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STREET-LEVEL BUREAUCRATS IN CHILD PROTECTION POLICY IMPLEMENTATION: EVIDENCE FROM MERAUKE, INDONESIA

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ABSTRACT
This study examines the role of healthcare workers and cross-sectoral coordination in handling violence against children cases in Merauke Regency from a public policy perspective. Drawing on the theoretical frameworks of Street-Level Bureaucracy, Boundary Spanning, and Collaborative Governance, this qualitative case study explores how frontline actors translate policy into practice amid local constraints. The findings indicate that healthcare workers serve as a crucial entry point in identifying child violence through clinical and ethical discretion in the absence of integrated cross-sectoral standard operating procedures (SOPs). The continuity of services, from the emergency medical response to long-term recovery and social reintegration, is sustained through informal boundary-spanning mechanisms based on interpersonal communication among frontline actors (healthcare workers, psychologists, and the Integrated Service Center for the Empowerment of Women and Children [UPTD PPA]). Nevertheless, the effectiveness of this collaborative system is constrained by substantial structural limitations, including insufficient human resources in both quantity and capacity, the absence of dedicated healthcare financing schemes for victims, geographical challenges, and socio-cultural resistance, such as customary dispute resolution and family stigma. This study concludes that child protection in a decentralized governance context is not a sector-specific endeavor but a continuous process whose success depends on the adaptive resilience of frontline actors.

INTRODUCTION

Violence against children is both a major public health concern and a social protection issue that continues to require the attention of all sectors of society, particularly public policymakers. According to the World Health Organization (WHO), an estimated one billion children aged 2–17 years worldwide experienced at least one form of violence (World Health Organization [WHO], 2026). Meanwhile, in Indonesia, data from the Online Information System for the Protection of Women and Children (SIMFONI PPA) recorded 15,396 cases of violence against children throughout 2025, including 11,049 cases of sexual violence, with the majority occurring in domestic settings, particularly within the nuclear family (SIMFONI PPA, 2025). The consequences of such violence extend beyond physical injuries and short-term health problems, often resulting in serious long-term impacts (WHO, 2026), including depression, anxiety, suicidal ideation, behavioral disorders, declining academic performance, substance abuse, and an increased likelihood of becoming perpetrators of violence in adulthood (Novitasari et al., 2025).

Recognizing these risks, Indonesia has progressively strengthened its child protection framework through a series of legal and policy reforms. Constitutional guarantees under Article 28B(2) of the 1945 Constitution have been translated into a range of statutory and policy instruments, including Law No. 35 of 2014 on Child Protection, Law No. 11 of 2012 on the Juvenile Criminal Justice System, Law No. 12 of 2022 on Sexual Violence Crimes, and Government Regulation No. 78 of 2021 on Special Protection for Children. These legal foundations have been

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complemented by a number of national policy initiatives, such as Child-Friendly Cities (Presidential Regulation of the Republic of Indonesia No. 25 of 2021), Child-Friendly Schools (Minister of Women's Empowerment and Child Protection Regulation No. 8 of 2014), Integrated Service Centers for the Protection of Women and Children (Minister of Women's Empowerment and Child Protection Regulation No. 4 of 2018), and the National Strategy for the Prevention of Child Marriage, all of which seek to strengthen child protection across family, educational, community, and institutional settings. More recently, this commitment was further consolidated through Presidential Regulation No. 101 of 2022 concerning the National Strategy for the Elimination of Violence against Children (Stranas PKTA), which establishes a coordinated policy framework and strategic direction for national and subnational efforts to progressively eliminate violence against children.

Despite these extensive legal and institutional efforts, empirical data indicates a persistent upward trajectory over recent years. Historical records from SIMFONI PPA show that reported cases grew steadily from 14,446 in 2021 to 19,628 in 2024 (SIMFONI PPA, 2025), a momentum that clearly sustains the high figures observed in 2025. Furthermore, national survey data further show that one in two Indonesian children has experienced at least one form of violence during their lifetime, suggesting that the actual prevalence substantially exceeds the number of officially reported cases (KemenPPPA, 2024b). Taken together, these findings indicate that the expansion of legal and policy commitments has yet to be accompanied by comparable improvements in implementation outcomes, underscoring the continued urgency of strengthening the mechanisms through which child protection policy is translated into effective protection on the ground.

The persistence of this implementation gap highlights that the effectiveness of child protection policy depends not only on the existence of comprehensive legal and policy frameworks, but also on how these frameworks are translated into practice by the institutions responsible for their implementation. In response, the Government of Indonesia has established a child protection system involving multiple ministries, agencies, and local government institutions with mandates related to child protection (KemenPPPA, 2024a). This institutional arrangement reflects the recognition that violence against children is a multidimensional problem that cannot be addressed by a single institution alone. Accordingly, effective responses require coordinated action across interconnected sectors, including healthcare, social protection, education, and law enforcement (KemenPPPA, 2024a). Within this multisectoral system, the healthcare sector occupies a particularly significant position because healthcare workers in hospitals and primary healthcare facilities are often the first professionals to identify suspected cases of violence against children (Chen et al., 2022). This position places healthcare workers not only as providers of medical care but also as the initial gateway to the identification and management of such cases.

