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Report on the Achievement of the Millennium Development Goals Indonesia 2010

REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS INDONESIA 2010

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Foreword

The Millennium Declaration represents the consensus of the Heads of State and representatives from 189 countries achieved during meetings at the United Nations in New York in September 2000 in asserting 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 human development.

The Government of Indonesia has mainstreamed the MDGs in all phases of development, from planning and budgeting to implementation as provided in the Long-Term Development Plan for 2005-2025, the National Medium-Term Development Plan (RPJMN) 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, allocation of funds in central and local government budgets to support achievement of the MDGs targets have been increased each year. 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 it was 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 also to demonstrate the nation's commitment to accomplishing the goals of the Millennium Declaration of the United Nations of 2000.

This report provides details on achievement of the development goals and the MDGs indicators which show the status of achievement in 2010. Based on these achievements, this report briefly outlines the challenges faced and the efforts needed to achieve the MDGs targets, which can be used as a basis for formulating the necessary activities to achieve the MDGs targets by 2015. Successes that have been achieved are a manifestation of the commitment and hard work by the Government and also by all component of the society towards a more prosperous Indonesia. This achievement also represents Indonesia's contribution to global development and to realization of a world community which is more prosperous and just.

In conclusion, I would like to extend my gratitude to everyone who has helped with the writing 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 MDGs 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 Abbreviation

ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin-based combination therapy
ANC	Antenatal Care
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
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
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
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	Coalition of developing countries pressing for reforms of agriculture in developed countries
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
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)
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)
LJK	*Lembaga Jasa Keuangan* (financial service institution)
LMIC	Lower Middle Income Country
MA	*Madrasah Aliyah*
MDGs	Millennium Development Goals
MDR-TB	Multidrug-Resistant TB
MI	*Madrasah Ibtidaiyah*
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MONE	Ministry of National Education
MSS	Minimum Service Standards
MTs	*Madrasah Tsanawiyah*
Musrenbangdes	*Musyawarah Perencanaan Pembangunan Desa* (Village Development Plan)
NCCC	National Council for Climate Change
NER	Net Enrollment Rate
NFE	Non-formal Education
NPL	Non-Performing Loans
NUSSP	Neighborhood Upgrading and Shelter Sector Program
ODS	Ozone Depleting Substances
PAUD	*Pendidikan Anak Usia Dini* (Early Childhood Education)
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
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)
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)
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 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. Therefore, the MDGs serve as an important reference for preparing the 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 Plan (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 the financial turmoil during 2007/2008 have influenced the dynamics of Indonesian. The rate of economic growth has dropped to 4-5 percent, as compared to the growth before the crisis of 5-6 percent. Food prices have increased and as the highest household expenditure for lower middle income group and the poor, these increases have put more burdens on their shoulders. Extreme climate change have 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 global community to achieve the MDGs.

Achievement of the MDG Targets

As of 2010, Indonesia has achieved various MDGs 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 Millennium Development Goals (MDGs) targets which have already been achieved include:

MDG 1 – The proportion of people having per capita income of less than US$1 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 enrollment 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 in 1990 to 244 cases per 100,000 populations in the year of 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 almost 50 percent from 31 percent in 1989 to 18.4 percent in 2007. The target of 15.5 percent by 2015 is estimated can be achieved.

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

MDG 3 - The net enrollment ratios (NER) of girls to boys in secondary education (*SMA/MA/*Package C) and higher education in 2009 were recorded to be 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 need hard work to be achieved are as follows:

MDG 1 - Indonesia has raised the targets 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 MDGs 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 reducing disparities and empower all the people of Indonesia.

The number, 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 of 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 Java, which comprises only 7 percent of the total area of Indonesia. In addition, no less than 80 percent of the 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 as mandated by the Presidential Instruction No. 3 of 2010 regarding the Equitable Development Programs are as follows:

- The Government will publish the Roadmap for Accelerating the Achievement of the MDGs which will be used as a reference for all stakeholders to speed up achievement of the MDGs in Indonesia.
- The provincial governments will prepare "Regional Action Plans for Accelerating the MDGs Achievement" 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 MDGs 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 to disadvantaged and remote areas will be increased.
- Partnerships between the Government and the private sector (Public Private Partnership 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 MDGs 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 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 and use 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 target 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 gross enrolment rate (GER) at primary education level (*SD/MI*/Package A) was 116.77 percent and the nett 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 acelerating the achievment 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: (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 government 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 sector 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, which 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 for the 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 are considered to be 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 (IEC) 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 emission, 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 on water and sanitation systems to serve growing urban populations. In rural areas, communities are expected to play a larger role, with communities 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 hand phones, telephone land lines 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

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

	Indicators	Baseline	Current	MDGs 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 USD 1 (PPP) a day						
1.1	Proportion of population below USD 1 (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*
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						

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

	Indicators	Baseline	Current	MDGs Target 2015	Status	Source
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	▼	
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES						
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS						

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

	Indicators	Baseline	Current	MDGs Target 2015	Status	Source
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)		●	
6.10	Proportion of Tuberculosis cases detected and cured under directly observed treatment short courses				●	

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

	Indicators	Baseline	Current	MDGs Target 2015	Status	Source
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 SBM/ USD 1.000 (1990)	2.1 SBM/ USD 1.000 (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%	▼	
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						

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

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
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

GOAL 1 :
ERADICATE EXTREME POVERTY AND HUNGER

PNPM Mandiri-Rural (infrastructure) by World Bank

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 (PPP) A DAY**

Indicators		Baseline	Current	MDGs 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 USD 1 (PPP) a day						
1.1	Proportion of population below USD 1 (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 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 (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. Indonesia measures the level of poverty by using the national poverty line which amounts approximately with USD 1.50 (PPP). 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.

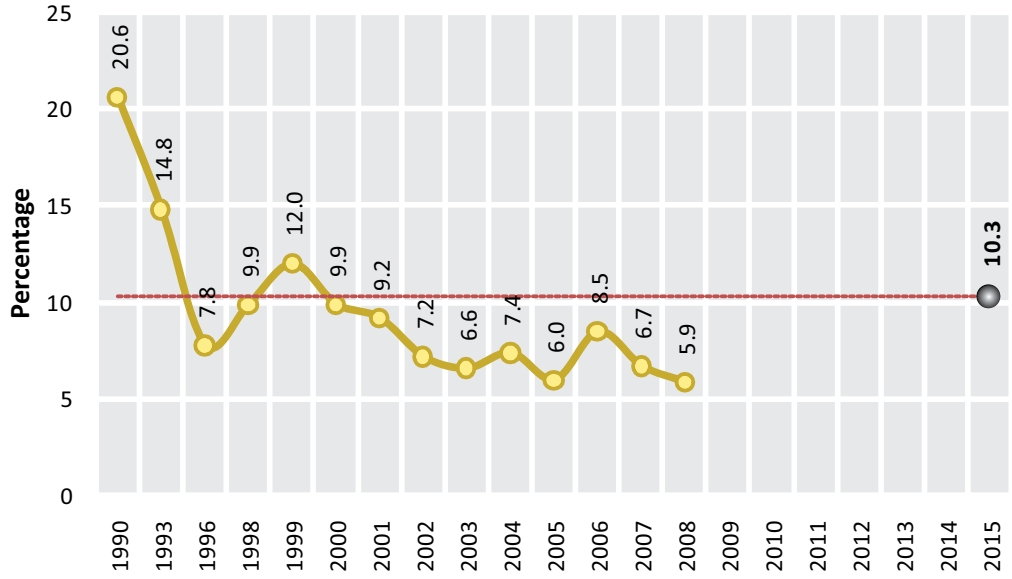


***Figure 1.1**. Progress in reducing extreme poverty (USD 1/ capita/day) as compared to the MDG target*

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

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

Based on the trend of poverty reduction as well as the efforts mentioned above, it is hoped that the result that has been achieved by 2008 in reducing extreme poverty (USD 1.00 PPP) will be sustained and the trend to further reduction continued**.**

There remain significant disparities in the incidence of poverty among the provinces of Indonesia. From the 33 provinces, 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 islands of Jawa and

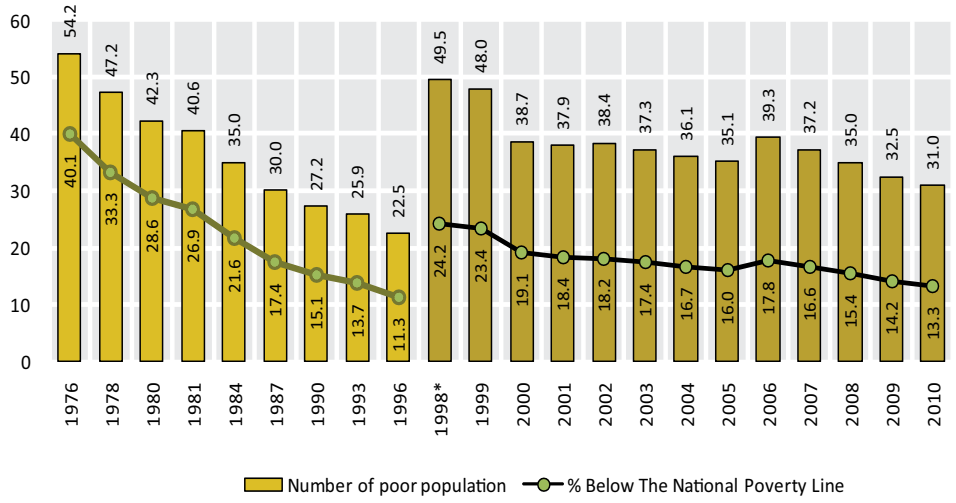


Figure 1.2.
Long-term trends in poverty reduction in Indonesia measured using the indicator for National Poverty Line, 1976-2010

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.*

Bali, the provinces of Jawa Tengah, Yogyakarta and Jawa Timur also have a n incidence of poverty that is 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).

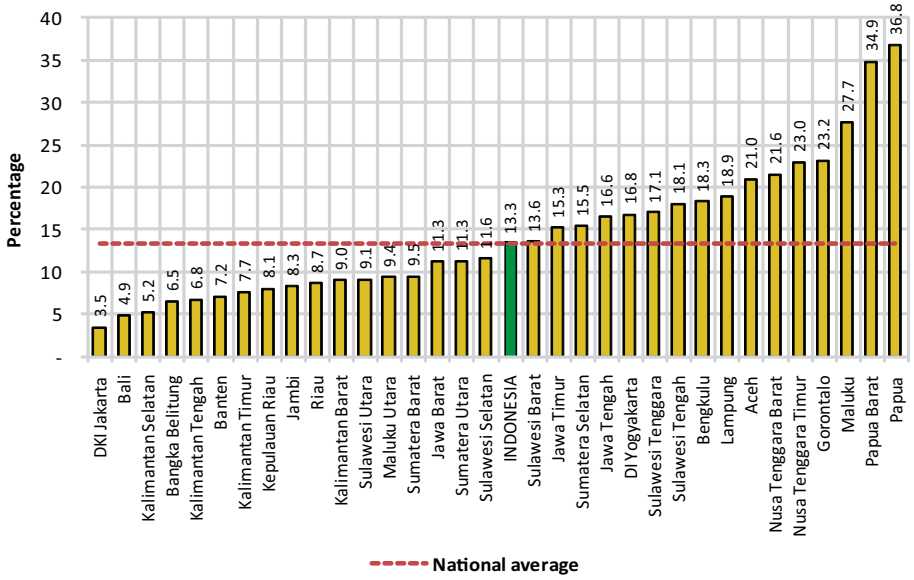


Figure 1.3.
Percentages of population below the national poverty line by province of Indonesia, 2010

Source:
BPS, Susenas 2010

The poverty rate is significantly higher in rural areas than in urban centers in 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.

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 only 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 Rp 1,600 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 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 human resources, 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 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 (RPJMN 2010-2014).

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

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 improvement, especially for marginalized communities.

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.

Improving access of micro and small enterprises to productive resources by the People's Small Enterprises Credit Program (*KUR*), access to micro-businesses 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.

Improving the effectiveness of the synchronization and 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 (*TKPKD*) in order to accelerate poverty reduction at the local level 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 areas, border areas and the outer island, including the construction of basic infrastructure and support facilities (including electricity, water, connecting roads, inter-island facilities) in underserved areas, border areas and small islands.

Increased efforts in the regions will also be applied to increase capacity and accelerate the achievement of the Millennium Development Goals in 2015 through provision of assistance to local governments to formulate Regional Action Plans to achieve the MDGs (RAP MDGs). Forums will be increase between provinces and between 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 of State 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	MDGs 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 the 1990-2009 period 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 the 1990-1995 period. 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-crises 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 the 1990-1997 and 2004-2008 periods 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 the labor market, even though jobs were mostly created in the informal sector (**Figure 1.5**).

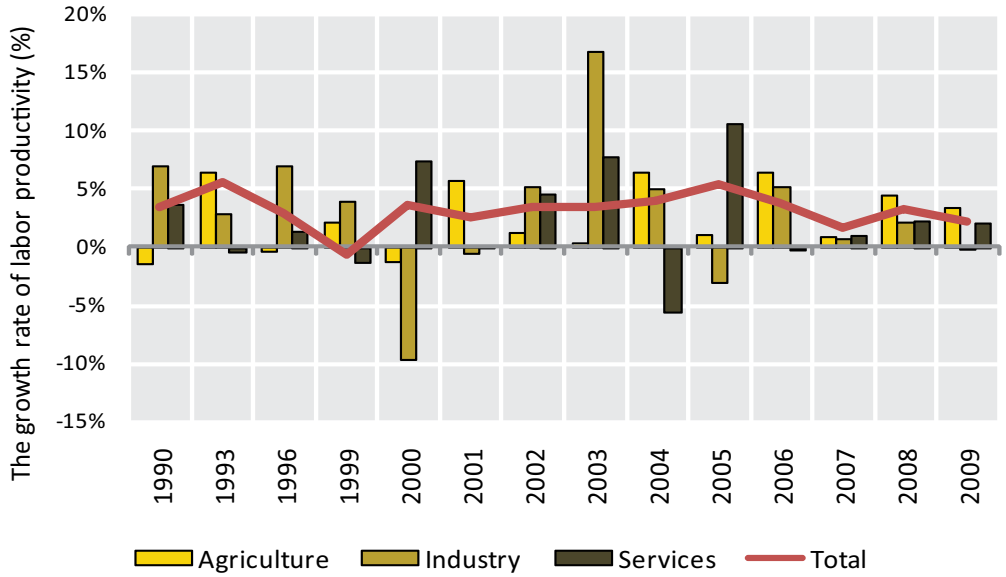


Figure 1.4. *Growth rate of labor productivity (percentage), 1990, 1993, 1996, 1999, 2000-2009*

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

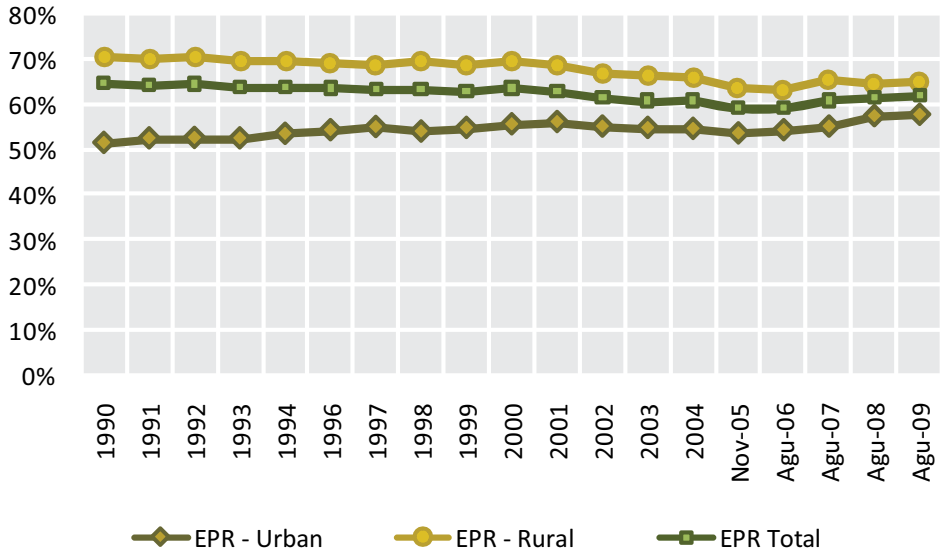


Figure 1.5. *Employment ratio to working age population, 1990-2010*

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 included 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**).

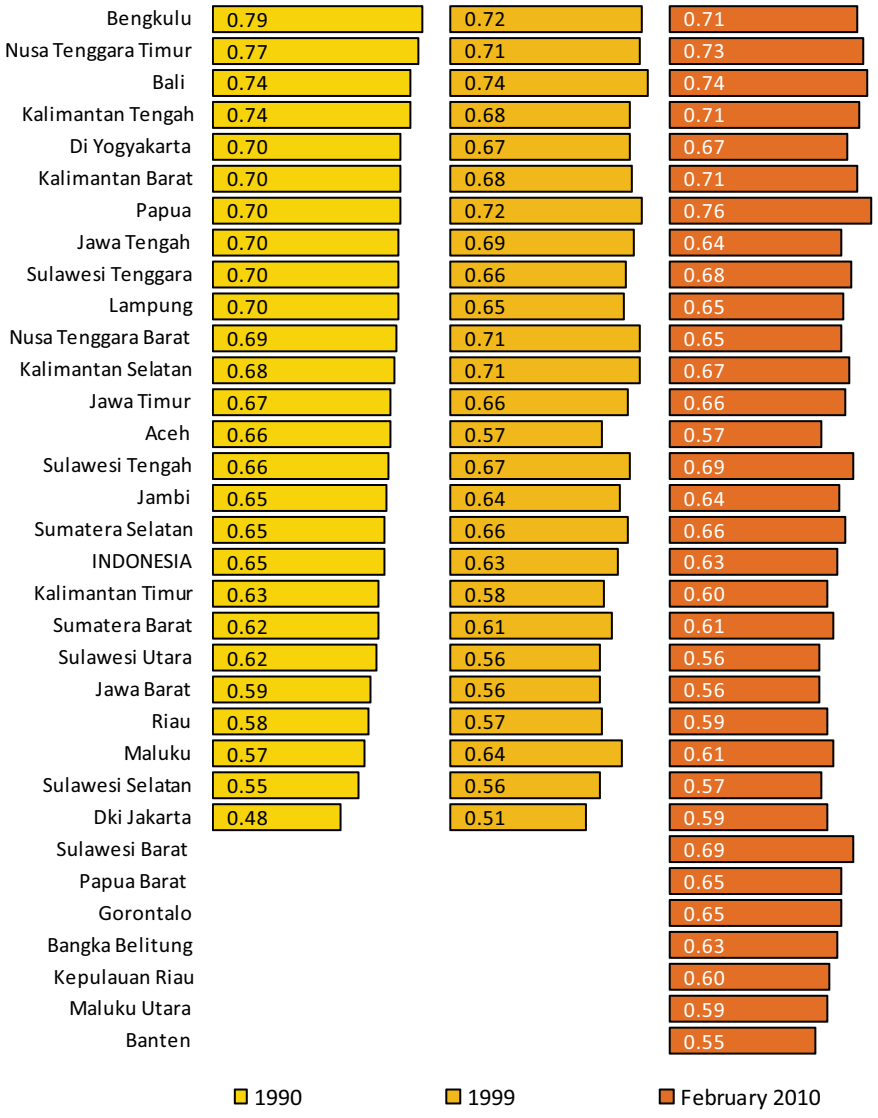


Figure 1.6. *Employment to population ratio by province, 1990, 1999 and 2010*

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.

Distinguished by urban and rural areas, it can be seen that from 1990 until 2010 the workforce participation rate (*TPAK*) in urban areas increased substantially, 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.

Although the number of people that continue their education to a higher level of education has increased, Indonesia still must deal with the uneven distribution of quality workers. Data in 1990 showed that 5.88 percent of workers holding diploma and university degree

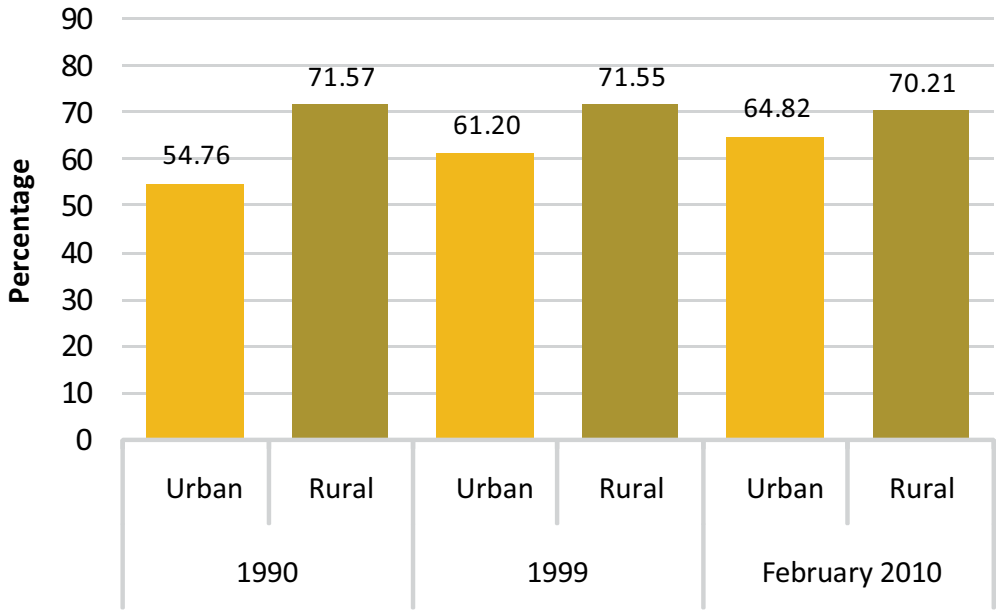


Figure 1.7. *Workforce participation rate (percentage) by region, 1990, 1999 and 2010*

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

were in urban areas, while only 0.57 percent of them worked in rural areas. Similarly for the secondary education level, or high school, there is a yawning 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**).

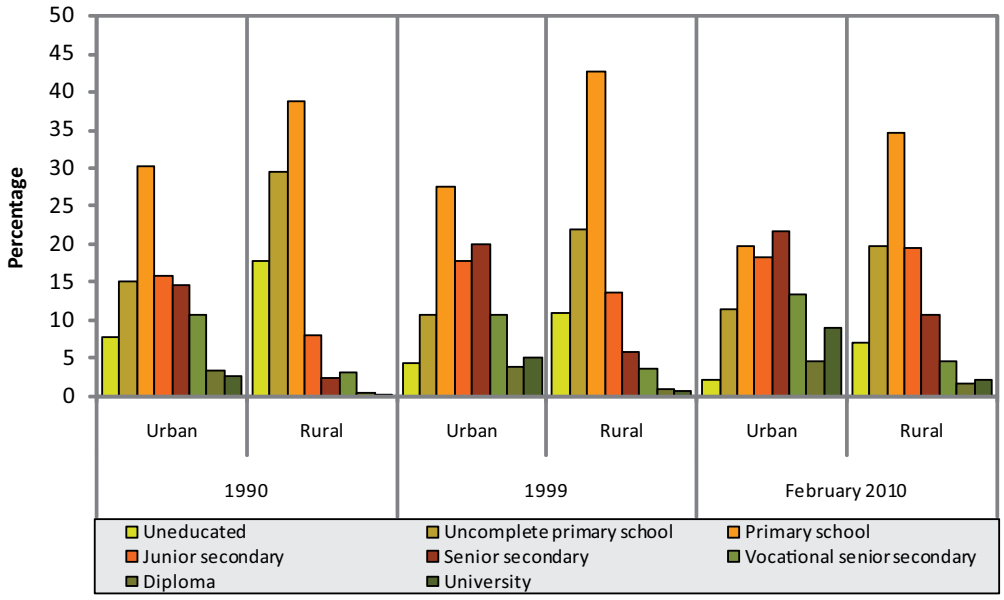


Figure 1.8. *Proportion of workers based on their latest education and by region, 1990, 1999 and 2010*

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

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**).

