or Islamic boarding schools (pesantren).

4.1. Social Care Provided by Parents and Extended Families

4.1.1. Social Care by Parents

In the communities studied, parents bear the primary responsibility for child care. When one parent is unable to care for their child, due to being a migrant worker, for example, or due to divorce, the responsibility falls to the other parent. Either the mother or father remains the primary caregiver, providing social care.

> "[In] their own homes, I suppose, here. Maybe in cities, there are daycares, playgrounds, and so on. But in the village, there aren't any, so if the child isn't enrolled in PAUD, they're cared for by their parents at home." —Health Worker Interview, Jember.

Single parents who work and care for their children require support from other family members to help provide care. Extended family members such as grandparents, uncles, aunts, and older children step in to provide child care, either for short or long periods. However, there are variations in how child care is arranged. When fathers take on the primary caregiving role, they tend to involve extended families more in fulfilling all the child's needs, including preparing meals and ensuring the child attends school. Conversely, when mothers are the sole caregivers, they are less likely to involve the extended family in caregiving. They continue to provide for the child's needs, including preparing meals and providing school essentials, and only rely on extended family when they need help due to work, illness, or other reasons.

4.1.2. Short-Term Social Care Provided by Extended Families

In short-term care, extended families help parents by taking on some caregiving responsibilities, such as taking children to school, watching over them, and keeping them company while playing. Children entrusted to extended families are generally younger, from toddlers to primary school age, as parents perceive older children as capable of managing their own needs for short periods of time. Occasionally, extended families also enlist older children to look after their younger siblings, especially when parents are ill or busy. Parents who entrust their children to extended families for a few hours or days find this arrangement acceptable, as do the extended family members and local health workers.

4.1.3. Long-Term Social Care Provided by Extended Families

The study also uncovered cases where children must live with other family members for extended periods. Focus group participants, including community leaders and health workers, indicated that migrant workers often leave child-rearing responsibilities to their families for long durations. In some cases, such as during a divorce, parents choose to leave the village for work and entrust their children to extended families or relatives. In East Lombok, children born from child marriages are often cared for by extended families.

> "There are also neglected children, sometimes because the parents move or both are overseas, and the children are left with relatives—either the mother's or father's side. These families are close by because their economic situation is stable..." —Community Leader and Religious Leader, Focus Group Discussion, East Lombok.

According to some extended families acting as substitute caregivers, children are often entrusted to their care for one to more than three years. This caregiving arrangement is not permanent, even if it lasts for several years. Children entrusted to extended family members for long periods either live with the caregiver's household or stay nearby, but still under the supervision of the substitute caregiver.

The long-term caregiving arrangement is closely tied to the type of work available to substitute caregivers, especially female caregivers. One participant shared the story of a child who moved from the care of an aunt, who had been the primary caregiver for four years, to that of a married sibling after the aunt decided to become a migrant worker. Another option available to parents is to involve family members with more free time or those not employed, such as elderly grandparents. In addition to grandparents, aunts and uncles also frequently step in as substitute caregivers.

Long-term caregiving, which shifts the responsibility from both parents to extended family members, also transfers the financial, emotional, physical, and time burdens to the substitute caregivers. The extent of this burden depends on several factors, especially the duration of care, as well as the economic and social conditions of the caregiver's family, which may also include other caregiving responsibilities. While no family members in the study rejected the idea of long-term caregiving—and many expressed willingness to provide care—discussions revealed that fatigue is a real concern. In East Lombok, neighbors often step in to care for children for short periods, such as when parents or caregivers are working or have other obligations outside the home. Leaving children with neighbors is more common in Jember, while parents in East Lombok may feel hesitant to burden their neighbors with childcare. In Jember, interview participants mentioned that neighbors who help look after children typically do so voluntarily, although some may receive a financial financial payment or food as compesation. Caregivers usually entrust their children to neighbors with whom they have a close relationship, who live nearby, and who are not employed.

4.1.4. Challenges Faced by Parents and Extended Families in Providing Social Care for Children

The numerous caregiving responsibilities reduce a caregiver's time to work, which in turn limits their family's financial capacity. Caregivers often choose part-time work or jobs that are close to home, such as micro/small/medium enterprises (UMKM), farming, or casual labor with low wages. The limited job opportunities in the study areas, dominated by informal and poorly paid work, exacerbate the difficulties caregivers face. To cope with economic hardships and to meet children's care needs, parents and caregivers often resort to borrowing money from relatives, neighbors, or loan sharks. The care needs caregivers perceive as essential are not limited to basic needs such as proper nutrition, but may also include daily allowance.. Participants in Jember shared the story of a caregiver who prevented her child from going to school because she could not provide any daily allowance, and she could not bear to see her child go without snacks.

In East Lombok, migrant workers are seen as being better able to meet family needs, including those related to care, compared to the informal jobs available in the villages. However, in Jember, migrant workers often still face economic hardships due to having to pay off debts. Regardless of the wage or remittance amount they receive, the decision to become a migrant worker creates caregiving issues related to their absence.

Parents and substitute caregivers also encounter challenges in dealing with the diverse developmental needs of children. For example, they struggle with regulating excessive gadget use, monitoring children's social interactions, and providing sex education. Participants noted that single fathers, elderly caregivers, and parents with low educational backgrounds and limited child-rearing knowledge encounter more difficulties than single mothers or other substitute caregivers. According to health workers and community leaders, the lower a caregiver's capacity to care for a child, the higher the likelihood that the child will experience violence, child marriage, or adopt risky behaviors.

Caregiving capacity can be improved through services that support children's growth and development. However, participants expressed frustration with the difficulty in accessing these services, particularly if they do not own private transportation. While services like community health posts (Posyandu) are available at the village level, other services, such as public health centers (puskesmas) and SLBs, are generally only available at the sub-district or district capital levels. Additionally, participants mentioned difficulties with poor road conditions, inadequate lighting, and the lack of public transportation to reach local health posts, schools, and Quranic study centers, making access to these services unsafe for children, pregnant women, and the elderly. Furthermore, some facilities, such as schools, are located along busy roads without safe crossing points.

4.2. Care Provided by Non-Family and Community Actors

Parents and extended families who provide primary care still require support from non-family members within the community due to the diverse needs of children, and the need to fulfill other roles such as working or caring for the elderly or sick family members.