This role is further reinforced by national regulations. Indonesia's Minister of Health Regulation No. 68 of 2013 concerning the Obligations of Healthcare Providers to Report Suspected Violence Against Children stipulates that healthcare workers are required to provide emergency medical care, conduct initial counseling, explain the child's condition and the suspected causes to parents or guardians, discuss subsequent management, make referrals when necessary, ensure the child's safety, document all findings in the medical record, prepare a visum et repertum upon request by law enforcement authorities, and provide relevant information to the police in accordance with applicable regulations (Kemenkes, 2020). Consequently, the responsibilities of healthcare workers in handling child victims of violence extend beyond clinical care to encompass protective functions and coordination with other sectors.

To date, most studies have positioned healthcare workers primarily within the context of clinical service delivery. Existing research has largely focused on the accuracy of diagnosis and the development of screening tools for child violence (Chen et al., 2022; Bjursell et al., 2025), the

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medical examination required to substantiate cases of child sexual violence (Fathya et al., 2020), the role of physicians in handling violence cases in Indonesia (Ocviyanti et al., 2019), the authority of primary healthcare physicians in managing sexual violence cases (Sari et al., 2025), and the competencies and barriers faced by healthcare workers in recognizing and reporting signs of violence (Hanafi et al., 2025). Although these studies have made important contributions, they primarily emphasize the clinical and professional dimensions of healthcare practice. Comparatively little attention has been given to how healthcare workers perform their roles as part of an integrated child protection system involving multiple institutions, particularly from the perspective of public policy implementation. Yet, once identification and medical management have been completed, child victims continue to require a range of additional services, including psychological support, social protection, legal assistance, educational support, and social reintegration. Accordingly, the effectiveness of case management depends not only on the quality of medical services but also on the extent to which those services are connected to the broader child protection system.

This perspective becomes even more relevant in the context of policy implementation at the local level. Previous studies on child protection policy implementation have consistently identified inter-agency coordination as one of the principal challenges. Fitriyanti et al. (2022), for example, in their study of child protection policy implementation in Rokan Hilir Regency, identified several factors influencing implementation, including policy standards, resource availability, organizational characteristics, inter-agency communication, the behavior of implementing actors, and prevailing social, economic, and political conditions. Similar findings were reported by Junanti et al. (2025) in their study of the Child-Friendly Regency/City policy in Bengkulu and by Kurniawan et al. (2025) in their research on child protection in Tulang Bawang Regency. Together, these studies demonstrate that child protection policy implementation at the local level continues to face significant coordination, institutional, and administrative challenges.

Nevertheless, most of this literature examines coordination primarily from an institutional or governance perspective. Relatively few studies have specifically explored how frontline actors (street-level bureaucrats) such as physicians, healthcare workers, psychologists, and child protection service officers translate child protection policies into everyday practice when interacting directly with victims. Contemporary scholarship in public administration continues to affirm that street-level bureaucrats occupy a genuinely pivotal position in the policy process: rather than merely executing decisions made elsewhere, they are widely recognized as central and indispensable actors whose day-to-day discretionary practices effectively determine what a policy becomes in practice (Cohen, 2023).

Recent scholarship further reinforces this perspective by emphasizing that direct-delivery interactions between frontline officials and citizens constitute the primary arena through which public services are delivered, experienced, and their outcomes shaped in practice (Gofen et al., 2024). This centrality is especially salient in developing-country contexts, where frontline workers must routinely translate policy mandates into practice under conditions of state capacity shortage, institutional weakness, and considerable structural constraint (Lotta et al., 2021). In practice, however, the decisions made by these frontline actors often determine whether victims can promptly access protection, follow-up services, and the recovery mechanisms they require. These challenges become even more pronounced in cases of child sexual violence, where healthcare workers operate under intense pressure, must make rapid decisions, and are not always supported by adequate coordination systems (Riskiyana et al., 2026).

Against this backdrop, Merauke Regency in South Papua Province provides a particularly relevant context for this study. The region continues to face challenges associated with its vast geographical area, limited access to public services, and shortages of resources in the healthcare and education sectors (Sukirman et al., 2024). Consequently, the implementation of child protection policy in Merauke is determined not only by the existence of formal regulations but

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also by the capacity of frontline actors to translate policy into practice through cross-sectoral coordination amid complex local conditions.

Accordingly, this study aims to examine how healthcare workers perform their roles in handling cases involving child victims of violence and how cross-sectoral coordination is established throughout the child protection process in Merauke Regency, South Papua Province. Drawing on the Street-Level Bureaucracy perspective, this study seeks to understand how frontline actors translate child protection policy into practice while identifying the challenges that affect the continuity of services from medical intervention to the protection and recovery of child victims.

Furthermore, to understand how child protection policy is translated into practice by actors who interact directly with child victims of violence, this study adopts Street-Level Bureaucracy (SLB), as proposed by Lipsky (1980), as its primary theoretical framework. Collaborative Governance (Ansell & Gash, 2007) and Boundary Spanning (Williams, 2002) are employed as complementary frameworks that extend the analytical scope of SLB to the relational and institutional levels. These three perspectives serve as complementary analytical lenses operating at different levels of analysis: the individual level (SLB), the interorganizational relational level (Boundary Spanning), and the collaborative level involving public and non-public actors (Collaborative Governance). By integrating these three perspectives, this study moves beyond merely describing what frontline actors do toward explaining why and how they perform their roles under conditions of structural constraint.

