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REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS IN INDONESIA 2010

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Foreword

The Millennium Declaration represents the consensus of the Heads of State and representatives from 189 countries achieved at the United Nations in New York in September 2000, and asserts the world's commitment to achieve the Millennium Development Goals (MDGs) by 2015. The MDGs place people as the main focus of development and include components to achieve the ultimate objective of improving the welfare of the people.

The Government of Indonesia has mainstreamed the MDGs in all phases of development, as specified in the Long-Term Development Plan for 2005-2025, the National Medium-Term Development Plans for 2004-2009 and 2010-2014, as well as the Annual Work Plans and the state budget documents. Based on pro-growth, pro-job, pro-poor and pro-environment strategies, allocations of funds in central and local government budgets have been increased each year to support achievement of the MDG targets. Productive partnerships with civil society organizations and the private sector have also contributed to accelerating achievement of the MDGs.

The Report on the Achievement the Millennium Development Goals in Indonesia 2010 is the sixth national report prepared. The first report was published in 2004, and subsequently followed by the publication of reports in 2005, 2007, 2008 and 2009. This report aims to provide information on the progress achieved by Indonesia to 2010, and to demonstrate the nation's commitment to accomplish the goals of the Millennium Declaration of the United Nations of 2000.

This report provides details on achievement of the MDGs and presents the status of their achievement in 2010. This report also briefly outlines the challenges faced and the efforts required to achieve the MDG targets by 2015. Successes that have been achieved are a manifestation of the commitment and hard work by the Government and all members of society towards a more prosperous Indonesia. This achievement also represents Indonesia's contribution to global development and realization of a more prosperous and just world community.

In conclusion, I would like to extend my gratitude to all those who have contributed to preparation and publication of **The Report on the Achievement the Millennium Development Goals in Indonesia 2010**. Hopefully, this report will contribute to Indonesia achieving the objectives of human development and a more prosperous society in the future.

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May the MDG Report be used by all interested parties both within government and the concerned stakeholders in efforts to accelerate the achievement of the Millennium Development Goals by 2015.

Jakarta, September 2010
Minister for National Development Planning /
Head of National Development Planning Agency

Prof. Dr. Armida S. Alisjahbana, SE, MA

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List of Abbreviations

ARV	Anti Retroviral
ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin-based combination therapy
AMI	Annual Malaria Insidence
ANC	Antenatal Care
API	Annual Parasite Insidence
ART	Antiretroviral Therapy
ASEAN	The Association of Southeast Asian Nations

BAPPENAS	*Kementerian Negara Perencanaan Pembangunan Nasional* (The National Development Planning Agency)
BCC	Behavioral Change Communication
BCG	Bacillus Calmette Guérin
BEONC	Basic Emergency Obstetric-Neonatal Care
BOE	Barrels of Oil Equivalent
BOK	*Biaya Operasional Kesehatan* (subsidy for operational cost for health facilities)
BOS	*Bantuan Operasional Sekolah* (School Operational Assistance)
BPS	*Badan Pusat Statistik* (Central Bureau of Statistics)
BSM	*Beasiswa Miskin* (Scholarship for Poor Children)
CBE	Compulsory Basic Education
CBST	Clinical-based Substitle Therapy
CDR	Case Detection Rate
CEONC	Comprehensive Emergency Obstetric-Neonatal Care
CLTS	Community-Led Total Sanitation
CO_2	Carbon Dioxide
CoBILD	Community-Based Initiatives for Housing and Local Development
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organizations
CST	Care, Support and Treatment
DOTS	Directly Observed Treatment Short-Course
DPR	*Dewan Perwakilan Rakyat* (House of Representatives)
DPRD	*Dewan Perwakilan Rakyat Daerah* (Regional House of Representatives)
DPT 3	Trivalent vaccines against three infectious diseases in humans: diphtheria, pertussis (whooping cough) and tetanus
DSR	Debt Service Ratio
DTPK	*Daerah Terpencil Perbatasan dan Kepulauan* (Remote Border and Island)
ECED	Early Childhood Education and Development
EFA	Education for All
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
FMU	Forest Management Unit
FSW	Female Sex Worker
G-20	The group of 20 is a forum for 20 industrialized and developing countries to review key issues of the global economy
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GHG	Green House Gasses
GPI	Gender Parity Index
HCFC	Hydrochlorofluorocarbon
ICCSR	Indonesia Climate Change Sectoral Roadmap
ICT	Information and Communication Technology
IDHS	Indonesia Demographic Health Survey
IDU	Infecting Drug Users
IEC	Information, Education and Communications
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ITN	Insecticide-Treated Nets
Jamkesmas	*Jaminan Kesehatan Masyarakat* (National Health Security Program)

JOTHI	Jaringan Orang Terinveksi HIV Indonesia
KIP	*Kampung* Improvement Program (*Kampungs* are the informal, unplanned and, until recently, unserviced housing areas, which form a large part of most Indonesian cities)
KPA	*Kawasan Pelestarian Alam* (Nature Conservation Area)
KPU	*Komisi Pemilihan Umum* (General Elections Commission)
KSA	*Kawasan Suaka Alam* (Nature Reserve Area)
KUR	*Kredit Usaha Rakyat* (People-Based Small Business Loan Program)
LDR	Loan to Deposite Ratio
LJK	*Lembaga Jasa Keuangan* (financial service institution)
LMIC	Lower Middle Income Country
LPI	Logistic Performance Index
MA	*Madrasah Aliyah*
MDGs	Millennium Development Goals
MDR-TB	Multidrug-Resistant TB
MI	*Madrasah Ibtidaiyah*
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MONE	Ministry of National Education
MOLT	Ministry of Labour and Transmigration
MSME	Micro, Small and Medium Enterprises
MSS	Minimum Service Standards
MTs	*Madrasah Tsanawiyah*
Musrenbangdes	*Musyawarah Perencanaan Pembangunan Desa* (Village Development Plan)
NCCC	National Council for Climate Change
NER	Net Enrolment Rate
NFE	Non-formal Education
NMTDP	National Medium Term Development Plan
NPL	Non-Performing Loans
NSEP	Needle Syringe Exchange Program
NUSSP	Neighborhood Upgrading and Shelter Sector Program
ODS	Ozone Depleting Substances
PAUD	*Pendidikan Anak Usia Dini* (Early Childhood Education)
PDAM	Perusahaan Daerah Air Minum (Municipal Drinking Water Company)
Perumnas	*Perumahan Nasional* (national state-owned public housing company)
PHBS	*Perilaku Hidup Bersih Sehat* (clean and healthy behavior)
PKH	*Program Keluarga Harapan* (Family Hope Program)
PLWHA	People Living with HIV/AIDS
PNPM	*Program Nasional Pemberdayaan Masyarakat* (National Program for Community Empowerment)
Posyandu	*Pos Pelayanan Terpadu* (Integrated Health Post, a community-based basic health monitoring and services at village level)
PPP	Purchasing Power Parity
PPP	Public Private Partnerships
Puskesmas	*Pusat Kesehatan Masyarakat* (Primary Health Center)
Pustu	*Puskesmas Pembantu* (auxiliary health centers)
RASKIN	*Beras Miskin* (Rice for the Poor Program)
RBM	Roll Back Malaria

Riskesdas	*RIset Kesehatan Dasar* (basic health research, conducted by MOH-RI)
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* (National Medium-Term Development Plan)
RPJPN	*Rencana Pembangunan Jangka Panjang Nasional* (National Long-Term Development Plan)
Rusunawa	*Rumah Susun Sewa* (low cost rental public housing)
Sakernas	*Survei Tenagakerja Nasional* (National Labour Force Survey), conducted by the Central Bureau of Statistics
SBM	School-Based Management
SD	*Sekolah Dasar* (Primary School)
SDKI	*Survei Demografi dan Kesehatan Indonesia* (Indonesian Demography and Health Survey)
SKRT	*Survei Kesehatan Rumah Tangga* (Household Health Survey)
SMA	*Sekolah Menengah Atas* (Senior High School)
SMC	Small and Medium Scale Enterprises
SMP	*Sekolah Menengah Pertama* (Junior High School)
SPR	School Participation Rate
STBM	*Sanitasi Total Berbasis Masyarakat* (Community-Led Total Sanitation/CLTS)
STI	Sexually-Transmitted Infection
Susenas	*Survei Sosial Ekonomi Nasional* (National Socio-Economic Survey), conducted by Central Bureau of Statistics
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UMR	*Upah Minimum Regional* (Regional Minimum Wage)
UNCBD	United Nations Convention on Biological Diversity
UNDP	The United Nations Development Programme
UNFCCC	United Nations Framework Convention on Climate Change
UNICEF	United Nations Childrens' Fund
UPP	Urban Poverty Project
VCT	Voluntary Counseling and Testing
WB	The World Bank
WBG	The World Bank Group
WHO	World Health Organization
WTO	World Trade Organization

Introduction

Indonesia's commitment to achieving the Millenium Development Goals (MDGs) indicates the nation's commitment to improving the welfare of its people and also its commitment to improvement of the welfare of the global community. The MDGs serve as an important reference for preparing national development planning documents. The Government of Indonesia has mainstreamed the MDGs in the National Long-Term Development Plan (*RPJPN* 2005-2025), the National Medium-Term Development Plans (RPJMN 2004-2009 and 2010-2014), the National Annual Development Plans (*RKP*), as well as documents of the State Budget (*APBN*).

In the last five years, although the country has still not fully recovered from the 1997/1998 economic crisis, Indonesia has yet again been faced with global challenges which are quite substantial. Volatility in oil and food prices, global climate change and financial turmoil during 2007/2008 influenced the dynamics of Indonesian development. The rate of economic growth dropped to 4-5 percent, as compared to the growth before the crisis of 5-6 percent. Food prices have increased and as the largest component of household expenditure of the lower middle income group and the poor, these increases have put a larger burden on their shoulders. Extreme climate change has also resulted in the failure of crops, damages to public property and public health problems.

In the midst of this unfavorable global environment, Indonesia has continued to attain gradual progress and development in all sectors as a manifestation of the nation's commitment to work together with the global community to achieve the MDGs.

Achievement of the MDG Targets

As of 2010, Indonesia has achieved several MDG targets. The status of achievement can be grouped into three categories: (a) targets that have been achieved; (b) targets for which significant progress has been demonstrated and which are expected to be achieved by 2015 (on- track); and (c) targets which still require hard work to achieve.

The targets which have already been achieved include:

MDG 1 – The proportion of people having per capita income of less than USD 1.00 a day has declined from 20.6 percent in 1990 to 5.9 percent in 2008.

MDG 3 - Gender equality in all types and levels of education have almost been achieved as indicated by the net enrolment ratios (APM) of girls to boys in *SD/MI/Paket A* and *SMP/MTs/Paket B* of 99.73 and 101.99 respectively, and the literacy rate of women to men among 15-24 year olds of 99.85 in 2009.

MDG 6 - The prevalence of tuberculosis decreased from 443 cases per 100,000 population in 1990 to 244 cases per 100,000 in 2009.

The MDG targets for which significant improvement has been demonstrated and which are expected to be achieved by 2015 (on-track) are as follows:

MDG 1 - The prevalence of underweight children under-five years of age decreased by almost 50 percent: from 31 percent in 1989 to 18.4 percent in 2007. It is expected that the target of 15.5 percent can be achieved by 2015.

MDG 2 - The net enrollment rate (NER) for primary education has almost reached 100 percent and the literacy rate of the population reached 99.47 percent in 2009.

MDG 3 - The NER of girls to boys in secondary education (*SMA/MA/*Package C) and higher education in 2009 were 96.16 and 102.95 respectively. Thus, it is expected that the 2015 target of 100 can be achieved.

MDG 4 - The mortality rate of children under-five years of age decreased from 97 per 1,000 live births in 1991 to 44 per 1,000 live births in 2007 and is expected to reach the target of 32 per 1,000 live births in 2015.

MDG 8 - Indonesia has managed to develop open, rule-based, predictable, non-discriminatory trading and financial systems – as indicated by the positive trends in indicators related to trade and the national banking system. At the same time, significant progress has been made in reducing the ratio of foreign debt to GDP from 24.6 percent in 1996 to 10.9 percent in 2009. The Debt Service Ratio has also been reduced from 51 percent in 1996 to 22 percent in 2009.

The MDG targets which have shown a reasonable improvement but which still require hard work to be achieved are as follows:

MDG 1 - Indonesia has raised the target for poverty reduction and is committed to give special attention to reducing poverty levels as measured against the national poverty line from the level of 13.33 percent in 2010 to 8 to 10 percent in 2014.

MDG 5 - The maternal mortality rate has fallen from 390 in 1991 to 228 per 100,000 live births in 2007. Hard work is needed to achieve the 2015 target of 102 per 100,000 live births.

MDG 6 - The proportion of people with HIV/AIDS has increased, particularly among high risk groups such as injecting drug users and sex workers.

MDG 7 - Indonesia has a high level of greenhouse gas emissions, but the country remains committed to increase forest cover, eliminate illegal logging and implement a policy framework to reduce carbon dioxide emissions by at least 26 percent over the next 20 years. Moreover, currently only 47.73 percent of households have sustainable access to improved drinking water, and 51.19 percent of households have access to basic sanitation. Special attention is required to achieve the MDG targets for Goal 7 by 2015.

The nation's success in development has resulted in various international awards. Progress in economic development over the last five years has enabled Indonesia to make progress in catching up with developed countries. Developed countries under the Organization of Economic Cooperation and Development (OECD) have recognized and appreciated development progress in Indonesia. Therefore, along with China, India, Brazil and South Africa, Indonesia was invited to join the "enhanced engagement countries" group, or countries whose engagement with developed countries is increasingly enhanced. Since 2008 Indonesia has also joined the Group-20 or G-20, twenty countries controlling 85 percent of the world's Gross Domestic Product (GDP), which has a very important and decisive role in shaping global economic policies.

New Initiatives to Move Forward

Indonesia's continued success in achieving the MDGs is dependent upon achievement of good governance; productive partnerships at all levels of the community; implementation of a comprehensive approach to achieving pro-poor growth, improving public services, improving coordination among stakeholders while improving allocation of resources; and effectively decentralizing responsibilities to reduce disparities and empower all the people of Indonesia.

The size, growth and distribution of the population is one important consideration in the achievement of the MDGs. Accelerating the achievement of goals and targets of the MDGs requires a comprehensive and integrated approach to population management, including improved access to reproductive health and family planning services as well as protection for reproductive rights. Currently, the population of Indonesia is 237.5 million people (according to interim results of the 2010 Population Census, *BPS*), having more than doubled in comparison with the population recorded in 1971. Although the annual population growth rate decreased from 1.97 percent during the 1980-1990 period to 1.49 percent in the period 1990-2000, and to 1.30 percent in 2005, the estimated total population of Indonesia in 2015 is projected to reach 247.6 million (Indonesian Population Projection of 2005-2025). Approximately 60.2 percent will live in the island of Java, which comprises only 7 percent of the total area of Indonesia. In addition, no less than 80 percent of national industry is concentrated in Java.

The Government is committed to maintaining a socio-economic and cultural environment enabling citizens, civil society organizations and the private sector to actively participate in promoting the welfare of all Indonesians. In accelerating achievement of the MDGs, the roles played by civil society, including community organizations and especially women's groups, have provided significant contributions, particularly to the sectors of education, health, clean water and the environment. In the future, the Government will continue to give special attention to community movements at the grassroots level in order to accelerate achievement of the MDGs and improve the welfare of the people in a sustainable manner.

Several steps to accelerate achievement of the MDGs during the next five years are mandated by Presidential Instruction No. 3 of 2010 regarding Equitable Development Programs. These include the following:

- The Government will publish "The Roadmap for Accelerating the Achievement of the MDGs" to be used as a reference for stakeholders to speed up achievement of the MDGs in Indonesia.
- Provincial governments will prepare "Regional Action Plans for Accelerating Achievement of the MDGs" which will be used as a basis for planning and improving coordination of efforts to reduce poverty and improve people's welfare.
- The allocation of funds at the central and regional levels will continue to be improved in support of the intensification and expansion of MDG achievement programs. Funding mechanisms will be formulated to provide incentives to local governments which perform well in achieving the MDGs.
- Support to the expansion of social services in disadvantaged and remote areas will be increased.
- Partnerships between the Government and the private sector (Public Private Partnerships or PPP) in social sectors, especially in education and health, will be enhanced to expand the sources of funding to support achievement of the MDGs.
- Mechanisms for improving Corporate Social Responsibility (CSR) initiatives will be strengthened to support MDG achievement.
- Development cooperation to achieve the MDG targets related to debt conversion (debt swap) with creditor countries will be further enhanced.

Summary by Goal

MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Indonesia has achieved the target of halving the incidence of extreme poverty as measured by the indicator of USD 1.00 per capita per day. Progress is also being made to further reduce poverty as measured against the national poverty line from the current rate of 13.33 percent (2010) to the targeted rate of 8 to 10 percent by 2014. The prevalence of undernourished children under five years of age decreased from 31.1 percent in 1989 to 18.4 percent in 2007 and Indonesia is on track to achieve the MDG target of 15.50 percent in 2015. Priorities for the future to reduce poverty are to expand employment opportunities, improve supporting infrastructure and strengthen the agricultural sector. Special attention will be given to: (i) expanding credit facilities for micro, small and medium enterprises (MSMEs); (ii) empowering poor people through better access to and use of resources to improve their welfare; (iii) improving access of the poor to social services; and (iv) improving the provision of social protection to the poorest of the poor.

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Indonesia is on track to achieve the MDG targets for primary education and literacy. The country aims to go beyond the MDG education target for primary education by expanding the target to junior secondary education (*SMP* and *madrasah tsanawiyah*-MTs, grades 7 to 9) to the universal basic education targets. In 2008/09 the gross enrolment rate (GER) at primary education level (*SD/MI*/Package A) was 116.77 percent and the net enrolment rate (NER) was 95.23 percent. At the primary education level, disparity in education participation among provinces has been significantly reduced with NER above 90 percent in almost all provinces. The main challenge in accelerating achievement of MDG education target is improving equal access of children, girls and boys, to quality basic education. Government policies and programs to address this challenge include: (i) expansion of equitable access to basic education particularly for the poor; (ii) improvement of the quality, efficiency, and effectiveness of education; and (iii) strengthening governance and accountability of education services. The policy to allocate 20 percent of the national budget to the education sector will be continued to accelerate the achievement of universal junior secondary education by 2015.

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Progress has been achieved in increasing the proportion of females in primary, junior secondary schools, senior high schools and institutions of higher education. The ratio of NER for women to men at primary education and junior secondary education levels was 99.73 and 101.99 respectively, and literacy among females aged 15-24 years has already reached 99.85. As a result, Indonesia is on track to achieve the education-related targets for gender equality by 2015. In the workforce, the share of female wage employment in the nonagricultural sectors has increased. In politics, the number of women in the Indonesian parliament increased to 17.9 percent in 2009. Priorities for the future are to: (i) improve the role of women in development; (ii) improve protection for women against all forms of abuse; and (iii) mainstream gender equality in all policies and programs while building greater public awareness on issues of gender.

MDG 4: REDUCE CHILD MORTALITY

The infant mortality rate in Indonesia has shown a significant decline from 68 in 1991 to 34 per 1,000 live births in 2007. With this rate, the target of 23 per 1,000 live births in 2015 is expected to be achieved. Likewise, the child mortality target is expected to be achieved. However, regional disparities remain as constraints to achieve the targets, reflecting the discrepancy in accessing health services, particularly in underserved and remote areas. The future priorities are to strengthen health systems and improve access to health services especially in poor and remote areas.

MDG 5: IMPROVE MATERNAL HEALTH

Of all the MDGs, the lowest rate of global achievement has been recorded in the improvement of maternal health. In Indonesia, the maternal mortality rate (MMR) has gradually been reduced from 390 in 1991 to 228 per 100,000 live births in 2007. Extra hard work will be needed to achieve the MDG target by 2015 of 102 per 100,000 live births. Even though the rates for antenatal care and births attended by skilled health personnel are relatively high, several factors such as high risk pregnancy and abortion still remain constraints that require special attention. Critical measures to reduce maternal mortality are improving the contraceptive prevalence rate and reducing the unmet need through expanding access and improving quality of family planning and reproductive health services. For the future, priorities to improve maternal health will be focused on expanding better quality health care and comprehensive obstetric care, improving family planning services and provision of information, education and communication messages to the community.

MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

In Indonesia, the HIV/AIDS prevalence rate has increased, especially among high risk groups, i.e. injecting drug users and sex workers. The number of HIV/AIDS cases reported in Indonesia more than doubled between 2004 and 2005. The incidence of malaria per 1,000 population decreased from 4.68 in 1990 to 1.85 in 2009. Meanwhile, in TB control, the case detection rate and successfully treated TB cases have already reached the 2015 targets. The communicable disease control approaches are focusing on preventive measures and mainstreaming into the national health system. Beyond that, communicable disease control efforts must involve all stakeholders and strengthen health promotion activities to increase public awareness.

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Indonesia has a high rate of greenhouse gas emissions, but has worked to increase forest cover, eliminate illegal logging and is committed to implementing a comprehensive policy framework to reduce carbon dioxide emissions over the next 20 years. The proportion of households with access to improved sources of drinking water increased from 37.73 percent in 1993 to 47.71 percent in 2009. At the same time, the proportion of households with access to improved sanitation facilities increased from 24.81 percent in 1993 to 51.19 percent in 2009. Acceleration of achievement of the targets for improving access to improved water and sanitation facilities will be continued with increased support. Attention will be given to investments in water and sanitation systems to serve growing urban populations. In rural areas, communities are expected to play a larger role, taking responsibility for operation and management of infrastructure with advisory support from local authorities. The role and detailed responsibilities of local governments in natural resource management and water supply/sanitation will be better delineated and their skills enhanced. The proportion of households living in urban slums in Indonesia has declined from 20.75 percent in 1993 to 12.12 percent in 2009.

MDG 8: BUILDING GLOBAL PARTNERSHIP FOR DEVELOPMENT

Indonesia is an active participant in a wide variety of international forums and is committed to continuing to build successful partnerships with multilateral organizations, bilateral partners and representatives of the private sector to achieve a pro-poor pattern of economic growth. Indonesia has benefited from close collaboration with the international donor community and international finance institutions. The Jakarta Commitment was signed with 26 development partners in 2009 to provide a roadmap for all concerned to improve cooperation and management of development assistance in Indonesia. Indonesia has commited to reducing international borrowing as a percentage of GDP and this is demonstrated by the reduction of foreign debt to GDP from 24.6 percent in 1996 to 10.9 percent in 2009. Indonesia's debt service ratio has also continued to decline from 51 percent in 1996 to 22 percent in 2009. The private sector has made major investments in information and communications technology and access to cellular telephones and internet communications has increased dramatically over the past five years. In 2009 some 82.41 percent of the population had access to cellular telephones.