4.2.1. Neighbors Providing Care Support

Box 1. Informal Alternative Child Care for Migrant Worker Children

In Jember, an initiative by a former migrant worker's family to care for children of current migrant workers (PMI) has emerged, where they volunteer to care for children even though there is no familial relationship between the caregiver and the child's family. This initiative is as an example of an informal alternative caregiving system within the community.

The former migrant worker's family has been caring for a child who has lived with them from the age of 10 months and is now 11 years old. The child's biological parents are divorced, the mother is a migrant worker, and the father lives out of town. Initially, the child's mother wanted to place the child in an orphanage, as the maternal side of the family was unwilling to care for the child, and the father was caring for his sick parents. The orphanage refused to accept the child as they only take in children who can care for themselves. Ultimately, the former migrant worker's family offered to take in the child.

The family does not receive any government incentives to meet the child's needs, although the child's biological parents occasionally send money for necessities. The family finds it difficult to provide care given the bureaucratic process to access programs such as the Indonesia Smart Program (PIP). Because the child is still registered under the mother's Family Registration Card (KK), it requires a parental statement to access aid. Instead, the village issued a letter of certification.

This family cares for the child out of compassion, desiring to provide the child with adequate care and nurturing despite the child not living with its biological parents.

4.2.2. Formal Institutions as Providers of Temporary Care

4.2.2.1. Early Childhood Education (PAUD) Institutions

According to community members in Jember and East Lombok, community-run educational institutions, such as Early Childhood Education (PAUD), madrasah, and pesantren, contribute to educating children. Some caregivers make indirect use of PAUD institutions as temporary care facilities for preschool-aged children (0–6 years). In East Lombok, PAUD centers also serve as play spaces for children.

"...That's why I'm happy to send my child to school because when I'm at work, I don't have to worry about them. If they're at home, I don't know what they're doing, where they are, or who they're with, so it's better to send them to school. I think the reason some people send their children there isn't just because they want them to attend school, but because they want their child to be in a safe place while they're at work. It's only a couple of hours, from 8 or 9 in the morning until 10." —Health Worker Interview, Jember.

4.2.2.2. Daycare Centers (TPA)

Some villages have daycare facilities (TPA), although their numbers are limited and not widely utilized by caregivers. In the two villages studied in Jember, only one TPA exists, serving primarily parents working in the formal sector and those with middle- to upper-middle incomes.

"...Many parents who are workers ended up sending their children here, and that's how we established this TPA..." —TPA Manager Interview, Jember.

Daycare centers are typically privately owned, with higher fees compared to the community-run PAUD units. They often offer additional services, such as child pick-up and drop-off, as well as longer operating hours (from morning to evening). The TPA in Jember accepts children aged 1.5 to 7 years, with operating hours adjusted to the needs of the parents (until midday or afternoon). A teacher is assigned to take children from kindergarten to the daycare after school. Special caregiving services like TPAs are more commonly found in city centers, far from where the study participants reside. In addition to challenges related to cost and distance, because most child care practices are still carried out directly by parents, extended families, and neighbors, caregivers do not identify TPAs as a viable social care service for the ones they are caring for.

4.2.2.3. Islamic Boarding Schools (Pesantren) and Madrasahs

Parents see madrasah and pesantren as valuable in enabling them to work while their children are of school age (7-15 years). In addition to providing educational support, madrasah and pesantren also assist parents and caregivers by offering children religious guidance. Parents and caregivers in East Lombok also note that pesantren help to reduce children's use of gadgets as they have gadget limitation rules.

> "Educational institutions, whether at the PAUD level or pesantren, are very helpful to parents who otherwise would be solely responsible for guiding their children. Sending them to a pesantren or a similar institution in the neighborhood ensures that parents are partly relieved of this responsibility while their children are in safe environments." —Community Leader, Focus Group Discussion, East Lombok.

We found many pesantren and madrasah facilities in Jember and East Lombok. Typically, children attend madrasah or pesantren from morning until afternoon or evening. One village in Jember has a diniyah madrasah that holds Quranic study sessions in the morning from 5:00 to 8:00 AM before regular lessons begin from 8:00 AM to 2:00 PM. This schedule allows parents to do their activities in the morning and afternoon. Children often attend formal school in the morning and continue with their studies at a pesantren in the afternoon and evening. In this arrangement, it is still possible for children to live with their families rather than in the pesantren environment.

Some pesantren schools in Jember and East Lombok also offer boarding facilities. These schools can be categorized as providing alternative care, especially for children from families where parents, as primary caregivers, cannot fully care for them. In Jember, pesantren and orphanages also serve as facilities where migrant workers' children can be placed while their parents work abroad. Children from economically well-off families are often placed in pesantren, while those from poorer families are often sent to orphanages (which charge no fees).

Madrasah and pesantren usually require payment. Parents are expected to pay for school fees and additional costs (such as uniforms and educational materials), although there are exceptions. Madrasah in Jember and East Lombok waive school fees and uniform costs for orphans, neglected children, and children from low-income families, as well as for children of migrant workers and children of informal sector workers.

4.2.3. Other Community Initiatives and Facilities Supporting Care Providers

Quranic study sessions held in the evening or at night are one of the community initiatives that indirectly assist parents and caregivers in fulfilling their caregiving roles. Quranic study centers (TPQ) and evening Quranic education (diniyah) are common practices in East Lombok and Jember. In East Lombok, these sessions are attended by preschool children (3-6 years old) as well as junior high school students). Children study the Quran in community facilities such as PAUD/kindrgarten mosques in the afternoon, and at night. The lessons take place in the home of a Quranic teacher.

Parents and caregivers appreciate these activities as they provide an opportunity for their children to engage in positive activities. In East Lombok, parents and caregivers also noted that Quranic study strengthens children's religious education and serves as a way for children to spend their free time under supervision. However, since TPQ sessions are only held in the afternoon and evening, this support does not fully assist caregivers who work during the day.

Financial difficulties are a significant challenge for families trying to provide adequate care, and this is a concern within the community. We found that donations from wealthier residents to poorer families, often in the form of zakat or other donations, help alleviate the financial burden families face in meeting household and child care needs.

Box 2. Civil Society Organizations (CSOs) and Private Sector Programs Addressing Care Challenges

CSOs and private institutions run several programs related to caregiving, including child-rearing programs and economic empowerment for families. Aisyiyah is currently developing a program for orphanages, which aims to extend its reach to children outside the institution.

In East Lombok, the Foundation for Women-Headed Family Empowerment (PEKKA) runs the Akademi Paradigta Indonesia (API) program, which seeks to build caregiver capacity through various training modules such as child-rearing practices, maternal leadership in families, home-based caregiving, family role distribution, and the role of village governments.