METHODS

This study employed a qualitative approach using a single-case study design, focusing on the implementation of child protection policy in Merauke Regency, South Papua Province. Data were collected through two complementary methods: semi-structured interviews and document analysis of literature and policy documents relevant to the study context. Semi-structured interviews were selected because they enabled the researcher to explore predetermined topics while allowing participants to elaborate on their responses based on their professional experiences and reasoning (DiCicco-Bloom & Crabtree, 2006).

Participants were selected using purposive sampling, specifically criterion sampling, a strategy in which participants are recruited based on predefined criteria relevant to the phenomenon under investigation (Palinkas et al., 2013). The study involved five participants representing key points within the referral pathway for managing cases of violence against children in Merauke Regency: three physicians (one working at the Regional General Hospital and two at primary healthcare centers), one psychologist providing support to victims of violence, and one officer from the Integrated Service Center for the Empowerment of Women and Children (UPTD PPA) under the Office of Women's Empowerment, Child Protection, Population Control, and Family Planning (DP3AP2KB) of Merauke Regency.

The relatively small number of participants is consistent with the principle of information power proposed by Malterud et al. (2015), which suggests that sample adequacy in qualitative research is determined not merely by the number of participants but by the extent to which the sample provides relevant and specific information about the phenomenon being studied.

Data were collected using a semi-structured interview guide developed based on a review of the literature and regulations related to child protection. The interviews focused on five main topics: the identification of violence against children, decision-making during the initial stage of case management, cross-sectoral coordination, structural barriers, and recovery and continuity of services. Participation was voluntary, and informed consent was obtained from all participants prior to the interviews. To ensure confidentiality, participants were anonymized using identification codes, and all interview data were handled confidentially. The interviews were audio-recorded, transcribed verbatim, and conducted in Bahasa Indonesia before being carefully translated into English for publication using a conceptual-equivalence approach to

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preserve participants' intended meanings. In addition to the interview data, relevant policy documents and academic literature were collected and reviewed to support the triangulation and contextualization of the findings (Bowen, 2009).

The data were analyzed using thematic analysis (Braun & Clarke, 2006). The analysis began with repeated reading of the interview transcripts, followed by open (inductive) coding to generate initial codes that closely reflected participants' accounts. These codes were then grouped into broader categories. An evidence matrix was subsequently developed to organize the codes and supporting quotations, which facilitated the identification of four overarching themes. To maintain an inductive focus during data analysis, the theoretical frameworks of Street-Level Bureaucracy (Lipsky, 1980), Boundary Spanning (Williams, 2002), and Collaborative Governance (Ansell & Gash, 2007) were deliberately excluded from the coding process; instead, they were employed strictly as interpretive lenses during the discussion of the findings.

Artificial intelligence (AI)-assisted tools were used only to support selected stages of the research process. Claude AI was used to facilitate the identification of relevant literature, while ChatGPT was used to improve the readability of the manuscript and to assist in organizing the coding matrix during qualitative data analysis. These tools were not used to generate, interpret, or validate the study findings. All analytical decisions, interpretation of the data, verification of references, and the final manuscript were undertaken independently by the authors, who assume full responsibility for the accuracy and integrity of the work.

RESULTS AND DISCUSSION

Table 1 presents a summary of the thematic analysis. Following the open coding and axial coding processes, the interview data were organized into ten axial codes, which informed the development of four overarching themes. These themes provide the analytical framework for the findings presented in the following section

Table 1. Summary of the Thematic Analysis and Coding Framework

Representative Open Codes	Categories	Theme
Initial medical assessment; Clinical suspicion; Injury documentation; Victim safety prioritization; Trauma-informed communication	Recognition and Assessment of Child Violence; Trauma-informed Initial Response; Protective Decision-making	Identifying Violence and Initiating Protection: Healthcare Workers as the Frontline
Referral pathway; Positive interagency coordination; Multi-sector case management; Boundary-spanning collaboration	Referral Mechanisms; Interagency Coordination; Boundary-spanning Practices	Cross-sectoral Coordination as the Foundation for Sustainable Child Protection
Family reluctance to report; Community stigma; Absence of integrated SOP; Human resource limitation	Family and Socio-cultural Barriers; Institutional Challenges; Resource Constraints	Structural Constraints in the Implementation of Child Protection
Longitudinal psychological recovery; Post-case social reintegration; Family psychoeducation; Psychological readiness for reintegration	Continuity of Care and Recovery	Child Protection as a Continuous Recovery Process

Identifying Violence and Initiating Protection: Healthcare Workers as the Frontline

All participants described the management of cases involving child victims of violence as beginning with a critical initial stage: the ability to recognize suspected violence from the very first contact with the child. Unlike most medical conditions, which can generally be identified

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through relatively clear clinical signs, cases of violence against children often present in ambiguous ways. Children are not always able to openly disclose what they have experienced, while family members may provide incomplete information or even attempt to conceal the true cause of the child's injuries. D2, a physician working at a primary healthcare facility, confirmed this ambiguity when describing encounters with patients in the emergency department:

> *"Patients who have experienced violence are not always honest. Sometimes they say they fell or give other explanations. That's why we need to explore the situation further and collaborate with other professionals."*