Overview of Status of MDGs Targets

	Indicators	Baseline	Current	MDG Target 2015	Status	Source
GOAL 1. ERADICATE EXTREME POVERTY AND HUNGER						
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than USD1.00 (PPP) a day						
1.1	Proportion of population below USD 1.00 (PPP) per day	20.60% (1990)	5.90% (2008)	10.30%	●	World Bank and *BPS*
1.2	Poverty gap ratio (incidence x depth of poverty)	2.70% (1990)	2.21% (2010)	Reduce	▶	*BPS, Susenas*
Target 1B: Achieve full and productive employment and decent work for all, including women and young people						
1.4	Growth rate of GDP per person employed	3.52% (1990)	2.24% (2009)	-		National PDB and *BPS, Sakernas*
1.5	Employment-to-population (over 15 years of age)	65% (1990)	62% (2009)	-		*BPS, Sakernas*
1.7	Proportion of own-account and contributing family workers in total employment	71% (1990)	64% (2009)	Decrease	▶	
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger						
1.8	Prevalence of underweight children under-five years of age	31.0% (1989)*	18.4% (2007)** 17.9% (2010)**	15.5%	▶	* *BPS, Susenas* **MOH, *Riskesdas* 2007; 2010 (interim data)
1.8a	Prevalence of severe underweight children under-five years of age	7.2% (1989)*	5.4% (2007)** 4.9% (2010)**	3.6%	▶	
1.8b	Prevalence of moderate underweight children under-five years of age	23.8% (1989)*	13.0% (2007)** 13.0% (2010)**	11.9%	▶	
1.9	Proportion of population below minimum level of dietary energy consumption:				▼	*BPS, Susenas*
	1400 kcal/capita/day	17.00% (1990)	14.47% (2009)	8.50%		
	2000 kcal/capita/day	64.21% (1990)	61.86% (2009)	35.32%		
GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION						
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete full course of primary schooling						
2.1	Net Enrolment Ratio (NER) in primary education	88.70% (1992)**	95.23% (2009)*	100.00%	▶	* MONE ** *BPS, Susenas*
2.2.	Proportion of pupils starting grade 1 who complete primary school.	62.00% (1990)*	93.50% (2008)**	100.00%	▶	* MONE ** *BPS, Susenas*
2.3	Literacy rate of population aged 15-24 year, women and men	96.60% (1990)	99.47% (2009) Female: 99.40% Male: 99.55%	100.00%	▶	*BPS, Susenas*

Status: ● Already achieved ▶ On-track ▼ Need special attention

	Indicators	Baseline	Current	MDG Target 2015	Status	Source
GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN						
Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015						
3.1	Ratios of girls to boys in primary, secondary and tertiary education					
	- Ratio of girls to boys in primary schools	100.27 (1993)	99.73 (2009)	100.00	●	*BPS*, *Susenas*
	- Ratio of girls to boys in junior high schools	99.86 (1993)	101.99 (2009)	100.00	●	
	- Ratio of girls to boys in senior high schools	93.67 (1993)	96.16 (2009)	100.00	▶	
	- Ratio of girls to boys in higher education	74.06 (1993)	102.95 (2009)	100.00	▶	
3.1a	Literacy ratio of women to men in the 15-24 year age group	98.44 (1993)	99.85 (2009)	100.00	●	
3.2	Share of women in wage employment in the non-agricultural sector	29.24% (1990)	33.45% (2009)	Increase	▶	*BPS*, Sakernas
3.3	Proportion of seats held by women in national parliament	12.50% (1990)	17.90% (2009)	Increase	▶	*KPU*
GOAL 4: REDUCE CHILD MORTALITY						
Target 4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate						
4.1	Under-five mortality rate per 1,000 live births	97 (1991)	44 (2007)	32	▶	*BPS*, IDHS 1991, 2007; * *BPS*, *Riskesdas* 2010 (interim data)
4.2	Infant mortality rate per 1,000 live births	68 (1991)	34 (2007)	23	▶	
4.2a	Neonatal mortality rate per 1,000 live births	32 (1991)	19 (2007)	Decrease	▶	
4.3	Proportion of one-year-old children immunized against measles	44.5% (1991)	67.0% (2007) 74.5% (2010)*	Increase	▶	
GOAL 5: IMPROVE MATERNAL HEALTH						
Target 5A: Reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio						
5.1	Maternal Mortality Ratio (per 100,000 live births)	390 (1991)	228 (2007)	102	▼	*BPS*, IDHS 1993, 2007
5.2	Proportion of births attended by skilled health personnel (%)	40.70% (1992)	77.34% (2009)	Increase	▶	*BPS*, *Susenas* 1992-2009
Target 5B: Achieve, by 2015, universal access to reproductive health						
5.3	Current contraceptive use among married women 15-49 years old, any method	49.7% (1991)	61.4% (2007)	Increase	▶	*BPS*, IDHS 1991, 2007
5.3a	Current contraceptive use among married women 15-49 years old, modern method	47.1% (1991)	57.4% (2007)	Increase	▼	
5.4	Adolescent birth rate (per 1000 women aged 15-19)	67 (1991)	35 (2007)	Decrease	▶	
5.5	Antenatal care coverage (at least one visit and at least four visists)					
	– 1 visit:	75.0%	93.3%	Increase	▶	
	– 4 visits:	56.0% (1991)	81.5% (2007)		▶	
5.6	Unmet need for family planning	12.70% (1991)	9.10% (2007)	Decrease	▼	

Status: ● Already achieved ▶ On-track ▼ Need special attention

	Indicators	Baseline	Current	MDG Target 2015	Status	Source
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES						
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS						
6.1	HIV/AIDS Prevalence among total population (percent)	-	0.2% (2009)	Decrease	▼	MOH estimated 2006
6.2	Condom use at last high-risk sex	12.8% (2002/03)	Female: 10.3% Male: 18.4% (2007)	Increase	▼ ▼	*BPS*, IYARHS 2002/2003 & 2007
6.3	Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS					
	– Married	-	Female: 9.5% Male: 14.7% (2007) Female: 11.9% Male: 15.4% (2010)*	Increase	▼	*BPS*, IDHS 2007; *Riskesdas* 2010 (interim data)
	– Unmarried	-	Female: 2.6% Male: 1.4% (2007) Female: 19.8% Male: 20.3% (2010)*	Increase	▼	*BPS*, IYARHS 2007; *Riskesdas* 2010 (interim data)
Target 6B: Achieve, by 2010, universal access to treatment forHIV/AIDS for all those who need it						
6.5	Proportion of population with advanced HIV infection with access to antiretroviral drugs	-	38.4% (2009)	Increase	▼	MOH, 2010 as per 30 November 2009
Target 6C: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases						
6.6	Incidence and death rates associated with Malaria (per 1,000)					
66.a	Incidence rate associated with Malaria (per 1,000):	4.68 (1990)	1.85 (2009) 2.4% (2010)*	Decrease	▶	MOH 2009; MOH, *Riskesdas* 2010 (interim data)
	- incidence of Malaria in Jawa & Bali	0.17 (1990)	0.16 (2008)	Decrease	▶	API, MOH 2008
	- Incidence of Malaria outside Jawa & Bali	24.10 (1990)	17.77 (2008)	Decrease	▶	AMI, MOH 2008
6.7	Proportion of children under 5 sleeping under insecticide-treated bednets	-	3.3% Rural: 4.5% Urban: 1.6% (2007) 7.7% (2007)* 16.0% (2010)**	Increase	▼	*BPS*, IDHS 2007; * MOH, *Riskesdas* 2007; ** MOH, *Riskesdas* 2010 (interim data)
6.8	Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	-	21.9% (2010)	-		*Riskesdas* 2010 (interim data)
6.9	Incidence, prevalence and death rates associated with Tuberculosis					
6.9a	Incidence rates associated with Tuberculosis (all cases/100,000 pop/year)	343 (1990)	228 (2009)	Halted, begun to reverse	●	TB Global WHO Report, 2009
6.9b	Prevalence rate of Tuberculosis (per 100,000)	443 (1990)	244 (2009)		●	
6.9c	Death rate of Tuberculosis (per 100,000)	92 (1990)	39 (2009)		●	

Status: ● Already achieved ▶ On-track ▼ Need special attention

Indicators		Baseline	Current	MDG Target 2015	Status	Source
6.10	Proportion of Tuberculosis cases detected and cured under directly observed treatment short courses				●	
6.10a	Proportion of Tuberculosis cases detected under directly observed treatment short course (DOTS)	20.0% (2000)*	73.1% (2009)**	70.0%	●	* TB Global WHO Report, 2009
6.10b	Proportion of Tuberculosis cases cured under DOTS	87.0% (2000)*	91.0% (2009)**	85.0%	●	** MOH Report-2009
GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY						
Target 7A: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources						
7.1	The ratio of actual forest cover to total land area based on the review of satellite imagery and aerial photographic surveys	59.97% (1990)	52.43% (2008)	Increase	▼	Ministry of Forestry
7.2	Carbon dioxide (CO_2) emissions	1,416,074 Gg CO_2e (2000)	1,711,626 Gg CO_2e (2008)	Reduce at least 26% by 2020	▼	Ministry of Environment
7.2a	Primary energy consumption (per capita)	2.64 BOE (1991)	4.3 BOE (2008)	Reduce		Ministry of Energy and Mineral Resources
7.2b.	Energy Intensity	5.28 BOE/ USD1,000 (1990)	2.1 BOE/ USD1,000 (2008)	Decrease		
7.2c	Energy Elasticity	0.98 (1991)	1.6 (2008)	Decrease		
7.2d	Energy mix for renewable energy	3.5% (2000)	3.45% (2008)	-		
7.3	Total consumption of ozone depleting substances (ODS) in metric tons	8,332.7 metric tons (1992)	0 CFCs (2009)	0 CFCs while reducing HCFCs	▶	Ministry of Environment
7.4	Proportion of fish stocks within safe biological limits	66.08% (1998)	91.83% (2008)	not exceed	▶	Ministry of Marine Affairs & Fisheries
7.5	The ratio of terrestrial areas protected to maintain biological diversity to total terrestrial area	26.40% (1990)	26.40% (2008)	Increase	▶	Ministry of Forestry
7.6	The ratio of marine protected areas to total territorial marine area	0.14% (1990)*	4.35% (2009)**	Increase	▶	*Ministry of Forestry / **Ministry of Marine Affairs & Fisheries
Target 7C: Halve, by 2015, the proportion of households without sustainable access to safe drinking water and basic sanitation						
7.8	Proportion of households with sustainable access to an improved water source, urban and rural	37.73% (1993)	47.71% (2009)	68.87%	▼	*BPS, Susenas*
7.8a	Urban	50.58% (1993)	49.82% (2009)	75.29%	▼	
7.8b	Rural	31.61% (1993)	45.72% (2009)	65.81%	▼	
7.9	Proportion of households with sustainable access to basic sanitation, urban and rural	24.81% (1993)	51. 19% (2009)	62.41%	▼	
7.9a	Urban	53.64% (1993)	69.51% (2009)	76.82%	▼	
7.9b	Rural	11.10% (1993)	33.96% (2009)	55.55%	▼	

Status: ● Already achieved ▶ On-track ▼ Need special attention

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers						
7.10	Proportion of urban population living in slums	20.75% (1993)	12.12% (2009)	6% (2020)	▼	*BPS*, *Susenas*
GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT						
Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial systems						
8.6a	Ratio of Exports + Imports to GDP (indicator of economic openness)	41.60% (1990)	39.50% (2009)	Increase	▶	*BPS* & The World Bank
8.6b	Loans to Deposit Ratio in commercial banks	45.80% (2000)	72.80% (2009)	Increase	▶	BI Economic Report 2008, 2009
8.6c	Loans to Deposit Ratio in rural banks	101.30% (2003)	109.00% (2009)	Increase	▶	
Target 8D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long-term						
8.12	Ratio of International Debt to GDP	24.59% (1996)	10.89% (2009)	Reduce	▶	Ministry of Finance
8.12a	Debt Service Ratio (DSR)	51.00% (1996)	22.00% (2009)	Reduce	▶	BI Annual Report 2009
Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications						
8.14	Proportion of population with fixed-line telephones (teledensity in population)	4.02% (2004)	3.65% (2009)	Increase	▶	Min. of Comm & Info Technology, 2010
8.15	Proportion of population with cellular phones	14.79% (2004)	82.41% (2009)	100.00%	▶	
8.16	Proportion of households with access to internet	-	11.51% (2009)	50.00%	▼	*BPS*, *Susenas* 2009
8.16a	Proportion of households with personal computers	-	8.32% (2009)	Increase	▼	*BPS*, *Susenas* 2009

Status: ● Already achieved ▶ On-track ▼ Need special attention

GOAL 1 :
ERADICATE EXTREME POVERTY AND HUNGER

PNPM Mandiri-Rural (infrastructure)

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

TARGET 1A: HALVE, BETWEEN 1990 AND 2015, THE PROPORTION OF PEOPLE WHOSE INCOME IS LESS THAN USD 1.00 (PPP) A DAY

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Goal 1. Eradicate Extreme Poverty and Hunger						
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than USD1.00 (PPP) a day						
1.1	Proportion of population below USD 1.00 (PPP) per day	20,60% (1990)	5,90% (2008)	10,30%	●	*BPS* and the World Bank
1.2	Poverty gap ratio (incidence x depth of poverty)	2,70% (1990)	2,21% (2010)	Decrease	▶	*BPS*, *Susenas*

Status: ● Already achieved ▶ On track ▼ Need special attention

CURRENT SITUATION

Indonesia has already achieved Target 1A for reduction of extreme poverty. The incidence of extreme poverty (using the measurement of USD 1.00 purchasing power parity per capita per day) has been reduced from 20.6 percent in 1990 to 5.9 percent in 2008. **Figure 1.1** presents the trend for the declining percentages of the population estimated to have levels of consumption below USD 1.00 (PPP) per capita per day as measured by World Bank/*BPS* annually from 1990 to 2008. The declining trend is expected to be sustained to 2015 and beyond.

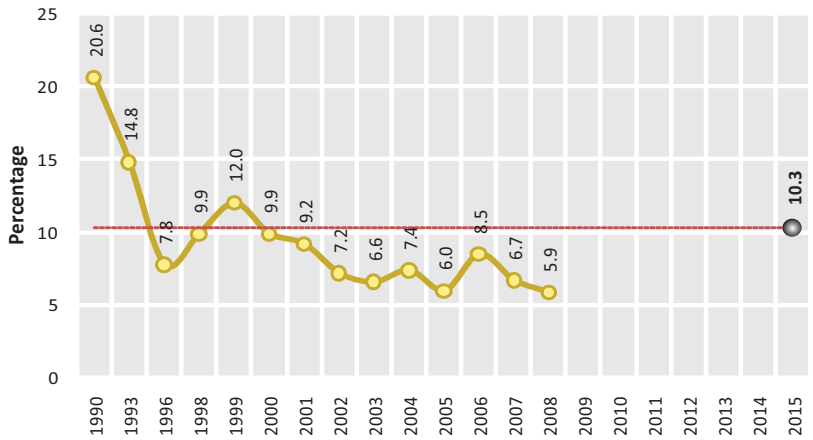
Using the prevailing national poverty line (USD 1.50 PPP per capita per day), the incidence of poverty has generally trended downwards. Although the MDG target as measured by USD 1.00 (PPP) has already been achieved, the Government of Indonesia is not yet satisfied. In applying this national poverty line, the level of poverty in 2009 was 14.15 percent and in 2010 it was reduced to 13.33 percent (**Figure 1.2**).

There has been an improvement in the level of welfare of those below the poverty line. This statement is supported by the fact that there has been a reduction in the Poverty Gap Index which in 2009 was 2.5 and had declined to 2.2 in 2010.

The reduction in the incidence of poverty has been supported by implementation of the National Community Empowerment Program (*PNPM Mandiri*) which was implemented in all

sub-districts in 2009 in synergy with other poverty reduction programs from three clusters, improved data on the poor, and the emergence of initiatives by local governments to reduce poverty (Box 1A). The implementation of the People's Small Enterprise Credit Program (*Kredit Usaha Rakyat – KUR*) has assisted members of the community to start micro enterprises to increase their incomes. Initiatives to reduce poverty have also been supported by the efforts of civil society organizations (CSOs).

Figure 1.1. Progress in Reducing Extreme Poverty (USD 1.00/ Capita/Day) as Compared to the MDG Target



***Source**: BPS, Susenas (several years) and the World Bank 2008.*

Based on the trend in poverty reduction as well as the efforts mentioned above, it is expected that the result that was achieved by 2008 in reducing extreme poverty (USD1.00 PPP) will be sustained and the trend to further reduction continued**.**

There remain significant disparities was in the incidence of poverty among the 33 provinces of Indonesia. Poverty rates in 17 provinces are below the national average, while in 16 provinces they are above (see **Figure 1.3**). Provinces where the incidence of poverty is more than double the national average (13.33 percent) include Papua (36.80 percent), Papua Barat (34.88 percent) and Maluku (27.74 percent). On the island of Sumatera the incidence of poverty is still higher than the national average in the provinces of Aceh, Sumatera Selatan, Bengkulu and Lampung. On the island of Jawa , the provinces of Jawa Tengah, Yogyakarta and Jawa Timur have poverty rates that are higher than the national average. On Sulawesi, the provinces of Sulawesi Tengah, Sulawesi Tenggara and Gorontalo also have poverty rates higher

than the national rate while the same is true for the provinces of Nusa Tenggara Barat (NTB) and Nusa Tenggara Timur (NTT). The three provinces with the lowest incidence of poverty in 2010 were Jakarta (3.48 percent), Kalimantan Selatan (5.21 percent) and Bali (4.88 percent).

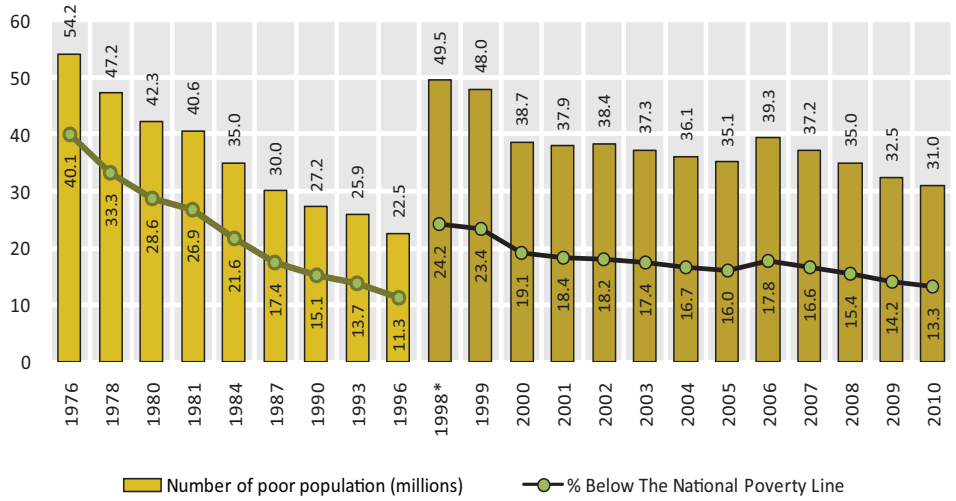


Figure 1.2. Long-term Trends in Poverty Reduction in Indonesia Measured Using the National Poverty Line, 1976-2010

Source: *BPS, Susenas (several years).*

*Note: * Since 1998, a change in the method of calculating the poverty line was adopted by improving the quality of non-food items, including: the cost of education (originally bqsed on the cost of elementary education, then increased to cover costs of junior high school education), the cost of health care (initially based on standard costs at a Primary Health Center, then increased to include costs of services of a general practitioner); as well as transport costs (initially only costs of transport within a city were estimated, then transport costs were increased to also provide for inter-city transport costs in accordance with the increased mobility of the population). As a result the poverty line increased and the population below the poverty line increased.*

The poverty rate is significantly higher in rural areas than in the urban centers of Indonesia, and special attention is required to increase development in the rural areas. The poverty rate in rural areas of Indonesia was 16.56 percent in 2010 compared to only 9.87 percent in urban areas.

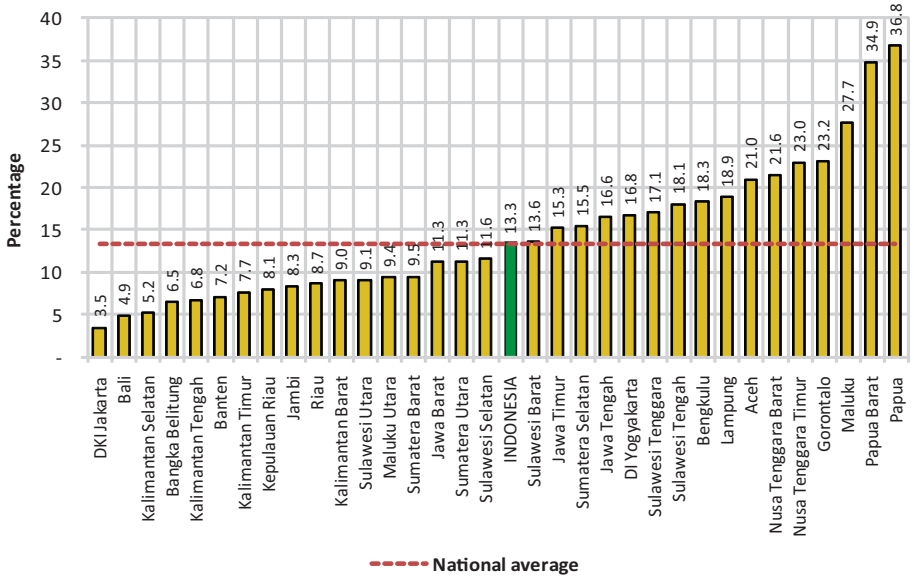


Figure 1.3. Percentages of Population Below the National Poverty Line by Province of Indonesia, 2010

Source: *BPS, Susenas 2010*

Box 1.1.
In the District of SIKKA: Those who Celebrate, Gamble and Are Lazy Are Not Considered to Be Poor

The district government of Sikka in East Nusa Tenggara (NTT) has a special approach to encourage the poor in the region to work harder to emerge from poverty. The Head of the local government in Sikka, Sosimus Mitang, has established a rule that anyone who engages in celebrations more than twice a year, those who gamble and allow their farm land to go fallow, will not be classified as poor. Revocation of the status of poor would make them lose their right to obtain assistance from various aid schemes for the poor such as direct cash assistance, rice subsidies for the poor and conditional cash transfers. The local rules have been in effect since last year and have encouraged the poor to not just rely on support from the government but also to take initiative to be self-reliant.

To encourage underprivileged communities to engage in business activities, the local government in Sikka will also implement a "rice for work" program. Based on a local decision, rice from *Raskin* will not be shared at the subsidized price of Rp1,600 per kilogram, but recipients will be required to work, for example, to participate in building village infrastructure. The motto of Sikka Regency , namely: "Let us build the village of Sikka to be a village of conscience", seems to relate directly to the local policies that have been established.

The local government has also adopted the method of Pro-Poor Planning, Budgeting, Monitoring and Evaluation to improve the quality of local programs and budgets. Quality improvement and changes in priorities in the budget allocation is reflected by the increase in Sikka district budget allocations for programs that support achievement of the MDGs in the 2010-2011 budget to more than 67 percent, especially for poverty reduction (22.8 percent), improvement of education (21.07 percent) and health improvement (19.55 percent).

Source: National Workshop on Pro-Poor Planning, Budgeting, Monitoring and Evaluation, Kendari May 2010; Gatra, 11/30/2009; Pos Kupang, 11/12/2008

CHALLENGES

1. **Improving the business climate to be more conducive at the local level** to creation of economic opportunities, to increase business revenues, employment opportunities and people's purchasing power.

2. **Improving the effectiveness of the implementation of social assistance and social protection programs**, including increasing the number and capacity of educated and trained field workers who have the capacity to administer social welfare services.

