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REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS IN INDONESIA 2011

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Foreword

Indonesia being a signatory to the Millennium Declaration of 2000 along with 189 other countries did not necessarily transpire because of the Millennium Development Goals (MDGs) per se; it was rather because the belief that the MDGs are indeed in step with Indonesia's development goals. With that in mind, the Government of Indonesia has proceeded to mainstream the MDGs across the board, i.e. from development programming to development implementation, as is evident in its Long Term Development Plan for 2005-2025, the National Medium Term Development Plans for 2004-2009 and 2010-2014, and the Annual Working Plans and corresponding budgeting documents. Based on pro-growth, pro-job, pro-poor, and pro-environment strategies, funding allocations in both national and sub-national budgets in support of achieving the MDGs have been on the rise annually. Productive partnerships with the civil society and the private sector have likewise contributed to accelerated achievement of the MDGs.

This Report on The Achievement of The Millennium Development Goals in Indonesia 2011 is the seventh edition of its kind that has been published nationwide since its first publication in 2004. It aims to inform on the progress that we have collectively made and to demonstrate the people's commitment to bringing the United Nations Millennium Declaration of 2000 to fruition. Moreover, it summarizes the conditions, trends, and significant efforts on the acceleration of the goal achievement as of 2011, to be used as a basis to develop efforts required to achieve the MDG targets by 2015.

The Report was prepared by a Team comprising a Steering Team and a Technical Team/ Working Group that reported to the Minister of National Development Planning/Head of BAPPENAS. Our utmost appreciation and gratitude goes to members of the Writing Team for their hard work and contribution to finalize this MDGs Report.

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- Dr. Ir. Lukita Dinarsyah Tuwo, MA and Dra. Nina Sardjunani, MA for coordinating the writing process while at the same time performing quality assurance with regard to the content of the Report on The Achievement of The Millennium Development Goals in Indonesia 2011.
- The Coordinating Ministry for People's Welfare, the Ministry of Education and Culture, the Ministry of Religious Affairs, the Ministry of Women's Empowerment and Children's Protection, the Ministry of Health, the National Population and Family Planning Board, National Agency of Drug and Food Control, the Ministry of the Environment, the Ministry of Energy and Mineral Resources, the Ministry of Forestry, the Ministry of Public Works, the Ministry of Community Housing, the Ministry of Agricultural Affairs, the Ministry of Marine Affairs and Fisheries, the Ministry of Finance, the Ministry of Communications and Information, the Ministry of Foreign Affairs, the Bank of Indonesia, the National Election Commission, and the Central Bureau of Statistics for data, information, and content contributions.

- Our gratitude goes also to our development partner the United Nations Development Programme (UNDP) for its support to the writing process of this MDGs Report, and as well as to all other parties too many to mention one by one.

Let's hope that it will make a valuable contribution to the Indonesian nation with regard to achieving stronger human development and a more prosperous community in times to come.

Prof. Dr. Armida S. Alisjahbana, SE, MA
Minister of National Development Planning/
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Acronyms

ABAT	*Aku Bangga Aku Tahu* (I Know and I'm Proud Of It)
AKBA	*Angka Kematian Balita* (Under Five Mortality Rate)
APBD	*Anggaran Pendapatan dan Belanja Daerah* (Regional Budget)
APBN	*Anggaran Pendapatan dan Belanja Nasional* (State Budget)
APK	*Angka Partisipasi Kasar* (Gross Enrollment Ratio)
APM	*Angka Partisipasi Murni* (Net Enrollment Ratio)
APS	*Angka Partisipasi Sekolah* (School Enrollment Ratio)
ARG	*Anggaran Responsif Gender* (Gender Responsive Budget)
ART	Antiretroviral treatment
ARV	Antiretroviral
ASEAN	Association of South-East Asian Nations
ASFR	Age Specific Fertility Rate
ASI	*Air Susu Ibu* (breast milk)
Balita	*Bawah lima tahun* (under-five)
Bappenas	*Badan Perencanaan Pembangunan Nasional* (National Development Planning Agency)
BBLR	*Berat Badan Lahir Rendah* (Low Birth Weight)
BBM	*Bahan Bakar Minyak* (oil fuel)
BCG	Bacillus Calmette-Guerin
BKKBN	*Badan Kependudukan dan Keluarga Berencana Nasional* (National Population and Family Planning Board)
BLM	*Bantuan Langsung Masyarakat* (Direct Block Grant)
BOK	*Bantuan Operasional Kesehatan* (Health Operational Assistance)
BOS	*Bantuan Operasional Sekolah* (School Operational Assistance)
BP3AKB	*Badan Pemberdayaan Perempuan, Perlindungan Anak, dan Keluarga Berencana* (Women's Empowerment, Children's Protection, and Family Planning Board)
BPD	*Bank Pembangunan Daerah* (Local Development Bank)
BPO	*Bahan Perusak Ozon* (Ozone-depleting Substances)
BPR	*Bank Perkreditan Rakyat* (People's Credit Bank)
BPS	*Badan Pusat Statistik* (Central Board of Statistic)
Perum Bulog	*Perusahaan Umum Bulog or Badan Urusan Logistik* (Logistics AffairsBoard)
BUMN	*Badan Usaha Milik Negara* (Government-owned Corporation)
CAR	Capital Adequacy Ratio
CBEIS	Community-Based Education Information System
CDR	Case Detection Rate
CFCD	Corporate Forum for Community Development
CFCs	Chlorofluorocarbons
CLTS	Community Led Total Sanitation
CO2	Carbon dioxide
CPE	Customer Premises Equipment
CPR	Contraceptive Prevalence Rate
CSR	Corporate Social Responsibility
CTU	Contraceptive Technology Update
DAD	*Dana Alokasi Desa* (Village Allocation Fund)
DAK	*Dana Alokasi Khusus* (Special Allocation Fund)
Desa Pinter	*Desa Punya Internet* (Village with Internet Access)
DO	*Definisi Operasional* (Operational Definition)
DOTS	Directly Observed Treatment, Shortcourse

DPR	*Dewan Perwakilan Rakyat* (House of People's Representatives)
DPT-HB	Diphtheria-Pertussis-Tetanus – Hepatitis B
DSR	Debt Service Ratio
Fasyankes	*Fasilitas pelayanan kesehatan* (Health Service Facility)
FWT	Fixed Wireless Telephone
GBS	Gender Budget Statement
GPI	Gender Parity Index
GRK	*Gas Rumah Kaca* (Greenhouse Gas)
GWM LDR	Giro Wajib Minimum Loan to Deposit ratio / Minimum Obligatory Reserves Loan to Deposit Ratio
HCFCs	Hydrochlorofluorocarbons
HIV/Aids	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HPB	*Harga pembelian beras* (rice purchase price)
HPMP	HCFC Phase-out Management Plan
IIX	Indonesia Internet Exchange
IPG	Indeks Paritas Gender (Gender Parity Index)
Jamkesda	*Jaminan kesehatan daerah* (local health security)
Jamkesmas	*Jaminan kesehatan masyarakat* (community health security)
Jampersal	*Jaminan Persalinan* (childbirth security)
JPS	Jaring Pengaman Sosial (social security net)
K1	*Kunjungan kehamilan ke-1* (1st pregnancy visit)
K4	*Kunjungan kehamilan ke-4* (4th pregnancy visit)
KB	*Keluarga Berencana* (family planning)
Kemendagri	*Kementerian Dalam Negeri* (Ministry ofHome Affairs)
Kemdikbud	*Kementerian Pendidikan dan Kebudayaan* (Ministry of Education and Culture)
Kemenhut	*Kementerian Kehutanan* (Ministry for Forestry Affairs)
Kemenkes	*Kementerian Kesehatan* (Ministry of Health Affairs)
Kemenkeu	*Kementerian Keuangan* (Ministry of Finance)
Kemenkokesra	*Kementerian Koordinator Bidang Kesejahteraan Rakyat* (Coordinating Ministry for People's Welfare)
Kemen PPN	*Kementerian Perencanaan Pembangunan Nasional* (Ministry of National Development Planning)
Kemen PU	*Kementerian Pekerjaan Umum* (Ministry of Public Works)
Kementan	*Kementerian Pertanian* (Ministry of Agricultural Affairs)
Kominfo	*Kementerian Komunikasi dan Informasi* (Ministry of Communications and Information)
KH	*Kelahiran Hidup* (live birth)
KIA	*Kesehatan Ibu dan Anak* (Maternal and Child Health)
KIE	*Komunikasi, Informasi dan Edukasi* (communication, information and education)
KKP	*Kementerian Kelautan dan Perikanan* (Ministry of Marine Affairs and Fisheries)
KLB	*Kejadian Luar Biasa* (extraordinary event)
KLH	*Kementerian Lingkungan Hidup* (Ministry of Environment)
KPP&PA	*Kementerian Pemberdayaan Perempuan dan Perlindungan Anak* (Ministry of Women's Empowerment and Children's Protection)
KPU	*Komisi Pemilihan Umum* (General Elections Commission)
KRR	*Kesehatan Reproduksi Remaja* (Adolescent Reproductive Health)
KS-1	*Keluarga Sejahtera I* (Welfare Family I)
KUR	*Kredit Usaha Rakyat* (People's Business Credit)
LDR	Loan to Deposit Ratio
LPA	Line Probe Assay
LSM	*Lembaga Swadaya Masyarakat* (Non-governmental Organization)

LULUCF	Land use, land use change and forestry
MDGs	Millennium Development Goals
MDR-TB	Multi-drug Resistant Tuberculosis
MI	Madrasah Ibtidaiyah (Islamic elementary school)
MKJP	*Metode Kontrasepsi Jangka Panjang* (long-term contraception method)
MOP	*Medis Operasi Pria* (Vasectomy)
MOW	*Medis Operasi Wanita* (Tubectomy)
MP3EI	*Masterplan Percepatan dan Perluasan Pembangunan Ekonomi Indonesia* (Master Plan for Accelerated and Expansion of Economic Development in Indonesia)
MRV	Measurable, Reportable and Verifiable
MTBS	*Manajemen Terpadu Balita Sakit* (Integrated Management of Childhood Illness)
MTs.	Madrasah Tsanawiyah (Islamic Secondary School)
NPL	Non-performing Loans
NTRL	National Tuberculosis Referral Laboratory
NUSSP	Neighborhood Upgrading and Shelter Sector Project
OJK	*Otoritas Jasa Keuangan* (Financial Services Authority)
Opsus	*Operasi Pasar Khusus* (Special Market Operations)
P2DTK	*PNPM Pengembangan Daerah Tertinggal dan Khusus* (Development of Underdeveloped and Special Regions)
PAMSIMAS	*Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat* (Community-based Drinking Water and SanitationProvision)
PAUD	*Pendidikan Anak Usia Dini* (Early Childhood Education)
PBB	*Perserikatan Bangsa-Bangsa* (United Nations)
PDB	*Produk Domestik Bruto* (Gross Domestic Product)
Perda	*Peraturan Daerah* (Local Rule)
PISEW	*PNPM Infrastruktur Sosial-Ekonomi Wilayah* (Regional Social Economic Infrastructure PNPM)
PKBR	*Penyiapan Kehidupan Berkeluarga bagi Remaja* (Family Life Preparation for Adolescent)
PKH	*Program Keluarga Harapan* (The Hopeful Family Programme)
PKK	*Pembinaan Kesejahteraan Keluarga* (Family WelfareMovement)
PLIK	*Pusat Layanan Internet Kecamatan* (Sub-district Internet Services Center)
PLP2K-BK	*Penanganan Lingkungan Perumahan dan Permukiman Kumuh Berbasis Kawasan* (Territory-based Management of Settlements and Slum Housings)
PMK	*Peraturan Menteri Keuangan* (Regulation of the Minister of Finance)
PMT	*Pemberian Makanan Tambahan* (Supplementary FoodProgram)
PMT-AS	*Pemberian Makanan Tambahan Anak Sekolah* (Supplementary FoodProgram for School Children)
PNPM	*Program Nasional Pemberdayaan Masyarakat* (National Community Empowerment Program)
PNPM-KP	*PNPM Kelautan dan Perikanan* (Marine Affairs and Fisheries PNPM)
PONED	*Pelayanan Obstetrik dan Neonatal Emergensi Dasar* (Basic Emergency Obstetric and Neonatal Services)
PONEK	*Pelayanan Obstetrik dan Neonatal Emergensi Komprehensif* (Comprehensive Emergency Obstetric and Neonatal Services)
Poskesdes	*Pos Kesehatan Desa* (village health post)
Posyandu	*Pos Pelayanan Terpadu* (Integrated Service Post)
PPIP	*PNPM Infrastruktur Perdesaan* (Rural Infrastructure PNPM)
PPN	*Perencanaan Pembangunan Nasional* (National Development Planning)
PPP	Public-Private Partnership

PPP	Purchasing Power Parity
PPRG	*Perencanaan dan Penganggaran yang Responsif Gender* (Gender Responsive Planning and Budgeting)
Pra-KS	Pra-Keluarga Sejahtera (Pre-Welfare Family)
PSK	*Pekerja Seks Komersial* (Commercial Sex Worker)
PT	*Perguruan Tinggi* (college)
PUAP	*Pengembangan Usaha Agribisnis Perdesaan* (Development of Rural Agribusiness Enterprises)
PUG	*Pengarusutamaan Gender* (Gender Mainstreaming)
PUGAR	*Pemberdayaan Usaha Garam Rakyat* (People's Salt Enterprise Empowerment)
Puskesmas	*Pusat Kesehatan Masyarakat* (Community Health Center)
PUS	*Pasangan Usia Subur* (Reproductive-age Couple)
PUMP	*Pengembangan Usaha Mina Perdesaan* (Rural Fisheries Development)
Pustu	*Puskesmas Pembantu* (Aauxiliary Community Health Center)
RA	*Raudlatul Afthal* (Islamic pre-school)
RAD	*Rencana Aksi Daerah* (Sub-national Action Plan)
Raskinda	*Beras Miskin Daerah* (local rice subsidy for the poor)
Raskindes	*Program Beras Miskin Desa* (village rice subsidy for the poor program)
RDT	Rapid Diagnostic Test
Renstra	*Rencana Strategis* (Strategic Plan)
Riskesdas	*Riset Kesehatan Dasar* (Basic Health Research)
Risti	*Resiko tinggi* (high risk)
RK	*Ruang Kelas* (classroom)
RKB	*Ruang Kelas Baru* (new classroom)
ROA	Return on Assets
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* (National Medium Term Development Plan)
RPJPN	*Rencana Pembangunan Jangka Panjang Nasional* (National Long-Term Development Plan)
RPJMD	*Rencana Pembangunan Jangka Menengah Daerah* (Sub-national Medium Term Development Plan)
RS	*Rumah Sakit* (hospital)
RTS	*Rumah Tangga Sasaran* (Target Household)
RTSM	*Rumah Tangga Sangat Miskin* (Deprived Household)
Sakernas	*Survei Angkatan Kerja Nasional* (National Workforce Survey)
SBI	*Sertifikat Bank Indonesia* (Bank of Indonesia Certificate)
SBN	*Surat Berharga Negara* (Government Securities)
SD	*Sekolah Dasar* (Elementary School)
SDKI	*Survei Demografi dan Kesehatan Indonesia* (Indonesia Demographic and Health Survey)
SDLB	*Sekolah Dasar Luar Biasa* (Elementary School for Exceptional Children)
SDM	*Sumber Daya Manusia* (Human Resources)
SIP	*Surat Ijin Praktik* (Practice License)
SIPBM	*Sistem Informasi Pendidikan Berbasis Masyarakat* (Community-based Educational Information System)
SKRRI	*Survei Kesehatan Reproduksi Remaja Indonesia* (Indonesia Adolescent Reproductive Health Survey)
SMA	*Sekolah Menengah Atas* (Senior High School)
SMP	*Sekolah Menengah Pertama* (Junior High School)
SMPLB	*Sekolah Menengah Pertama Luar Biasa* (Senior High School for Exceptional Children)

SPAM	*Sistem Penyediaan Air Minum* (Drinking Water Supply System)
SR	Success Rate
SSL	*Satuan Sambungan Layanan* (Service Connection unit)
STBM	*Sanitasi Total Berbasis Masyarakat* (Community-based Total Sanitation)
STBP	*Surveilans Terpadu Biologis dan Perilaku* (Integrated Biological and Behavioral Surveillance)
STR	*Surat Tanda Register* (Certificate of Registry)
Susenas	*Survei Sosial Ekonomi Nasional* (National Social Economic Survey)
TAC	Total Allowable Catch
TB	*Tuberkulosis* (tuberculosis)
TPA	*Tempat Pembuangan Akhir* (final waste disposal site)
TOMA	*Tokoh Masyarakat* (community figure)
TOGA	*Tokoh Agama* (Religious Figure)
UKBM	*Upaya Kesehatan Berbasis Masyarakat* (community-based health effort)
ULN	*Utang Luar Negeri* (external debt)
UMKM	*Usaha Mikro, Kecil, dan Menengah* (Micro, Small, and Medium Enterprises)
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFCCC	United Nations Framework Convention on Climate Change
UNICEF	United Nations Children's Fund
USO	Universal Service Obligation
Valas	*Valuta Asing* (foreign exchange)
VCT	Voluntary Counseling and Testing
Wajar Dikdas	*Wajib Belajar Pendidikan Dasar* (Compulsory Basic Education)
WHO	World Health Organization

Introduction

Indonesia's commitment to achieving the MDGs is a reflection upon the state's commitment to its people's welfare while contributing to the welfare of the world community. In this respect, the MDGs have been a key reference in the National Long Term Development Plan (RPJPN) for 2005-2025, the National Medium Term Development Plans (RPJMN) for 2004-2009 and 2010-2014, Annual Government Work Plans (RKPs), and State Budget (APBN) documents.

In addressing these commitments, however, Indonesia faces considerable global challenges. Free trade, rising oil prices followed by ever-increasing fuel oil subsidies, climate change and global warming and their multiplier effect on ever-increasing food prices – they all color the social and economic dynamics of Indonesia's national development.

Outcomes of the MDGs for 2011

Outcomes of the MDGs can be divided into three groups. In the first group are goals which have been achieved. In the second group goals which have demonstrated meaningful progress and which are on track for achievement by or prior to 2015. In the third group are goals of which achievement still require a great deal of work.

MDGs which have already been achieved:

- **MDG 1**, i.e. the proportion of people whose income is less than USD 1.00 (PPP) per capita per day.
- **MDG 3**, i.e. NER of female to male for tertiary schools (SMA/MA/Package C) participants, and literacy ratio of female to male aged 15-24 years.
- **MDG 6**, i.e. curbed the spread and reduced new cases of tuberculosis (TB). These have been indicated by incident and mortality rates, and the proportion of detected and treated tuberculosis cases under the DOTS program.

MDGs which have demonstrated meaningful progress and which are on track for achievement by 2015:

- **MDG 1**, i.e. the very significant progress that has been achieved with the poverty depth index, the proportion of self-employed workers and casual employees and family workers to work opportunities, and halving of the proportion of people experiencing hunger.
- **MDG 2**, i.e. NER in primary education (SD/MI/Package A), proportion of pupils starting grade 1 who complete primary school, and the literacy rates for people aged 15-24 years, for both male and female, of which all have neared a rate of 100 percent.
- **MDG 3**, i.e. NER ratio for female to male at primary school (SD/MI /Package A), junior secondary education (SMP/MTs/Package B), and higher education levels which have nearly achieved a rate of 100 percent, contributions made by women in wage employment in the non-agricultural sector, and the proportion of seats occupied by women in the parliament which has risen significantly.
- **MDG 4**, i.e. a reduction rate which has neared two-thirds of neonatal, infant, and under-five mortality rates, and the proportion of children aged under-1 which have been immunized against measles has risen considerably.

- **MDG 5**, i.e. improved contraceptive prevalence rate for married women using modern methods, lowered teenage pregnancy rates for females aged 15-19 years, and increased coverage of antenatal services for both first and fourth pregnancy visits.
- **MDG 7**, i.e. reduced consumption of ozone-depleting substances, proportion of fish stocks within safe biological limits, and ratios of protection areas for biodiversity preservation to total areas of forest as well as ratios of marine protected areas to total areas of territorial waters, of which both have risen.
- **MDG 8**, i.e. the success that has been achieved in developing transparent regulations-based, predictable, non-discriminatory financial and trading systems as indicated by export and import ratios to GDP, loan to savings ratios at commercial banks, and loan to savings ratios at BPRs, of which all have risen significantly. Moreover, it also concerns the success that has been achieved in addressing debt which allows for longer-term debt management as indicated by sharply declining ratios of external debts to GDP and ratios of repayment of external debt principals and interests to export revenues. Further success is to be gained with regard to use of information and communications technology as indicated by an increase in the proportion of people with access to both landlines and cellular telephones.

MDGs which have demonstrated progress, although their achievement still require a great deal of work:

- **MDG 1**, i.e. reduction by half of the percentage of people living below the national poverty line.
- **MDG 5**, i.e. the reduction by three-fourth of the maternal mortality rate per 100,000 live births and lowered unmet family planning needs.
- **MDG 6**, i.e. curbed the spread and reduced new cases of HIV/AIDS as indicated by reduced prevalence of HIV/AIDS, condom use during high-risk sex, and an increase in the proportion of population aged 15-24 years whom have comprehensive knowledge on HIV/AIDS, including both married and unmarried males and females, and universal access to HIV/AIDS medication as indicated by the proportion of people with advanced HIV infection whom have access to antiretroviral (ARV) drugs. Meanwhile, the curbing of malaria and the reduction of new malaria cases as indicated by an increase in the proportion of under-five children sleeping under insecticide-treated mosquito nets remain inadequate.
- **MDG 7**, i.e. the ratio of forrest cover areas, the volume of CO_2 emission, the consumption of primary energy per capita, energy elasticity, and the proportion of households with sustainable access to safe drinking water and proper sanitation in urban and rural areas.
- **MDG 8**, i.e. inadequate increase in the proportion of households with access to the Internet and with ownership of personal computers.

Indonesia's achievements in its development of welfare have been widely recognized on a global scale. Indonesia has been invited by industrialized countries to join the Organization for Economic Cooperation and Development (OECD) and the group of enhanced engagement countries. Through the international engagement with industrialized countries, Indonesia has been part of the G-20 Forum, a group of 20 countries which together count for 85 percent of the world's gross domestic product (GDP). Indonesia's role in global policymaking has become very important.

Significant Efforts to Accelerate the Goals Achievement in Indonesia

To accelerate the achievement of the MDGs, the president of Indonesia passed Presidential Instruction (Inpres) 3/2010 concerning Just Development Programming. One of the mandates denoted within the Inpres was all ministries/ agencies, governors, and district heads/ mayors to take the steps that are necessary in accordance with each respective duties, functions, and competences to see through the implementation of just development programs, which includes the achievement of the Millennium Development Goals (MDGs).

Implementation of Inpres 3/2010 can be outlined as follows:

1. Incorporation of Millennium Development goals, targets, and indicators into Government planning and budgeting systems at the National, Province, and District/ City levels for both the medium term (5 years) and the short term (annually);
2. Formulate Roadmap for Accelerated Achievement of the MDGs in Indonesia for 2010-2015 which will serve as reference for all stakeholders in planning, implementing, monitoring, and evaluating a wide range of programs and activities for accelerated achievement of the MDGs;
3. Establishment of a National MDGs Coordinating Team under coordination of the Ministry of National Development Planning/ Bappenas with membership comprising any ministry/ agency that has relevance with efforts relating to accelerating achievement of the MDGs. The team's key duty is to take charge in coordinating planning, implementation, and monitoring and evaluation of the MDGs;
4. Formulate Sub-national Action Plans (RADs) for accelerated achievement of the MDGs in 33 provinces that involve the following series of activities:
    a. Formulate technical guidelines for provincial sub-national action plans (RADs) that address accelerated achievement of the MDGs and provide guidance for sub-national regions, notably the provinces, in preparing action plan documents which are coherent, practical, and in tune with national policy for accelerated achievement of the MDGs in the regions;
    b. Facilitation of the formulation process for provincial sub-national action plans (RADs) carried out by the National MDGs Coordinating Team for Provincial MDGs Coordinating Teams in order to arrive at a consensus with regard to MDG targets and indicators at province and district/ city levels, identify steps in formulating provincial MDGs action plans, and carrying out an exercise of province action planning for accelerated achievement of the MDGs that includes the identification of targets, objectives, and indicators;
    c. Formulate technical guidelines for operational definitions of MDGs indicators that contain a list of MDGs objectives, targets, and indicators, definition concepts, benefits, calculation methods, and data sources that were used in order to arrive at a consensus which allows for MDGs data and information to be made comparable across provinces;
    d. Formulate technical guidelines for reviewing provincial MDGs action plans for use as reference in reviewing provincial MDGs action plans and identifying whether they are in step with national program policies and MDGs;
    e. Formulate technical guidelines for monitoring and evaluating provincial MDGs action plans to ensure that MDGs programs and activities implementation as set forth in provincial MDGs action plans are in accordance with identified plans, to identify and anticipate issues faced in the implementation of accelerated achievement of the MDGs in order to address them, and to formulate follow-through measures for accelerated achievement of the MDGs.
5. Enactment of Circulars of the Ministry of National Development Planning and the Ministry of Interior 0068/M.PPN/02/2012 and 050/583/SJ concerning Accelerated Achievement of the Millennium Development Goals for 2011-2015 to among others encourage sub-national regions to prepare programs and activities and to allocate budgets in local development work plans (RKPDs), local government unit work plans (SKPDs), and local government unit work plans and

budgets by making reference to the MDGs work plans of each respective province in order to accelerate achievement of MDGs objectives, targets, and indicators;

6. Strengthened financial support for accelerated achievement of the MDGs:
   a. Formulate a policy framework of funding for accelerated achievement of the MDGs through public-private partnerships (PPP) in order to encourage the private sector to form partnerships with the Government in an effort to accelerate achievement of the MDGs;
   b. Formulate harmonizing guidelines for the implementation of corporate social responsibilities (CSRs) in order to create synergies between CSR activities and programs and activities designed to accelerate achievement of the MDGs, which include efforts to achieve synergy with (i) CSR and MDGs objectives, (ii) community groups targeting, (iii) CSR and MDGs localities; and (iv) CSR and MDGs performance indicators.
7. Formulate guidelines for the granting of incentives to sub-national regions to support accelerated achievement of the MDGs as guidance in identifying, implementing, and monitoring the granting of local incentives which have demonstrated satisfactory performances in achieving the MDGs;
8. Disseminating and advocating accelerated achievement of the MDGs to all stakeholders, including the House of People's Representatives, professional associations, universities, the mass media, non-governmental organizations, national ministries/ agencies, and local government units;
9. Presentation of the MDGs Awards with the purpose of expressing appreciation to stakeholders and development actors that have achieved admirable accomplishments in accelerating achievement of the MDGs in Indonesia and building a sustainable incentive and disincentive mechanism to serve as a catalyst in accelerating achievement of the MDGs in Indonesia. This activity is coordinated by the Special Envoy on MDGs to the President;
10. Strengthening availability of data and information on indicators of the MDGs in order to strengthen MDGs achievements planning, monitoring, and evaluation systems. This activity is jointly implemented by the Central Statistics Body (BPS) and the Ministry of National Development Planning/ Bappenas.
11. Within the regional sphere, specifically ASEAN, Indonesia is also active in supporting efforts in strengthening MDGs cooperation to reduce developmental gaps in the region. The ASEAN Roadmap for the Attainment of the Millennium Development Goals was adopted during Indonesia's ASEAN Chairmanship in 2011 which reflects Indonesia's commitment and significant contribution in supporting the establishment of regional policies to accelerate the attainment of the MDGs

Summary of MDGs Achievements in Indonesia

MDG 1: ERADICATE POVERTY AND HUNGER

Poverty mitigation efforts in Indonesia have shown meaningful progress, which has been in accordance with the MDGs as was demonstrated by the reduced proportion of people living under the national poverty line, i.e. from 15.10 percent (1990) to 12.49 percent (2011) even when the Poverty Depth Index went down from 2.70 to 2.08 during the same time period. The rate of GDP growth per worker strengthened from 3.52 percent (1990) to 5.04 percent (2011). Additionally, a reduction was observed in the proportion of people suffering hunger between 1989 and 2010 as the prevalence of under-five children with low weight went down from 31 percent to 17.9 percent.

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Efforts to achieving universal primary education have been in step with the MDGs, as is demonstrated by the implementation of basic 9-year education in Indonesia. In 2011, the Net Enrolment Ratio (NER) in primary education reached 95.55 percent; Proportion of pupils starting grade 1 who complete primary school was 96.58 percent; and the literacy rate for the population aged 15-24 years reached 98.75 percent for women and 98.80 percent for men.

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Efforts to promoting gender equality and women's empowerment have largely been on track for MDGs achievement by 2015. In 2011, the NER of girls to boys at primary school level (SD/MI/Package A) was 98.80; at junior secondary school (SMP/MTs/Package B) the figure was 103.45; while at higher education level it was 97.82. The literacy ratio of women to men in the 15-24 year group age reached 99.95 percent in the same year.

Meanwhile, targets in step with the MDGs include the NER of females to males at senior high school which reached 101.40 in 2011. An increase in contribution by females is observed in the labor affairs sector, notably in wage employment in the non-agricultural sector, which reached 36.67 percent in 2011. Additionally, the proportion of seats occupied by women in the parliament has likewise gone up: it reached 18.4 percent in 2011.

MDG 4: REDUCE CHILD MORTALITY

Efforts to reducing child mortality rates have been in step with the MDGs. This was demonstrated by the mortality rate of under-five children that went down from 97 (1991) to 44 per thousand live births (2007); the lowered infant mortality rate that went down from 68 to 34 per thousand births; and the lowered neonatal mortality rate that went down from 32 to 19 per thousand births. In the meantime, the proportion of under-1 children that received measles immunization went up from 44.5 percent (1991) to 87.30 percent (2011).

MDG 5: IMPROVE MATERNAL HEALTH

The proportion of delivery aided by trained health workers has been successfully increased from 40.7 percent (1992) to 81.25 percent (2011), however, on the other hand, the maternal mortality rate could only be reduced from 390 (1991) to 228 per 100,000 live births (2007). Meanwhile, the contraceptive prevalence rate for married women aged 15-49 years went up from 47.1 percent (1991) to 60.42 percent (2011).

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

Efforts to curb the spreading, lower the number of new cases, and create access to HIV/AIDS medication continue to require hard work, innovation, and creativity. The prevalence of HIV/AIDS remains fairly high at 0.3 percent in 2011, while access to new ARV has reached 84.1 percent of people with advanced HIV/AIDS infection. The incident rate for malaria has dropped significantly from 4.68 (1990) to 1.75 per 1,000 people (2011). Meanwhile, the incident rate for tuberculosis has successfully reached the MDGs target in 2011 that was to be achieved by 2015 when it dropped from 343 (1990) to 189 cases per 100,000 people/year.

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Achieving a majority of the targets for ensuring environmental preservation still require a great deal of work. The ratio of actual forest cover to total land area dropped from 59.97 percent in 1990 to 52.52 percent in 2010, while CO2 emission increased from 1.377.983 Gg CO2e (2000) to 1,791,372 GgCO2e (2005). Moreover, the proportion of household with sustainable access to safe drinking water went up from 37.73 percent (1993) to 42.76 percent (2011), while those with proper sanitation increased from 24.81 percent (1993) to 55.60 percent (2011).

MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Indonesia's financial and trading systems have become more transparent, regulations-based, predictable, and non-discriminatory. This can be measured from economic transparency indicators which indicate an increase in the export and import ratios to the GDP from 41.6 percent in 1990 to 45 percent in 2011. Meanwhile, the external debt ratio to the GDP dropped from 24.59 percent in 1996 to 8.28 percent in 2011.

The proportion of people with cellular telephones went up from 14.79 percent in 2004 to 103.90 percent in 2010. However, in 2011, the proportion of households with Internet access reached only 26.21 percent while the proportion of households with personal computers was only 12.30 percent in 2011.