In such situations, identifying violence depends not only on physical examination but also on healthcare workers' ability to recognize more subtle indicators through clinical observation, communication, and professional judgment regarding the child's condition and surrounding environment. D1 emphasized that sensitivity to nonverbal cues is a crucial competency for frontline healthcare workers:

> *"Healthcare workers cannot focus solely on injuries or physical complaints. We also have to pay attention to the child's surroundings, facial expressions, eye contact, and other nonverbal cues."*

The three physicians interviewed described a remarkably consistent pattern. They explained that suspicion of violence rarely arises from the child's disclosure during the initial examination. Instead, it often emerges when the history provided by family members is inconsistent with the clinical findings. Such discrepancies prompt healthcare workers to gather further information before deciding on the next course of action. This finding is consistent with previous research on the role of primary healthcare workers in Indonesia in the early detection of violence against women and children, which likewise highlights their pivotal role in identifying victims, providing medical care and psychological intervention, and documenting cases (Asbar et al., 2025). Moreover, in some cases, crucial information only emerges gradually as trust is established. This reflects the considerable psychological barriers experienced by children at the initial stage, as described by D1:

> *"The first challenge is that children often do not want to talk. They may feel ashamed, afraid, or threatened, especially when the perpetrator is someone close to them."*

This finding was reinforced by the psychologist (P1), who explained that child victims are often not emotionally prepared to disclose their experiences of violence. In practice, children frequently require time before they are able to reveal what actually happened. P1 emphasized the importance of Psychological First Aid (PFA) during this critical stage:

> *"During the first meeting, the most important thing is to help the child feel safe. It's not about starting therapy immediately, but about providing Psychological First Aid: look, listen, and link."*

The approach described by P1 is consistent with the look, listen, and link principles outlined in the Psychological First Aid guide developed by WHO (2011), which emphasize establishing safety and connectedness as the essential first steps before more comprehensive psychological interventions are undertaken.

The importance of healthcare workers' role becomes even more evident once violence is suspected and decisions regarding the next steps must be made. All physicians emphasized that their first priority is neither administrative procedures nor legal processes, but ensuring that the child's medical condition is stabilized. D1 highlighted how the hospital's role extends beyond that of a healthcare institution to become a temporary place of protection for the child:

> *"When a child is in the hospital, they are relatively safe because medical staff and other personnel are present. If we suspect violence, we would never send the child home immediately."*

Once urgent medical needs have been addressed, healthcare workers begin contacting other relevant actors, including psychologists, the Integrated Service Center for the Empowerment

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of Women and Children (UPTD PPA), and law enforcement agencies, depending on the circumstances of each case. In this way, the identification process serves as the critical entry point that shapes the subsequent chain of protection. D3, a physician working at a primary healthcare facility, described how proactive action is taken immediately without waiting for rigid bureaucratic approval in order to protect the child:

> *"When the victim is a child, we usually report the case immediately to UPTD PPA or the women's empowerment office. In cases involving adult victims of domestic violence, we may wait for a complaint or the victim's consent, but when the victim is a child, we usually report it immediately because the child needs protection."*

One physician further explained that when child sexual violence is suspected, the primary focus extends beyond conducting a physical examination to ensuring that medical evidence is properly documented while safeguarding the child's psychological well-being. At the same time, the child and their family are informed about the stages of case management, including the possibility of referral to psychological services and social protection. A similar practice was described by UPTD PPA, which noted that most cases referred from healthcare facilities have already undergone an initial identification process, allowing coordination to focus immediately on subsequent protection needs. UPTD PPA Merauke acknowledged the vital role of healthcare workers during this emergency phase:

> *"Physicians and healthcare facilities play a crucial role in responding to victims of violence because they are the primary providers of emergency care, especially for victims of physical and sexual violence who require immediate intervention."*

Furthermore, the decisions made during this initial stage ultimately shape the entire trajectory of case management, influencing access to psychological services, legal proceedings, and social protection. Conversely, if healthcare workers fail to respond appropriately or exercise poor discretion, the child protection process becomes vulnerable to disruption. This challenge is reflected in the sociological realities described by D2, where the boundaries between medical intervention and legal protection often collide with the reluctance of families to pursue further action:

> *"If the family does not see it as a problem or does not want to pursue the case further, we usually only provide medical treatment."*

These findings are consistent with Lipsky's (1980) Street-Level Bureaucracy perspective, which conceptualizes frontline actors as policy implementers who exercise discretion when responding to complex situations that cannot be fully governed by formal procedures. In the present study, healthcare workers are compelled to rely on such discretion because formal regulatory arrangements at the local level remain insufficiently developed. This pattern echoes a broader body of international scholarship applying street-level bureaucracy theory specifically to public health settings, which has repeatedly shown that healthcare workers in resource-constrained health systems must exercise considerable professional discretion to compensate for gaps in formal protocols, supervision, and institutional support (Ramani et al., 2020). Walker and Gilson (2004) demonstrated that frontline health workers were expected to meet high service demands despite resource shortages, heavy workloads, inadequate working conditions, and limited managerial support. Under these circumstances, they developed various coping mechanisms and work routines to rationalize their inability to provide care that met the professional standards they aspired to uphold.