3. **Increasing access of the poor to basic needs and services** (non-income poverty indicators) such as adequate food (calories), health services, clean water and sanitation.

4. **Optimizing the participation of poor communities** especially in the implementation of

poverty reduction programs.

5. **There are disparities in poverty among provinces and between income groups** which require different handling in Java / Bali as compared to outside of Java / Bali.

6. **A large number of households are classified as near poor that are vulnerable to economic and social shocks** (natural disasters, climate disruption and social conflicts).

POLICIES

The government is committed to establishing a more conducive environment for all stakeholders to work to reduce poverty. It is planned that the incidence of poverty as measured by the national poverty line will be reduced to 11.5-12.5 percent in 2011 in accordance with the the Government's Annual Work Plan for 2011 and to 8 to 10 percent by 2014 in accordance with the National Medium-Term Development Plan 2010-2014.

Efforts to reduce poverty will be carried out in four priority areas, namely:

1. **Improving and enhancing the quality of family-based social protection policies.** This will be done through pooling of efforts to target social protection programs based on the family unit, such as for *Jamkesnas*, scholarship assistance and early education for children from poor families, provision of subsidized rice for poor families (*Raskin*), and conditional cash assistance through the Family Hope Program. In addition, social protection policies will be improved, especially for marginalized communities.

2. **Refining and improving the effectiveness of the implementation of the National Community Empowerment Program (*PNPM Mandiri*).** This work will focus on improving the quality of institutions at the community level to enable them to better engage in the development process, as well as by enhancing the integration process of community empowerment as a component of the development process.

3. **Improving access of micro, small and medium enterprises to productive resources thought the People's Small Enterprises Credit Program (*KUR*).** Access of micro-businesses to credit will continue to be expanded, and the quality of *KUR* improved by increasing the range of financial services provided to cooperatives and SMEs, as well as by increasing capacity and services of non-bank financial institutions, through the revitalization of the cooperative education and training system.

4. **Improving the effectiveness of the coordination of poverty reduction.** Efforts are required to: (i) improve the coordination and synchronization by the National Team for Acceleration of Poverty Reduction, (ii) increase the role of the Regional Teams for Coordination of Poverty Reduction including the maintenance and use of poverty data that are consistent

and accurate for planning, implementation and monitoring of poverty reduction programs in the regions, (iii) strengthening the independence of the village in the government and community development, and (iv) addressing the needs of pockets of poverty, especially in disadvantaged and underserved areas, border areas and the outer islands, including the construction of basic infrastructure and support facilities (including electricity, water, connecting roads, inter-island facilities).

Increased efforts in the regions will also be applied to increase capacity and accelerate the achievement of the MDGs by 2015 through provision of assistance to local governments to formulate Regional Action Plans to achieve the MDGs. Forums will be expanded among provinces and districts to share learning and successful experiences of local innovation and local policies (local wisdom) related to poverty reduction.

To implement this agenda, the Vice President and senior cabinet officials will take the lead in improving coordination of policies and programs to reduce the incidence of poverty. Cabinet members to be directly involved include the Coordinating Minister for People's Welfare, the Coordinating Minister for Economic Affairs, the Minister of Health, the Minister of National Education, the Minister of Social Affairs, the Minister of Finance, the Minister for Cooperatives and SMEs, and the Minister of National Development Planning (*Bappenas*).

TARGET 1B: ACHIEVE FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL, INCLUDING WOMEN AND YOUNG PEOPLE

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Goal 1. Eradicate Extreme Poverty and Hunger						
Target 1B: Achieve full and productive employment and decent work for all, including women and young people						
1.4	Growth rate of GDP per person employed	3,52% (1990)	2,24% (2009)	-		National GDP and *BPS, Sakernas*
1.5	Employment-to-population (over 15 years of age)	65% (1990)	63% (2010)	-		*BPS, Sakernas*
1.7	Proportion of own-account and contributing family workers in total employment	71% (1990)	63% (2010)	Decrease	▶	

Status: ● Already achieved ▶ On track ▼ Need special attention

Current Situation

The growth of the workforce has been positive and the long-term trend of job creation is also positive. The open unemployment rate has fallen from 8.10 percent in 2001 to 7.41 percent in 2010. Other indicators such as the proportion of formal employment in general have increased, while the proportion of informal workers has dropped in recent years. Taking this trend into account, the target set by the Government in the National Medium-Term Development Plan for 2010-2014 is to lower the open unemployment rate to around 5-6 percent by 2014, and this target is expected to be achieved.

Growth of gross domestic product (GDP) per worker during 1990-2009 showed a considerable degree of variation, with an average annual growth of about 2.53 percent. The growth of labor productivity before the 1997-1998 crisis was relatively high, amounting to 5.42 percent during 1990-1995. Yet, after the crisis (from 1998/9 to 2008) growth of labor productivity declined, averaging 3.36 percent per year. This was due to the reduced capital accumulation per worker during the post-crisis period (**Figure 1.4**).

The ratio of employment to working age population during the 1990-2009 period has undergone relatively small, but quite dynamic changes. Strong economic growth during 1990-1997 and 2004-2008 allowed the employment growth rate to exceed the rate of growth of the workforce. Employment opportunities created at that time were able to absorb new entries in the labor market, even though jobs were mostly created in the informal sector (**Figure 1.5**).

Figure 1.4. Growth Rate of Labor Productivity (Percentage), 1990, 1993, 1996, 1999, 2000-2009

Source: *BPS, Sakernas and Indonesian Statistics (Computed), 1990, 1993, 1996, 1999, 2000-2009*

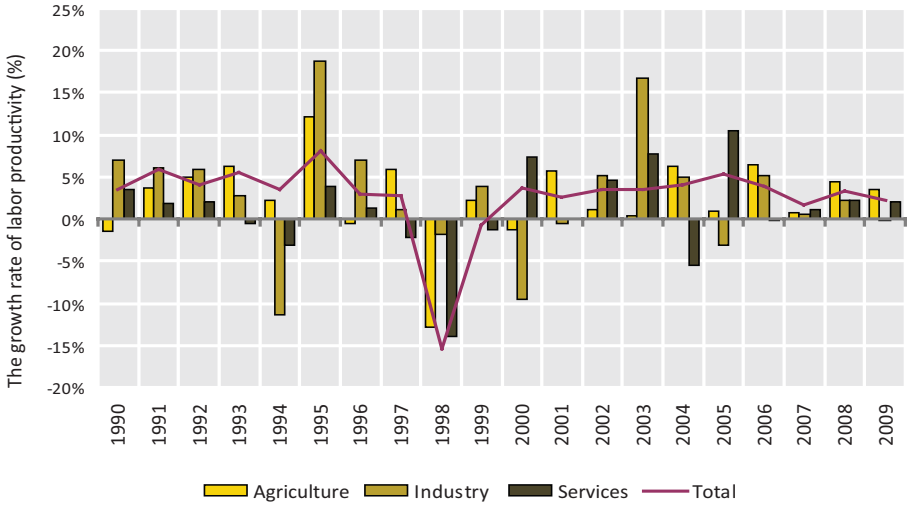
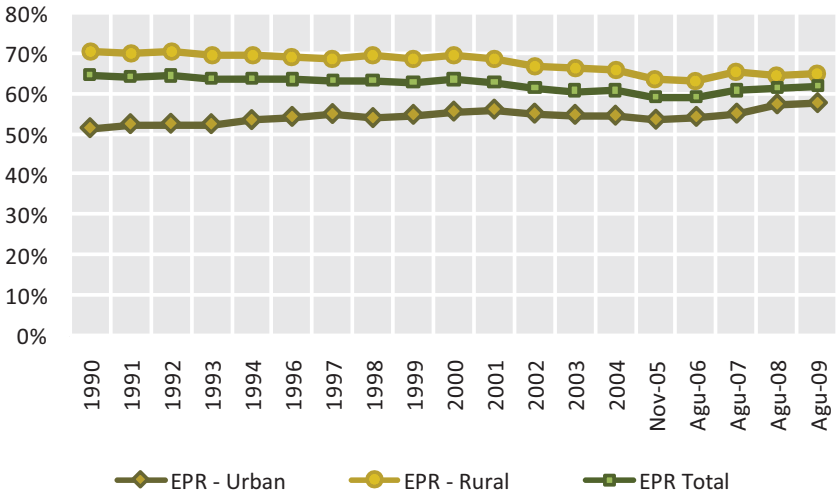


Figure 1.5. Employment Ratio to Working Age Population, 1990-2010

Source: *BPS, Sakernas (Computed), 1990-2010*



The last two decades have seen the ratio of employment to the working age population decline from 65 percent to 62 percent. Growth of the working age population has been greater than the growth of the workforce, indicating that there is a higher preference among students to continue their schooling to a higher level of education rather to find a job after graduating.

At the provincial level, the ratio of employment to the working age population generally declined between 1990 and 2010. The province where the ratio remained unchanged is Bali, whereas provinces with increasing employment to population ratios include Kalimantan Barat, Papua, Sulawesi Tengah, Sumatera Selatan, Riau, Maluku, Sulawesi Selatan and DKI Jakarta, which experienced the highest increase of approximately 0.11 (**Figure 1.6**).

In the urban areas of Indoneisa the workforce participation rate (*TPAK*) increased substantially from 1990 to 2010, from approximately 55 percent to 65 percent (**Figure 1.7**). Meanwhile, the workforce participation rate in rural areas has decreased from about 72 percent in 1990 to 70 percent in 2010.

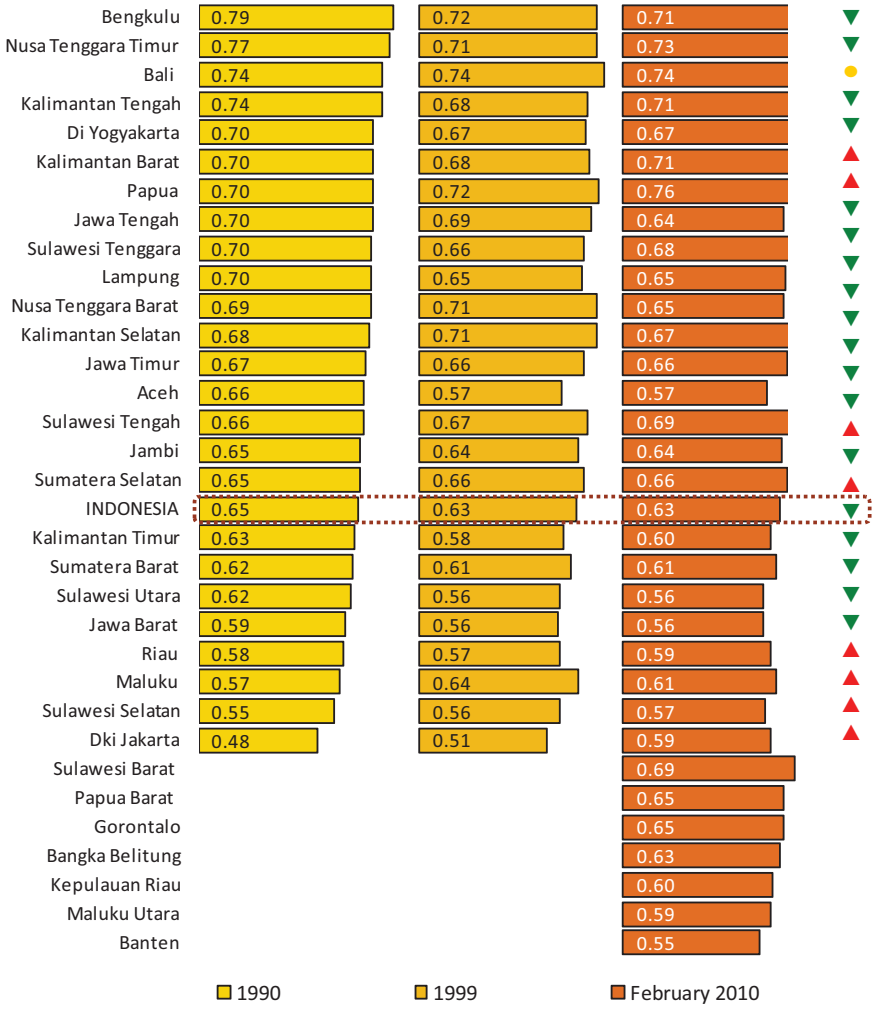


Figure 1.6. Employment to Population Ratio by Province, 1990, 1999 and 2010

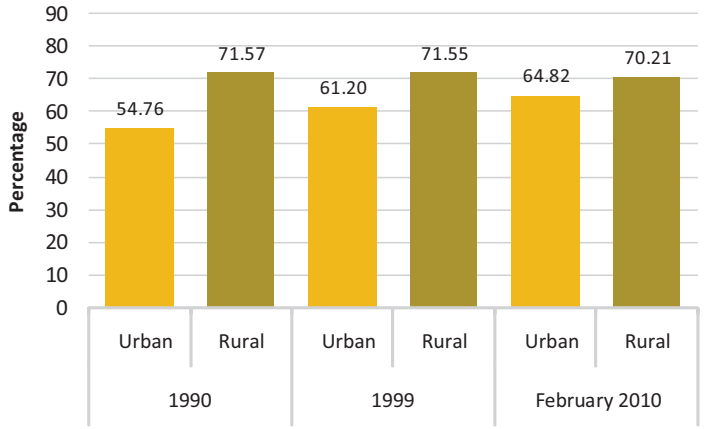
Source: *BPS, Sakernas (computed), 1990, 1999 and 2010.*

Note: The triangle is green if the growth moves in line with national trends. If moving to the opposite direction, the triangle is in red. Constant ratio is represented with a yellow dot.

Although the number of people that continue their education to a higher level has increased, Indonesia still must deal with the uneven geographic distribution of skilled workers. Data in 1990 showed that 5.88 percent of workers in urban areas had a diploma or university degree, while the same was the case for only 0.57 percent of workers in rural areas. Similarly for the secondary education level, or high school, there is a large gap between urban and rural areas. The percentage of workers with an elementary education and those who never went to school is higher in rural areas (**Figure 1.8**).

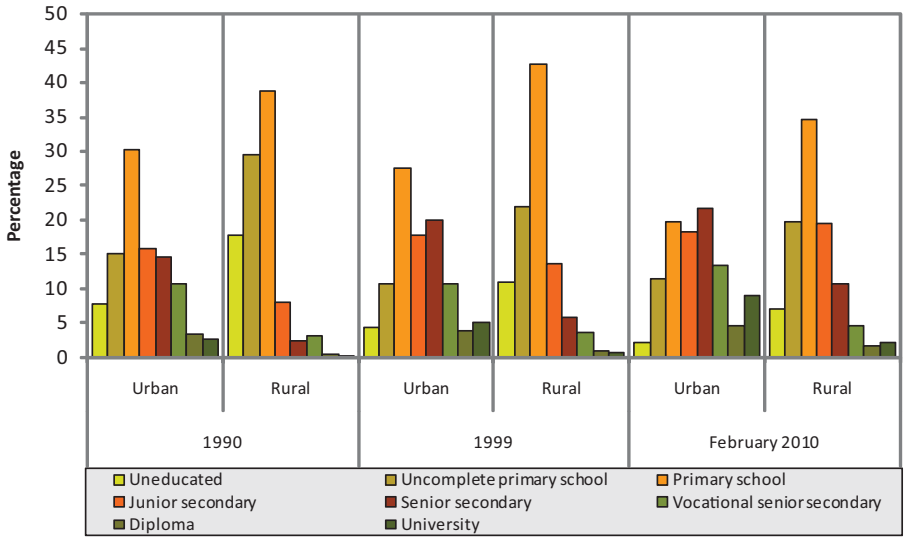
The quality of job opportunities created has improved. The proportion of informal workers, such as own-account and/or contributing family workers, in total employment diminished moderately, from 71 percent in 1990 to 64 percent in 2009 (**Figure 1.9**).

Figure 1.7. Workforce Participation Rate (Percentage) by Region, 1990, 1999 and 2010



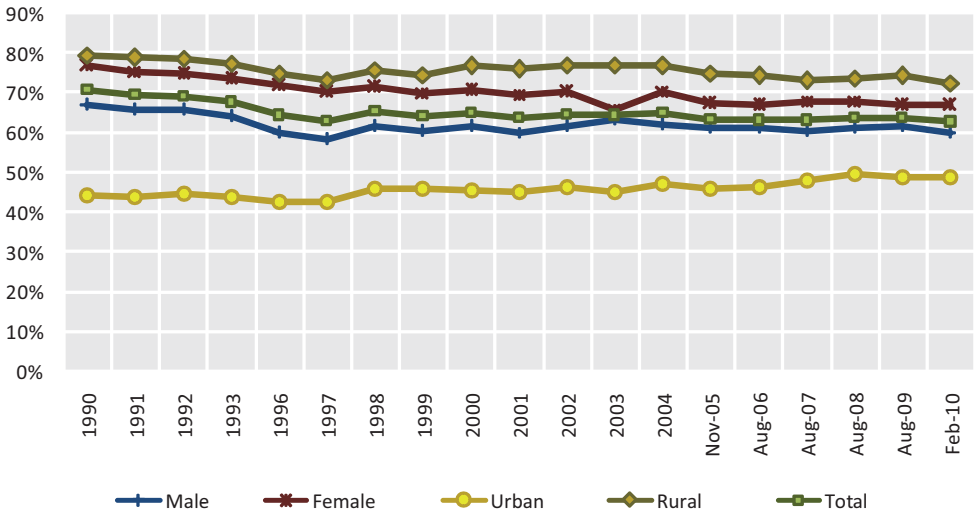
Source:
BPS, Sakernas (computed), 1990, 1999 and 2010

Figure 1.8. Proportion of Workers Based on Their Latest Education and by Region, 1990, 1999 and 2010



Source:
BPS, Sakernas (computed), 1990, 1999 and 2010

Figure 1.9. Proportion of Vulnerable Workers to Total Workers, 1990-2010



Source:
BPS, Sakernas (computed), 1990-2010

The decreasing proportion of informal workers was brought about by increasing wage employment. This type of employment grew by 1.9 percent per year during the 2008-2009 period. Labor productivity has also continued to show strong growth in recent years.

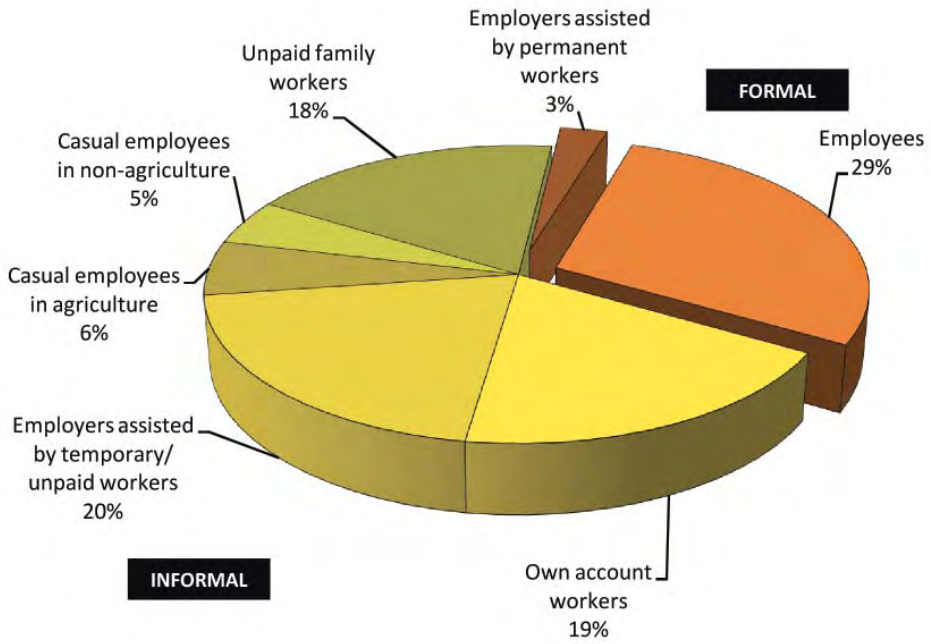


Figure 1.10. Proportion of Workers According to Job Status, February 2010

Source: *BPS, Sakernas (computed), 2010*

CHALLENGES

The first involves expanding employment opportunities in the formal sector. Investment recovery has not yet met expectations and this is a constraint to achieving a higher rate of economic growth, particularly in the industrial sector.

The second is accelerating worker transition from lower to higher productivity jobs. Challenges here include moving "labor surplus" from the traditional or the informal sector to more productive and better paid employment. Worker transition from the many traditional sectors with low productivity can also encourage wage increases and improvement in workers' outputs.

Lastly, maintaining or improving welfare for workers who still work in the informal sector and narrowing the wage gap between workers at the same level of productivity are challenges. Current wage movements are determined by increases in prices rather than productivity. Therefore, the components for determining the Regional Minimum Wage (*Upah Minimum Regional*/*UMR*) should not only include inflation factors, but also productivity factors and job performance.

POLICIES

The policies that will be implemented are as follows:

1. **Creating as many employment opportunities as possible by promoting investment and business expansion.**

2. **Improving the environment and mechanisms of industrial relations to promote employment and business opportunities.**

3. **Creating employment opportunities through government programs.**

4. **Improving the labor productivity**. The approach to improve labor productivity is by improving worker quality and competencies.

5. **Improving the productivity of workers in the agricultural sector.** This will include: expanding the scope of agricultural sector management by intensifying research to improve agricultural productivity; and providing workers with the necessary knowledge and skills, through education, training and agricultural extension. The improvement of workers knowledge and skills will in turn enhance agricultural productivity.

6. **Developing social security and empowering workers.** Strategies for providing workers with social security include, among others, developing social security programs that give workers the greatest possible benefits.

7. **Implementing key manpower regulations.**

TARGET 1C: HALVE, BETWEEN 1990 AND 2015, THE PROPORTION OF PEOPLE WHO SUFFER FROM HUNGER

Indicators		Baseline	Current	MDG Target 2015	Status	Source
GOAL 1. Eradicate Extreme Poverty and Hunger						
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger						
1.8	Prevalence of underweight children under-five years of age	31.0% (1989)*	18.4% (2007)** 17.9% (2010)**	15.5%	▶	* *BPS, Susenas* **Kemkes, *Riskesdas* 2007; 2010 (interim data)
1.8a	Prevalence of severe underweight children under-five years of age	7.2% (1989)*	5.4% (2007)** 4.9% (2010)**	3.6%	▶	
1.8b	Prevalence of moderate underweight children under-five years of age	23.8% (1989)*	13.0% (2007)** 13.0% (2010)**	11.9%	▶	
1.9	Proportion of population below minimum level of dietary energy consumption:				▼	*BPS, Susenas*
	1400 kcal/capita/day	17.00% (1990)	14.47% (2009)	8.50%		
	2000 kcal/capita/day	64.21% (1990)	61.86% (2009)	35.32%		

Status: ● Already achieved ▶ On track ▼ Need special attention

CURRENT SITUATION

The nutritional status of the community has improved over time, as indicated by the decline in the prevalence of underweight children under five years of age.

Indonesia has made significant progress in improving nutrition outcomes over the past two decades. The prevalence of underweight children under five years of age who are moderately and severely underweight, declined from 31.0 percent in 1989 to 21.6 percent in 2000. A slight rise was seen between 2000 and 2005, reaching 24.5 percent in 2005. However, in 2007 it decreased to 18.4 percent (*Riskesdas* 2007) and to 17.9 percent in 2010 (*Riskesdas* 2010). The figures indicate that Indonesia is on track to achieve the MDG target of 15.5 percent (**Figure 1.11**). In the National Medium-Term Development Plan 2010-2014 the Government has set the new target for this indicator to be less than 15.0 percent in 2014.