In Jember, the Tanoker organization initiated a mutual-help caregiving program for children of PMI, where residents assist in meeting care needs, such as providing food or temporarily looking after children when their parents are unavailable. This initiative receives funding from wealthier residents and from the village budget. Although Migrant Care in Jember does not have a specific child care program, the village's migrant worker (Desbumi) cadre ensures that substitute caregivers are designated while parents are working abroad.

In addition to caregiving programs, CSOs also run initiatives to improve family economic conditions through female empowerment. PEKKA, for example, offers cooperatives, PEKKA mart, and production programs for members and non-members at the village level. In Jember, the Fatayat Women's Organization similarly works to improve family economies through women's economic empowerment programs such as sewing and weaving vocational training.

In addition to CSOs, private sector organizations also provide financial support services, including cooperatives and microfinance institutions. These organizations, found in both Jember and East Lombok, assist families in need of loans to meet household and child care needs.

Sustainability remains a challenge for many programs. For example, one CSO program that was attempted by a village could not fully succeed without continued support from the CSO.

Chapter

05

Social Norms Shaping and Influencing Social Care Practices in the Community

In the social care practices identified within the communities where this study was conducted, women—whether as mothers, grandmothers, aunts, older sisters, or neighbors—tend to take on a larger caregiving role compared to men. This section discusses the social norms that contribute to caregiving practices within the community.

5.1. Social Norms in Social Care

This study found that the division of gender roles within households fundamentally affects social care practices. In Jember and East Lombok, the most common caregiving arrangement is that men/husbands are primarily responsible for fulfilling material needs (typically considered as the breadwinners), while women/wives fulfill all other caregiving needs for children, such as providing meals, preparing clothes and school supplies, also accompanying and supervising the children. In Jember, although male caregivers in migrant worker families receive remittances from their spouses to meet family needs, they still continue to work. This division of roles is generally accepted by male and female interviewees.

Decision-making related to daily child care such as determining schedules, meal plans, and selecting clothing, is generally done by women. However, female caregivers in East Lombok shared that major decisions about child care, such as choosing educational institutions, are usually made by men. This gendered division of roles leads women to spend more time at home, reinforcing the practice of women taking on caregiving and other domestic duties.

Findings from the study areas identify several factors that promote the gender division of labor, where caregiving tasks are more commonly carried out by women. First, the cultural and traditional values that women are expected to fulfill caregiving roles within households are deeply embedded in society. This belief was commonly voiced by female participants in both study areas. The findings also highlight societal values that demand women/wives serve and meet the needs of men/husbands, with men often being seen as in need of care. Discussions with female caregivers in East Lombok pointed out that Islamic teachings contribute to these values, with society largely believing that wives are rewarded for serving or fulfilling their husband's needs. According to participants, these values are often embraced by women themselves or used by men to justify their expectations for women to meet their needs. One male participant, a community leader in Jember, referred to a Javanese cultural term, 3M—*masak* (cooking), *manak* (giving birth or having children), and *macak* (beautifying oneself)—to describe the prescribed roles for women in the household. These values, in turn, reinforce the idea that caregiving responsibilities should be almost entirely placed on women.

Second, men tend to be reluctant to engage in caregiving and domestic duties. Findings from the study areas reveal that men/husbands often refuse to help with domestic chores when asked by their wives, due to several reasons. Discussions with caregivers, community leaders, and cadres at the community level revealed that men who take on caregiving tasks are often ridiculed and seen as unusual. This sentiment was frequently expressed by male and female participants across the study areas. This ridicule discourages men

from performing caregiving tasks, although some men choose to disregard the criticism and continue with caregiving duties.

One male community leader in East Lombok explained that men often wish to help with caregiving but are deterred by negative societal perceptions, such as the stigma of 'men being afraid of their wives.' As a result, when they do help, they tend to avoid tasks that are visible to the community, such as hanging laundry. Female participants in both areas also noted that women are often criticized for 'not being devoted' when they allow their husbands to perform domestic tasks. In Jember, this criticism only occurs when men take on a dominant role in domestic chores, but not when they merely assist. Additionally, female participants in both areas felt that men are reluctant to take on caregiving duties because they perceive them as women's work.

Male participants at the community level also expressed that cultural expectations around gender roles 'force' men to work outside the home, meaning they are typically only seen as the breadwinners and are not involved in caregiving tasks. According to participants, men would like to be involved in child care, but the need to earn a living often keeps them away from home.

> "In our area, 90% of child-rearing responsibilities fall on the mothers. Fathers may want to care for their children or family, but due to the need to provide for the family, they are forced to go out and work." —Community Leader, Focus Group Discussion, East Lombok.

> "Additionally, in our community, working is seen as a matter of dignity. So when a man is not working, he is ridiculed and considered to have no dignity." —Community Leader, Focus Group Discussion, East Lombok.

Third, there is a belief that women are naturally more skilled at caregiving and possess an 'instinctive maternal sense' to understand children's needs. Male and female participants in the study areas agreed that women tend to be more patient and better suited to child-rearing compared to men. Women are also viewed as more capable of meeting all caregiving needs because they can also take over the role of men in providing for the family, whereas men are not expected to do the same. On the other hand, men are often seen as less competent in caregiving tasks. One discussion with female caregivers in East Lombok explored the notion that men are generally positioned as needing to be served, which leads them to not be trained for domestic tasks from an early age. This makes them unfamiliar with caregiving tasks when they start their own households. Furthermore, discussions with female caregivers revealed a lack of trust in men's ability to handle caregiving duties, as women believe men do not have the capacity to perform domestic tasks as effectively as women.

This study also identified some exceptions to the gender role division in caregiving tasks within the community. Role shifts often occur when a wife is unable to perform caregiving and other domestic

duties, such as when she is ill or has just given birth. In these cases, men are generally more willing to take on caregiving and domestic responsibilities, and society tends to be more accepting of this. However, in some instances, female informants shared their experiences of continuing to handle caregiving tasks even when they were sick because they felt that men either could not or were unwilling to step in to fulfill caregiving needs. Additionally, men/husbands are more likely to become involved in caregiving when there are no other options, particularly when their wives are working. This was found in East Lombok, where men/husbands helped prepare children's needs and took them to school because their wives had to work in the morning.