In this sense, the discretionary behavior observed among healthcare workers in Merauke is not an isolated local anomaly but a pattern consistent with what previous street-level bureaucracy research in public health has already documented across other country contexts. For example, D2 stated that *"there is no specific written SOP yet,"* a finding echoed by UPTD PPA, which explained that *"a joint cross-sectoral SOP is not yet available; each institution currently operates according to its own internal SOP."* Even where an SOP

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formally exists, its implementation has yet to become fully operational, as acknowledged by D3: *"The SOP exists. However, there is still no documented workflow or flowchart available."*

Cross-Sectoral Coordination as the Foundation for Sustainable Child Protection

The findings indicate that the management of cases involving child victims of violence in Merauke Regency does not end with the provision of medical care. All participants described how, once the child's immediate healthcare needs have been addressed, the protection process continues through the involvement of multiple institutions, including UPTD PPA, psychologists, law enforcement agencies, referral healthcare facilities, schools, and the child's family. As a regional technical unit formally mandated to provide services for the management, protection, and recovery of women and child victims of violence, UPTD PPA is specifically designed to perform this cross-institutional coordinating function (KemenPPPA, 2018). D1 reinforced this perspective by emphasizing that clinical intervention represents only one component of the victim's overall recovery process:

> *"We must not forget that the child is a victim. We cannot assume that everything is over once the examination is completed... It is not simply a matter of observing the child in the emergency department and then sending them home; we also need to consider whether further care is required."*

Interestingly, this coordination does not always take place through formal bureaucratic mechanisms. Although each institution has distinct roles and responsibilities, practice in the field shows that working relationships are more often sustained through direct and continuous communication. When physicians identify suspected violence against a child, their focus extends beyond completing the medical examination to ensuring that the child is promptly connected to the services they require. D1 explained how healthcare workers at the hospital actively initiate referrals to child protection agencies:

> *"In principle, physicians here can contact UPTD PPA as soon as they identify signs indicating violence against a child... Once contacted, UPTD PPA comes to the hospital."*

Similarly, both psychologists and UPTD PPA regard coordination as an integral part of victim support. This pattern suggests that the effectiveness of child protection depends less on each institution fulfilling its responsibilities independently than on the ability of frontline actors to maintain continuity of services. In practice, no single institution possesses the capacity to meet all of a victim's needs. Each actor addresses only one part of the protection process, making successful case management dependent upon effective collaboration with other institutions. This finding is particularly evident in the referral pathway described by UPTD PPA. Upon receiving a report, the agency does not immediately focus on legal proceedings. Instead, it first assesses the victim's needs before coordinating with the relevant institutions. A UPTD PPA officer in Merauke described the complexity of this multi-actor coordination process through the following example:

> *"The UPTD service pathway begins when a complaint is received from the victim and their mother, followed by an assessment of the victim's needs. UPTD PPA then coordinates with the temporary shelter, the Women's and Children's Protection Unit of the District Police (UPPA Polres) for legal proceedings, psychologists for psychological recovery, the Regional General Hospital for the visum et repertum and initial medical examination, schools to ensure the child's educational needs are met, primary healthcare centers for follow-up medical care, and the public prosecutor's office. After the court's decision, UPTD PPA also coordinates with the military village supervisory officer (Babinsa), the community police officer (Bhabinkamtibmas), the customary clan leader, schools, and the child's family to support the child's reintegration into the community."*

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This pathway illustrates that child protection is a dynamic and evolving process that responds to the changing needs of the victim rather than a series of administrative procedures that conclude once a report has been filed.

A similar perspective emerged from the healthcare workers. All three physicians explained that identifying suspected violence against a child does not mark the end of their responsibilities after providing medical care. Rather, medical examination is viewed as the entry point to a broader child protection process. Consequently, communication with psychologists, UPTD PPA, and law enforcement agencies forms part of their routine practice in managing these cases. P1 (Psychologist) described this interdependence across sectors, particularly how psychological assessment informs subsequent legal processes through UPTD PPA:

> *"I usually receive a formal request for assistance or accompaniment. Most often, the request comes through UPTD PPA... UPTD PPA then forwards or uses my report as needed, for example, for the police or the court."*

In this context, cross-sectoral coordination is driven more by interpersonal relationships than by formal mechanisms. D3 described the speed of these interactions: "Communication between our facility and the women's empowerment office is fast."

Such practices enable institutions to respond promptly to victims' needs without waiting for lengthy administrative procedures. In certain situations, this flexibility becomes a key factor in maintaining continuity of services, particularly in cases of child sexual violence that require immediate intervention for both medical management and forensic purposes.

Furthermore, findings also demonstrate that coordination involves not only information sharing but also a clear division of responsibilities based on the expertise of each institution. Physicians focus on stabilizing the victim's medical condition and documenting clinical findings; psychologists address psychological recovery; UPTD PPA coordinates protection services and victim support; while law enforcement agencies conduct criminal investigations. This competency-based division of roles was highlighted by P1 when describing situations involving clinical indications beyond the scope of psychology:

> *"If I suspect sexual violence, I cannot establish the diagnosis medically. I provide a recommendation for a medical examination or an internal examination if necessary. I submit that recommendation to UPTD PPA, and UPTD PPA follows it up with the healthcare facility or the physician. I do not take over the medical role myself."*

From the perspective of Boundary Spanning, these findings demonstrate that frontline actors actively transcend organizational boundaries in carrying out their responsibilities. Boundary spanning refers to the competencies that enable individuals to build working relationships across institutional boundaries through trust, communication, and informal networks, rather than relying solely on formal organizational structures (Williams, 2002). In this study, frontline actors work not only within the mandates of their respective institutions but also continuously cultivate relationships with other organizations to ensure that victims' needs are met. Activities such as sharing information, making referrals, coordinating actions, and adapting services to the evolving circumstances of each case represent forms of boundary-spanning practice that enable child protection services to function as an integrated system.