Disparities in the prevalence of underweight children under five years of age remain and require more effective intervention. Even though the national prevalence of underweight children under five years of age has nearly achieved the MDG target, disparities exist among provinces, between rural and urban areas, and among socio-economic groups. *Riskesdas* 2007 indicated that the prevalence of underweight children under five years of age ranged from 10.9 percent (DI Yogyakarta) to 33.6 percent (Nusa Tenggara Timur) **(Figure 1.12).**

Figure 1.11. Trend in the Prevalence of Underweight Children Under Five Years of Age (1989-2010) Using the WHO 2005 Standard and the MDG Target for this Indicator in 2015

Source:
BPS, Susenas 1989 to 2005 and Riskesdas 2007 and 2010to 2005 and Riskesdas 2007 and 2010

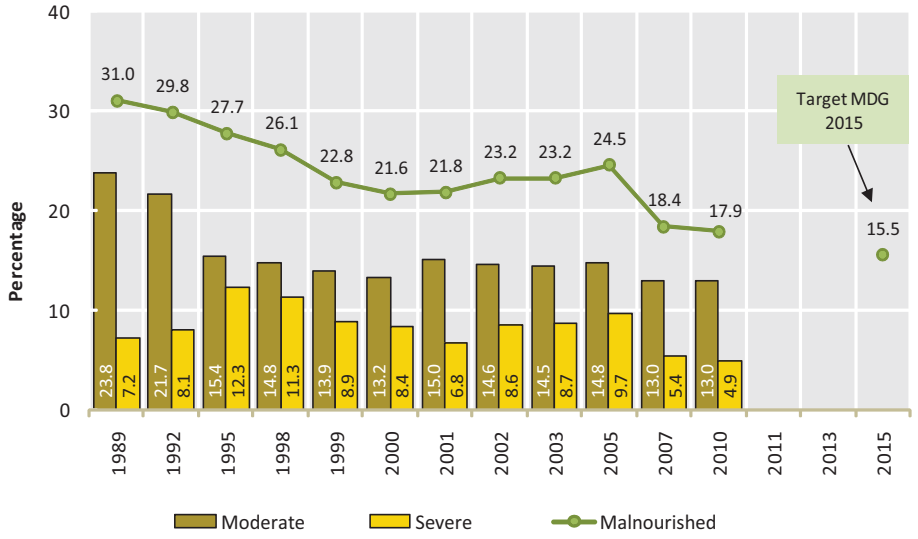
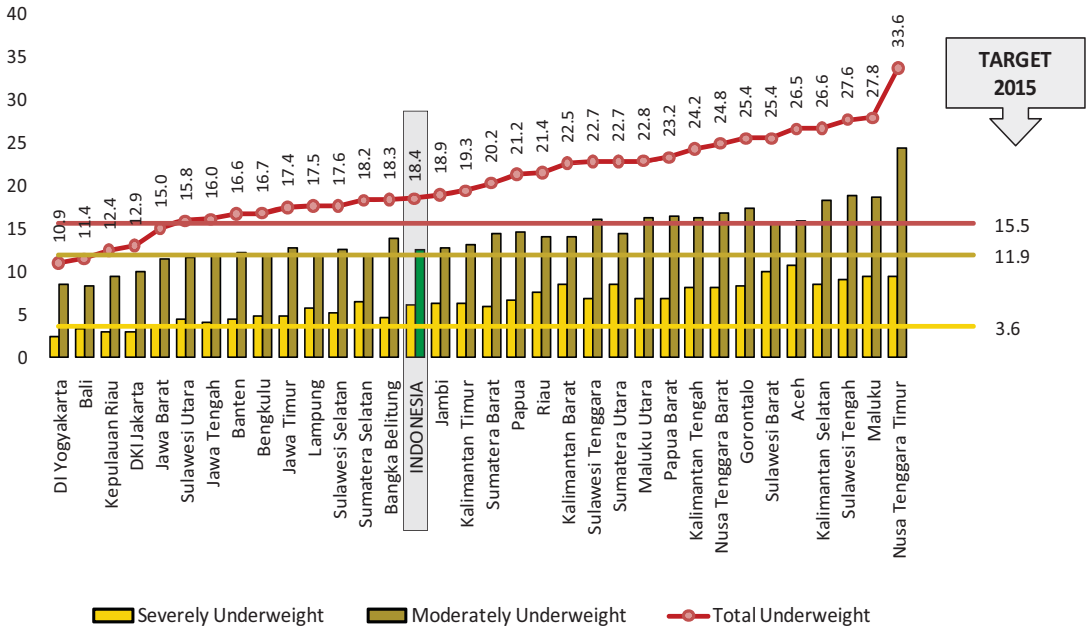


Figure 1.12 The Prevalence of Underweight Children Under Five Years of Age by Province (2007)

Source:
MOH, Riskesdas 2007



The prevalence of underweight children under five years of age in rural areas in 2007 was 20.4 percent, while in urban areas it was 15.9 percent). The prevalence of severe underweight children under five years of age was 5.4 percent (**Table 1.1)**

Region	Severely Underweight	Moderately Underweight	Total Underweight
Rural	6.4	14	20.4
Urban	4.2	11.7	15.9
Indonesia	**5.4**	**13**	**18.4**

Table 1.1 Underweight Prevalence Among Children Under Five Years of Age by Rural and Urban Areas of Indonesia (2007)

Source: *MOH, Riskesdas 2007*

The proportion of the population with a daily kcal intake of less than 2,000 calories is still high. The *Susenas* 2002-2008 data showed that the average dietary calorie intake in 2002 was 1,986 kcal per capita per day which was below the minimum requirement of 2,000 kcal per capita per day. However, it had increased to 2.038 kcal per capita per day in 2008 (**Figure 1.13).**

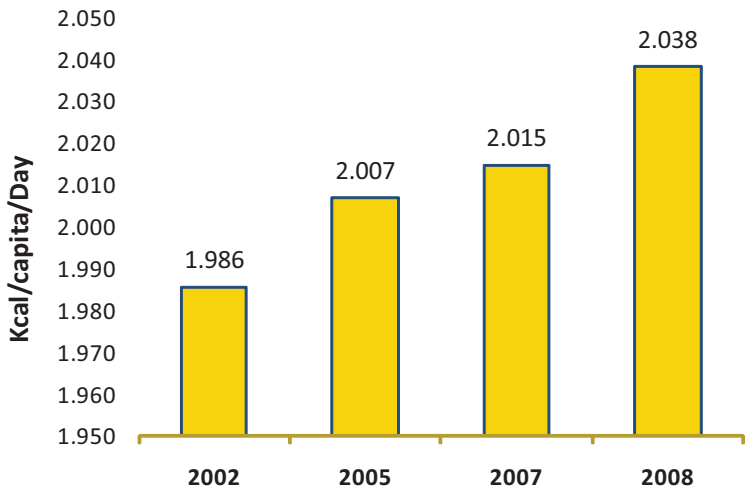


Figure 1.13. Trends in the Average Calorie Consumption for Rural and Urban Households (2002-2009)

Source: *BPS, Susenas, various years*

The Government of Indonesia is committed to improving the nutritional status of the population, particularly the poor. To address the high prevalence of malnutrition among children, the government has implemented the Food and Nutrition Action Plan 2006-2010, with the following immediate objectives: (i) improvement of family nutrition awareness (*kadarzi*) through community-based growth monitoring and counseling; (ii) prevention of nutrition-related diseases such as diarrhea, malaria, tuberculosis, and HIV/AIDS; (iii) promotion of healthy lifestyle behavior; and (iv) improvement of food fortification. In its efforts to fulfill the global accord, the government established a health sector policy in the National Medium-Term Development Plan 2004-2009 which covers the community nutrition improvement program.

Box 1.2.
Achievement of MDG Target 1C in Tabanan District in the Province of Bali

Tabanan district is located in the southern part of the island of Bali. The district has a total area of 839,33 km^2 comprised of highlands and beach areas. Tabanan is classified as an agricultural district with rice fields amounting to 23,358 Ha or 28 percent of the total land area. The district is comprised of 10 sub-districts and has a population of 410,162 people.

Tabanan is one of the districts that has achieved the MDG Target 1C where in 2007 the prevalence of underweight children of five years of age was 7.1 percent, far below the national average of 18.4 percent. The prevalence of *stunting was* 25.5 percent (below the national average of 36.8 percent), the prevalence of wasting was 9.5 percent (below the national average of 13.6 percent, and the overweight children was 6.8 percent (national average 12.2 percent).

In the last six months, around 87.8 percent of the children under five years of age have been weighed at the *posyandu*, a community-based institution involved in the nutrition improvement program. The nutrition improvement program at the *posyandu* is conducted by a nutrition cadre with the assistance of the nutrition staff of the *puskesmas*. The coverage of vitamin A supplements for children of 6-59 months in Tabanan was around 86.1 percent which is above the national coverage of 71.5 percent. The health and nutrition program in Tabanan shows promise in improving nutrition status of children. In addition, the coverage of the basic immunization intervention program was very high where BCG covered around 93.4 percent of children, measles 93.2 percent, Polio 3 82.7 percent, HB 3 81.3 percent, and DPT 3 78.8 percent.

CHALLENGES

1. **Low nutritional status among children under five years of age was affected by economic and socio-cultural factors such as**: (i) lack of access to quality and safe food, particularly due to poverty; (ii) inappropriate child care due to low levels of education among mothers; and (iii) inadequate access to health, water and sanitation services. Moreover, lack of awareness and commitment of the government contributes to the existence of the malnutrition problem.

2. ***Empowering the poor and low-educated people to improve their access to quality and safe food.*** The *Riskesdas* 2007 data indicates that the prevalence of underweight children under five among the poorest (Quintile 1) was around 22.1 percent (severe underweight 6.7 percent and moderate underweight 15.4 percent), and among the second poorest (Quintile 2) was 19.5 percent (severe underweight 5.7 percent and moderate underweight 13.8 percent) which is above the MDG target of 15.5 percent.

3. ***Developing a balanced food consumption pattern*.** The food consumption pattern of the Indonesian population is still unbalanced. *Susenas* 2009 data indicated that Indonesian food consumption is dominated by cereals, mainly rice, while other foods such as meat

and vegetable is low.

4. ***Improving the quality of food consumption.*** Measured by the Desirable Dietary Pattern (*PPH: Pola Pangan Harapan*) score, the quality of food consumption of Indonesians is still low. In the period 2002-2007, the quality of food consumption in Indonesia has improved as indicated by an increase in the *PPH* score from 77.5 in 2002 to 83.6 in 2007. However, it is still below the ideal *PPH score of 100* (**Figure 1.14**) .

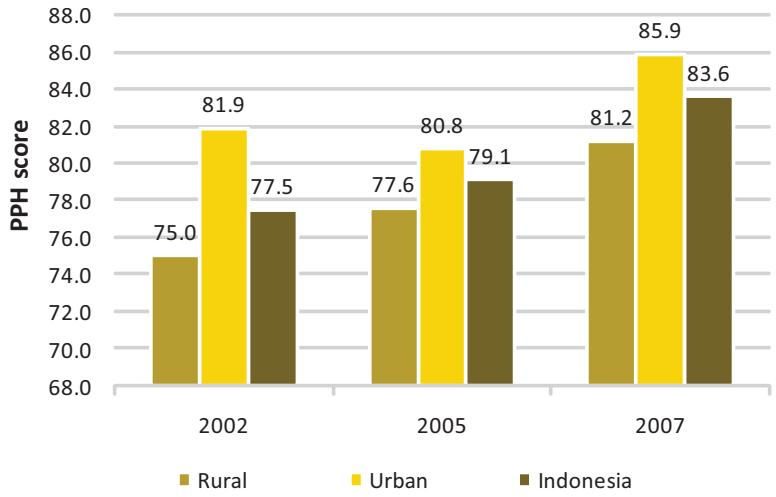


Figure 1.14. Trend in the Desirable Dietary Pattern (PPH) Score of Food Consumption For Rural and Urban Households, 2002-2007

Source: *BPS, Susenas, several years*

5. ***Improving exclusive breast-feeding practice.*** Recently, the practice of exclusive breast feeding has declined so that in 2007 only about 32 percent of children under six months were exclusively breastfed.

6. ***Strengthening the community-based nutrition improvement program at the grass roots level.*** The role of the community in dealing with malnutrition has been declining. Community participation in dealing with malnutrition, particularly among children under five years of age, has been undertaken in the integrated services posts (*posyandu*). However, the *Posyandu* activities have tended to decline under decentralization as indicated by the large variations of malnutrition rates among provinces.

7. ***Strengthening institutions responsible for food and nutrition improvement*.** Malnutrition is a multidimensional issue. However, nutrition policy development and program planning and management are inadequate in both capacity and institutional linkages. The national food security institution is not functioning effectively in eliminating hunger and manutrition.

POLICIES

The priorities to reduce the prevalence of underweight/undernourished children under five years of age to less than 15 percent and to boost the proportion of the population consuming the minimum level of dietary energy are as follows:

1. **Increase access of the poor, particularly children under five years of age and pregnant women, to adequate nutritious and safe food and other interventions such as nutrient supplementation.** Develop specific pro-poor assistance interventions in provinces and districts with high prevalence of malnutrition. Other strategies that will be developed include: (i) socialization and advocacy on social and cultural behavior for healthy lifestyle, particularly to promote exclusive breast-feeding and infant feeding practices; and (ii) investments in basic infrastructure (health, water, sanitation), particularly in rural and urban slum areas.

2. **Strengthen community empowerment and revitalize *posyandus.*** Strengthen food and nutrition service delivery at the grassroots level through revitalization of *posyandu* and integration of nutrition in the early child education program (*PAUD*).

3. **Improve food security at the local level particularly to reduce disparity among regions.** Ensure food security at the local level by: (i) increasing agricultural productivity; (ii) improving the efficiency of food distribution and handling systems; and (iii) acceleration of locally based food diversification programs**.**

4. **Strengthen institutions at central and regional levels giving them stronger authority in formulating policy and programs on food and nutrition.**

GOAL 2 :
ACHIEVE UNIVERSAL PRIMARY EDUCATION

Future Vision

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

TARGET 2A: ENSURE THAT, BY 2015, CHILDREN EVERYWHERE, BOYS AND GIRLS ALIKE, WILL BE ABLE TO COMPLETE A FULL COURSE OF PRIMARY SCHOOLING

Indicators		Baseline	Current	MDG Target 2015	Status	Source
GOAL 2: Achieve Universal Primary Education						
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete full course of primary schooling						
2.1	Net Enrolment Ratio (NER) in primary education	88.70% (1990)**	95.23% (2009)*	100.00%	▶	* MONE ** BPS, Susenas
2.2.	Proportion of pupils starting grade 1 who complete primary school.	62.00% (1990)*	93.00% (2008)**	100.00%	▶	* MONE ** BPS, Susenas
2.3	Literacy rate of population aged 15-24 years, women and men	96.60% (1990)	99.47% (2009) Female: 99.40% Male: 99.55%	100.00%	▶	BPS, Susenas

Status: ● Already achieved ▶ On track ▼ Need special attention

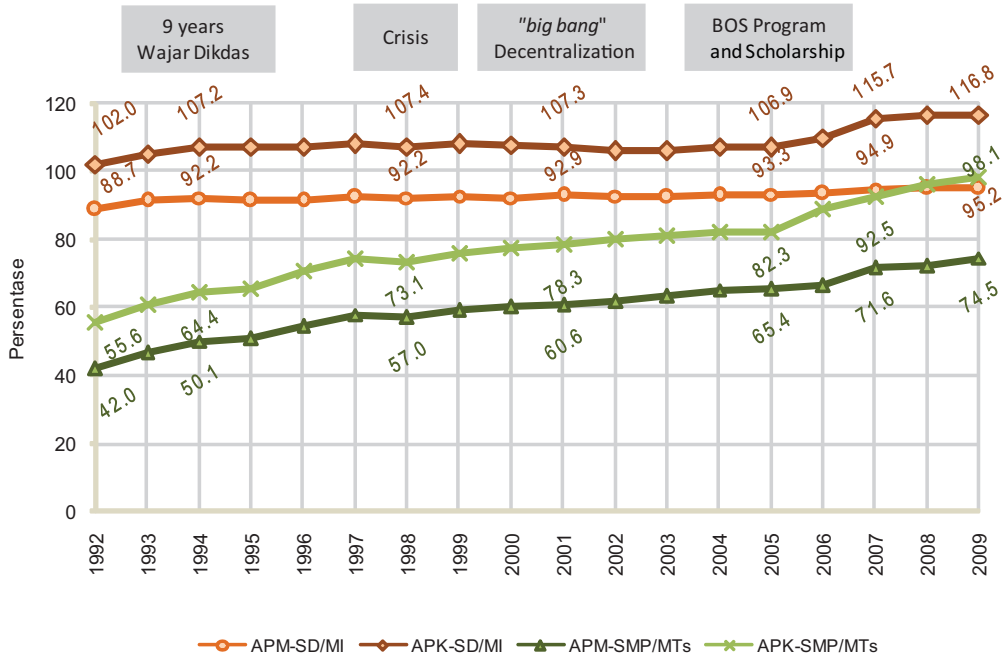
CURRENT SITUATION

Education development aims to improve equal access, quality, relevance, and efficiency in education management. As a commitment to education, in 1994 the government launched Compulsory Basic Education (CBE) to ensure that all chidren aged 7–15 years attend basic education up to the junior secondary level (*SMP/MTS*). The involvement of Indonesia in the Millennium Declaration, the Dakar Declaration on Education for All, and the Convention on the Rights of Children strengthened government commitment to education and to achieve equal access for all Indonesian children.

A number of important measures which have been taken to accelerate the achievement of MDGs by 2015 have resulted in significant progress as indicated by improvement in education participation at primary education level (SMP/MI) and the literacy rate of the population aged 15-24 years.

The Net Enrolment Rate (NER) has increased. Nationally, the primary school (*SD/MI*) net enrolment rate (NER) improved significantly from 88.7 percent in 1992 to 92.5 percent in 1997 despite the financial crisis. In 2008/2009, the NER increased to 95.23 percent while the gross enrolment rate (GER) was more than 100 **(Figure 2.1)**. With consistent effort it is expected that Indonesia will achieve the MDG education target by 2015. The country aims to go beyond the MDG education target for primary education by expanding the universal basic education target to include junior secondary education (*SMP* and *madrasah tsanawiyah-MTs*, grades 7 to 9). In 2008/09, NER and GER at *SMP/MTs*/*Package B* had reached 74.52 percent and 98.11 percent, respectively. Improvement of education participation at both primary (*SD/MI*) and junior secondary education (*SMP/MTs*) levels is a result of the government policy to improve sustainable access to basic education.

Figure 2.1. Trends for Net Enrolment Rates for Primary and Junior Secondary Education Levels (Including Madrasah)



Source: *BPS, Susenas and MONE Statistics.*

The early entry phenomenon which has occurred in the last several years has contributed to the difficulty in achieving the NER of 100 percent at the primary school level (SD/MI) since some children under 7 years of age are already enrolled in primary school (*SD/MI*) and some children aged 12 years are already enrolled in junior secondary education (*SMP/MT*). Therefore, to measure the education participation of children aged 7-12 years the school participation rate (SPR) is also used as an indicator. In 2009 the SPR of children aged 7-12 years was 97.95 percent. This figure indicates that around two percent of children aged 7-12 years are not enrolled in basic education.

Educational attainment of the population aged 16-18 years has shown promising progress.

Susenas data indicates that the percentage of children aged 16-18 years who completed primary education increased from 87.8 percent in 1995 to 93.0 percent in 2008 **(Figure 2.2**). This figure reflects the improvement in educational efficiency as the drop out rate at primary schools, including madrasah, has tended to decrease and the continuation rate from *SD/MI* to *SMP/MTs* has increased.

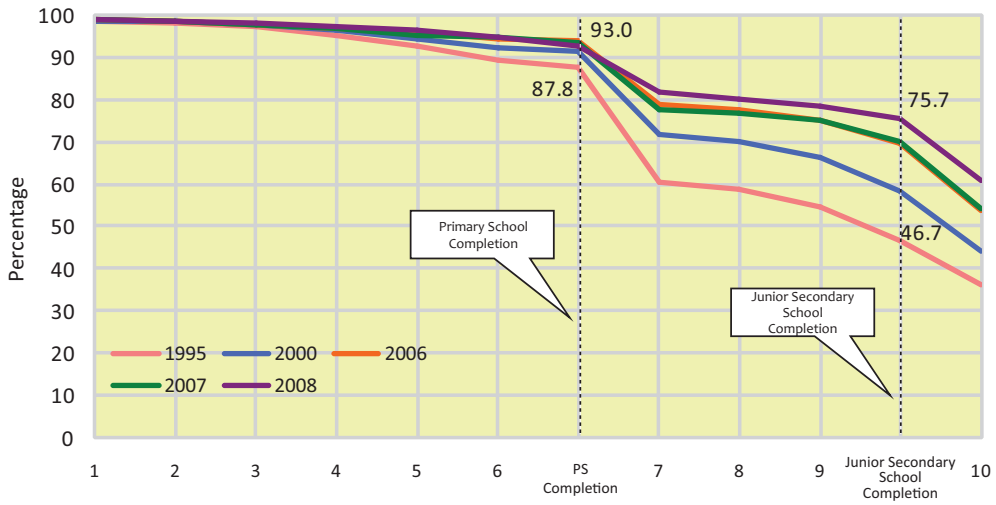


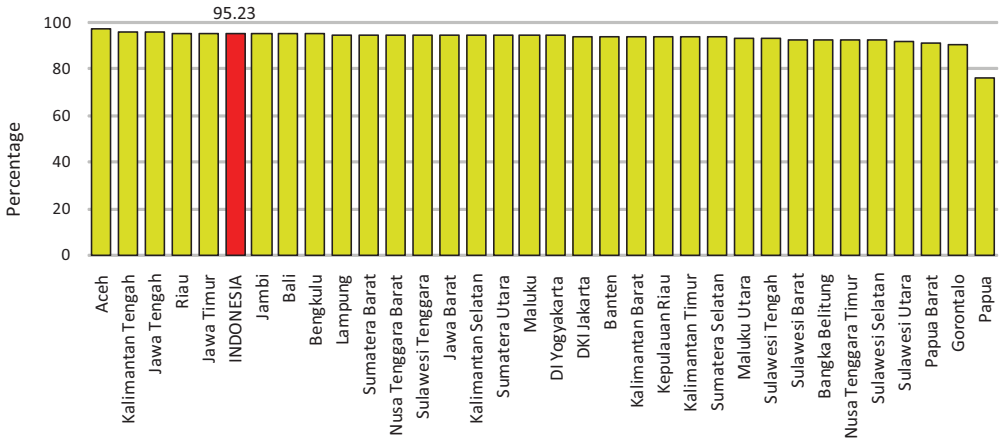
Figure 2.2.
Trend of Highest Education Attended by Population Aged 16-18 Years Old, 1995-2008

Source:
BPS, Susenas 1995, 2000, 2006, 2007, 2008.