Overview of Status of MDGs Targets in Indonesia

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
GOAL 1. ERADICATE POVERTY & HUNGER						
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day						
1.1	Proportion of population below $1 (PPP) per day	20.60% (1990)	5,90% (2008)	10.30%	●	World Bank and *BPS*
1.1a	Percentage of people living under the national poverty line	15.10% (1990)	12.49% (2011)	7.55%	▼	*BPS, Susenas*
1.2	Poverty gap ratio (incidence x depth of poverty)	2.70% (1990)	2.08% (2011)	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)	5.04% (2011)	-		National GDP and *Sakernas*
1.5	Employment-to-population (over 15 years of age)	65% (1990)	63.85%(2011)	-		*BPS, Sakernas*
1.7	Proportion of own-account and contributing family workers in total employment	71% (1990)	44.24% (2011)	Decrease	▶	
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger						
1.8	Prevalence of underweight under-five age	31.00% (1989)*	17.90% (2010)**	15.50%	▶	**BPS, Susenas* **MOH *Riskesdas*
1.8a	Prevalence of severe underweight children under-five years of age	7.20% (1989)*	4.90% (2010)**	3.60%	▶	
1.8b	Prevalence of moderate underweight children under-five years of age	23.80% (1989)*	13.00% (2010)**	11.90%	▶	
1.9	Proportion of population below minimum level of dietary energy consumption::				▼	*BPS, Susenas*
	- 1400 Kcal/capita/day	17.00% (1990)	14.65 % (2011)	8.50%		
	- 2000 Kcal/capita/day	64.21% (1990)	60.03 %(2011)	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 a full course of primary schooling						
2.1	Net Enrolment Ratio (NER) in primary education	88.70% (1992)*	95.55 %(2011)**	100.00%	▶	*BPS, Susenas **MOEC
2.2.	Proportion of pupils starting grade 1 who complete primary school.	62.00% (1990)	96.58 % (2011)	100.00%	▶	MOEC
2.3	Literacy rates for people aged 15-24 years, women and men	96.60% (1990)	98.78 % (2011) Female: 98.75 % Male: 98.80 %	100.00%	▶	*BPS, Susenas*

Indicator		Baseline	Current	2015 MDGs Target	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	Ratio of girls to boys in primary, secondary and tertiary education					
	- Primary school female/male NER	100.27% (1993)	98.80% (2011)	100.00	▶	*BPS, Susenas*
	- Junior high school female/male NER	99.86% (1993)	103.45% (2011)	100.00	▶	
	- Senior high school female/male NER	93.67% (1993)	101.40% (2011)	100.00	●	
	- College female/male NER	74.06% (1993)	97.82% (2011)	100.00	▶	
3.1a	Literacy ratio of women to men in the 15-24 age group	98.44% (1993)	99.95% (2011)	100.00	●	
3.2	Share of women in wage employment in the nonagricultural sector	29.24% (1990)	36.67% (2011)	Increase	▶	*BPS, Sakernas*
3.3	Proportion of seats held by women in national parliament	12.50% (1990)	18.4% (2011)	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 1000 live births)	97 (1991)	44 (2007)	32	▶	*BPS*, IDHS 1991, 2007; **BPS, Susenas* 2011
4.2	Infant mortality rate (AKB) rate (per 1000 live births)	68 (1991)	34 (2007)	23	▶	
4.2a	Neonatal mortality rate (per 1000 live births)	32 (1991)	19 (2007)	Decrease	▶	
4.3	Proportion of one-year-old children immunized against measles	44.5% (1991)	87.30% (2011)*	Increase	▶	
GOAL 5: IMPROVE MATERNAL HEALTH						
Target 5A: Reduce by three quarters the maternal mortality ratio						
5.1	Maternal Mortality Ratio (per 100,000 live births)	390 (1991)	228 (2007)	102	▼	*BPS*, IDHS
5.2	Proportion of births attended by skilled health personnel (%)	40.70% (1992)	81.25% (2011)	Increase	▶	*BPS, Susenas*
Target 5B: Achieve universal access to reproductive health						
5.3	Current contraceptive use among married women 15-49 years old, any method	49.70% (1991)	61.34% (2011)*	Increase	▶	*BPS*, IDHS 1991, 2007 **BPS, Susenas* 2011 **MOH *Riskesdas* 2010
5.3a	Current contraceptive use among married women 15-49 years old, modern method	47.10% (1991)	60.42% (2011)*	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:	75.00%	92.70% (2010)**	Increase	▶	
	- 4 visits:	56.00% (1991)	61.40% (2010)**		▶	
5.6	Unmet need for family planning	12.70% (1991)	9.10% (2007)	Decrease	▶	

Indicator		Baseline	Current	2015 MDGs Target	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)	-	0.30% (2011)	Decrease	▼	MOH 2011
6.2	Condom use at last high-risk sex	12.8% (2002/03)	Female: 35.00% (2011)*	Increase	▼	*BPS, SKRRI* 2002/ 2003 **STBP*, MOH 2011
			Male: 14.00% (2011)*		▼	
6.3	Proportion of population age 15-24 year with comprehensive knowledge on HIV/AIDS	-	11.40% (2010)	Increase	▼	MOH, *Riskesdas* 2010
Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it						
6.5	Proportion of population with advanced HIV infection with access to antiretroviral drugs	-	84.10% (2011)	Increase	▶	MOH, 2011
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)	1.75% (2010)	Decrease	▶	MOH, 2010
6.7	Proportion of children under 5 sleeping under insect icidetreated bednets	-	16.50% (2010) Rural: 13.50% Urban: 11.40%	Increase	▶	MOH, *Riskesdas* 2010
6.8	Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	-	34.70% (2010)			MOH, *Riskesdas* 2010
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					
6.9a	Incidence rates associated with Tuberculosis (all cases/100,000 people/year)	343 (1990)	189 (2011)	Halted, begun to reverse	●	WHO Global TB Report, 2011
6.9b	Prevalence rate of Tuberculosis (per 100,000)	443 (1990)	289 (2011)		●	
6.9c	Death rate of Tuberculosis (per 100,000)	92 (1990)	27 (2011)		●	
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)	20.00% (2000)*	83.48% (2011)**	70.00%	●	*WHO Global TB Report **MOH report, 2011
6.10b	Proportion of tuberculosis cases cured under DOTS	87.00% (2000)*	90.30% (2011)**	85.00%	●	
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)	52.52% (2010)	Increase	▼	Ministry of Forestry Affairs
7.2	Carbon dioxide (CO_2) emission	1.377.983 Gg CO2e (2000)	1,791,372 Gg CO2e (2005)	Reduce at least 26% by 2020	▼	Ministry of the Environment

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
7.2a.	Primary energy consumption (per capita)	2.64 BOE (1991)	4.95 BOE (2010)	Reduce from previous state of BAU 6.99		Ministry of Energy and Mineral Resources
7.2b.	Energy intensity	5.28 SBM/ USD 1,000 (1990)	4.61 SBM/USD 1,000 (2010)	Decrease		
7.2c.	Energy elasticity	0.98 (1991)	1.6 (2010)	Decrease		
7.2d.	Energy mix for renewable energy	3.5% (2000)	5.00% (2010)	-		
7.3	Total consumption of ozone depleting substances (ODS) in metric tons	8,332.7 metric tons (1992)	0 CFC, halon, CTC, TCA, methyl bromide 6,689.21 metric tons HCFC (2010)	0 CFCs while reducing HCFCs	▶	Ministry of the Environment
7.4	Proportion of fish stocks within safe biological limits	66.08% (1998)	96,86% (2011)	Not exceed	▶	Ministry of Maritime Affairs & Fisheries
7.5	The ratio of terrestrial areas protected to maintain biological diversity to total terrestrial area	26.40% (1990)	27.54% (2010)	Increase	▶	Ministry of Forestry Affairs
7.6	The ratio of marine protected areas to total territorial marine area	0.14% (1990)*	4.97% (2011)**	Increase	▶	*Ministry of Forestry Affairs **Ministry of Maritime Affairs & Fisheries
Target 7C: Halve, by 2015, the proportion of the population 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)	42.76% (2011)	68.87%	▼	*BPS, Susenas*
7.8a	Urban	50.58% (1993)	40.52% (2011)	75.29%	▼	
7.8b	Rural	31.61% (1993)	44.96% (2011)	65.81%	▼	
7.9	Proportion of households with sustainable access to basic sanitation, urban and rural	24.81% (1993)	55.60% (2011)	62.41%	▼	
7.9a	Urban	53.64% (1993)	72.54% (2011)	76.82%	▶	
7.9b	Rural	11.10% (1993)	38.97% (2011)	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)	12.57% (2011)	6% (2020)	▼	*BPS, Susenas*
GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT						
Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system						
8.6a	Ratio of Exports + Imports to GDP (indicator of economic openness)	41.60% (1990)*	45% (2011)**	Increase	▶	*BPS and The World Bank **BPS and Ministry of Trade

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
8.6b	Loans to Deposit Ratio in commercial banks	45.80% (2000)*	78.80% (2010)**	Increase	▶	*BI Economic Reports 2008, 2009 **Indonesian Banking Statistics, BI (2011)
8.6c	Loans to Deposit Ratio in rural banks	101.30% (2003)*	107.6% (2011)**	Increase	▶	
Target 8D: Deal with debt of developing countries through both national and international efforts in order to manage debt over long run						
8.12	Ratio of International Debt to GDP	24.59% (1996)	8.3% (2011)	Reduce	▶	Ministry of Finance
8.12a	Debt Service Ratio (DSR)	51.00% (1996)*	21.1% (2011)**	Reduce	▶	*BI Annual Report 2009 **External Debt Statistics, BI (2011)
Target 8F: In cooperation with the private sector, make available benefits of new technologies, especially information and communications						
8.14	Proportion of the population with fixed-line telephones (teledensity in population)	4.02% (2004)	3.60% (2010)	Increase	▶	Ministry of Communication and Information 2010
8.15	Proportion of population with cellular phones	14.79% (2004)	103.90% (2010)	100.00%	▶	
8.16	Proportion of households with Internet access	-	26.21% (2011)	50.00%	▼	*BPS, Susenas* 2011
8.16a	Proportion of households with personal computers	-	12.30% (2011)	Increase	▼	

GOAL 1:
ERADICATE EXTREME POVERTY AND HUNGER

Source: PNPM Support Facility

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

TARGET 1A **HALVE, BETWEEN 1990 AND 2015, THE PROPORTION OF PEOPLE WHOSE INCOME IS LESS THAN $1 A DAY**

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day						
1.1	Proportion of population below $1 (PPP) per day	20.60% (1990)	5.90% (2008)	10.30%	●	World Bank and *BPS*
1.1a	Percentage of people living under the national poverty line	15.10% (1990)	12.49% (2011)	7.55%	▼	*BPS, Susenas*
1.2	Poverty gap ratio (incidence x depth of poverty)	2.70% (1990)	2.08% (2011)	Reduce	▶	*BPS, Susenas*

Status: ●Already Achieved ▶On track ▼Need Special Attention

CONDITIONS AND TRENDS

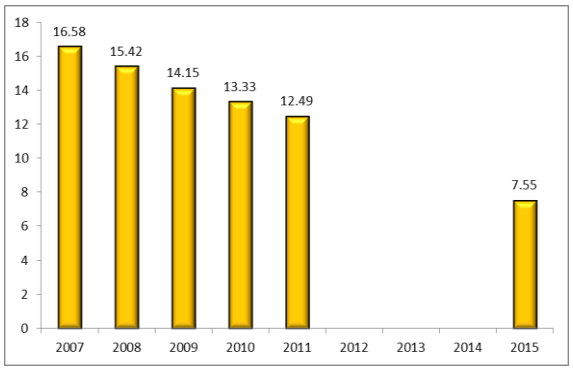


Figure 1.1. Percentage of people living under the national poverty line
Source: *BPS, Susenas* various years

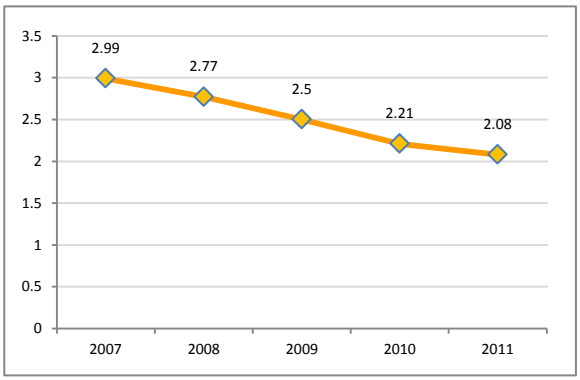


Figure 1.2. Poverty gap ratio
Source: *BPS, Susenas* various years

Efforts addressing poverty in Indonesia have demonstrated significant progress. This is shown by two indicators: the percentage of the population living below the national poverty line, and the poverty gap ratio (incidence x depth of poverty).

The proportion of people living below the national poverty line continues to decrease, i.e. from 13.33 percent in 2010 to 12.49 percent in 2011 (Figure 1.1). Welfare level of the population below the poverty line experienced an improvement. This was shown by a decrease in the national Poverty gap ratio (incidence x depth of poverty) that was at 2.21 percent in 2010 and went down to 2.08 percent in 2011 (Figure 1.2). However, the poverty level in rural areas continues to be higher compared with urban areas and continues to require strengthened rural development. In 2011, Indonesia's poverty level in rural areas was 15.72 percent and in urban settings 9.23 percent.

The proportion of people living below the poverty line continues to vary, both inter-province and inter-rural and urban at province level (Figure 1.3). Papua, West Papua, Maluku, East Nusa Tenggara, and West Nusa Tenggara are five provinces which had the highest poverty levels. However, higher poverty levels in Papua, West Papua, Maluku, and NTT were apparent in rural areas only. The proportion of poor rural people in Papua and West Papua was lower and in Maluku it was more or less equivalent to the average national figure, though in NTT the proportion of the urban poor was larger compared to their rural counterpart. Papua, West Papua, Maluku, and Gorontalo had the highest disparity in terms of proportion of people living below the poverty level in both rural and urban settings. Diversity in terms of the proportion of poor rural people inter-province was likewise significant, stretching between 4.65 percent and 41.58 percent, with the highest proportion of rural people living below the poverty line being in Papua, West Papua, Maluku, and Gorontalo.

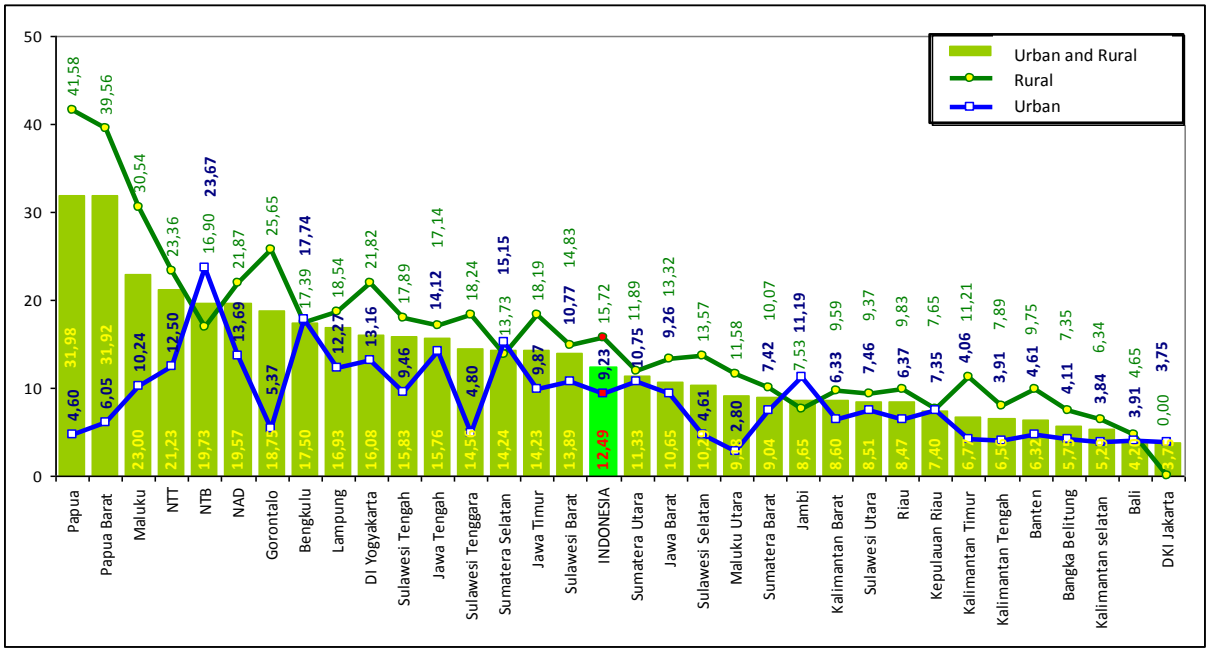
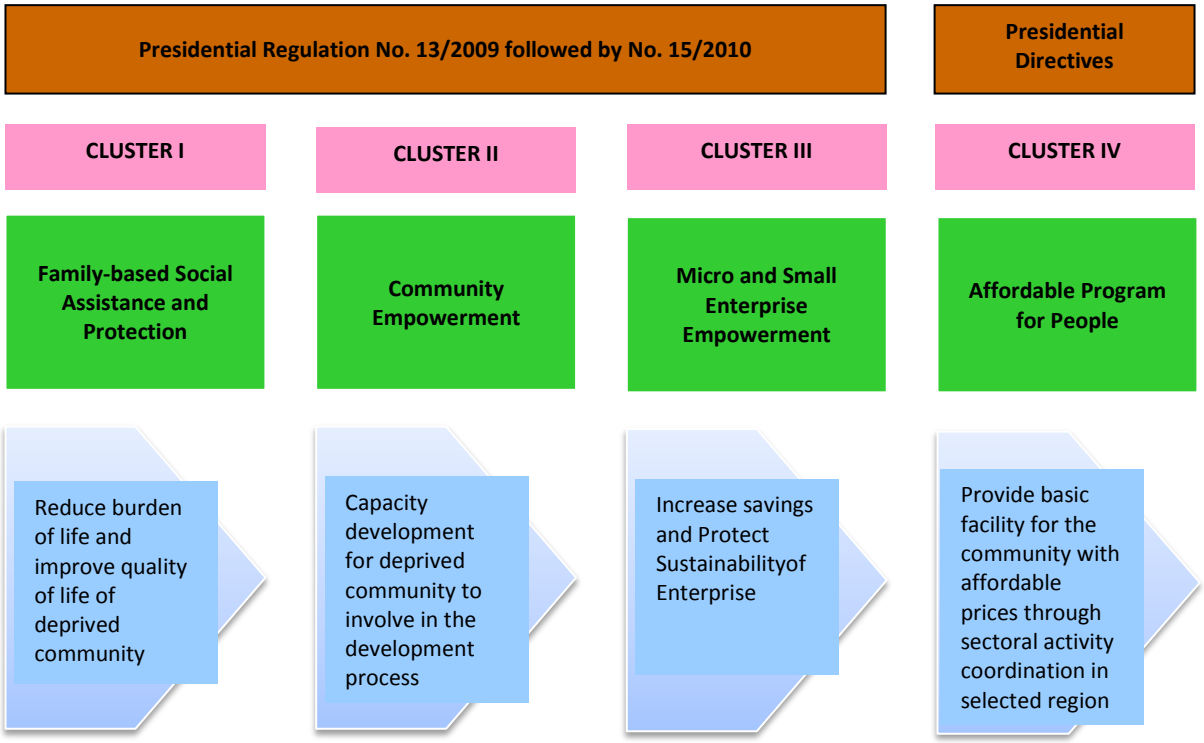


Figure 1.3. Proportion of poor people in rural and urban areas at province level, 2011
Source: *BPS, Susenas* 2011

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

Affirmative actions have been made by the government in eradicating poverty, as stated in the Presidential Decree No. 13/2009 on Poverty Reduction Coordination followed by the Presidential Decree No. 15/2010 on Accelerated Poverty Reduction. Poverty reduction programs are conducted through four poverty reduction cluster programs, i.e. Cluster (1) social assistance and protection programs (Jamkesmas, assistance for deprived students, Keluarga Harapan Program, and Rice for the Poor Program - Raskin); Cluster (2) empowerment of the poor (PNPM Mandiri) The National Community Empowerment Program; Cluster (3) empowerment of small and medium enterprises (KUR - People's Business Credit) and other SME programs, and Cluster (4) pro-community programs aimed at providing subsidy for basic facilities in specific areas (PPI fishing communities, urban deprived community, and communities in disadvantaged areas).



In 2011, assistance has been given to deprived students or 4,666,220 SD/MI/SDLB students, 1,995,100 SMP/MTs/SMPLB students, 1,292,374 SMA/SMK/MA students, and 126,538 PT/PTA students. Furthermore, in 2012 assistance will be given to 4,390,780 deprived students of SD/MI/SDLB, 1,946,020 of SMP/MTs/SMPLB, 1,489,813 of SMA/SMK/MA, and 303,856 of PT/ PTA.

Subsequently, implementation of the government-funded health insurance (Jamkesmas) has covered 59.1 percent of the poor in 2010 and increased to 63.1 percent in 2011. Basic Jamkesmas and referrals have increased in coverage of first level outpatient care (RJTP) from 34,397,878 in 2010 to 61,790,618 patients in 2011. Meanwhile, coverage of first level hospitalization (RITP) patients increased from 1,268,294 in 2010 to 1,690,618 in 2011. For coverage of outpatient settings, (RJTL) patients increased from 4,743,591 in 2010 to 5,244,215 in 2011 patients. Coverage of patients in subsequent levels of hospitalization (RITL) increased from 1,189,885 in 2010 to 1,194,419 in 2011. In addition, childbirth coverage (Jampersal) reached 1,572,751 deliveries (496 districts/cities from 497 districts/cities) in 2011.

The core National Community Empowerment Program (PNPM Mandiri) has been implemented in 6,622 sub-districts consisting of 5,020 Rural PNPM sub-districts, 1,153 Urban PNPM sub-districts, 215 Rural Infrastructure PNPM sub-districts (PPIP/RIS), 237 Regional Social Economic PNPM sub-districts (PISEW) and 7 districts for the Underdeveloped and Special Regions Development Program (P2DTK). Total allocated PNPM core funds from the state and regional budgets for 2011 amounted to Rp 13.14 trillion, with an amount of Rp 9.58 trillion for the Rural PNPM, Rp 1.67 trillion for the Urban PNPM, Rp 1.01 billion for the Rural Infrastructure PNPM (PPIP/RIS), Rp 527.8 billion for the Regional Social Economic PNPM (PISEW) and Rp 345.9 billion for the Development of Underdeveloped and Special Regions (P2DTK). In 2011, additional PNPM funding had been approved from the revised state budget (PNPM-P) amounting Rp 1.82 trillion, targeted for the rural PNPM with an amount of Rp1.29 trillion and Rp 524 billion for the urban PNPM. This budget is an additional funding allocated for the Direct Community Assistance Program (BLM) for Urban and Rural PNPM locations, as well as to increase employment opportunities through productive economic efforts, particularly in sub-districts with high Indonesian labor rates. Meanwhile, in 2012, the core PNPM was implemented in 6,680 sub-districts comprising 5,100 Rural PNPM sub-districts, 1,151 Urban PNPM sub-districts, 187

Rural Infrastructure PNPM sub-districts (PPIP/RIS), and 237 Regional Socio-Economic Development PNPM sub-districts (PISEW). Total core PNPM funds allocated from the state and regional budgets for 2012 amounted to Rp 13.60 trillion, with an amount of Rp 10.49 trillion for the Rural PNPM, Rp 1.71 trillion for the Urban PNPM, Rp 862.5 billion for the Rural Infrastructure PNPM (PPIP/RIS), and Rp 536.5 billion for the Regional Socio-Economic PNPM (PISEW).

Implementation of the PNPM is also supported by the PNPM Reinforcement (support) which includes the following: (i) The Generation PNPM as an effort to improve the quality of education and health of future generations, which in 2011 was conducted in 120 sub-districts in 25 districts and 5 provinces (ii) The Marine and Fisheries PNPM (PNPM-KP) that was implemented in 351 Maritime and Fishery districts/cities in 2011 by providing Direct Community Assistance (BLM) that reached 1,106 fishermen groups in 132 districts/cities, 2,070 farmer groups in 300 districts/cities, 408 processing groups in 53 districts/cities , and 1,670 salt producing community businesses in 40 districts/cities (iii) The Rural Agribusiness Development Program (PUAP) which in 2011 was implemented in 10,000 farmer groups (gapoktan), for the development of agribusinesses and improvement in quality. (iv) The Tourism PNPM that is aimed to increase the capacity of the community and expand business opportunities in tourism, in 2011, which had been carrying out in 569 villages in 83 districts / cities.

Implementation of cooperative and SME development programs in the cluster 3 program for poverty reduction in 2011 shows significant results. The People's Business Credit (KUR) for SMEs and cooperatives for 2011 amounted Rp 29.0 trillion with more than 1.9 million customers and average credit financing of USD 15.12 million. Most KUR credit is micro KUR, amounting 47.3 percent and received by micro enterprises by as much as 89.1 percent of KUR debtors, which are mostly from poor communities. Meanwhile, the rate of KUR return is also good with non-performing loans (NPL) amounting only 2.1 percent.

The KUR program is aimed to facilitate the people who are able to meet their basic needs, but still require assistance in accessing capital to support the stability of income and to increase their level of welfare through development of productive micro and small-scale businesses. The target groups are feasible community enterprises that are not yet bankable, and Indonesian Migrant Workers (TKI).

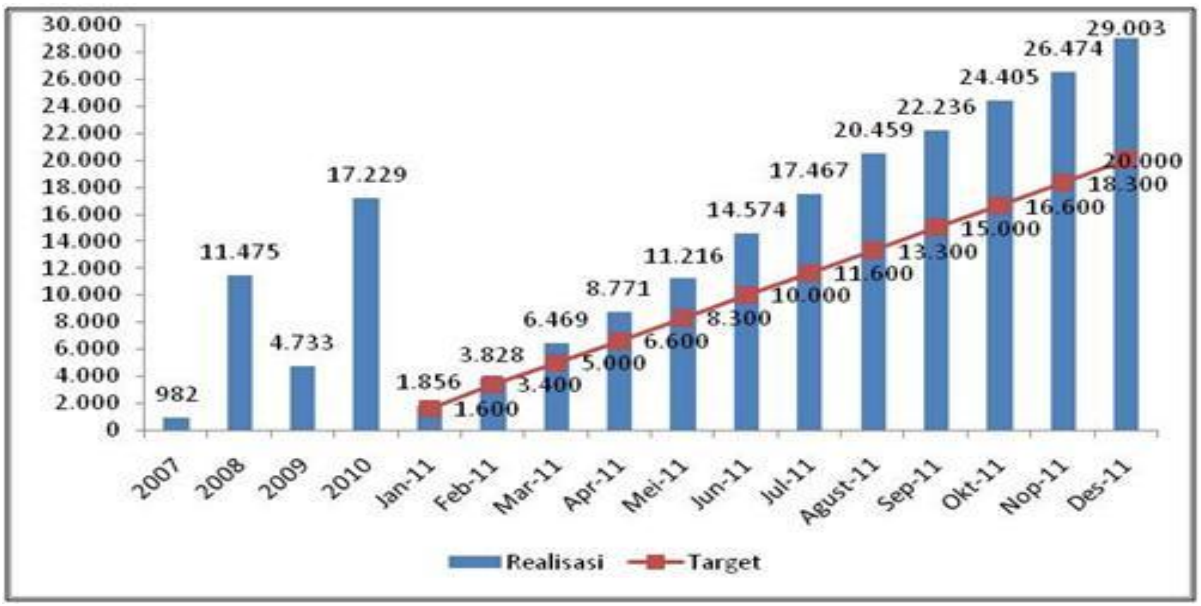


Figure 1.4. Target Achievement of KUR Distribution (Billion Rp)
Source:The Coordinating Ministry for Economic Affairs

In addition, the government has issued a Presidential Regulation No. 65/2011 on Accelerated Development of Papua and West Papua, which is then elaborated in the 2011-2014 Action Plan to Accelerate Development in the Papua and West Papua Provinces. Socio-economic development policies that were made, include: (a) Poverty reduction programs, that prioritizes the provision of social security, capacity building and provision of working capital for the poor, (b) Educational programs, that prioritizes on improving basic education primarily to ensure that teaching and learning activities are able to continue across villages with adequate facilities and number of teachers, as well as setting up vocational education, (c) Health care programs, that prioritizes on improving services of integrated health posts, subsidiary community health centers, and improving community healthcare services at the village level.

Box 1.1.
The Hopeful Family Program (PKH)

PKH is a social security program providing cash assistance to destitute households (RTSMs) with attached conditions concerning the implementation of specific requirements. Over the short term, the program aims to reduce the burden of RTSMs while over the longer term it's expected to break the chain of inter-generation poverty to allow the next generation to escape the poverty trap. Conditions that must be met are requirements pertaining to health and education. RTSMs encompass people with the lowest income whom are identified from data collected through the 2008 Social Security Program by the Central Statistics Agency (BPS). Implementation of the program is expected to reduce poverty and to strengthen quality of human resources. Achievement of five components of the MDGs will be indirectly assisted if the PKH is implemented in an optimum manner: reduced proportion of poor people and those experiencing hunger, increased access to primary education, gender equality, reduced infant and under-five mortality rates, and reduced maternal mortality rates. At the start of program implementation in 2007, only 387,928 RTSMs were included from 7 provinces, 48 districts/cities, and 337 sub-districts. Plans were in place for 2011 to include 1,116,000 RTSMs in 25 provinces, 119 districts/cities and 1.379 sub-districts.

Table 1.1. Places of implementation of the Desired Family Program.

2007	Initial implementation in 7 provinces (DKI, West Java, East Java, West Sumatra, Gorontalo, North Sulawesi, NTT), 48 districts/cities, and 337 sub-districts. Recipients numbered 387,928 RTSMs.
2008	Was developed in 6 provinces (Banten, Aceh, North Sumatra, D.I. Yogyakarta, South Kalimantan, and NTB) to include 13 provinces, 70 districts/ city, and 629 sub-districts. Recipients numbered 620,484 RTSMs.
2009	Was developed in 150 sub-districts dispersed over 12 provinces and 43 districts/cities (PKH sites for 2007-2008) with an additional recipient number of 105,892 RTSMs, bringing the total to 726,376 RTSMs.
2010	Was developed in 7 Provinces (Bengkulu, Riau Islands, West Kalimantan, Central Kalimantan, Bali, Central Sulawesi, South Sulawesi) to include 20 provinces, 88 districts/cities, 954 sub-districts, bringing the total figure of RTSMs to 816,376.
2011	Was developed in five Provinces (Riau, Lampung, South Sumatra, Central Java, North Maluku) to include 25 provinces, 119 districts/ cities, 1,379 sub-districts. Recipients numbered 1,116,000 RTSMs.

Box 1.2.
Rice Subsidy for the Poor (Raskin)

The Raskin Program started with the special market operations (opsus) for rice in 1998. At the time, opsus counted among one of the government's efforts to address the monetary/economic crisis. Increased rice prices because of the crisis that went on since May 1997 did have an impact as it hampered community needs regarding food. Weakened purchasing power, increased living costs, lost income sources, and decreased food production, all of these resulted in food insecurity that, unless addressed urgently, could potentially lead to social and political insecurities. To address this, the government took a number of measures including, among others, by forming a Food Security Monitoring Team and by implementing a food assistance program (through rice market operations). Rice opsus is a mechanism of channeling food assistance to food-insecure communities. The program broke ground for another social assistance initiative, namely the Social Safety Net (JPS), the present reincarnation of the Raskin Program. Because of various obstacles, efforts to have the Raskin program continue including all poor households could only be realized in 2008 (Table 1.1) when the percentage of targeted households (RTS) under the Raskin Program included all poor households (100 percent). In 2009, the program was initially set to reach all poor households (100 percent) totaling 18.5 million RTS, 15kg/RTS, for a period of 10 months and at a purchase price of IDR 1,600, with the total subsidy figure reaching IDR 12,987 trillion.

Table 1.2. Development of the Raskin Program 2004-2010

DESCRIPTION	2004	2005	2006	2007	2008	2009	2010	2011
Number of poor households [in millions]	15.75	15.79	15.50	19.10	19.10	18.50	17.50	17,50
Targeted households (RTS) [in millions]	8.59	8.30	10.83	15.78	19.10	18.50	17.50	17,50
Percentage of RTS [%]	54.56	52.56	69.86	82.62	100.0	100.0	100.0	100,0
Rice allocation/ RTS/ month [kg]	20	20	15	10	15	15	13 (5 mo) 15 (7 mo)	15
Duration [month]	12	12	10	11	12	12	12	12
Rice purchase price (HPB) [IDR/kg]	3,549	3,351	4,275	4,275	4,619	5,500	6,285	6.450
Community purchase price [IDR]	1,000	1,000	1,000	1,000	1,600	1,600	1,600	1.600
Rice price subsidy (IDR)	2,549	2,351	3,275	3,275	3,019	3,900	4,685	4.850
Total subsidy/year [IDR T]	5.3	4.7	5.3	5.7	10.1	12.99	13.9	15,27

Source: Kemenkokesra, Bulog (2011)

In 2011, the Raskin Program included all poor families as targeted households (RTS). Funds amounting to IDR 15.27 trillion were used to distribute rice in the amount of 3.15 million tons to 17.5 million poor families. Each family received 15kg rice for a 12 month period with a rice ceiling of 3,147 million tons. Families could purchase rice for IDR 1,600 per kg.

Box 1.3.
Implementation of the Raskin Program in Boalemo District, Gorontalo

The Raskin Program was seen as a mandate by the Boalemo district government and because of that the district head and his ranks implemented the program *wholeheartedly*. The Raskin Program became an entry point for comprehensive poverty alleviation programming, which includes the Mandiri Integrated Hamlet Program, a program focusing on development of cheap but healthy and habitable settlements for RTMs. The purpose of turning the Raskin Program into an entry point was to optimize development in order to raise the community's living standard and welfare. Optimization was accomplished by synergizing and coordinating the Local Government Unit Program across the board using a broad range of funding sources for community empowerment. The Mandiri Integrated Hamlet Program targets hamlets which are socially and economically vulnerable, and which meet the following criteria: relatively poor population, population has low education level, poor social and economic facilities/ infrastructure, and inhabitable housing.

For the purpose of optimization, the Boalemo District government supported the Raskin Program using the APBD, engaged a broad range of stakeholders (including targeted households), developed management mechanisms managed by RTS households, organized district-wide work consultations of RTS Forum chairpersons, and opened a community complaints service with a direct line to the district head's cellular telephone. Regional budget support was allocated for: (i) transport to isolated and remote hamlets, to ensure proper Raskin pricing, (ii) Raskin redemption price subsidy for beneficiaries registered under the RTS-BPS, (iii) local rice subsidy for the poor (Raskinda) and the village rice subsidy for the poor program (Raskindes) for households not registered under the state budget RTS-PM Raskin, but still regarded as poor according to PKK/ Dasawisma data, and (iv) capital strengthening for RTS "Cerdas" under the "POSDAYA" Program (Raskin rice treated as business capital). Raskindes funds were obtained from donors, including DPRD and DPR RI members, civil servants, businesspersons, banking circles, and reporters.

To reinforce commitment of village heads, the district head took the initiative of holding a district-level Raskin Award. The selection procedure borrows from the mechanism used by the Coordinating Ministry in the Social Welfare Sector which engages elements of universities and NGOs. Nominees are asked to make their presentations before than assessment team chaired by the district head.

Because of the degree of care and focus in strengthening community welfare as indicated by its achievements, including being the recipient of a best practices award, Boalemo District has been recognized multiple times, including by the World Bank for the implementation of good governance under the P2TPD program worth IDR 18 billion between 2007-2010, and for the commitment of the local government toward early childhood between 2008-2009 worth IDR 5.96 billion, and as well by UNICEF for its concern toward primary education between 2008-2009 worth IDR 4.9 billion.

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
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)	5.04% (2011)	-		National GDP and *Sakernas*
1.5	Employment-to-population (over 15 years of age)	65.00% (1990)	63.85% (2011)	-		*BPS, Sakernas*
1.7	Proportion of own-account and contributing family workers in total employment	71.00% (1990)	44.24% (2011)	Decrease	▶	

Status: ●Already Achieved ▶On track ▼Need Special Attention

CONDITIONS AND TRENDS

In general, the achievement of this target shows sufficient growth. The growth rate of GDP per worker has increased to 5.04 percent in 2011 from only 3.52 percent in 1990. When viewed by sector, the GDP of labor in the agricultural sector grew at the highest rate of 8.62 percent, 0.99 percent in the industrial sector, and 1.72 percent in the service sector. Labor productivity that is measured by the GDP per worker that has increased suggests that the good economic condition in Indonesia has supported the creation and maintenance of good employment opportunities, with good income and working conditions. The growth in productivity needs to be accompanied by improvements in the education and training systems to ensure the readiness of the workforce in entering the labor market.