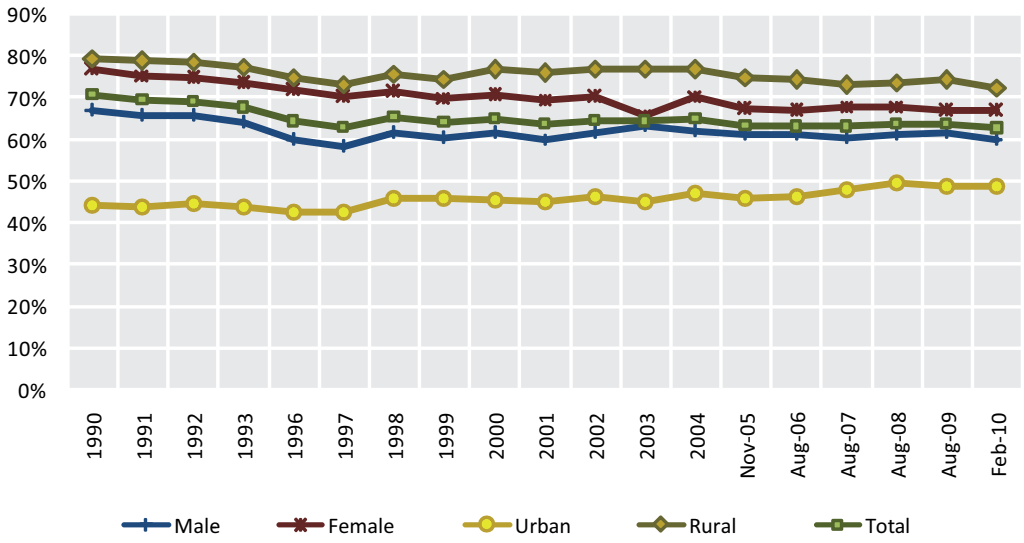


Figure 1.9.
Proportion of vulnerable workers to total workers, 1990-2010

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

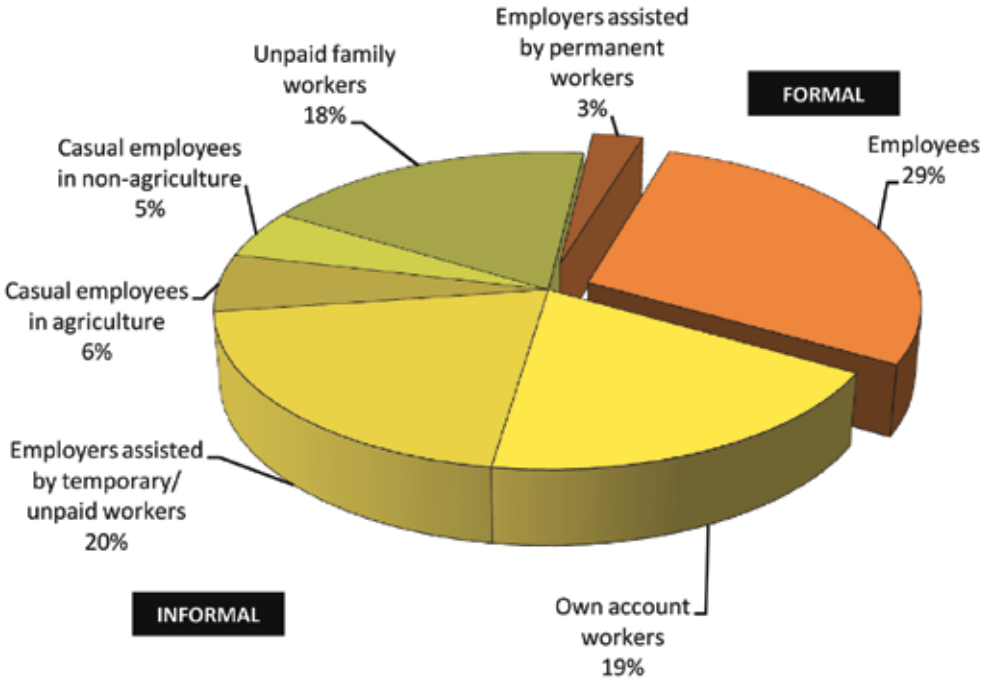


Figure 1.10.
Proportion of workers according to job status, February 2010

Source:
BPS, Sakernas (computed), 2010

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

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 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 the price rather 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 competences.
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 business; and providing workers with the necessary knowledge and skills, through education, training and agricultural extension. The improvement of worker's 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	MDGs 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 community nutritional status 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, decreased 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 indicated that Indoneia is on track in achieving the MDG target of 15.5 percent (**Figure 1.11**). In the National Medium Term Development Plan (*RPJMN* 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 requires 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).**

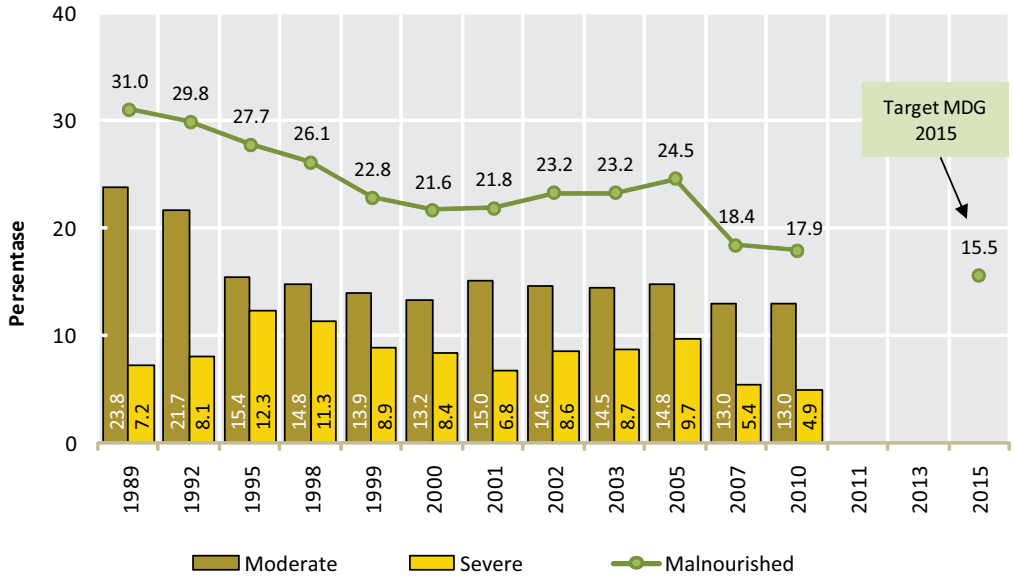


Figure 1.11. *Trend in the prevalence of underweight children under five years of age (1989-2010) using the WHO 2005 standard and the MDG Target for this indicator in 2015*

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

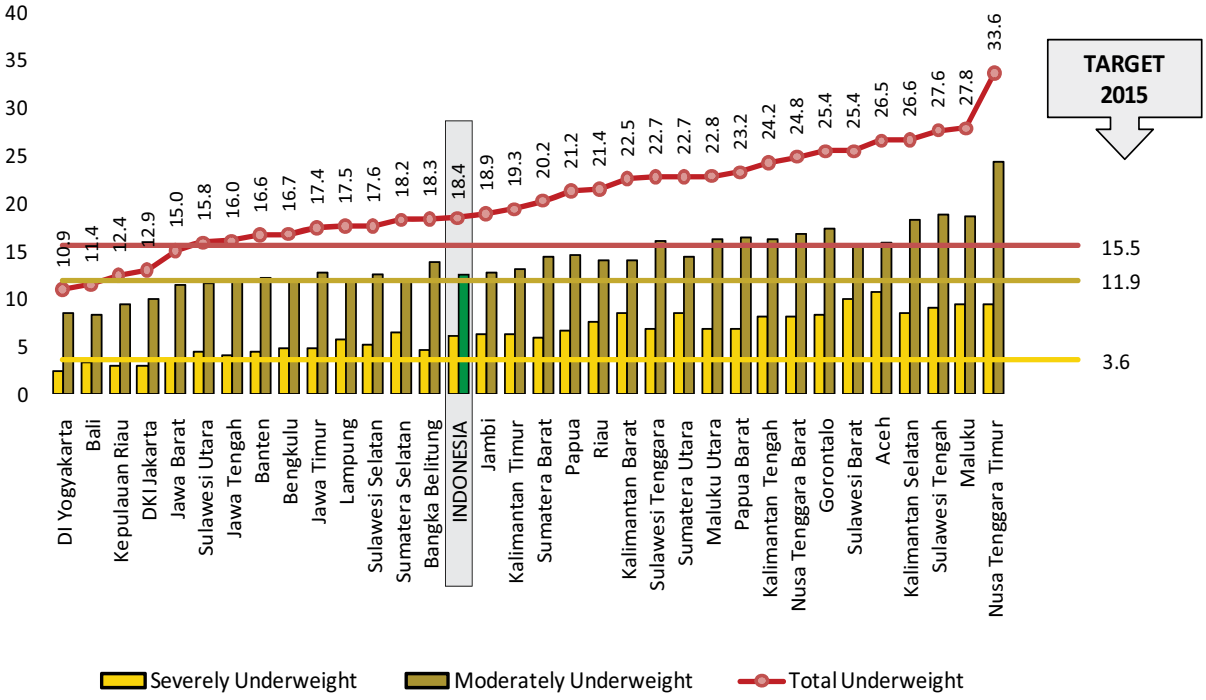


Figure 1.12 *The prevalence of underweight children under five years of age by province (2007)*

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).**

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

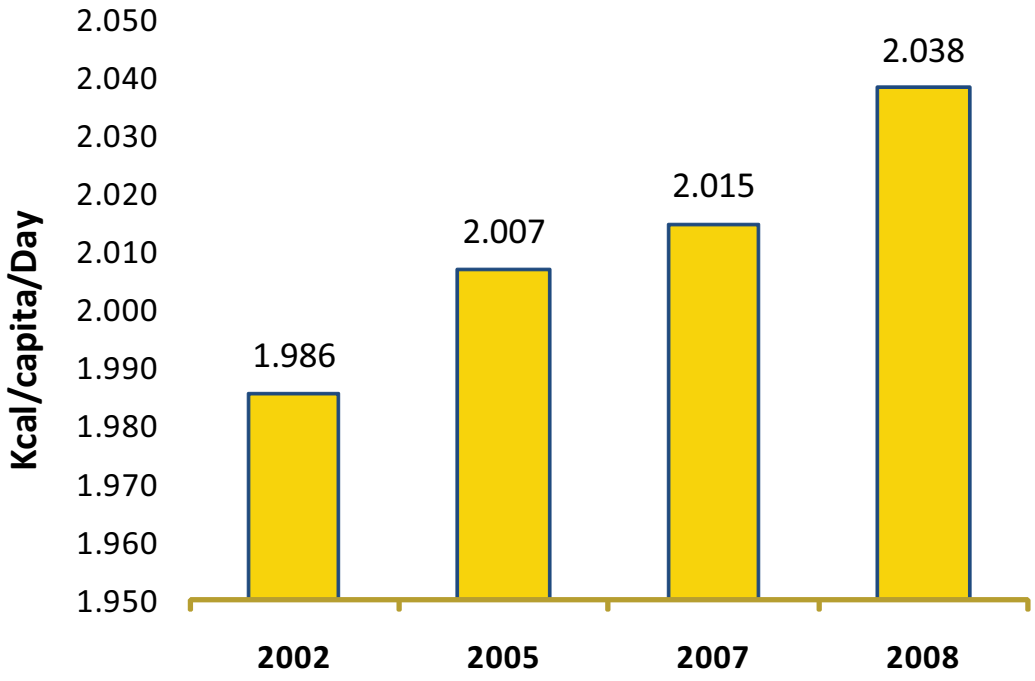


Figure 1.13. *Trends in the average calorie consumption for rural and urban households (2002-2009)*

Source: *BPS, Susenas, various years*

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 Tabanan District in the Province of Bali

Tabanan district is located in the southern part of the island of Bali island. 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 existance 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 balanced food consumption pattern.*** Food consumptton 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 remain 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 Indonesian is still low. In the period of 2002-2007 quality of food consumption of Indonesian has improved 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**) .

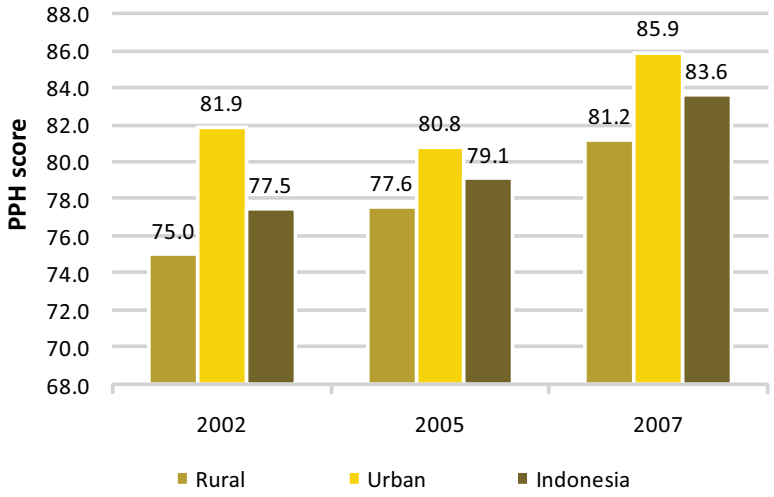


Figure 1.14. *Trend in the desirable dietary pattern (PPH) score of food consumption for rural and urban households, 2002-2007*

Source: *BPS, Susenas, various years*

5. ***Improving exclusive breast-feeding practice.*** Recently, the practice of exclusive breast feeding has declined where 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 Integrated Services Post (*Posyandu*). However, the *Posyandu* activities tended to declined under decentralization as indicated by huge variations of malnutrition rates among provinces.
7. ***Strengthening institutions responsible for food and nutrition improvement.*** Malnutrition is 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 consumption 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 to 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 untegration nutrition to early child education program (*PAUD*).
3. **Improve food security at 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 local-based food diversification program*.*
4. **Strengthen institutions at central and regional levels with stronger authority in formulatimg policy and program on food and nutrition.**

GOAL 2 :
ACHIEVE UNIVERSAL PRIMARY EDUCATION

Future Vision by World Bank

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	MDGs 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 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

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 a Compulsory Basic Education (CBE) to ensure that all chidren aged 7–15 years attend basic education up to the junior secondary education level (SMP/MTS). The involvement of Indonesia in the MDGs, 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 achieved 74.52 percent and 98,11 percent, respectively. Improvement of education participation at both primary (*SD/MI*) and junior secondary education (SMP/MTs) levels are a result of the government policy in improving sustainable access to basic education.

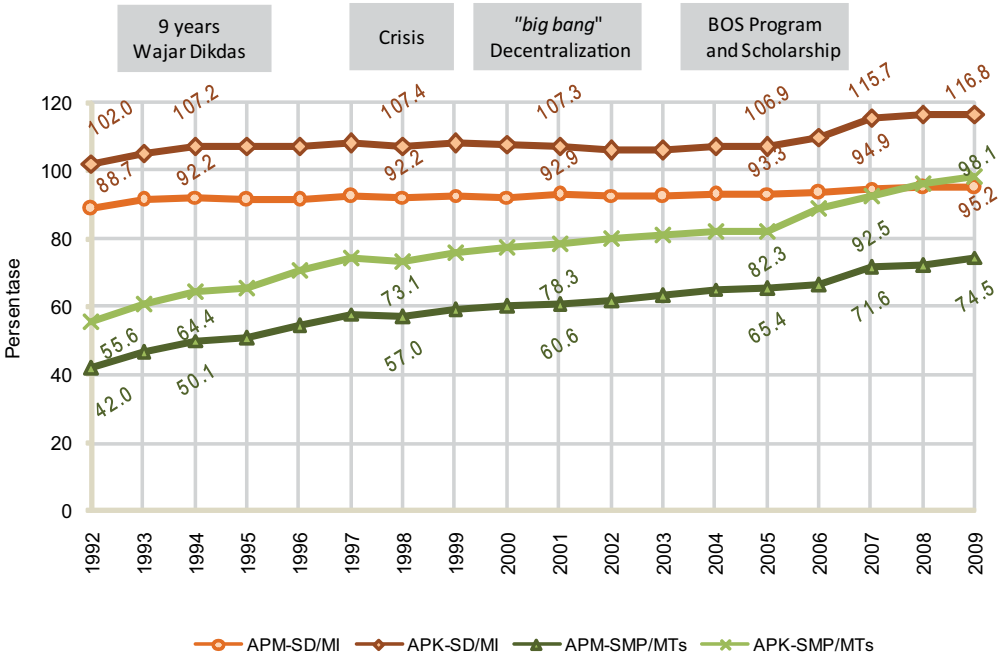


***Figure 2.1**. Trends for Net Enrolment Rates for primary and junior secondary education levels (including Madrasah)*

***Source**: BPS, Susenas and MONE Statistics.*

The early entry phenomenon which has occured 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 of the children under aged 7 years 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 the 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.

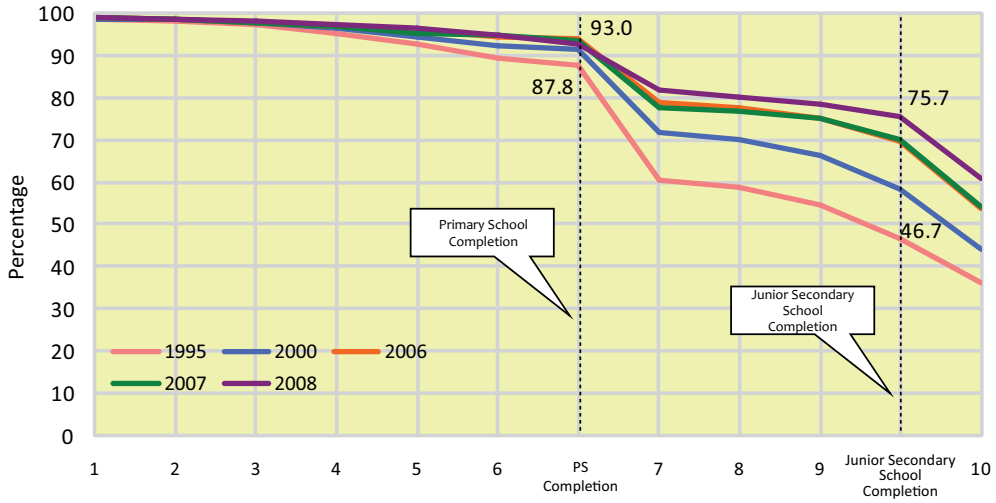


Figure 2.2.
Trend of highest education followed by population aged 16-18 years old, 1995-2008

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 the 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.

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

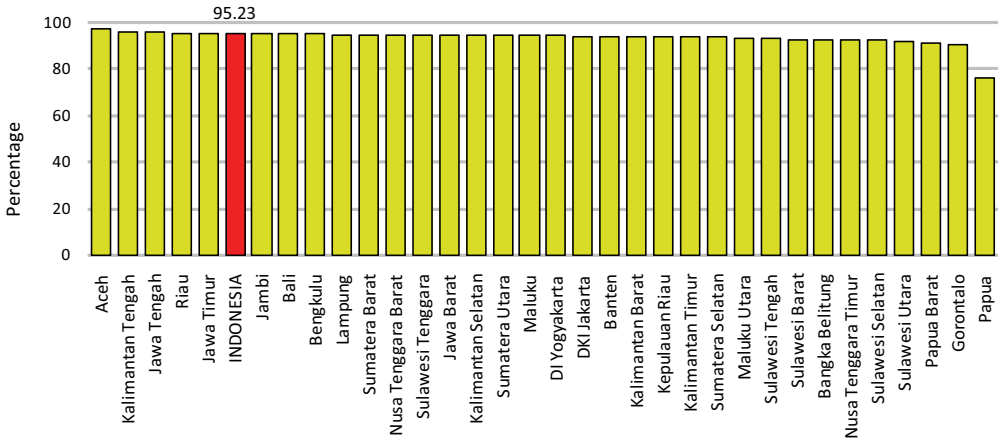


***Figure 2.3**. NER of primary education (**SD/MI**) by province, 2009*

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

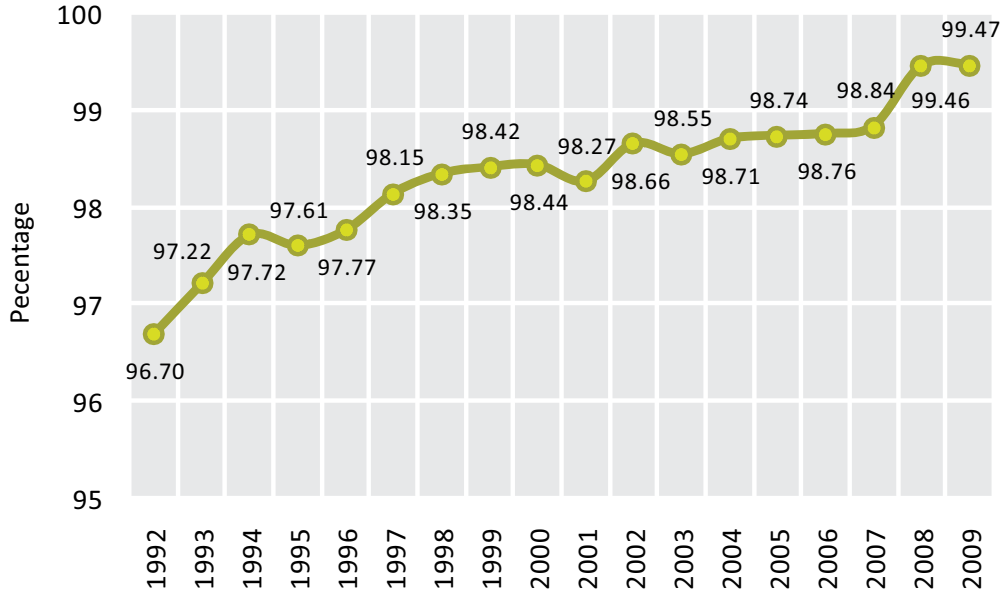


***Figure 2.4.** Trend of literacy rate among population aged 15-24 years, 1992-2009*

***Source:** BPS, Susenas*

literacy rate was 79.69 percent **(Figure 2.5**). Daerah Istimewa Yogyakarta (DIY) was the 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 population aged 15-24 years remain illiterate and 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

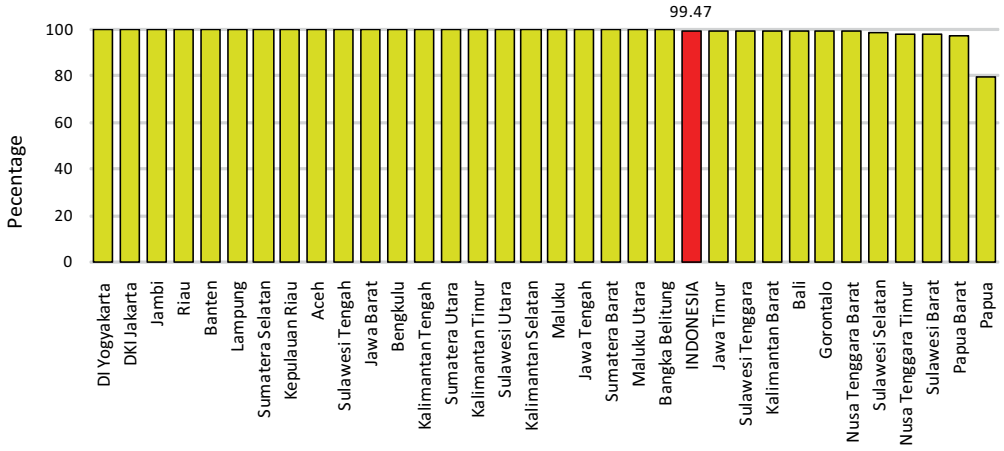


Figure 2.5.
The literacy rate among the population aged 15-24 years, 2009

Source:
BPS, Susenas

allocations for the education *DAK* have been increased from year to year, reaching Rp 9.3 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 quality of buildings.

In addition, starting in 2005 the government has provided School Operational Assistance (Bantuan Operacional 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 Rp 19.26 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 contributed to the acceleration of universal 9 years basic education and reduce 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 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 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 profesionalism 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 currently 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 an adequate infrastructure, books and teaching learning equipments to meet the minimum standards.** The number of primary schools particularly in remote and underserved areas are 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 ofnon-formaleducation (NFE) programs for the drop-out students and for children who are not able to enroll in formal schooling.** The provision of NFE

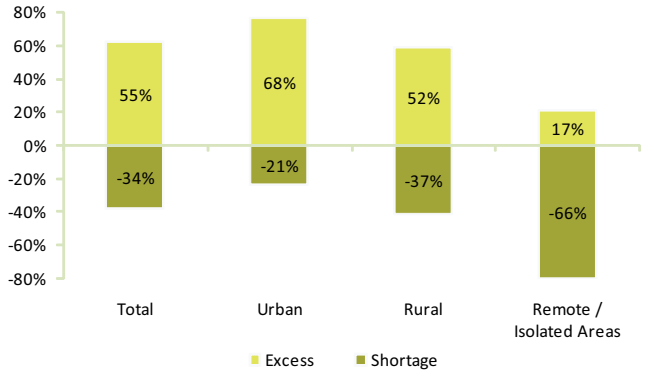


Figure 2.6. *Teacher distribution in urban, rural, and remote areas of Indonesia, 2007/2008*

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

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 MDGs 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 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 schools themselves. However, governance and education management are not optimally and effectively implemented. Low capacity in implemeting new roles in decentralization experience 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 on 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.

1. 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.

1. Strengthening Governance and Accountability:

a. **Improve local government capacity in managing 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

by ADB

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	MDGs 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	●	
	- 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	▶	BPS, Susenas
	- 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 an equal access and participation to both male and female. 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 indicated that the GPI of NER for primary education, junior secondary education, and senior secondary education during the period of 1993-2009 where the GPI NER ranged from 95 to 105. Meanwhile, the GPI of NER for higher education fluctuates with the

tendency to rise significantly. In 2009, the GPI at primary schools (*SD/MI/*Package A) was 99.73, while at the junior secondary education 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.