At the primary school level, disparity in education participation has been reduced. The *Susenas* 2009 indicated that the NER of all provinces were above 90 percent, except for Papua where the NER was 76.09 percent (**Figure 2.3).** Several critical factors have prevented Indonesia from achieving universal basic education. On the demand side, poverty is considered to be a major factor contributing to the low participation in schooling. Some school aged children have to work and leave school due to poverty. On the supply side, factors contributing to lowering the participation rate include: (i) insufficient educational infrastructure, including teaching-learning materials and equipment; (ii) lack of highly qualified teachers, particularly in remote underserved areas; (iii) lack of relevant curriculum and the low quality of the teaching learning process; and (iv) lack of funding for school operations. Moreover, the low quality of governance in education management contributes to disparities in access to quality basic education.

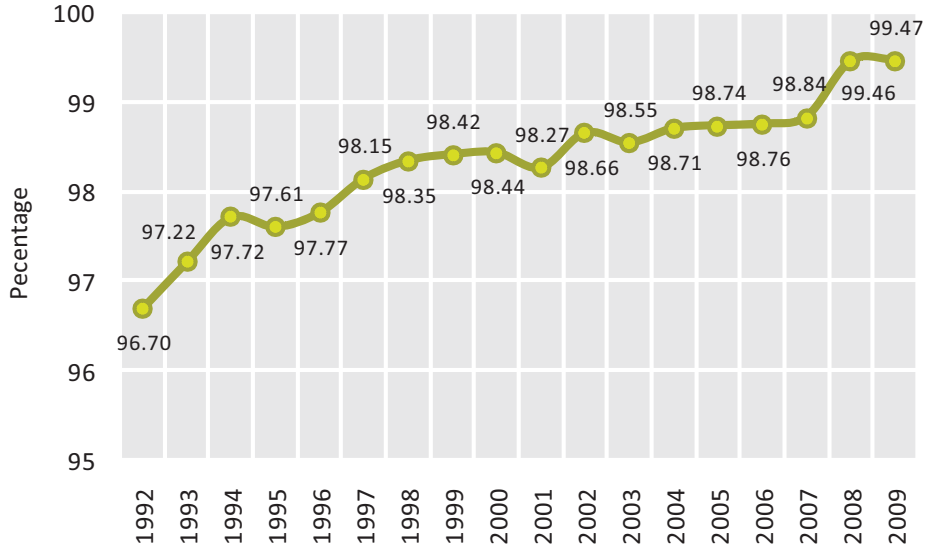
The literacy rate of the Indonesian population aged 15-24 years has increased significantly. The *Susenas* data of 1992 to 2009 indicated that the literacy rate of 15-24 year olds increased from 96.71 percent in 1992 to 99.47 percent in 2009 **(Figure 2.4)**. Improvements in the participation rate at basic education contributed to increasing people's capability in reading and writing. Improvement in the proportion of pupils of *SD/MI* first grade who are able to continue to the fifth grade and complete primary school contributed to improvement of the literacy rate.

Figure 2.3. NER of Primary Education (*SD/MI*) by Province, 2009



Source: *BPS and MONE, Susenas 2008/09.*

Figure 2.4. Trend of Literacy Rate Among Population Aged 15-24 Years, 1992-2009



Source: *BPS, Susenas*

There is no disparity among provinces in the literacy rate of 15-24 year olds. In 2009, all provinces had nearly reached the literacy rate of 100 percent, except Papua where the literacy rate was 79.69 percent **(Figure 2.5**). DI Yogyakarta was the only province with a literacy rate of 100 percent meaning that all people in this province had been freed from illiteracy. Nevertheless, the achievement of 99.47 percent in the literacy rate in 2009, means that some 0.5 percent of the population aged 15-24 years remain illiterate. The majority of the illiterate are women, the poor and people living in rural areas.

Improvement in access and quality of basic education in Indonesia has resulted from implementation of the policy to achieve universal basic education. In 2009, the government allocated 20 percent of the national budget for education. Starting in 2003 government has also provided specific or earmarked funding (*Dana Alokasi Khusus-DAK*) to local governments to support the compulsory basic education program, particularly for the rehabilitation of

primary school buildings and provision of furniture. The budget allocations for the education *DAK* have been increased from year to year, reaching Rp9.3 trillion in 2010. The use of the *DAK* was extended not only for primary education but also for junior secondary education and can be used for building new class rooms, rehabilitation, and improving the quality of buildings.

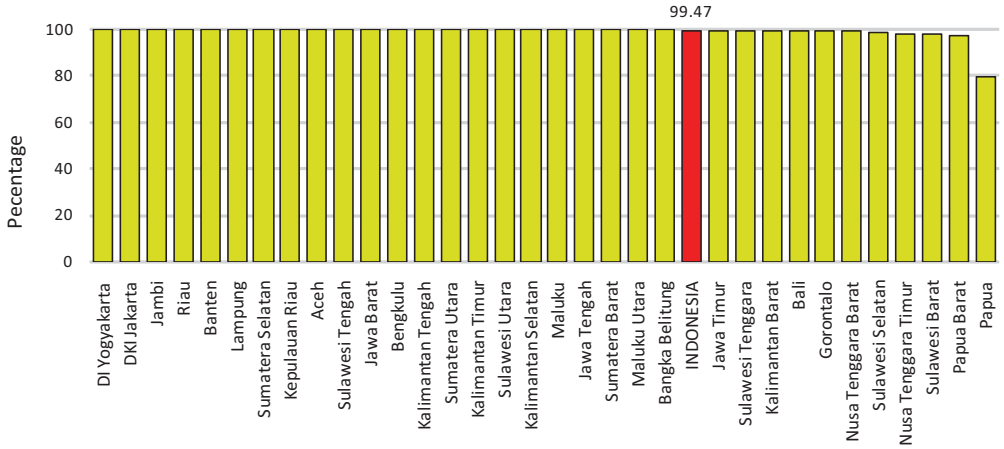


Figure 2.5. The Literacy Rate Among the Population Aged 15-24 Years, 2009

Source: *BPS, Susenas*

In addition, starting in 2005 the government has provided School Operational Assistance (*Bantuan Operasional Sekolah - BOS)* funding directly to schools to reduce the burden of operational costs. The block grants are disbursed to all private and public primary schools (*SD/MI*) and junior secondary schools (*SMP/MTs*) and are aimed to eliminate school fees. For schools located in poor areas, the *BOS* was very beneficial since it replaced financial contributions from parents to schools, particularly for tuition fees. Several districts provide District *BOS* from their local budget. Over the last six years the coverage and unit costs of *BOS* had been improved. In 2010 *BOS* covers 43.7 million students comprising 37.59 million students of general schools (*SD* and *SMP*) and 6.18 million students of madrasah (*MI* and *MTs*) with a total budget of Rp19.26 trillion.

To help the poor, the government also provides Scholarships for Poor Children (*BSM*: *Beasiswa Siswa Miskin*) to improve access of the poor to basic education. The coverage of *BSM* will be continually improved. In 2010 the *BSM* covers 3.7 million students in basic education. The program contributes to the acceleration of universal 9 years basic education and reduces the drop-out rate. MONE data indicates the decreasing trend of the drop-out rate at *SD/MI* from 2.74 percent in 2005 to 1.7 percent in 2009 (MONE, 2010).

Box 2.1.
Bernardus Tosi (Chairman of the School Committe at One-Roof School for Primary and Junior Secondary School Students, Nitneo, Kupang Barat, Nusa Tenggara Timur) "***Our children should not suffer like we did ….***"

A middle-aged man took a deep breath and began to tell his stories:

After completing primary school, a teacher persuaded me to continue my education. We come from a poor family; and my parents did not even dare to imagine that I would go to junior high school. The distance from my house to the school was approximately 24 kilometers. When I arrived at school, I used to take off my shoes and walk into class barefoot. I usually walked to school half-naked because if I wore the uniform, it would be wet and the fabric could be easily torn apart.

Now, when the afternoon comes, I like to sit on the porch of my house and see children walking home from school. A bunch of kids walk by in a uniform. They walk around and have a fun chat, while some of them laugh cheerfully. I am really proud and happy to know that they do not have the trouble of going to school as I did. Now we have built a one-roof elementary school and junior high school (*SATAP*) so that the farthest distance of the school from a student's home is only about two kilometers. Bernardus Tosi concluded his story by saying, "I and all the people here are very happy with the one-roof school. Our children should not suffer like we did ...."

Large schoolyard in front of One-Roof *SD-SMP Nitneo*, Kupang Barat, NTT: The pride of local people

Source: Summary Report AIBEP School and District Survey, 2009-2010

CHALLENGES

1. **Reaching the unreached is a major challenge in achieving the MDG target of 100 percent, particularly due to poverty.** For the poor and near poor family, school costs are often unaffordable, so that children are not able to attend school. Poverty is a major factor contributing to low enrollment in basic education with lack of affordability being the reason for 70 percent of non-attendance at school (AIBEP 2008). Costs are still significant and often unaffordable for poor parents, particularly for daily travel, lunches, uniforms

and books (*Bappenas*, 2009).

2. **Improving school readiness to reduce the drop-out rate and improve the completion rate for basic education.** Only a small proportion of Indonesia's 28 million children aged 0-6 participate in early childhood education and development (ECED) programs. Participation in the program is inequitable and biased towards the better-off, with poor children less likely on average to be enrolled in any form of ECED. Almost three times as many of the richest children participate compared with the poorest children in pre-school (*Taman Kanak-Kanak/TK)* programs.

3. **Improving the professionalism and equal distribution of teachers.** There is a strong correlation between teachers' academic qualifications, overall school effectiveness, and improved learning outcomes. However, in 2009, around 57.4 percent of the 2.6 million teachers were under qualified (**Table 2.1**). Moreover, the distribution of teachers among regions is unbalanced which affects the quality of teaching-learning **(Figure 2.6)**.

Education Level	Number of Teachers				Proportion (%)			
	≤ Senior S	Diploma 1-3	≥ Dipl. 4 / S1	Total	≤ Senior SS	Diploma 1-3	≥ Dipl. 4 / S1	Total
Pre-Primary (*TK*)	119,984	71,080	32,378	223,22	53.70	31.81	14.49	100
Primary School (*SD/MI*)	374,728	758,294	364,637	1,497,659	25.02	50.83	24.35	100
Junior Secondary School (*SMP/ MT*)	29,083	101,890	341,972	502,915	5.78	20.26	73.96	100
Senior Secondary School (*SMA/SMK/MA*)	11,806	29,876	341,633	475,917	3.08	7.79	89.13	100
TOTAL	**535,601**	**961,120**	**1,110,590**	**2,607,311**	**20.54**	**36.88**	**46.60**	**100**

Table 2.1. Number and Proportion of Teachers by Academic Qualifications and School Levels for Indonesia (2009), Not Including Madrasah Teachers

Source: Directorate General of Quality Improvement of Teachers and Education Personnel, MONE, 2010

4. **Providing adequate infrastructure, books and teaching learning equipment to meet the minimum standards.** The number of primary schools particularly in remote and underserved areas is less than adequate. *Not all schools provide text books required by students.* Moreover, in 2008 only around 32 percent of *SD/MI* and 63 precent of *SMP* had a library.

5. **Improving the coverage of non-formal education (NFE) pro-grams for the drop-out students and for children who are not able to enroll in**

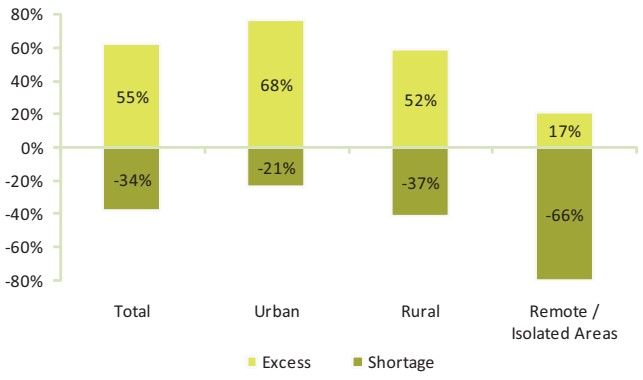


Figure 2.6. Teacher Distribution in Urban, Rural, and Remote Areas of Indonesia, 2007/2008

Source: *MoNE Educational Indicators in Indonesia 2007/2008*

formal schooling. The provision of NFE programs particularly for out-of-school children, namely Package A (primary education equivalency programs) is an essential element in accelerating progress towards achievement of the MDG for basic education in Indonesia. However, the program is still facing problems of coverage and quality.

6. **Developing better financing and a fund transfer mechanism to improve efficiency, accountability, and equity in funding and to ensure the equitable access to quality basic education.** In line with the increased commitment of the government and community to education, the government has dramatically increased public funding allocations for education from 11.4 percent in 2001 to 20 percent in 2009. However, the increased transfer of resources from central government to districts and to schools has resulted in reduction of local budget allocations for education (substitution effect).

7. **Improving education management accountability and efficiency in a decentralized system.** Through decentralization, the principal responsibilities, authority, and resources for the delivery of education are transferred to lower levels of government, while some decision-making power is transferred to individual schools. However, governance and education management are not optimally and effectively implemented. Low capacity in implemeting new roles in decentralization is experienced by both central and local government.

POLICIES

1. **Improving Equitable Access:**
   a. **Formulate and implement policy at national and local levels to accelerate provision of adequate infrastructure and teaching-learning facilities, rehabilitation of schools, construction of new schools, and establishment of one roof schools, particularly in poor, underserved and remote areas including *madrasah* and *pesantren*.**
   b. **Ensure education financing mechanisms are more pro-poor to address inequitable allocation of funds and education resources**. An affirmative policy for the poor is essential to accelerate access to quality education services. This should include increasing the number of cost-based scholarships for poor students in primary and, especially, junior secondary schools in targeted areas with the lowest enrollment rates, and ensuring matching funds from revenue-rich districts.
   c. **Strengthen the effectiveness, efficiency, and accountability of the implementation of *BOS*.** Capacity of local government and school level in managing the implementation of *BOS* will be strengthened. Moreover, community participation will be increased in planning, monitoring, and evaluation of *BOS* by enhancing the school committee.
   d. **Accelerate provision of holistic and integrated ECED services in rural and underserved areas.** Districts will be encouraged or mandated to allocate a share of their budget to support an increase in holistic and integrated ECED services in underserved areas. Institutional capacity at district, provincial, and central level to improve planning and

monitoring of program performance will be strengthened.

e. **Accelerate provision of equivalency programs and enhance quality for school dropouts.** Equivalency program (Packets A and B) will be more narrowly targeted to poor and drop out students.

2. Improving Quality and Relevance:

a. **Accelerate improvements in pre-service and in-service teacher training provision.** In order to increase learning quality, a policy will be developed for all teacher training institutes (*Lembaga Pendidikan Tenaga Kependidikan/LPTKs)* to review their curriculum and courses based on the competency stated in the Teacher Law.

b. **Reform curriculum and improve teaching and learning quality.** Curriculum reform will be conducted to develop and improve the curriculum and teaching-learning process which will enable students to develop their intellectual, emotional, spiritual, and social capacities.

c. **Improvement of training on school based management (SBM) targeted to school principals and supervisors.** The training will cover teacher support and staff performance appraisal, monitoring and supervision, financial planning and management, and community participation.

3. Strengthening Governance and Accountability:

a. **Improve local government capacity in managing the basic education program.** District institutional capacity will be strengthened through expanding coverage of capacity development programs in education management including analysis, planning and budgeting, monitoring and evaluation, as well as financial management.

b. **Strengthen accountability in education resource management.** The strategies will include: (i) evaluating budget efficiency and funding mechanisms; (ii) developing performance-based budgeting tied to quality standards and incentive mechanisms; (iii) strengthening performance evaluation and quality assurance systems; (iv) strengthening management information systems;

c. **Increase community participation.** Improvement of community participation in education management will be conducted through: (i) advocacy to stakeholders for increased resource mobilization; (ii) promotion of public-private partnerships with explicit roles for parents and the community in school performance and school-based management (SBM)

GOAL 3 :
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Boys and girls at elementary school (above) and staff of geothermal in North Sulawesi (below)

GOAL 3:
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

TARGET 3A: ELIMINATE GENDER DISPARITY IN PRIMARY AND SECONDARY EDUCATION, PREFERABLY BY 2005, AND IN ALL LEVELS OF EDUCATION NO LATER THAN 2015

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Goal 3: Promote Gender Equality and Empower Women						
Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015						
3.1	Ratios of girls to boys in primary, secondary and tertiary education					
	- Ratio of girls to boys in primary schools	100.27 (1993)	99.73 (2009)	100.00	●	*BPS, Susenas*
	- Ratio of girls to boys in junior high schools	99.86 (1993)	101.99 (2009)	100.00	●	
	- Ratio of girls to boys in senior high schools	93.67 (1993)	96.16 (2009)	100.00	▶	
	- Ratio of girls to boys in higher education	74.06 (1993)	102.95 (2009)	100.00	▶	
3.1a	Literacy ratio of women to men in the 15-24 year age group	98.44 (1993)	99.85 (2009)	100.00	●	
3.2	Share of women in wage employment in the non-agricultural sector	29.24% (1990)	33.45% (2009)	Increase	▶	*BPS, Sakernas*
3.3	Proportion of seats held by women in national parliament	12.50% (1990)	17.90% (2009)	Increase	▶	*KPU*

Status: ● Already achieved ▶ On-track ▼ Need special attention

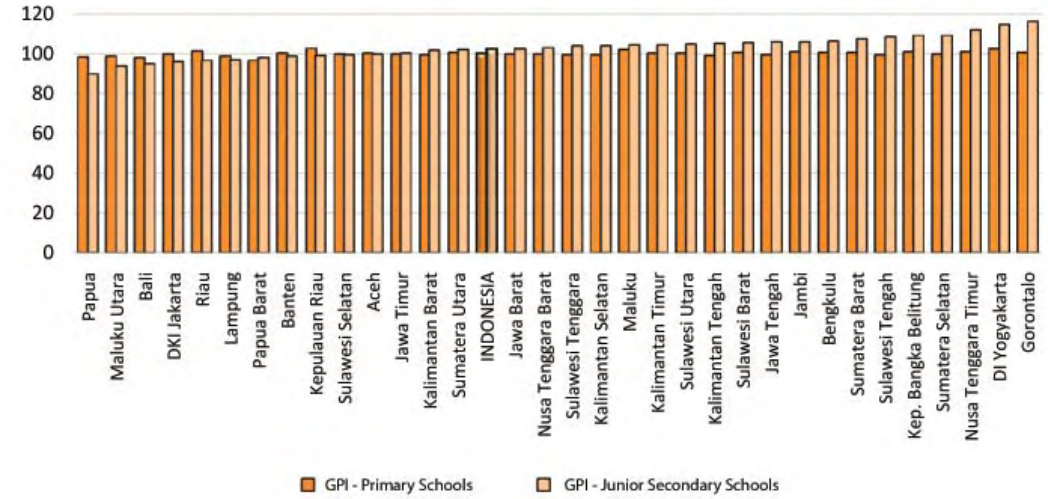
Current Situation

One of the human development goals of Indonesia is to achieve gender equality by building human resources without differentiating between men and women. Significant progress has been achieved in education, employment, and politics.

Improvement of gender equality in education had been conducted through providing equal access and participation for both males and females. Measured by the gender parity index (*GPI*) of the NER or the ratio of NER of females to males, gender equality in education showed significant progress**.** Using this indicator, the MDG target to achieve gender equality at all levels of education will be met by 2015. *Susenas* data from 1993 to 2009 indicates that the GPI of NER for primary education, junior secondary education, and senior secondary education during the period of 1993-2009 ranged from 95 to 105. Meanwhile, the GPI of NER for higher

education fluctuates with a tendency to rise significantly. In 2009, the GPI at primary schools (*SD/MI*/Package A) was 99.73, while at the junior secondary level (*SMP/MT*/Package B) it was 101.99, at the senior secondary education level (*SM/MA*/Package C) it was 96.16, and at all levels of higher education it was 102.95.

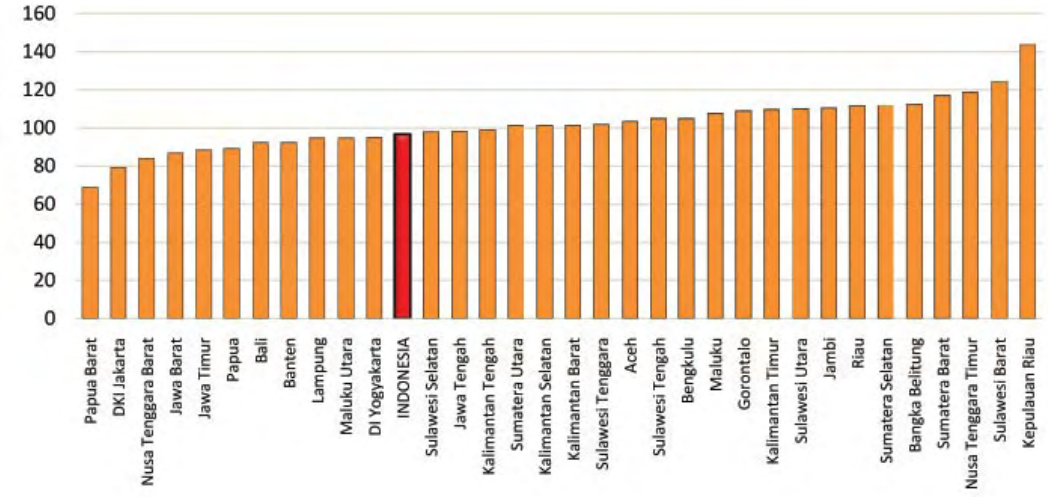
Figure 3.1. Gender Parity Index (GPI) of Net Enrolment Rates (NER) for Primary (*SD/MI*/Package A) and Junior Secondary Schools (*SMP/MTs*/Package B) by Province, 2009



***Source**: BPS, Susenas 2009*

Disparities among provinces are still a major issue, particularly at senior and higher education levels. The *Susenas* 2009 data shows that the GPI of NER at the primary level ranged from 96.39 (Papua Barat) to 102.5 (Kepulauan Riau) which indicate that the NER of females to males was close to homogenous among provinces. At the junior secondary level the GPI ranged from 89.54 (Papua) to 116.17 (Gorontalo), while at the senior secondary level it ranged from 68.60 (Papua Barat) to 143.22 (Kepulauan Riau). In several provinces the GPI exceeded 110 which indicates that the NER of female students is much higher than that of males. While provinces with GPI less than 90 include DKI Jakarta, Jawa Barat, Jawa Timur, Nusa Tenggara Barat, Papua, and Papua Barat (6 provinces). **(Figure 3.2).**

Figure 3.2. Gender Parity Index (GPI) of Net Enrolment Rates (NER) Senior Secondary Schools by Province, 2009



***Source**: BPS, Susenas 2009*

Moreover, the MDG target for the ratio of literacy of females to males in the 15-24 years age group has been achieved. In 2009, the national GPI for literacy of the 15-24 years age group was almost 100, with the female literacy rate at 99.4 percent and the male literacy rates at 99.5 percent. However, in 15 provinces, the literacy rate for females in this age group is slightly lower than that for males.

In the employment sector, the National Labor Force Survey (*Sakernas*) indicates that the open unemployment rate of females had declined by more than 6 percentage points from 14.71 percent in 2005 to 8.47 percent in 2009, while the open unemployment rate for males declined by only 1.6 percent, from 9.29 percent to 7.51 percent during the same period. Meanwhile, the labor participation rate of women increased by around 50 percent. The increase was lower than that of men, which increased by an average of 84 percent during the same period. Moreover, progress in employment, was also shown by the increase in the share of women in wage employment in the nonagricultural sectors. *Sakernas* data shows that the share of women in wage employment in the nonagricultural sectors has increased from 29.02 percent in 2004 to 33.45 percent in 2009.