Although it is not a common practice, this study found instances where men took on a more significant caregiving role than women. Such practices were observed in two villages in Jember, particularly in households where women were more financially capable. In one case in Jember, a female participant who worked as a teacher and community cadre described a division of roles where her husband, who worked from home, assumed most of the caregiving responsibilities. The participant noted that the community ridiculed this role division, but she chose to ignore it, and her husband did not mind continuing with the caregiving tasks.

Consistent with the findings on social care practices by substitute families, this study observed a connection between gender roles and child-rearing arrangements for single parents. Children raised by single parents are relatively common in both study areas, due to parents working as migrant workers or due to divorce. In East Lombok, single fathers typically delegate caregiving duties to female relatives, such as aunts or grandmothers, while the father's role is limited to providing material support. In contrast, in Jember, single fathers remain the primary caregivers, with assistance from female relatives, such as grandmothers, to meet children's care needs.

On the other hand, in both areas, single mothers tend to independently meet their children's caregiving needs, without assistance from others. Female relatives who take on caregiving responsibilities—such as aunts, grandmothers, or married sisters—often already have their caregiving duties, either for their children or for sick/elderly family members. For example, during data collection we met a woman who cared for her young child and her pre-teen sibling. We also met a woman who cared for her biological child, niece, and elderly parents.

5.2. The Influence of Social Norms on Caregiving Practices in the Community

Based on discussions with caregiver participants, women generally do not perceive the division of gender roles as a challenge. However, they do express fatigue due to the lack of accessible support or assistance. They are also reluctant to ask for help, as domestic work is seen as their responsibility. This sentiment emerged in discussions with female caregivers in East Lombok, where they voiced frustrations about the many tasks and roles they must fulfill. At the same time, they felt that complaining was not justified, and they tended to normalize these feelings.

> "My husband is tired from working too, we often think that way. So, it feels like it's just my responsibility, and asking for help seems pointless, so I do it myself. If I ask [my husband] to wash the clothes, I feel guilty, so I end up doing it." —Female Caregiver, Focus Group Discussion, East Lombok.

Working women bear a double burden, as they are still primarily responsible for most caregiving duties. Societal values and cultural expectations place different demands on working men and women. When men work, they are excused from caregiving responsibilities because it is assumed they have fulfilled their role as breadwinners. In contrast, women often continue to manage caregiving and domestic tasks without help from their husbands, even when both are working.

In both study areas, working women reported struggling to balance work with household responsibilities. They often feel guilty and anxious when they must leave their children unsupervised while working. At the same time, they tend to internalize these feelings, as the cultural norm dictates that caregiving and child-rearing are their duties.

Study participants observed that children's caregiving needs are often not fully met, partly due to family economic conditions. This situation drives women to seek employment to help support the family. However, women's roles as primary caregivers limit their options for work. Female caregivers shared a desire for jobs with flexible hours that would allow them to fulfill caregiving duties. Women who work but continue to provide care often end up in the informal sector, which offers little support for caregiving tasks.

Finally, the gender division of caregiving roles increases the risk that children will not receive adequate care. Findings from both study areas show that men/fathers tend to be less involved in child care, either due to their reluctance or because social norms discourage women from asking for help from their partners. This creates a situation where children receive inadequate care, as fathers remain minimally involved in child-rearing, further reducing support for mothers in meeting children's caregiving needs.

Box 3. Challenges to Women's Participation in the Workforce

Women continue to face significant challenges in actively participating in the workforce. In East Lombok, there remains a stigma surrounding women who work, especially those who migrate for work. The stigma stems from a belief that women working abroad defy their role as homemakers by choosing to work far from their husbands and families.

Women are sometimes unable to work due to restrictions from their husbands, who prevent them from seeking employment under the assumption that providing for the family is the man's responsibility. In addition to needing permission from their husbands, women face limited job opportunities and lower wages compared to men. This situation often forces women to work in the informal sector, where they lack job security and protection. Many women work as daily laborers, vendors, or community health workers, typically in part-time roles.

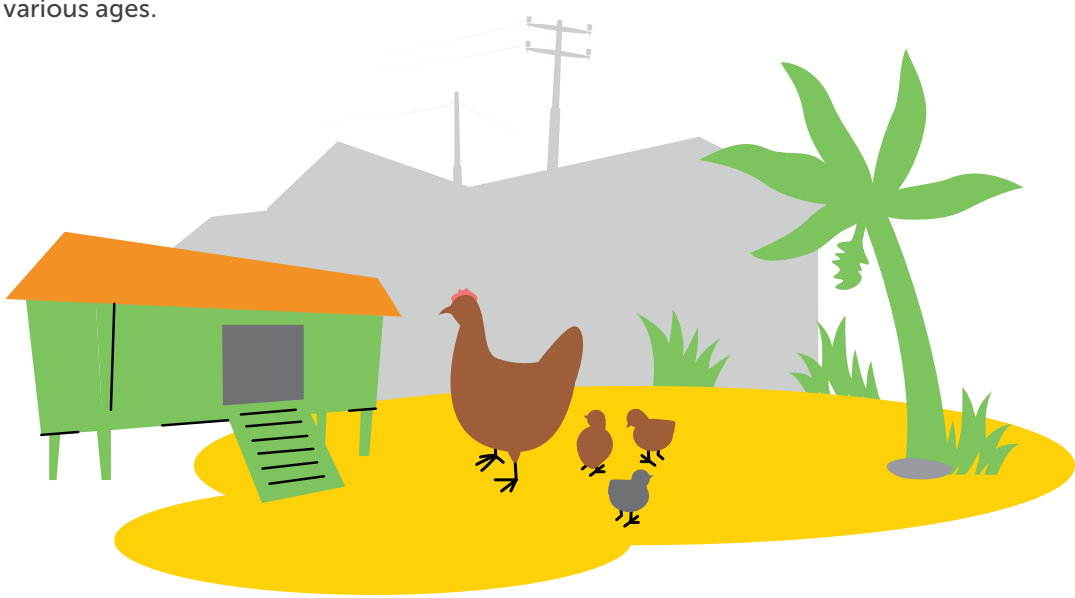
Ultimately, working is often not seen as a choice for women but rather as a last resort when the family's economic needs cannot be met by the husband alone. In East Lombok, it is common for wives to work to support their husbands. For example, wives may work to help prepare materials for their husbands, who work as traders.

In addition to gender norms, the caregiving practices observed in this study, which heavily involve extended family or kinship roles, reflect social norms that prioritize family involvement in providing social care. In addition to primary caregivers, child-rearing is often supported by family members and relatives who typically live nearby. This practice is common in both study areas and is based on family relationships, with no financial compensation involved.