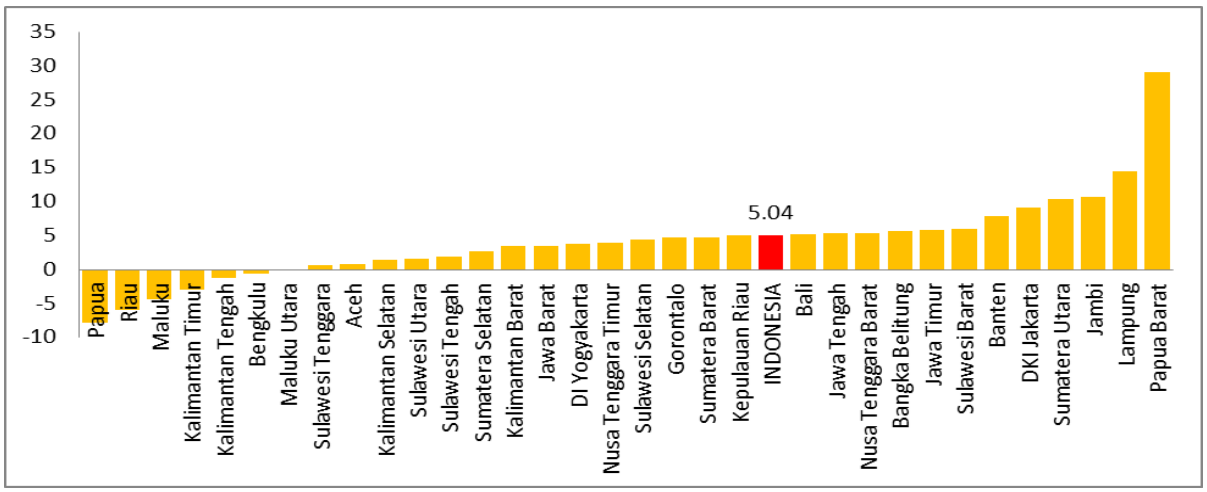


Figure 1.5. Growth rate of GDP per person employed
Source: National GDP and *Sakernas* (*BPS*) 2011

Growth in indicator ratios of employment to the working age population over the past 20 years (during 1990-2011) has shown relatively small changes, namely in the range of 60-65 per cent. For men, the ratio reaches approximately 80 percent, while for women; the ratio is in the range of 40-50 percent. These figures show that the proportion of men who work is higher than the proportion of women. When viewed further, the growth of the working age population is higher than the growth of the workforce, which indicates a high preference to continue their education to subsequent levels

rather than seeking a job after completing school. This tendency is also evident from the growth of the non-workforce that is greater than workforces, for the 15-19 age group, and a decline in the ratio of the workforce participation rate.

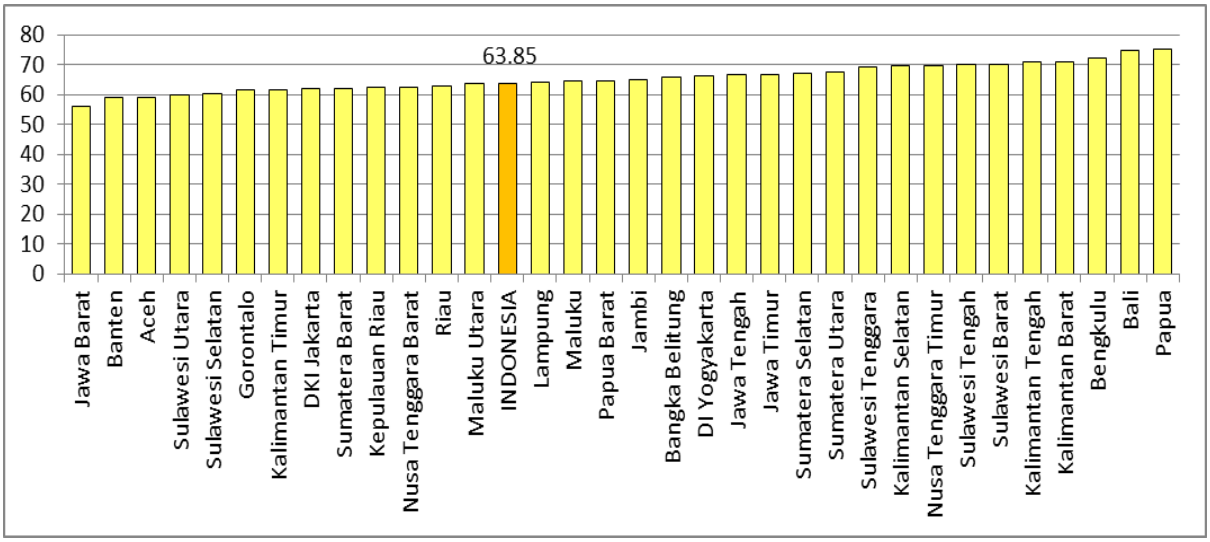


Figure 1.6. Employment-to-population (over 15 years of age)
Source: Sakernas, BPS 2011

Vulnerability in the labor market is indicated by the proportion of the workforce who are self-made (including ones that employ temporary laborers), non-agricultural self-employed and domestic workers to the total labor employment. The proportion reached 71.00 percent in 1990, 46.89 percent in 2010, and 44.24 percent in 2011. Vulnerable labor forces are those who work under uncertain conditions, and are less likely to have formal work regulations, access to benefits or social security programs, and are more "at risk" in the economic cycle. This indicator is very gender sensitive because workers are unpaid, especially domestic workers, which tends to be dominated by women. The vulnerable labor market is also associated with poverty.

The proportion of vulnerable labor forces to total employment according to province also shows the same pattern. Almost all provinces experienced a decline in proportion of vulnerable labor forces, although the decline is not evenly distributed. When provinces are compared, a considerable gap is evident in 2011 between the highest (Papua) and lowest (Riau Islands) proportion of vulnerable labor forces.

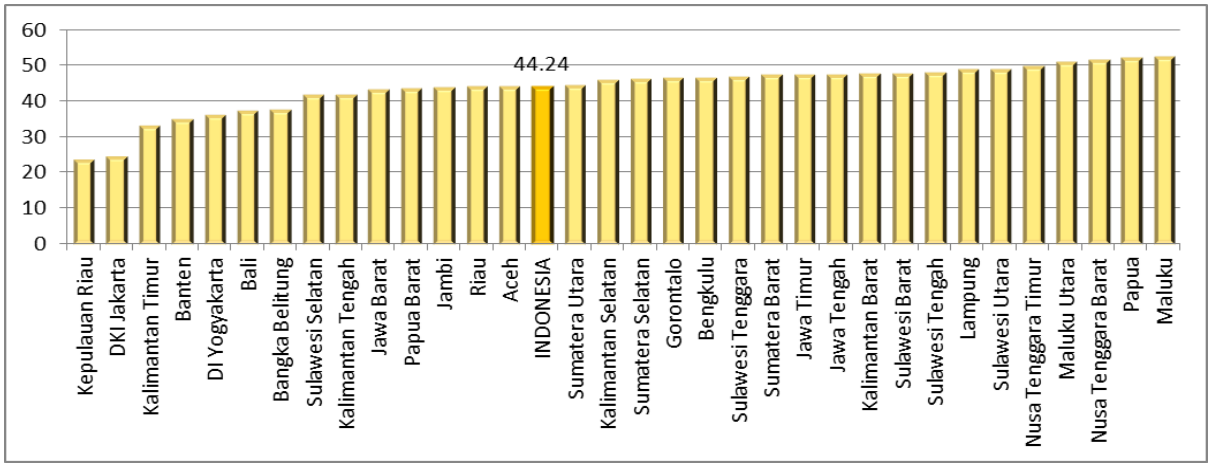


Figure 1.7. Proportion of own-account and contributing family workers in total employment
Source: Sakernas BPS 2011

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

To accelerate the attainment of the MDGs, the Government has determined to create employment opportunities, especially the young workforce as one of the strategic issues in the Government Work Plan for 2013. This strategy is used to accelerate the reduction of national unemployment rates, which decreased in 2013 to approximately 5.8 - 6.1 percent. Strategies implemented to create employment opportunities for the young workforce are as follows:

1. Reduce low-educated labor forces, by providing second chances to those who had left school earlier and provide incentives for the young to remain in school. Those who are still in school are prepared with a curriculum based on the needs of the industry.
2. The young labor forces that are already in the job market are given competency-based training, internship program apprenticeship program and career development within the company.
3. Limited managerial and professional expertise is addressed by a competency-based training curriculum and training in the workplace. The number of competency-based training institutions is increased in collaboration with the industry, associations of professionals and certified bodies which are facilitated by the Government.
4. Preparing dropouts school or children who are unable to continue their schooling to return or provided with vocational education, training, internships, and practical work.
5. The interested young are given entrepreneurial training. An entrepreneurial approach focuses on practical skills and planning for starting businesses, building and developing managerial competence, as well as skill stimulating and developing entrepreneurial ways of thinking.
6. The young, especially those in rural areas, are provided with empowerment programs, such as building collective business groups and practical training programs.

The targets to be achieved, are: (1) 502,880 youths to receive competency-based training, (2) 600,000 to receive industry-recognized certificates of competence, (3) 34,750 youths that are accepted for internships and obtain certificates of competence, (4) 52,080 youths granted access to businesses and entrepreneurships as well as expanding networks so that the young people are able obtain job market information. These efforts are carried out by various ministries/institutions implementing the program/activities. By focusing on employment-creating programs for the youth, it is expected that the decrease in the number of youth unemployment will be accelerated.

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

	Indicator	Baseline	Current	2015 MDGs Target	Status	Source
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger						
1.8.	Prevalence of underweight under-five age	31.00% (1989)*	17.90% (2010)**	15.50%	▶	*BPS, Susenas **MOH, Riskesdas
1.8.a.	Prevalence of severe underweight children under-five years of age	7.20% (1989)*	4.90% (2010)**	3.60%	▶	
1.8.b.	Prevalence of moderate underweight children under-five years of age	23.80% (1989)*	13.00% (2010)**	11.90%	▶	
1.9	Proportion of population below minimum level of dietary energy consumption:				▼	BPS, Susenas
	- 1400 Kcal/capita/day	17.00% (1990)	14.65% (2011)	8.50%		
	- 2000 Kcal/capita/day	64.21% (1990)	60.03% (2011)	35.32%		

Status: ●Already Achieved ▶On track ▼Need Special Attention

CONDITIONS AND TRENDS

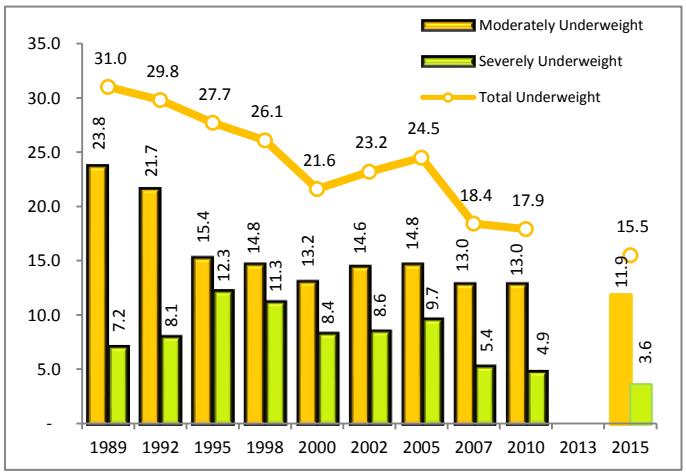


Figure 1.8. Prevalence of underweight under-five age, by Province
Source: *BPS*, *Susenas* various years and *Riskesdas* (MOH) 2007, 2010

Food and nutrition are among the key agendas in national development. Food and nutrition have direct linkage to the status of community health. Materialization of food and nutritional security is inextricably linked to efforts to raising the health quality of both the individual and the community, and to strengthened competitiveness of human resources, which in turn will develop into a nation's competitiveness.

Indonesia is on track to achieving the MDGs, particularly target 1C: reducing the under-five malnutrition rate from 24.5 percent in 2005 to 17.9 percent in 2010 (Riskesdas 2010). This trend must be maintained in order for Indonesia to achieve the targeted rate that has been identified for 2015, i.e. 15.5 percent. However, Indonesia faces yet another challenge relating to food and nutrition, namely the high prevalence of stunting under-five children. Riskesdas data of 2010 showed this prevalence to be at 35.6 percent.

On the other hand, although it has been indicated that there is a decrease in proportion people with calories intake that is below that of the minimum consumption level, tougher and smarter efforts must be put in place to speed up the reduction of this proportion by 2015. According to the 2011 Susenas, the proportion of people nationwide with daily calories intake below 2,000 Kcal and 1,400 Kcal per day was respectively at 60.03 percent and 14.65 percent.

As malnutrition greatly affects community health and productivity, efforts need to focus on increasing calories intake of the population that has had a daily intake of less than 1,400 Kcal per capita per day. Considering that the proportion of people with low calories intake varies greatly, attention should focus on those regions where higher proportion of people have a calories intake of less than 1,400 Kcal per capita per day, e.g. North Maluku, Papua, West Papua, and Maluku.

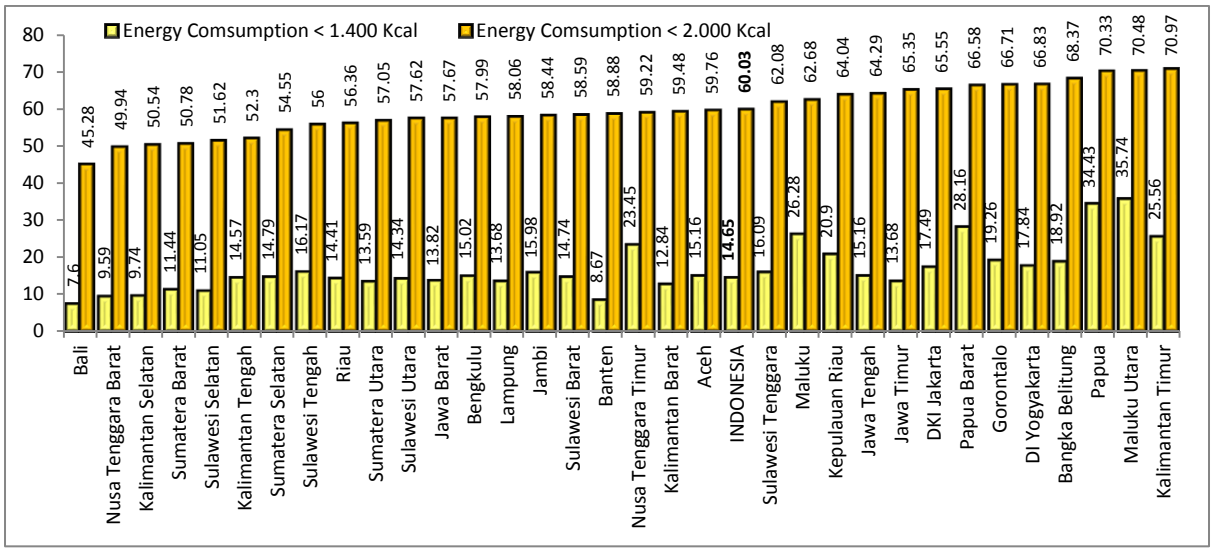


Figure 1.9. Proportion of people with calories intake < 1,400 Kcal and < 2,000 Kcal, 2011
Source: *BPS, Susenas* 2011

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

At the 2010 session, member states of the UN agreed that to achieve Goal 1 acceleration and preservation of food and nutritional development goals need to focus on: (i) Simultaneous increasing of productivity and quality of agricultural yields which will not only reduce hunger but also mother and child mortality rates through improved nutrition and increased family income and economic growth. In this connection, smallholders require direct access to fertilizers, prize seedlings, farm equipment, local irrigation, and post-harvest storage; (ii) Food security aiming at achieving equitable access to diverse foods by taking into account consumption of food made of local ingredients and the different nutritional needs of community groups. Geographical areas with very high and high food insecurity receive main priorities for food distribution, including breast milk supplements for the poor and fortified food; (iii) Intervention packages that take a sustainable services approach and that focus on pre-pregnant mothers, pregnant mothers, infants, and under-two children; (iv) Implementation of a gold standard for baby food that involves early breastfeeding initiation, exclusive breastfeeding until infants are six months old, and breast milk supplements from the age of 6-24 months, during both normal and disaster emergency situations.

GOAL 2:
ACHIEVE UNIVERSAL PRIMARY EDUCATION

Source: Ministry of Women's Empowerment and Children's Protection

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**

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling						
2.1	Net Enrolment Ratio (NER) in primary education	88.70% (1992)*	95.55% (2011)**	100.00%	▶	**BPS, Susenas* ***MOEC*
2.2.	Proportion of pupils starting grade 1 who complete primary school	62.00% (1990)	96.58 % (2011)	100.00%	▶	MOEC
2.3	Literacy rates for people aged 15-24 years, women and men	96.60% (1990)	98.78 % (2011) Female: 98.75 % Male: 98.80 %	100.00%	▶	*BPS, Susenas*

Status: ●Already Achieved ▶On-track ▼Need Special Attention

CONDITIONS AND TRENDS

Education is the basic right of every citizen that the government must meet. As a form of commitment in providing opportunity to education, in 1994, the Government of Indonesian declared compulsory primary education for children between the ages of 7-15 years, encompassing education at SD/MI level and SMP/MTs level. Achievements in primary education services are measured by three indicators: (i) NER Primary School (SD/MI); (ii) Proportion of pupils starting grade 1 who complete primary school; and (iii) literacy rate for people aged 15-24 years.

Efforts to provide opportunity for all school-age children to complete primary education showed encouraging results. In terms of access, participation in education at SD/MI/equivalent level experienced a significant rise as is shown by NER and GER indicators. However, NER and GER by themselves cannot completely explain the existing realities. For SD/MI/equivalent level and children aged 7-12 years, although the rise has not been as steep as that for the SMP/equivalent level, at 90 percent the increase was satisfactory nonetheless. With this proportion in mind, the remaining target of education participants has been categorized as children with various difficulties in accessing education, including distance to school combined with lack of public transportation and the parents' economic indigence.

The Net Enrolment Ratio (NER) experienced an increase. The NER at primary education (SD/MI) level rose significantly from 88.70 percent in 1992 to 95.55 percent in 2011 with the Gross Enrollment Rate (GER) exceeding 100 percent (Figure 2.1). If the current level of progress is maintained, it is estimated that Indonesia will achieve the educational MDGs in 2015. The rise in the primary education NER indicator is a reflection of sustainable government policy of increasing access to primary education.

This early entry phenomenon of the last few years has contributed to difficulty in achieving the NER target of 100 percent at the primary education level since a portion of children aged 6 years and under have already started in primary school and some children aged 12 years were even at the junior secondary level (SMP/ MTs). For this reason, the School Participation Rate (SPR) is also used to measure education participation for ages 7-12 years. According to data off the 2011 *Susenas* (*BPS*), SPR for ages 7-12 years reached 97.58 percent. This means that only 2.42 percent of children aged 7-12 years have not attended school.

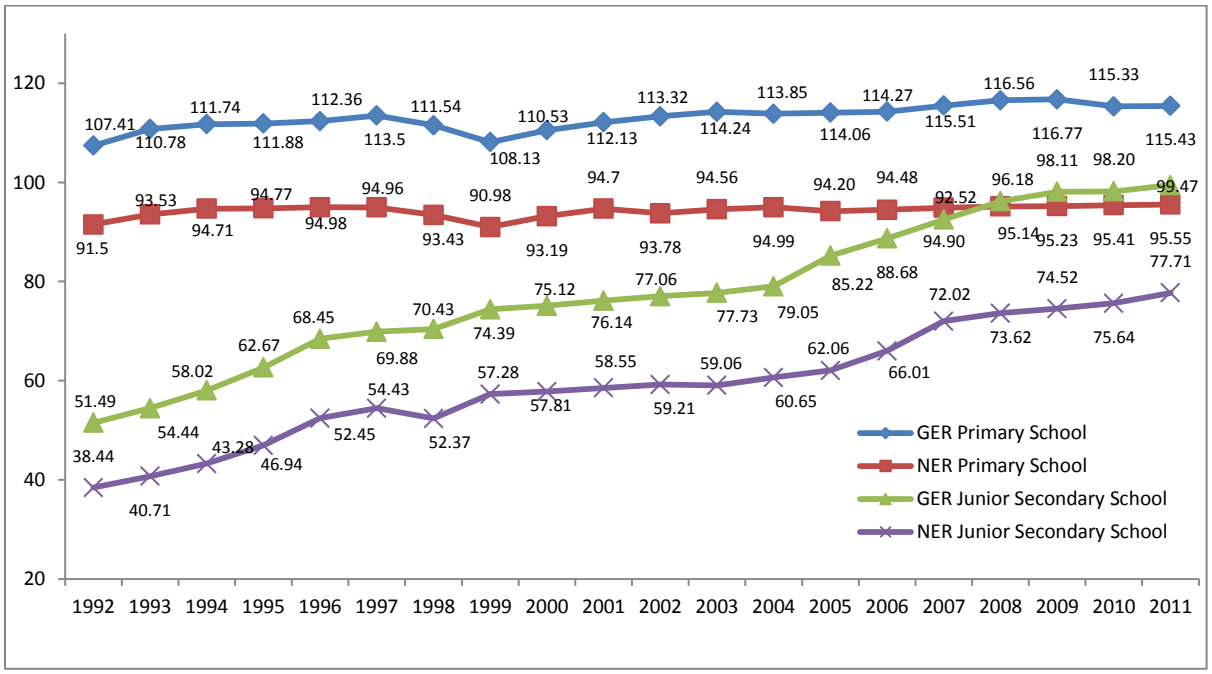


Figure 2.1. Progression of NER and GER indicators for Primary School (SD/MI) and Junior Secondary School (SMP/MTs), 1992-2011
Source: Ministry of Education and Culture

The very sharp difference between GER and NER for the primary education (SD/MI/equivalent) level, and more notably so for the junior secondary (SMP/MTs/equivalent) level, indicates that many students are late in completing their primary education that impact will be felt at the junior secondary level. However, besides the delay there is yet another problem of more serious consequence, namely school dropouts, primarily at the primary school, as once they quit at this level, students will not go to continue to the junior high school/equivalent schooling.

The indicator of first graders finishing primary school has shown significant progress. In 2011, 96.58 percent of first graders remained in school and completed primary school, a rise from 62.0 percent in 1990. Data by province indicate that in 2011 disparities of achievement among provinces have narrowed, ranging now from 95.11 percent in Papua to 96.88 percent in West Nusa Tenggara. This is indicative of improved efficiency of internal education marked by reduced dropout and increased schooling continuation rates. However, efforts are still needed to raise the retention rate, notably so in provinces that remain below the national average.

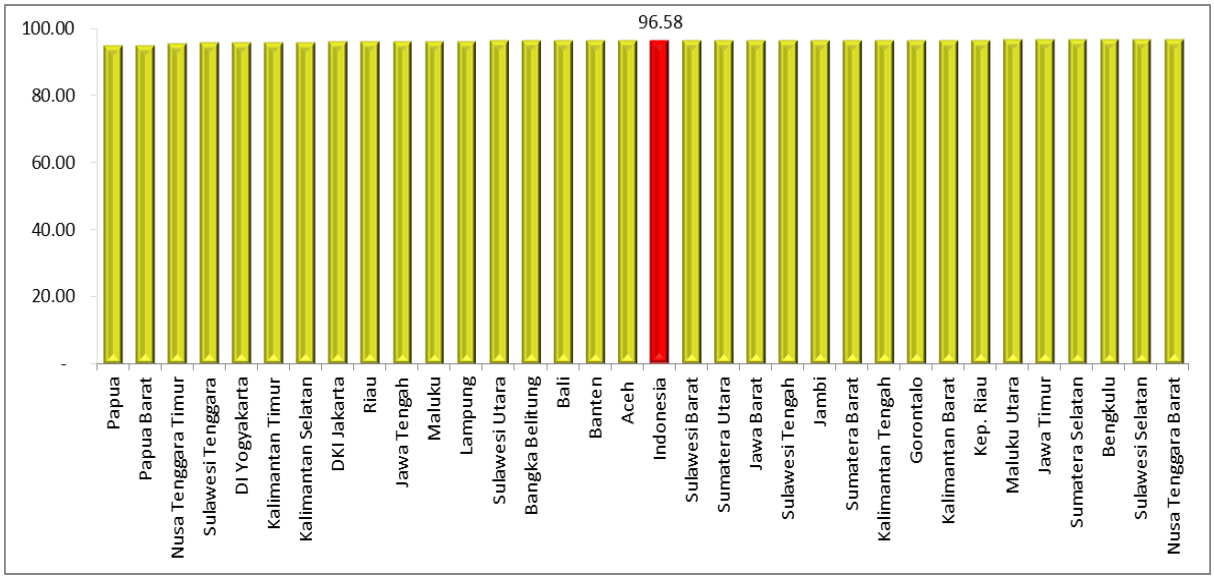


Figure 2.2. Proportion of pupils starting grade 1 who complete primary school, 2011
Source: Ministry of Education and Culture

On the other hand, the literacy rate continues to improve as can be seen from the literacy rate indicator. Progress in literacy rates for females and males aged 15-24 years indicates improvement from year to year. According to Susenas data, literacy rate rose from 96.60 percent in 1990 to 98.78 percent in 2011, 98.80 percent for males and 98.75 percent for females (Figure 2.3).

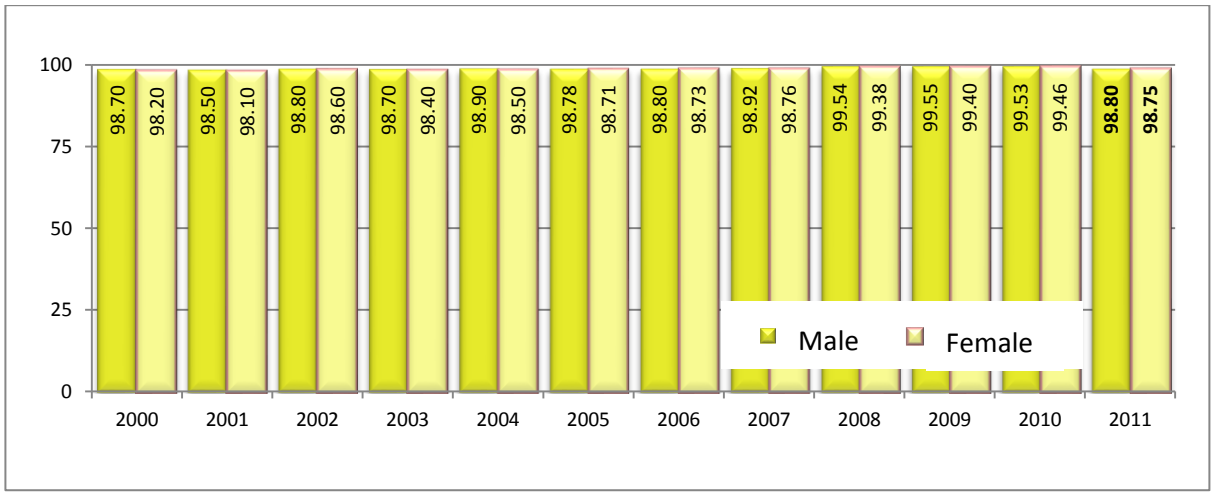


Figure 2.3. Progression of male and female literacy rates aged 15-24 years, 2000-2011
Source: *BPS, Susenas* 2000-2011

This achievement was supported by two key efforts. The first was education services at the primary education (SD/MI) level that reached a Gross enrollment rate of 102.58 percent in 2011. Extensive delivery of primary education services through the compulsory learning program that led to improved reading, writing, and arithmetic skills. The second was improved retention rates, or the proportion of first graders going all the way through to grade VI in the education system.

The remainder of a half percent of people aged 15-24 years can be explained by the fact that when they were 7-12 years of age, i.e. in between 1993-2002, access to primary education (SD/MI/equivalent schooling) was not as good as it is today and also by the fact that Gross retention rates were rather poor. For that reason, the illiterate proportion for 2011 of the 15-24 year age

group has in fact never gone to school while another proportion dropped out and experienced relapsed illiteracy because of a lack of preservation of reading, writing, and arithmetic skills.

This condition at the sub-national level indicates that disparity among provinces as concerns literacy skills, marked by the literacy rate of the 15-24 year age group, is rather uniform, except for Papua Province which reached a rate of 74.57 percent only in 2011 (Figure 2.4). For that reason, improved participation at primary education level promotes improved reading and writing skills.

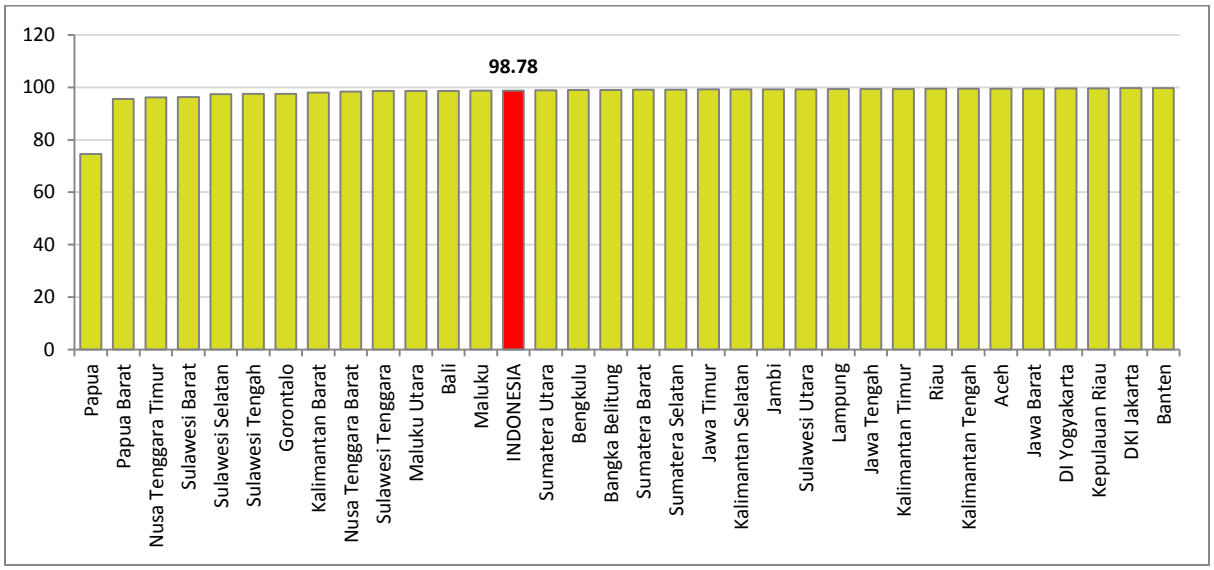


Figure 2.4: Literacy rates for people aged 15-24 years by province, 2011
Source: *BPS, Susenas* 2011

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

In the framework of providing equitable education services, the Government of Indonesia has carried out accessible and quality primary education through, among others, School Operation Assistance (BOS). The program has been in place since 2005 and is designed to free poor students of education fees while alleviating the cost burden for others. By providing BOS for all primary education (SD/MI/Salafiyah Ula) and junior secondary education (SMP/MTs/Salafiyah Wustha) students in 2011, over 42.1 million people benefited. In 2012, to support completion of the nine-year compulsory education program, the government raised the BOS program cost unit for primary education (SD/MI/Salafiyah Ula) schooling to IDR 397 thousand (district) and IDR 400 thousand (city) between 2009-2011. Meanwhile, at the junior secondary education (SMP/MTs/Salafiyah Wustha) level, the cost level was increased to IDR 570 thousand (district) and IDR 575 thousand (city) to IDR 710 thousand/ student/year, benefitting 13.38 million students. The BOS program is an extremely effective tool to suppress the school dropout rate and to lower the school discontinuation rate, and has been successful in alleviating education costs, notably for parents with low economic means.

To encourage poor students to continue school, the Government of Indonesia has applied a full pro-poor policy that provides subsidies for poor students in all education levels (nearly 8.2 million in 2011). Approximately 6.67 million were primary school students (4,553,604 and 2,124,657 students, respectively). The program was expected not only to assist in alleviating the burden of education costs for poor students, but also to draw dropouts back to school.

To support quality enhancement and fair, equitable, and accessible distribution of learning opportunities for all children in Indonesia, the Government of Indonesia has, since 2003, made

education facilities and infrastructure support available through the Special Allocation Budget (DAK) program for general and extraordinary primary school and junior high school levels. In 2011, with a total budget of IDR 10,041.3 billion, DAK activities in the education sector included, among others, the construction of new classrooms (RKB) and fittings, the construction of libraries and fittings, the rehabilitation of severely and moderately damaged classrooms (RK), the construction of other classrooms and improved quality of education that were carried out in 491 districts/cities throughout Indonesia. In 2011, through State Budget (APBN) allocations, 450 one-roof primary-junior high school (SD-SMP) buildings in, notably, remote, backward, and border regions in order to reach students that had no access to education services. Moreover, last September, upon the President's directive, the "National Movement for Rehabilitation of SD and SMP Buildings in 2011" was launched, which targets 21,500 general schools (SD/SMP) and 3,030 madrasah (MI/MTs). The movement is hoped to address severely damaged general schools (SD/ SMP) classrooms in 2012 and madrasah schools (MI/MTs) classrooms in 2014.

To enhance teacher professionalism, Law 14/2005 concerning Teachers and Professors requires teachers to possess academic qualification, competence, and proper certificates. In 2011, 1,020,824 public school teachers were certificated. To enhance the welfare of teachers whom are assigned to remote areas, in 2011, the Government of Indonesia has provided special allowances for 44,000 teachers for all education levels. These efforts are expected to strengthen performance, professionalism, and the learning and teaching process.

To improve calories intake of education participants, the Government of Indonesia, by virtue of Inpres 1/2010, implemented the school children complementary food supplementation (PMT-AS) program with the engagement of a broad range of sectors. In 2011, targets numbered 1,200,000 nursery school and SD students and 180,000 RA and MI students by prioritizing isolated, remote and border regions, small islands, and/or outermost islands, and inland regions in 27 districts. The program is expected to bridge the need of increasing nutritional intake and physical endurance of school children.