In politics, progress has been achieved as indicated by the issuance of laws that mandate a quota of 30 percent women's representation in parliament. These include Law No. 27/2007 on the General Election Commission (*KPU*), Law No. 2/2008 on political parties, and Law No. 10/2008 on General Elections, the election of members to the House of Representatives (*Dewan Perwakilan Rakyat-DPR*), the Regional Representative Council (*Dewan Perwakilan Daerah-DPD*) and the Regional House of Representatives (*Dewan Perwakilan Rakyat Daerah-DPRD*). The quota for female legislative candidates as mandated by the laws has been fulfilled by all political parties participating in the 2009 General Election.

Box 3.1.
Overview of MDG achievement in disaster and conflict areas: The case of Aceh

The results of a survey of households performed by *KAPAL Perempuan* in three relocated villages in 2008 in the district of Aceh Besar, namely Kampung Persabahatan, Desa Lambaed and Desa Cot Preh, showed that: (i) average household expenditures were greater than household incomes; (ii) most households spent money to buy drinking water (58.4 percent) due to a scarcity of improved water sources; (iii) almost all of the facilities at the relocated villages, including school buildings (elementary and junior high school) and auxiliary health centers (*puskesmas pembantu/PUSTU*), could not be used due to a lack of teachers, medical personnel (including midwives) and supporting equipment; and (iv) other public facilities, such as markets, were not yet functional at the time of the survey. These conditions influenced the level of poverty, health and education of the refugees who had been relocated permanently to the three villages.

In that context, *KAPAL Perempuan* has worked to improve leadership, education as well as economic and political participation of women in the three relocated villages. The organization facilitates leadership education for women while assisting to develop women's economic resources through establishment of savings and loan groups and viable business activities. Eight savings and loan groups were established which then joined into an association called "*Beudoh Beusareh*", meaning "Rising Together". These women's groups have been able to accumulate savings and loan capital. They have also managed to integrate their priorities into the agenda of the Village Development Plan (*Musrenbangdes*), which provides assistance to improve the availability of midwives and education for women. Slowly but surely, these women's groups have assumed the role of initiator for change in their villages, which is one condition for the achievement of MDGs in areas affected by conflict and disaster. Women's participation has become a driving force behind the improvement of public welfare. (Written by *KAPAL Perempuan*, a women's organization that focuses on the issues of alternative education, gender and pluralism.

CHALLENGES

1. **Improving gender equality at all levels of education in all provinces.** Disparity among provinces in education participation remains in several provinces, particularly due to poverty. The challenge is not only improving the NER of females but also for males depending on the situation. The primary focus is to target children from poor families, particularly those in remote and rural areas. Special attention is needed to achieve gender parity among geographically distinct provinces which have differing characteristics and cultural values.

2. **Implementing law enforcement to ensure equal opportunities without discrimination for women and men in employment and in the job place.** Indonesia has set out several laws and regulations to ensure equal treatment for women and men in employment. Law enforcement and strong coordination among government institutions at all levels needs to

be strengthened to ensure synergy between national and regional laws, and comprehensive coordination and monitoring is required to ensure enforcement of laws and regulations on employment at the provincial and district levels. Other challenges which require continual attention are to provide protection for women workers to ensure the fulfillment of their rights as well as extension of social insurance for women who work in the informal sector.

3. **Improving women's participation in legislative and political institutions.** Some women lack knowledge and skills in politics and decision making. Gender-sensitive political education for both male and female legislative candidates is urgently needed. There is a need to ensure greater participation of women in decision-making positions at the national, provincial, and district levels. Women (voters and legislative candidates) need to be given the opportunity to participate in decision making processes related to politics, economics, and social issues.

POLICIES

Policies on improving gender equality and women's empowerment will be carried out in all sectors and institutions at both the national and local levels. This will include: (i) improving the quality of life and the role of women in development; (ii) improving the protection of women's rights against all forms of violence; and (iii) improving capacity of gender mainstreaming institutions and women's empowerment. To implement these policies, the strategies to improve gender equality are grouped into four areas:

1. **Education:**
   a) Improve access and quality of education to reduce gender inequality among regions and among socio-economic groups
   b) Improve access and quality of gender responsive non-formal education.

2. **Employment:**
   a) Prioritize the enforcement of existing laws, including synchronizing policies and employment regulations, including policies to protect female workers, at the national and regional levels, as well as company/employers, to ensure that men and women are able to equally participate without discrimination in the labor force.
   b) Strengthen coordination between central and local government to ensure the enforcement of labor laws and regulations.
   c) Strengthen labor inspection through improving the number, capacity and competency of labor inspectors to ensure better enforcement of core labor standards.
   d) Provide social protection to women who work in the informal sector.
   e) Improve the qualifications of female workers and job seekers.

3. **Politics,** through improvement in political education and participation :
   a) Improve partnerships with civil society organizations (CSO) to improve women's

participation in politics;

b) Design module on voter education for women's groups, the poor, disabled, and elderly;
c) Improve voter education concerning women legislative candidates; and
d) Improve political education for female members of political parties.

4. **A strategy to implement gender mainstreaming in local government processes will be carried out** through developing a general guideline for local government agencies to integrate a gender perspective into planning, implementation, budgeting, monitoring, and evaluation processes of development policies, programs, and activities at the local levels, both provincial and district levels.

Box 3.2.
The Acceleration of Gender Mainstreaming in Indonesia

In 1998, *Bappenas* and the State Ministry for Women's Empowerment developed the Gender Analysis Pathway (GAP), a specific gender analysis tool for planners to use in the analysis and formulation of development policies, programs and activities which are gender responsive. This was followed by enactment of the Presidential Instruction Number 9 of 2000 on Gender Mainstreaming (*Pengarusutamaan Gender*/*PUG*) in National Development, which instructs all ministries/agencies and local governments to implement gender mainstreaming and then integrate gender perspectives into planning.

In 2007, *Bappenas* evaluated the implementation of gender mainstreaming in 18 ministries/agencies, seven provinces and seven selected districts/cities. Results from the evaluation showed that the strategies of gender mainstreaming had not been well implemented in most development sectors. Therefore, in order to accelerate the implementation of gender mainstreaming, gender perspectives are not only integrated into the planning system, but also the budgeting process. This initiative began with the issuance of the Decree of State Minister for National Development Planning/Head of *Bappenas No. Kep.30/M.PPN/HK/03/2009* on the Steering Committee and Technical Team of Gender Responsive Planning and Budgeting which is aimed at coordinating the implementation of gender responsive planning and budgeting across sectors and across ministries.

Efforts to accelerate the implementation of gender mainstreaming are carried out through putting the implementation of gender responsive budgeting (*anggaran responsif gender*/ARG) to the test. For the first time in the 2010-2014 *RPJMN*, gender mainstreaming policies are integrated into the planning and budgeting process, which include gender disaggregated policies, indicators and targets from various ministries and agencies. This was followed by issuance of the Ministry of Finance Regulation Number 119/*PMK*.02/2009 on Guidelines for the Preparation and Review of Ministry/Agency Work Plan and Budget and the Preparation, Review, Approval and Implementation of Budget Implementation for the Fiscal Year 2010, and then followed by *PMK* Number 104/*PMK*.02/2010 regarding the same subject for the Fiscal Year of 2011, which helps to accelerate the implementation of gender responsive budgeting.

Meanwhile, gender mainstreaming has also been implemented by some local governments. In 2010, gender responsive budgeting was tested in seven pilot ministries and agencies. Each ministry and executing agency prepared terms of reference (TOR) and gender budget statements, which are gender-specific accountability documents prepared by ministry/agency to inform whether an activity is gender responsive or not. In 2011, the application of gender responsive budgeting will be extended to various development priorities.

During 2009, the Provincial Education Office of Central Java has initiated various gender mainstreaming programs and activities in the field of education, which among others include: (a) Preparation of the Regional Action Plan (*RAD*) for Gender Mainstreaming in the Education Sector for 2009-2013; (b) Completion of Modules and Supplement Modules which function as a learning and understanding medium for facilitators; (c) Implementation of the Gender Responsive Family Education (*Pendidikan Keluarga Berwawasan Gender*/*PKBG*) associated with life skills in six sub-districts from three districts/cities, which were represented by two sub-districts respectively; (d) establishment of the Facilitator/Focal Point Forum in the education sector in 2008; and (e) implementation of gender mainstreaming programs and activities in the education sector by districts/cities using financial support from the provincial budget.

GOAL 4 :
REDUCE CHILD MORTALITY RATE

PNPM Weighing Children at Health Post in Magetan, East Java

GOAL 4: REDUCE CHILD MORTALITY RATE

TARGET 4A: REDUCE BY TWO-THIRDS, BETWEEN 1990 AND 2015, THE UNDER-FIVE MORTALITY RATE

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Goal 4: Reduce Child Mortality						
Target 4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate						
4.1	Under-five mortality rate per 1,000 live births	97 (1991)	44 (2007)	32	▶	*BPS*, IDHS 1991, 2007; * *BPS, Riskesdas* 2010 (interim data)
4.2	Infant mortality rate per 1,000 live births	68 (1991)	34 (2007)	23	▶	
4.2a	Neonatal mortality rate per 1,000 live births	32 (1991)	19 (2007)	Decrease	▶	
4.3	Proportion of one-year-old children immunized against measles	44.5% (1991)	67.0% (2007) 74.5% (2010)*	Increase	▶	

Status: ● Already achieved ▶ On-track ▼ Need special attention

CURRENT SITUATION

The health of children in Indonesia has been improving steadily over time. This is reflected in declining rates of infant and child mortality. In 1991, the under-five mortality rate was 97 deaths per 1,000 live births, and it had fallen to 44 in 2007 (IDHS 2007). Over the same period, the infant mortality rate had fallen from 68 to 34 deaths per 1,000 live births**.** The decline in neonatal mortality has been somewhat slower, falling from 32 in 1991 to 19 deaths per 1000 live births in 2007 (**Figure 4.1**).

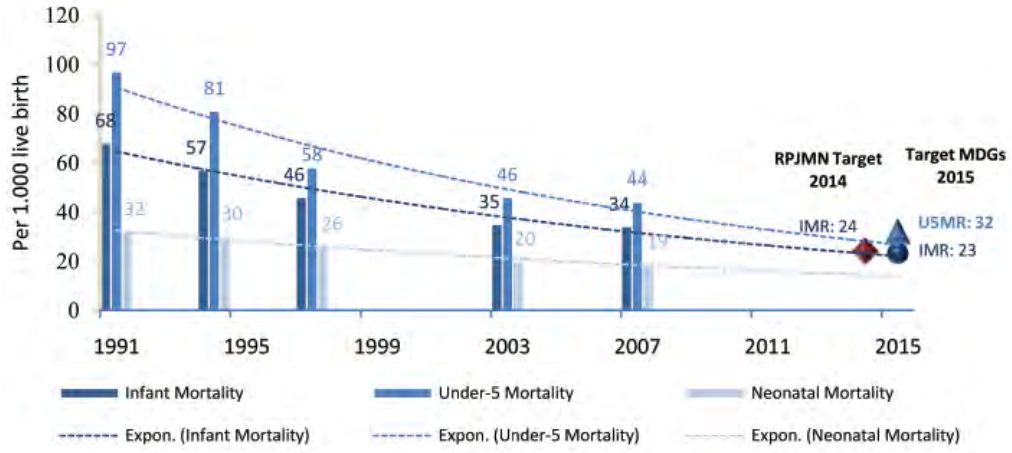


Figure 4.1. National Trend of Child, Infant and Neonatal Mortality Rates, 1991-2015

Source: *BPS, IDHS several years*

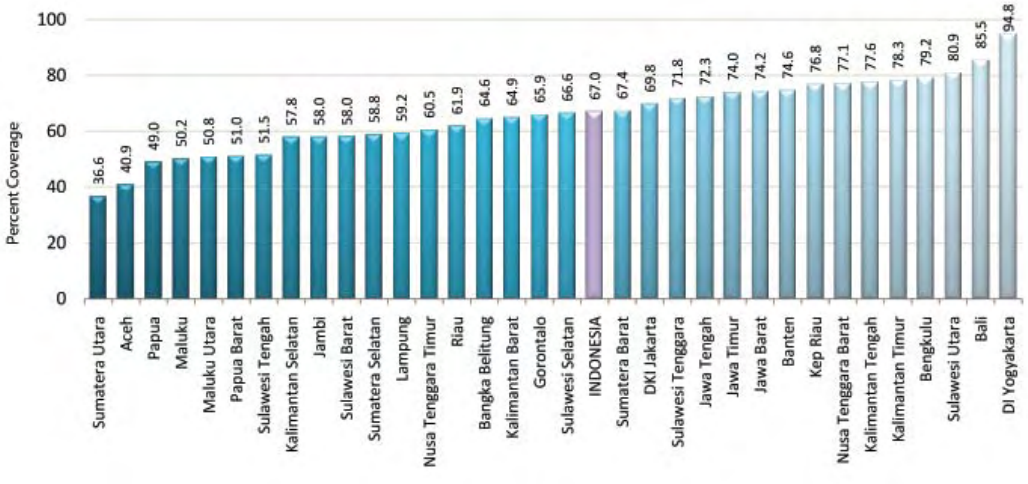
Disparities in neonatal, infant and under-five mortality rates by demographic, as well as social and economic status remain major problems. The highest child mortality rate is in Sulawesi Barat (96), and the lowest rate is in DI Yogyakarta (22). Children of less educated mothers generally have higher mortality rates than those born to more educated mothers. Children in richer households have lower mortality rates than those in poorer households.

Most child, infant and neonatal mortality causes are preventable. An effective preventive measure is immunization.

In general, full immunization coverage continues to increase. During the period 2002-2005, coverage of major immunization programs - BCG, DPT3, and hepatitis - reached 82 percent, 88 percent and 72 percent, respectively. The national coverage of immunization against measles in 2007 reached 67 percent (IDHS, 2007).

There are 18 provinces with lower immunization coverage against measles than the national average. The provinces with the lowest coverage are North Sumatra (36.6 percent), Aceh (40.9 percent), and Papua (49.9 percent), while the province with the highest coverage is DI Yogyakarta, with 94.8 percent coverage (**Figure 4.2**). The national coverage of measles immunization continued to increase and reached 74.5 percent in 2010 (interim data of *Riskesdas* 2010).

Figure 4.2. Proportion of One-Year-Old Children Immunized Against Measles, by Province 2007



***Source**: BPS, IDHS 2007.*

Box 4.1.
MDG target achievement in reducing infant mortality in Bantul District: district government's commitment a key to success

With a population of 942,579, Bantul regency in Yogyakarta combines plains, highlands and coastlines. The strong commitment of the head of this regency (*Bupati*) to reducing infant mortality is reflected in his dedication and leadership in tackling health issues.

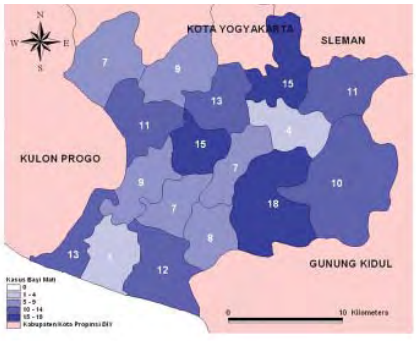
The *Bupati* of Bantul has involved officers from the district level down to villages and hamlets in identifying and tackling the health issues. This effort, which also involve community action, were launched in the district's medium-term development plan for 2007-2010. They focus on addressing four major health issues – the *DB4MK* - including maternal mortality (MMR), infant mortality (IMR), malnutrition and dengue hemorrhage fever.

The program aims at: (1) changing the mindset, behavior and practices of officers and the community in dealing with health issues; (2) reducing maternal deaths; (3) reducing infant mortality; (4) reducing morbidity of Dengue Fever; (5) reducing malnutrition cases; and (6) improving the TB case detection rate.

Monthly monitoring is conducted on the basis of village leader reports and cross-checking with *puskesmas* (primary health care) reports . When a village reports NO CASES of those 4 major health issues occurring over a period of one year, the Bupati gives the village a reward of Rp100 million. So far, rewards have been awarded to Girirejo village in Imogiri sub-district in 2007, and Karangtalun village in Imogiri sub-district and Sendangsari village in Pajangan sub-district in 2008. In 2009, Jatimulyo village of Dlingo sub-district received the award

Achievements are the result of special attention being paid to mothers, babies and toddlers through *posyandu* (integrated health post), Maternal and Child Health services, MCH monitoring book, immunization covering all infants, BEONC (basic emergency obstetric and neonatal care), maintaining better community nutrition, communicable disease control and prevention, and environmental health.

Map of Distribution of
Infant Death Case in Bantul District



Every village has village midwives and all *puskesmas* have doctors. Each sub-district and village has to be able to record and report all incidences of child and infant deaths. The *DB4MK* movement is an effort to maintain the declining trend in infant mortality by addressing health issues through local government at all levels, from village level to district level.

CHALLENGES

1. **Low coverage of immunization.** Program monitoring, synchronization of effective evidence-based interventions with universal coverage, integration of such interventions into results-based sector planning, and budgeting are still insufficient.

2. **Ineffective early detection and prompt treatment of sick children (IMCI).** About 35 - 60 percent of children have no access to proper health services when ill and 40 percent are unprotected from preventable diseases. Management, staff training, funding and grass-roots promotion of IMCI still need to be improved.

3. **Limited efforts in improving nutrition outcomes for children**. More cost-effective, feasible and adaptable nutrition interventions need to be explored.

4. **Low participation of family and community in child health**. Only 30 percent of mothers apply good health practices. Information, Education and Communications (IEC) programs for behavior change need to be improved.

5. **Lack of interventions in controlling for environmental risk factors**. Risk factors for infant and child mortality are strongly related to environmental health – clean water, basic sanitation and levels of indoor pollution.

6. **Persistent low access to proper health services**. About 20 percent of births have no access to proper health services, while most babies born in Indonesia are at high risk (*Riskesdas* 2007).

POLICIES

Current policies on child health in Indonesia focus on core interventions of health services and covers: immunization, IMCI, child nutrition program, strengthening the role of the family, and enhancing access to health facilities, as described in the following:

1. **Improving immunization coverage against measles** through: ensuring that adequate resources are availabie and roles between central and local government in program implementation are defined.

2. **Strengthening strategies to address the key IMCI implementation, through: : (i)** focusing on IMCI training for health workers; (ii) strengthening management structures at the central and district levels; (iii) ensuring that essential drugs are available; (iv) implementing IMCI at the household and community levels; and (v) counseling for mothers and caregivers.

3. **Addressing the key nutritional concerns in children to reduce stunting prevalence, as follows:** (i) emphasizing exclusive breast-feeding; (ii) pursuing food supplementation

strategies; (iii) promoting child growth; (iv) introducing communication for behavior change (BCC); and (v) pursuing micronutrient interventions, increased dietary intake, food fortification and direct supplementation.

4. **Developing strategies at family level for child health**, consisting of: (i) protecting children in malaria-endemic areas with insecticide-treated nets; (ii) providing children with a full course of immunizations before their first birthday; (iii) recognizing sick children and seeking care from appropriate providers; (iv) feeding and offering more fluids, including breast milk, to children when they are sick; and (v) treating infected children with appropriate home treatment.

5. **Strengthening behavior change interventions** by increasing clean and healthy life behavior (PHBS) practices at the household level.

6. **Improving newborn care and maternal health**, through: (i) implementing the newborn and child survival strategy; (ii) focusing on 'essential obstetric and neonatal care'; (iii) training for community health workers to promote safe delivery practices; and (iv) providing vaccinations and iron supplementation.

7. **Strengthening and improving health facilities,** by: (i) promoting primary health care and revitalize *posyandus*; (ii) enabling Basic and Comprehensive Emergency Obstetric and Neonatal Care (BEONC and CEONC); and (iii) ensuring adequate funding for operating costs for hospitals and primary health centers.

8. **Improving community participation and mobilization through *posyandu* activities** that include: monitoring the nutritional status of infants and toddlers through observation of monthly body weighing, complete basic immunization and other health services.

9. **Enhancing policy advocacy** that is targeted at provinces with lower levels of achievement on indicators for child health, through: (i) improved resource allocation; (ii) increased provision of public budgets for health; (iii) developing monitoring instruments; (iv) improved capacity of health personnel; and (v) addressing strategic needs of health workers in remote areas, underserved, border and island areas.

10. **Integrating cross sectoral strategies to accelerate achievement of targets for child, infant and neonatal mortality.**

GOAL 5 :
IMPROVE MATERNAL HEALTH

Puskesmas: the "spearhead" of health services

GOAL 5: IMPROVE MATERNAL HEALTH

TARGET 5A: REDUCE BY THREE-QUARTERS, BETWEEN 1990 AND 2015, THE MATERNAL MORTALITY RATIO

TARGET 5B: ACHIEVE, BY 2015, UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

	Indicators	Baseline	Current	MDG Target 2015	Status	Source
Goal 5: Improve Maternal Health						
Target 5A: Reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio						
5.1	Maternal Mortality Ratio (per 100,000 live births)	390 (1991)	228 (2007)	102	▼	*BPS*, IDHS 1993, 2007
5.2	Proportion of births attended by skilled health personnel (%)	40.70% (1992)	77.34% (2009)	Increase	▶	*BPS*, *Susenas* 1992-2009
Target 5B: Achieve, by 2015, universal access to reproductive health						
5.3	Current contraceptive use among married women 15-49 years old, any method	49.7% (1991)	61.4% (2007)	Increase	▶	*BPS*, IDHS 1991, 2007
5.3a	Current contraceptive use among married women 15-49 years old, modern method	47.1% (1991)	57.4% (2007)	Increase	▼	
5.4	Adolescent birth rate (per 1000 women aged 15-19)	67 (1991)	35 (2007)	Decrease	▶	
5.5	Antenatal care coverage (at least one visit and at least four visists)					
	- 1 visit:	75.0%	93.3%	Increase	▶	
	- 4 visits:	56.0% (1991)	81.5% (2007)		▶	
5.6	Unmet need for family planning	12.70% (1991)	9.10% (2007)	Decrease	▼	

Status: ● Already achieved ▶ On-track ▼ Need special attention

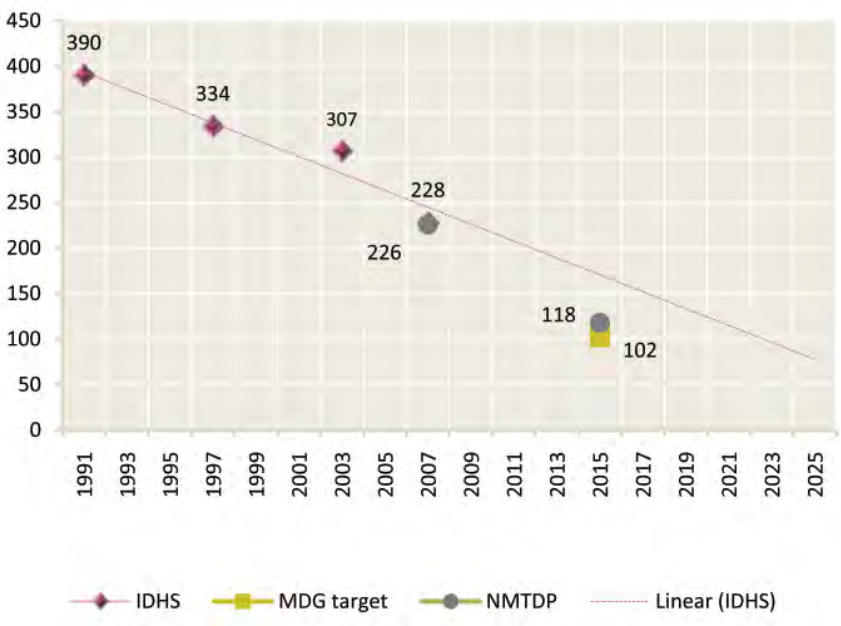
CURRENT SITUATION

Indonesia's Maternal Mortality Ratio (MMR) remains high. With current trends, MMR has been falling gradually, but extra efforts are required to achieve 102 deaths per 100,000 live births by 2015.