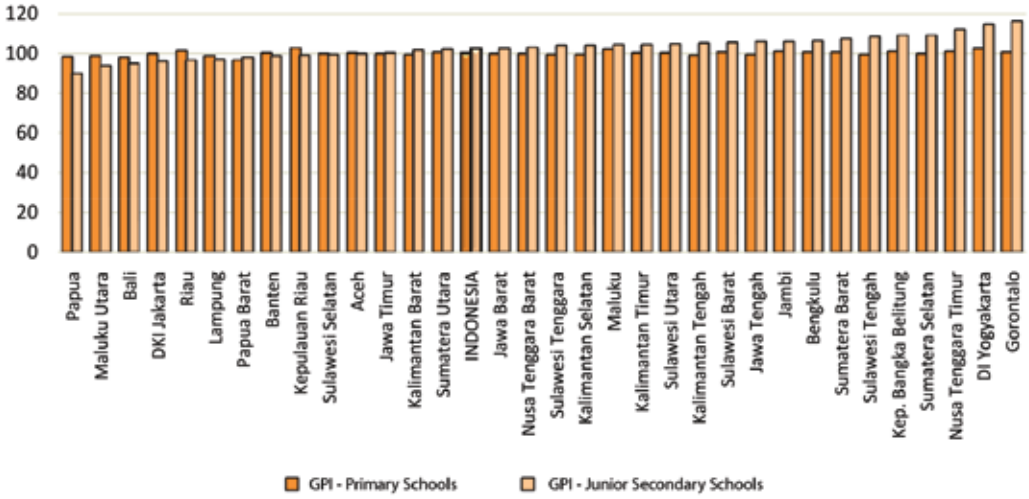


Figure 3.1. *Gender Parity Index (GPI) of Net Enrolment Rates (NER) for primary (SD/MI/Package A) and junior secondary schoolsl (SMP/MTs/Package B) by province, 2009*

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 indicate 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).**

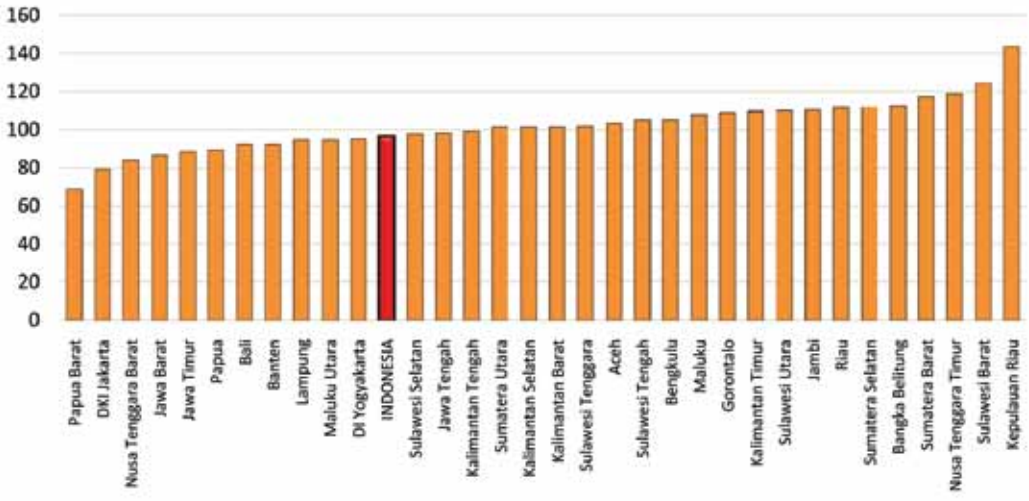


Figure 3.2. *Gender Parity Index (GPI) of Net Enrolment Rates (NER) senior secondary schools by province, 2009*

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 acihieved.** 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*) indicated that the open unemployment rate of females had declined by more than 6 percent 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 for men with an average increase 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 showed 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 MDGs 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, therefore, 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 challenge which need continual attention is **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 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 this policy, **the strategies to improve gender equality are grouped into four areas**:

1. **In 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. **In employment:**
   a) Prioritize the enforcement of existing laws, including synchronizing policies and employment regulations, including the policies to protect women 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 quality of female workers and job seekers..

3. **In politics,** through improvement in political education and partisipation, include:
   a) Improve partnerships with civil society organizations (CSO) to improve women's participation in politics;
   b) Design moduls on voter education for women's groups, the poor, disabled, and elderly;
   c) Improve voter education concerning women legislative candidates;
   d) Improve political education for female members of political parties.
4. **A strategy to implement gender mainstreaming in local governance processes will be carried out** through developing a general guideline for local governments 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 Implementation 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 the 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 still have 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 has 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 Health & Bright by World Bank

GOAL 4: REDUCE CHILD MORTALITY RATE

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

Indicators		Baseline	Current	MDGs 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**).

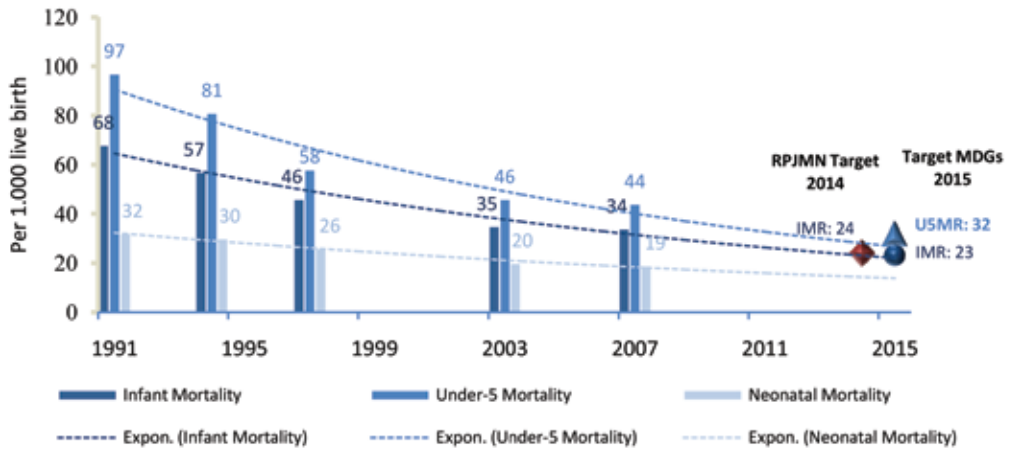


Figure 4.1. *National Trend of Child, Infant and Neonatal Mortality Rates, 1991-2015*

Source: *BPS, IDHS several years*

Disparities in neonatal, infant and under-five mortality rates by demography, 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 of 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 - have 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 were North Sumatra (36.6 percent), Aceh (40.9 percent), and Papua (49.9 percent), while the province with the highest coverage is DIY, with 94.8 percent coverage (**Figure 4.2**). The national coverage of measles immunization continuous to increase and reached to 74.5 percent in 2010 (interim data of *Riskesdas* 2010).

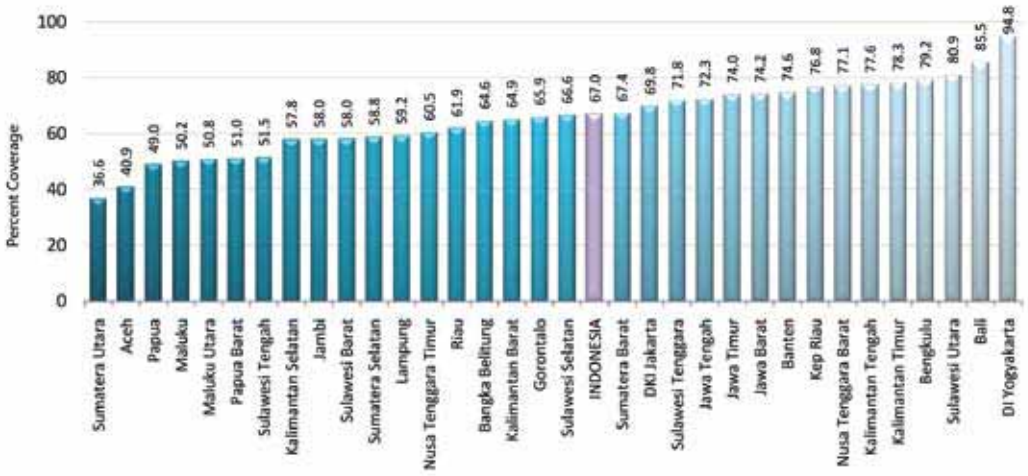


***Figure 4.2**. Proportion of one-year-old children immunized against measles, by province 2007*

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

Box 4.1.
MDG target achievement in reducing infant mortality by Bantul District: district government commitment a key to succes

With a population of around 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.

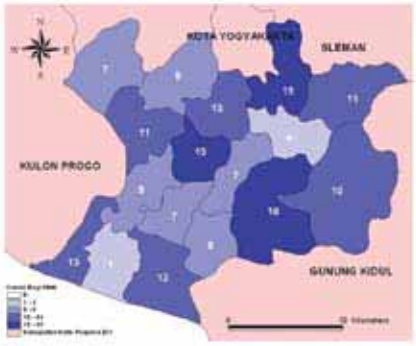
The *Bupati* of Bantul has involved officers from the district down to villages and hamlets (RW) in identifying and tackling the health issues. This effort, which also involve community action, were launched in the district's medium-term development plan for 2007-2010. They focus on addressing four major 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 practice of officers and 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 TB case detection rate.

Monthly monitoring is conducted on the basis of village leader reports and cross-checked with *puskesmas* (primary health care) reports . When a village rreports NO CASE of those 4 major health issues occurring over a period of one year, the Bupati gives the village a reward of Rp 100 million.. So far, rewards have been awarded to o 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 particular attention being paid to l 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, 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 rend 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. 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 policy of child health in Indonesia focuses 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 inmplementation 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 mother 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 chang 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 providing 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 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 service by World Bank

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	MDGs 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 it will require extra efforts to achieve 102 deaths per 100,000 live births by 2015.

The maternal mortality figures gradually decrease 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.

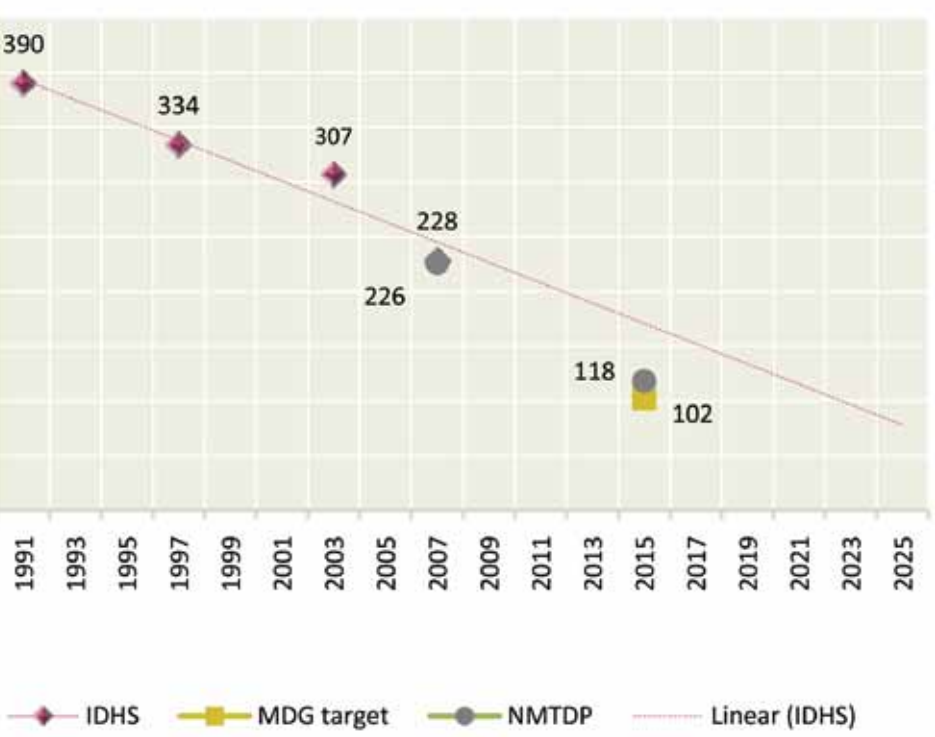


Figure 5.1. *National trends and projections for the Maternal Mortality Ratio 1991-2025*

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, 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 assited by health personnel is DKI Jakarta (98.14 percent) and the lowest is Maluku (42.28 percent), as shown in **Figure 5.2**.

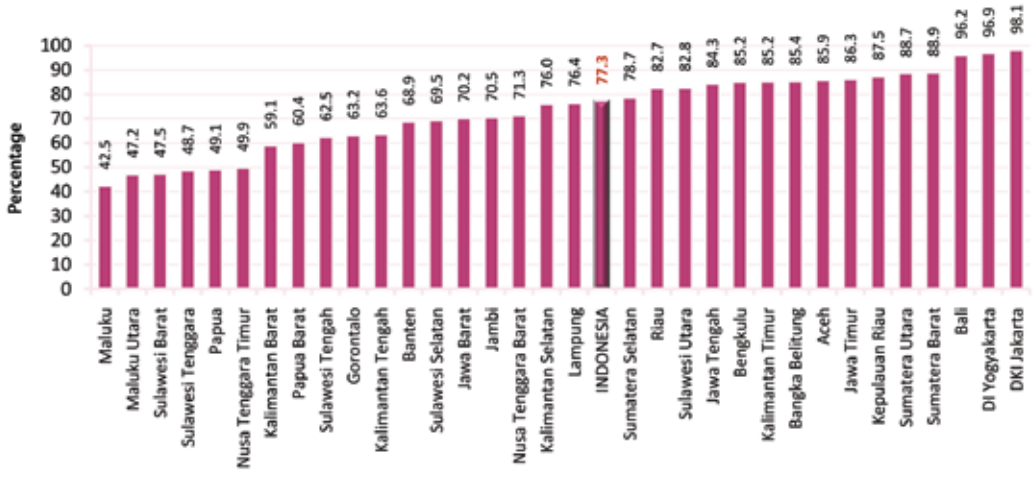


Figure 5.2. *Percentage of births assisted by skilled provider, by provinces , 2009*

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 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 minimum of 4 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 of maternal health.

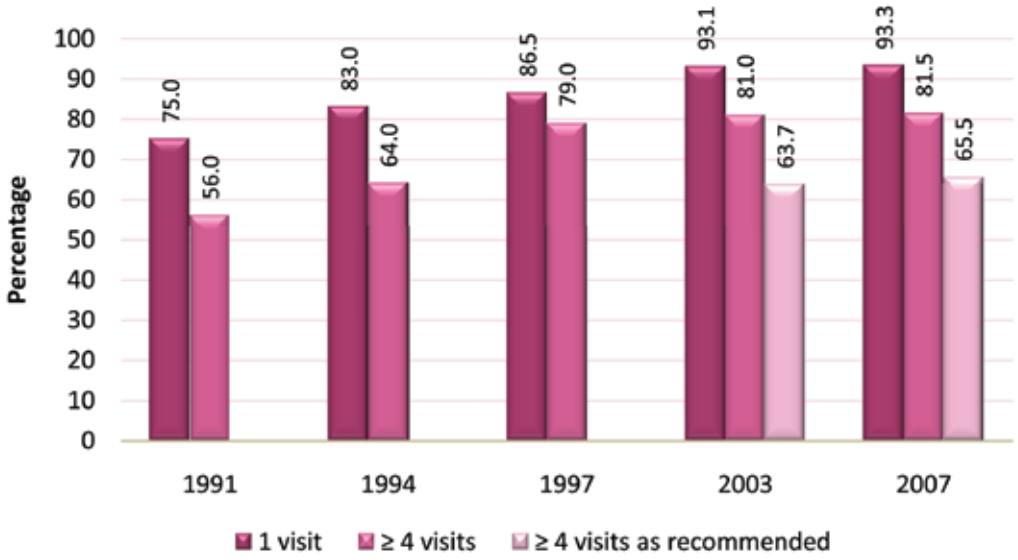


Figure 5.3.
First and fourth antenatal visits, in Indonesia, 1991-2007

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. For the use of modern methods increased from 47.1 percent in 1991 to 57.4 percent in 2007. Moreover, in 2007, among modern methods, injectables are the most commonly used method (32 percent), followed by the pill (13 percent) as reported in IDHS 2007.

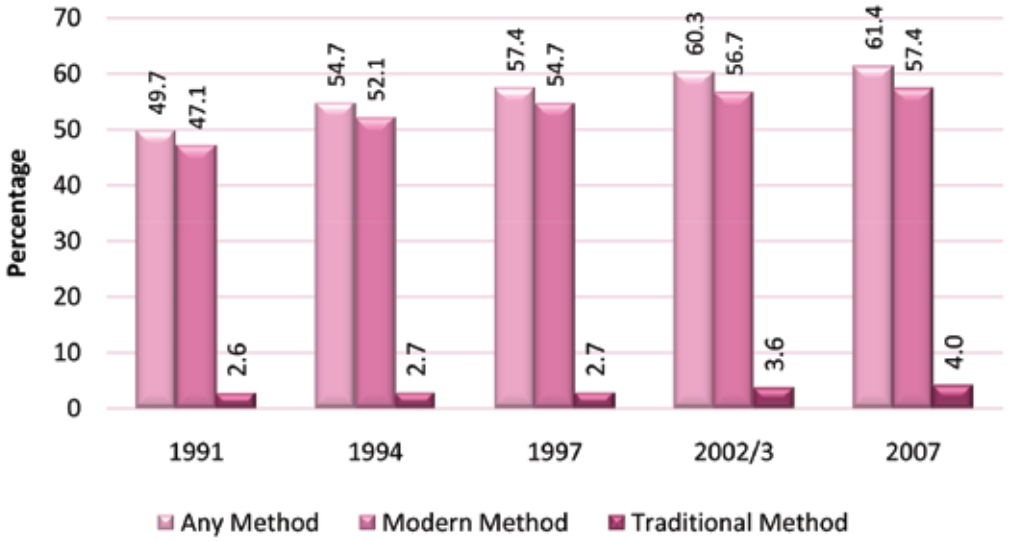


Figure 5.4. *Trend of CPR in married women aged 15-49, 1991-2007*

Source: *BPS, IDHS 2007*

The CPR varies among provinces, level of educations, 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**).

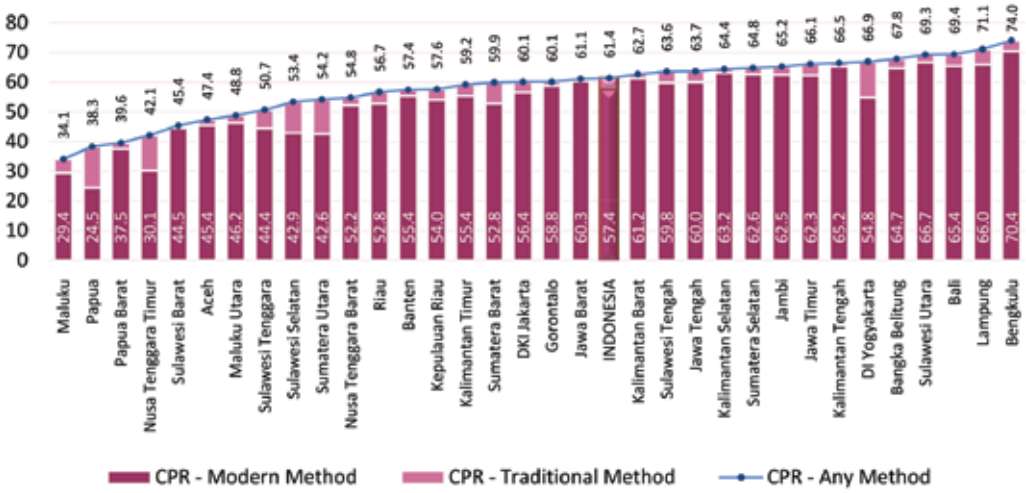


Figure 5.5. *Contraceptive Prevalence Rate by method, by province, 2007*

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 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 contraceptives method.

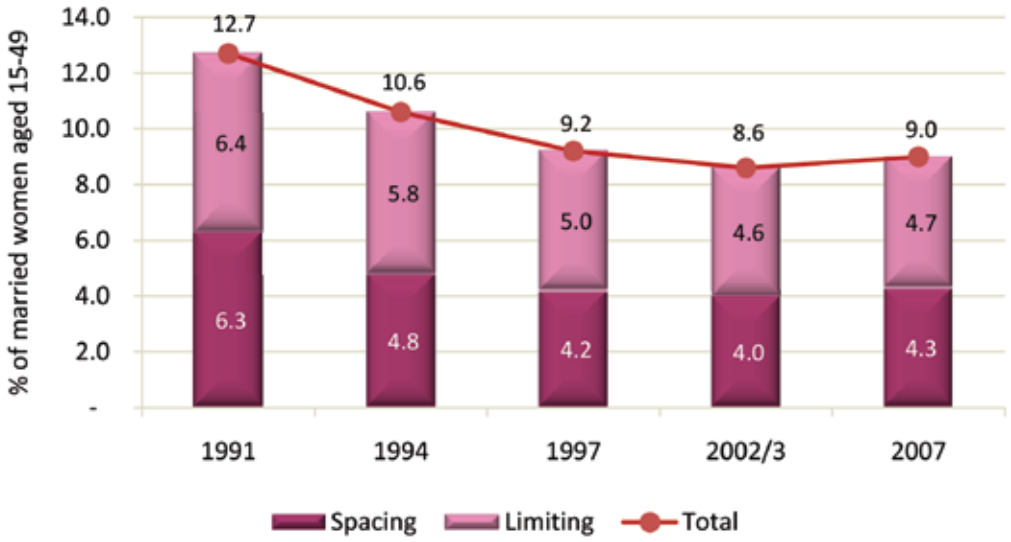


Figure 5.6.
Unmet needs, Indonesia 1991-2007

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

Unmet need varies greatly among provinces, regions and 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 in 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 reflect 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.

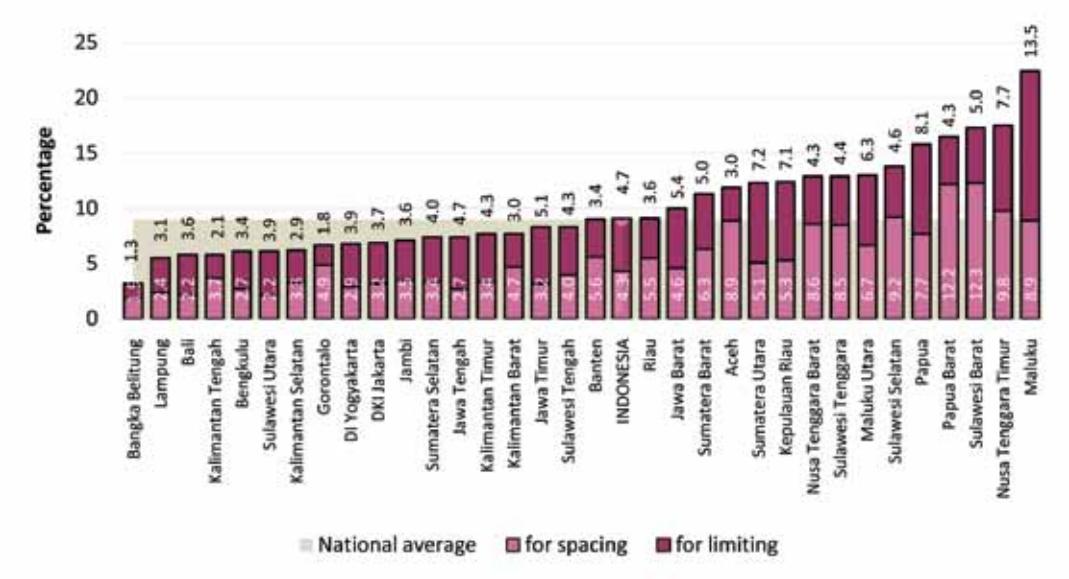


Figure 5.7.
Unmet need by intended purposes by province, Indonesia 2007

Source:
BPS, IDHS 2007

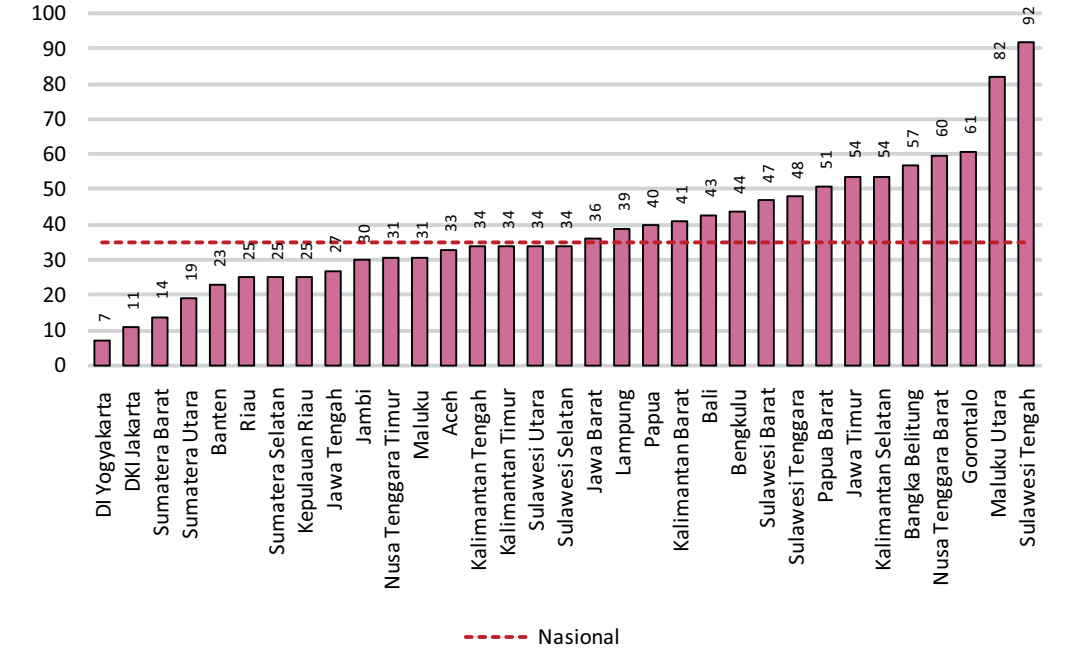


Figure 5.8.
Age Specific Fertility Rate aged 15-19 by province, 2007

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 Adolescent Birth Rate is counted using the ASFR aged 15-19 (number of birth 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 1000 married women (IDHs 2007), which has decreased notably from 67 births per 1000 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, is higher in rural areas than married women 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 f 250,000 inhibitants. Prior to the partnership, many mothers had died during delivery; but after the partnership was initiated, the proportion of births assisted by health professional increase 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 Rp 50,000.00 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 practice tradition), 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 participate in internships in each *puskesmas*; (b) better working relationships between midwives and TBAs; (c) an agreement to work in partnerhsip in assisting prospective delivering mothers; (d) supervision support is being provided by the village/sub-district apparatuses; 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 (DTPK)**. The availability and quality of Basic Emergency of Obstetric and Neonatal Care (BEONC) and Comprehensive Emergency of 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 the maternal deaths figure 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 used.