Within the context of Merauke, these practices appear to rely more heavily on professional relationships that have developed across institutions than on fully standardized formal coordination mechanisms. This observation is reinforced by UPTD PPA's acknowledgment that no formally binding collaborative regulatory framework currently exists: "*A joint cross-sectoral SOP is not yet available. At present, each institution continues to operate according to its own internal SOP.*" A similar situation exists at the primary healthcare level, where D2 stated that *"there is no specific written SOP yet,"* while also emphasizing that boundary-spanning practices continue to function

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effectively because *"the workflow is already clear, even though there is no written SOP."*

Moreover, beyond boundary spanning, the multi-actor referral pathway described by UPTD PPA—linking hospitals, primary healthcare centers, the Women's and Children's Protection Unit of the District Police, psychologists, schools, the public prosecutor's office, and village-level and customary authorities such as the Babinsa, Bhabinkamtibmas, and the customary clan leader—closely resembles what Ansell and Gash (2007) describe as collaborative governance, an arrangement in which multiple public and non-public stakeholders engage jointly in a consensus-oriented process to address a shared problem that no single actor can resolve alone. Consistent with Ansell and Gash's (2007) emphasis on face-to-face dialogue and trust-building as preconditions for effective collaboration, the findings show that this multi-actor network in Merauke functions not through a formally codified governance structure but through recurring, trust-based interactions among frontline actors who have come to rely on one another's roles over time. In this sense, the coordination observed in this study reflects an emergent, informally institutionalized form of collaborative governance, one sustained by relational trust among frontline actors rather than by binding cross-sectoral regulation.

Structural Constraints in the Implementation of Child Protection

The findings indicate that the implementation of child protection in Merauke Regency is shaped not only by the capacities of frontline actors but also by a range of structural constraints that define their day-to-day working environment. One of the most consistently reported challenges across all interviews concerns barriers originating from victims' families and their surrounding social environment. The physicians explained that many cases are identified only after violence has occurred repeatedly because families delay bringing children to healthcare facilities. D1 confirmed this pattern of chronic delayed reporting, which is often driven by the perpetrator's manipulation:

> *"Many cases are only reported once the child begins to understand what has happened. For example, a child may have been experiencing violence since the age of five but only reports it at eleven or twelve. That means the abuse has been going on for years... If the perpetrator threatens the child or offers incentives, such as snacks or money, the child may remain silent for a very long time."*

In some cases, parents or other family members deliberately conceal what has occurred in order to preserve the family's reputation, avoid conflict, or because the perpetrator is a relative of the victim. As a result, healthcare workers often receive victims only after their physical and psychological conditions have become increasingly complex, leaving fewer intervention options available. Similar patterns of delayed disclosure have been documented in national studies on child sexual violence in Indonesia, which identify cultural taboos surrounding sexuality as one of the principal factors preventing children and their families from reporting violence, thereby exacerbating its consequences (Rachman & Katili, 2025).

This finding was further reinforced by the psychologist, who explained that victims' recovery is often hindered not by limitations in therapeutic interventions but because children continue to live in environments that are not yet fully safe. P1 (Psychologist) described the complex social realities that frequently trap victims:

> *"The services may already be sensitive to victims' needs, but the broader system and social realities do not always support their recovery. For example, some child victims of violence still have to live in the same house as the perpetrator, or they are unable to leave because of family or economic circumstances. Family factors play a very significant role."*

UPTD PPA likewise identified social stigma as one of the primary barriers to managing cases of violence against children in Merauke. Many families are reluctant to report cases because they regard sexual violence as a source of family shame, fear negative judgments from the

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community, or remain economically dependent on the perpetrator. This finding is consistent with national evidence showing that the majority of frontline victim support workers in Indonesia consider discomfort in discussing sexual issues and community stigma to be major barriers to reporting child sexual violence (ECPAT, 2022). As explained by a representative of UPTD PPA Merauke:

> *"From the family's perspective, many are reluctant to report cases because they consider them a family disgrace, are economically dependent on the perpetrator, are concerned about community stigma, or are influenced by customary practices. In terms of stigma, there is still considerable fear of how the community will perceive them."*

In addition, the influence of customary values in certain situations shapes families' decisions to resolve cases internally through informal reconciliation rather than pursuing legal action. This lack of firm action often becomes a source of frustration for frontline healthcare workers, as expressed by D1:

> *"Another challenge is when cases are settled within the family. That is sometimes very disappointing for us... The child must be kept safe, protected from contact with the perpetrator, and continuously accompanied so that information can be obtained properly. Ideally, cases like this should not simply be resolved through reconciliation."*

Beyond these social barriers, the study also identified several institutional constraints that may affect the quality of policy implementation. The findings indicate the absence of an integrated operational framework to guide cross-sectoral coordination in managing cases involving child victims of violence. Although individual agencies have established their own internal standard operating procedures, these procedures appear to remain fragmented and are not supported by a shared mechanism that clearly defines inter-agency roles, responsibilities, referral pathways, and coordination procedures. This condition may contribute to variations in how cases are managed across institutions, with coordination tending to rely on communication among personnel and established professional relationships rather than on standardized institutional arrangements. Consequently, the continuity and consistency of service delivery may vary, particularly in cases requiring collaboration across multiple sectors. Similar institutional challenges have been documented in previous research, which found that the absence of standardized cross-sectoral procedures, together with limited training and inadequate privacy in service settings, may constrain the early identification of violence and the delivery of coordinated interventions by healthcare workers in Indonesia (Emqi & Hartini, 2023).