The maternal mortality figures gradually decreased from 390 deaths per 100,000 births in 1991 to 228 in 2007 (IDHS 2007) as seen in Figure 5.1. It is estimated by WHO that 15-20

percent of pregnant women in both developed and developing countries will experience high risk and/or complications during pregnancy or at birth.

Figure 5.1. National Trends and Projections for the Maternal Mortality Ratio 1991-2025

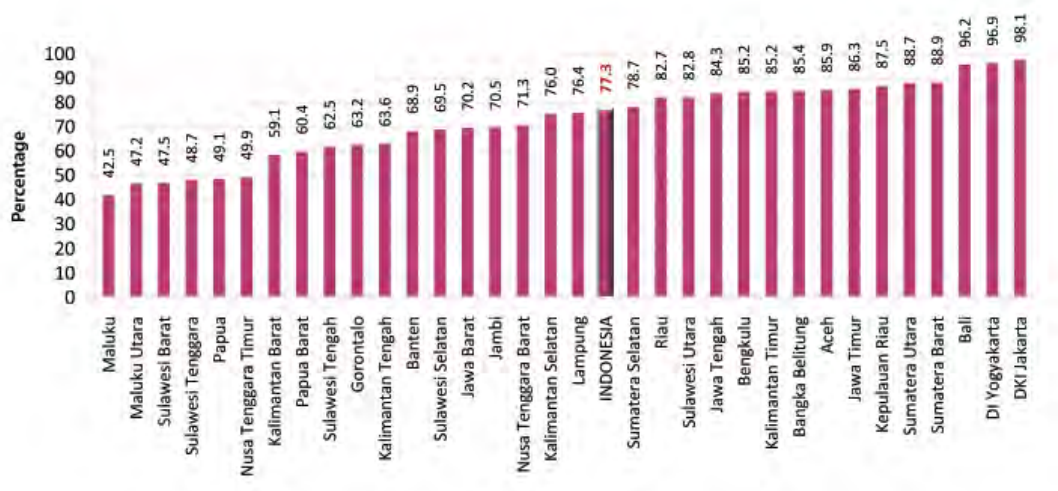


***Source**: BPS, IDHS several years.*

The most effective way to reduce maternal mortality is to have births attended by a skilled health provider. Currently, 77.34 percent of births are assisted by a skilled health provider (*Susenas* 2009). This figure continues to increase, from 66.7 percent in 2002, and reached 82.3 percent in 2010 (interim data from *Riskesdas* 2010).

Disparity in births assisted by skilled personnel among regions remains a major problem. The 2009 *Susenas* data showed that the highest proportion of births assisted by health personnel is DKI Jakarta (98.14 percent) and the lowest is Maluku (42.28 percent), as shown in **Figure 5.2**.

Figure 5.2. Percentage of Births Assisted by Skilled Provider, by Provinces , 2009



***Source:** BPS, Susenas 2009*

Deliveries in health facilities have been steadily increasing. In 2007, deliveries in health facilities represented 46.1 percent of all deliveries (IDHS 2007). *Riskesdas* 2010 reported an increase in attended deliveries in health facilities to 59.4 percent. However, there are disparities among regions, residence (rural vs. urban) and socio-economic status. There are regional differences in delivery in health facilities, ranging from 90.8 percent in Bali to 8.4 percent in Sulawesi Tenggara. The percentage of deliveries in health facilities is higher in urban areas (70.3 percent) than in rural areas (28.9 percent). Mothers with no education are much more likely to deliver at home than mothers with secondary or higher education (81.4 and 28.2 percent, respectively). Mothers who are in the lowest wealth quintile are almost five times as likely to deliver at home as mothers in the highest wealth quintile (84.8 and 15.5 percent, respectively).

Antenatal care (ANC) is crucial in ensuring the mothers are healthy during pregnancy and in convincing mothers to deliver in health facilities. Mothers with no antenatal care are more likely to deliver at home (86.7 percent) than mothers with four or more antenatal visits (45.2 percent).

Ninety-three percent of women receive antenatal care from a health professional during pregnancy (Figure 5.3). Some 81.5 percent of pregnant women have at least four ANC contacts during pregnancy, but only 65.5 percent of pregnant women have complied with the recommended schedule of the minimum of four ANC visits. Even with relatively high coverage, ANC still needs attention, especially since MMR remains high. One aspect to be considered is quality of ANC services in ensuring early diagnosis and prompt treatment, beside an integrated and holistic approach to maternal health.

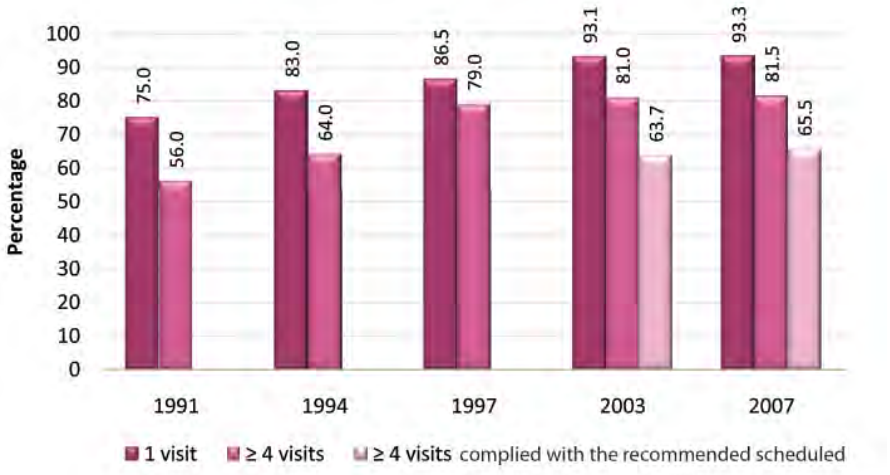


Figure 5.3.
First and Fourth Antenatal Visits, in Indonesia, 1991- 2007

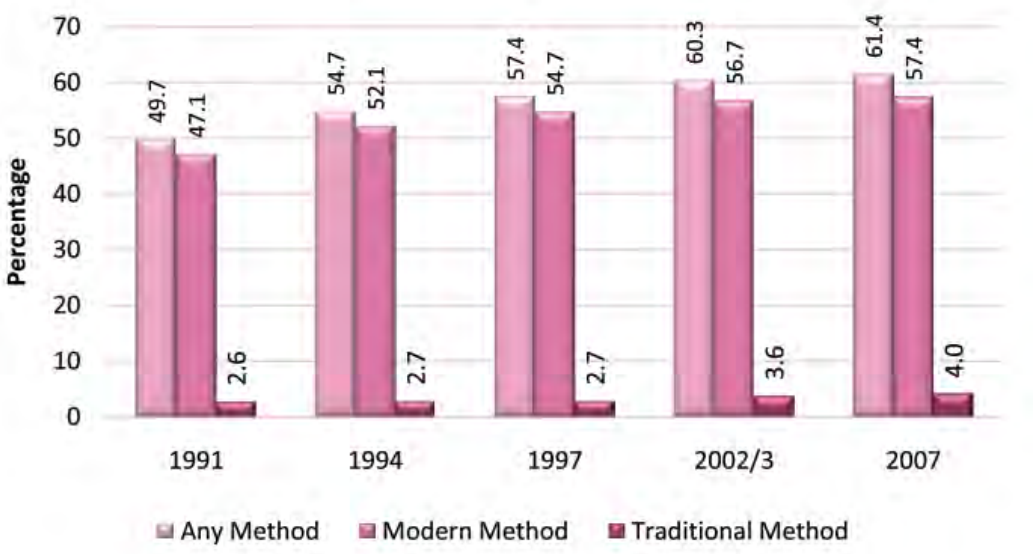
Source:
BPS, IDHS several years.

Continuum of care is a critical element in the strategy to achieve maternal and child health targets. Regarding the pre-pregnancy period, contraceptive and reproductive health will be the crucial issues to be improved.

The contraceptive prevalence rate increased during the last five years. Nationally, the

contraceptive prevalence rate (CPR) increased from 49.7 percent in 1991 to 61.4 in 2007. The use of modern methods increased from 47.1 percent in 1991 to 57.4 percent in 2007. To 2007, among modern methods, injectables were the most commonly used method (32 percent), followed by the pill (13 percent) as reported in IDHS 2007.

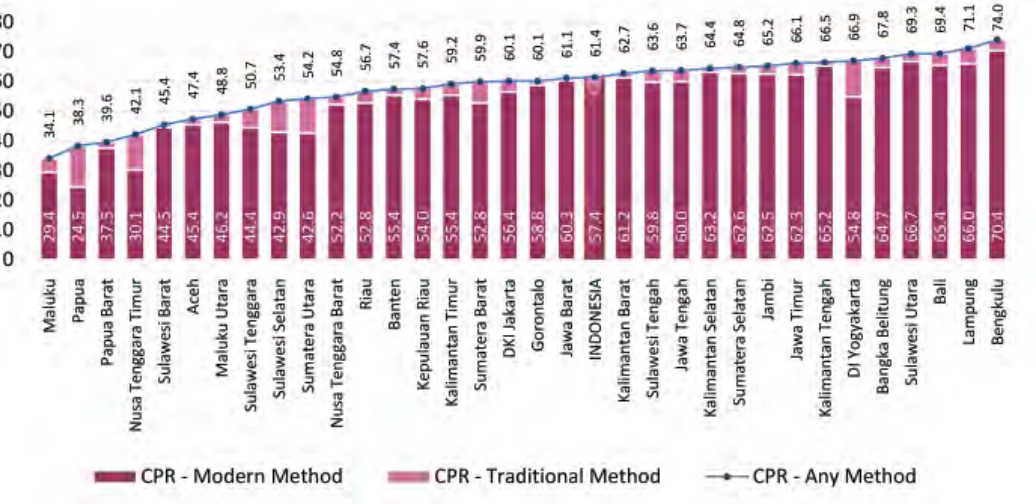
Figure 5.4. Trend of CPR in Married Women Aged 15-49, 1991-2007



Source: *BPS, IDHS 2007*

The CPR varies by province, level of education, and wealth quintiles. The lowest CPR for any method, is in Maluku (34.1 percent), while the lowest for modern methods is in Papua (24.5 percent). The highest for any methods is in Bengkulu, at 74.0 percent and 70.4 percent, respectively. Disparity of CPR among provinces indicates the uneven coverage of family planning programs (**Figure 5.5**).

Figure 5.5. Contraceptive Prevalence Rate by Method, by Province, 2007



Source: *BPS, IDHS 2007*

Contraceptive use in urban areas is slightly higher than in rural areas (63 and 61 percent respectively). The 2007 IDHS shows that the use of modern methods is relatively similar (57 and 58 percent respectively). Contraceptive use in general is high where the respondent's level of education and wealth quintile is high, while the use of modern contraceptive methods among women increases with their level of education; except for implants.

The number of couples of reproductive age who want to space pregnancy or limit births, but do not use any contraceptives (unmet need), is 9.1 percent (4.3 percentage points are for spacing and 4.7 percentage points for limiting) (IDHS 2007). These numbers have been stagnant since 1997 (**Figure 5.6**). IDHS 2007 shows that 60 percent of married women with 2 children, 75 percent of married women with 3-4 living children, and 80 percent of married women with 5 or more live children, do not want more children, but are not using any contraceptive method.

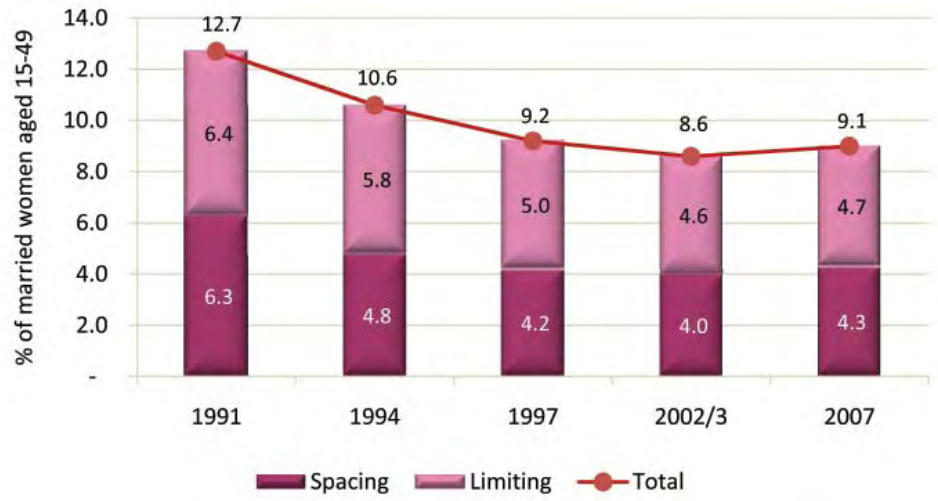


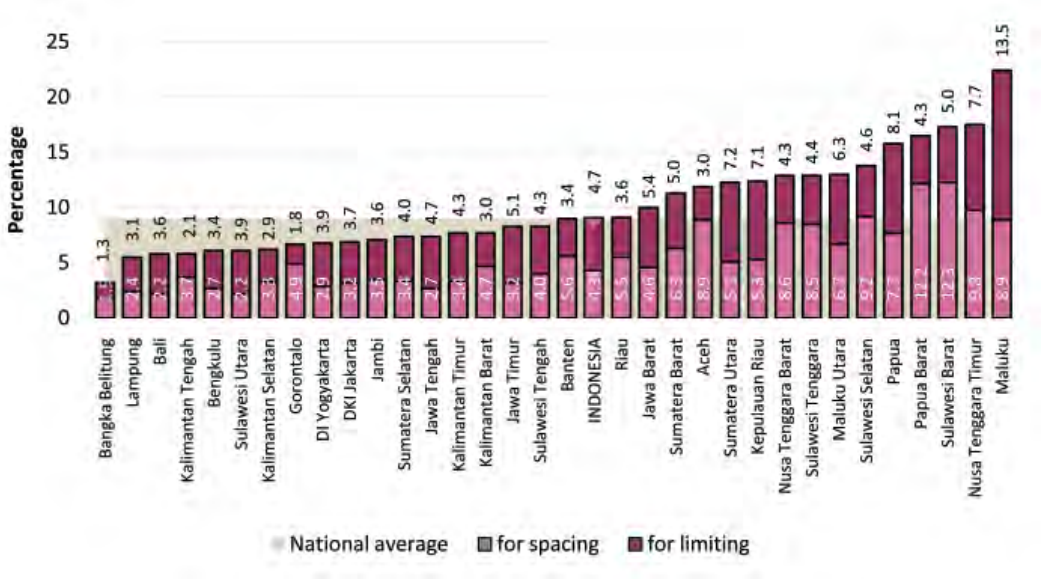
Figure 5.6.
Trend of Unmet Needs in Indonesia 1991-2007

Source:
BPS, IDHS 1991, 1994, 1997, 2002/2003, 2007.

Unmet need varies greatly among regions and according to socio-economic status. The lowest unmet need is found in Bangka Belitung (3.2 percent) and the highest in Maluku (22.4 percent). Higher unmet need was found in rural areas (9.2 percent) compared with urban (8.7 percent). In addition, unmet need also tends to be inversely correlated with a higher level of education and welfare quintile: it is 11 percent for women with no education and 8 percent for women with higher education (secondary and above); while for women in the lowest quintile it is 13 percent and 8 percent for women in the highest quintile. This indicates that the more educated and prosperous the group, the more information and services of family planning and reproductive health have been accessed.

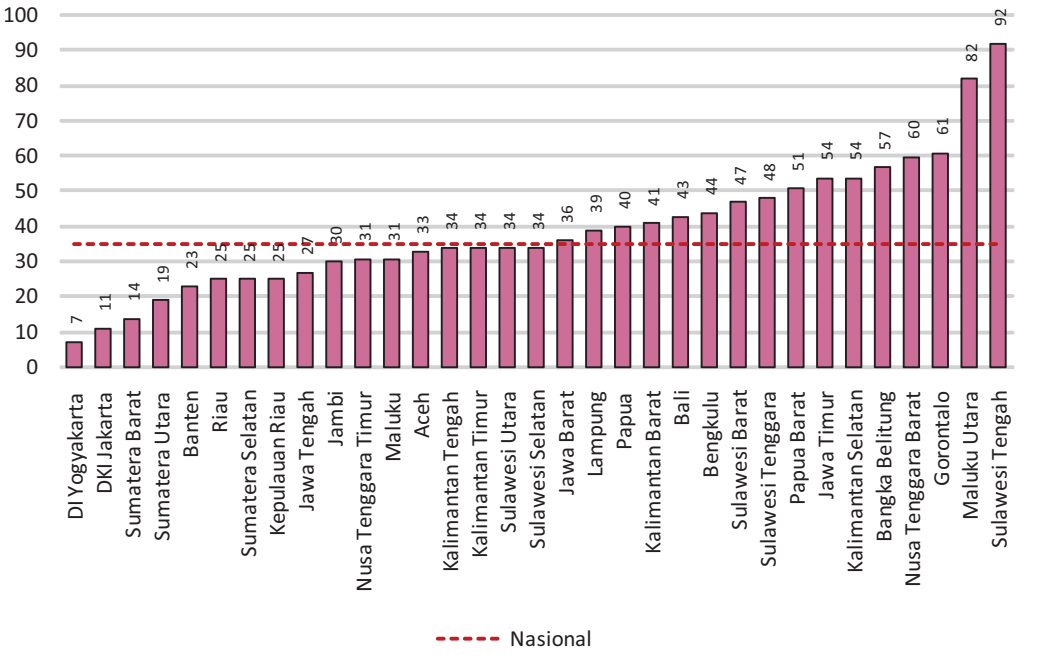
High unmet need is also caused by concern about side effects and the inconvenience of using contraceptives, which reflects the low quality of family planning services. Moreover, 12.3 percent women aged 15-19 are not willing to use any contraceptive because of side effects, 10.1 percent because of health problems and 3.1 percent because their husbands forbid them to do so.

Figure 5.7. Unmet Need by Intended Purposes by Province, Indonesia 2007



Source:
BPS, IDHS 2007

Figure 5.8. Age Specific Fertility Rate Aged 15-19 by Province, 2007



Source:
BPS, IDHS 2007

The CPR and unmet need contribute to the Total Fertility Rate (TFR), in addition to increasing maternal mortality, with an estimated 6 -16 per cent caused by unsafe abortion practices. Unmet need leads to unwanted and unintended pregnancies, which in turn lead to termination of pregnancies. Since abortion is illegal in Indonesia, pregnant women seek unsafe abortion services. The need for family planning is further underlined by the high adolescent birth rates in Indonesia, especially in rural areas.[1]

1 The Adolescent Birth Rate is counted using the ASFR aged 15-19 (number of births by married women aged 15-19 years divided by number of married women aged 15-19)

The Age Specific Fertility Rate (ASFR) for individuals aged 15-19 has reached 35 births per 1,000 married women (IDHs 2007), which has decreased notably from 67 births per 1,000 married women (IDHS 1991). The disparity among provinces, among regions, and socio-economic statuses are the main challenges. The highest ASFR for the age group 15-19 is found in Sulawesi Tengah (92 births), while the lowest is in Yogyakarta (7 births). Furthermore, 16 provinces still have ASFR for age 15-19 above the national average. The 2007 IDHS reported that the percentage of married women aged 15-19 who ever delivered, was higher in rural areas than in urban areas, with 13.7 percent and 7.3 percent respectively, and was also higher for those with a low level of education, 13.6 percent among uneducated mothers and 3.8 percent among mothers with secondary or higher education. The persistently high adolescent birth rate reflects the lack of information, access and quality of family planning and reproductive health services.

Box 5.1.
The Partnership between Midwives and Traditional Birth Attendants in Takalar District, Province of Sulawesi Selatan

Takalar District in South Sulawesi Province is the first district in Indonesia with regional regulations (*PERDA*) regarding partnership between midwives and traditional birth attendants/ TBAs (*Bidan-Dukun* Partnership). This Perda aims at "safeguarding" all efforts in reducing maternal mortality rate (MMR) in the district. The district has a population of 250,000. Prior to the partnership, many mothers had died during delivery; but after the partnership was initiated, the proportion of births assisted by health professionals increased dramatically and the maternal mortality rate in the district continues to decrease. Based on Takalar District Health Office data, in 2009, the MMR in the region was zero, compared to eight, three and one, respectively, in 2006, 2007 and 2008.

In general, the partnership is intended to reduce the infant mortality rate and the maternal mortality rate. The concept of partnership involves TBAs assisting midwives in caring for mothers from early pregnancy until delivery. "I received Rp50,000. for every mother I brought to the clinic," said Daeng Sina (55), a TBA from Bontomarannu *Puskesmas* in Galesong. There are 89 midwives/village midwives and 189 TBAs in Takalar.

The *Bidan-Dukun* partnership is based on a persuasive approach, adapting "*sipakatau*" (local traditional practice), by positioning midwives and TBAs at the same level with a principle of sincerity, mutual need and mutual benefit. The achievements of this program are: (a) about 25-30 TBAs have participated in internships in each *puskesmas*; (b) better working relationships between midwives and TBAs; (c) an agreement to work in partnerhsip in assisting staff delivering mothers; (d) supervision support is being provided by the village/sub-district; and (e) expansion of coverage in births assisted by health personnel from 55 percent in 2006 to 100 percent in 2007.

CHALLENGES

1. **Limited access to quality health care facilities, especially for the poor in disadvantaged areas, remote, border and island areas**. The availability and quality of Basic Emergency Obstetric and Neonatal Care (BEONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEONC), *posyandu* and blood transfusion units are still unequal and not entirely affordable. In addition to that, the referral system is weak, from community to primary to referral facilities. This is exacerbated by geographic and transportation barriers to access health facilities and health workers.

2. **Limited availability of health personnel both in terms of quantity, quality and their distribution, especially midwives**. Health workers are sometimes inadequately trained;[2] as well as lacking medical equipment, medicines and blood supplies that are crucial to handling obstetric emergencies, especially in remote and poor areas.

3. **Lack of knowledge and awareness on the significance of safe motherhood**. Some socio-economic indicators, such as affordability and education, are low, as well as cultural factors, which may constrain demand and contribute to maternal deaths in Indonesia.

4. **Low nutritional and health status of pregnant women.** The percentage of women of reproductive age (15-45 years old) who suffer from chronic protein energy malnutrition is relatively high, 13.6 percent (*Riskesdas* 2007). The low nutritional status, in addition to escalating health risks for pregnant women, is one cause of high prevalence of low birth weight (LBW) among infants.