6. **The Maternal Mortality Ratio remain 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 needs to be implemented immediately.

POLICIES

Policies to be implemented include:

1. **improving facility-based outreach services by improving quality and quantity of**

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

***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 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 device/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 (RPJMN 2010-2014).

3. **expanding the village midwife function, including partnering with TBAs,**; and strengthening the 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 model" and save woman's life by giving her adequate care in time.

5. **reducing financial barriers** through: PKH (conditional cash transfer), Jamkesmas (social health insurance 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.

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

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

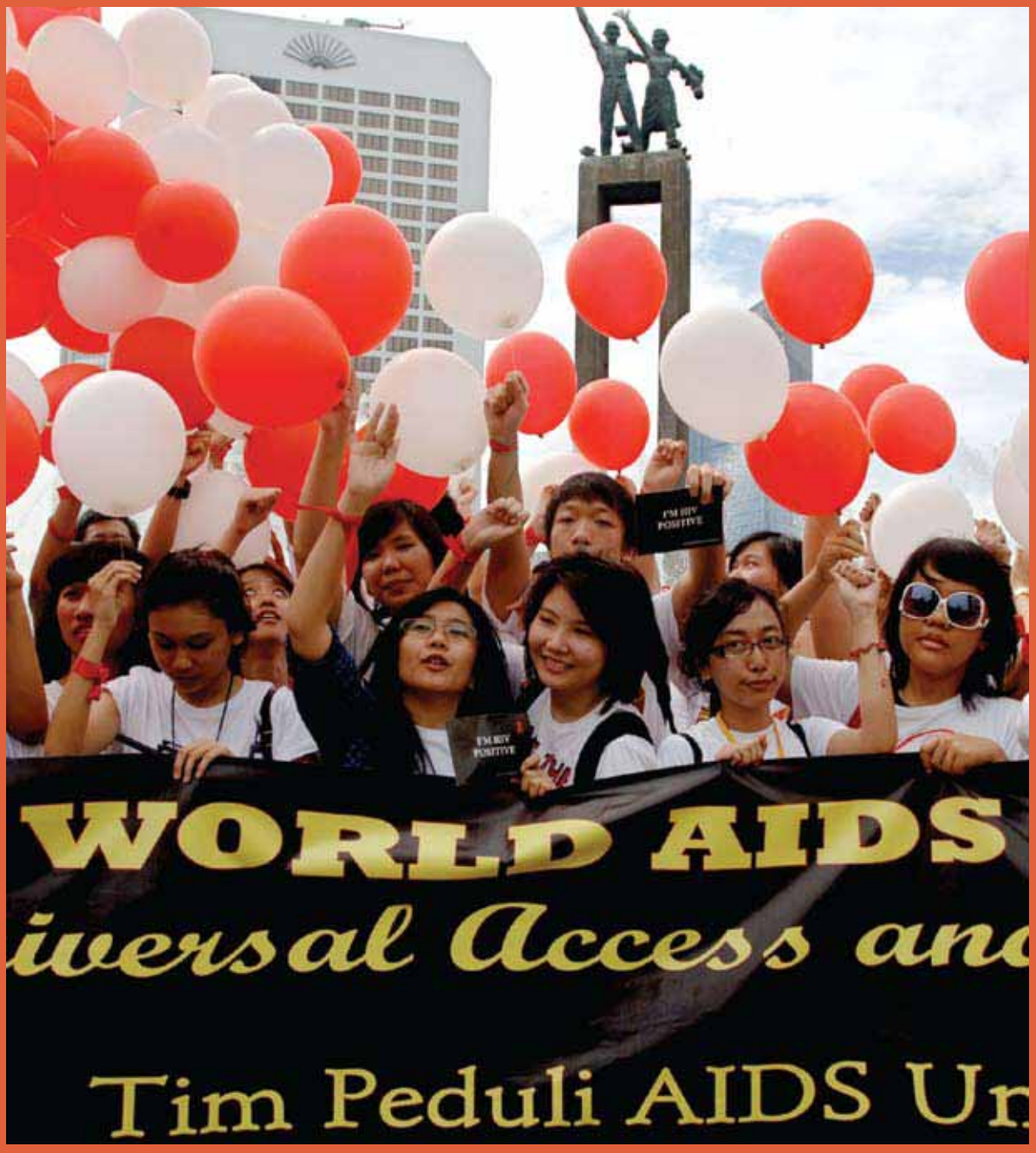
10. **Providing an enabling environment to support management and stakeholderparticipation in policy development and the planning process, and** promote collaboration across programs, across sectors, between public and private sector entities, including developing linkages with the community to implement 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** (**MMSs**) 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 by Antara

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	MDGs 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 all over Indonesia, and the number varies among provinces (**Figure 6.2**).

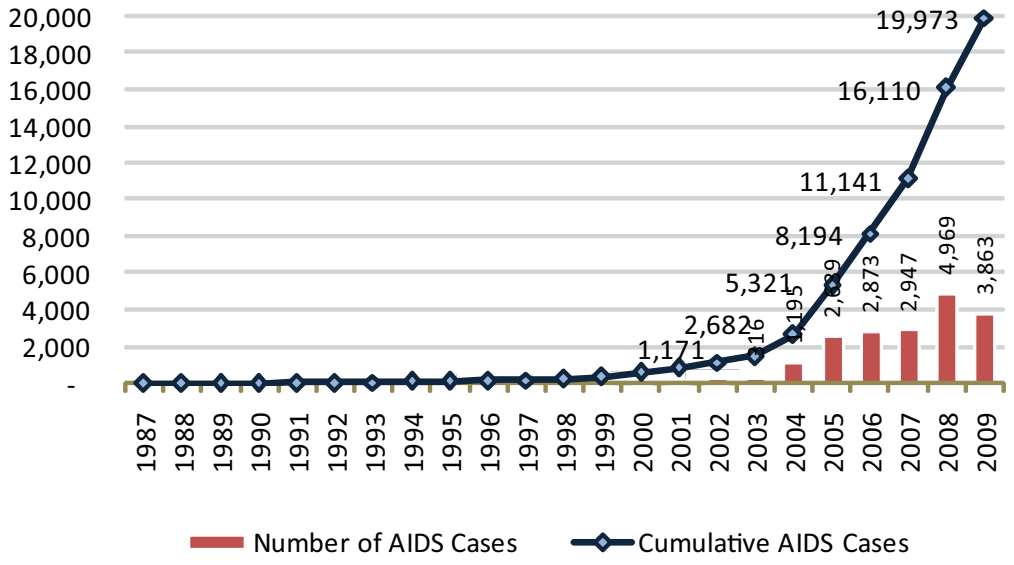


Figure 6.1. *AIDS cases per 100,000 population in Indonesia, 1989-2009*

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

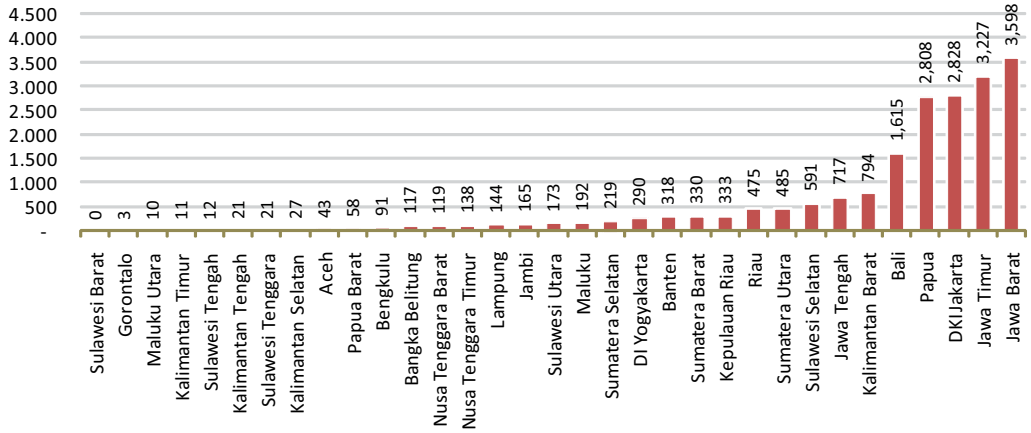


Figure 6.2. *Number of AIDS cases in Indonesia, by province, 2009*

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

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 about 0.1 percent. Based on AIDS transmission, 91 percent of AIDS cases occur in reproductive age, 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.

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 pattern among age-groups, residence (rural vs. urban) as well as level of education (**Figure 6.4**.)

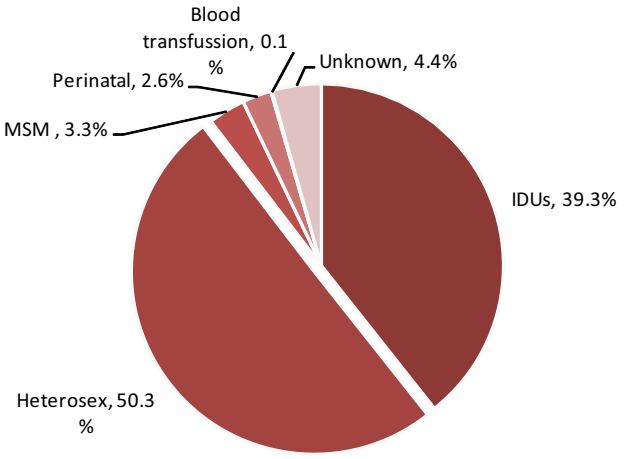


Figure 6.3. *Distribution of HIV Infections, by population group, 2009*

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

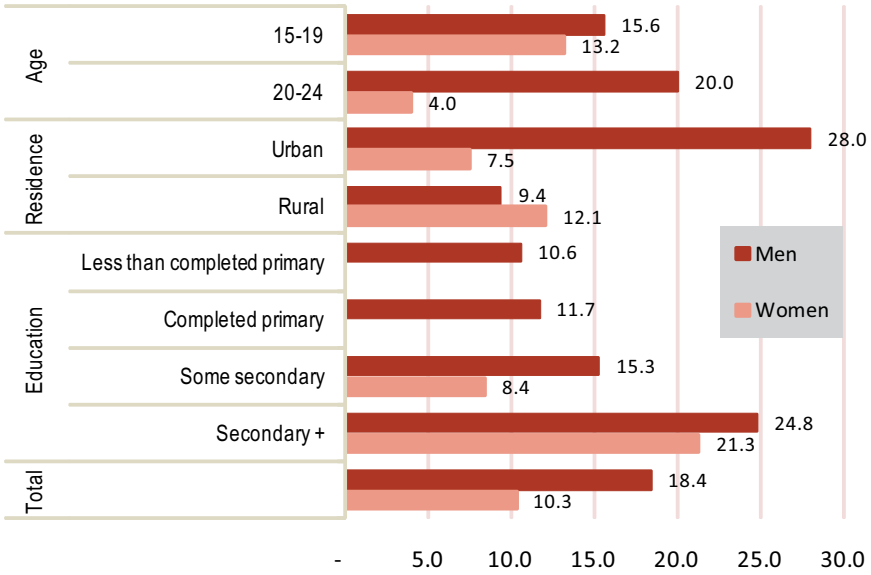


Figure 6.4. *Percentage of unmarried women and men age 15-24 who have ever had sex, who use of condom at last sex, according to background characteristic, 2007*

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 14.7 percent among married men and 9.5 percent among 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 in married men improved to 15.4 percent, while in women married increased to 11.9 percent. Among unmarried men, the correct and comprehensive knowledge of HIV/AIDS increase significantly to 20.3 percent, as well as unmarried women, to 19.8 percent[1].

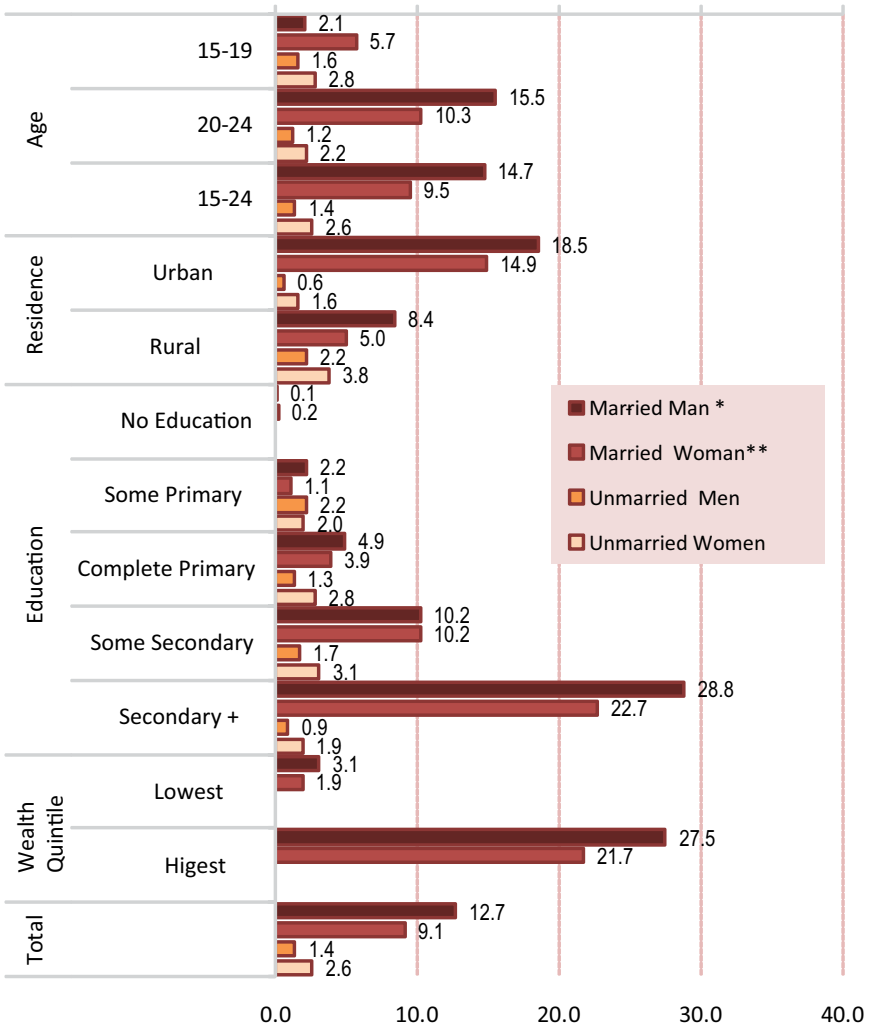


Figure 6.5.
Proportion of men and woemn aged 15-24 with correct of comprehensive knowledge about AIDS, by back ground characteristic, Indonesia 2007

Note:
**) covering age group of 15-54 years old for married man, 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

1 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).

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 in the highest wealth quintile is higher than for the lowest quintile.

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 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).

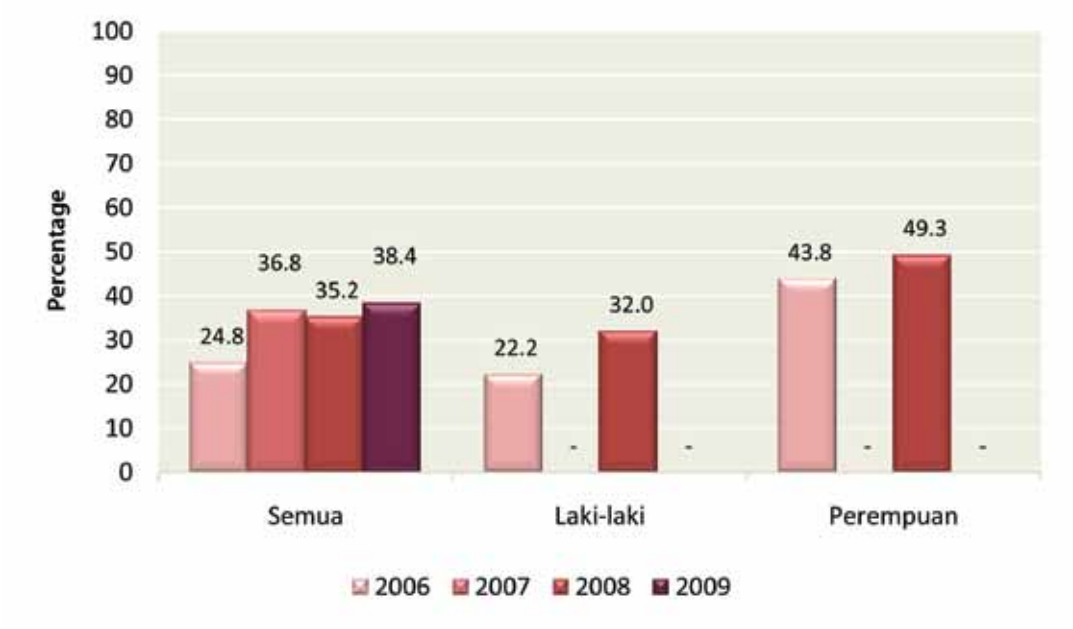


Figure 6.6.
Coverage of ART interventions in Indonesia, 2006–2009

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 is selected as a pilot model in the accelerated program of controlling HIV/AIDS. One of the efforts is to mobilize local government in the prevention and mitigation of HIV/AIDS, through development of two one-stop service clinics. The program is intended to provide sexually transmitted infections (IMS) 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 500 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 [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 as: JOTHI (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.

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, diagnostic, treatment, care, safety blood transfusion 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 with HIV/AIDS epidemic.

3. **The weakness of inter-sectoral coordination as well as monitoring and evaluation systems**. Tackling the disease needs to involving participation by a number of sector agencies and places great demands on effective coordination of strategies and interventions.

4. **There are some constraints due to stigma and discrimination of PLWHA in the community as well as the existence of gender inequalities and violations of Human Rights.** While BCC and IEC programs are being pursued as part of the HIV/AIDS strategy, they may not be sufficiently effective nor well-targeted; and socio-geographically, they may not be keeping pace with the spread of the disease, as it spreads nationwide.

5. **Limited facility, human resources both in capacity and quality as well as availability of ARV in term of quantity and quality.**

POLICIES

1. **Improving access by strengthening public health services so that they have the necessary skills and resources to anticipate and respond to the epidemic**, through: (i) improving the number and quality of health-care facilities in providing sustainable promotion, diagnostic, prevention, treatment and care; (ii) strengthening the ability to apply prevention, (iii) improving coverage of prevention, care and treatment; (iv) developing national guidelines for mainstreaming HIV/AIDS and adapting them to specific situations; and (v) human resource planning in controlling HIV/AIDS.

2. **Enhancing community mobilization to improve HIV/AIDS prevention, care and treatment interventions** through: (i) providing of IEC services; (ii) undertaking community outreach that focuses on the most-at-risk populations; (iii) social marketing of condoms; (iv) assuaging prejudices–among health workers, in the community, and among patients; and (v) creating an enabling and conducive environment to reduce stigmatization and discrimination.

3. **Mobilizing additional financial resources for a successful HIV/AIDS strategy,** through: (i) integrating HIV/AIDS into development programs; (ii) mobilization of additional financial resources in controlling HIV/AIDS, and (iii) development of public private partnership (ppp);

4. **Improving cross-sector coordination and good governance,** by: (i) establishing a concerted system within government that synergize various levels of organization and institutions that contribute towards an integrated strategy, (ii) strengthening the role of National and Local AIDS Commissions, (iii) strengthening cross-sectoral partnerships (iv) defining the respective roles of central, provincial and district health authorities; (v) formulating national guidelines for mainstreaming HIV/AIDS; and (vi) pursuing an inclusive approach;

5. **Strengthening information and monitoring and evaluation systems**, through: (i) conducting health situation monitoring and analysis including, in particular, second generation surveillance; and (ii) providing information to policy makers.

TARGET 6C: HAVE HALTED BY 2015 AND BEGUN TO REVERSE THE INCIDENCE OF HIV/AIDS, MALARIA AND OTHER MAJOR DISEASES

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES						
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)

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

CURRENT SITUATION

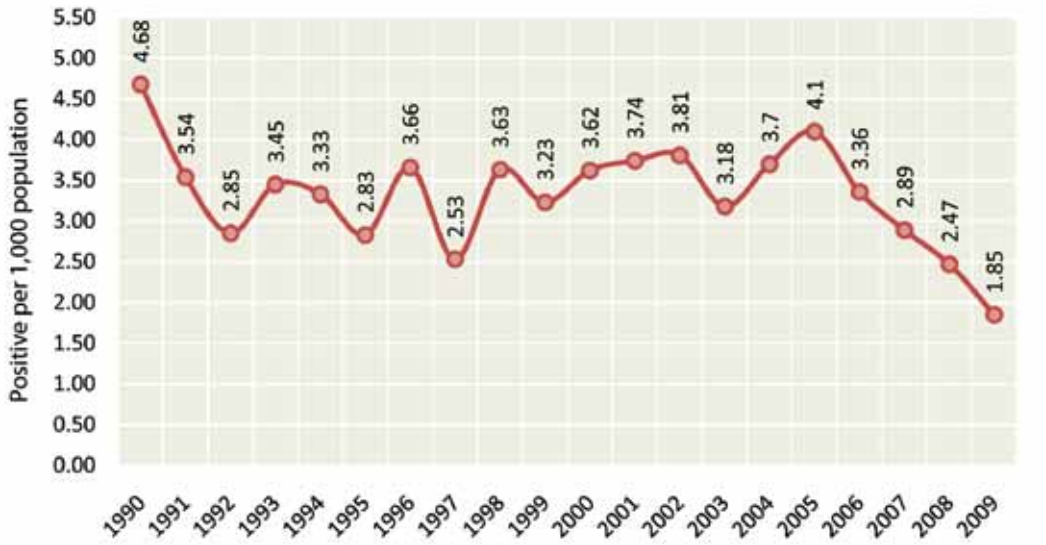


Figure 6.7. *Annual Parasites Incidence of Malaria, Indonesia 1990-2009*

Source: *Ministry of Health, several years*

Incidence and death rates associated with Malaria. The malaria incidence rate during the period of 2000-2009 shows that malaria cases tend to decline: in 2000, incidence

was at 3.62 cases per 1000 population; in 2009, it had declined to 1.85 cases per 1000 population[2] (**Figure 6.7**). While national prevalence based on clinical diagnosis (Annual Parasite Incidence - API) is 2.89 percent (*Riskesdas* 2007). This indicator decreased 2.4 percent in 2010 (interim data from *Riskesdas* 2010).

There is disparity in malaria incidence among regions. This figure varies among regions ranging between 0.3 percent in Bali and 31.4 percent in Papua. There are 20 provinces with API above the national average rate (> 2.4 percent), as can be seen in **Figure 6.8**.

The vector of malaria in Jawa and Bali is dominated by plasmodium vivax malaria that in most cases is drug-resistant. In the outer islands, most of malaria cases are plasmodium

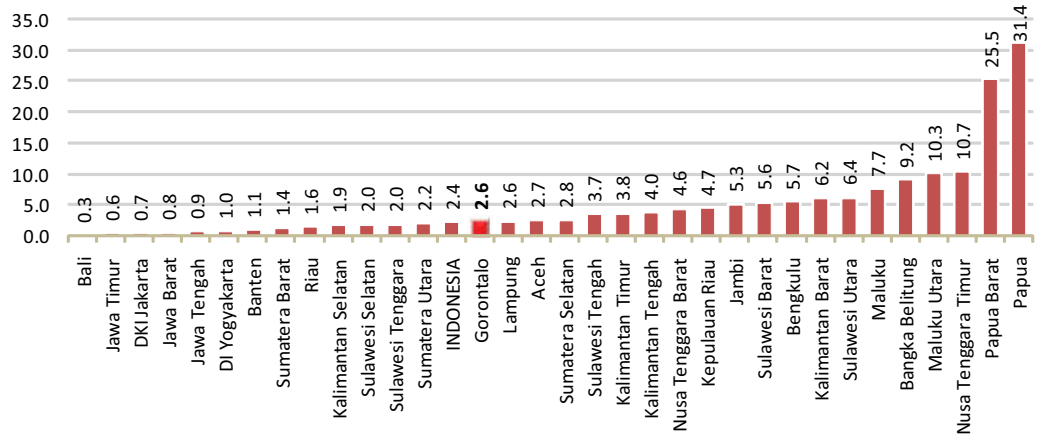


Figure 6.8.
API Malaria by province, 2010

Source:
Ministry of Health, 2010

falciparum and plasmodium vivax that are commonly treatment-susceptible.

The propotion of children under 5 sleeping under insecticide-treated bed nets continues to improve. The proportion of children under-five sleeping under insecticide-treated bed-nets in 2007 was 7.7 percent, and increased to about 16.0 percent in 2010 (interim data, *Riskesdas* 2007). Some 32 percent of households own some type of mosquito net; but ownership of treated nets is very low–only 4 percent of households have at least one ever-treated net (ITN)[3]. Households in rural areas are likely to have a higher incidence of insecticide treated bed nets, (IDHS 2007).