Limited human resources also emerged consistently across all interviews. UPTD PPA reported a significant imbalance between workload and staffing, noting that the unit *"consists of only five staff members responsible for handling all cases involving women and children across Merauke Regency,"* a situation that has the potential to delay case management. This shortage of personnel is not unique to Merauke. At the national level, an institutional evaluation conducted by Kemenko PMK [Coordinating Ministry for Human Development and Cultural Affairs] (2023) likewise identified inadequate numbers and capacities of human resources, limited financial resources, and changes in local leadership as recurring challenges faced by UPTD PPA offices throughout Indonesia. At the same time, the psychologist emphasized the limited availability of professionals qualified to provide psychological recovery services for victims of violence. P1 noted:

> *"The number of psychologists remains very limited, so victims cannot always receive the psychological services they need in a timely manner."*

From the perspective of healthcare facilities, the physicians also acknowledged that not all healthcare workers have received specialized training in identifying and managing cases involving child victims of violence. D2 explained:

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> *"I don't think all staff members have sufficient knowledge. Some have received training, but only a few... The last training was about two or three years ago."*

Although several primary healthcare centers have personnel who have received specialized training, this capacity remains unevenly distributed. Accordingly, D3 emphasized the need for the District Health Office to expand capacity-building programs:

> *"Training should not be limited to only certain primary healthcare facilities (FKTPs). It should reach all primary healthcare facilities. If every FKTP receives training, screening capacity will improve, and healthcare workers will feel more confident in handling these cases."*

Another challenge relates to the financing of services. Several participants explained that victims' medical needs cannot always be fully covered under the existing health financing schemes. A representative of UPTD PPA Merauke stated:

> *"One of the recurring challenges concerns victims' health insurance, because there is currently no health insurance scheme specifically covering medical expenses for victims of violence that are not reimbursed by BPJS."*

Although referral hospitals have attempted to address this issue through local policy initiatives—as D1 explained, "UPTD PPA has a dedicated funding arrangement through a memorandum of understanding with the Regional General Hospital"—this mechanism has not yet become a sustainable long-term solution. P1 (Psychologist) also pointed to a funding gap following the emergency medical phase:

> *"As far as I know, many costs are covered by the government once the case has entered the UPTD PPA system. However, long-term needs are not always fully covered."*

For victims from economically disadvantaged families, this situation may delay both case management and the follow-up services required for sustained psychological recovery.

Merauke's geographical conditions further compound these challenges. The region's vast service area and dispersed settlements mean that not all victims have equal access to healthcare facilities or child protection services. From both regulatory and victim support perspectives, UPTD PPA Merauke confirmed this geographical constraint:

> *"In terms of accessibility, many areas are remote and difficult to reach, which ultimately prevents some victims from reporting their cases."*

Long travel distances often delay victims' arrival at healthcare facilities, making both medical examinations and forensic documentation more difficult. For victim support personnel, these geographical conditions also limit the frequency of follow-up monitoring after initial services have been provided.

Despite these constraints, the implementation of child protection does not come to a halt. On the contrary, all participants described various forms of day-to-day adaptation that enable services to continue. These findings suggest that structural constraints not only hinder policy implementation but also shape how frontline actors carry out their responsibilities. From the perspective of Street-Level Bureaucracy, limited resources, highly complex cases, and uncertainty are defining conditions that directly influence policy implementation in practice (Lipsky, 1980). However, the findings of this study demonstrate that frontline actors respond not only through the exercise of individual discretion but also by developing cross-sectoral coordination and adaptive practices to sustain the continuity of services.

Child Protection as a Continuous Recovery Process

The findings indicate that all participants shared a relatively consistent understanding that the management of cases involving child victims of violence does not end once the child's medical needs have been addressed or legal proceedings have begun. This perspective was consistently expressed across all participant groups. The three physicians emphasized that successful medical treatment does not represent the endpoint of case

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management. Once the child's physical condition has stabilized, their attention shifts to subsequent needs that cannot be met through healthcare services alone. Child victims require psychological support, legal protection, family support, and continued monitoring after they leave the healthcare facility. D1 confirmed this shift in focus by emphasizing the importance of post-emergency follow-up in the hospital:

> *"We must not forget that the child is a victim. We cannot assume that everything is over once the examination is completed... It is not simply a matter of observing the child in the emergency department and then sending them home; we also need to consider whether further care is required."*

UPTD PPA provided a more comprehensive picture of how this process is implemented in practice. After the child's medical, psychological, and legal needs have begun to be addressed, the institution's role does not end with the completion of legal proceedings. Ongoing support continues through coordination with various community stakeholders and educational institutions. UPTD PPA Merauke described how this continuum of support extends beyond the court's decision to ensure the child's long-term well-being:

> *"After the court's decision, UPTD PPA also coordinates with the military village supervisory officer (Babinsa), the community police officer (Bhabinkamtibmas), the customary clan leader, schools, and the child's family to support the child's reintegration into the community."*

All participants also viewed successful recovery as being strongly influenced by the quality of the environment to which the child returns after the case has been addressed. When families are able to provide emotional support, communities accept victims without stigma, and cross-sectoral services continue over time, children's opportunities for recovery increase substantially. P1 emphasized the critical importance of this supportive environment, noting that even sensitive professional services cannot fully succeed if the child's domestic circumstances remain unchanged:

> *"The services may already be sensitive to victims' needs, but the broader system and social realities do not always support their recovery. For example, some child victims of violence still have to live in the same house as the perpetrator, or they are unable to leave because of family or economic circumstances. Family factors play a very significant role."*

When considered alongside the three preceding themes, the findings suggest that recovery is the outcome of the entire implementation process constructed by frontline actors. Healthcare workers' ability to recognize suspected violence at the initial stage opens the pathway to protection. Cross-sectoral coordination enables services to continue across institutional boundaries. Meanwhile, the various adaptations developed in response to structural constraints—ensure that services can continue despite less-than-ideal institutional conditions. Recovery, therefore, should not be understood as an isolated stage but rather as the cumulative result of the decisions, coordination, and adaptive practices that have taken place since the child first entered the protection system.

From the perspective of Street-Level Bureaucracy, this orientation reflects the ongoing professional decisions made by frontline actors as they respond to victims' changing needs throughout the case management process (Lipsky, 1980). At the same time, Boundary Spanning explains how such continuity can only be achieved when institutional boundaries are bridged through sustained communication and coordination, even in the absence of rigid formal procedures (Williams, 2002), as reflected in D2's observation: *"The workflow is already clear, even though there is no written SOP."* Furthermore, Collaborative Governance provides a framework for understanding recovery as the product of complementary contributions from multiple organizations working together (Ansell & Gash, 2007), including the collaborative arrangement between UPTD PPA and independent psychologists who provide victim support, rather than the work of any single institution in isolation. Taken together, these findings demonstrate that child protection cannot be

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understood as a series of episodic or sector-specific services. Rather, it is a continuous process that begins with the early identification of suspected violence, progresses through cross-sectoral coordination, is sustained through adaptive responses to structural constraints, and culminates in the recovery and social reintegration of child victims.

Theoretically, this study extends the Street-Level Bureaucracy perspective by demonstrating that frontline discretion alone is insufficient to explain child protection policy implementation. The findings suggest that frontline actors simultaneously perform boundary-spanning roles, enabling them to sustain service continuity through informal cross-sectoral relationships despite the absence of integrated institutional mechanisms. Rather than operating as separate analytical perspectives, Street-Level Bureaucracy, Boundary Spanning, and Collaborative Governance are shown to complement one another in explaining how child protection policies are translated into practice in resource-constrained settings.

CONCLUSION

This study concludes that the implementation of child protection policy in Merauke Regency is a dynamic and continuous process whose success depends on the discretion, adaptive capacity, and collaborative efforts of frontline actors (street-level bureaucrats). In the absence of formal operational regulations, particularly a joint cross-sectoral Standard Operating Procedure (SOP), healthcare workers, psychologists, and UPTD PPA officers proactively exercise their professional and ethical discretion to identify child victims of violence and initiate early protective interventions. The continuity of services—from emergency medical management in healthcare facilities to the stage of psychological recovery—is sustained through informal boundary-spanning practices that rely on rapid interpersonal communication. These practices further evolve into a dynamic form of collaborative governance, manifested through strategic partnerships between public actors, such as UPTD PPA, and non-public actors, such as independent psychologists, enabling them to complement one another's institutional capacity limitations in providing support for victims.

Nevertheless, the sustainability of this responsive child protection system continues to be constrained by multidimensional structural challenges at the local level. Limited numbers and capacities of frontline personnel, the absence of dedicated long-term healthcare financing for victims of violence, the geographical challenges associated with serving a vast territory, and socio-cultural barriers—including persistent community stigma and the continued reliance on customary reconciliation to resolve cases—remain major obstacles to ensuring comprehensive recovery for child victims.

From a practical perspective, these findings suggest that effective child protection cannot rely solely on the discretion, professional commitment, and informal collaboration of frontline actors. While such adaptive practices have enabled services to continue despite institutional limitations, their long-term sustainability depends on their institutionalization through formal collaborative governance arrangements. Local governments should therefore transform existing informal collaborative practices into structured interagency mechanisms supported by clear operational procedures, sustainable resources, and shared accountability across sectors. Institutionalizing these adaptive practices would reduce dependence on individual initiatives while strengthening the consistency, continuity, and resilience of child protection services.

Accordingly, local governments should prioritize the institutionalization of legally binding integrated cross-sectoral SOPs, strengthen the capacity of frontline personnel through continuous training and professional development, and establish sustainable public financing mechanisms to ensure comprehensive protection, rehabilitation, and recovery services for child victims of violence. Collectively, these measures would help bridge the implementation gap by embedding frontline discretion within a more coordinated, accountable, and sustainable collaborative governance framework.

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