Discussions at the community level also highlighted the influence of religious norms on caregiving practices. Both Jember and East Lombok are predominantly Muslim regions, so the religious norms identified in this study are linked to Islamic values and teachings. Male and female participants in both areas shared a similar understanding that religious teachings support the division of caregiving tasks between men and women. Additionally, religion teaches women/wives to honor and serve men/husbands, who are viewed as the heads of the household. These teachings are widely accepted in society and intersect with deeply rooted cultural and gender values in households, reinforcing the idea that caregiving is primarily the responsibility of women. In addition to gender role division, religious values emphasize the importance of religious education as part of child-rearing, leading to the establishment of many religious schools such as Quranic Education Centers, which are generally held in the evenings and attended by children of various ages.

Findings from East Lombok also identified opportunities to encourage a shift in norms and the gender division of caregiving through religious leaders and cadres. Discussions with participants mapped out the role of religious leaders in supporting this shift by teaching religious values that promote a more equitable division of caregiving tasks within households and encouraging the involvement of fathers in child-rearing. One religious leader shared his experience of incorporating discussions about gender roles into his sermons.

However, the discussion also identified challenges from the perspective of religious leaders, who often believe that caregiving should ideally remain the responsibility of women. At the same time, community-level discussions recognized the role of cadres in helping to promote shifts in gender norms by spreading awareness about the division of caregiving responsibilities between men and women in households.



Chapter

06

Policies, Regional Programs, and Community Needs for Available Social Care Services and Implementation Challenges

This section outlines the social care policies that have been established by the central and regional governments, specifically in the Jember and East Lombok regions.

In this study, the community expressed a greater need for policies and programs that would enable them to improve their family's economic conditions. The study found that while regional governments have implemented various programs aimed at addressing stunting, however, for the community, cash and non-cash social assistance programs, along with the stunting prevention initiatives, are seen as not fully addressing the need to improve economic conditions. Families and male community leaders emphasized the need for vocational training and the availability of job opportunities. Meanwhile, female caregivers expressed a need for flexible employment opportunities that would allow them to continue caregiving responsibilities.

According to participants from the central and regional governments, the government, through social protection and economic empowerment programs for vulnerable households, is attempting to meet the need to improve family economic conditions. According to district officials, social assistance programs such as Direct Cash Assistance (BLT), the Family Hope Program (PKH), Non-Cash Food Assistance (BPNT), the Indonesia Smart Program (PIP), and the National Health Insurance (JKN) are considered helpful in meeting household needs, including child care needs. The Social Services Department (Dinas Sosial) in Jember views the social assistance programs as not fully tailored to the needs of the region due to their rigid criteria and benefits. For example, children

of migrant workers who are cared for by relatives cannot access assistance, even if the caregiver family is eligible, if the child is still registered under the parent's family card, which does not qualify for assistance. Economic empowerment programs in East Lombok are implemented by Social Services and village governments (Pemdes) through skills training for vulnerable female groups.

At the regional level, initiatives to encourage the implementation of caregiving economic policies are beginning to be seen in the strengthening of daycare centers (TPA). The Jember DP3AKB has developed a standardization guideline for daycare services that aligns with policies set by the Ministry of Education and Culture (Kemendikbud). This standardization is being implemented in 15 daycare centers at the district level, focusing on management, service delivery, facilities and infrastructure, as well as monitoring and evaluation. However, this standardization is hindered by funding constraints and has not been fully optimized.

The regional government has implemented the Holistic Integrative Early Childhood Development (PAUD HI) policy to improve access to early childhood education for communities. However, it appears that the regional government has yet to realize the potential of PAUD HI to improve access to child care services and support women's labor force participation. Both in Jember and East Lombok, village governments also have programs that strengthen PAUD through village budget allocations. However, PAUD services have not been developed in accordance with the national PAUD HI policy, which includes child care services.

At the village level, programs like the Family Learning Center (PUSPAGA) and Integrated Community-Based Child Protection (PATBM) are expected by regional government officials to enhance family caregiving capacities. In Jember, particularly at the village level, the Family Welfare Program (PKK) through the Griya Asih program also has the potential to address community caregiving issues. The Jember DP3AKB, for example, provides training to Griya Asih and PKK cadres on caregiving, violence, and basic counseling skills. Meanwhile, the East Lombok DP3AKB focuses on strengthening the PUSPAGA and PATBM institutions through village budget allocations.

Budget and human resource limitations are barriers to providing social care services in the community. The limited village budgets and the lack of staff for PUSPAGA in Jember and East Lombok mean that caregiver capacity-building services have not been fully implemented and are not available in all villages. The shortage of caregivers makes it difficult to provide daycare services at the village level. In this study, no community cadres were identified as working as caregivers in daycare centers or PAUD. Community cadres have the potential to become social care service providers, but they cannot fulfill this role if they continue to be seen as volunteers and their contributions in supporting family caregiving are not acknowledged.

The commitment of officials and local leaders (including the Head of Village) also poses a challenge to implementing various social care-related programs. According to one participant from the local government, the low commitment of the Head of Village to allocate village funds for Griya Asih activities is a challenge for the program's sustainability in villages in Jember. In East Lombok, the local government's priority on stunting prevention and management has resulted in less attention given to social care programs such as family caregiving and the support needed for caregiving while parents are working.

Data collection and the use of data also present challenges in implementing social care policies and programs. The Manpower and Transmigration Office (Dinas Tenaga Kerja dan Transmigrasi) does not have data on children from PMI families because they consider it the responsibility of DP3AKB. Children from PMI families who are cared for by relatives (registered in the Integrated Social Welfare Data/DTKS) cannot be included in the database because they are not listed on the same Family Card. Most educational institutions initiated by foundations or communities, such as PAUD, kindergarten (TK), madrasah, pesantren, and Quranic education centers (TPQ), are not registered in the Ministry of Education's information system or the Ministry of Religious Affairs' offices, and therefore cannot receive operational funding.