Provision of antimalarial medicines in public health services has increased over time. The use of antimalarial medicines in Indonesia covered 49.1 percent, but access to treatment, especially of ACT[4], is still inadequate on a national scale. While interim data of *Riskesdas* 2010 reported that proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs (full dose ACT) is 21.9 percent and it is 33.6 percent in total population of all age-groups.

2 Since 2007 MOH has issued a policy to use a single indicator to measure incidence of malaria, i.e. API. This policy requires that all positive cases should be confirmed with blood smear test and treated with combination therapy, ACT (Artemisinin-based Combination Therapies).

3 An insecticide-treated net (ITN) is 1) a factory-treated net that does not require any further treatment, or 2) a pretreated net obtained within the past 12 months, or 3) a net that has been soaked with insecticide within the past 12 months.

4 ACT: Artemisinin-based combination therapy

Box 6.2.
Combating Malaria in Sabang Municipality, Aceh Province

Malaria remains a public health problem that influences morbidity, infant and under-5 children mortality as well as maternal mortality. Sabang is one of areas in Indonesia with malaria endemic that has become prominent internationally since 1970s as a specific area for malaria research and pilot projects to eradicate malaria.

In order to reduce and eliminate malaria in Kota Sabang, comprehensive interventions have been made by combining preventive, curative and promotive efforts. These efforts include providing doctors and malaria program managers; procurement of materials and laboratory equipment/ microscopes for malaria in *puskesmas* and some referral hospitals (Sabang General Hospital, the local Air Force Hospital and the local Navy Hospital); and assigning an entomologist and an assistant entomologist at the District Health Office (DHO) of Kota Sabang. Training has also been given to build the capacity of officers and the community/cadres of community malaria workers. Case management training has been carried out for malaria program managers, head of *puskesmas*, midwives of *puskesmas* and village midwives. Other training has included microscopic training, case detection and focused mitigation training for *puskesmas* and the DHO personnel; indoor residual spraying (IRS) training; training for malaria community cadres to perform active surveillance or active case detection (ACD); training for cadres in distributing bed-net; and training for village malaria post (*Posmaldes*) and *Posmaldes* cadres. Achievements of aforementioned interventions are: (i) that the Annual Malaria Incidence (AMI) of Kota Sabang in 2009 significantly fell to 32.65 cases per 1,000 population from 269 cases per 1,000 population in 2001; (ii) the Annual Parasite Incidence (API), it was recorded at 2.7 positive cases per 1,000 population, decreasing from 100.9 positive cases per 1,000 population in 2001.

In order to achieve the malaria elimination program in 2013, the DHO has conducted free malaria blood tests for all inhabitants in that area. The effort was made in collaboration with all sectors in the Kota Sabang. Other support in the achievement of malaria control in Sabang included a free medical treatment program for the poor. In 2008, free medical treatment programs were able to reach 18,759 people and this number continued to grow until the end of 2009. In addition, the municipality has also started to develop a Malaria Database Recording and Reporting System. The database will facilitate intervention efforts for malaria-struck populations, and also enable localization of control area for areas with malaria outbreaks in a small scope at village level.


CHALLENGES

1. **Ineffective malaria preventive actions**. Insufficient preventive efforts in malaria infection control are due to ineffective implementation of epidemiological surveillance, vector control and limited supply of malaria-related information systems, as well as insufficient understanding of appropriate malaria preventive action at community and family levels.

2. **Limited capabilities at local level**. Health services may not be sufficiently equipped and staffed to respond promptly to needs. Case management may suffer from weak logistic planning at the facility level.

3. **Inadequate monitoring and evaluation system.** Oversight capabilities remain limited; monitoring and evaluation activities are insufficient to allow good planning and budgeting for the national Malaria program.

4. **Limited financial resources to support the Roll Back Malaria (RBM).** So far, domestic financing–through national and sub-national budgets–has been relatively modest. Therefore, a financial mobilization strategy for both international and domestic funding will be expanded for medium and long-term programs.

POLICIES

To accelerate efforts to achieve MDG targets related to malaria, improving and strengthening the implementation of a universal coverage RBM strategy are crucially needed, through:

1. **Developing strategies for social mobilization that focus on promoting community awareness about prevention interventions and malaria control**, through: (i) developing IEC and BCC messages that are tailored to specific regional and community situations; (ii) developing social mobilization strategies; (iii) strengthening the malaria information system; (iv) strengthening mechanisms to monitor progress at local levels; (v) providing and promoting the use of insecticide treated bed nets (vi) improving vector control; (vii) strengthening epidemiological surveillance and outbreak control systems; (viii) developing cross-sectoral intervention models such as larvaciding and biological control; and (ix) developing a capacity to assess the efficacy of the malaria control efforts.

2. **Strengthening health services in prevention, control and treatment,** through: (i) promoting prevention and control in the community; (ii) ensuring early detection and care seeking; (iii) responding to the need for case management in a timely manner; (iv) strengthening village malaria post (*posmaldes*); (iv) integrating the malaria program with maternal and child health program interventions; (vi) strengthening accurate and prompt diagnosis; and (vii) improving effective malaria treatment.

3. **Improving capacity of human resources at all aspects.** To be able to implement the strategies, human resources need to be equipped with the appropriate skills and improved capacity in: advocacy; malaria detection and rapid treatment; and logistics management.

4. **Improving management structures and governance that include strategies, work programs, and information systems**, through: (i) strengthening monitoring and evaluation systems; (ii) developing opportunities for collaboration between public agencies and exploring public-private synergies; (iii) ensuring better use of donor

support; and (iv) controlling drug quality and use.

5. **Improving financial support.** Long-term and predictable funding will be needed to maintain the sustainability of the programs, through the private sector and the international community.

TARGET 6C: HAVE HALTED BY 2015 AND BEGUN TO REVERSE THE INCIDENCE OF MALARIA AND OTHER MAJOR DISEASES (TUBERCULOSIS)

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES						
Target 6C: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases						
6.9	Incidence, prevalence and death rates associated with Tuberculosis			Halted, begun to reverse		TB Global WHO Report, 2009
6.9a	Incidence rates associated with Tuberculosis (all cases/100,000 pop/year)	343 (1990)	228 (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)		●	
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

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

CURRENT SITUATION

The TB control program has been improved. The case detection rate (CDR) increased from 54.0 percent in 2004 to 73.1 percent in 2009. In addition, treatment outcomes show success, increasing from 89.5 percent to 91 percent in the same period. These two indicators now exceed the targets set for MDGs, whiche are 70 percent and 85 percent for CDR and success rates (SR) resepectively. Indonesia was the first high TB burden country in the WHO South-East Asia Region to achieve the global targets for case detection (70 percent) and treatment success (85 percent). In 2010, cure rates within DOTS programs reached 83.5 percent coverage (interim data of *Riskesdas* 2010).

In order to improve the effectiveness of the TB control program, Indonesia has applied the internationally recommended control strategy, DOTS as current national policy. Key interventions in DOTS strategy are: commitment, adequate and prompt diagnosis; availability and sustainability of drug distribution;, tracking people with TB in order to

ensure that treatment is not interrupted or drop-out occurs. These can be monitored by controlling by means of a cohort system that allows good recording and reporting of treatment.

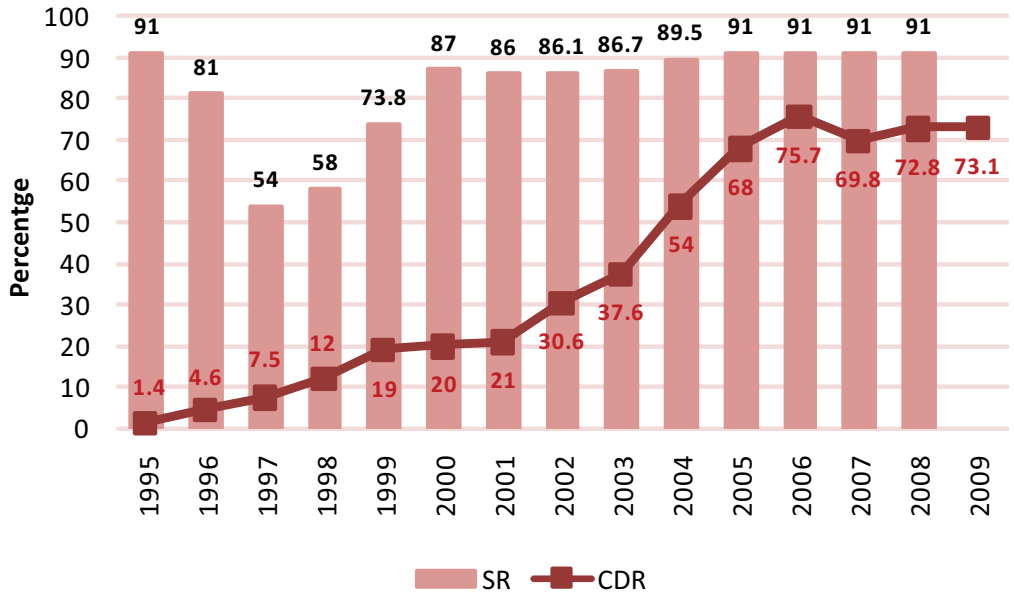


Figure 6.9.
The National Case Detection Rate (CDR) and Success Rate (SR) of TB (%) 1995-2009)

Source:
MoH-RI, Directorate CDC, DG of CDC&EH, several years

Box 6.3.
TB Control in Pulomerak, Kota Serang, Banten Province

Tuberculosis has become a public health problem in Pulomerak, Banten. Initiated by the Head of *Puskesmas* Pulomerak, Serang; Paguyuban TB Pulomerak (the Pulomerak TB Association) was formed on December 30, 2004. This association holds regular meetings which aim, among others, to: (1) share personal experiences with having TB until cured; (2) provide motivation to patients under treatment to routinely taking medicines until they are cured; (3) establish a forum for new pulmonary tuberculosis patients, which consists of former patients and pulmonary tuberculosis patients seeking treatment at *Puskesmas* Pulomerak.

This association was established with self-supporting funds from its members. These funds are intended to support TB patients who have financial difficulties, for instance to provide transportation funding support to access *puskesmas*. The association also develops motivators out of former TB patients who are expected to assist in early detection of TB suspects. This association is fully supported by the District Health Office, and collaborates with the provincial health office (PHO). Based on those experiences, similar associations have been established in district Pandeglang, Lebak and Kota Cilegon.

Activities carried out by the association include: (1) sharing experiences with one another during treatment, so that patients become more motivated to recover; (2) mutually reminding other patients when they are late for or fail to get medical treatment; (3) disseminating information about the benefits of pulmonary tuberculosis treatment in *puskesmas* and bringing people suspected of suffering from TB to *puskesmas*; (4) contributing Rp1,000.00 every week for all members since July 2005, which is used for routine PMT meetings. If there are donors, the money is put into a cash account; (5) imposing a fine of Rp5,000.00 for each violation on members who do not follow the rules (e.g. spitting or littering); (6) holding revolving deposit-credit gathering (arisan) once in two weeks for members who agreed to participate, with deposit of Rp5,000.00; (7) giving door prizes to members who follow the counseling prior to the treatment (door prize provided by donors).

The impact of community and patient engagement in TB control through this establishment can be seen from the increasing achievement of TB programs in Banten Province, from 67 percent in 2005 to 78 percent in 2009

Documentation: MOH

CHALLENGES

1. **The low community awareness and community behaviors increase the risk of infection.** This is reflecting the following factors: (i) Ineffective Advocacy, communication and social

mobilization (ACSM)[5]; (ii) access to services is limited; and (iii) potency in partnership between public and private entities needs to be explored.

2. **The high case detection rate has not been followed by the availability of adequate health care services**. Detection and treatment services for TB are not yet routinely delivered through all health services and there is significant variation between regions. In addition, the high case of MDR-TB due to inadequate TB care and treatment..

3. **Insufficient TB control policies with appropriate local strategies.** There is a need to pay particular attention to strengthening health services, information and financing at local level for TB program.

4. **Insufficient information system to improve evidence-based policy making.** At present, implementation of some components in the TB Strategy, health systems strengthening, participation of care providers, ACSM, research is still inadequate.

5. **There is a shortage of financial resources available to combat TB in Indonesia**. Funding so far has mainly come from donors. Therefore, there will be a need for increased mobilization of local resources, including through initiatives that draw more attention to TB, and by means of efficiency improvements in current program spending.

POLICIES

1. **Expanding DOTS coverage** by: (i) expanding and intensifying ACSM and facilitate access;(ii) improving political support and strengthening decentralization programs; (iii) expanding access to health care and free of charge medicines, (iv) improving logistics and effective drugs management systems; (v) improving active promotion in TB control; (vi) improving effective communication to people with TB, providers and stakeholders, (vii) improving evaluation and monitoring system and measuring the impact of treatment under DOTS.

2. **Improving capacity and quality in TB program** by: (i) strengthening laboratory diagnostic capacity in all health care facilities; (ii) implementing the International Standards for TB Care (ISTC); (iii) improving partnerships involving governments, NGOs and the private sector in an integrated movement for national TB mitigation ; (iv) ensuring availability of adequate health personnel both in quantity and quality; (v) ensuring the availability and sustainability of drug supply, (vi) improving collaboration in TB/HIV programs; (vii) promoting community-based treatments;; (viii) expanding case detection rate and coverage of TB treatment and care services in all health services; (ix) improving counseling support services; and (x) providing standardized facility and infrastructure for TB services.

5 ACSM is still a new area in the TB program strategy and much more guidance and technical support is necessary. Involvement of communities in TB care is essential. A survey of Knowledge, Attitudes and Practice (KAP) conducted recently reported the following findings: (i) knowing what is TB (76 percent) and knowing that TB can be totally cured (85 percent); (ii) stigmatization according to TB (keep TB a secret if a family member had TB) is low, about 13 percent; (iii) most of the community does not know that anti-TB drugs are free and provided by local health facilities (only 19 percent knew). Only 16 percent of respondents could correctly identify the signs and symptoms of TB.

3. **Enforcing policies and regulations in TB control,** will require: (i) strengthening the capacity of the health system to prevent and control infectious disease; (ii) reviewing and adjusting the design of TB control schemes to local conditions; (iii) supportive advisory services that facilitate adoption of correct practices; (iv) periodic evaluation at national and local levels to increase accountability and motivation to perform; (v) periodic surveys to identify special risks; (vi) drug quality control: (vii) public-private collaborative arrangements; and (viii) establishing TB control capacity as a district level priority.

4. **Strengthening health information and monitoring and evaluation system**, through: (i) expanding research related to TB; (ii) expanding network of microscopic test; and (iii) implementing surveillance.

5. **Promoting the allocation of funds to finance the Stop TB program, both at the central level and among local authorities**, through: (i) improving the government commitment in allocating fund to the national budget (*APBN*) to TB control program; and (ii) improving the local commitment in allocating fund in its local government budget (*APBD*) as part of MSS (Minimum Services Standards).

GOAL 7:
ENSURE ENVIRONMENTAL SUSTAINABILITY

Geothermal in North Sulawesi, by ADB

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGET 7A: INTEGRATING THE PRINCIPLES OF SUSTAINABLE DEVELOPMENT IN NATIONAL POLICIES AND PROGRAMS AND REVERSING THE LOSS OF ENVIRONMENTAL RESOURCES

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
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 SBM/ USD 1.000 (1990)	2.1 SBM/ USD 1.000 (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

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

Current Situation

Indonesia's policies on the environment have been formulated with the goal of achieving development in harmony with the natural environment to benefit present and future generations. The current Long-Term National Development Plan (2005-2025) and the National Medium-Term Development Plans (2004-2009 and 2010-2014) have mainstreamed the principles of sustainable development in national development policies and programs.

Global warming leading to climate change is having negative impacts on the environment, and Indonesia is vulnerable. The government is giving a high priority to the mitigation and adaptation to the effects of climate change. This is a mandate of the Law Number 32, 2009 concerning environmental protection and management. Furthermore, a National Council for Climate Change (NCCC) was established in 2008 to strengthen coordination of climate change policy and to strengthen the position of Indonesia in international forums on climate change. The NCCC is chaired by the President, and the membership consists of 20 members of the Cabinet.

The government was a participant in the Copenhagen summit in December 2009 and is a signatory to the United Nations Framework Convention on Climate Change (UNFCCC). Indonesia was the first developing country to announce an emissions reduction target of 26 percent by 2020 from BAU (Business as Usual) levels and the target may be increased to reach 41 percent with international assistance.

In March 2010 the government launched the Indonesia Climate Change Sectoral Roadmap (ICCSR) with the aim of further mainstreaming climate change into national development planning. The ICCSR outlines the strategic vision that places special emphasis on the challenges faced by the nation in the forestry, energy, industry, transport, agriculture, coastal areas, water resource, waste and health sectors.

The ratio of actual forest cover to total land area based on a review of satellite imagery and aerial photographic surveys was 52.43 percent in 2008. This constitutes a reduction of forest cover as compared with the baseline year of 1990 when forest cover was 59.97 percent. However, since 2002 new policies and programs have begun to reverse the trend towards degradation of forest resources that started during the 1990s. Degradation of Indonesia's forests and reduction in biodiversity occurred on a large scale prior to 2002 due to unsustainable forest management practices, illegal logging, forest fires, and conversion of forest lands to other uses.

Conservation and restoration efforts have been increased since 2002. The Ministry of Forestry's National Movement for Forest and Land Rehabilitation resulted in the reforestation of over two million hectares during 2003-2007. The trend in percentages of actual forest cover of the total land area of Indonesia from 1990 to 2008 is presented in **Figure 7.1.**

The total area of lands legally designated by the government in 2010 as forest lands and subject to regulation by the Ministry of Forestry has increased in recent years to 136.88 million hectares or about 72.89 percent of the total land area of Indonesia. Two

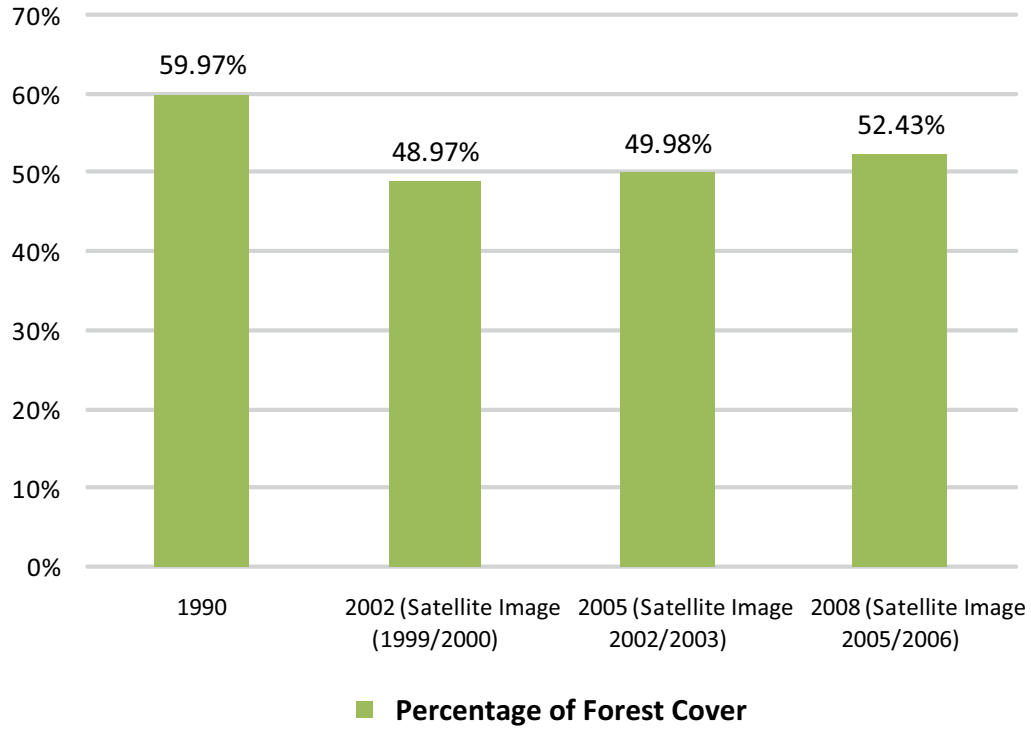


***Figure 7.1**. The percentage of forest cover of the total land area of Indonesia from 1990 to 2008*

***Source**: Ministry of Forestry (1990-2008).*

types of forest classifications are considered to provide protection to terrestrial areas and contribute to maintaining biological diversity:

- Protection Forest Areas (Kawasan Pelestarian Alam or KPA & Kawasan Suaka Alam or KSA) include areas designated to maintain the diversity of flora and fauna and their habitats. Protection areas in Indonesia include nature reserves, forest conservation areas, game and nature preserves, wildlife reserves and national parks. In 2010 a total of 23.31 million hectares had been designated to be classified as Protection Areas by the Ministry of Forestry and 19.88 million hectares (or 85.28 percent of this area) retained forest cover
- **Protected areas are those areas** designated to maintain natural systems, the built environment and historical or cultural assets to promote sustainable development. Protected areas include KPA, KSA, *Taman Buru* and Protection Forests. In 2010, 55.03 million hectares were classified as protected areas in Indonesia. Forest cover in the

protected areas was 51.43 million hectares or about 93.46 percent of the total area of protected areas.

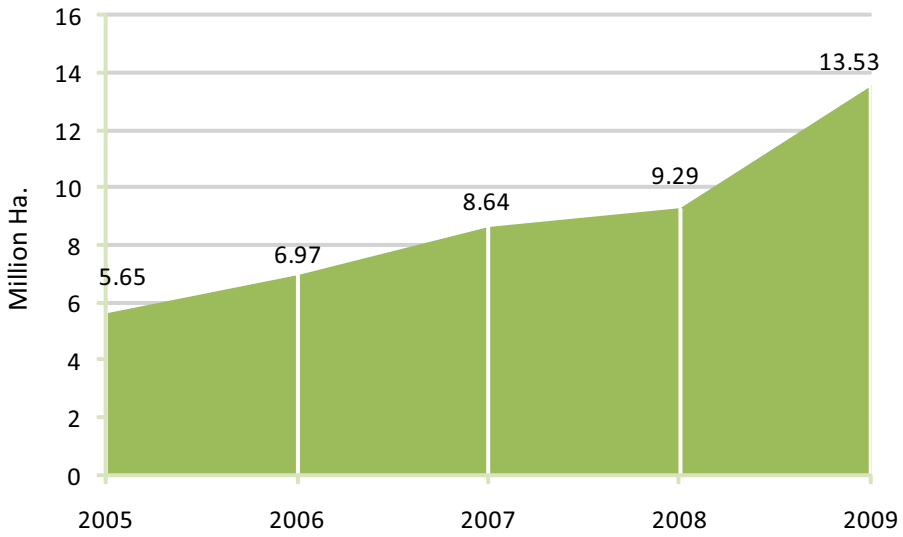


Figure 7.2. *Areas of Indonesian marine conservation areas, 2005-2009*

Source: *Ministry of Marine Affairs and Fisheries*

The area of marine conservation areas has been increased by the government in recent years and the total area allocated for this use reached 13.53 million hectares in 2009 or 4.35 percent of the national territorial waters of 3.1 million square kilometers (Figure 7.2). The Ministry of Marine Affairs and Fisheries plans to expand the area of marine conservation areas to 15.5 million hectares by the end of 2014 or approximately 5 percent of Indonesian territorial waters, and to 20 million hectares by 2020.

Various types of marine conservation areas have been established to maintain biodiversity or to represent a special ecological function such as spawning grounds or feeding areas for marine species (**Table 7.1**). Marine areas, including mangroves, sea grass beds and other vegetative areas also play an important role in absorbing CO_2 from the atmosphere.

Table 7.1. *Indonesian marine conservation areas (2009)*

Source: *Ministry of Marine Affairs and Fisheries*

No	Types of marine conservation areas	Number of areas	Total area (million hectares)
1	Marine national parks	7	4.043
2	Marine natural tourism parks	18	0.767
3	Marine reserves	7	0.337
4	Marine natural reserves	8	0.271
5	National water conservation areas	1	3.521
6	Regional marine conservation areas	35	4.589
	Total	**76**	**13.529**

Green House Gases (GHG), including among others carbon dioxide, methane, and hydrofluorocarbons (HFCs), are produced by human activities. Excessive concentrations of these chemicals in the biosphere are triggering global warming and climate change. Green house gas emissions are measured in terms of CO_2 or CO_2 gas equivalent concentration levels. Efforts to reduce greenhouse gas emissions have been agreed internationally through the Kyoto Protocol which Indonesia ratified through Indonesian Law No. 17/2004 on the Ratification of the Kyoto Protocol.

The consumption of ozone depleting substances (ODS) has been significantly reduced in accordance with the Montreal Protocol. The Indonesian government ratified the Montreal Protocol and has banned import of five ODS types that are CFCs, Halon, CTCs, TCA and Methyl Bromide for non quarantine and pre-shipment (QPS). Efforts have also been undertaken to prevent the emission of ozone depleting substances - particularly CFCs - into the atmosphere. Efforts to raise the awareness of the public on the issue of protecting the ozone have contributed to the success of this initiative.

By 2007 the consumption of chlorofluorocarbons (CFCs) in Indonesia had been reduced to a minimal level (see Figure 7.3). There has been a gradual replacement of ozone depleting substances that have a high ozone depleting potential such as CFCs and other ODS types including Halon, CTC, TCA with the temporary use of substitutes with a smaller ozone depleting potential, such as hydrochlorofluorocarbon (HCFC) compounds and/or substances that are non-ozone depleting. Although the import and use of ozone depleting substances has been significantly restricted, Indonesia is also facing challenges to combat illegal importation of ozone depleting substances.