5. **Low rates of contraceptive use and high unmet need remain major challenges**. The high IMR and MMR, mother's age at child birth (too old; too young), high abortion rates, and low contraceptive use.

6. **The Maternal Mortality Ratio remains uncertain, as the system for recording causes of maternal deaths is not robust.** The rate is currently obtained from a survey using a direct estimation procedure, where information collected on the survivorship of all live births of the respondent's natural mother (i.e. the respondent's brothers and sisters) drawing on the Indonesia Demographic and Health Survey (IDHS) since 1994. To obtain accurate death rates and causes of death, a complete vital statistics model should be compiled through registration, or a population census with the cause of death recorded. This needs to be implemented immediately.

2 The education and training programs with crash program approaches, sometimes poorly done , have resulted in insufficiently skilled health workers, especially when they have to work in difficult circumstances where in fact they are most needed.

POLICIES

Policies to be implemented include:

1. **improving facility-based outreach services by improving quality and quantity of *puskesmas*, BEONC, CEONC,** Mother and Baby Friendly Hospital (CEONC[3]) and *posyandu* revitalization;

2. **increasing access to family planning services,** by means of expanding the service network (coverage and access) and integrating family planning with other reproductive health programs with a focus on the poor and underserved areas;

Continuing family planning revitalization in order to control the population is one of the key features of policies to achieve universal access to reproductive health by 2015, and will be pursued through a series of strategies, among others:

1. Supervising and building self reliance to participate in family planning by:

a. increasing participation and self-reliance training for family planning through 23,500 government and private family planning clinics, by providing material support for the clinics, free contraceptive devices/drugs and free family planning services for the poor;

b. improving knowledge, attitudes and behavior of teenagers related to adolescent reproductive health, HIV/AIDS, addictive drugs use, life skill education and family life education for adolescents;

c. improving human resources capacity in the family planning program at all levels, in the aforementioned 23,500 clinics in order to assist, participate and develop self-reliance in family planning.

2. Improving promotion and community mobilization by:

a. developing media communications and intensifying information, communication and education for population control and family planning;

b. improving knowledge, attitudes and behavior related to population control, family planning and reproductive health;

c. improving commitment and participation across sectors and local governments in population and family planning program implementation;

d. promoting and strengthening partnerships with the private sector, NGOs, and communities in family planning program implementation.

Source: National Medium Term Development Plan 2010-2014.

3. **expanding the village midwife functions, including partnering with TBAs,**; and strengthening community based care through TBA-midwife partnerships, integrated health post (*posyandu*), village health post (*poskesdes*)

4. **strengthening the referral system**, to reduce the "three delays" and save a women's lives by giving adequate care in time.

3 UN guidelines recommend a minimum of one comprehensive emergency obstetric care facility and four basic emergency obstetric care facilities per 500,000 population.

5. **reducing financial barriers** through: the Family Hope Program (*PKH*) - a household-based conditional cash transfer, Jamkesmas (social health funds assistance for the poor), *BOK* (subsidy for non-salary operating cost for primary health facilities).

6. **Improve the continuum of care,** that includes integrated service delivery for mothers and children from pregnancy to delivery, the immediate postnatal period, and childhood.

7. **Increasing the availability of health workers** (general practitioners, specialists, village midwives, paramedical staff) in terms of quantity, quality and distribution; focusing to fulfill needs in remote, underserved, border and island areas, through pre-service and in-service training of key health personnel and implementing a contractual service provider scheme.

8. **Raising awareness about safe motherhood at the community and household level** by strengthening the public health education.

9. **Improving adequate micronutrient intake by pregnant women**.

10. **Providing an enabling environment to support management and stakeholder participation in policy development and the planning process, and** promote collaboration across programs, across sectors, between public and private sector entities, including developing linkages with the community to implement the synergies in advocacy and services provisions.

11. **Improving the information system**, in particular by: (i) introducing analytical methods to measure maternal deaths drawing on diverse sources of varying quality; (ii) focusing on groups and areas most at risk of maternal death; and (iii) developing models for identifying effective safe motherhood strategies.

12. **Strengthening coordination mechanism by defining modalities for sharing roles and responsibilities between central, provincial and district authorities** and introducing better program oversight and management through surveillance, monitoring, evaluation and financing; while focus and intensify priority targeting of interventions to poor and underserved areas. In addition, building effective partnerships across programs and sectors to make use of synergies in service provision and advocacy.

13. **Addressing particular issues related to decentralization and** strengthen and sharpen the tasks in achieving health **Minimum Services Standards** (**MSS**) as part of target indicators of MDGs, to ensure the achievement of health development goals at all levels.

GOAL 6 :
COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Campaign of HIV/AIDS Care

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

TARGET 6A: HAVE HALTED BY 2015 AND BEGUN TO REVERSE THE SPREAD OF HIV/AIDS

TARGET 6B: ACHIEVE, BY 2010, UNIVERSAL ACCESS TO TREATMENT FOR HIV/AIDS FOR ALL THOSE WHO NEED IT

Indicators		Baseline	Current	MDG Target 2015	Status	Source
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases						
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS						
6.1	HIV/AIDS Prevalence among total population (percent)	-	0.2% (2009)	Decrease	▼	MOH estimated 2006
6.2	Condom use at last high-risk sex	12.8% (2002/03)	Female: 10.3% Male: 18.4% (2007)	Increase	▼ ▼	*BPS*, IYARHS 2002/2003 & 2007
6.3	Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS					
	- Married	-	Female: 9.5% Male: 14.7% (2007) Female: 11.9% Male: 15.4% (2010)*	Increase	▼	*BPS*, IDHS 2007; *Riskesdas* 2010 (interim data)
	- Unmarried	-	Female: 2.6% Male: 1.4% (2007) Female: 19.8% Male: 20.3% (2010)*	Increase	▼	*BPS*, IYARHS 2007; *Riskesdas* 2010 (interim data)
Target 6B: Achieve, by 2010, universal access to treatment forHIV/AIDS for all those who need it						
6.5	Proportion of population with advanced HIV infection with access to antiretroviral drugs	-	38.4% (2009)	Increase	▼	MOH, 2010 as per 30 November 2009

Status: ● Already achieved ▶ On-track ▼ Need special attention

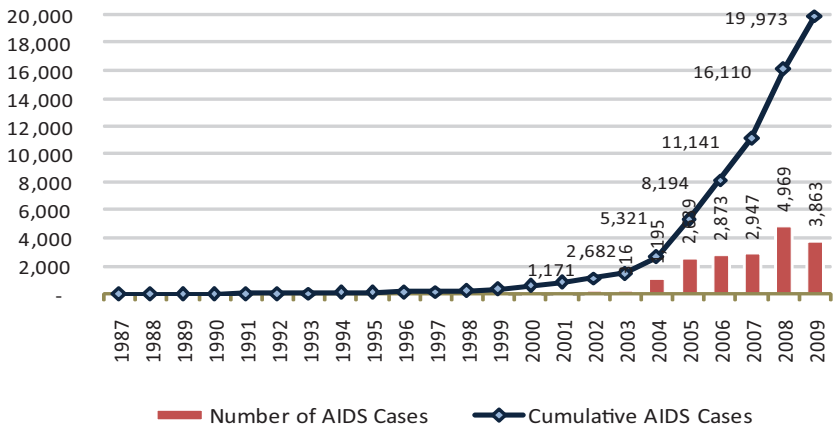
CURRENT SITUATION

The number of new HIV infections has been increasing in Indonesia. During the period 1996 to 2006, the number of HIV cases increased by some 17.5 percent and it is estimated that some 193,000 people are currently living with HIV in Indonesia. Although in most parts of Indonesia

the AIDS epidemic is generally concentrated among high-risk populations with an estimated national adult prevalence of 0.22 percent in 2008, two provinces in Tanah Papua (Papua and Papua Barat) are shifting to a generalized epidemic with prevalence of 2.4 percent among the general population aged 15-49 (IBBS, CDC MoH 2007).

Cumulatively, the number of AIDS cases tends to increase, and in 2009 with 19,973 cases, it was more than double the number in 2006, when AIDS cases totaled 8,194 (**Figure 6.1**.). Cases of HIV and AIDS can be found throughout Indonesia, and the number varies among provinces (**Figure 6.2**).

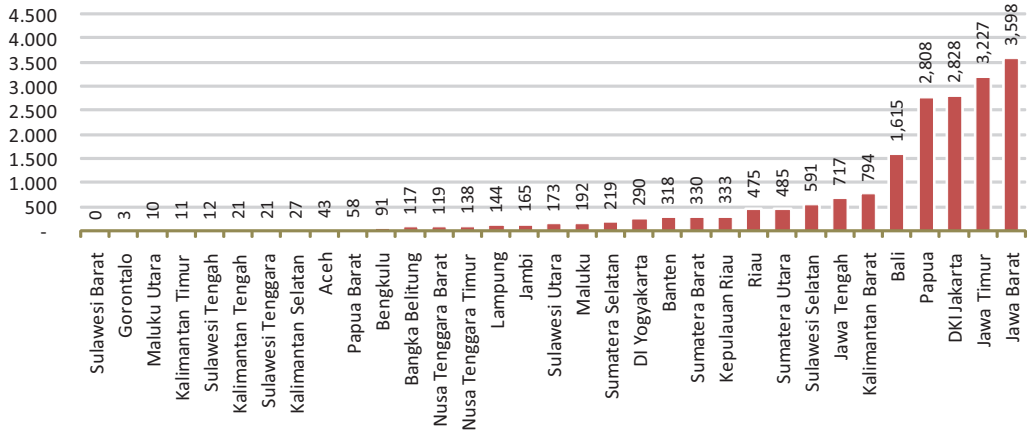
Figure 6.1. AIDS Cases per 100,000 Population in Indonesia, 1989-2009



Source: *DG of CDC and EH, MoH, several years.*

Modes of HIV/AIDS transmission as of December 2009 are indicated in Figure 6.3. Heterosexual groups represent most reported new HIV cases (50.3 percent), 3.3 percent are homosexual, about 2.6 percent are the result of perinatal infection due to mother-to-child transmission, and blood transfusion result in about 0.1 percent of cases. Some 91 percent of AIDS cases occur in the reproductive age group 15-49 years old (MOH 2009). At current rates, HIV infection in Indonesia is set to continue increasing over the next five years as people increasingly engage in unprotected sex, and the spread of HIV through injection drug use accelerates.

Figure 6.2. Number of AIDS Cases in Indonesia, by Province, 2009



Source: *DG of CDC and EH, MoH, 2009*

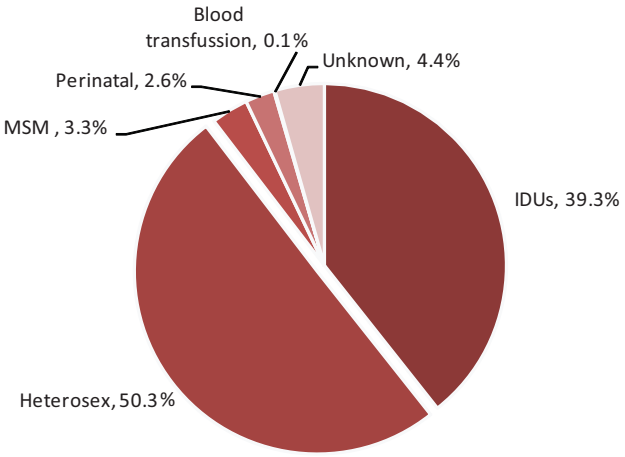


Figure 6.3. Distribution of HIV Infections, by Population Group, 2009

Source: *Surveillance reports, National AIDS Programme, Ministry of Health, Indonesia, 2009*

Another related factor in HIV/AIDS transmission is the absence of condom use during intercourse. In total, the percentage of young unmarried people who report condom use during their most recent sexual encounter is only about 18.4 percent of young unmarried men and 10.3 percent of young unmarried women. Condom use shows different patterns among age-groups, residence (rural vs. urban) as well as level of education (**Figure 6.4**.)

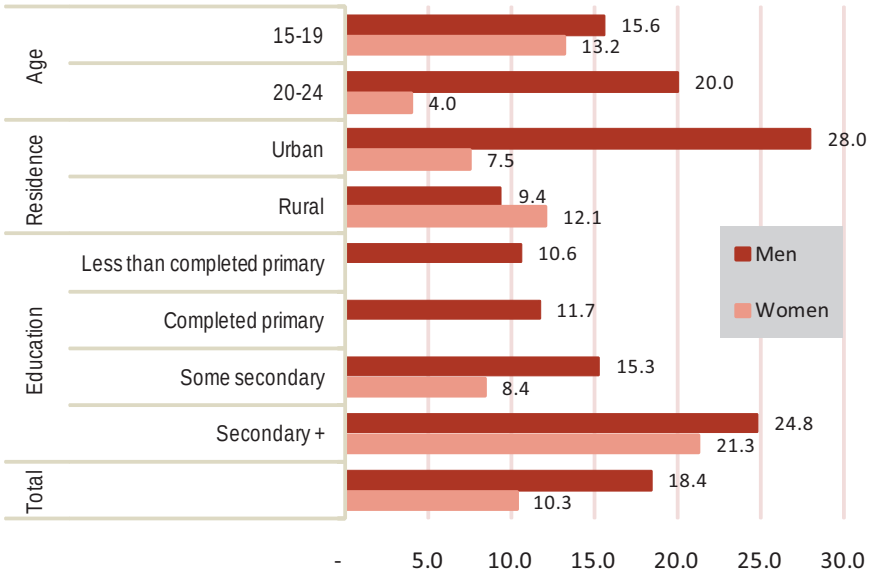


Figure 6.4. Percentage of Unmarried Women and Men Age 15-24 Who Have Ever Had Sex, Who Used of Condom at Last Sexual Activity, According to Background Characteristic, 2007

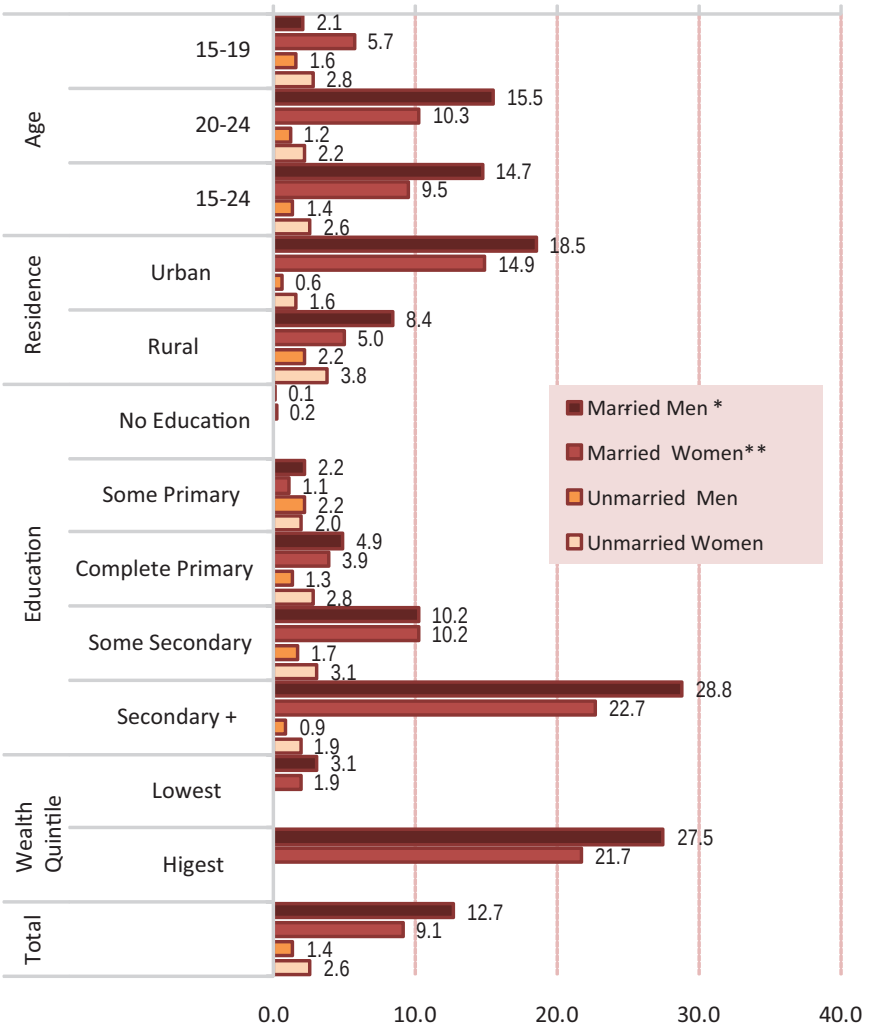
Source: *BPS, Indonesian Youth and Adolescence Reproductive Health Survey (IYARHS) 2007.*

Knowledge about HIV and its prevention is an important prerequisite for adopting healthy behaviors. While most youth (15-24 years old) in the country are aware of HIV/AIDS, comprehensive and correct knowledge about HIV is only found among 14.7 percent of married men and 9.5 percent of married women. Among youth who are unmarried, the correct and comprehensive knowledge of AIDS is only found in 1.4 percent of unmarried men and 2.6 percent of unmarried women. Interim data from *Riskesdas* 2010 shows that correct and comprehensive knowledge about HIV/AIDS of married men improved to 15.4 percent, while of married women

increased to 11.9 percent. Among unmarried men, the correct and comprehensive knowledge of HIV/AIDS increased significantly to 20.3 percent, as well as among unmarried women, to 19.8 percent[4] .

Knowledge of married men and women in urban areas was higher than in rural areas. The higher the level of education, the higher the percentage of correct and comprehensive knowledge about AIDS. (**Figure 6.5**). Likewise, with regard to socio-economic status, knowledge among those in the highest wealth quintile is higher than for the lowest quintile.

Figure 6.5. Proportion of Men and Women Aged 15-24 with Correct and Comprehensive Knowledge About AIDS, by Background Characteristic, Indonesia 2007



Note:
**) covering age group of 15-54 years old for married men, except when describing married men by age group.*
***) covering age group of 15-49 years old for married women, except when describing marreid women by age group*

Source:
BPS, IDHS and IYARHS 2007

4 Indicators used to measure the comprehensive knowledge about HIV/AIDS in 2010 Riskesdas consists of two indicators on methods of HIV/AIDS transmission prevention (limiting sexual intercourse to one HIV-negative partner -partner who has no other partners - and using condoms during sexual intercourse) and two indicators of wrong perception against the spread of HIV/AIDS (a person cannot get HIV by sharing food with a person with HIV/AIDS or transmitted by mosquito bites).

Availability of antiretroviral therapy (ART) continues to increase. In 2009, ART is available at 180 facilities, and is being offered to 38.4 percent of the total estimated cohort of eligible People Living with HIV/AIDS (PLWHA), an increase in coverage from 2006, when the percentage was 24.8 percent, as can be seen in **Figure 6.6** (MOH report 2010). Without effective prevention, the need for ARV therapy among the 15-49 age group is projected to increase three fold from 30,100 in 2008 to 86,800 in 2014 (National AIDS Strategy Action Plan - NASAP 2010-2014).

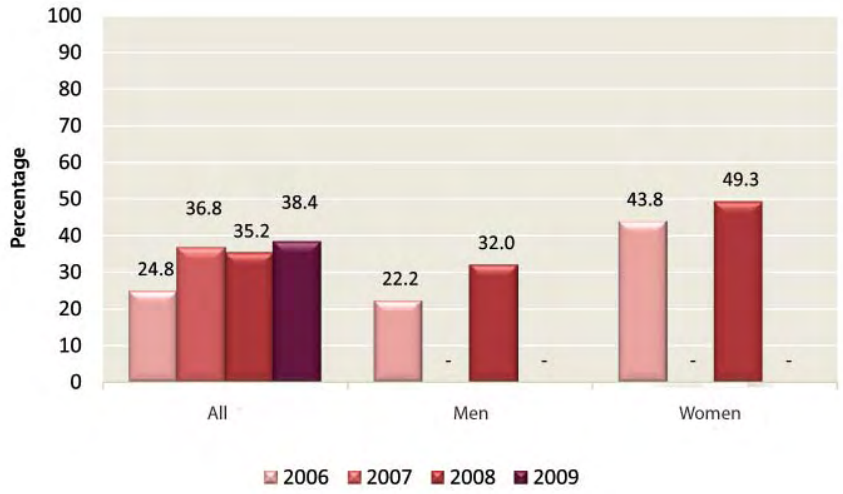


Figure 6.6. Coverage of ART Interventions in Indonesia, 2006–2009

Note : *Antiretroviral treatment (ART) is given to individuals with advanced HIV infection as per national treatment protocols*

Source: *Country reports*

Box 6.1.
HIV/AIDS Control in Kota Pontianak, Province of Kalimantan Barat

The escalation of HIV/AIDS cases in Pontianak is quite alarming. Therefore, the Municipality of Pontianak was selected as a pilot model in the accelerated program of controlling HIV/AIDS. One of the efforts was to mobilize local government in the prevention and mitigation of HIV/AIDS, through development of two one-stop service clinics. The program provides sexually transmitted infections (STI) and HIV/AIDS services and also a mobile clinic.

The local government has a strong commitment in responding to the HIV/AIDS issues. This is indicated by the Pontianak Municipality's budget allocations of Rp500 million for AIDS mitigation, improving access to STI services by increasing *puskesmas* with this specific service (from two *puskesmas* established at the beginning of the program to 22 *puskesmas*). In addition, in an effort to control HIV, the Kota Pontianak has developed a range of services which, among others, include: CBST – clinical-based substitute therapy (methadone), needle syringe exchange program (NSEP), Voluntary Counseling and Testing (VCT) services, care and support for people with HIV/AIDS (PLWHA) or Care, Support and Treatment (CST).

Community outreach to key populations (female sex workers [FSW], clients, transvestites, gay or men who have sex with men (MSM), injecting drug users [IDUs] and prisoners) is actively managed. Outreach is established by cadre regeneration, recruiting cadre from each risk group to reach similar key populations (MSM to reach MSM, FSW to reach FSW). The key population in Kota Pontianak are: *JOTHI* (Network for PLWHA), *Perwapon* (for transvestites), Pontianak Plus (for PLWHA and PLWHIV), Arwana Plus Support, *Sahabat* (ex-IDUs), *Kesuma* Family (PLWHIV), Stop AIDS (transvestites and ex FSW) and community empowerment (ex FSW). Some of them are involved in organizing the CD4 test (a measure of the number of helper T cells per cubic millimeter of blood, used to analyze the prognosis of patients infected with HIV).

Another essential element is the role of the community in disseminating information. The community-based unit of Pontianak Timur sub-district (the Community Care Association for Community-Based Drug Abuse Services) actively participates in conducting socialization about the danger of drugs and HIV/AIDS in many villages/*kelurahans*. In addition, they have a drop-in center (rehabilitation) for the addicts, under the coordination of the village leader (lurah). One community that organizes regular meetings related to HIV/AIDS is "*Komunitas Gang Tebu*", a gathering of the community consisting of housewives (*kelompok ibu-ibu arisan* –housewives gathering meeting with a revolving deposit).

CHALLENGES

1. **Limited access to health services related to HIV/AIDS prevention, care and treatment**. Strengthening the health-care system is crucial in dealing with HIV/AIDS cases, especially in prevention, diagnosis, treatment, care, safety in blood transfusions and universal precautions.

2. **The limited budget allocations along with the availability and sustainability of funds in controlling HIV and AIDS**. The availability and sustainability of funding remain major obstacles in tackling the HIV/AIDS epidemic.