Box 2.1.
"SIPBM, a Community-based Educational Information System in Polewali Mandar District"

To support compulsory 9-year primary education, the Government of Indonesia continues to implement a broad range of policy programs to improve participation in education in order to reduce dropout and illiteracy rates. For the purpose of proper targeting of policy programs, accurate data are required on education conditions that can ably describe the population by school age and status, and the reasons why children are not in school and how many.

In 2003, a rather new data collecting model was introduced in South Sulawesi. With cooperation of the Research and Development Agency (Balitbang) of the Ministry of Education and Culture, UNICEF, and UNESCO, the Community-based Educational Information System (SIPBM) was introduced. The program allows for data collecting for children aged 0-18 years, accurately screening education information with the help of the community, notably in remote areas lacking proper access, in order to provide a clear illustration for use in educational development planning, particularly with regard to the 9-year compulsory learning program.

The Bantaeng District was among the five UNICEF districts that were picked to be the first to implement the SIPBM program. They were followed in the same year by two other districts: Bone and Polewali Mandar. Program implementation took place in 2004. In the districts Takalar and Mamuju, the SIPBM program was developed in early 2005. Through funding support from the Ministry of Education and Culture, Polewali Mandar collected data in 13 sub-districts and in 2007 a comprehensive district education profile was produced.

SIPBM data were able to describe a clear portrait of education issues faced at the village/ward level and even at the hamlet/neighborhood level. The program proved useful in stimulating participation of local communities and decision-makers in resolving village education issues.

In 2004, action plans drafted for 11 pilot villages in Polewali Mandar saw 11 SD dropouts return back to school at SDN No 030 Tapango. On 28 December 2004, with the help of the Tapango sub-district head, the Tapango village chief, the principal of SDN No 030 Tapango, the school committee, and the SIPBM district facilitator, every student that dropped out were handed over by the school committee to the school.

Using SIPBM data, government apparatus and local governments have commenced a primary school distant learning classroom for the villages of Kurrak and Pallata, awarded scholarships for students of low economic means through the Village Allocation Budget (DAD) for the village of Batu, and awarded scholarships through village *Amil Zakat* funds in the village of Bussu, Tapango Sub-district. SIPBM data have been acknowledged to having played, in 2007, a useful role in the back-to-school movement of Polewali Mandar's the *Tuntas Wajar Dikdas* program, *Tuntas Buta Aksara*, and *Tuntas PAUD*. A total of 418 dropouts were successfully returned to the education system.

GOAL 3
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Source: Ministry of Women's Empowerment and Children's Protection

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	2015 MDGs Target	Status	Sources
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	Ratio of girls to boys in primary, secondary and tertiary education					*BPS, Susenas*
	- Ratio of girls to boys in primary school	100.27% (1993)	98.80% (2011)	100.00	▶	
	- Ratio of girls to boys in junior high school	99.86% (1993)	103.45% (2011)	100.00	▶	
	- Ratio of girls to boys in senior high school	93.67% (1993)	101.40% (2011)	100.00	●	
	- Ratio of girls to boys in higher education	74.06% (1993)	97.82% (2011)	100.00	▶	
3.1a	Literacy ratio of women to men in the 15-24 age group	98.44% (1993)	99.95% (2011)	100.00	●	
3.2	Share of women in wage employment in the nonagricultural sector	29.24% (1990)	36.67% (2011)	Increase	▶	*BPS, Susenas*
3.3	Proportion of seats held by women in national parliament	12.50% (1990)	18.4% (2011)	Increase	▶	*KPU*

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

One of the objectives of human development in Indonesia is to achieve gender equality in various fields of development, employment, and politics. This achievement of gender equality will support the effort to improve the quality of human resources, both males and females. In the education sector, efforts have been made to improve gender equality by providing equal access and opportunities to males and females. And these efforts have indicated advances. These advances, among others are indicated by the improved Gender Disparity Index or GPI ratio of females to males in various levels of education, where gender equality is indicated by a ratio of 1 or close to 1. Based on National Socio-economic Survey Data in 1993 to 2011 indicates that the GPI in primary and junior high school education ranged from 95-105, while the GPI in senior high school education fluctuated with the tendency to rise significantly. In 2011, the GPI at Primary School (SD/MI/Package A) was 98.80; 103.45 in Junior High School (SMP/MTs/Package B); 101.40 in Senior High School (SMA/MA/Package C); and 97.82 for higher education.

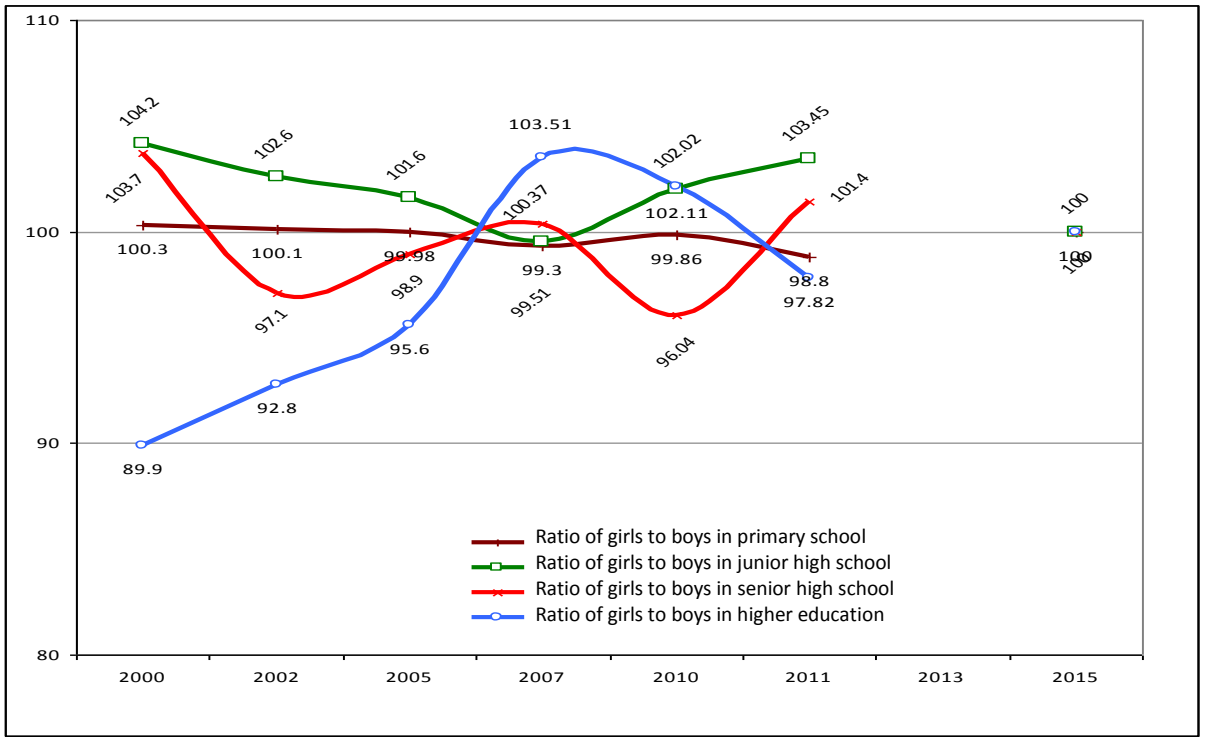


Figure 3.1. Gender Disparity Index (GPI) of females to males, 2000-2011
Source: *BPS*, *Susenas* several years

In the meantime, MDGs target for the ratio of literate females to males in Indonesia for the 15-24 years age group was also achieved. The ratio of literate females to males at national level reached 99.95 percent in 2011 (Figure 3.2). The diversity in literacy GPI among provinces ranged from 86.88 percent (Papua) to 101.15 percent (East Nusa Tenggara). The success in achieving the target in this sector was supported by the correct selection of literacy elimination strategy, which was functional literacy education. Through functional literacy education, citizens were taught literacy skills that serve to support day-to-day life.

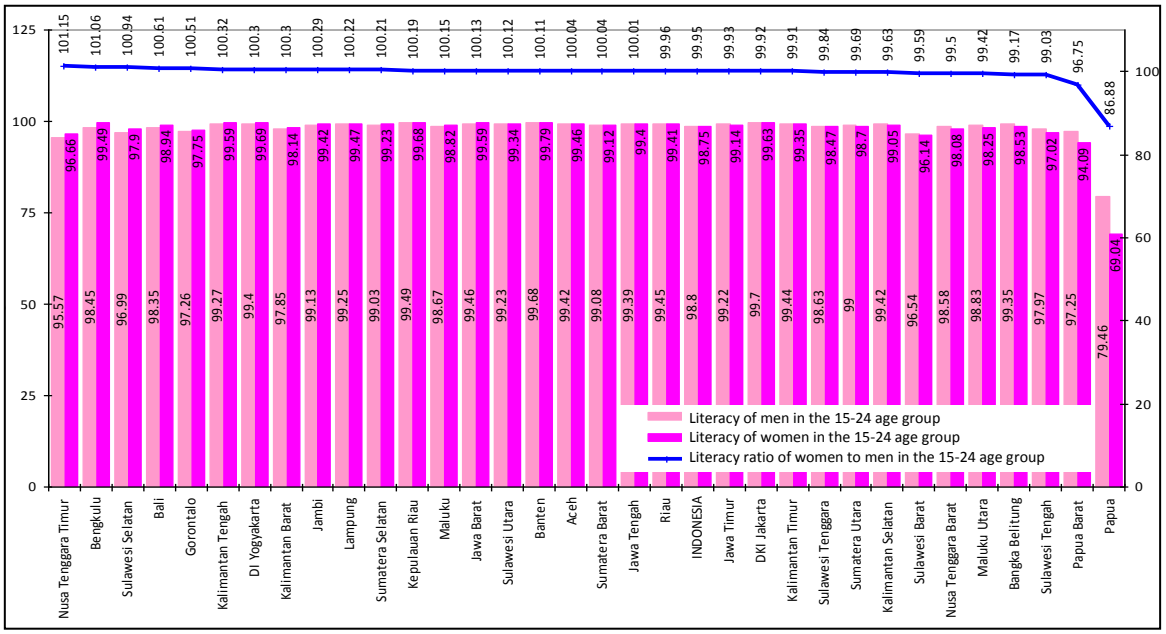


Figure 3.2. Diversity of literacy levels of males and females, 2011
Source: *BPS*, *Susenas* several years

In the labor force, Indonesia has followed the MDG target to increase female contribution in wage employment in the non-agriculture sector. The contribution of females in wage employment in the non-agriculture sector has increased from 29.24 percent in 1990 to 36.67 percent in 2011. However, national attention is still directed at the diversity of female contribution in wage employment in the non-agriculture sector among provinces. There were 20 provinces with female contribution in the non-agriculture sector lower than the national average. The provinces with the lowest female contribution were East Kalimantan (26.50 percent), West Papua (28.41 percent) and Papua (29.67 percent), whereas the highest female contribution was in Gorontalo at 44.62 percent (Figure 3.3).

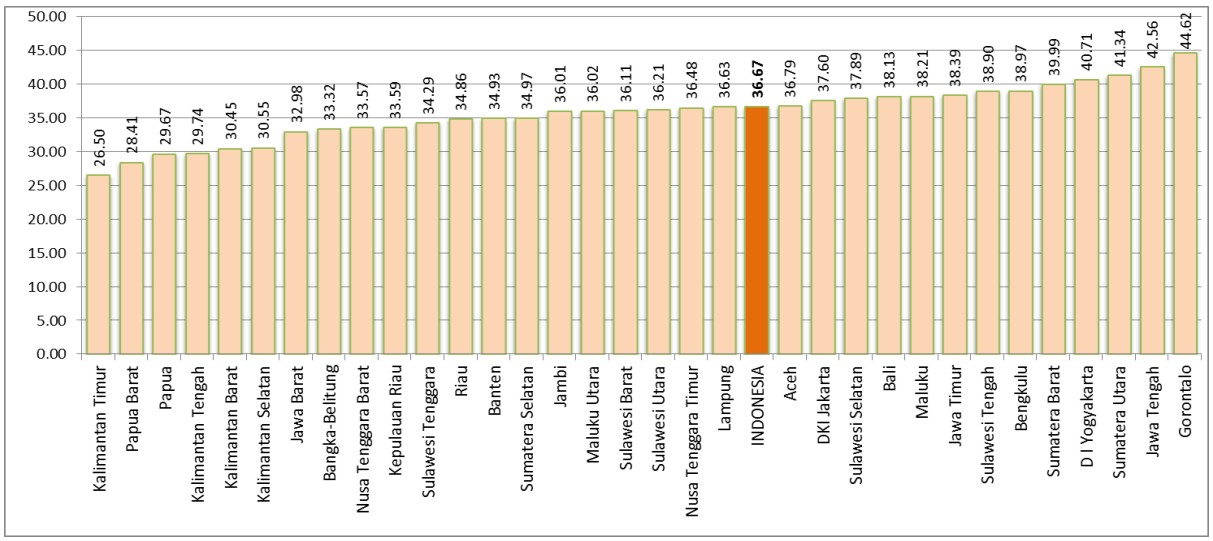


Figure 3.3. Share of women in wage employment in the nonagricultural sector, by province 2011
Source: *BPS*, 2011 National Labor Force Survey

In addition, efforts toward gender equality in politics that have been made all this time also produced results. The role of women in politics, as illustrated by the proportion of parliament seats occupied by women, has increased significantly. This proportion increased from 12.5 percent in 1990 to 18.4 percent in 2011.

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

The success in the effort to improve gender equality and women empowerment in Indonesia was generally achieved because of the incessant gender mainstreaming (PUG) efforts since 1999. Related to the literacy ratio, gender equality was also achieved thanks to the selection of the correct education strategy, which was functional literacy. With this strategy, the literary skill learned is an ability that serves to support day-to-day life both for men and women. Apart from that, especially at junior high school level, policies that promote male GPI improvement need to be considered.

In order to accelerate the implementation of PUG, then gender perspective should not only be integrated into the planning system, but also budgeting. This initiative began with the issue of Minister of National Development Planning/Head of National Development Planning Agency Decree Kep.30/M.PPN/HK/03/2009 concerning the Steering Team and Gender Responsive Budgeting and Planning Technical Team (PPRG), to coordinate cross sector and cross ministry PPRG implementation. For the very first time in National Medium-Term Development Plan (RPJMN) 2010-2014, gender mainstreaming policies were integrated into the planning and budgeting system, which contained policies, indicators, and targets disaggregated gender from various ministries and institutions. This was followed up by the issue of Minister of Finance Regulation (PMK) 119/PMK.02/2009 concerning Preparation Instructions and K-L Budget and Work Plan Reviews and

Preparation, Reviews, Validation and Implementation of DIPA in the 2010 fiscal year, and followed by PMK 104/PMK.02/2010 concerning the same matters for the 2011 fiscal year, which helps to accelerate the implementation of PPRG.

In 2010, ARG was tested on seven ministries and pilot organizations. Each prepared a terms of reference (TOR) and gender budget statement (GBS), which were gender-specific accountability documents compiled by ministries/institutions to inform that an activity is already gender responsive. In 2011, ARG expanded its application to various development priority areas, and was directed to support the Sub-national Action Plan for Accelerated Achievement of the Millennium Development Goals (RAD MDGs). This was carried out by identifying gender issues throughout all MDGs (not just Goal 3), and integrating gender perspective in sub-national regional planning and budgeting, which supports the implementation of sub-national regional activities to accelerate achievement of the Millennium Development Goals.

In addition, since mid 2011, National Strategy (Stranas) for Accelerated PUG has been compiled via PPRG. The Stranas was compiled by four ministries/institutions, which were the Ministry of National Development Planning/Head of National Development Planning Agency, Ministry of Finance, Ministry of Women's Empowerment and Children's Protection, and the Ministry of Interior, the engines that drive PPRG forward. The National Strategy for Accelerated PUG via PPRG is to accelerate implementation of gender mainstreaming according to the 2010-2014 National Medium-Term Development Plan (RPJMN), which altogether supports good governance, sustainable development, and achievement of the MDGs targets. Apart from that, Stranas was compiled for PPRG implementation to have more direction, be more systematic, and synergized, both at national and provincial level.

Box 3.1.
Efforts to Accelerate Gender Mainstreaming (PUG) in Indonesia

In follow-up to application of PPRG, in 2011, Minister of National Development Planning/Head of National Development Planning Agency implemented the 2009-2010 PPRG Implementation Trial Evaluation on seven ministries/institutions (Ministry of Finance, Ministry of National Development Planning/Head of National Development Planning Agency, Ministry of Women's Empowerment and Children's Protection, Ministry of Education and Culture, Ministry of Health Affairs, Ministry of Defense, and Ministry of Public Works) while four provincial governments have applied PPRG on their own initiative: Banten, DI Yogyakarta, Central Java, and East Java. The evaluation's scope addressed six PUG prerequisites: legal basis; commitment and institutional; the PPRG tool, inclusive of programs and activities; human resources capacity; data and information; and funding.

Evaluation results indicate that all seven trial ministries/institutions and each local government unit in the four provinces have successfully compiled a minimum of 1 GBS, as targeted. In fact, several ministries/institutions have exceeded the target to be tested, such as the Ministry of Public Works. The Ministry of Public Works has been classified as a 'newcomer' in adopting gender equality and PUG implementation, with strong enough commitment. This is reflected in its 2010-2014 Strategic Plan, which has advanced aspects of gender equality, and the level of implementation has been organized through Minister of Public Works Decree 363/KPTS/M/2009 concerning Formation of a Gender Mainstreaming Team for the Public Works Department. This decree has been renewed through Minister of Public Works Decree 134/KPTS/M/2011 concerning Amendments to Minister of Public Works Decree 363/KPTS/M/2009 concerning Formation of a Gender Mainstreaming Team for the Ministry of Public Works. The same commitment is reflected in the echelon-1 level with the compilation of a Gender Aspect Integration Guide in the Budget and Program Planning in the Ministry of Public Works, by the Public Works Secretariat General in 2009.

Next, ideally, PPRG is to be implemented by every technical planning unit, and directly coordinated by the Planning Bureau and KLN, not by the PUG Secretariat. This has been accommodated in the Minister of Public Works Decree 134/KPTS/M/2011. PUG Working Group members have provided their support in briefing gender and PUG concepts, including analysis compilation and/or GBS. This eases widespread gender perspective integration in the sphere of the Ministry of Public Works.

In the meantime, PUG has also been implemented at several regions such as Central Java. Gender mainstreaming in the education sector in Central Java Province was implemented intensively and sustainably since 2002 until today. Programs implemented are gender mainstreaming (PUG) capacity building for all stakeholders and PUG implementation trial on formal, informal, and non-formal education units throughout the districts and cities in Central Java Province.

The success of PUG implementation in the education sector in Central Java has been supported by several factors, including: (i) Strengthened PUG capacity and advocacy in the education sector which has been practiced continuously, starting from province level to district/city level; (ii) Regulations for accelerated PUG implementation in Central Java is expressed in the 2008-2013 RPJMD, and next, was followed up by the issue of Gubernatorial Circular 903/13113 of 2010 on Formulating Guidelines for Central Java Province RKA-SKPD, RKA-PPKD and RBA-RSD Documents for FY 2011 and the following years; (iii) Synergy between the Ministry of Education and Culture as the PUG implementer and the Gender/Women Study Center as the gender expertise center in Central Java and Organizations as well as PUG drivers, such as the Women's Empowerment, Children's Protection, and Family Planning Agency (BP3AKB) and the Sub-national Development Planning Agency (Bappeda); (iv) Optimized utilization of education PUG block-grant funds from the Ministry of Education with provincial budget funds; (v) PUG fund block-grant from provinces to districts/cities, followed by facilitation and monitoring of PUG implementation at formal, non-formal and informal education units.

Currently, several education units have already integrated gender equality and justice, both in school environments, school visions and mission statements, learning materials, and educational facilities paying attention to the difference in the needs of males and females. In fact, education PUG is currently not only managed through the PUG Education Working Group, but has also been integrated in the Primary Education Program through the Gender Responsive Budget Piloting Program for the Education Sector.

GOAL 4
REDUCE CHILD MORTALITY RATE

Source: Center for Public Communication, the Ministry of Health

GOAL 4:
REDUCE CHILD MORTALITY RATE

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate						
4.1	Under-five mortality rate (per 1000 live births)	97 (1991)	44 (2007)	32	▶	*BPS*, IDHS
4.2	Infant mortality rate (AKB) (per 1000 live births)	68 (1991)	34 (2007)	23	▶	
4.2a	Neonatal mortality rate (per 1000 live births)	32 (1991)	19 (2007)	Decreasing	▶	
4.3	Proportion of one-year-old children immunized against measles	44.5% (1991)*	87.30% (2011)**	Increasing	▶	**BPS*, IDHS ***BPS, Susenas* 2011

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

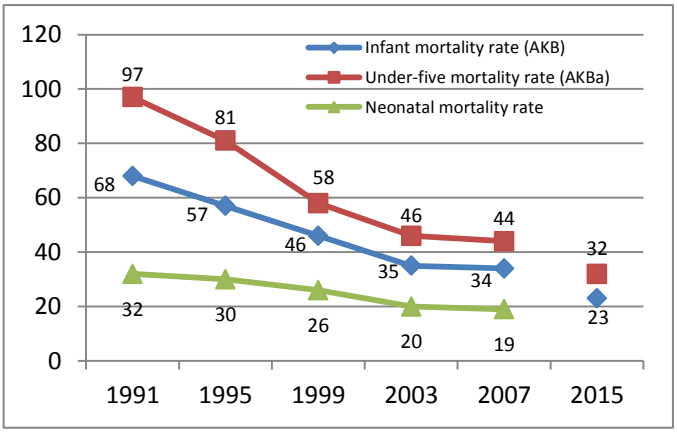


Figure 4.1. Declining under-5, infant, and neonatal mortality rates, 1991-2007
Source: IDHS (*BPS*), several years

The status of child health in Indonesia has been improving. This is indicated by declining rates of neonatal, infant, and under-five mortality (Figure 4.1). Under-five mortality declined sharply from 97 per 1,000 live births in 1991 to less than half, which were 44 in 2007. Infant mortality rate significantly declined from 68 per 1,000 live births in 1991 to 34 per 1,000 live births in 2007. Over the same period neonatal mortality rate also declined from 32 per 1,000 live births to 19 per 1,000 live births.

Nevertheless, when comparing the IDHS of 2002-2003 to 2007, the declines in neonatal, infant, and under-5 mortality tend to be stagnant. The main cause of under-5 mortality was neonatal complications (asphyxia, low birth weight, and neonatal infections), infectious diseases (primarily diarrhea and pneumonia) as well as closely related to nutritional problems (malnutrition). Other issues were the disparity among provinces on neonatal mortality, infant mortality and under-5 mortality are relatively high. This condition was caused by issues of quality and access to health services, socio economic and cultural issues, infrastructure development as well as the openness of areas to educational and economic development.

Efforts to improve the health of children is affected by increased coverage of services received since pregnancy period through: quality prenatal care, delivery attended by healthcare professionals primarily in health facilities, neonatal care (through neonatal visits), immunization coverage primarily measles immunization, neonatal treatment, and treatment of ill infants and children under-5 according to standardized basic health facilities and referral health facilities. Coverage of care can also be improved through increasing knowledge of families and the community on care during pregnancy and during the neonatal, infant and toddler stages, as well as early detection of disease and care seeking behavior to health facilities.

This improvement in child health is related to disease prevention efforts, including immunization. Complete basic immunization for children covers BCG once, DPT-HB 3 times, polio 4 times, and measles once. On average, 77.9 percent of children aged 12-23 months have been immunized with BCG, 74.4 percent have obtained immunization against measles, 66.7 percent have obtained immunization against polio, and 61.9 percent have obtained DPT-HB immunization (2010 *Riskesdas,* MOH).

Disparity of provision of the immunizations for children aged 12-23 months according to province (Figure 4.2) is BCG from 53.6 percent (Papua) to 100 percent (DI Yogyakarta); measles from 47.1 percent (Papua) to 96.4 percent (DI Yogyakarta); polio from 40.5 percent (Papua) to 96.4 percent (DI Yogyakarta), and DPT-HB from 35.7 percent (West Sulawesi) to 96.4 percent (DI Yogyakarta).

Figure 4.2 indicates the disparity in providing immunization. First, DPT-HB immunization in each province is the lowest out of the four basic immunizations, followed in order by polio immunization, then measles immunization, and BCG as the highest. Second, the tendency to provide immunization is different between DPT-HB, polio and BCG immunization on one side and measles on the other side. Third, according to the first and second tendency, there were 17 provinces with a proportion of children aged 12-23 months that were below the average in receiving immunization. Next, there were 4 provinces having a proportion of immunization coverage that was far lower than the national average, even the lowest throughout Indonesia, which were Papua, West Sulawesi, Aceh, and North Sumatera.

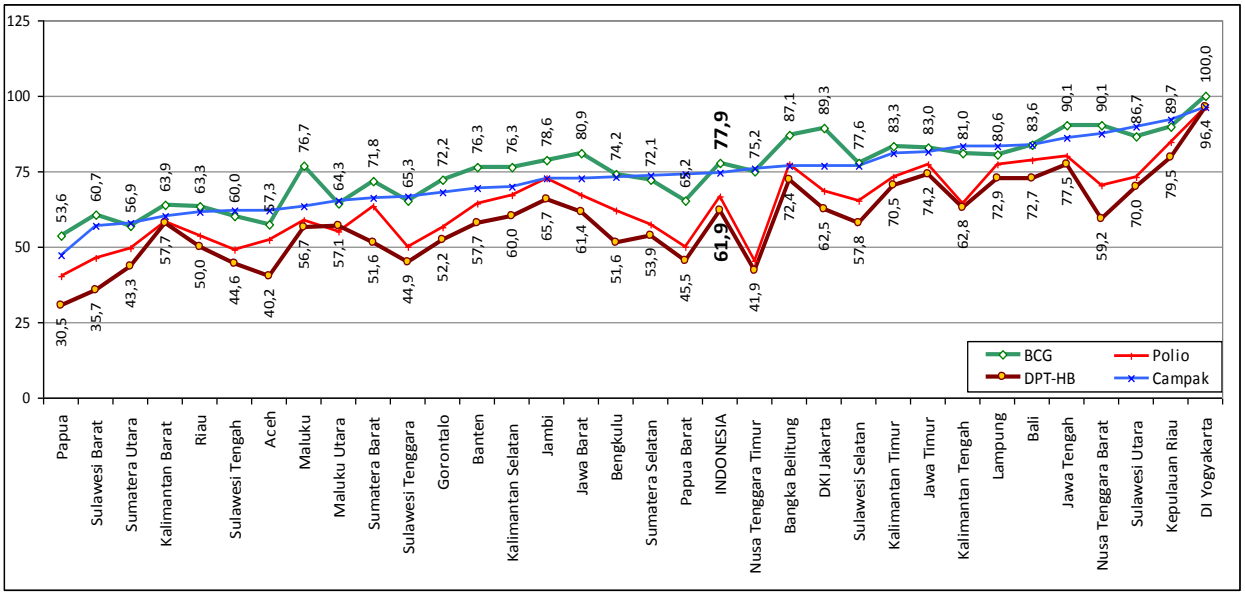


Figure 4.2. Disparity in basic immunization delivery for children aged 12-23 months, 2010
Source: 2010 Basic Health Research, Ministry of Health Affairs

Paying attention to the disparity, the provision of immunization for children is at least affected by two factors that are vaccine availability and parents. The education level of the head of the family and family economic capacity level indicate an extremely clear and positive correlation where the higher the level of education of the head of the family, and the higher the family economic capacity level, the higher the possibility for the child to obtain immunization. Next, at national level, there is the tendency that children living in urban areas have a higher possibility of obtaining immunization compared to those living in rural areas.

In the meantime, 2011 *Susenas* data indicates the percentage of 1-year-old children immunized against measles was 87.30 percent. Baseline indicator used is the 1991 IDHS (44.5 percent). However the most recent IDHS data available is 2007 (67.0 percent). For the year 2007, there is also *Susenas* data indicating 84.67 percent. The analysis at provincial level indicated that there were 18 provinces with measles immunization coverage lower than the national average. Provinces with the lowest immunization coverage were Papua (69.92 percent), West Sulawesi (76.02 percent), and North Sumatera (78.29 percent). The province with the highest immunization coverage was DI Yogyakarta with 98.31 percent (Figure 4.3).

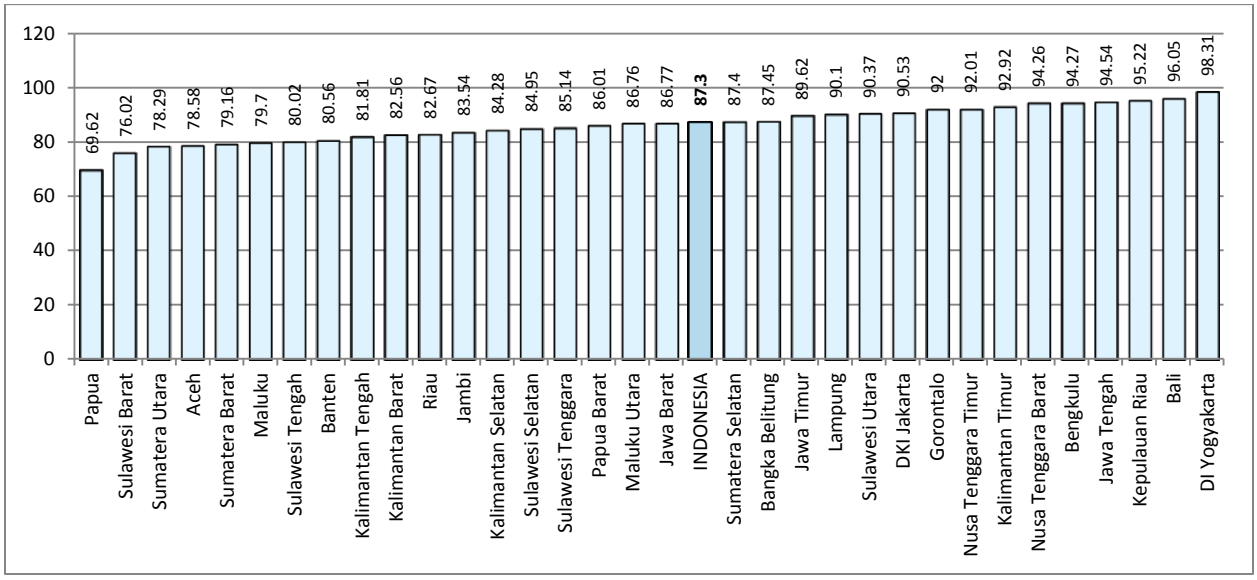


Figure 4.3. Percentage of 1-year-old children immunized against measles, 2011
Source: *BPS*, 2011 *Susenas*

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

Various initiatives have been implemented to improve the health of children in Indonesia, namely through a continuum of care based on life cycles, a continuum of care based on healthcare services (promotive, preventive, curative and rehabilitative), a continuum of care pathway when the child is at home, in the community (services from integrated health posts and village health posts), at primary health care facilities, and referral health care facilities.

Efforts to speed up the decline of infant mortality rate focuses on the cause of death, considering 56 percent of infant deaths occur during the neonatal period and 46 percent of deaths in children under the age of five occur during the neonatal period. Efforts to accelerate the decline of infant mortality and mortality of children under the age of five focuses mainly on improving access and quality of neonatal

care, reducing prevalence and deaths due to diarrhea and pneumonia, reducing and managing malnutrition and poor nutrition as well as increasing measles immunization coverage.

Reducing neonatal mortality rate is made through efforts such as improving deliveries attended by healthcare personnel primarily in health facilities, increasing neonatal care visits by health workers to 3 times (6-48 hours after birth, day 3 to day 7 and day 8 through to day 28), providing Basic Emergency Obstetric and Neonatal Care (PONED) at PONED community healthcare centers (a minimum of 4 PONED community healthcare centers per district/city), and providing Comprehensive Emergency Obstetric and Neonatal Care (PONEK) in PONEK hospitals (a minimum of 1 PONEK hospital per district/city). Since 2010, the government has launched the Jampersal Program (a government-funded childbirth insurance program) which is one of the breakthroughs in accelerating the reduction of maternal and neonatal mortality. Childbirth insurance is aimed to protect and save pregnant women, childbirth, postpartum and neonatal infants from complications and risks of death. This childbirth insurance provides insurance in prenatal care, deliveries, postpartum care, and newborn care for all mothers and newborns that do not have health insurance yet.

To control diarrhea cases and deaths due to diarrhea as the most common cause of death after neonatal complications, it is crucial to provide and evenly distribute ORS and zinc at the community level and in healthcare facilities in addition to exclusive breastfeeding success rates, provision of clean water, provision of family latrines, hygiene and sanitation, as well as diarrhea treatment that is up to standards. To control pneumonia cases and deaths due to pneumonia as the third leading cause of deaths in infants and under-5 children, it is important to provide and distribute antibiotics in healthcare facilities in addition to exclusive breastfeeding success rates, complete basic immunization, hygiene and sanitation, indoor and outdoor pollution prevention, as well as standardized treatment of pneumonia.

In efforts to increase immunization coverage for measles in addition to establishing an equitable supply and distribution of vaccines using a cold chain system, increasing immunization socialization both through electronic and print media becomes very important, as well as carrying out specific approaches for areas with difficult access due to geographical and weather factors, using sustainable outreach service (SOS) approaches.

Efforts taken to reduce neonatal, infants, and children under-5 mortality are interventions at the family and community levels, at the level of primary healthcare services and referral healthcare services. Interventions at the family and community levels, are among others; implementation of the Maternal and Child Book (KIA) even in referral healthcare facilities, strengthening of integrated health service posts, increased monitoring of growth and development of infants and children under-5, complete basic immunization, administering vitamin A in infants and children under the age of five, and iron folate to pregnant women, administering ORS and zinc when suffering from diarrhea, PHBs counseling including washing hands with soap, mother and toddler classes, early detection of sick infants and children under the age of five, including early detection of infants and toddlers suffering from poor nutrition and malnutrition, community feeding centers and home visits.

There are also interventions at the level of basic services and referrals which include quality and integrated prenatal care, delivery that is assisted by healthcare personnel especially in healthcare facilities, handling of emergency cases through PONED community health centers and PONEK hospitals, post partum care for mothers and newborns, family planning services and family planning (KB) service referrals, neonatal care, and care for sick infants and children under the age five according to standards (among others, Integrated Management of Child Illnesses), managing malnutritioned children under the

age of five (Therapeutic Feeding Center) and referral services for malnutrition cases with complications, and referral services for sick infants and children under the age of five.