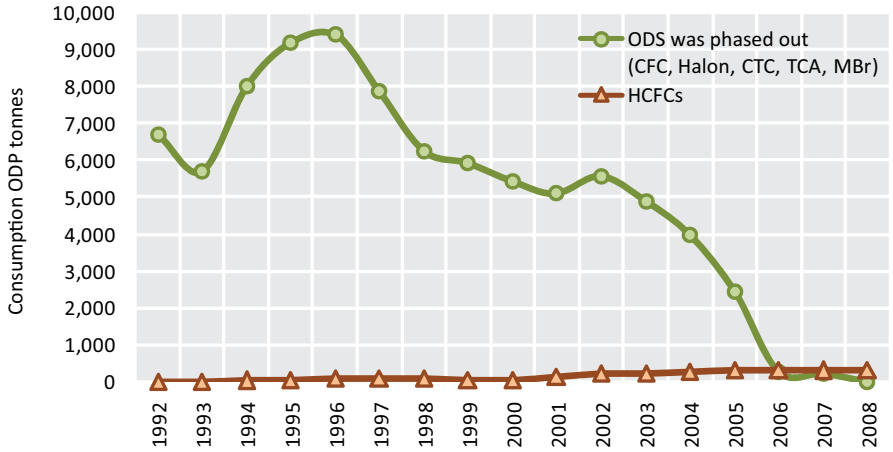


***Figure 7.3**. Ozone Depleting Substance Consumption in Indonesia from 1992 to 2008*

***Source**: Ministry of Environment*

Total energy use tripled in Indonesia between 1990 and 2008. Total energy usage in 1990 reached 247.975 million BOE, and by 2008 total energy use had increased to 744.847 million BOE as shown in **Figure 7.4.** Oil-based fuels represent the most commonly used fossil fuel energy group.

The ratio of energy usage to GDP growth is expected to continue to decline. At the same time the use of non-renewable energy in Indonesia double between 1990 and 2008. In addition to emissions that affect climate change, the availability of non-renewable energy

is limited. To maintain national energy security in the future and reduce dependency on petroleum, the Ministry of Energy and Mineral Resources will strive to develop renewable energy resources.

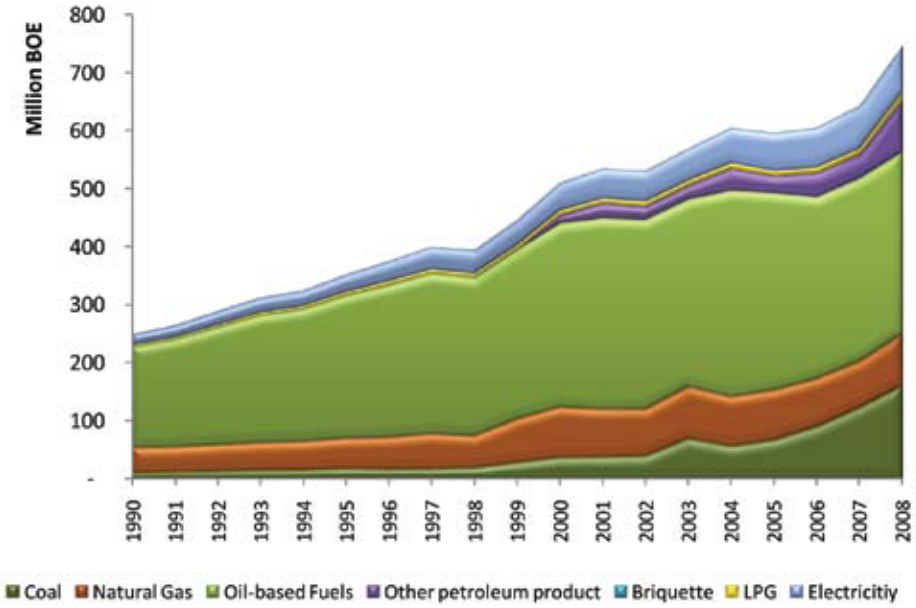


Figure 7.4. *Total energy use of various types for the years 1990-2008 (equivalent to Barrels of Oil (BOE) in millions)*

Source: *Ministry of Energy and Mineral Resources*

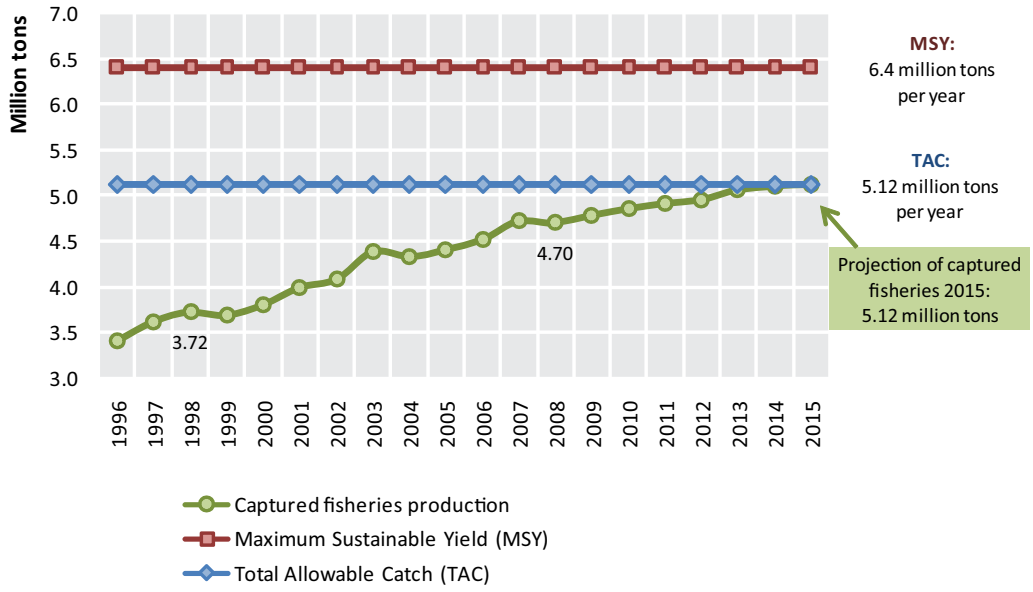


Figure 7.5. *The captured fisheries production in Indonesia*

Source: *Ministry of Marine Affairs and Fisheries*

For fish stocks within safe biological limits, the maximum sustainable yield (MSY) for capture fisheries is estimated to be around 6.4 million tons per year, while the total allowable catch (TAC) is 80 percent of MSY or 5.12 million tons per year. The total production of captured fisheries in Indonesia increased from 3.72 million tons or 66.08 percent of TAC in 1998 to 4.70 million tons or 91.8 percent of TAC in 2008. The captured fisheries production is projected to be 5.12 million tons or equal to TAC in 2015. The utilization of fisheries resources, especially resources from the sea, is based on precautionary and sustainable principles so that the production will not exceed safe biological limits.

CHALLENGES

Various factors have resulted in the reduction of forest cover in Indonesia since 1990, including: forest fires, illegal logging, forest conversion, and unsustainable forest management practices. Forest fires and the clearing of forests by burning not only result in the depletion of forest resources, but also generate large amounts of CO_2. Illegal logging is one of the major causes of depletion of forest resources in Indonesia. Forest conversion to meet the demands of the community for cultivation represents one of the causes for the decline in forest resources that is difficult to control.

Climate change creates tremendous challenges for sustainable development in Indonesia. Actions are needed, both to mitigate global climate change and to implement measures to enable Indonesians to adapt to the adverse impacts of climate change.

In marine and coastal management, in order to reduce the effects of climate change, it is important to achieve long-term conservation, management and sustainable use of marine living resources and coastal habitats through appropriate application of the precautionary and ecosystem approaches.

One of the causes of climate change is the high-level of carbon dioxide released into the atmosphere in consuming energy. The use of alternative energy sources that produce lower levels of carbon dioxide or that do not give rise to carbon dioxide emissions is one of the ways to mitigate climate change**.**

While Indonesia has been successful in the elimination of CFCs, the use of HCFCs as a temporary substitute for CFCs also has a negative impact on the ozone layer, even though its ozone depleting potential is far smaller. The use of HCFCs as a refrigerant is a temporary measure and is a controlled substance under the Montreal Protocol. Under the accelerated phase-out of HCFCs adopted at MOP-19, HCFC production and consumption is to be frozen by 2013 and phased out by 2030 for manufacturing industries.

POLICIES

Box 7.1.
District Wakatobi and its "Environment Warrior"

"We, the people of Wakatobi, did not work in vain.", the words were the spontaneous response from Ir. Hugua, the Head of the District of Wakatobi, after receiving the MDG Leadership Award in Jakarta last year, granted by the Coordinating Ministry for People's Welfare in cooperation with the Leadership Park Institute. It was a proper reaction and reflected a sense of pride considering that Hugua had only taken over as the leader of Wakatobi just four years ago. Wakatobi itself is also quite a new district, having split from the district of Buton in the province of Sulawesi Tenggara, seven years ago.

Hugua has used his personal capacity, also the natural resources of the small islands of Wakatobi and the willingness of all elements of the society to 'solve' the challenges of MDGs. One of his success stories is in changing people's behavior. Initially, it was of course not easy, especially if that behavior was directly related to the necessities of their lives and had become a traditional practice. Long before he became the Head of the district of Wakatobi, this father of two sons was known as an 'Environmental Warrior' who never gave up. In the midst of people relying on coral reefs as home building materials, he was never detered. His ability to approach residents in coastal areas in their homes, by offering solutions to build houses using wood material, finally obtained results.

The United Nations (UN) has also given awards to the district of Wakatobi for its success in lowering the poverty rate to 7 percent in a short period, as well as its success in the 12-year compulsory education program and improving the health of the community.

During the World Ocean Conference held in mid-May 2009 in Manado (North Sulawesi), Hugua was one of the local leaders who was recognized by the World Wildlife Fund (WWF) for his commitment to preserve the population of sea turtles and the diversity of coral reefs along the coasts of Wakatobi. This was revealed by survey data that within a period of one year the sea turtle nesting populations in the area of the islands of the district have been increased.

Challenges
Only seven of 142 islands in the district of Wakatobi are inhabited. The coral reefs in Wakatobi are structures as steep walls - 60 percent are in very good condition. It is estimated that there are about 750 coral reef species together with 942 species of fish on the reefs. The cultivation and exploitation of coral reefs or selling of ornamental fish are not allowed in Wakatobi.

Currently, the coral reefs in this district are considered to be among the best preserved in the triangle area of coral reefs worldwide. However, increasing of sea temperatures has caused coral bleaching in Wakatobi. Bleaching of coral reefs is caused by an increase in the illegal use of anesthesia in the capture of ornamental fish and sunlight. In collaboration with the Ministry of Research and Technology, the district Wakatobi is conducting research on biodiversity in these islands where land comprises only 3 percent of the total area of the district. The rest is sea. Hopefully the challenges mentioned will be overcome with support from all concerned parties.

*Sources**: Kompas (05/23/2010); Antara (01/04/2007); Beritabaru.com (12/23/2009**)*

The policies and initiatives to be taken by the government are as follows:

1. Increase the area of protected forests and marine conservation areas while significantly reducing the rate of deforestation;
2. Combat illegal logging in all regions to maintain forest and conservation areas;
3. Launch a national movement to rehabilitate forests and critical lands (Gerhan), establish a Forest Planning Unit in every province, and delegate authority to issue permits to use forest areas with less than 1 ha to the governors;
4. Establish Forest Management Units (FMU) and funding mechanisms to strengthen forest management;
5. Socialize and provide fiscal and non-fiscal incentives to encourage energy saving and the use of more efficient and environmentally friendly alternative sources of energy, such as utilization of renewable energy sources;
6. Implement programs to protect the ozone layer through enforcement of the ban on the use of ozone destroying substances which are prohibited by law;
7. Mitigate global warming while adapting to the negative impacts of climate change through mainstreaming climate change issues into key sectors of development;
8. Expand Marine Conservation Areas, rehabilitate mangroves and coral reefs in coastal areas and increase absorption of carbon in the marine and fisheries sectors.

TARGET 7B: REDUCE BIODIVERSITY LOSS, ACHIEVING, BY 2010, A SIGNIFICANT REDUCTION IN THE RATE OF LOSS

Current Situation

Indonesia is endowed with rich biodiversity in the level of ecosystems, species and genetic. In terms of ecosystem biodiversity, Indonesia is estimated to have 90 ecosystem types, from snow peaks at Jayawijaya, alpine, sub-alpine, mountain to lowland tropical rainforests (Sumatera, Kalimantan), coastal forest, grasslands, savannah (Nusa Tenggara), wetlands, estuaries, mangrove and marine and coastal ecosystems, including sea grass beds (Sunda Strait) and coral reefs (Bunaken) to deep sea ecosystems. These diverse ecosystems provide the habitats for very diverse fauna and flora species, some of which are endemic (found only in a certain area). About 515 mammal species, 511 reptile species, 1,531 bird species, 270 amphibians and 2,827 invertebrate species are found in Indonesia. In addition, Indonesia has more than 38,000 species of plants, which include about 477 palm species and 350 timber producing tree species.

In 1993 the Government of Indonesia launched the Biodiversity Action Plan for Indonesia (BAPI) as a document to set the priorities and investment in biodiversity conservation. Ten years later, BAPI was updated into a new national biodiversity strategy and action

plan entitled "*The Indonesian Biodiversity Strategy and Action Plan* (IBSAP)" in order to address issues raised in the UNCBD. Learning from the experience of BAPI 1993, IBSAP was built up through a participatory process and addressed more current environment issues. IBSAP identified new needs, actions, opportunities, challenges as well as constraints in implementing biodiversity conservation.

Efforts will be made to reduce the rate of loss of biodiversity significantly. Recovery efforts will continue while improving security and law enforcement, development of populations, and increasing awareness on biodiversity among the general public. Monitoring will be improved, including mapping the distribution of several umbrella and flagship species (**Figures 7.6, 7.7, 7.8, 7.9**).

Figure 7.6.
Distribution of the Sumatran Tiger
(*Panthera tigris sumatrae*)

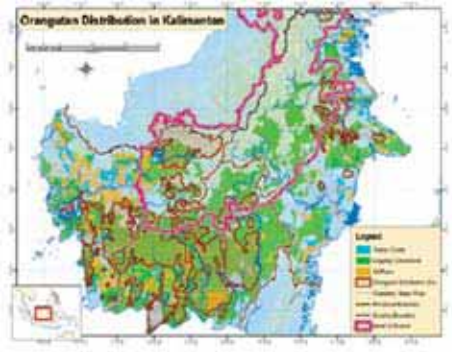


Figure 7.7.
Distribution of the Kalimantan Orangutan
(*Pongo pymaeus sp*)

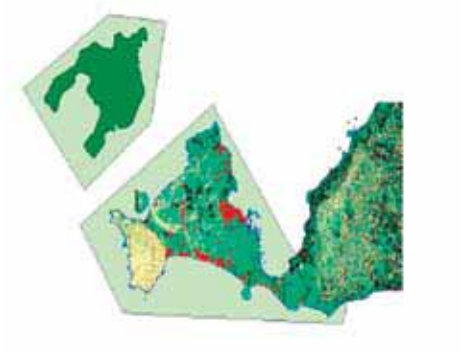


Figure 7.8.
Distribution of the Javan Rhino
(Rhinoceros sondaicus sondaicus)

Figure 7.9.
Distribution of the Sumatran Rhino in Leuser
(*Dicerorhinus sumatrensis sp***)**

There has been a positive trend towards increased protection of endangered aquatic species. A significant increase in the number of protected marine fish species occurred during the years 1998 -2004, reaching 80 species. The number of protected freshwater fish species also increased during 1998-2001, reaching 35 species and continued to increase until 2009**.** It should be noted that the ratios of the numbers of protected and endangered freshwater and marine fish species (less than 500 species of fish) to the total number of fish species in Indonesia (6,000 fish species) are small (**Figure 7.10**).

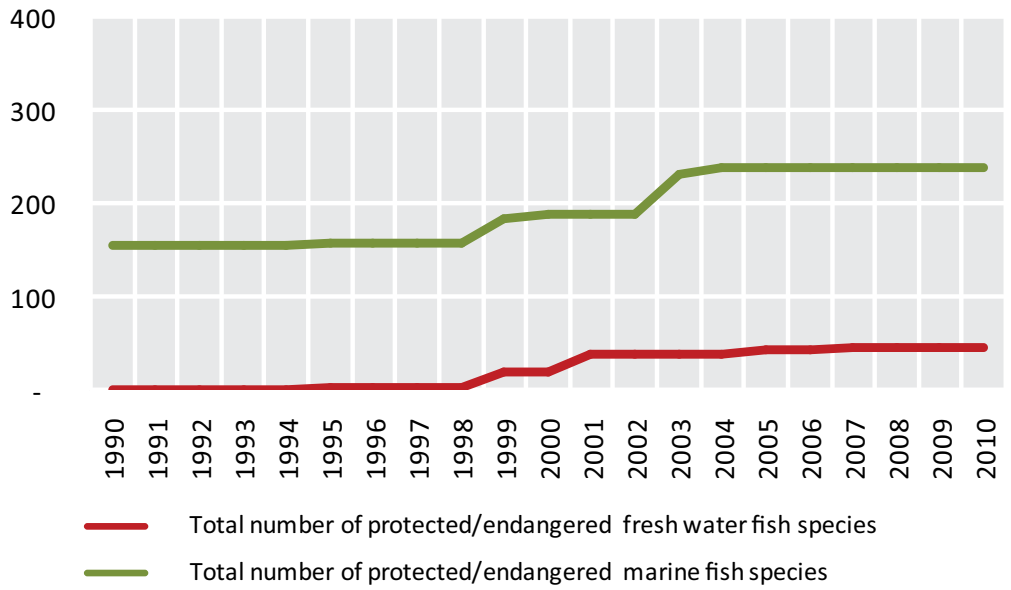


***Figure 7.10**. The total number of fish species and the number of protected fresh water and marine species by year, 1990-2010*

***Source**: Ministry of Marine Affairs and Fisheries.*

CHALLENGES

Despite the richness, the biodiversity of Indonesia has been threatened due to the extraction of natural resources in unsustainable ways. Conversions of the ecosystems for industrial development, settlements, transportation, and other purposes has reduced biodiversity. This has resulted not only in the degradation of biodiversity in the level of ecosystems, but also in the level of species and genetic. However, data on the status of species and genetic biodiversity is limited. The reports from international agencies such as IUCN have been used as indicators on threats towards species. For example, in 1988 126 bird species, 63 mammal species, 21 reptile species and 65 other animal species were declared to be on the brink of extinction. Four years later, the Red List of IUCN indicated that 772 flora and fauna species were threatened with extinction, consisting of 147 mammal species, 114 birds, 28 reptiles, 68 fishes, 3 molluscs, 28 other fauna species, and 384 flora species.

The range of distribution of ebony *(Diospyros celebica*), ulin (*Eusideroxylon zwageri*), sandalwood (*Santalum album*) is also narrowing. This is the case with many Dipterocarps species**.** About 240 plant species have been declared rare, many of which are relatives of cultivated plants. At least 52 orchid species (Orchidaceae) are declared rare, as well as 11 rattan species, nine bamboo species, nine betel palm species, six durian species, four nutmeg species, and three mango species (Mogea et al. 2001).

Several fish species are also threatened with extinction. For instance, chinese herrings (*Clupea toli*) which dominated the eastern coast of Sumatra and flying fishes (*Cypselurus* spp.) in the southern coast of Sulawesi. Other threatened fish species are batak (*Neolissochilus* sp.) the pride of Toba lake often used in indigenous ceremonies, bilih (*Mystacoleucus padangensis*) which is endemic in Singkarak Lake, botia *(Botia macraranthus*), the ornamental fish unique to Batanghari river, which used to be consumed

by local communities but have now become rare.

Unfortunately, the erosion of genetic diversity, particularly in wild species, is not well documented.

POLICIES

1. Improved conservation of biodiversity, through monitoring and facilitating the development of Biodiversity Parks.
2. Development of essential ecosystem conservation areas, through efforts to reduce conflicts and pressure on national parks and other conservation areas, improvements in the management of essential ecosystems, improved handling the management of those who enter conservation areas without permission and initiatives to promote the recovery of conservation areas.
3. Protection of forests, through efforts to reduce forest crimes and prosecution of criminal cases related to conservation areas.
4. Development of conservation of species and genetic biodiversity, by improving biodiversity and working to increase populations of endangered species, including with international and regional cooperation.
5. Control forest fires, through efforts to reduce hot spots, reduce burning areas and improve human resource capacity to control forest fires.
6. Develop environmental services and ecotourism through the management and development of ecosystems and species conservation in coastal zones and marine ecosystems including improved management of coral reefs, mangroves, seagrass areas, as well as the identification and mapping of marine conservation areas and protected species.

TARGET 7C: HALVE, BY 2015, THE PROPORTION OF PEOPLE WITHOUT SUSTAINABLE ACCESS TO SAFE DRINKING WATER AND BASIC SANITATION

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
Goal 7: Ensure Environmental Sustainability						
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

CURRENT SITUATION

Drinking Water

Household access to improved sources of drinking water has continued to rise. *SUSENAS* data shows that access to improved drinking water increased from 37.73 percent in 1993 to 47.71 percent in 2009 (**Figure 7.11**). Access to improved drinking water sources tends to be higher for households in urban areas than in rural areas. The relatively low access to improved drinking water sources reflects the rate of development of drinking water infrastructure, particularly in urban areas, which has not been able to match population growth. At the same time, drinking water facilities are often not well maintained and are not managed on a sustainable basis.

Regional disparities in access to improved drinking water are significant in Indonesia. As shown in **Figure 7.12,** t he provinces where the highest percentages of the population have access to improved drinking water sources are: DI Yogyakarta, Bali and Sulawesi Tenggara. Banten, Aceh and Bengkulu are the three provinces with the lowest proportion of households with access to improved drinking water sources.

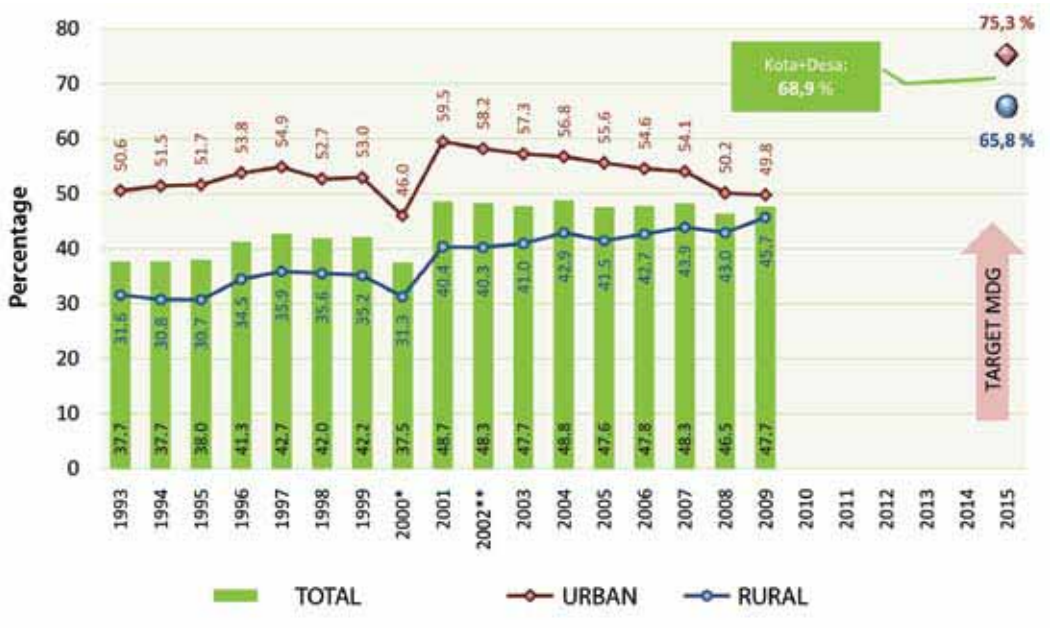


Figure 7.11. *Proportions of rural, urban and all households with access to improved drinking water sources in Indonesia (1993-2009)*

Notes:
Data does not include Timor Timur.

Source:
Susenas, several years

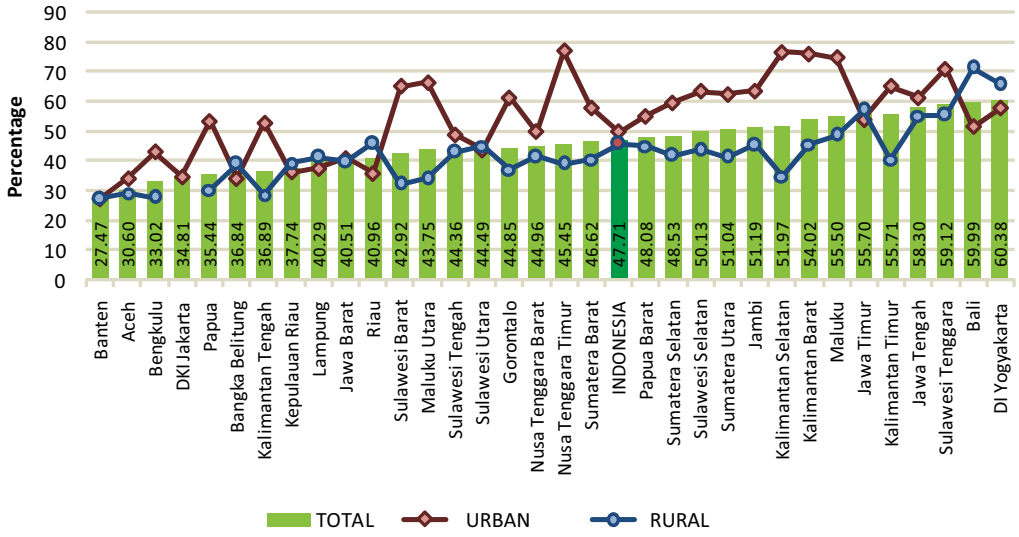


Figure 7.12. *Percentages of households with access to improved drinking water sources by urban and rural populations by province (2009)*

Source:
Susenas 2009

Sanitation

Household access to basic sanitation facilities continues to increase. *SUSENAS* data shows reasonable improvement of access to sanitation from 24.81 percent of households in 1993 to 51.19 percent in 2009 (**Figure 7.13**). Population growth is the main challenge faced in improving sanitation coverage. To continue and increase access to basic sanitation, Indonesia must give special attention to achievement of this MDG by 2015, including improving the quality of sanitation infrastructure.