Table 1. Overview of National and Regional Policies/Programs on Social Care for Children

Policies/ Programs	National	Regional	Challenges and Gaps
Care Economy	The care economy is a national policy outlined in the National Long-Term Development Plan (RPJPN) 2025-2045. This policy focuses on strengthening regulations and caregiving infrastructure, improving access to care services, and recognizing and reinforcing caregivers as workers. The Ministry of Women's Empowerment and Child Protection (KemenPPPA), through the Taman Asuh Anak Ceria (TARA) program, has developed daycare standardization guidelines in collaboration with the National Standardization Agency (BSN) and the Ministry of Education and Culture (Kemendikdbud), which provides operational funding to daycare centers (TPA) registered in the Basic Education Database (Dapodik).	As of the time of this study, the district and village governments have yet to establish regulatory frameworks to increase women's participation in the workforce. In Jember, the DP3AKB has developed Minimum Service Standard (SPM) guidelines for standardizing daycare centers, in line with national policies. The DP3AKB has also begun initiating daycare standardization, although it is currently limited to centers at the district level.	At the central level, the care economy policy is still focused on expanding services in the formal sector. In 2024, the care economy policy is still in the process of being integrated into the National Medium-Term Development Plan (RPJMN) 2025-2029, and the Government Work Plan (RKP), along with its corresponding regulations and the roles of each ministry/agency.

Policies/ Programs	National	Regional	Challenges and Gaps
Holistic Integrative Early Childhood Education (PAUD HI)	This policy targets children aged 0-6 years by integrating services to meet their educational, health, and caregiving needs. In 2024, the Ministry of Coordinating Human Development and Cultural Affairs (KemenkoPMK), as the leading sector, is mapping programs, services, and human resources in the regions, including opportunities for the integration of programs, services, and modules from various ministries/agencies.	The Jember government, through its 1000 PAUD program, requires Early Childhood Education (PAUD) to be integrated with Posyandu (community health post). The strengthening of PAUD is being implemented in both study regions, including through village budget allocations for the PAUD's operational costs.	However, the findings of this study suggest that PAUD services in villages have not been integrated with caregiving services. Although village funds for PAUD development can be allocated to cover operational costs, these funds are insufficient, meaning PAUD services remain fee-based. Few prospective workers are willing to become caregivers at daycare centers (TPA) due to the long working hours. PAUD teachers do not receive remuneration when they serve as caregivers at daycare centers. Daycare centers at the village level lack the capacity to meet the established standards.

Policies/ Programs	National	Regional	Challenges and Gaps
Family and Community-Based Social Care Policies/ Programs	The Ministry of Women's Empowerment and Child Protection (KemenPPPA) has the Family Learning Center (PUSPAGA) program, which provides education, consultation, and counseling to families. The National Population and Family Planning Agency's (BKKBN) Bina Keluarga Balita (BKB) program enhances the capacity of caregivers in caring for children aged 0-6 years, focusing on meeting their nutritional and developmental needs. The Ministry of Manpower (Kemenaker) has the Migrant Productive Village (Desmigratif) program, which focuses on empowering PMI and their families. This program includes a community parenting component, which provides guidance and capacity building for substitute caregivers and educates the public to get involved in the care of PMI children.	The Jember local government will use the Griya Asih program from the Family Welfare Program (PKK) to function similarly to PUSPAGA. The East Lombok district has implemented the BKB program in several areas. At the regional level, especially in Jember, the Desmigratif program involves local government agencies and Civil Society Organizations (CSOs). However, the Desmigratif program is still under evaluation by the Ministry of Coordinating Human Development and Cultural Affairs (Kemenko PMK) and the Ministry of Manpower (Kemenaker), particularly concerning community parenting.	In Jember, the PUSPAGA program has not yet been implemented. Participation in the Griya Asih program in Jember remains low. In Lombok, the PUSPAGA program does not operate due to a lack of funding. However, the implementation of the BKB program remains limited to activities such as play for toddlers before, during, and after visits to Posyandu (community health post). In Jember, the implementation of the Desmigratif program is still limited to the construction of play areas, and the aspects of community parenting have not yet been fully realized.

Policies/ Programs	National	Regional	Challenges and Gaps
Social Protection Programs	The central government provides a range of cash and non-cash social assistance programs, such as Direct Cash Assistance (BLT), the Family Hope Program (PKH), Non-Cash Food Assistance (BPNT), the Indonesia Smart Program (PIP), and the National Health Insurance (JKN). PKH includes the Family Capacity Enhancement Meeting (P2K2) program, aimed at improving the well-being and quality of life of beneficiary families (KPM). P2K2 covers several modules on topics including health and nutrition, education and caregiving, financial management, and child protection.	In Jember, the local government has initiated the J-Keren health assistance program, which is available to all residents with a Jember ID card. P2K2 sessions are held annually at the village level, facilitated by PKH facilitators from the district. The program also tries to involve men and other family members in its activities.	However, social assistance programs are still not reaching all communities in need. The frequent changes in local leadership often lead to the discontinuation of policies and programs. For instance, the J-Keren program is likely to cease because of a change in leadership.
Economic Empowerment Programs	N/A (Currently, there are no national-level programs related to economic empowerment in the available data).	In East Lombok, the Social Service Office and Village Governments have implemented economic empowerment programs by providing skills training for vulnerable female groups.	Those involved in this economic empowerment program have not fully targeted women from vulnerable families. The lack of compensation for participating in the training is believed to be the reason for the low involvement of women from vulnerable families, as they prefer working over attending the training.

Chapter

07

Discussion

This study aims to provide a deeper understanding of child care services among the families of informal workers and migrant workers in rural areas, as part of the broader spectrum of vulnerable families in Indonesia. In line with this goal, the study captures community perspectives on social care, including which groups require care, the challenges they face, and the support they need. The study highlights how social norms within communities intersect with the community's perception of social care, influencing the division of caregiving responsibilities, caregiving practices, and the support needed for social care practices within the community.

7.1. Social Norms and Community Perception Shaping Social Care Practices

For participants, the basic needs of children—an essential aspect of social care—remain unmet. Parents or families providing social care for children view social care as a process aimed at fulfilling the emotional and material needs of children, which is often seen as part of child-rearing. On the other hand, local government officials, service providers, community leaders, and family welfare organizations see social care as a combination of policies, programs, and efforts to improve the well-being of children, families, and vulnerable groups.

Caregivers and service providers emphasize the economic difficulties families face as the primary barrier to providing adequate social care. The limited job opportunities in these areas are seen as causing economic hardship, which in turn hinders the fulfillment of children's emotional and material needs. Parents and caregivers have not yet articulated a clear need for social care services to help meet these needs. Families, local governments, and service providers agree on the necessity of economic empowerment programs that would allow families to better care for their children. Therefore, social care policy should be directly connected to addressing these basic needs.