In order for the services mentioned above to be implemented, availability of healthcare personnel becomes very important both in type and competence (midwives, nurses, nutrition field workers, and nutritionists, doctors, Child Specialists, Obgyn physicians and Anesthesiologists). For areas experiencing issues with availability and continuity of health workers, several other strategies are then carried out, among others: education programs for specialist doctors (PPDS), physicians with additional authority, senior resident placement, assignment of specific individuals (residents and D3 health personnel), assignment of special teams (contracting in and contracting out). For areas with difficult access, a special approach is needed to provide services such as sustainable out services methods (SOS), increasing competency of personnel not only in early detection but also in administering first aid or other approaches that are considered appropriate which has already started trials in Jayawijaya and Buru Island Districts.

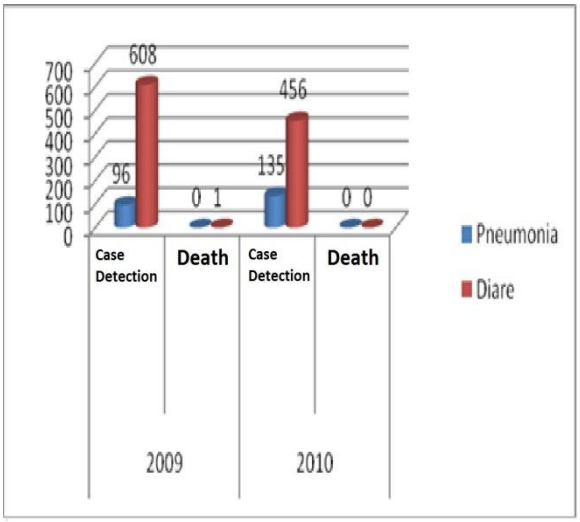
No less important is the supply and distribution of medicine and complete medical equipment that are ready to use which will support standardized service in addition to facilitative supervision conducted regularly.

Successful health care services depend on improvements in infrastructure and transportation, the role of professions and universities as well as non-governmental organizations and donor agencies in supporting the quality of health care.

Implementation of Integrated Management for Under-5 Illness (MTBS) at the Sei Malang Health Center in 2009 and 2010 shows the following results; the graph above shows increased incidences of pneumonia patients, for diarrhea patients despite a decrease in cases, discovery rates are still high. Cases of deaths due to diarrhea has fallen from 2009 (1 case) to no deaths in 2010, likewise for 2009 and 2010 where there were no cases of deaths found due to pneumonia.

Influence of the MTBS program on immunization of infants, shows an increase in immunization coverage from 38 percent Universal Child Immunizations (UCI) in Villages (in 2009) to 57 percent (in 2010). Nutrition programs for children under the age of five, shows an increase in detected cases of underweight children to severely underweight children or from 66 cases (in 2009) to 72 cases of underweight children under the age of five (in 2010). Cases of severely underweight children under the age of five have also increased from zero cases (in 2009) to one case (in 2010). These results indicate that the implementation of the MTBS program shows a positive impact in increasing early detection, treatment, and immediate referrals, so that if the MTBS program is continuously implemented in the correct way, a decrease in morbidity and mortality of children under the age of five is to be expected.

Box 4.1.
Implementation of MTBS at Sei Malang Health Clinic North Hulu Sungai District, South Kalimantan Province



Picture 4.1. Sei Malang Health Clinic Activities
Source: Ministry of Health Affairs

The main cause of under-five mortality in Indonesia is newborn complications such as infection diseases, diarrhea, pneumonia and malnutrition. The World Bank reported that the Integrated Management of Childhood Illness (MTBS) is an intervention that is cost effective for the issue of under-five mortality caused by acute respiratory infections, diarrhea, measles, malaria, malnutrition, or a combination of these. Most of these causes of death can be prevented by basic health service simple technology. MTBS offers comprehensive and integrative services for sick under-five children covering: evaluation, classification, identification of actions to be taken, administering medication, counseling for mothers, and follow-through. There are several benefits from MTBS: sick under-five children are evaluated at all aspects including the completeness of under-five essentials (giving exclusive ASI, PMT, vitamin A, immunization, etc), giving rational medication, and monitoring under-five children until recovery.

The Sei Malang health clinic has applied MTBS since 2003 and currently implements it every day for all sick under-five children. This health clinic owns one primary health clinic, 5 auxiliary health centers, and 5 village health posts, with 49 employees. The workplace has an area of 64.5 square kilometers, comprising 2 urban and 19 rural villages (2 villages are in the extremely disadvantaged category) and a population of 31,499. The MTBS trained workforce in this health clinic grew from 1 physician and 1 midwife in 2003 to 2 general practitioners, 3 midwives and 1 nurse. To help with MTBS implementation at the workplace, the health clinic has organized workshops for midwives, village midwives, and auxiliary health center nurses.

GOAL 5:
IMPROVE MATERNAL HEALTH

Source: Maternal Health Directorate, Ministry of Health

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

Indicator		Baselines	Present	2015 MDGs Target	Status	Source
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
5.2	Proportion of births attended by skilled health personnel (%)	40.70% (1992)	81.25% (2011)	Increase	▶	*BPS*, *Susenas*
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)	61.34% (2011)*	Increase	▶	**BPS*, IDHS ***BPS*, *Susenas*
5.3a	Current contraceptive use among married women 15-49 years old, modern method	47.1% (1991)	60.42% (2011)*	Increase	▶	
5.4	Adolescent birth rate (per 1000 women aged 15-19)	67 (1991)	35 (2007)	Decrease	▶	BPS, IDHS
5.5	Antenatal care coverage (at least one visit and at least four visists)					
	- 1 visit:	75.0%	92.8% (2010)**	Increase	▶	*BPS, IDHS **MOH, *Riskesdas*
	- 4 visits:	56.0% (1991)	61.3% (2010)**		▶	
5.6	Unmet need for family planning	12.70% (1991)	9.10% (2007)	Decrease	▶	*BPS*, IDHS

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

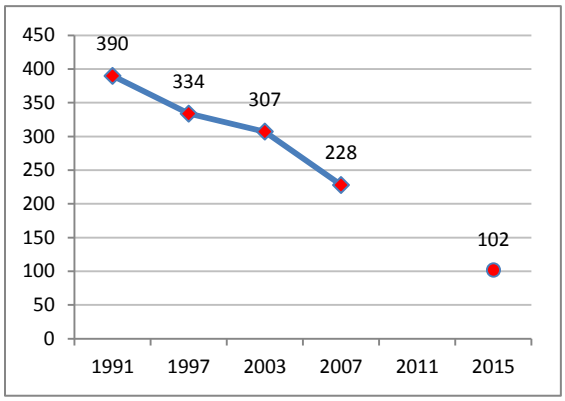


Figure 5.1. Maternal mortality and 2015 MDGs target
Source: BPS, various years of IDHS

Maternal mortality is one of the MDG targets that require hard work to achieve the target of 102 per 100,000 live birds by 2015. Maternal mortality declined from 390 in 1991 to 228 per 100,000 live births in 2007 (Figure 5.1). WHO estimates that approximately 15-20 percent of pregnant women, both in developed and developing nations, will experience high risk and/or complications. One of the most effective methods to reduce mortality is by improving births attended by skilled health personnel.

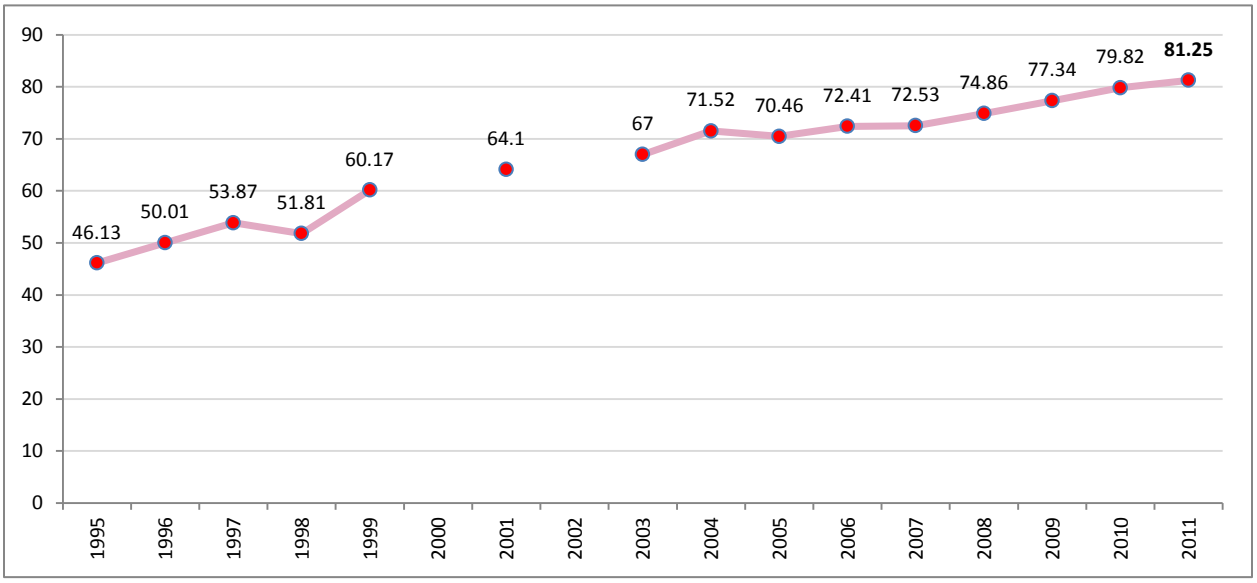


Figure 5.2. Progress in births attended by skilled health personnel, 1995-2011
Source: BPS, various years of *Susenas*

Proportion of births attended by skilled health personnel has increased significantly at national level from 46.13 percent in 1995 to 81.25 percent in 2011 (Figure 5.2). 2010 *Riskesdas* (MOH) data indicates that the proportion was 82.20 percent. However, deliveries in health facilities remained low as high as 55.4 percent (Riskesdas, 2010). Health facilities able to offer obstetric and basic emergency neonatal services (PONED) and obstetric and comprehensive emergency neonatal services (PONEK) continued to improve. The percentage of health clinics offering PONED care was 54 percent (2010 Health Profile) whereas city/ district hospitals offering PONEK reached 87.61 percent (MOH, 2011).

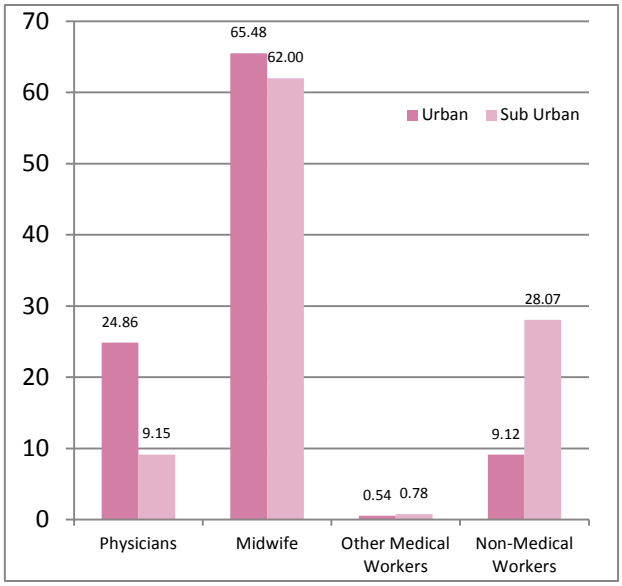


Figure 5.3. Birth attendants in rural and urban areas, 2011
Source: BPS, 2011

Deliveries with the assistance of skilled health personnel, such as physicians, midwives, and other medical workers vary among rural and urban areas. The comparison of delivery assistance between expecting mothers in rural areas and urban areas indicate a different situation (Figure 5.3.). Both in rural and urban areas, midwives have the highest proportion as birth attendants and other medical workers have the lowest proportion, both in rural areas and urban areas. The proportion of midwives as birth attendants was 62.00 percent in rural areas whereas it was 65.48 percent in urban areas. For other medical workers, it was 0.78 percent in rural areas and 0.54 percent in urban areas.

Disparity of births attended by skilled health personnel among regions were still wide. The 2011 *Susenas* results indicate that the existent of midwives and physicians were the two most important in delivery assistance. In figure 5.3, it indicates that the proportion of birth attended by physicians in urban areas were higher than in rural areas, which was 24.86 percent in urban areas and 9.15 percent in rural areas. Next, a large portion of delivery assistance (above 60 percent) was carried out by midwives. There was no significant difference in proportion between rural and urban areas.

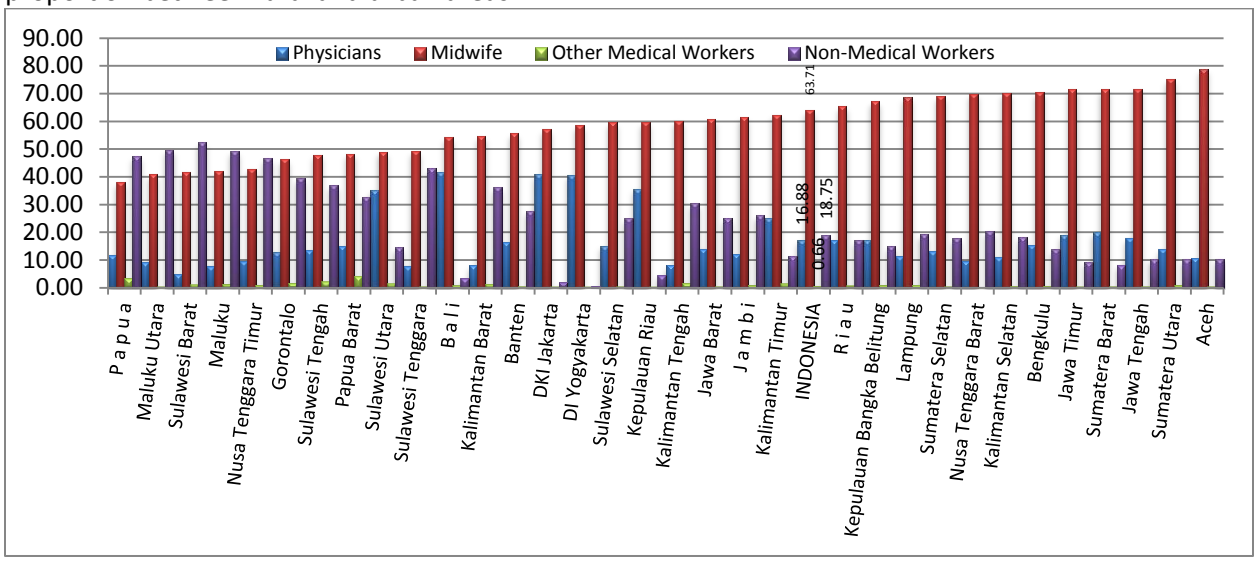


Figure 5.4. Birth attended by medical workers and non-medical workers, 2011
Source: BPS, 2011 Susenas

Furthermore, the *Susenas* data also indicate that the high rate of delivery attended by non-medical worker, including midwives and even own family members was likely due to unavailable medical workers. The highest proportion of delivery assistance by non-medical worker was in West Sulawesi and North Maluku. In these two provinces, more than half of deliveries were assisted by non-medical worker. The role of non-medical workers was the lowest in the delivery assistance in DI Yogyakarta, Bali, and DKI Jakarta.

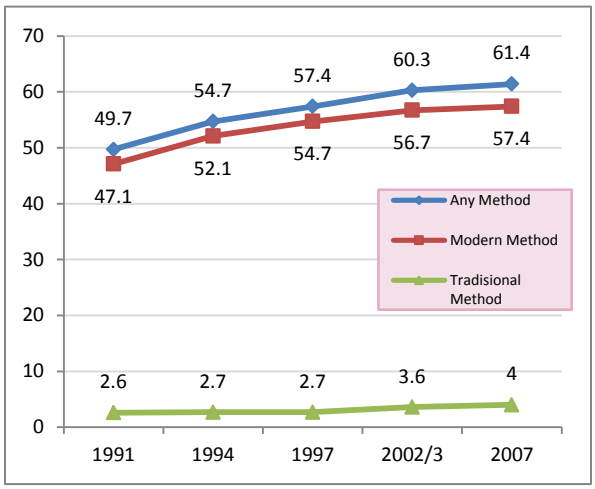


Figure 5.5. Contraceptive prevalence rate for married women aged 15-49 years
Source: *BPS*, various years of IDHS

Maternal, infant, and child health care use the continuum care strategy, which is the achievement of health levels through a series of concerted effort from pre-pregnancy. One of the most important services in this period is the contraception and reproductive health service. The contraceptive prevalence rate/ CPR for married women aged 15-49 years using all methods indicates an increase from 49.7 percent in 1991 to 61.4 percent in 2007 while CPR with modern methods rose from 47.1 percent in 1991 to 57.4 percent in 2007 (Figure 5.5). Next, 2011 *Susenas* data indicates a 61.34 percent increase in CPR for all methods and a 60.42 percent increase for modern methods.

The contraceptive prevalence rate also varies between provinces (Figure 5.6), which was 24.57 percent (Papua) to 71.79 percent (Central Kalimantan). Next, the proportion of modern method contraceptive use was much lower compared to all methods in Papua, indicating that the proportion of traditional contraceptive use was the highest compared to 32 other provinces. The extremely low level of modern contraceptive use and the high proportion of traditional contraceptive use make this province require special attention.

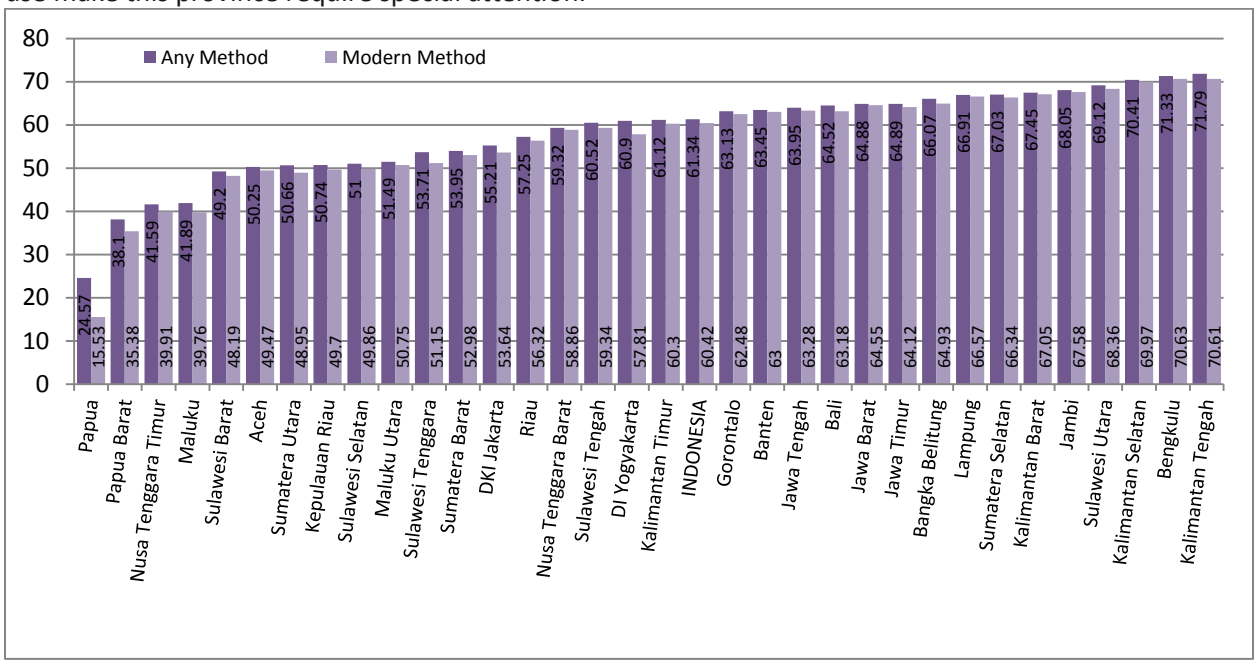


Figure 5.6. Contraceptive prevalence rate disparities between provinces, 2011
Source: BPS, 2011 Susenas

Apart from that, unmet need for family planning still occured. Fulfillment of the need for contraception is influenced by two factors, which are the availability according to the coverage of each and needs. The unmet need for family planning positively tend to decline for 16 years since 1991, which was from 12.7 percent to 9.1 percent in 2007 (BPS, IDHS). Next, unmet needs are also closely related to economic capacity and age, both in rural and urban areas (2010 Riskesdas). The lower the economic capacity, the

higher the level of unmet needs. This situation indicates that the higher the economic capacity, then the higher to ability to obtain this equipment. Unmet needs in married women are also related to age. The older the woman, the higher the unmet needs, except if the married woman is aged 10-14 years. Bearing in mind this tendency, it also occurs in the productive age group in terms of economy. Therefore, it can be interpreted that the level of needs or level of awareness also determines this. The proportion of unmet needs relatively equal between rural and urban areas indicates something positive, which is the level of awareness of rural citizens on the importance of family planning equal to urban citizens.

The decline in adolescent birth rates aged 15-19 years also indicates positive development. Female teenagers in this age group are vulnerable to the survival of babies. *Riskesdas* of 2010 found that married women aged 15-19 years have the highest baby mortality, which was 3.3 percent while the average status of the last child born to women aged 10-59 years was 1.3 percent (the status of the last child born five years before the survey). This positive development is indicated by female teenager birth rates for every one thousand females in this age group. This birth rate sharply declined by almost half in 16 years since 1991 (2007 IDHS).

Expecting mothers require antenatal care, which is care for mothers during pregnancy carried out by health workers according to standard. The indicator used is the first visit (K1) and fourth visit (K4). Antenatal care for mothers during their pregnancy rose (Figure 5.7). Services for 1 visit rose from 75 percent in 1991 to 92.8 percent in 2010. While the percentage of mothers who received care at least 4 times also rose from 56.0 percent in 1991 to 61.3 percent in 2010.

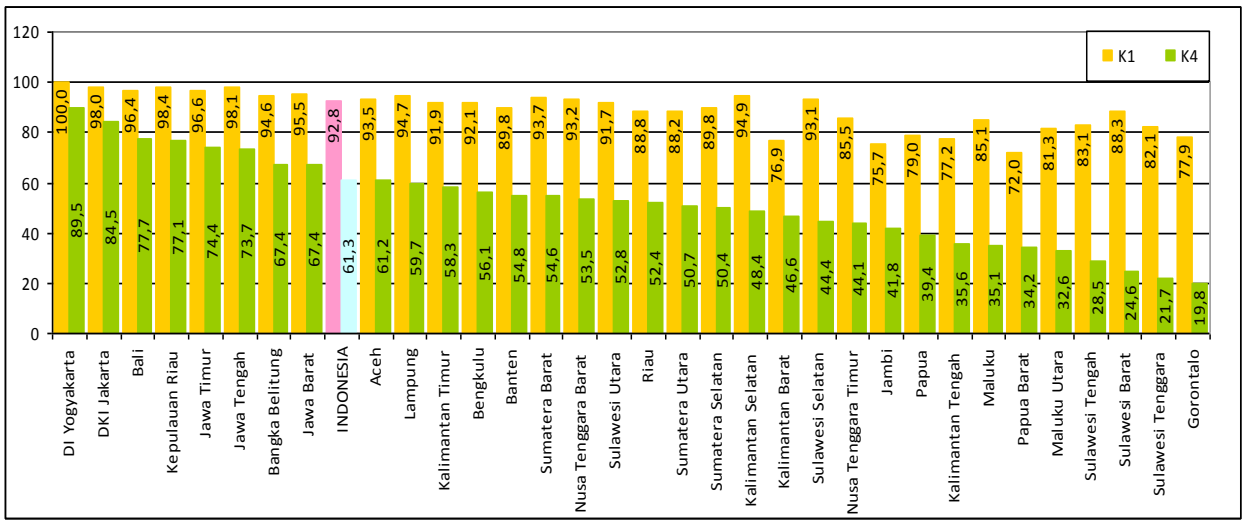


Figure 5.7. Variety of K1 and K4 antenatal services between provinces, 2010
Source: *Riskesdas* (MOH), 2010

However, this positive illustration of antenatal services varies between provinces with quite high diversity, especially for four visits or more. The proportion of expecting mothers who received care at least once ranges from the lowest at 72.0 percent (West Papua) to 100.0 percent (in Yogyakarta). While the proportion of expecting mothers who received care four or more times ranged from as low as 19.8 percent (Gorontalo) to 89.5 percent (in Yogyakarta). Next, the proportion of care for expecting mothers, both K1 and K4, in 25 provinces was actually lower in comparison to the national average.

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

In terms of handling various obstacles faced by mothers in labor, among others, three essential programs have been developed, i.e. Government Financing for Maternal and Neonatal Health (*Jampersal*), Mother Class, and Maternity Waiting Home. In addition, the decline in maternal mortality has been strengthened by the family planning program.

Government Financing for Maternal and Neonatal Health Service (*Jampersal*)

Jampersal is insurance for the funding of mothers giving birth and their infants. This insurance is intended to reduce financial constraints for expecting mothers to receive labor insurance, which includes pregnancy examinations, childbirth services including postnatal family planning, and care for newborns. Therefore, this insurance is intended to prevent the death of babies and their mothers. Services for expecting mothers cover pregnancy examinations, delivery assistance, childbirth services including post-delivery family planning services, and referred preparation services if there are any complications during any of the periods. The target of this program is expecting mothers, maternal, and mothers of infants until 42 days after delivery and for the baby, it covers care for newborns until the age of 28 days.

Jampersal covers the whole of Indonesia, but is not limited according to government administrative areas and this has become one of the perks of the program, which are services based on portability principles. Labor insurance does not recognize boundaries, but claims are submitted to the local Health Office, not to the hometown of the target. The legal basis of the service is Minister of Health Affairs Regulation 2562/2011 concerning *Jampersal* Technical Guidance.

Jampersal funding is part of Community Health Insurance (*Jamkesmas*) funds. Therefore, the management of *Jampersal* is the City/ District Management Team/ Health Office. *Jampersal* funding is a basic service and referral service in the form of social assistance spending (bansos) sourced by the state budget allocated for health services and basic service reference for Jamkesmas participants, delivery services as well as *Jamkesmas* high-risk labor participant reference and the targeted community that has not received this labor insurance as the beneficiary of the insurance. *Jampersal* funds for basic health services have been distributed to the account of the city/ district Health Office, as one with *Jamkesmas* funds. After these funds have been distributed to the Health Office as the organization in charge of this program (through SP2D) and the account of the Hospital, the status of the funds changes to Jamkesmas participant and Labor Insurance beneficiary. *Jamkesmas* and *Jampersal* funds are not part of the funds transferred from regions to the city/ district government. Thus, allocation of these funds does not pass through regional treasury (Regulation of the Director General of Treasury PER-21/PB/2011)

The management of *Jampersal* activities is carried out together by the government, provincial government, and city/ district government. The selection of this method is intended so that the implementation of management activities is able to run effectively and efficiently. To manage *Jampersal*, a Management Team was formed at national level, provincial level, and city/ district level. The management of *Jampersal* is integrated with Community Health Insurance (*Jamkesmas*) and Health Operational Assistance (BOK). The organization of *Jamkesmas* and BOK management consists of (i) *Jamkesmas* and BOK Coordination Team (cross sector) and (ii) *Jamkesmas* and BOK Management Team (cross sector), both reaching city/ district level.

Mother Class

This class was developed to increase knowledge and change the behavior of mothers and families. With this, it is hoped that the awareness of the importance of health during pregnancy, labor and childbirths increases and that they know about health improvement efforts. This class is a study group of expecting mothers that starts from the beginning of pregnancy with 10 students. Apart from expecting mothers, husbands or other family members are expected to join this class at least once so that they understand various important materials such as labor preparation. The general purpose of this class is to increase knowledge, change the attitude and behavior of mothers so that they understand about pregnancy, body changes and complaints during pregnancy, prenatal care, delivery, child care, post-delivery family planning, newborn care, local myths/ beliefs/ customs, infectious diseases and birth certificates.

Picture 5.1. Expecting Mothers Class in a Health Clinic in Jembatan Kembar, West Lombok District, NTB Province
Source: Ministry of Health Affairs

In this class, expecting mothers study together, discuss and share their experiences on Maternal and Child Health (KIA) thoroughly and systematically and the class is conducted according to schedule and continuously. The class for expecting mothers is facilitated by midwives/ health workers, using the Expecting Mothers Class packet, which consists of the KIA Book, flipchart, Expecting Mothers Class Guidelines, Expecting Mothers Class Facilitator Handbook, and Expecting Mothers exercise book. This program is implemented in all provinces and it is hoped that it is carried out by all village midwives.

Maternity Waiting Home

This waiting home is intended to provide easy and quicker access to health officers and services for expecting mothers before delivery. In some parts of Indonesia, such as disadvantaged areas, borders, and islands, access is still an issue because of infrastructure and transportation limitations, geographic conditions and difficult weather, as well as the lack of health workers. All of this will complicate the referral process to the closest health service facilities (fasyankes) when expecting mothers or mothers in labor experience complications. In areas difficult to reach and in high-risk pregnancy cases that clearly required handling in a satisfactory fasyankes, expecting mothers should already be at the closest fasyankes several days before labor. Because of this, there needs to be a place near the fasyankes or referral (hospital) where expecting mothers can live temporarily before going into labor.

Maternity Waiting Home may be in the form of a house or room that is part of a house or building. It can also be selected from the expecting mother's family or relative's home, as long as the distance is close to the fasyankes and easy access and transportation. The availability of Birth Waiting Homes is expected to increase maternity coverage aided by health workers in fasyankes, as well as to improve early detection and handling of maternal complications, which will finally play a role in the acceleration of reducing maternal mortality.

Based on its location and function, the Birth Waiting Home can be classified into three, which are as follows: (i) Poskesdes Waiting Home, which is a waiting home near Poskesdes, used by non-risk expecting mothers; (ii) Health Clinic Waiting Home, which is a waiting home near a Health Clinic, used by non-risk expecting mothers or expecting mothers with manageable risks according to the capacity of the Health Clinic; (iii) Hospital Waiting Home, which is a waiting home near a hospital, used by high-risk expecting mothers.

Picture 5.2. *'Mitra Sehat'* Birth Waiting Home, Nilo Dingin Village, Lembah Masurai Sub-district, Merangin District, Jambi Province
Source: Ministry of Health Affairs

Family Planning Program

Efforts to reduce maternal mortality are strengthened by the Family Planning Program through increased Family services quality and access and reproductive health as well as improvement in the advocacy, communication, information, and education of family planning. With the increase in understanding and awareness on family planning and reproductive health, productive-age couples/ PUS will be able to plan pregnancies well so that the health and welfare of the mother and child can also be improved. In addition, the increase in understanding of reproductive health in the teen group will also increase marriage age and reduce birth rates in the teen group.

Next, in order to increase the contraceptive prevalence rate (CPR), decrease unmet needs for family planning, reduce birth rates in the teen group/ 15-19 years; and to decrease CPR disparities, unmet needs, and 15-19 years age specific fertility rate among provinces, rural and urban areas, and social economic status, various strategic efforts have been implemented to address, among others: (i) provision of free contraceptive drugs and equipment for PUS from poor families (pre-prosperous families/ Pre-KS and prosperous families I/ KS-1) throughout Indonesia; (ii) family planning services in Jampersal, including post-delivery and post-miscarriage family planning services throughout Indonesia; (iii) family planning services in islands and galciltas (disadvantaged, remote, and outskirt areas) as well as specific targets through improving long term family planning services access/ MKJP and the development of an integrated reproductive health services network, including good quality family planning services and teen reproductive health services. These services have been provided in 18 provinces; (iv) improve medical worker competency, through contraceptive technology update (CTU) training for physicians and midwives throughout Indonesia in order to improve the quality of family planning services for the people; (v) implementation of Family Life Preparation for Teens Program (PKBR)/ generation planning throughout Indonesia. Through the PKBR program, it is hoped that there

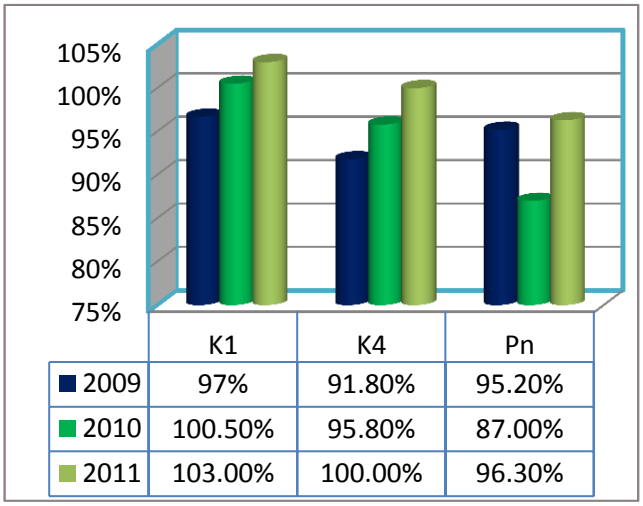
will be “Tough Teens”, who are teenagers who have healthy behaviors and avoid KRR Triad risks (sexuality, drugs and HIV/AIDS) as well as teenagers who understand reproductive health and the importance of postponing marriage age.

The 2011 the National Population and Family Planning Board Mini Survey data indicate that the prevalence of active family planning participants using the modern method reached 67.5 percent. This cannot be separated from the National Medium-Term Development Plan (RPJMN) 2010-2014 policies and strategies directing family planning program revitalization in the development and socialization of gender responsive population control policies. The enforcement of these policies has successfully been carried out by Situbondo District in the effort to increase the participation of men in family planning.

Box 5.1.
Health Clinic Expecting Mothers Class, Jembatan Kembar, West Lombok, NTB

The expecting mothers class at Health Clinics have started since 2009. Because there are still cases of maternal complications that are referred to health facilities too late, the low deliveries by health workers, and the high cases of maternal mortality in 2010, the West Lombok Ministry of Health created a policy stating that all expecting mothers are required to follow expecting mothers class activities. These activities are carried out at all villages at different locations such as Health Clinics, Village health posts, cadre homes, village offices, village halls, huts and other places easily accessed by expecting mothers. The activities are carried out over 4 meetings. Each meeting is 2 hours, and ends with exercise from pregnant mothers. Funding is obtained from various sources such as Jamkesmas, BOK, NICE and Indocement. As of 2009, there were 60 classes. As of 2010, there were 100 classes. And as of 2011, there were 102 classes.