There is a wide gap in terms of sustainable access to basic sanitation among provinces and between urban and rural areas. The highest level of access to basic sanitation is 80.37 percent in DKI Jakarta while the lowest level, amounting to 14.98 percent, is found

in the province of Nusa Tenggara Timur (**Figure 7.14**). There are 21 provinces with a larger gap than the national average in terms of access to basic sanitation in rural and urban areas, with the largest gaps occurring in the provinces of Kepulauan Riau, Maluku Utara and Kalimantan Barat. Nationally, some 69.51 per cent of urban populations have access to adequate sanitation facilities compared to only 33.96 percent in rural areas.

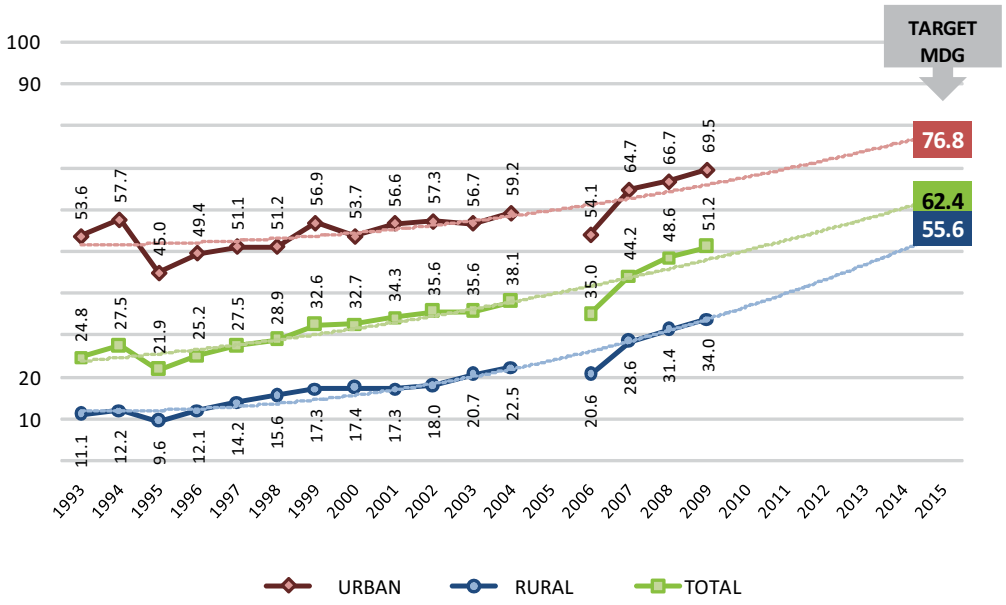


***Figure 7.13**. Proportions of rural, urban and all households with access to improved basic sanitation (1993-2009) and the MDG targets for these indicators in 2015*

Note:
Data does not include Timor Timur

***Source**:*
BPS, Susenas 1993 – 2009.

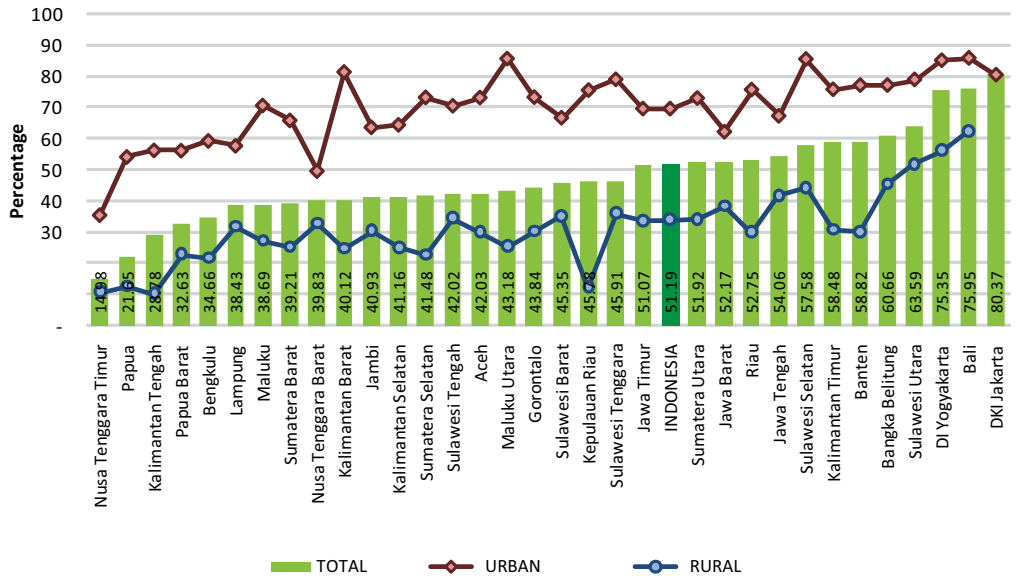


***Figure 7.14**. Proportions of households with access to improved sanitation facilities by rural/urban areas by province (2009)*

Note:
Data does not include Timor Timur

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

Box 7.2.
The success story of Lumajang District, Jawa Timur Province in achieving target 7c of the MDGs: drinking water and sanitation

Lumajang District in East Java Province has an area of 1,790.9 km^2 and about one million people living in a region dominated by plains and mountains. Efforts to improve access to safe drinking water and basic sanitation in Lumajang were initiated in 2003 through the ***Community-Based Drinking Water and Sanitation*** Program. Later in 2007, the Community-Based Total Sanitation (STBM) was introduced, using the Community Led Total Sanitation (CLTS) approach. With these programs, Lumajang has achieved a significant progress in meeting the needs of drinking water and sanitation through community empowerment activities, institutional strengthening at all levels and the campaign for improving community hygiene behavior.

After three years of STBM implementation, four of the ten sub-districts in Lumajang reached the status of Open Defecation Free (ODF) in 2009. They were Gucialit, Senduro, Padang and Kedungjajang Sub-district. In general, access to latrines in the district has reached 74 percent and the Head of Lumajang Local Government has committed to make Lumajang an ODF District by 2013.

Infrastructure provision is not only limited to latrine supply, but also includes the manufacturing of healthy latrines with different choices, ranging from the cheapest to the most expensive depending on the ability of the customer. This has changed the public's perception that making a toilet is difficult, requiring a large area and high costs.

Currently, there are four centers of the latrine industry in the district, namely Gucialit, Pasrujambe, Pasirian and Yosowilangun, that have successfully built more than 400 healthy latrines based upon requests from the community since March 2010. A network has been developed by the management in cooperation with the suppliers of building materials. On the other hand, collaboration with local leaders of the community to provide information to the public has also increased demand. As for the builders, both the management's builders and local builders have been employed. The success story of Lumajang District as a district with an innovative breakthrough in promoting community-based total sanitation was awarded the Jawa Post Autonomy Award in 2009.

In order to satisfy the needs of drinking water, development of facilities continues to take place. Tirto Lestari is one of the district-level community forums which consist of several Facility Management Unit (UPS) for drinking water. This association functions as a forum for sharing experiences and solving problems related to the actual implementation in the field, including the facilitation of village level meetings. One of the guided units, Tirta Mandiri, has succeeded in fully meeting the needs of drinking water for the community.


During Phase I (2009), a drinking water piped system of 17 kilometers from the water sources near the border of Probolinggo District has been successfully built to meet the needs of water for several community groups in three sub-districts, with a total cost of about Rp600 million. In the second phase (2010), a self-supporting drinking water network of approximately 15 kilometers which involves three sub-districts is taking place, targeted to benefit 33 groups from five villages (Gucialit, Dadapan, Kalisemut, Meraan and Krasak).

CHALLENGES

1. The regulatory framework for water supply and sanitation is still less than adequate.
2. Cross sectoral policy coordination on provision of improved facilities for water supply and sanitation is less than adequate. Many institutions and organizations are involved in development of water supply and sanitation and more intensive coordination is required.
3. The quality and quantity of drinking water in urban areas has declined. There are still many households in urban areas that rely on non-piped drinking water sources of poor quality and the demand for water exceeds the supply from these sources.
4. The growth of urban populations has been greater than the development of improved water and sanitation infrastructure. Investments in connections of urban water supply have failed to keep pace with the growth in urban populations.
5. Community awareness of the importance of clean water use and sanitation practices remains low.
6. The provision of improved drinking water by urban water utilities owned by the local governments (PDAM) and non-publically owned water supply companies (non-PDAM) is limited, especially in urban areas.
7. The capacity of local governments to ensure that improved drinking water and sanitation systems are in place or operating correctly is limited, while the supply and management of improved drinking water and sanitation has become a responsibility of regional governments.
8. Investment in improved drinking water supply and sanitations systems has been less than adequate, both from public and private sources. This results from a dependency on central government budget allocations to support initiatives related to drinking water and sanitation facilities. The weak financial performance of the PDAM is the reason why they are unable to obtain alternative financing.

POLICIES

1. Increasing coverage of improved drinking water, through: (i) the development and improvement of water systems; (ii) development and improvement of installations; (iii) development and improvement of transmission and distribution networks, especially in urban areas; and (iv) In the rural areas, the development of drinking water supply systems will be community-based with cross-sectoral support.
2. Increasing access of the community to basic sanitation, through: (i) increasing investment in the management of central wastewater systems; and (ii) provision of community based sanitation systems with special attention to provision of support to poverty households.
3. Improving the regulatory frameworks at the central and regional levels to support provision of drinking water and basic sanitation, through addition, revision, and the deregulation.

4. Ensuring the availability of drinking water, through: (i) the control of ground water use by domestic and industrial users; (ii) protection of ground and surface water sources of from domestic pollution through increased coverage of sanitation services; and (iii) the utilization of technology development and utilization of alternative water sources including water reclamation.
5. Increasing public awareness about the importance of healthy behavior (PHBS), through communication, information and education as well as infrastructure development for water supply and sanitation facilities in schools.
6. Improving the development planning system for drinking water and basic sanitation, through: (i) the preparation of the master plans for water supply systems (RIS-SPAM); (ii) preparation of City Sanitation Strategies (SSK); and (iii) monitoring and evaluating implementation.
7. Improving the management of drinking water and basic sanitation through: (i) preparation of business plans, corporatization, asset management, and capacity building of human resources for institutions and communities; (ii) increasing cooperation among government agencies, between government agencies and among the government, the private sector and the public; (iii) improved linkages between the management systems applied by the communities with government systems, and (iv) optimizing the utilization of financial resources.
8. Increase local investment spending to improve access to improved drinking water and basic sanitation that is focused on services for the urban population, especially the poor.
9. Improving the investment climate to stimulate the active participation of the private sector and the community through: (i) Public Private Partnerships, as well as Corporate Social Responsibility (CSR); and (ii) the development and marketing of appropriate technology for water supply systems and sanitation.

TARGET 7D: BY 2020, TO HAVE ACHIEVED A SIGNIFICANT IMPROVEMENT IN THE LIVES OF AT LEAST 100 MILLION SLUM DWELLERS

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
Goal 7: Ensure Environmental Sustainability						
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

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

Current Situation

The proportion of households living in urban slums[1] in Indonesia has declined from 20.75 percent in 1993 to 12.12 percent in 2009. The rapid rate of urbanization (0.96 percent) has resulted in growth in the number of urban slum dwellers in absolute terms from 2.7 million in 1993 to 3.4 million in 2009. Because of this, special efforts are required to achieve the target of improving the lives of urban slum dwellers by 2020.

Significant disparites are found among provinces in the proportion of the urban populations categorized as slum households. As seen in **Figure 7.15,** the provinces where with the highest percentage of slum households are found are Nusa Tenggara Timur, Papua and DKI Jakarta. The provinces with the lowest proportions of slum households are DI Yogyakarta, Jawa Tengah and Kalimantan Barat.

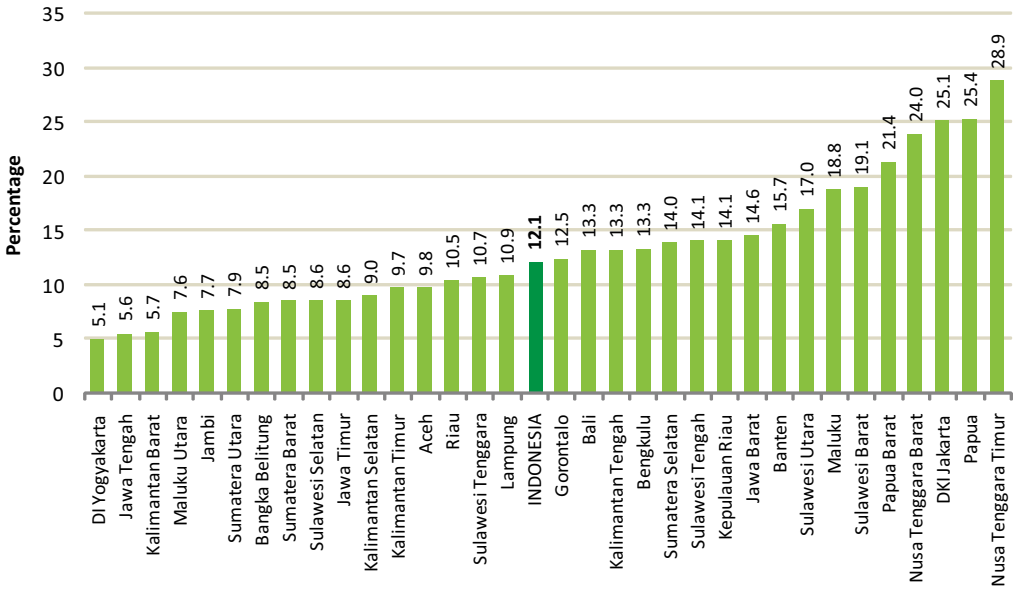


***Figure 7.15**. The proportion of urban slum households by province, 2009*

***Source**: BPS, Susenas.*

1 The indicator used to estimate the number of urban slum households refers to the definition of slums in Act No.4 of 1992 on Housing and Settlements, namely the lack of access to an improved drinking water source, lack of access to basic sanitation, less than the minimum floor area per resident of the dwelling and the durability of construction materials of the dwelling. Meanwhile, 'urban' households are those which meet the definition of this term as used by BPS. An improved source of drinking water is one located at least 10 feet from sewage and / or protected from other sources of contamination, and include piped water, public taps, boreholes or pumped water, protected wells and protected springs, well water, and rain water systems. Improved basic sanitation facilities are defined as those that are safe, hygienic, and comfortable and that protect the surrounding environment from contact with human waste, use covers with goose neck pipe connected to the sewer system or septic tank, including cemplung latrines (pit latrines) protected with a seal slab and vents, as well as composting toilets. In accordance with Permenpera No. 22/PERMEN/M/2008 on Minimum Service Standards Division Provincial Housing and Local district / city, a home can be categorized as unfit for human habitation if the residential floor area per capita is less than 7.2 square meters. The last indicator of a slum household is the durability of the materials used in construction of the dwelling including roofing in the form of palm fiber / sago palm and other, walls are of bamboo or other materials, the most extensive area of floor space is soil or other. A slum household is defined as a household which meets a minimum of two of these three classifications..

The government needs to increase efforts to accelerate the achievement of the MDG target to reduce the proportion of urban slum households. There have been many initiatives by the Government of Indonesia to reduce the proportion of urban slum households, including through the Kampung Improvement Program (KIP), urban renewal, the Urban Poverty Project (UPP), the Community-Based Initiatives for Housing and Local Development (CoBILD), the Neighborhood Upgrading and Shelter Sector Program (NUSSP) and Environmental Management for Housing and Slum-Based Regions (PLP2K-BK). In addition, there are several community empowerment programs, including the National Program for Community Empowerment (PNPM), being implemented by several ministries which have responsibilities to assist slum dwellers.

CHALLENGES

The major challenges in reducing the proportion of urban slum households in Indonesia are as follows:

1. Limited access of low-income households to land for housing in urban areas. The high rate of population growth in urban areas, the limited availability of land for housing in urban areas and the high market price for land are all factors which make it difficult for the poor to occupy decent and affordable space for housing in the urban areas. The result is that land that can be accessed by low-income households is usually marginal land or urban slum areas.
2. Limited access to housing finance. The housing finance system in Indonesia is not able to accommodate the needs for financing and home improvement and home construction in stages. Banks are generally not able to provide loans to members of the community who have no fixed income or are working in the informal sector, while most slum residents work in the informal sector.
3. Limited capacity of the government and the private sector to build houses. The formal sector, namely private developers and Perumnas, are only able to meet the needs of only about 10 percent of the total housing need each year, either through new construction or improvements in existing housing. While the gap in housing needs is met through self-help housing development. Overall, all housing needs cannot be met each year.
4. Limited provision of basic facilities for urban settlements. In general, urban slums have inadequate basic facilities and infrastructure, including drinking water facilities, roads, drainage, sanitation, electricity and other public facilities. While the government has limited capacity to develop and to manage these facilities. In addition, the role of various institutions and individuals outside of government in the provision of basic facilities and infrastructure is still very limited.
5. Previous programs have produced less than optimal results in improving the lives of slum dwellers. Handling of slums requires cross-sectoral planning and execution of activities. Lack of coordination and synergy across sectors has produced results that are less than optimal.

POLICIES

The direction of policies and strategy to reduce the proportion of households living in urban slums is as follows:

1. Increasing the provision of decent and affordable housing for low-income communities through public housing development which can be rented (Rumah Susun Sederhana Sewa – Rusunawa), facilitation of new development / improvement of the quality of self-help housing and the provision of infrastructure, facilities and utilities and other initiatives to increase access to land in urban areas.
2. Increasing the accessibility of low income households to decent and affordable housing through a liquidity facility, micro-credit housing and the national housing savings program.
3. Improving the quality of residential environments through the provision of infrastructure, basic facilities, and adequate public utilities, integrated with real estate development in order to achieve cities without slums.
4. Improving the quality of planning and implementation of housing and human settlements through capacity building and coordination of various stakeholders in housing and settlement development and the preparation of action plans to improve the lives of slum dwellers.

GOAL 8 :
DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

JAKARTA COMMITMENT:

AID FOR DEVELOPMENT EFFECTIVENESS INDONESIA'S ROAD MAP TO 2014

GOVERNMENT OF INDONESIA AND ITS DEVELOPMENT PARTNERS

I. Strengthening Country Ownership over Development
   a. strengthening capacities and using stronger government systems
   b. improving the international governance of aid and strengthening south-south cooperation

II. Building More effective and inclusive partnerships for development
   a. developing a new partnership paradigm
   b. strengthening existing aid instruments and shaping new ones
   c. expanding dialogue to include new actors

III. Delivering and accounting for Development results
   a. strengthening focus on, and capacity to manage by, development results
   b. working together to review progress across development partnerships

GOAL 8:
DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGET 8A DEVELOP FURTHER AN OPEN, RULE-BASED, PREDICTABLE, NON-DISCRIMINATORY TRADING AND FINANCIAL SYSTEM

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
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	▶	

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

CURRENT SITUATION

Greater economic openness supported by an improved regulatory framework for trade has yielded benefits in expanding international trade and improving the quality of economic growth in Indonesia. The volume of Indonesian trade has increased substantially since 1980 and has led to growth of the national economy and the expansion of employment opportunities.

The indicator for economic openness is calculated as the ratio of national exports and imports to GDP, and it has shown improvement. In recent years, the average level of Indonesian economic openness reached 45 percent. For the 1990-2008 period, the indicator has shown a positive trend from 41.6 percent recorded in 1990 to a level of 46.9 percent in 2008 **(Figure 8.1)**. However, in 2009 the level of economic openness dropped to 39.5 percent as a result of the global economic crisis that impacted negatively on the performance of Indonesian exports and imports.

In recent years, there has been some diversification of the market destinations of Indonesian exports resulting from the broadening and strengthening of international trade cooperation. Indonesia's five main non-oil and gas export destinations are Japan, the United States, China, India and Singapore. However, in recent years, non-oil and gas exports to these traditional markets have been decreasing while other export markets have been increasing. The shares of non-oil and gas exports to traditional export destinations

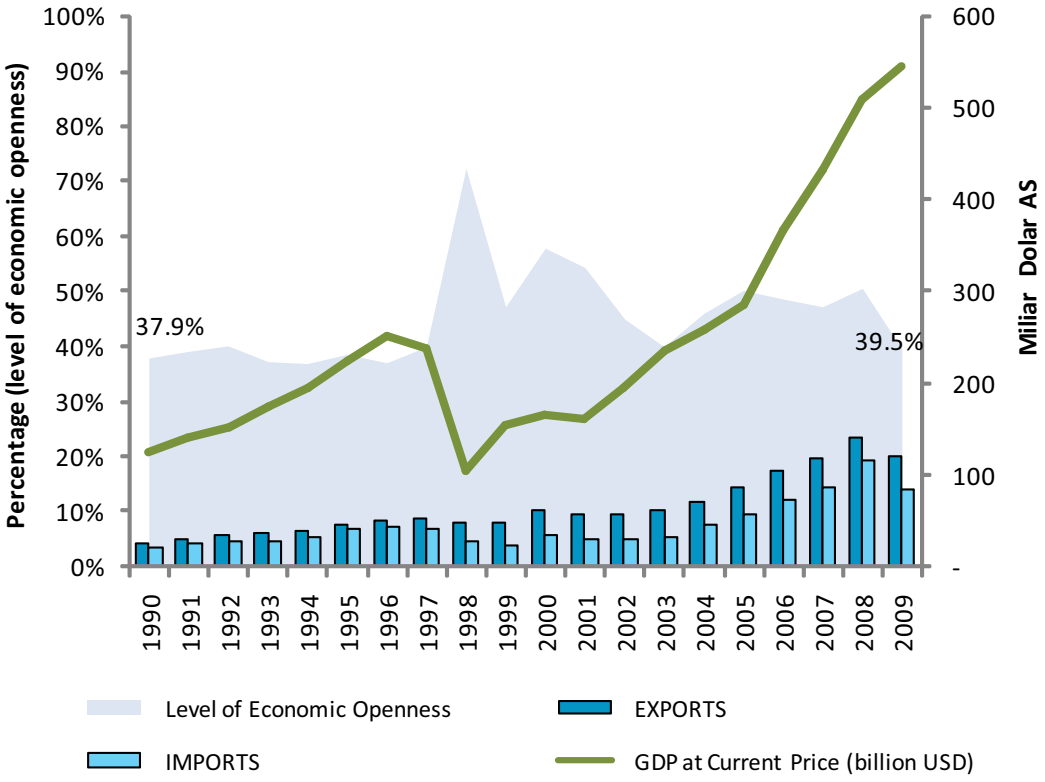


Figure 8.1. *The trends for imports, exports, GDP growth and the ratio of imports and exports to GDP as the MDG indicator for economic openness*

Source: *BPS and the World Bank, 2009 .*

have decreased from 50.2 percent in 2000 to 47.9 percent in 2009, while China's position as a primary destination for Indonesian exports has improved. In 2009, ten countries as the primary destinations of Indonesian exports received 67.6 percent of Indonesian exports (see **Table 8.1**). On the other hand, ten countries as the main sources of Indonesian imports contributed to 75.7 percent of Indonesian imports in the same year.

Table 8.1. *Ranking of the ten countries which were the main destinations of Indonesian non-oil and gas exports and the origin of Indonesian non-oil and gas imports in 2009*

Source: *Ministry of Trade (computed by Bappenas), 2010 .*

Indonesian non-oil and gas exports			Indonesian non-oil and gas imports		
Country of Destination	Percent Share (%)	Percent Cumulative Share (%)	Country of Origin	Percent Share (%)	Percent Cumulative Share (%)
1. Japan	12.29	12.29	1. China	17.33	17.33
2. USA	10.74	23.03	2. Japan	12.60	29.93
3. China	9.15	32.18	3. Singapore*	11.86	41.79
4. Singapore*	8.15	40.33	4. USA	9.04	50.83
5. India	7.54	47.87	5. Thailand*	5.87	56.70
6. Malaysia*	5.78	53.65	6. South Korea	4.89	61.59
7. South Korea	5.31	58.96	7. Australia	4.33	65.92
8. Netherlands	2.98	61.94	8. Malaysia*	4.09	70.01
9. Taiwan	2.95	64.89	9. Germany	3.03	73.04
10. Thailand*	2.67	67.56	10. India	2.67	75.71

**Members of ASEAN*

Comprehensive reforms in Indonesia's financial sector, particularly in the banking

sector, have been established based on the difficult lessons of the economic crisis of 1997/1998, including by strengthening the resilience of the banking industry through higher capitalization and better supervision. Therefore, the Bank of Indonesia and the Government continue to improve the regulatory framework and supervision of the banking sector while providing room for bank intermediation.