Communities have a specific view on abandoned children and social care. Study participants consider children who are not cared for by both parents to be abandoned, with their caregiving needs not being met. This view may be shaped by community perceptions of family structure. The community continues to view the nuclear family as consisting of two parents and children, with both parents responsible for care. In families where this structure is not present—especially where one parent is absent or has to balance caregiving with work—social care provided to children is often deemed inadequate. The study found that despite the challenges faced by parents and extended families in providing care, the expectation remains that families should carry out the caregiving and child-rearing roles.

The division of caregiving responsibilities between men and women is strongly linked to social norms in the community. Traditional gender roles are deeply ingrained, with women expected to provide care and men expected to be the breadwinners. However, the study also found instances where men assumed caregiving duties when mothers or other women were ill, gave birth, had to work, or were divorced.

7.2. Social Care Practices for Children Rely on Parents, Extended Families, and Community Resources

In the study areas, most of the social care practices for children are still carried out by parents and extended families. Parents (fathers and mothers) or single parents (fathers or mothers) remain the primary caregivers for children of PMI or children from single-parent or divorced families. Parents also involve extended family members—such as grandparents, uncles, aunts, or older siblings—to help with caregiving on a temporary basis or to take on long-term caregiving (for over a year).

The community, including non-relatives, also provides temporary caregiver support to help families meet children's needs for basic education, religious education, and supervision. Some forms of social care support are informal. Families rely on neighbors to watch over children who are not yet in school or those who return from school. This process is informal, as neighbors are not paid for their help. It is common in the community for families with school-age children to use formal schools, including religious schools with longer hours (from morning until afternoon), as a service that provides temporary supervision while caregivers work or engage in other activities. Additionally, strong religious norms within the community lead to children being entrusted to Quran study sessions at Quranic Education Centers (TPQ) in the afternoons.

Early Childhood Education (PAUD), which operates for just a few hours per day, has the potential to be a formal social care provider, allowing mothers or other caregivers to work for short periods or engage in other activities. However, entrusting caregiving duties to formal institutions such as PAUD and daycare (TPA) was not commonly observed in this study. The study found that there was little demand for TPA services from the community. Families preferred to entrust their children to extended family members or neighbors rather than formal institutions. This preference is likely influenced by social norms that still view the family as the primary caregiver.

Extended families as substitute caregivers allow children to remain within a family structure, but without sufficient resources, extended families bear additional burdens. Families tasked with caregiving often face limited job opportunities, which forces them to work in the informal sector with minimal income and protection. The study found that the caregiving burden predominantly falls on women—whether as mothers, older sisters, aunts, or grandmothers. Women themselves tend not to seek or ask for help. This situation highlights how caregiving practices within the community are deeply intertwined with norms regarding the division of caregiving roles.

7.3. The Study Identifies Government Policy Strategies, Local Implementation, and Community-Based Initiatives for Social Care

Parents and families view their caregiving responsibilities as being linked to meeting the material needs of children and families, which cannot be delegated to others. As such, caregivers expect support to help meet these needs. The support they seek includes financial assistance, job training, and employment opportunities. Women, as the primary caregivers, hope to work and earn a decent income while still fulfilling their caregiving duties. Meanwhile, community-based social care programs focus specifically on strengthening caregiving capacity and meeting nutritional needs. However, the provision of basic family needs through social assistance programs is still seen as inadequate by the community.

The national policy on the Care Economy Roadmap, established by the central government, aims to increase job opportunities for women. At the local level, governments need to align this goal with the realities of the community. The focus of local governments in the study areas on PAUD and TPA is still primarily on education, with limited focus on increasing employment opportunities. Local governments have not yet developed strategies to support the approach of care by extended families and communities, which is prevalent in the study areas.

Existing social protection policies have not been able to accommodate the role of extended families as substitute caregivers. In the study, families of migrant workers and single-parent families rely on extended families, including elderly relatives, to care for their children over extended periods. Financial and psychosocial support for extended families acting as substitute caregivers for long periods is not regulated within alternative caregiving policies and thus cannot be addressed by social assistance programs such as the Family Hope Program (PKH).

Changing social norms regarding caregiving roles should also be part of the roadmap, but no programs in the study areas specifically target these shifts. Without interventions aimed at changing social norms surrounding caregiving responsibilities and women's roles, women will continue to face barriers to employment. In the study, capacity-building or educational programs for caregivers predominantly involved mothers and rarely included fathers. Moreover, no programs were identified to change societal views on caregiving responsibilities and the division of roles. This outlook has led to a low demand for social care assistance from the government or the private sector in the community.

Chapter

08

Recommendations

The recommendations of this study are formulated to adapt the Care Economy Roadmap policies to the community's situation. These recommendations are based on the findings of the study and consider key concepts related to social care, as well as the 5R concepts (recognize, reduce, redistribute unpaid care work, reward, and represent paid care work) recommended by the ILO to create an inclusive social care system.

The social care practices observed in the community still primarily rely on family-based and kinship-based care, with women as the primary caregivers. This situation is intertwined with social norms related to social care, where the division of caregiving labor remains unequal between men and women. The community also expects support to improve their economic conditions so that families can provide adequate social care for children. The analysis indicates that to enhance women's employment opportunities, several conditions must be met before the national Care Economy Roadmap policies can be implemented at the local level, particularly in communities.

First, since social norms influence caregiving practices within the community, the division of social care labor remains unbalanced between men and women. Therefore, social norm change must be prioritized to redistribute caregiving work within the community. This change is necessary to balance the caregiving roles between women and men. The norm change should also focus on introducing the perspective that the government, private sector, and community should assist with the caregiving work performed by families and extended families, even if it is informal. Changing this perspective could stimulate the demand for caregiving services from families, growth in social care services by the private sector

and communities, and ultimately support the central government's goal of expanding inclusive care services.

Second, the caregiving practices found in the community still rely heavily on family, kinship, and community-based institutions. Therefore, the implementation of care economy policies at the local level should focus on strengthening community caregiving resources. This approach aligns with the existing caregiving practices, which already use family, neighbors, and established community systems. For example, the establishment of a daycare center (TPA) in residential areas should involve local cadres or residents who are still part of the community. Ideally, TPAs could be organized by the community itself. Neighbors as temporary caregivers, informal alternative care, PAUD, and TPQ (Quranic education centers) represent potential community-based care models that could be developed to meet short-term and long-term caregiving needs. The caregiving practices identified in families of informal workers and PMI in rural areas demonstrate that families need social care services that are temporary and long-term. There is a range of identified social care needs in this study. This underscores the need to develop social care services as a continuum of different types of care.