One of the obvious results from the expecting mothers class in West Lombok is the increased program coverage and the decline in maternal mortality from 131/100,000 live births (2010) to 74/100,000 live births (2011). The class needs relevant cross sector support in order to optimize achievement of the expected goal.



	K1	K4	Pn
2009	97%	91.80%	95.20%
2010	100.50%	95.80%	87.00%
2011	103.00%	100.00%	96.30%


PEMERINTAH KABUPATEN LOMBOK BARAT
DINAS KESEHATAN
PUSKESMAS JEMBATAN KEMBAR

JL. Raya Lembar, Jembatan Kembar – Kec. Lembar, Kode Pos. 83364 Telp. (0370) 681055

Sertifikat

No : 445.1 / PKM-JK / / 2011

Dengan ini Kepala Puskesmas Jembatan Kembar Kecamatan Lembar, memberikan penghargaan kepada :

Nama :
Alamat :
Dusun :

"TELAH MENGIKUTI KEGIATAN KELAS IBU DESA SEKOTONG TIMUR KECAMATAN LEMBAR"
Yang dilaksanakan pada tanggal 3 s/d 6 Mei 2011 di POSKESDES DESA SEKOTONG TIMUR.

DI KELUARKAN DI JEMBATAN KEMBAR
Kepala Puskesmas Jembatan Kembar

SARIYANTO, SKM. MM
NIP. 19640101 1988031 060

The certificate given to mothers who joined this expecting mothers class at the Jelambar Health Clinic

Figure 5.8. K1, K4 and Pn coverage data in 2009, 2010, and 2011 at Jembatan Kembar Health Clinic
Source: Ministry of Health

Box 5.2.
***'Mitra Sehat'* Birth Waiting Home at Nilo Dingin Village, Lembah Masurai Sub-district, Merangin District, Jambi Province**

This village has an area of 10,000 square kilometers with a population density of 35 people/sq km. It's located in quite difficult geographical conditions with hills and valleys. It is located approximately 27 kilometers from the capital city of Lembah Masurai Sub-district and 85 kilometers from the capital city of Merangin District. To reach the closest health service facility, you must walk on foot for 1-6 hours. Aware of this difficult condition for expecting mothers, the government along with the Desa Nilo Dingin community has taken the initiative to prepare a Waiting Home. At first, they rented a residential home nearby the local Polindes. Then, a special home was constructed using independent funds with the approval of the village meeting. This waiting home has 20 rooms and accommodates 20 expecting mothers. The number of expecting mothers who stay at this waiting home increases from year to year.

Box 5.3.
Success of the Sitobondo Government in Increasing Male Family Planning Participants

Situbondo district has been listed as able to increase the number of new family planning MOP participants in a phenomenal and extraordinary way in 2010. In 2009, the total number of family planning MOP participants only reached 248 people, increasing significantly to 1,552 people (2010), and reaching 1,848 people (2011). This significant increase cannot be separated from commitment, effort, and hard work from the head of the family planning local government unit and all related partners. Several issues hindered family planning MOP achievements in Situbundo District covering (1) limited access to information on family planning side effects, effectiveness, service areas, and family planning benefits; (2) limited medical workers and places for MOP services; (3) the socio cultural condition is not optimal yet including Toga and Toma; (4) religious interpretation (abiding to religion and forbidden to Islam laws) for the use of MOP; and (5) the low work motivation of family planning officers in the field following regional autonomy.

To address these issues, strategies have been implemented covering (1) the mapping and analysis of family planning achievement conditions, covering program data, Revised Budget Support, human resources and family planning field workers (PLKB, PPLKB, and PPKBD); (2) socio cultural approach to Toga and Toma; (3) develop and strengthen sustainable partnerships both with individuals and other institutions (Government, Toga/ Toma, NGOs); (4) improve the capacity of NGOS implementing family planning covering medical workers and family planning instructors in order to provide services and family planning KIE, especially MOP; (5) motivate individuals and communities who have become MOP participants to spearhead in attracting new MOP participants; (6) cooperate with both print and electronic mass media to improve KIE for MOP programming; and (7) compile mechanisms for post service complication settlements.

These efforts have been successful in motivating the commitment of several parties towards MOP family planning, which has impacted successfulness of male family planning in Situbondo, addressing, among others (1) increased commitment of the district head, the sub-district heads, and the military sub-district commander in increasing MOP family planning participants with the issuing of a letter of the Deputy District Head that has set a target of 50 MOP/sub-district participants; (2) improved budget support with the development of a family planning services building; (3) increased commitment of the sub-district head to promoting MOP at community forums; (4) increased TOGA and TOMA support with the issuing of an ulema decree on MOP vis-à-vis Islamic laws; (5) increased availability of human resources for MOP services; and (6) increased access to MOP program services and information via the

radio.

Picture 5.3 Family Planning Services in Situbondo District
Source: Ministry of National Development Planning/Bappenas

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

Inauguration of the Malaria Center in North Maluku by Dr. Endang Rahayu Sedyaningsih, MPH, DR.PH (late.), 2010
Source: Ministry of Health

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS						
6.1	HIV/AIDS prevalence among total population (percent)	-	0.3% (2011)	Decrease	▼	MOH 2011
6.2	Condom use at last high-risk sex	12.8% (2002/03)	Female: 35% (2011)*	Increase	▼	*BPS, SKRRI* 2002/ 2003
			Male: 14% (2011)*		▼	**STBP*, MOH 2011
6.3	Proportion of population age 15-24 year with comprehensive knowledge on HIV/AIDS	-	11.4% (2010)	Increase	▼	MOH, *Riskesdas* 2010
Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it						
6.5	Proportion of population with advanced HIV infection with access to antiretroviral drugs	-	84.1% (2011)	Increase	▶	MOH, 2011

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

HIV prevalence in Indonesia is obtained through a mathematical modeling that shows that the estimated prevalence of HIV in Indonesia is 0.3 percent in 2011 and also through prevalence surveys conducted in Papua and West Papua. Meanwhile, the cumulative number of reported HIV cases in 2011 amounted to 77,779 cases with highest HIV cases occurring in the Province of DKI Jakarta (19,899 cases), East Java (9,950 cases), Papua (7,085 cases), and West Java (5,741 cases). Based on reports of AIDS cases up to December 2011, the cumulative number of AIDS cases through 2011 totaled 29,879 cases with highest AIDS cases occurring in the Province of DKI Jakarta (5,117 cases), East Java (4,598 cases), Papua (4,449 cases), and West Java (3,939 cases).

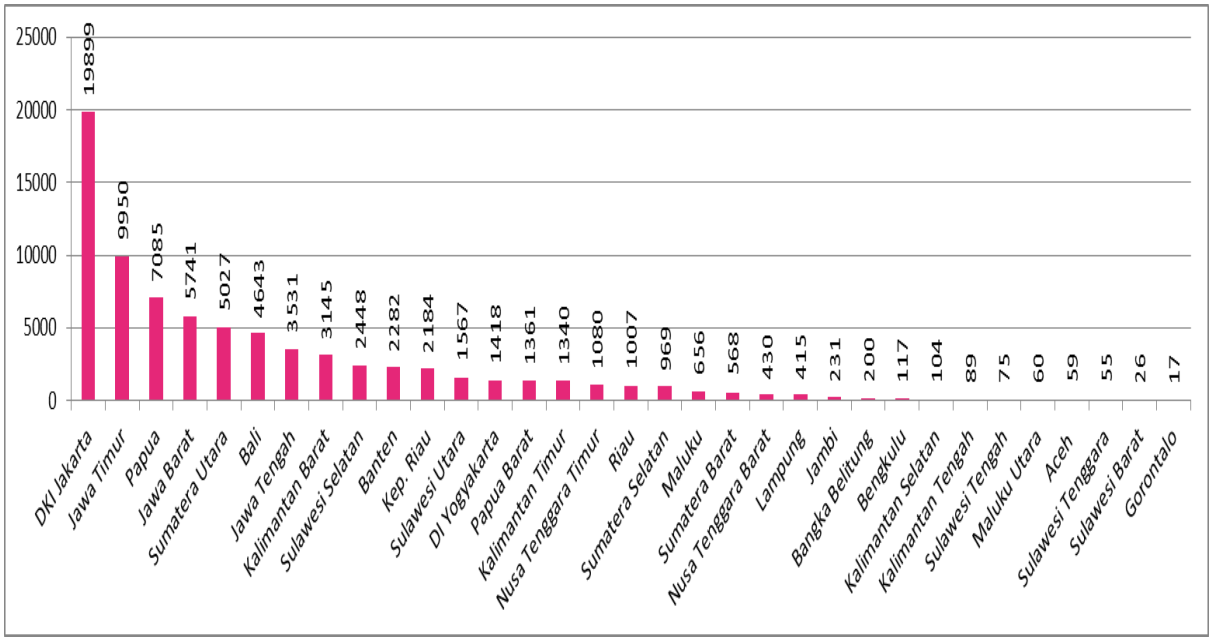


Figure 6.1. Cumulative Number of HIV Cases, December 2011
Source: Directorate General of Disease Control and Environmental Health, Ministry of Health Affairs, 2011

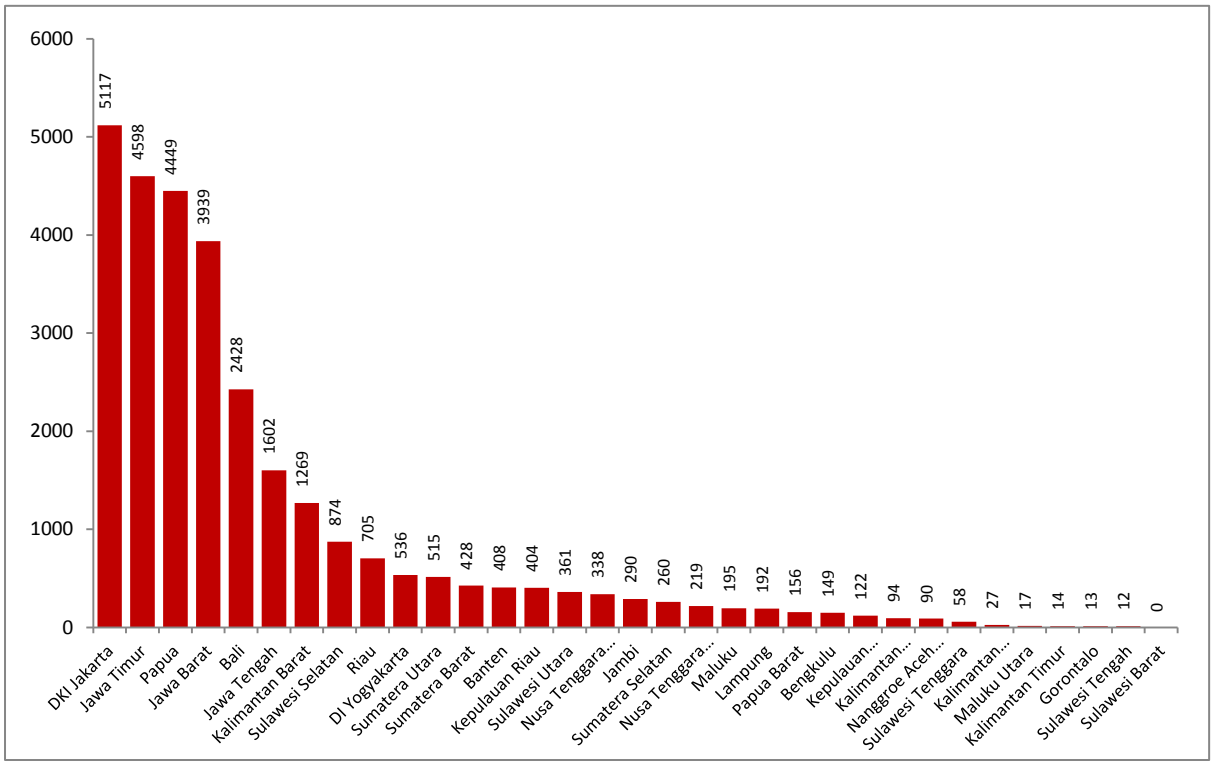


Figure 6.2. Cumulative Number of AIDS Cases, December 2011
Source: Directorate General of Disease Control and Environmental Health, Ministry of Health Affairs, 2011

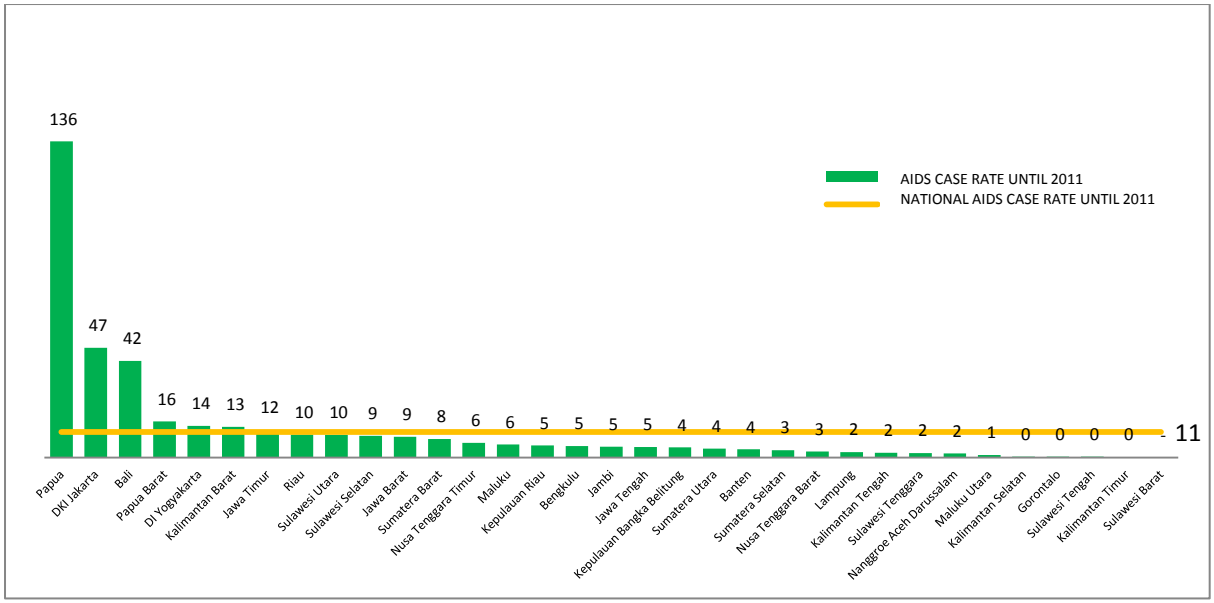


Figure 6.3. Provincial and National AIDS Case Rates Through 2011
Source: Directorate General of Disease Control and Environmental Health, Ministry of Health Affairs 2011

The cumulative number of cases per 100,000 of the population (AIDS case rate) compared to the cumulative number of AIDS cases shows different conditions because the distribution of population at every province is very diverse. Papua ranks first, while the cumulative figure of Jakarta, which is much larger, ranks second after Papua. Meanwhile, North Sulawesi with only 261 cumulative cases ranks ninth, compared to Central Java, which has 1,602 cases.

To address the rate of HIV and AIDS transmission of HIV and AIDS, prevention efforts have been made. One effort is to use condoms during sexual intercourse that has a high-risk of HIV and AIDS transmission. However, these efforts have not shown satisfactory results. Results from the Biological and Behavioral Integrated Survey (STBP) in 2011, showed that condom use has only reached 35 percent among commercial sex workers (CSWs) and 14 percent among CSW customers. The survey was conducted in 16 districts/cities in 10 provinces with CSW respondents and conducted in 12 district/ cities in 10 provinces with CSW customer respondents. Another preventive measure that can be taken is to increase knowledge among the people through Communication, Information, and Education (CIE) regarding the prevention of HIV and AIDS transmission. Efforts still need to be increased considering the percentage of 15-24 year-olds who have comprehensive knowledge about HIV and AIDS is still quite low, at 11.4 percent.

In efforts for treating the population infected with advanced stages of HIV, antiretroviral treatment (ARV) has been implemented. In 2009, the percentage of the population infected with advanced stages of HIV that is treated with Antiretroviral Therapy (ART) amounted to 76.5 per cent (19,572 PLWHA) and increased to 84.1 percent (24,410 PLWHA) in 2011. The number of people living with HIV/AIDS (PLWHA) who received antiretroviral therapy is increasing along with the increasing numbers of HIV counseling and testing facilities (CT) as well as ARV treatment.

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

The highest cumulative percentage of AIDS cases is in the 20-29 age group. Taking into account the incubation period from infection to progression into AIDS which takes 5-10 years and the percentage of teenagers in the 15-24 age group with comprehensive knowledge of HIV and AIDS only reaching 11.4 percent (Riskesdas, 2010), the adolescent group is the age group that is most at risk of contracting and transmitting HIV and AIDS.

In order to control the spread of HIV/AIDS and begin to reduce the number of new cases, particular efforts are needed to be focused on the youth group. Efforts that have been made to increase the knowledge of teenagers about HIV and AIDS is through the campaign “I Know and I’m Proud Of It” ("Aku Bangga Aku Tahu") (ABAT). The ABAT Campaign is an educational campaign on sexual practices that should be avoided before marriage and awareness on how the HIV and AIDS disease is transmitted. The first phase of the campaign was implemented in 10 select provinces, namely DKI Jakarta, West Java, Central Java, East Java, Bali, North Sumatra, Riau, West Kalimantan, Sulawesi, and Papua. Furthermore, it will be extended to all provinces in Indonesia. Thus it is hoped, that the government, businesses, the community, particularly the young, will be more knowledgeable about HIV and AIDS, and able to protect themselves and others from the transmission of the disease.

Another measure is through improvement of public access to treatment and integrated/ comprehensive HIV and AIDS services. By providing such integrated services, efforts for prevention, treatment, and care of HIV and AIDS cases including counseling and testing services, care, support and treatment, as well as management of side effects can be performed in one single service. This integrated effort has been approved and implemented throughout ASEAN. In Indonesia, the pilot demonstration of this integrated service has been implemented in Bogor, Tangerang, and Singkawang. In addition, the number of healthcare services for counseling and testing has increased from 156 in 2009 to 500 services in 2011. Hospitals providing care, support, and treatment have increased from 163 to 303, which consists of 235 main hospitals and 68 satellite hospitals.

Increased efforts in HIV and AIDS prevention has been made through the issuance of regional regulations regarding the prevention and management of HIV and AIDS. By early 2011, 10 Provincial Regulations, 1 Governor Regulation, 13 District/ City Regulations that are HIV and AIDS related have been issued. Regulations issued at the provincial level are as follows: East Java Provincial Regulation 05/2004 concerning the Prevention and Control of HIV and AIDS in East Java, Bali Provincial Regulation 3/2005 concerning HIV and AIDS prevention, Riau Provincial Regulation 4/2006, NTT Provincial Regulation 03/2007, DKI Provincial Regulation 05/2008, Governor of DKI Jakarta Regulation 78/2011 concerning the Prevention and Control of HIV and AIDS, NTB Provincial Regulation 11/2008 concerning the Prevention and Control of HIV and AIDS, West Kalimantan Provincial Regulation 2/2009 concerning the Prevention and Control of HIV and AIDS in West Kalimantan, North Sulawesi Provincial Regulation 1/2009 concerning the Prevention and Control of HIV and AIDS, South Sulawesi Provincial Regulation 04/2010 concerning the Prevention and Control of HIV and AIDS in South Sulawesi, DI Yogyakarta Provincial Regulation 12/2010 concerning HIV and AIDS Prevention, and By-law 8/2011 concerning the Prevention and Control of HIV/ AIDS.

Furthermore, regional regulations at the District/ City levels which have been issued, are as follows: Merauke District Regulation 05/2003, Jayapura District Regulation 20/2003, Nabire District Regulation 18/2003, Sorong City Regulation 41/2006, Banyuwangi District Regulation 06/2007, Gianyar District Regulation 15/2007 concerning HIV and AIDS Prevention, Buleleng District Regulation 5/2007 concerning HIV and AIDS Prevention, Tarakan City Regulation 6/2007 concerning the Prevention and Control of HIV and AIDS, Jembrana District Regulation 01/2008 concerning HIV and AIDS Prevention, Badung District Regulation 01/2008 concerning HIV and AIDS Prevention,

Malang District Regulation 14/2008 concerning HIV and AIDS Management in Malang District, Indramayu District Regulation 08/2009 concerning the Prevention and Control of HIV and AIDS in Indramayu District, and Cirebon City Regulation 1/2010 concerning the Prevention and Control of HIV and AIDS.

Box 6.1.
Decentralization of Antiretroviral Medication(ARV)

Decentralization of ARV drugs is currently being developed by the Ministry of Health Affairs in an effort to improve the ARV medication supply chain management in order to obtain a sufficient supply of ARV drugs in the appropriate amounts, at the right time and place, and supported with proper and accurate reporting. In decentralization, the Provincial Health Office is responsible for managing the reporting of hospitals and ARV distribution in the region. Stock of medication and buffer drugs will be kept at the Provincial Health Office, to facilitate ARV distribution and redistribution within the province. The decentralization model that is developed in each region is different depending on the characteristics of each region.

Decentralization of ARV medication started in 2010 and currently 5 provinces have carried out decentralization of ARV medication among others, West Java, Central Java, East Java, Bali, and Papua. Through decentralization, the Provincial Health Office is able to obtain information and regulate the distribution of ARV drugs in the region. In addition, decentralization also increases the accuracy of hospital reports, prevents stock outs, and reduces the lead-time of ARV distribution from 5 days to 2-3 days. Decentralization is expected to improve coordination among relevant institutions and facilitate provincial evaluations regarding issues in the region, especially matters of report management and management of ARV drug logistics.

TARGET 6C CONTROLLING THE SPREAD AND BEGIN TO REDUCE THE NUMBER OF NEW MALARIA CASES AND OTHER MAJOR DISEASES BY 2015

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
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)	1.75% (2010)	Decrease	▶	MOH, 2010
6.7	Proportion of children under 5 sleeping under insect icidetreated bednets	-	16.5% (2010) Rural: 13.5% Urban: 11.4%	Increase	▶	MOH, *Riskesdas* 2010
6.8	Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	-	34.7% (2010)			MOH, *Riskesdas* 2010

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

Efforts to reduce the number of malaria cases have shown positive results. A significant decline from 1990 to 2011, from 4.68 for every 1,000 people who are at risk dropped to 1.75 for every 1,000 of the population. According to the 2010 Riskesdas (Basic Health Research of the Ministry of Health Affairs) Malaria Case Rates totaled 2.4 percent of the people who were interviewed. However, if viewed from a concrete number, the amount is quite large, i.e. 256,592 people suffering from malaria and malaria cases are not found only in the Province of Jakarta. The numbers of malaria cases vary widely, but are concentrated in three endemic provinces, namely East Nusa Tenggara, Papua, and West Papua. Malaria case rates range from low, in Bali with only seven cases to the highest rate of incidence, which is present in three provinces, namely East Nusa Tenggara, Papua, and West Papua respectively totaling 69,645, 66,577, and 25,287 malaria cases. These three provinces cover nearly 63 percent of all malaria cases in 2011.

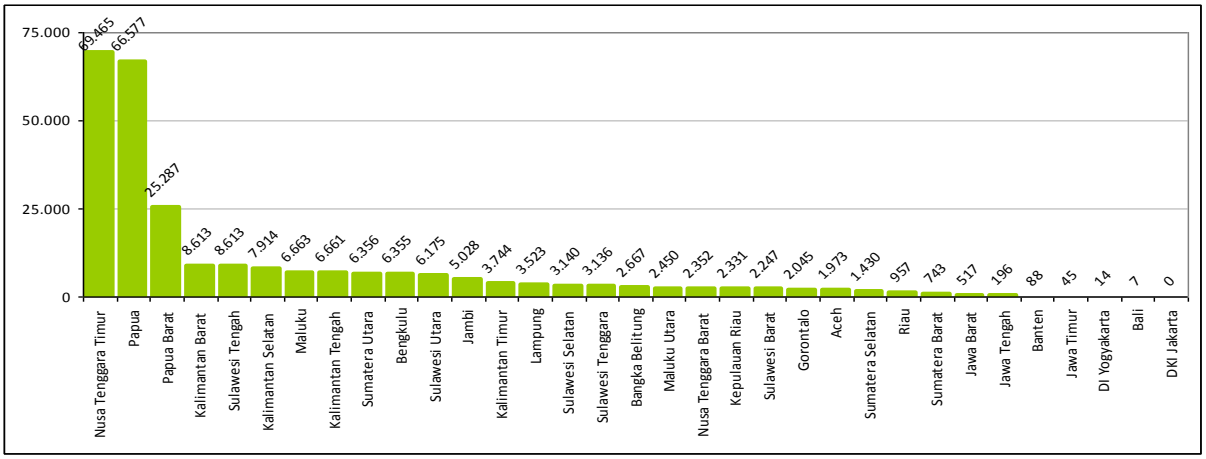


Figure 6.4. Malaria Cases Rates, 2011
Source: The Ministry of Health Affairs, 2011

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

Malaria cases and Extraordinary Events (*Kejadian Luar Biasa*) (KLB) in Indonesia is strongly linked with the following factors: (i) Environmental changes that cause the spread of malaria-transmitting mosquitoes, (ii) The relatively high mobility of the population, (iii) Climate changes that lead to a longer rainy season compared to the dry season, (iv) Prolonged economic conditions in certain areas where certain groups of the population become nutritionally deficient causing them to be more susceptible to malaria, (v) Treatments that are ineffective due to chloroquine resistance and the growing number of resistant areas, (vi) Declining concern and public awareness of integrated malaria prevention efforts.

In accordance with the Decree of the Minister of Health Affairs 293/MENKES/SK/IV/2009 dated April 28 2009 concerning the Elimination of Malaria in Indonesia the Malaria Elimination Effort covers eight main efforts in accomplishing the goal of Malaria Elimination by 2030. The first course of action is improving the quality and access to early detection and malaria treatments. The second is ensuring the quality of malaria diagnosis through laboratory tests and Rapid Diagnostic Tests (RDT). The third measure that must be taken is the protection of vulnerable groups, especially pregnant women and young children in high endemic areas. The fourth is improving the management of Extraordinary Events (KLB) and increasing surveillance of malaria cases. The fifth is vector intervention including vector surveillance. The sixth measure is strengthening the Malaria logistics management system. The seventh is strengthening human resources, and the eighth is operational research.

In an effort to reduce the number of malaria incidences especially in high endemic areas, prevention, and treatment are key. One way of preventing the spread of malaria is to reduce malaria transmission through protection of vulnerable age groups, i.e. infants, children under five years and pregnant women from malaria-transmitting mosquito bites with the use of insecticide-treated mosquito nets. Based on the existing data, the percentage of children under the age of five has risen to 16.5 percent. While the recovery efforts implemented on children under the age of five who are positive with malaria who are treated with appropriate anti-malarial drugs totaled 34.7 percent in 2010.

Box 6.2.
Efforts made by the Malaria Center in North Maluku in combating malaria for accelerated achievement of Goal 6 MDG, and toward elimination by 2020

76.27 percent of the North Maluku region is made up of water and most of its population lives on the coast, which are formerly swamp areas with many pools of stagnant water. These kinds of conditions are ideal for the breeding of malaria mosquitoes. It is no wonder that many areas in North Maluku, including South Halmahera are endemic malaria areas. Malaria is a major public health issue in North Maluku, South Halmahera in particular. An extraordinary event due to an incident of malaria attacks in South Halmahera occurred in 2003 through 2007 with a death toll of 268. In fact, in 2005, South Halmahera had the highest malarial annual case rate, which was 80.2/mile.

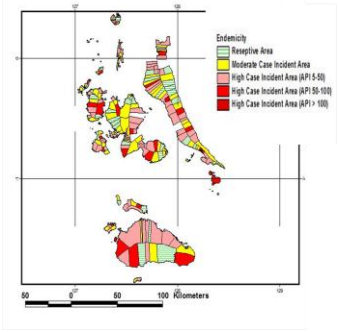
The issue of malaria has become a societal concern thus it becomes a responsibility across sectors and for all levels of society. In order for this to happen, a platform is needed to gather and mobilize, coordinate and synergize all capacities and resources needed to combat malaria which gave birth to the idea of a ***Malaria Center*** or **Malaria Control Center** (*Pusat Pengendalian Malaria*). The idea of establishing a Malaria Center was initiated by the North Maluku Provincial Health Office, which was immediately supported with the North Maluku Governor Instruction 3/2003 on the Establishment of a Malaria Control Center (Malaria Center) in the province of North Maluku. The Malaria Center is a coordinative instrumentality under the coordination of the District Head/ Mayor that carries out the duties and responsibilities of the regional administration in order to establish a society free of malaria transmission. A Malaria Center was established in South Halmahera, on December 8, 2004 with a ruling from the South Halmahera District Head 168/2004. The inauguration of the Malaria Center was performed by the Minister of Health Affairs on April 24, 2010.

In conducting measures to control malaria, the approach taken at the Malaria Center requires the involvement of the community in all the processes based on participation, which is vital to winning the war against malaria. Within the program, two malaria-combating cadres are trained from every village to learn about malaria, conduct meetings for preparation of the Community Action Plan to combat malaria and forming a Village Malaria Committee. In this way, the village community receives education on malaria and is further able to eradicate malaria that is community-based as well as improving the quality of their lives to living healthier. In addition, the local government will also provide support through the Malaria Villages Allocation Fund.

In addition, the Malaria Center also serves as a support for health care services for infants. Collaborating with Posyandu (integrated health service posts) at the village level and assisted by posyandu professionals, these centers conduct periodic examinations and rapid diagnosis of malaria for pregnant women and children, promoting the use of insecticide-treated mosquito nets among pregnant women and children who have received complete immunization. Integrated malaria prevention and treatment with healthcare services for mothers and children are the services that make the Malaria Center unique.

Malaria cases in North Maluku have decreased significantly. The annual malaria case rate has fallen from 80/1,000 (in 2005) to 40.2/1,000 in 2010. In addition, malaria parasite numbers in children aged below 9 years (parasite rate) has also decreased from 58.7 percent (2007) to 41.5 percent (2010). Furthermore, mortality rates from malaria fell from 205 cases (2003) to 1 case in 2010.

Picture 6.1 Removal of *Anopheles* larva (PLA)
Source: Ministry of Health Affairs



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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
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					
6.9a	Incidence rates associated with Tuberculosis (all cases/100,000 people/year)	343 (1990)	189 (2011)	Halted, begun to reverse	●	WHO Global TB Report, 2011
6.9b	Prevalence rate of Tuberculosis (per 100,000)	443 (1990)	289 (2011)		●	
6.9c	Death rate of Tuberculosis (per 100,000)	92 (1990)	27 (2011)		●	
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)*	83.48% (2011)**	70.0%	●	*WHO Global TB Report **MOH report, 2011
6.10b	Proportion of tuberculosis cases cured under DOTS	87.0% (2000)*	90.3% (2011)**	85.0%	●	

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

The TB Management Program has shown an increase in performance. An increase in Case Detection Rate (CDR) can be seen from 20.0 percent in 2000 to 83.48 percent in 2011. Efforts towards this target began in 1996, where the CDR only reached 4.6 percent (Figure 6.3). TB treatments lasts approximately 6-8 months, thus to reach treatment Success Rates (SR) an evaluation period of 9-12 months is needed, so that patients undergoing treatment in 2010 is only able to be reported in 2011. SR in 2000 reached 87.0 percent and rose to 90.3 percent in 2011. Both indicators are part of MDGs targets and have surpassed MDGs targets (which are 70 and 85 percent respectively). Indonesia is the first country among the 22 High TB Burden Countries in Southeast Asia that has reached the global target of 70 percent CDR and an 85 percent SR in 2005.

In addition, successful TB control is also indicated by the decline of TB case rates, which is measured by the number of cases per 100,000 people per year, prevalence levels, and TB death rates. The number of TB cases has decreased dramatically from 343 per 100,000 people in 1990 to only 189 cases 20 years later. Prevalence levels have also decreased from 443 cases per 100,000 people in 1990 to 289 in 2010. Meanwhile, the death rate of this disease also decreased from 92 cases per 100,000 people in 1990 to 27 in 2010.

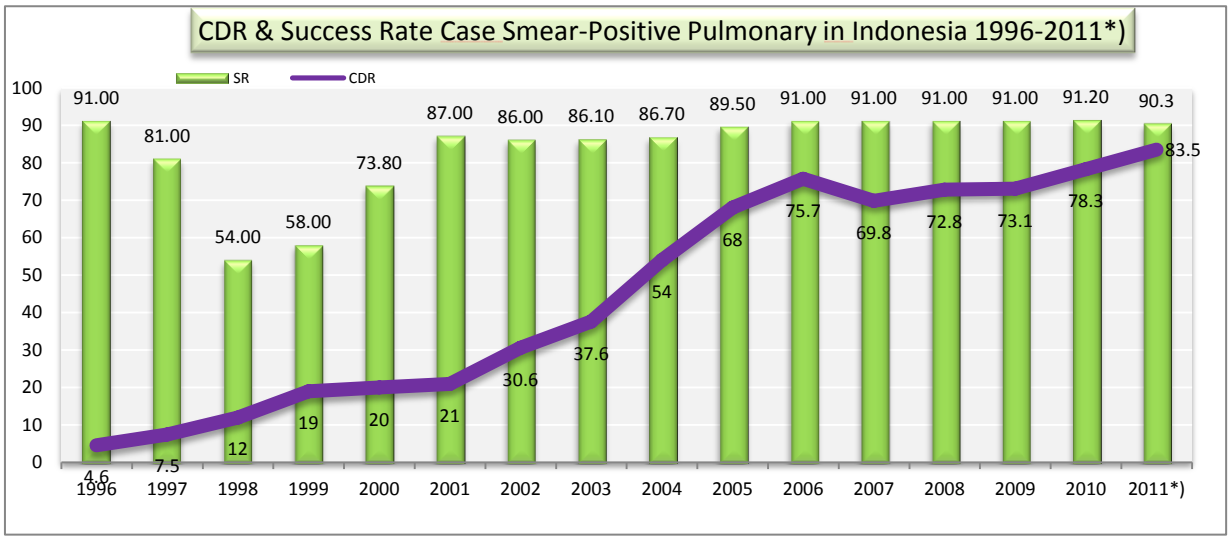


Figure 6.5. Case detection rate and success case smear-positive pulmonary in Indonesia, 1996-2011
Source: The Ministry of Health Affairs

Results of TB campaigns at the provincial level are varied (Figure 6.4). These differences occur in both detection rates of new cases and success rates of treatment and recovery between provinces. The detection rate of new cases in 2011 varied from 33.1 per cent (in Central Kalimantan) to three times the number or 111.0 percent in North Sulawesi. Furthermore, treatment success rates varied from 56.9 percent (West Papua) to a high success rate of 96.2 percent (Gorontalo). Meanwhile, rates of recovery ranged from 42.2 percent (West Papua) to double the amount, or 92.2 percent (North Sulawesi).