Banking resilience is reflected by several indicators which, among others, include the capital adequacy ratio (CAR) ranging from 16-20 percent, much higher than the minimum requirement of 8.0 percent. The ratio shows that in general national banks have enough strength to face potential risks in the future.

The improved banking resilience has been able to maintain public confidence in the banking industry. On the funding side, total third party funds (deposits) collected by national banks was Rp 1,973 trillion in 2009 while the credit disbursement reached Rp 1,437 trillion in the same year. Along with that, the function of banking intermediation continues to improve as reflected by the increasing loan to deposit ratio (LDR).

Indicators	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Assets (trillions of Rp)	1,030.5	1,099.7	1,112.2	1,196.2	1,272.3	1,469.8	1,693.5	1,986.5	2,310.6	2,534.1
Deposits (trillions of Rp)	699.1	797.4	835.8	888.6	963.1	1,127.9	1,287.0	1,510.7	1,753.3	1,973.0
Credits (trillions of Rp)	320.5	358.6	410.3	477.2	595.1	730.2	832.9	1,045.7	1,353.6	1,437.9
Loan to Deposit Ratio – LDR (%)	45.8	45.0	49.1	53.7	61.8	64.7	64.7	69.2	77.2	72.8
Return on Assets – ROA (%)	0.9	1.4	1.9	2.5	3.5	2.6	2.6	2.8	2.3	2.6
Non-Performing Loans – NPL (%)	18.8	12.1	8.1	8.2	5.8	8,0	6.1	4,1	3.2	3.3
Capital Adequacy Ratio – CAR (%)	12.7	20.5	22.5	19.4	19.4	19.5	20.5	19.2	16.8	17.4

***Table 8.2**. Selected indicators of the condition of commercial banks in Indonesia, 2000 – 2009*

***Source**: Bank of Indonesia, Indonesian Banking Statistics .*

In the period following the economic crisis, the LDR for commercial banks and rural banks continued to show a positive trend. Deposits and loans have sharply increased in recent years. In line with this trend, the LDR for commercial banks increased steadily from 45.8 percent in 2000 to 72.8 percent in 2009 (see **Table 8.2**). As for micro financing, credit disbursement by rural banks has risen to Rp 28.0 trillion in 2009, from approximately Rp 25.47 trillion recorded in 2008. The deposits of rural banks also increased from Rp 21.34 trillion to Rp 25.55 trillion during the same period. As a consequence, the LDR for rural banks increased significantly to 109.0 percent by the end of 2009 **(Table 8.3)**.

Indicators	2003	2004	2005	2006	2007	2008	2009
Total Number of Rural Banks	2,141	2,158	2,009	1,880	1,817	1,772	1,773
Total Assets (billions of Rp)	12,635	16,707	20,393	23,045	27,741	32,533	37,554
Deposits (billions of Rp)	8,868	11,161	13,168	15,771	18,719	21,339	25,552
Credits (billions of Rp)	8,985	12,149	14,654	16,948	20,540	25,472	28,001
Loan to Deposit Ratio – LDR (%)	101.32	108.85	111.2	107.46	109.73	119.37	109.6
Non-Performing Loans – NPL (%)	7.96	7.59	7.97	9.73	9.98	9.88	6.9

***Table 8.3**. Selected indicators of the condition of rural banks in Indonesia, 2003 – 2009*

***Source**: Indonesian Banking Statistics, Bank of Indonesia*

CHALLENGES

The global economic crisis in 2007-2008 resulted in the contraction of world trade by 12.2 percent in the year of 2009 (WTO). Yet, in the future the trade volume is expected to recover because global demand is expected to increase in 2010 along with the global economic recovery.

Another challenge in the future is to finalize negotiations on the Doha Round which have now lasted for eight years without reaching an agreement. The Doha development agreement will provide a strong foundation for global economic recovery and sustained growth. Challenges in the future that need to be a focus of attention include enhanced market access, balanced and well targeted rules, sustainably financed technical assistance and capacity building programs.

In addition, a national challenge remaining today is the poor performance of Indonesian logistics sector due to the high cost of logistics and the need to increase service quality. Based on the Logistics Performance Index (LPI) survey from the World Bank in 2007, Indonesia ranked 43rd of 150 countries surveyed, below Singapore (ranked 1st), Malaysia (ranked 27th) and Thailand (ranked 31st). The survey also revealed that Indonesian domestic logistics costs index was in the 93rd position, showing that domestic logistics costs in Indonesia were still high. In the latest survey, Indonesia has dropped to the 75th position, but still remains below the performance levels of several Southeast Asian countries (World Bank, 2009).

The main challenge in further developing rule-based, predictable and non-discriminatory financial systems, among others, are:

1. **Banking intermediary function is not yet optimized.** Although the Loan to Deposit Ratio (LDR) for commercial banks has a tendency to increase from year to year, this has not been accompanied by increasing investment loans. The low composition of investment loans can not be separated from the structure of deposits in banks which are mostly short-term funds with a maturity of one to three months so that there is the potential for funding mismatches in the long-term. Besides, the magnitude of the spread between lending and deposit interest rates is anticipated to be one cause of low impact of investment lending in banks to real sector growth.

2. **In micro lending to Small and Medium Enterprises (MSMEs),** several obstacles are still encountered, among others: (i) a lack of collateral owned by the MSMEs, so that MSMEs which have potential are deemed not bankable; (ii) high transaction fees; and (iii) poor quality of human resources (HR) in micro-finance institutions (*LKM*).

3. **In terms of micro-finance, the performance of rural banks (*Bank Perkreditan Rakyat - BPR*) has improved.** The advantages of rural banks compared to commercial banks are the services they provide to SMEs and low income people by prioritizing intimacy through direct services (door to door), and a personal approach with attention to local culture. However, due to a lack of information about the businesses owned by their customers, there is a tendency for the rural banks to focus on clients considered to be more bankable. In terms of micro-finance institutions in the form of non-banks

and non-cooperatives (*B3K*), obstacles are found in the legality aspect, regulation, supervision and other infrastructures that support the institution of Apex Bank and micro-insurance.

4. **There is a sense of urgency to establish an institution whose function is to supervise the overall health and stability of the financial system, especially in the wake of the global financial crisis**.

Policies

The Government continues to improve the ratio of exports and imports to GDP by improving the competitiveness of non-oil export products through market diversification and increasing the diversification and quality of products.

Based on the latest developments and problems faced by the financial sector, the direction of financial sector development for the 2010-2014 period is to improve the competitiveness and resilience of the financial sector for financing national development through, among others, increased economic stability and consolidating the performance and stability of the financial services industry. In addition, the Government also seeks to accelerate the intermediation function and distribution of public funds, including improved access to financial services institutions (*LJK*) for the poor.

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

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
Goal 8: Develop a Global Partnership for Development						
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

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

Current Situation

To satisfy the needs of national development, in addition to internal funding sources, borrowing still plays an important role although the proportion of debt to GDP continues to decline as mandated by the National Medium-Term Development Plan for 2010-2014. The Government always keeps the level of its debt through maintaining the net additional

debt for financing needs at a prudent level while implementing sound practices of debt management.

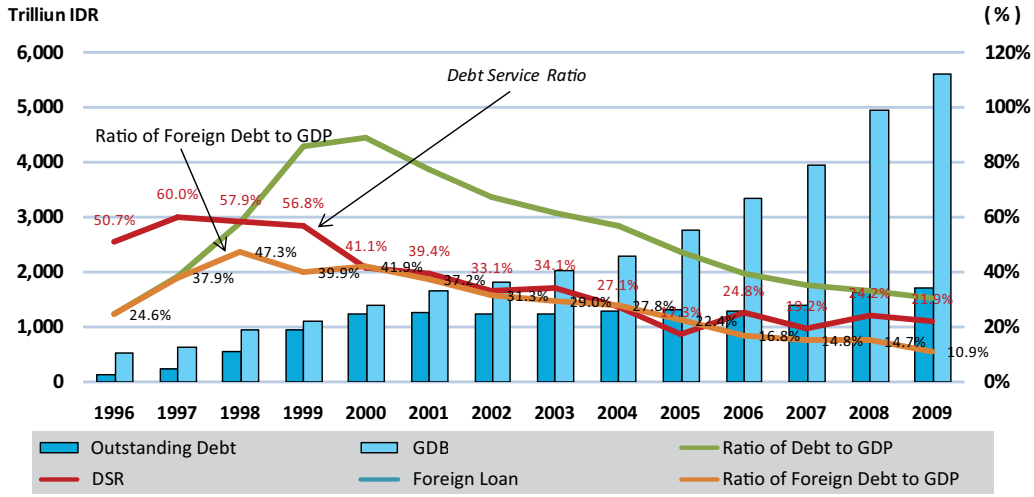


***Figure 8.2**. The trend of foreign debt to GDP and the Debt Service Ratio (DSR) during 1996-2009*

***Source**: Bank of Indonesia, Indonesian Economic Report, 2008; Bank of Indonesia, Statistics of Foreign Debt; and Ministry of Finance, 2010 .*

As a result, the ratio of debt stock consisting of Government Bonds and Foreign Debt to GDP had declined from a peak of 89 percent in 2000 to 30 percent in 2009. Meanwhile, the ratio of foreign debt stock to GDP fell from 24.59 percent in 1996 to only 10.89 percent in 2009 (**Figure 8.2**). These declining figures indicate the Government's increasing solvency as the effects of debt repayment to the economy is decreasing and fiscal sustainability is improving.

Foreign debt burden can also be seen from the ratio of principal and interest payments of foreign debt to exports revenue or the Debt Service Ratio (DSR). Along with the falling ratio of the Government debt stock to GDP, the DSR also declined after having reached a maximum of 60 percent in the crisis years, a level of 19.4 percent was recorded in 2007 and a level of 22 percent was recorded in 2009. In 2007, the DSR was 19.4 percent; and it reached 22 percent in 2009.

Despite unfavorable international capital markets in recent years, Indonesia has still been able to fulfill its financing needs through government bond issuance and external borrowing. The confidence of the market is increasing and this is demonstrated by the market's acceptance of international sovereign bonds issued at favorable rates. This also indicates Indonesia's resilience to the impact of the global financial crisis.

CHALLENGES

Accelerating national development to achieve the target growth rate of 6.3-6.8 percent per year during the 2010-2014 period is a major challenge for the Government. To deal with this challenge, the Government needs to find alternative sources of potential funding. In addition, it is necessary to build the national capacity to utilize all the existing resources effectively.

The Government also attempts to find alternative sources of funding which have low risks, are inexpensive and do not have a political agenda. Along with these efforts, the Government faces some challenges in the increasing market volatility and the decreasing availability of multilateral lending. By graduating from the status of Lower Middle Income Country (LMIC), low-cost funding sources are increasingly rare. This is a challenge for the Government to allocate the sources of funding more effectively, by achieving efficient cost and manageable risks within the dynamic of financial markets

POLICIES

Indonesia has graduated from the status of Lower Middle Income Country (LMIC) and will no longer be eligible to receive loans with the lowest interest rates and longer maturity from the multilateral and some bilateral lending institutions. Priorities of the Government in the management of loans and grants from multilateral and bilateral institutions for the coming years are as follows: (i) use of loans and grants to support achievement of the development targets in accordance with the National Medium-Term Development Plan and in harmony with Indonesia's commitment to achieve the MDGs; (ii) reduce the ratio of international debt to GDP while continuing to maintain a condition of negative net transfers; (iii) further improve the regulations and laws relating to international loans and grants; (iv) increase national ownership and application of improved national procedures for management of international funding; and (v) strengthen national capacity to manage programming and utilization of development funding effectively.

Box 8.1.
The Jakarta Commitment

The Government of Indonesia as a signatory to the Monterrey Consensus (2002) and the Paris Declaration on Aid Effectiveness (2005) is fully committed to the principles of aid effectiveness. Indonesia has been an active participant in the regional preparations for the Third High Level Forum on Aid Effectiveness (2008). In 2009, the Government and 26 key international development partners signed the "Jakarta Commitment: Aid for Development Effectiveness - Indonesia's Road Map to 2014". The Jakarta Commitment supports Indonesia's efforts to maximize the effectiveness of foreign aid in supporting development and defining the policy direction to achieve greater development effectiveness by 2014 and beyond. The roadmap for aid effectiveness sets out the strategic vision that Indonesia, along with development partners, have committed to. The agenda is based on the principles of the Paris Declaration and the Accra Agenda for Action commitments. The program will work to: (i) increase the utilization of international assistance in support of implementation of the National Medium-Term Development Plan; (ii) increase national ownership of development assistance; (iii) encourage and assist development partners to follow regulations and mechanisms established by the Government; (iv) support inclusion of development assistance in the national budget (APBN); and (v) encourage development partners to adopt "untied" systems.

The Jakarta Commitment is based on the spirit of mutual respect, support and accountability and will be implemented to achieve greater benefits in the achievement of Indonesia's development objectives, including the MDGs. It enjoins upon the Government and development partners to make available appropriate resources, knowledge and capacity to implement the Jakarta Commitment. The three main components of the Jakarta Commitment are as follows: (i) Strengthening Country Ownership over Development; (ii) Building More Effective and Inclusive Partnerships for Development; and (iii) Delivering and Accounting for Development Results.

The Government has established a Secretariat for Aid for Development Effectiveness (A4DES) to support implementation of the Jakarta Commitment. The A4DES Secretariat has established six thematic working groups comprised of representatives from the Government and development partners. The Working Groups function as forums for sharing information, discussing achievements and challenges, and reaching agreements on common steps to be taken to fully achieve the goals of the Jakarta Commitment. The thematic Working Groups are addressing issues and formulating policy recommendations related to: (i) procurement; (ii) public financial management; (iii) dialogue and institutional development; (iv) development of financing mechanisms; (v) monitoring and evaluation; (vi) capacity building and knowledge management.

TARGET 8F: IN COOPERATION WITH THE PRIVATE SECTOR, MAKE AVAILABLE THE BENEFITS OF NEW TECHNOLOGIES, ESPECIALLY INFORMATION AND COMMUNICATIONS

Indicators		Baseline	Current	MDGs Target 2015	Status	Source
Goal 8: Develop a Global Partnership for Development						
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%	▶	Min. of Comm & Info Technology, 2010
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

CURRENT SITUATION

The evaluation of the results of the implementation of communications and information development during the 2005-2009 period shows that the total teledensity of telecommunications access per 100 population has grown by approximately 212 percent, from 27.61 percent (2005) to 86.06[1] percent (2009) with the proportion of the wireless network reaching up to 95.8 percent (2009). The high deployment of wireless services, mainly cellular, is brought about by the decline in tariffs to 90 percent from USD 0.15/min in 2005 (the most expensive in Asia) to USD 0.015/min in the year of 2008 (the cheapest in Asia). This resulted from a full competition-based management and implementation of cost-based interconnection.

On the other hand, there are still huge disparities in the availability of the infrastructures; about 85 percent of the telecommunication infrastructures are concentrated in western Indonesia and there are still more than 30 thousand villages that do not have telecommunications facilities. The availability of internet access remains

1 Based on the number issued

limited, reaching only 11.51 percent of all national households. This is also true with the broadband infrastructure as the future infrastructure of communications and information which is still very limited, reaching only about one percent of the population and mostly taking the form of wireless broadband.

Meanwhile, in terms of the utilization of services, the 2005-2009 evaluation results show that the level of public e-literacy remains low so that the utilization of communications and information infrastructures and services has been inclined to be of a more consumptive nature and even begun to cause public unrest as a result of misuse and abuse of communications and information technology (ICT) in the form of fraud, identity theft, terrorism and pornography.

CHALLENGES

The challenges faced in the development of communications and information, especially during the 2009-2010 period, are as follows:

1. **Improving the management of limited resources**

   As the wireless network usage increases, the need for the spectrum of radio frequencies has also increased. Therefore, management of the spectrum of radio frequencies as a limited resource needs to be optimized to increase the efficiency of its allocation and utilization. The challenge faced today is the high level of illegal utilization of the radio frequencies spectrum. The violation has generated inefficiency in allocation and utilization of the spectrum of radio frequencies, the low quality of service due to the interference, and potential threats in case of interference with flight communications systems, services systems, search and rescue systems as well as security systems. On the other hand, service providers are also required to achieve efficient management of other limited resources.

2. **Promoting equitable infrastructures**

   The provision of communications and information infrastructures has not met the public needs optimally. The uneven distribution of ICT infrastructures, mostly concentrated in commercial areas (urban areas and western Indonesia), and the high cost of ICT services for the majority of the people have resulted in inequality (asymmetry) of information. The underdeveloped broadband infrastructures that may actually enable exchange of information in the form of voice, data and images (triple play) simultaneously at a high speed as well as the unintegrated infrastructures development into the communications and information convergence have resulted in ineffective infrastructures provision. The development of national broadband infrastructures, which currently reach only one percent of the population, should be carried out intensively and evenly given the important role it plays in improving the nation's competitiveness.

3. **Increasing the development of domestic manufacturing industries, applications, and local contents to spur demand**

   The high dependence on overseas manufacturing industries can be seen from the low

contributions/shares of the domestic industry in the capital expenditure of the national ICT infrastructures, especially telecommunications. Of the ten sector groups[2], the creative industry employment has recorded the third largest growth of 8.10 percent during the 2002-2006 period. As for the fourteen groups[3] of creative industries, employment for computer and software services has experienced the highest increase of 25.87 percent over the same period. However, this has not been accompanied by improvement in a number of issues such as law enforcement and legal protection for intellectual property rights, incubation of innovations and also development of local contents. The limited availability of contents which use Indonesian language designed to meet the public needs in particular fields (for instance: fisheries, forestry, plantation and agriculture) has inhibited the penetration of ICT in economic activities.

POLICIES

In order to achieve the information society of Indonesia, the development of communications and information during the 2010-2014 period is aimed at strengthening virtual domestic connectivity and increasing the utilization of ICT which is focused on: (1) continuing the efforts to reduce blank spots and digital gaps among regions in Indonesia; (2) facilitating the development of modern communications and information infrastructures which is carried out, among others, through facilitating the development of broadband access networks and digital TV; and (3) enhancing the supply and utilization of information and effective use of ICT as well as improving the quality of ICT human resources through the development of e-government and e-literacy.

2 The ten sectors are: (a) forestry, fisheries; (b) trade, hotels and restaurants; (c) public services; (d) processing industry; (e) transportation and communication; (f) buildings; (g) creative industry; (h) finance, real estate; (i) mining; (j) electricity, gas and water supply.

3 The fourteen groups of creative industry include: (a) advertising; (b) architecture; (c) art and antiques market; (d) craft; (e) design; (f) fashion design; (g) film, video and photography; (h) interactive games; (i) music; (j) performing arts; (k), publishing and printing; (l) computer and software services; (m) TV and radio; and (n) research and development.

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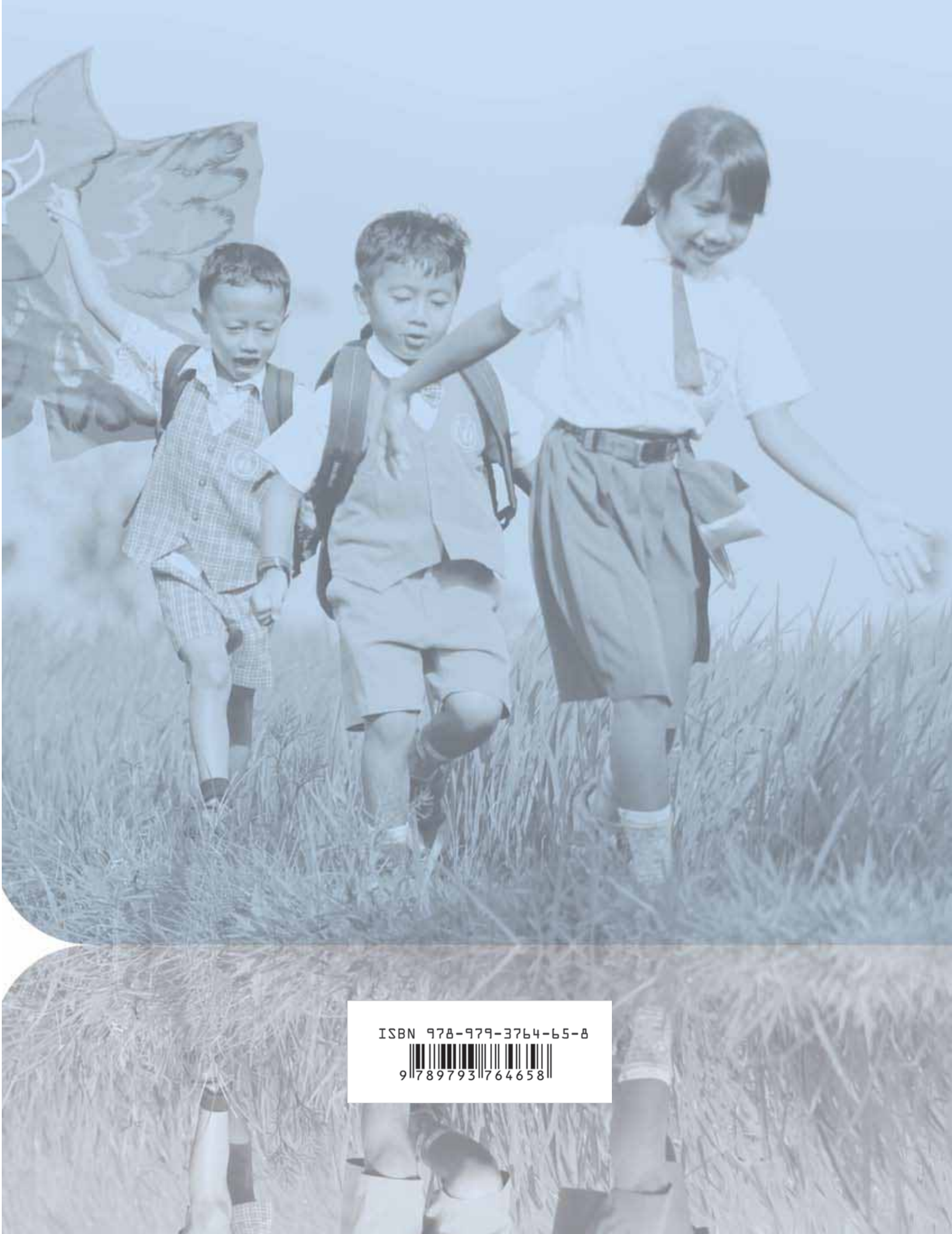
Photo credits

Cover	Student	Kementrian Pendidikan Nasional
Goal 1	PNPM Mandiri-Rural (infrastructure); Road Project at Tabanan, Bali	World Bank
Target 1A	RESPEK Program; Community attended a meeting to discuss RESPEK Program or Strategic Plan for Village Development. It is one of PNPM Mandiri-Rural pilots, initiated by Papua and West Papua Provincial Government to spur village development.	World Bank
Goal 2	Future Vision; With over 46 million students and 2.7 million teachers in more than 250,000 schools, Indonesia is the third largest education system in the Asia region and the fourth largest in the world behind China, India and the United State.	Amanda Beatty/ World Bank
Goal 2	Community-led pre-schools; More children from poor families need access to early education so they can be ready for school.	Luc– Charles Gacougnolle / World Bank
Goal 3	Boys and girls at elementary school dan Staff of geothermal in North Sulawesi	Asian Development Bank
Goal 4	PNPM Health & Bright Generation (Weighing Children at Health Post in Magetan, East Java).	World Bank
Goal 4	Posyandu.	Kementrian Kesehatan
Goal 5	Puskesmas: The “spearhead” of health service; Puskesmas (Community Health Center) remains the largest network of public health services providing primary level of care in Indonesia. The network comprises more than 8,000 Puskesmas, and 22,200 auxiliary health centers. In this picture a patient receives information about the importance to comply and to finish the 6-month TB treatment (DOTS) from Puskesmas nurses	Josh Estey / World Bank
Goal 6	KAMPANYE PEDULI HIV/AIDS. Mahasiswa Unika Atma Jaya Jakarta mengelar aksi kampanye peduli HIV/AIDS di Bundaran HI, Jakarta Pusat, Minggu (29/11). Kampanye tersebut dalam rangka menyambut hari HIV/AIDS se-dunia 1 Desembe mendatang serta mengajak masyarakat agar tidak mendiskriminasikan pengidap virus HIV/AIDS.	ANATARA / Yudhi Mahatma
Goal 7	Geothermal in North Sulawesi	Asian Development Bank
Goal 7	Nurseries developed by the community; Members of a community, men and women, take active and participative role in the process of planning, implementation of making seedlings, planting, plant maintenance and marketing of harvested goods. This effort aims to increase the welfare of the community by applying sustainable forestry management. The AFEP-FFI program is a strategy to prevent community members to seek for livelihoods that can destroy the forest such as illegal logging and traditional gold mining in the village of Krueng Sabee, Aceh Jaya District.	Yasser Premana / Multidonor (MDF)
Target 7C	Indonesia Water Supply and Sanitation Formulation and Action Planning Facility	Waspola
Goal 8	The Jakarta Commitment	Bappenas
Goal 8	Kids playing internet; Small grants disbursed through Strengthening the Capacity of Civil Society Organizations Project have afforded these children the opportunity to gain valuable computer skills at an early age. Through the project, 141 small grants have been provided to CSOs to support income generation, basic social services, and specific women-led activities in communities. ©Chaideer Mahyuddin	Chaideer Mahyuddin/ Multidonor (MDF)



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