Third, the community expects support to improve their economic conditions so that families can provide adequate social care for children. Therefore, both the central and local governments need to link the provision of social assistance, employment opportunities, and social care services. Families of PMI often do not receive assistance because they are considered to have sufficient income. However, the study finds that not all PMI families are financially stable. Providing social assistance to the extended families of PMI as substitute caregivers should be considered. There is also a need for jobs that allow families to continue performing caregiving duties.

The following recommendations are detailed for the key actors in social care: the government, the private sector, civil society organizations within the community, and families.

Central Government

- The Ministry of Women's Empowerment and Child Protection (KemenPPPA), as the leading sector for the Care Economy Radmap, needs to coordinate all relevant ministries and agencies to prepare the regulatory framework, action plans, and resources to drive local implementation focusing on providing care services, fulfilling basic needs, and economic empowerment as the initial steps in the implementation of a care economy and caregiving policies. The action plan for a care economy policy should be adaptable by the government, communities, and the private sector in alignment with the community's needs.

- The Ministry of Women's Empowerment and Child Protection (KemenPPPA) and The Ministry of Social Affairs (Kemensos) should integrate care economy policies into the national social protection system. There are various social protection instruments used by middle-income countries that can help families provide social care. For instance, providing child-centered social assistance so that children continue receiving support even if their family structure changes (e.g., when they are cared for by substitute family members). Assistance can also be provided in the form of subsidies for accessing social care services offered by the private sector or community organizations. Integrating care economy policies into social protection indirectly recognizes caregiving work that has traditionally been performed by family members.

- The Ministry of Women's Empowerment and Child Protection (KemenPPPA), The Ministry of Social Affairs (Kemensos), under the coordination of Kemenko PMK, need to ensure that regulations regarding alternative caregiving systems by extended families also support long-term care for children from PMI families or other vulnerable groups.

- All ministries and agencies that have social care policies and programs should allocate sufficient resources to create a social care ecosystem that enables adaptation at the local level and fosters collaboration across sectors, especially between government, the private sector, and civil society. This ecosystem should include creating inclusive and diverse access to social care services that meet the needs of the community, as well as providing resources and technical support to enhance service quality.

Local Governments (District and Village)

- Local governments need to engage communities as the center of developing social care services within the community. The form of social care services will depend on the community's needs. For instance, areas with many PMI families will require the development of alternative caregiving provided by extended families or other community members.

- Local governments should map social care needs and the current situation in their areas so that regional policies can address local realities. This mapping is essential as a foundation for creating localized versions of national policies and implementing national programs. Therefore, local governments need to continuously engage with the community to develop appropriate social care services. The private sector, including businesses, should also be involved in the planning and implementation processes. This can be applied in pilot programs for social care services at the local level.

- Local governments should encourage the use of village funds as a financial resource for care services within the community. Village funds can be allocated for services such as TPA, PAUD, and informal systems such as TPQ, which have been helping provide care. Village funds can also be used to enhance skills and provide appropriate compensation for women in villages who have been informally assisting with caregiving. This initiative will also provide opportunities for other women to work.

Civil Society Organizations (CSOs)

- CSOs should support community cadres, community leaders, and families involved in caregiving duties. This support is crucial to improving the quality of care services and finding care solutions that match the community's situation. The support aims to strengthen the community's ability to identify needs and available resources to share caregiving burdens, open access to services, and improve quality of life through social care.
- CSOs must take the lead in advocating for changes in social norms. So far, caregiving roles have largely fallen to women, so there is a need for changes in social norms that include the involvement of men in caregiving. Awareness campaigns, training, and support aimed at improving knowledge, attitudes, and daily behaviors are expected to help the community realize that caregiving should not solely be a burden on women, but men should also be involved.

- Using issue identification mapping, potential challenges, and available community resources, CSOs can base their advocacy and program design on these factors. Depending on the needs of the community, CSOs can prioritize one aspect of social care as an advocacy focus. Prioritizing one aspect of social care will help CSOs gather resources and guide the advocacy process.

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Appendix

Table 2. Key Informant Interviews (KII) at the Community, District, and National Levels

Level	Purpose & Topics	Participants/Informants
Community	As a follow-up to the FGD and community observations, specifically to gather additional data and interview informants who were not included in the FGD and community observation participants. Topic: Care arrangements and supporting facilities.	Caregivers and service providers.
Regional	Mapping and further exploring the social care programs and policies available in each local institution. Topic: Local institutional policies and programs.	Policymakers.
National	Mapping the priorities of government policies and programs related to social care in Indonesia Topic: National policies and programs.	Institutions and Divisions[3]: • Ministry of National Development Planning - Directorate for Poverty Alleviation and Community Empowerment • Ministry of National Development Planning- Directorate for Family, Women, Children, Youth, and Sports • Ministry of Women's Empowerment and Child Protection • Assistant Deputy for Child Rights Fulfillment • Ministry of Women's Empowerment and Child Protection - - Assistant Deputy for Gender Mainstreaming • Coordinating Ministry for Human Development and Cultural Affairs - Deputy for Coordination of Child, Women, and Youth Quality Improvement • Ministry of Social Affairs - Directorate for Social Protection and Social Welfare • Ministry of Education and Culture - Directorate for Early Childhood Education • Ministry of Manpower - Directorate for Placement and Protection of Indonesian Migrant Workers • BKKBN - Directorate for Family Welfare for Children

[3] The writing of the ministries and institutions follow the nomenclature that applies during the data collection (September to October 2024).

Table 3. National Consultation Participants

Category	Institution
Civil Society Organizations (CSO)	PEKKA National Secretariat
	Migrant Care
	Aisyiyah
	Human Resources Development Research and Development Institute, PBNU
	Indonesian Family Planning Association (PKBI)
Development Partners	International Labour Organization
	UNICEF
	World Bank

Table 4. Number of Participants and Activities

Region	Level	Number of Participants		Number of Activities		
		Male	Female	FGD	KII	Observation
Jember Regency	Community	16	23	12	3	7
	District	12	7	2	5	-
Total			30	14	8	7
East Lombok Regency	Community	21	25	13	5	5
	District	13	9	3	3	-
Total			34	16	8	5
National	Ministries/ Agencies	3	14	-	9	-
	National Consultation	1	7	2	-	-
Total		4	21	2	9	-

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