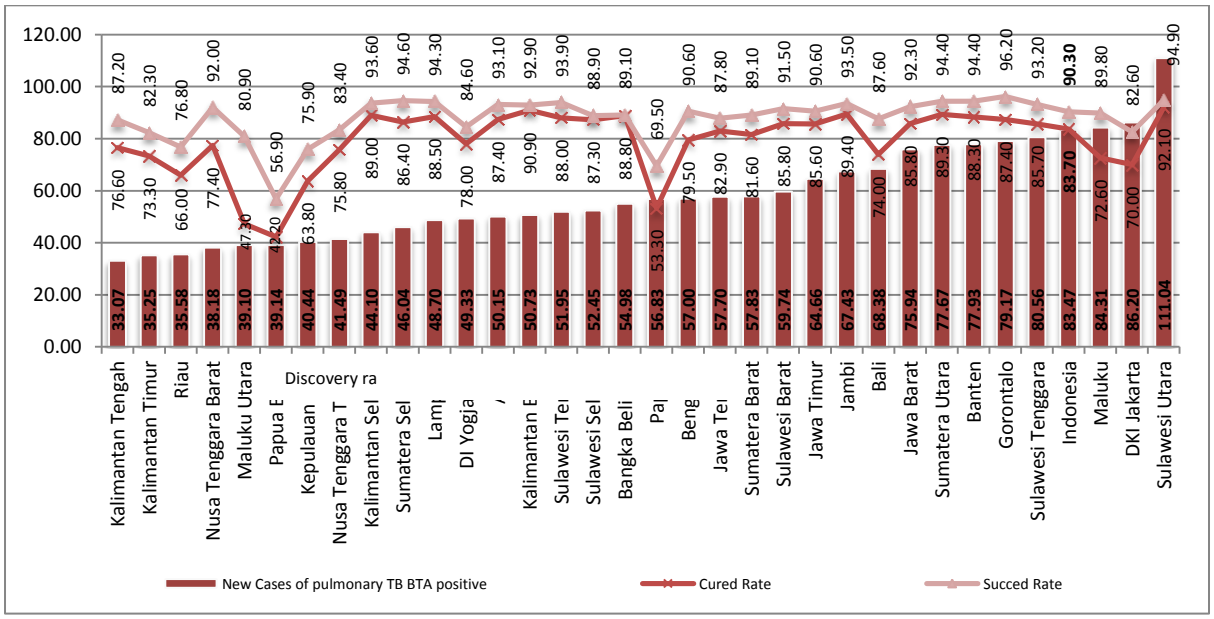


Figure 6.6. Rates of new Tuberculosis cases, successful treatment and recovery, 2011
Source: The Ministry of Health Affairs 2011 Report

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

Various key measures have been taken to reduce TB cases, which are increasing case detections and ensuring the recovery of these cases. These goals are accomplished through the following breakthrough strategies: (i) Including the DOTS strategy in Hospital Accreditations and Certificate of Registry (*Surat Tanda Register* or STR) or Practicing Licenses (*Surat Ijin Praktek* or SIP) by IDI and SIPA and used by the IAI as material for evaluation, for 33 provinces (ii) Initiating the use of Rapid Diagnostic Tests in TB examinations, through the implementation of the Line Probe Assay method (LPA)/ Hain test in the FKUI Microbiology Lab, the Dr. Soetomo Hospital Microbiology Lab as well as at the Labuang Baji Hospital, Makassar (iii) Establishing and implementing 3 National Tuberculosis Referral Laboratories (NTRL) (iv) Submitting TB drug prequalification to the WHO (v) Initiating the application of tuberculin tests in supporting TB diagnosis of children in 33 provinces (vi) Implementing the 17 GeneXpert as one of the TB Rapid Diagnostic Tests for MDR TB and HIV TB in stages at the Adam Malik Hospital, the UI Micro Lab, the Persahabatan Hospital, the Cipinang Hospital, the Hasan Sadikin Hospital, the Bandung Health Laboratory Center, the Moewardi Hospital Solo, the Karjadi Hospital, the UGM Medical School Micro Lab, the Dr. Soetomo Hospital, the Syaiful Anwar Hospital, the Labuan Baji Hospital, the Surabaya Health Laboratory Center, the Sanglah Hospital, the Jayapura Health Laboratory Center, the Unhas Medical School NECHRI Lab, and the Cilacap Hospital; (vii) Collaborating with Health Insurances with the concept of applying TB treatment standards with DOTS for all TB patients being treated as well as developing insurance-based payment schemes for TB patients (with Jamsostek, Jamkesmas, Jamkesda) with the participation of three state-owned companies (BUMN). (viii) Conducting National TB Prevalence Surveys in 33 provinces; (ix) Expanding healthcare services in stages for drug-resistant TB patients to all parts of Indonesia; (x) Preparing an *exit strategy* for TB management programs to minimize dependence on donor funds.

In addition, the National Strategy for TB Control is also established which is an effort to reach all targets with a focus on National Action Plan strategies. The first strategy is increasing expansion of quality DOTS services. The second is handling TB, MDR-TB, and children with TB, as well as the poor and vulnerable groups. The third is involving all government-owned, public, and private healthcare facilities, following the International Standards of TB Care. The fourth strategy is empowering communities and TB patients. The fifth is strengthening health systems, including human resources development and management of TB control programs. The sixth raising the commitment of central and local governments in TB programs and the seventh is promoting research, development and utilization of strategic information.

Efforts made to control infectious diseases; especially TB in Indonesia is funded by the state budget funds and regional budget funds, but often times the funds available are not sufficient. As a result, additional funds are obtained or supplemented with international funding in the form of grants or loans. In the administration of the United Indonesia Cabinet I (2004-2009) and the United Indonesia Cabinet II (2009-2014), one of the policies of the Ministry of Health Affairs policy is not to receive assistance in the form of loans. The policy is based on several considerations that may burden the government if the loan is accepted.

There are several grants that are received by Indonesia to support the implementation of the TB Control Program of which are grants from the The Global Fund ATM, the U.S. Government (USAID), the Canadian Government (CIDA), etc. So far The Global Fund (TGF) is one of the contributors who support the funding of TB control efforts, and support from the TGF is seen in the results of the activities. Case Detection Rates (CDR) in 2000 only reached 20 percent and the number increased with funding from TGF or other donors (USAID and CIDA). This comprehensive financial aid helps to support the detection and treatment of TB cases according to the DOTS strategy, and the CDR can be

increased significantly to reach the global target, which is above 70 percent in 2005. This financial support also gradually encourages an increase in contribution of government funding, so that in 2010 the central government was able to provide 100 percent funding of first-line drugs. In 2011 allocations for support where conducted for the procurement of Ziehl Neelsen reagents which covers about 20 percent of the total national requirement.

The TGF-ATM grant for TB Control in Indonesia began in 2003. Indonesia has received TGF-ATM grants as a TB component for the three following projects (1) Round 1: Strengthening DOTS Expansion in Indonesia (2003), (2) Round 5: Equitable Quality DOTS for all (2007), (3) Round 8: Consolidating Progress and Ensuring DOTS for All (2009). The total amount of funds obtained for the three rounds is USD 113,858,142. For Round 8, the recipients of TB Component GF-ATM grants were The Ministry of Health, and the School of Public Health-University of Indonesia (FKM UI) with an amount of USD 6,200,769 and Aisyiyah with an amount of USD 5,816,935.

TB Component GF ATM Grants are utilized in the following areas: Round 1. Main actions include: (1) Promoting DOTS strategy; (2) Strengthening the management system at the provincial and district/ city levels; (3) Increasing capability of health units to implement DOTS; (4) Improving the quality and quantity of human resources; (5) Strengthening partnerships; (6) Developing TB laboratories and its networks; (7) Strengthening the management of OAT; (8) Building partnerships and strengthening CBA; (9) Building connections between healthcare facilities; (10) Supporting the implementation of drug resistance surveys (DRS); (11) Expanding PPM to increase patient accessibility to DOTS services; (12) Improving recording methods and reporting by increasing supervision and monitoring; (13) Building TB HIV collaborations, and (14) Supporting operational research.

Round five. Main actions include: (1) Strengthening the management system at the provincial and district/ city levels; (2) Developing an annual work plan and budget; (3) Improving HDL programs; (4) Supervising and monitoring of all program operations; (5) Refining and improving case management; (6) Strengthening laboratory networks; (7) DRS; (8) Expanding DOTS to remote areas and vulnerable groups; (9) Tuberculosis treatment for children; (10) Managing TB resistant drugs and implementing DOTS Plus; (11) Increasing Advocacy, Communication and Social Mobilization (AKMS) (12) Conducting seroprevalence surveys; (13) Improving TB HIV collaborations, and (14) Building coordination and partnerships.

Round 8. Main actions include: (1) Strengthening program management at the State, Provincial, and District/ City levels; (2) Conducting Program Monitoring and Evaluation Meetings at the State, Provincial and District/ City levels; (3) Conducting supervision visits; (4) Assessing external quality standards of TB labs; (5) Training TB supervisors and health workers at all healthcare facilities and (6) Conducting surveys on awareness, attitudes and behaviors.

Box 6.3.
Community participation in managing TB through Village TB Posts

Picture 6.2. Health cadres in the Maumere District (NTT Province) and Sentani District (Papua Province) are holding discussions with healthcare workers on TB Village services, which are part of the UKBM

In recent years, TB control in Indonesia has been progressing quite rapidly; this is seen by the accomplishment of many important indicators of TB control. Success factors include greater access to healthcare services, adequate funding, support from the state and regional governments, participation from the public and private sectors is increasing, and more innovative efforts are being taken.

One innovative strategy is the integration of TB services in Community Based Health Efforts (UKBM). This type of service is one way to bring quality TB services closer to the people through community empowerment in villages. Services are carried out in village health posts (poskesdes), as a coordinator for UKBM, and become part of the Alert Village/ Healthy Village campaign. TB services that are conducted through UKBM, are as follows: TB counseling, identification of TB suspects, TB suspect referrals to health care facilities, monitoring treatment of TB patients, tracking missing cases, administering (storing TB medication supply), simple record taking and reporting, mapping of TB patients in the Village Siaga campaign region, as well as building partnerships, and participation with other sectors, etc. Currently, integrated TB services through UKBM have been implemented in the province of Lampung, East Kalimantan and West Sulawesi, Jambi and Papua. In 2012 it will be extended to the South Sumatra Province, Bangka Belitung, NTT, and Gorontalo.

GOAL 7:
ENSURE ENVIRONMENTAL SUSTAINABILITY

Source: Ministry of Public Works

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGET 7A INTEGRATE THE PRINCIPLES OF SUSTAINABLE DEVELOPMENT INTO COUNTRY POLICIES AND PROGRAMMES AND REVERSE THE LOSS OF ENVIRONMENTAL RESOURCES

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 7A: Integrate the principles of sustainable development into country policies and programmes 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)	52.52% (2010)	Increase	▼	Ministry of Forestry
7.2	Carbon dioxide (CO_2) emission	1,377,983 Gg CO_2e (2000)	1,791,372 Gg CO_2e (2005)	Reduce at least 26% by 2020	▼	Ministry of Environment
7.2a	Primary energy consumption (per capita)	2.64 BOE (1991)	4.95 BOE (2010)	Reduce from previous state of BAU 6.99		Ministry of Energy and Mineral Resources
7.2b	Energy intensity	5.28 SBM/ USD 1,000 (1990)	4.61 SBM/USD 1,000 (2010)	Decrease		
7.2c	Energy elasticity	0.98 (1991)	1.6 (2010)	Decrease		
7.2d	Energy mix for renewable energy	3.5% (2000)	5.00% (2010)	-		
7.3	Total consumption of ozone depleting substances (ODS) in metric tons	8,332.7 metric tons (1992)	0 CFC, halon, CTC, TCA, methyl bromide 6,689.21 metric tons HCFC (2010)	0 CFCs while reducing HCFCs	►	Ministry of Environment
7.4	Proportion of fish stocks within safe biological limits	66.08% (1998)	98.86% (2010)	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)	27.54% (2010)	Increase	►	Ministry of Forestry
7.6	The ratio of marine protected areas to total territorial marine area	0.14% (1990)*	4.97% (2011)**	Increase	►	*Ministry of Forestry **Ministry of Marine Affairs & Fisheries

Status: ●Already Achieved ►On Track ▼Need Special Attention

- Based on the 2010 MDG report, the baseline and the latest data for the total amount of carbon dioxide emissions is conditional, with a baseline of 1,416,074 Gg CO_2e (2000) and recent data of 1,711,626 Gg CO_2e (2008). The 2011 MDG report shows that the most current baseline is 1,377,983 Gg CO_2e (2000) and the current data shows 1,791,372 Gg CO_2e (2005).
- In 1992 ODS include CFC, Halon, CTC, TCA, and methyl bromide. 2015 target: to reduce HCFC consumption by 10 percent from the baseline (2009-2010 consumption level).

CONDITIONS AND TRENDS

Environmental preservation is a major prerequisite for the wellbeing and continuity of human life. The wellbeing of humans is met through development, but development must be carried out without damage to the environment. Development that is conducted without regard for the environment can lead to a decreased support capacity of environmental resources, which will decrease the capacity of fulfilling human needs. To protect the continuity of human welfare, efforts for sustainable development are needed, or development that is made with consideration to the balance of the three pillars of development (social, economic, and environmental).

In order to implement the principles of sustainable development, several policies on environmental management have been established with the aim of achieving development that is in harmony with environmental preservation efforts. With these policies, it is hoped that developments carried out at this time will still be able to provide benefits for the upcoming generations. Therefore, the principles of sustainable development have been mainstreamed in the National Long-Term Development Plan 2005-2025 and the National Medium-Term Development Plan 2004-2009 and 2010-2014. In addition, efforts for developing human resource capacity in proper environment management will continue to be made. One method is through environmental education for the young generation through Education for Sustainable Development.

Success in applying the principles of sustainable development in national developments are indicated by factors such as total forest cover, fishing intensity, carbon dioxide emissions, energy consumption and ozone depleting substances. Forrest cover areas are indicated by the ratio of the area to the total land area based on the review satellite imagery and aerial photography surveys. Energy consumption is indicated by the total consumption of primary energy per capita, energy intensity, energy elasticity, and energy mixes for renewable energy.

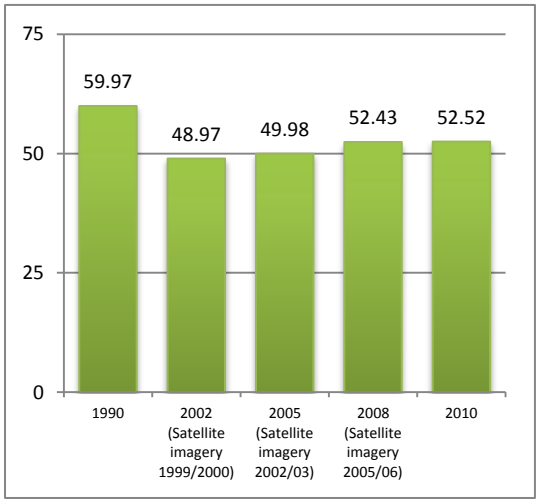


Figure 7.1. Percentage of forest area to total land area
Source: The Forestry Ministry

Attempts have been made to restore the ratio of forrest cover areas to total land area that is captured by satellite imagery and aerial photography surveys to the baseline in 1990 however, more effort is still needed to achieve it. Efforts of raising the ratio have been made in 2002 from a drastic decline from conditions in the base year 1990. Preservation and restoration efforts have increased since 2002, namely through the National Forest and Land Rehabilitation Movement. The ratio of forests has increased significantly from 48.97 percent in 2002 to 52.52 percent in 2010 (Figure 7.1).

In addition to these efforts, strict standards have been set for gas emissions and various efforts for raising awareness among stakeholders and the community on the importance of reducing Greenhouse Gas (GHG) emissions, primarily carbon dioxide. These efforts have been successful in gradually reducing the intensity of energy consumption. This is indicated by decreasing the ratio of energy consumption per GDP from a ratio of 5.28 SBM for every U.S. $ 1,000 to 4.61 for every U.S. $ 1,000 SBM in 2010. Although Indonesia has succeeded in increasing the efficiency of energy use for its development, the amount of primary energy consumption per capita has increased manifold. Primary energy consumption has increased from 2.64 BOE per capita in 1991 to 4.95 BOE in 2010.

Inventorization of GHG emissions shows an increase in emissions of 1,377,983 Gg CO_2e in 2000, to 1,791,372 Gg CO_2e in 2005. Meanwhile, excluding emissions from the forestry sector (Land use, land use change and forestry - LULUCF), total GHG emissions from three main types of greenhouse gases (CO_2, CH_4, N_2O) reached 556,728.78 Gg CO_2e in 2000. GHG emissions are not evenly distributed among the three main types of greenhouse gases. CO_2 emissions amounted 1,112,878.82 Gg, representing 80.80 percent of the national GHG emission; methane emissions (CH_4) amounted 236,617.97 Gg (CO_2e) or 17.20 percent, and dinitro oxide emissions (N_2O) amounted 28,341.02 Gg (CO_2e) or 2.00 percent. The sectors with the majority of GHG emissions is the land-use change and forestry sectors, followed by the energy sector, and emissions from peat fires, waste, agriculture and industries. Efforts to reduce GHG emissions will continue to be strived for in the coming years with implementation of low-carbon development based on the National Action Plan for Reducing GHG Emissions (RAN-GRK) which has been established in the Presidential Regulation No. 61/2011.

Table 7.1 Summary of national GRK emissions in 2000 (in Gg CO_2e)

	CO_2	CH_4	N_2O	PFC	Total
Energy	247,522.25	30,174.69	3,240.64	NO	280,937.58
Industrial Process	40,342.41	2,422.73	133.22	145.15	43,043.52
Agriculture	2,178.30	50,800.18	22,441.25	NO	75,419.73
LUCF[1]	821,173.35	56.35	24.47	NO	821,254.17
Waste	1,662.49	153,164.02	2,501.45	NO	157,327.96
Total	1,112,878.82	236,617.97	28,341.02	145.15	1,377,982.95

Source: Indonesia Second National Communication under the UNFCCC (KLH, 2010)

Table 7.2 Summary of GRK emissions during 2000-2005 for all sectors (in Gg CO_2e)

Source	2000	2001	2002	2003	2004	2005
Energy	280,937.58	306,774.25	327,910.62	333,950.21	372,123.28	369,799.88
Industrial Process	43,043.52	49,810.15	43,716.26	47,901.63	47,985.20	48,733.38
Agriculture	75,419.73	77,500.80	77,029.94	79,828.80	77,862.54	80,179.31
LUCF	649,254.17	560,546.00	1,287,494.79	345,489.33	617,423.23	674,828.00
Peat Fire	172,000.00	194,000.00	678,000.00	246,000.00	440,000.00	451,000.00
Waste	157,327.96	160,817.76	162,800.37	164,073.89	165,798.82	166,831.32
Total With LUCF & peat fire	1,377,982.95	1,349,448.96	2,576,951.98	1,217,243.86	1,721,193.07	1,791,371.89
Total Without LUCF & peat fire	556,728.78	594,902.96	611,457.19	625,754.53	663,769.84	665,543.89

Source: Indonesia Second National Communication under the UNFCCC (KLH, 2010)

Consumption of ozonedepleting substances (ODS) is regulated in international treaties through the Vienna Convention and Montreal Protocol, which has been ratified by the Indonesian Government in June 1992. Indonesia is classified as an Article-5 country by the Montreal Protocol based on ODS consumption of only 0.3 kg per capita. As an Article-5 country, Indonesia is obliged to halt the consumption of ODS according to the schedule set by the Montreal Protocol. Indonesia has succeeded in carrying out its commitment to eliminateODS imports or *Chlorofluorocarbons* (CFCs), Halon, *Carbon tetrachloride* (CTC), *Methyl chloroform* (TCA), *Methyl Bromide* (for nonquarantine and pre-shipping) by the end of 2007, or two years ahead of schedule for *Article-5* countries.

Countries that are part of the Montreal Protocol, in the 19th convention of participating countries have agreed to accelerate the elimination of *Hydrochlorofluorocarbons* (HCFCs), which is an alternative substance to CFCs in accordance with regulation XIX/6. *Article-5* countries have an

obligation to meet the reduction targets by 2013, or returning to *baseline* numbers. The *baseline* figure is the average consumption in 2009 and 2010, followed by a reduction in HCFC consumption by 10.00 percent by 2015, a reduction of 35.00 percent by 2020, a reduction of 67.50 percent by 2025 and the elimination of consumption by 97.5 percent by 2030 and an allowance to use HCFCs by 2.5 percent when necessary for equipment servicing which still uses HCFCs until 2040.

Another factor, within the framework of implementing the principles of sustainable development in national development, is the proportion of fish catches, which must be maintained within safe biological limits. Although the amount has increased, it is still maintained fewer than 100 percent of the *Total Allowable Catch* / TAC. The maximum sustainable yield/MSY of fishery resources in 2011 is an estimated 6.4 million tons per year, while the total allowable (JTB) is 80 percent of the MSY or 5.12 million tons. The percentage of fish catch has increased from 66.08 percent in 1992 to 98.86 percent in 2011.

In managing fish resources, the water territories of Indonesia are divided into 11 Fishery Management Regions (WPP). Although the total fish production does not exceed the TAC, several WPP have experienced over exploitation. As a result, prudence will used as a principle guideline in all forms of utilization of fish resources particularly from the sea.

Similarly, the ratio of conserved / protected waters to the total water territory area has also experienced a rapid increase. The ratio, which originally amounted 0.14 percent in 1990, increased to 4.97 percent in 2011, or covering an area of 15.41 million hectares. A table of areas of conserved water regions can be seen in Table 7.3. An increase in protected forest areas and conserved water regions is an example of the commitment of the Indonesian Government in supporting the MDGs and sustainable development.

Table 7.3. Conserved Water Regions 2011

No	Conservation Regions	Total Region	Area (Ha)
A	**Initiation of the Forestry Ministry**	**32**	**4,694,947.55**
	National Marine Parks	7	4,043,541.30
	Marine Theme Parks	14	491,248.00
	Marine Wildlife	5	5,678.25
	Marine Nature Reserves	6	154,480.00
B	**Initiation of the Marine Affairs and Fisheries Ministry**	**71**	**10,720,117.91**
	National Aquatic Parks	1	3,521,130.01
	Aquatic Reserves	3	453.23
	Marine Nature Reserves	3	445,630.00
	Aquatic Theme Parks	6	1,541,040.20
	Protected Marine Areas / Mangroves	2	2,085.90
C	**Regional Government**	**56**	**5,209,778.57**
	Total	**103**	**15,415,065.46**

Box 7.1.
Indonesia's HCFC Phase-Out Management Plan (HPMP)

The Vienna Convention and Montreal Protocol are international treaties that regulate the consumption of ozone depleting substances (ODS). One of the ODS consumptions that is currently being regulated is HCFCs. Actions to halt the consumption of HCFCs are very important because in addition to depleting the ozone layer, these chemicals also have a negative impact on the climate. Indonesia's HCFC Phase-out Management Plan (HPMP) Stage-1 proposal was approved at the 64th conference of the Executive Committee for the Implementation of the Montreal Protocol in July 2011. Contained in the proposal is an agreement for the elimination of HCFC use in air conditioning, refrigeration, and foam industries for the first phase of 2011-2018. The types of HCFCs that are a priority for removal in Indonesia are HCFC-22 and HCFC-141b.
The Indonesian government has prepared significant measures to reduce the rate of HCFC consumption that will help reach its target of reducing greenhouse gas emissions by 26 percent from business as usual levels by 2020. The various measures include issuing regulations and policies with regular interaction with relevant ministries, industry representatives, and implementing agencies in supervising and controlling the amount of ODS that enter Indonesia that can be implemented by setting quotas on ODS imports. Indonesia has set quotas on imports of CFC-type ozone depleting substances, through the Regulation of the Minister of Trade Affairs 24/M-DAG/PER/6/2006 on the Import of Ozone Depleting Substances. Taking into account the new target of eliminating consumption of HCFCs by 2015, the Government of Indonesia has amended existing regulations to control the import of HCFCs entering Indonesia, by issuing the Regulation from the Minister of Trade Affairs 03/M-DAG/PER/1/2012, which has been in effect since January 15, 2012. The fundamental changes made in these regulations include a more detailed specification of the Harmonized System Code (HS Code) for HCFC-category ozone depleting substances, so that by 2012 HCFC imports can be better monitored and controlled to minimize illegal trade and as skill training to increase the capacity of customs officers.

Setting quotas is one strategy that is used to achieve the target of gradual eradication of ODS. In efforts of eradicating HCFC, Indonesia will also conduct HCFC technology transfers into non-HCFC that is funded by the Multilateral Fund for the Implementation of the Montreal Protocol (MLF) to ensure that the target of eradicating ODS is achieved within the determined time period. In addition, public awareness activities and campaigns have been conducted to promote the preservation of the ozone layer among consumers, the local governments, and other government-related institutions. Strategies to eradicate HCFCs also need to include other considerations such as increasing energy efficiency, raising employment, and ultimately contributing to a Green Economy.

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

In order to increase the ratio of tree-covered areas and protected areas, the Indonesian government has conducted priority programs for the rehabilitation of forests and degraded land, including mangrove forests, beaches, peat land and marshes in priority water basin areas (DAS) throughout Indonesia with the target area of 2.5 million hectares for the period of 2010-2014. In addition, various efforts are made to improve forest management at sites by accelerating the establishment of forest boundaries and accelerating Forest Management Unit operations (Kesatuan Pengelolaan Hutan). Furthermore, various measures to reduce the number of hotspots and burned forest areas continue to be done to curb forest fire rates.

Furthermore, in efforts to improve energy mixes for renewable energy derived from geothermal energy, a significant course of action that has been made is the establishment of an agreement bill with the Ministry of Forestry, with aims to expedite the geothermal business licensing process in production forests and protected forests. It is also aimed to develop measures where geothermal activities can be done in conservation forests that still take into consideration the principles of conservation. In addition, geothermal utilization costs have been revised through revisions of the the Energy and Mineral Resources Ministerial Rule No. 2/2011 on implementation of feed-in tariffs that takes into account the availability of energy sources to generate electricity in certain areas and environment carrying capacity.

Energy elasticity and intensity figures indicate the level of energy efficiency. The smaller the intensity and elasticity of energy the more efficient the energy used. To use energy more efficiently, efforts have been made for energy conservation by conducting energy saving and energy audits. These efforts are carried out through: (i) increased public awareness, (ii) technical guidancefor energy saving, (iii) implementation of partnership programs for energy conservation through energy audit services for industries and construction, (iv) the implementation of energy managers in national work competency standards (v) labeling of energy efficiency levels (vi) monitoring the implementation of the Presidential Decree No. 13/2011, and (vii) the application of energy conservation Indonesian National Standard (SNI) in the construction sector.

Within the framework of programs to protect the ozone layer, the Indonesian government has strategies for the elimination of ODS consumption, namely:

(i) Developing regulations and policies, including:
    a. Establishing a HCFCs import quota system to control HCFC imports by Registered Importers and ODS Producing Importers;
    b. Regulations prohibiting the import of goods containing HCFCs;
    c. Regulations prohibiting the use of HCFCs in the manufacturing industry;
    d. Supervision of ODS use and imports to minimize illegal trade.
(ii) Conducting ODS eradicating programs with the help of grants from the *Multilateral Fund for the Implementation of the Montreal Protocol*, which includes the following:
    a. Implementation of HCFC technology transfers to non-HCFC in Air Conditioning (AC), refrigeration and foam manufacturing industries;
    b. Implementation of regulations prohibiting the import of CFC type ozone depleting substances such as CTC, TCA, *Methyl bromide* (non-quarantine and pre-shipment) since the end of 2007;
    c. Prohibiting imports of goods containing CFCs and halon into Indonesia since 1998;
    d. Certification for technicians and retrofit implementation competency and recycling of cooling systems;
    e. Increasing the effectiveness of ODS destruction facilities, coolant recycling and Halon use management, as well as
    f. Monitoring and distribution of *Methyl bromide* for quarantine and pre-shipping purposes.
(iii) Capacity and awareness building for the community and other stakeholders, includes:
    a. Training, dissemination of information and regular interaction regarding ozone layer preservation programs with local governments, ministries/relevant user industries, consumers and communities;
    b. Conducting ODS replacing technology transfer workshops in user industries;
    c. Promoting the use of non ODS goods and materials and ozone-friendly technologies in local governments, ministries/relevant user industries, consumers and communities.

In 2011, the Indonesian government has conducted a series of programs to improve the quality of fish resources and surrounding environment, or Spreading Fish Eggs in Territorial and Island Water

Regions through the "One Man One Thousand Fries" program that has been carried out by both the state and regional governments. In addition, Fish Houses have been constructed as part of the strategy for restoring fish resources and enrichment of fish stock.

Territorial Water Conservation Areas is planned to be expanded to 20 million hectares by 2020. Indonesia will also work closely with six other countries joined in the Coral Triangle Initiative / CTI, namely: Malaysia, Papua New Guinea, Philippines, the Solomon Islands, and Timor-Leste, in efforts to preserve the wealth of marine resources in the region. Efforts to increase sustainability of coastal and marine environments continues to be done either through rehabilitation or conservation of the habitat as well as increasing the status and protective measures for marine species or types of aquatic biota. This increase in conservation areas is also accompanied by efforts for effective management. In 2011, an assessment tool draft has been prepared to measure management affectivity of protected water regions in Indonesia.

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
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)	42.76% (2011)	68.87%	▼	BPS, Susenas
7.8a	Urban	50.58% (1993)	40.52% (2011)	75.29%	▼	
7.8b	Rural	31.61% (1993)	44.96% (2011)	65.81%	▼	
7.9	Proportion of households with sustainable access to basic sanitation, urban and rural	24.81% (1993)	55.60% (2011)	62.41%	▼	
7.9a	Urban	53.64% (1993)	72.54% (2011)	76.82%	▶	
7.9b	Rural	11.10% (1993)	38.97% (2011)	55.55%	▼	

Status: ●Already Achieved ▶On Track ▼Need Special Attention

CONDITIONS AND TRENDS

Environmental sustainability among others may be indicated by sustainable access to safe drinking water supply and sanitation in urban and rural areas. Household access to safe drinking water supplies in urban and rural areas continues to rise; however, disparity between provinces is still wide.

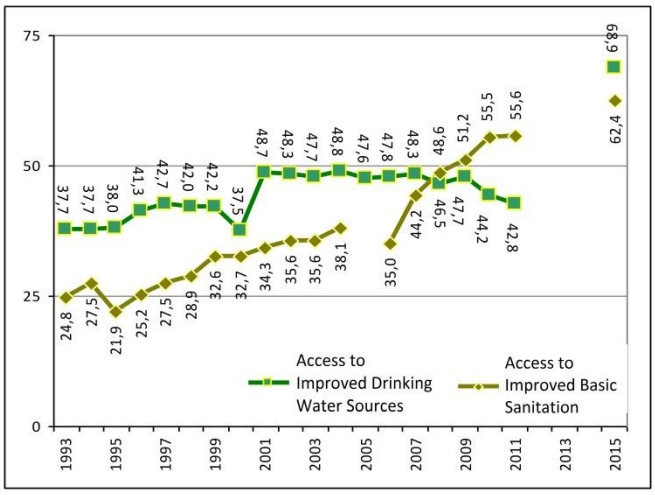


Figure 7.2. Proportion of households with access to safe drinking water and sanitation.
Source: BPS, Susenas various years

Data from the Susenas (National Socioeconomic Survey) indicates access to drinking water sources increased from 37.73 percent in 1993 to 42.76 percent in 2011 (Figure 7.2). However, when compared to the data from the Susenas 2009, a decline in access has occurred by 47.71 percent. In addition, access to drinking water supply in urban areas decreased from 49.82 percent in 2009 to 40.52 percent in 2011, while in rural areas showed a decrease from 45.72 percent in 2009 to 44.96 percent in 2011.

This descreasing trend is due to the increased consumption of bottled drinking water from 10.35 percent in 2009 to 19.37 percent in 2010 (BPS, 2011). Meanwhile, bottled water and refilled water is not accounted as a safe drinking water source. Increased consumption of bottled water and refilled water is one of the reasons for the decline in number of safe drinking water access in 2011. This is

due to the data collected that did not take into consideration the condition of households, which have more than one source of drinking water. The homes in Indonesia, particularly ones situated in urban areas, use bottled water or refilled water as primary sources of drinking water due to convenience (boiling is not necessary). While other sources of water for cooking and water for bathing, washing, toilet needs (MCK), generally use water from taps (piping), boreholes/ pumps, or shallow wells, some are still classified as a safe access to drinking water. This leads to an inaccurate depiction of the results of efforts made to increase access to safe drinking water sources, especially through the provision of tap water (piping) and other safe water sources. Another cause is the provision of drinking water infrastructure that is unable to keep pace with the population growth and increased levels of welfare of the society, due to urbanization and increased consumption, as well as inadequate drinking water infrastructure operations in some locations due to low water tariffs, limited competent human resources, and inefficient management. While in rural areas, efforts to raise the percentage of households with sustainable access to safe drinking water have been made through drinking water providing programs based on community empowerment (Pamsimas) with significant numbers.

Based on processed BPS data from the Ministry of Public Works, the proportion of safe drinking water access in urban and rural areas in 2011 reached 55.04 percent. This figure is obtained from the number of safe drinking water access in 2011 after taking into account the difference in percentage of respondents who use metered tap water and bore wells/ pumps as well as protected wells for bathing/ washing needs with respondents who use metered tap water, bore wells/ pumps and protected wells as their main source of drinking water, also taking into account the location of pump wells and protected wells that are located more than 10 meters from septic tanks, which amounted 12.28 percent. This difference indicates that 12.28 percent of respondents, who use metered tap water, bore wells/ pumps and protected wells for bathing/ washing have alternative access to drinking water other than bottled water. Thus, the attained number of safe drinking water access according to BPS data in 2011 amounting to 42.76 percent needs to be corrected by adding this difference for a total of 55.04 percent.

Based on baseline data for total safe drinking water amount in 2009 that reaches 47.71 percent and a corrected amount in 2011 of 55.04 percent, the increase in drinking water amount totals 7.33 percent within a period of 2 years, i.e. in 2010 and 2011.

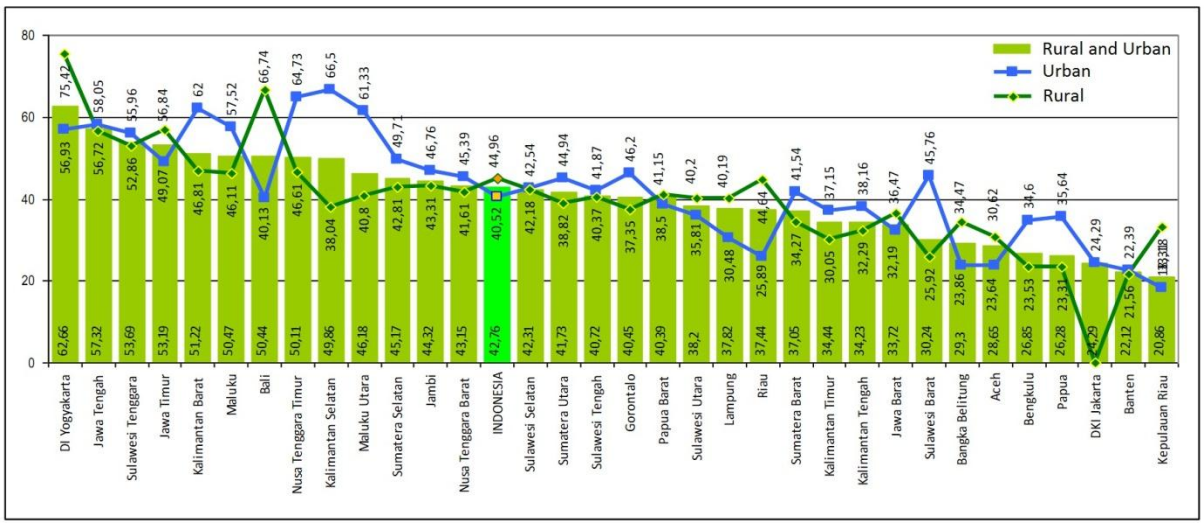


Figure 7.3. Proportion of households with sustainable access to safe drinking water sources, in urban areas, rural areas, and urban and rural areas, 2011.
Source: Susenas (BPS), 2011

Percentages of households with access to safe drinking water sources in 2011 have interprovincial disparities from 20.86 percent to 62.66 percent (Figure 7.3.). As much as 13 provinces out of 33 have percentages above the national average with the highest percentages occurring in Yogyakarta, Central Java, and South Sulawesi, while the provinces with the lowest access is Riau Islands, Banten, Jakarta and Papua.

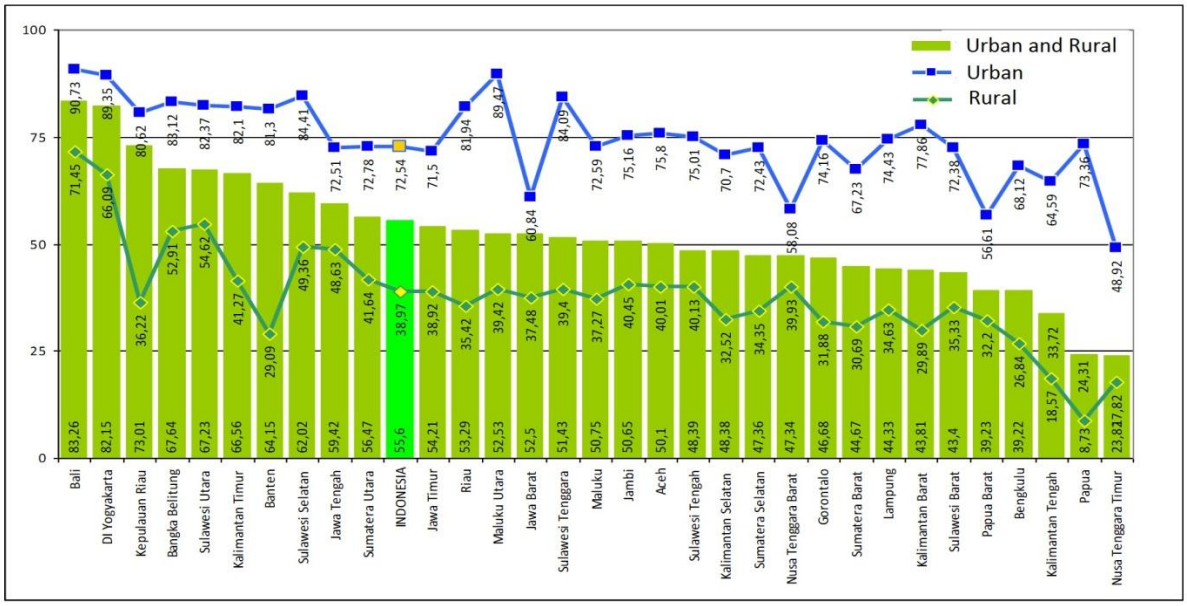


Figure 7.4. Proportion of households with sustainable access to proper sanitation, urban areas, rural areas, and total (urban and rural areas) 2011
Source: BPS, Susenas 2011

Household access to proper sanitation has increased nationwide; however, disparity between provinces is still evident. The proportion of households with access to proper sanitation varies from 22.97 percent to 84.57 percent, with a national average of 55.60 percent in 2011 (Figure 7.4.) Increased access to proper sanitation is much more rapid in rural areas than in urban areas. In 2011, the percentage of urban households with access to proper sanitation increased from 53.64 percent to 72.54 percent, while in rural areas access increased from 11.10 to 38.97 percent compared to the previous year.

In Figure 7.4, it can be seen that as many as 10 provinces from 33 provinces have a percentage above the national average of households with access to proper sanitation with the highest percentages evident in the provinces of Bali, Yogyakarta and Riau Islands, while the provinces with the lowest access are East Nusa Tenggara, Papua and Central Kalimantan.

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

Efforts carried out are in accordance with development priorities in improving infrastructure services according to the Minimum Service Standard, which focuses on providing basic infrastructure to support welfare development through increased accessibility to infrastructure, improved management of infrastructure services and development of human resources and institutions. These efforts were carried out within two major programs, which are (i) increasing the availability and accessibility of safe drinking water supply and proper sanitation for the community through (a) provision of regulations, and (b) ensuring the supply of drinking water resources; (c) improving management performance of provider administrators/ operators; (d) developing alternative sources

of funding through implementation of performance-based grants (output-based aid) and provision of loans for drinking water service institutions, and (e) promoting involvement of communities and the private sectors, and (ii) providing safe drinking water in accordance with the MDGs by (a) fulfilling the basic needs of households, especially in areas prone to water shortages, underdeveloped areas, and strategic areas, (b) increasing development of water catchment areas and water carrying channels and (c) providing adequate and integrated infrastructure, basic facilities and public utilities through real estate development in order to build a city without slums.

Provision of clean water for the people is one of the focuses of the 2010-2014 RPJMN in accelerating infrastructure developments. Drinking water supply through development of innovative financing is also adapted to project modalities through development of bundling for drinking water supply systems, such as water treatment plants (WTP), transmission, and distribution particularly in commercial scales, and unbundling systems for non-commercial drinking water supply, such as water meters. Drinking water services are enhanced through the provision of Drinking Water Supply Systems (SPAM) implemented in 2012 in 894 villages (through the PAMSIMAS program), 249 regions of Low-Income Communities (*Masyarakat Berpenghasilan Rendah* or MBR), cities, and 124 Water Supply Systems (SPAM) in sub-district capitals (IKK) as well as 140 special areas, and 3 regional areas. Meanwhile, wastewater infrastructure was provided in 136 regions, an increase of urban waste management was conducted by increasing/ constructing waste management facilities (TPA) in 94 districts/ cities and integrated waste processing infrastructure/ 3R was provided in 95 regions and management of urban drainages in 49 districts/ cities.

Box 7.2
Breakthrough Funding For Drinking Water Supplies

Currently, several financing options have been developed outside the state budget in order to support the provision of drinking water for the community, especially low-income neighborhoods (MBR), which are:

1. **Drinking Water Grant Programs**: The reality is that the people who are most vulnerable with no access to drinking water are low-income communities (MBR). This is mainly due to financial constraints in paying a relatively expensive fee for installing new drinking water connections. Considering this, the Government has implemented various drinking water subsidy programs in order to ease the cost of installing the SR (water connections) for low-income neighborhoods, known as Drinking Water Grant Programs (*Program Hibah Air Minum*). The program serves as compensation based on performance (output-based aid) of Local Governments in providing water connections (SR) for low-income communities with a compensation value of IDR 2-3 million per SR. Installation of SRs is carried out by the local waterworks (PDAM) with local government funding through investments. Reimbursement of funds to the local government is then provided after the SR operates smoothly for 2 (two) months which is verified technically and provided through water payment accounts. This program has been successful in increasing the number of water connections to 77,000 SR for the period of 2010-2011 in 34 districts/ cities. The program will continue to be implemented until 2014 with a target of approximately 280,000 SR subsidies.
2. **Banking Loans for local waterworks (PDAM):** Presidential Decree 29/2009 concerning the Provision of Security and Interest Subsidies by the Central Government is an alternative funding policy through national banking institutions to develop Water Supply Systems (SPAM). Assurance is given by the central government amounting 70% of the principal amount of credit investment that is due to banks and interest subsidies by the government amounts to a maximum of 5 percent of the investment credit interest. Local waterworks (PDAM) that can utilize this are PDAMs which have no outstanding debts to the Government and shows healthy performance based on BPKP audits (the Development and Finance Surveillance Agency) and

has implemented a full cost recovery tariff. There are 5 National Banks with a total investment credit allocation of IDR 4.22 billion, which have signed a Financing Agreement (PKP) with the Ministry of Public Works, namely BRI, BNI, Bank Jabar Banten, Bank Mandiri and Bank Kalsel. So far, there are 3 PDAMs that have signed the loan agreement with the Minister of Finance, namely the Bogor District PDAM with BRI, the Ciamis District PDAM with Bank Jabar and East Lombok District PDAM with BNI, with a total loan amount of IDR 50 billion.

3. **Community - Based National Program for Water Supply and Sanitation (PAMSIMAS):** The Pamsimas Program is aimed to improve access to drinking water and sanitation as well as to promote practices of clean and healthy living (PHBS) among people living in rural or suburban areas (peri-urban) through community empowerment by building awareness of drinking water and sanitation issues, development of initiatives in planning, implementation, operations, maintenance of facilities that are to be constructed as well as increasing the community's capacity in independently continuing and expanding clean water and sanitation facilities. The Pamsimas program started in 2008 with a target of as many as 5,500 villages in 110 districts/ cities in 15 provinces by 2012. By 2011, there was an increase in safe drinking water access for 3.7 million people and proper sanitation access for 2.5 million people.
4. **Corporate Social Responsibility (CSR):** Other financing that is also being developed currently is Private Business Developments (BUS) with funding distributed through CSR programs. CSR potential is expected to be optimally utilized through multi-stakeholder collaborative partnerships where all parties are committed to contribute according to their roles and abilities in achieving the MDG by 2015. On February 10, 2012, the Bidang Cipta Karya agreement for infrastructure and facilities development had been signed by district heads, the President Director of PT. Adaro Indonesia, the Director of the Bina Program, the Cipta Karya Directorate General, the Ministry of Public Works, and the Chairman of the Corporate Forum for Community Development (CFCD). This agreement was made through the Multi-Stakeholder Partnerships Collaboration (*Kerjasama Kemitraan Multi Pihak*) in the Upper North River District, the Tabalong District, and the Balangan District with total CSR funding of IDR 21.3 billion for the water sector through 2014. The funds are then proposed to fund potential water developments for water supply systems (SPAM) – District Capitals (IKK), construction of bore well towers, construction of intake and the Water Treatment Plants (WTP) at the PDAM (local waterworks), and for the funding of SR installations and construction of SPAM in water prone and underdeveloped rural areas.

Box 7.3
Implementation of Community-Based Sanitation Facilities (STBM) in Sumedang District to achieve MDGs 7C target

In order to meet the RPJMN target and Ministry of Health Affairs Strategic Plan for 2010 - 2014, the Ministry of Health Affairs has launched a Community-Based Sanitation Facilitating Program (STBM) as a priority national program in preventing and promoting disease control that is environmentally based. This is one of the programs supporting the MDG according to Presidential Instruction 3/2010 and is monitored periodically by the UKP4.

The Sumedang District is one of the 221 districts/cities in 31 provinces that have implemented the STBM program for the period of 2010-2014. Based on District Head Decree 10/2008 concerning the Musrenbang Delegation Forum, District Head Decree 113/2009 concerning the Sumedang Puseur Budaya Sunda, and District Head Decree 30/2010 on the STBM program, the **PNPM Perdesaan** (the National Program for Community Empowerment) for rural areas that have an open menu is synergized with the **STBM 5 pillar program** in order to reach the **Sumedang Sehat 2013** target (Healthy Sumedang 2013 program target). One form of its implementation is a program called the *Sauyunan Program* (*Sasarengan Urang Guyubkeun Pangwangunan*), which has been conducted since 2010, as an effort to integrate a participative development system into the sub-national development system, and to promote alignment of technocratic, political and participative planning, with two key agendas which is building community capacity and strengthening of local governments in their efforts in implementing community-based development. The SKPD Indicative Limit budget which usually amounts to IDR 5 million/year for a simple water quality monitoring at 32 health centers, increased up to IDR 28 million, rising again to around IDR 200 million to IDR 300 million so that the budget in 2012 reached IDR 1.8 billion which is allocated for the acceleration of the STBM program in 175 villages/ urban villages which has not yet covered the *Stop BAB sembarangan program* (Stop Casual Defecation Practices) and strengthening of the four pillars of the STBM program in 104 other villages that have Stopped Casual Defecation Practices in 2011. It also receives financial support from the BOK fund (Health Operational Assistance Fund) for Community Health Centers which have also defined the STBM program as one indicator of achievement in managing risk factors/ clinic sanitation in community health centers as defined in the BOK Technical Guidance 2012. The total budget in the BOK fund amounts to approximately IDR 100 million spread across 32 community health centers.

At the operational level, integration requires village-level development planning (a Village Medium-Term Development Plan and Village Government Work Plan) through City Development Planning Meetings (Musrenbang) in the village/ urban village, sub-district and district levels so that facilitation effectiveness in ensuring that the village administrations establish village regulations, implements the Regional Budget, as well as in ensuring accountability of Village Heads (through routine Village accountability reports – LKPJ Desa) becomes vital. Through Government Working Groups for Drinking Water and Sanitation (Pokja AMPL) all sanitation personnel from the planning, budgeting, implementation to monitoring and accountability sectors, work together so that development management is optimized. In order to implement the 5 pillars of the STBM program, according to the STBM program principles of Community-led Total Sanitation (CLTS), awareness building continues to be implemented so that the community is motivated to change their unhealthy habits into healthy ones, along with improvements and strengthening of internal institutions from human resources to support from other institutions in regulating and systems (management) that has made sanitation specifically the STBM program become a hot issue in the District of Sumedang.

Photo 7.1. Various activities from the STBM program and signing of the Stop Casual Defecation Practices Declaration (*Deklarasi Stop BABS*) by Sumedang's district head.

Sumedang's success rate in implementing the Pillar 1 of the STBM program (Stop BABS), at the end of 2011 was 104 villages and 4 districts that have succeeded in the SBS program (Stop Casual Defecation Practices) or ODF (open defecation free). Synergized with the PNPM project, various STBM five pillar programs have been conducted. In the implementation of Pillar 4 of the STBM program, the Sumedang District has conducted a Biogreen training program for composting organic waste in the Rancakalong Village, Rancakalong Sub-District, and the Cipaku Village, Sub-District of Darmaraja.

Box 7.4
Efforts to Accelerate Sanitation Development in Residential Areas

Issus on sanitation in residential areas in Indonesia are still evidently low in quality and services - both in urban and rural areas. To overcome these issues a breakthrough in the sanitation sector is needed. This breakthrough can be achieved through development strategies and programs, that are comprehensive, integrated, long-term, and involves various parties. In order to improve the quality of sanitation in residential areas as well as to keep pace with developments in the sanitation sector, the Indonesian Government has implemented the Program for Acceleration of the Sanitation Development in Residential Areas (PPSP) through the following actions:

1. Advocacy and campaigns to all stakeholders of sanitation development in residential areas
2. Coordination and synergy among agencies, stakeholders and levels of government (central, provincial, district / city)
3. Establishing regulations supporting sanitation development in residential areas
4. Assisting implementations in provinces and districts / cities
5. Building of stakeholder human resource capacity
6. Improving capacity planning, implementation and monitoring and evaluation of development of sanitation settlement
7. Program harmonization for sanitation development in residential areas

The Program for Acceleration of Sanitation Development in Residential Areas (PPSP) was conducted in 2 (two) stages, namely:

1. The first stage which is primarily preparation of policies for the PPSP program as a whole, as well as gaining support from various parties, such as political and administrative support, as well as funding preparations from various sources. This stage was carried out in 2009.
2. The second stage is the implementation stage of the PPSP program, which comprises preparations and implementation during the period of 2009-2014. These activities include the following:
   - Preparation activities which include organizing National Workshops in efforts to recruit district/city participants for the PPSP Program, holding Road Shows in several regions, preparation of facilitators, Workshops to Form Working Groups (Pokja), institutional and regulation development.

- Implementation of activities which include preparation of the City/District Sanitation Strategy (SSK), preparation of Program Memorandums, implementation, monitoring, guiding, evaluations and coaching.

The PPSP program that has been conducted during 2010-2014 is expected to raise centralized wastewater network services up to 5% of the total urban population (5 million people, 16 cities) and help in developing the SANIMAS program (Sanitation by Society) in 226 priority cities. The program is also expected to assist the implementation of 3Rs practices to reduce waste by 20% and improve waste management services in 240 priority cities. Implementation of the PPSP Program is targeted for large and moderately sized metropolitan cities, provincial capital cities, autonomuous cities, as well as urban areas in districts/cities with vulnerable sanitation conditions. By the end of 2014, It is expected that 330 districts/cities will have adopted Sanitation Strategies and 160 districts/cities among them will have begun to implement concrete developments.

To date, a total of 120 districts/cities have successfully put together an urban sanitation strategy (SSK) during 2010-2011. While in 2012 a total of 103 districts/cities are currently drafting SSKs and an additional 181 districts/cities are in preparations to participate in the PPSP program in 2013. Since 2010, physical developments in districts/cities have been made with funding from various sources. Based on existing data, as of 2012, 13 city-scale off-site Waste Water Processing Installations have been built, SANIMAS has been built in 66 locations, and 75 more locations are expected to be established in 2012.

Through the PPSP Program, districts/cities have managed to increase their chances of receiving fund for residential sanitation from the state and regional budgets and other sources of funding such as donors, corporate social responsibility (CSR) and Special Allocation Funds (DAK), where one of the products of the PPSP program or District / City Sanitation Strategies (SSK) have become a prerequisite for eligibility of receiving these funds. The funding sources mentioned include:

1. **Sanitation Grant Programs:** sAIIG (Australia – Indonesia Infra-Structure Grants for Sanitation) and Sanitation Grants. The sAIIG is a grant for wastewater and waste disposal programs that are dispersed based on measured performance (output-based) of the regional government as part of its agenda for 2012 to 2014. The scope of its activities is to distribute the grant received from the Australian Government through the State Government to Local Governments for wastewater and waste disposal sectors.
   Sanitation Grants are grant programs that focus on installing water connections (SR) for services from urban-scale centralized wastewater systems for Low-Income Communities. The program is also based on measured performance (output-based) of the Local Government with a compensation value of Rp 5 million / SR. Reimbursement of funds to the local government is then provided after the SR operates smoothly for 2 (two) months which is verified technically and provided through payment accounts for wastewater connection services.
2. **Foreign Loans:** Other financing solutions for provisions of sanitation infrastructure are through foreign loans. This alternative is aimed primarily for development of urban-scale centralized wastewater treatment that requires relatively large funding. Foreign loans are used for wastewater programs such as the Metropolitan Sanitation Management and Health Project (MSMHP) and Denpasar Sewerage Development Project (DSDP). Hopefully, through these programs, Wastewater Treatment Plants (WWTP) can be built and urban-scale piping networks are able to serve the needs of wastewater services for the urban population.
3. **Corporate Social Responsibility (CSR):** Other financing that is also being developed currently is Private Business Developments (BUS) with funding distributed through CSR programs. CSR potential is expected to be optimally utilized through multi-stakeholder collaborative partnerships where all parties are committed to contribute according to their roles and abilities in achieving the MDG by 2015.

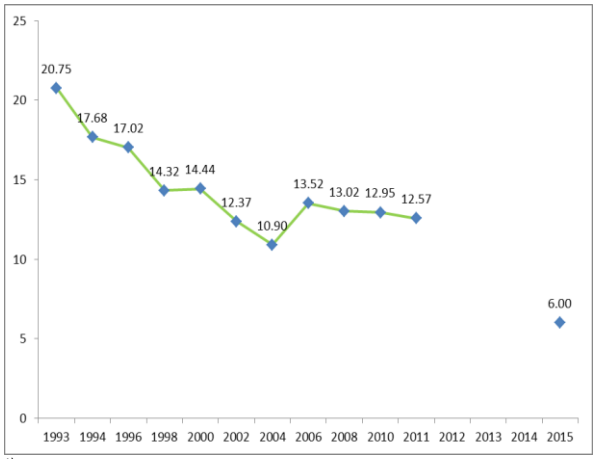
4. **Special Allocation Funds. (DAK):** DAK funds are organized in order to meet minimum service standards in infrastructure provision. DAK funds are also allocated to fulfill the MDGs targets, in addition to drinking water needs and sanitation in addition to road infrastructure development. This is in accordance with the Government Regulation No.14/2009, where there is a requirement or a minimum target, which has to be met by the government in order to optimize community services, particularly in the Public Works sector and residential areas. The PPSP program will be a prerequisite in obtaining DAK funding. Districts/cities that have not been following the Program for Acceleration of Sanitation Development in Residential Areas (PPSP) will have decreased chances of receiving allocation of Special Allocation Funds (DAK) for sanitation.

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers						
7.10	Proportion of urban population living in slums	20.75% (1993)	12.57% (2011)	6% (2020)	▼	*BPS, Susenas*

Status: ●Already Achieved ▶On Track ▼Need Special Attention

CONDITIONS AND TRENDS



[1)] The Susenas Census was not conducted in the Provinces of Aceh and Maluku

[2)] Census was only conducted in the province capitals of Aceh, Maluku, North Maluku, and Papua

Figure 7.5 Proportions of Households in Urban Slums, 1993 – 2011

Source: BPS, Susenas 2011

Proportion of households living in urban slums[1] has decreased 8.18 percent from 20. 75 percent in 1993 to 12.57 percent in 2011 (Figure 7.5). This figure indicates that the average rate of decline in the proportion of households in urban slums is 0.50 percent per year. Without a significant breakthrough, the target of 6% will be difficult to achieve within the predetermined time, i.e. by 2020.

Regional disparities based on the proportion of urban slums households are still quite large. Figure 7.6 suggests that the province with the highest proportion of urban slums households is West Papua. Meanwhile, the lowest proportion is East Java.

A decline in the proportion of households living in underdeveloped areas in the cities will be in line with the declining numbers of poor households. However, from an economic standpoint, an increase in income of poor households will not necessarily encourage them to immediately improve their housing conditions, considering the high costs required to improve the housing quality and area that they inhabit. Poor households will prioritize increase of income on other consumptions such as food and clothing.

[1]Indicators used to determine households in urban slums are lack of access to safe drinking water, lack of adequate access to basic sanitation, the minimum floor area of residence per capita, and durability of housing material.

To improve housing conditions, poor households, especially those living in urban areas, require a significant increase in income. On the other hand, increasing prices of building materials and land constraints in urban areas make it difficult for the poor to occupy decent housing without government intervention.

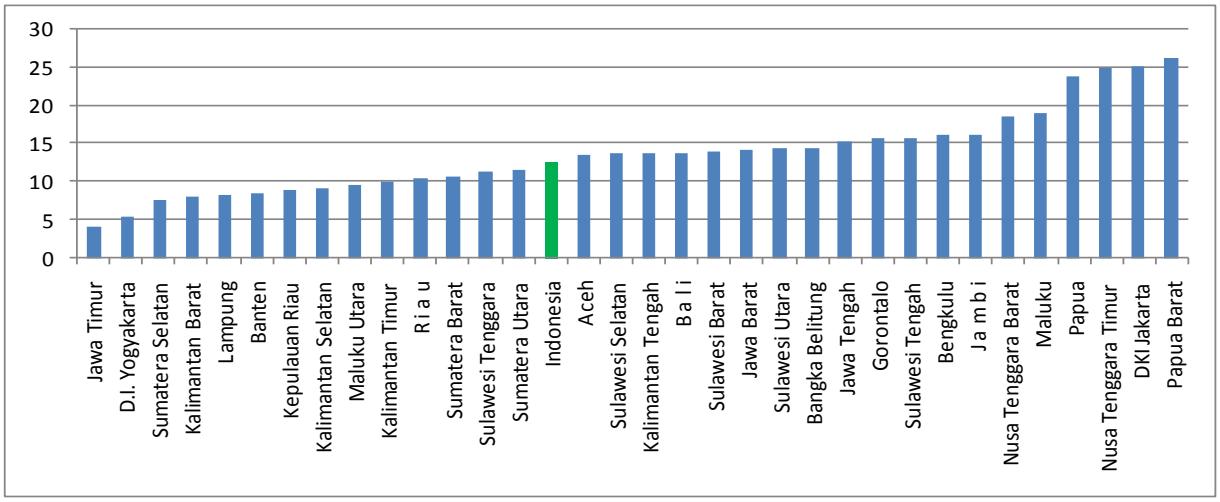


Figure 7.6. Proportion of households in city slums, by province, 2011
Source: Susenas (BPS), 2011

SIGNIFICANT EFFORTS FOR ACCELERATION OF THE GOAL ACHIEVEMENT

To manage households in urban slums one must take into consideration the status of the land they occupy. Generally, households in urban slums can be categorized into two groups. The first group is the poor who occupy housing on land legally in residences either they own or rent. The second group is poor households who occupy land illegally (squatters) which are generally characterized by impermanent building conditions.

For the first group, the government is conducting various interventions in the form of assistance for housing construction and improvements as well as providing facilities and basic neighborhood infrastructure such as roads, drinking water, and sanitation. Several programs that have been and are being conducted by the government to manage households in urban slums through community empowerment are: The Neighborhood Upgrading and Shelter Sector Program (NUSSP), the Urban Poverty Alleviation Program (P2KP), Community-Based Initiatives for Housing and Local Development (Co-Build), the Life Improvement Program for Poor Urban Communities and Regional-Based Plans for Management of Slum Housing and Neighborhoods (PLP2K-BK)

For the second group, there are no other options for the government other than relocation, considering the existence of the people on the land is endanger for their own and public lives. As an example, people who inhabit riverbanks or above the river can potentially cause flood because they are disrupting the flow of water and endangering their lives. Furthermore, those occupying public or private lands are prone to social conflict. One of the government programs to address the urban slum households who occupy land illegally is through providing low-cost apartment rental (Rusunawa).

To accelerate the management of households in urban slums, the government has developed a strategy to ensure integration, effectiveness, and efficiency, among others establishing Housing and Residential Working Groups and Slum Alleviation Policy and Action Plan/SAPOLA. With both strategies, the management of slums in urban areas is expected to not only focused on addressing existing households in urban slums but also preventing of growth and development of additional slums.

Table 7.4. Outcome of Slum Management Programs

PROGRAM	YEAR OF IMPLEMENTATION	PROGRAM COMPONENTS	PERFORMANCE
P2KP/ PNPM Mandiri Urban Areas Implemented in 33 Provinces, 268 Cities/ Districts and 10,923 Urban/ Rural Villages	1999 – present	▪ Improving quality of the environment (infrastructure) ▪ Improving the quality of Human Resources and Health ▪ Increasing accessibility in starting business operations	Beneficiaries: 14,805,923 KK (head of households)
NUSSP Implemented in 32 Cities/ Districts 1,353 Urban Villages	2005 – 2010	▪ Improving quality of the environment (infrastructure) ▪ Increasing accessibility to financial resources	Beneficiaries: 1,226,817 KK Area:7,608 Ha
Co – BILD 12 Cities	2000 – 2003	▪ Residential upgrading ▪ Increasing community access to land ownership	Beneficiaries: 10,000 KK
Rusunawa Development	2003 – present	▪ Construction of Rusunawa units (TB) ▪ Building Rusunawa basic infrastructure	Beneficiaries: 13,720 KK
PLP2K-BK Implemented in 20 Provinces 31 Cities/Districts 33 location	2010 - 2011	▪ Improving public infrastructure, facilities and utilities (PSU) ▪ Improving quality of the environment ▪ Increasing accessibility to business operations.	Beneficiaries: 33,000 KK Area: 165 Ha

Source: Ministry of Public Works and Ministry of Community Housing, 2011

Box 7.4
Contribution of Urban PNPM Toward Achieving the MDGs

Poverty reduction is a policy that is consistently strived for by the Government. One form of this effort is seen in the implementation of the National Program for Community Empowerment (PNPM Mandiri), since 2007, as one of the four clusters of the poverty reduction strategy 2009-2014. Specifically for urban areas, the government has defined the P2KP (Urban Poverty Reduction Program) as an Urban PNPM.

The Urban PNPM program, which is based on community empowerment, is geared towards supporting efforts in improving the Human Development Index (HDI) and completing the Millennium Development Goals (MDGs) so that poverty is reduced by 50 percent by 2015.

Using the empowerment approach principle, through the Urban PNPM Program, the community is encouraged to formulate their own development needs of their region through a participatory planning process. The community has also set up Community Organizations, which are generically referred to as Independent Community Boards/Institutions (BKM/ MFI), which are expected to serve as the driving force of communities in developing their respective regions independently and sustainably.

Photo 7.2 Urban PNPM Mandiri Activities

During 2007-2011, Urban PNPM BLM Funds that were distributed to the community amounted to IDR 6.36 trillion. The funds were used for the construction and rehabilitation of housing infrastructure which have benefited almost 11 million households, with the following breakdown:

Table 7.4 Neighborhood Infrastructure Development and Rehabilitation

No	Type of Activity	Volume		Beneficiary (KK)
1	Roads	23,755,722	meters	8,678,900
2	Bridges	220,439	meters	737,178
3	Repair/ improvement of unfit housing	92,976	units	215,467
4	MCK (bathing/ washing/ toilet)	64,377	units	729,660
5	Clean Water			
	- Piping	1,282,505	meters	199,125
	- Clean water structures	27,755	units	577,758
6	Irrigation			
	- Irrigation channels	179,372	meters	83,249
	- Irrigation structures	227	units	8,888
7	Health facilities	5,182	units	292,344
8	Educational facilities	5,868	units	97,470

Source : Ministry of Public Works, 2011

Box 7.5
Regional-based Management of Slum Housing and Rundown Neighborhoods (PLP2K-BK)

The spread of slums, specifically in urban areas, has caused much impact such as fires and flooding, social conflict, declining levels of public health and quality of neighborhood infrastructure and facilities. These conditions need to be addressed in order to establish habitable neighborhoods in an environment that is sound, safe, harmonious, and orderly. As a result, beginning in 2010 a Regional-based Plan for Management of Slum Housing and Neighborhoods (PLP2K-BK) has been implemented using an integrated regional approach (multi-sector). The target of the PLP2K-BK program until the end of 2014 is 655 acres.

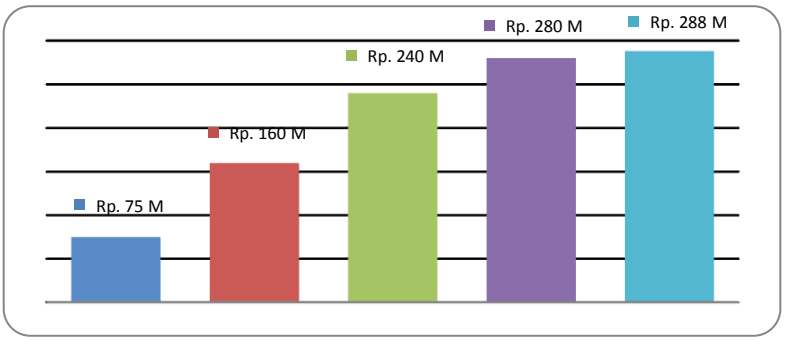


Figure 7.7 PLP2K-BK Program Target and Allocation 2010 - 2014

The PLP2K-BK program is principally an attempt to manage and increase the environmental quality of slums through sustainable means by implementing the tridaya approach of improving and providing public infrastructure, facilities, and general utilities (PSU) that are sufficient in sustaining decent and productive livelihoods and lives of the community. The target of the PLP2K-BK program is slum housing and rundown neighborhoods, which are defined in the local city/ district spatial zoning plan, as residential areas with the following location criteria: 1) clustered area of at least 10 acres, 2) defined by the local government as a slum location, and 3) intensity of squalor and social issues.

The PLP2K-BK has several main program components that are integrated among others: 1) planning of PLP2K-BK, 2) establishing a community driving force (TPM), 3) preparing community-action plans, 4) preparing the detailed engineering design, 5) development of public infrastructure, 6) supervising the construction of public infrastructure, and 7) monitoring and evaluation. All of these programs begin with a location verification based on the proposed location from the local government that complies with the PLP2K-BK criteria for site location, so that development of public infrastructure and facilities is in line with the needs of the community (participatory planning) through community gathering forums.

Districts/cities that have received assistance in managing slums through the PLP2K-BK program totaled 33 locations in 31 districts/cities in 2010-2011. Regional planning in each location has different coverage, depending on the issues and interactions of the urban systems. By 2011 slum housing and rundown neighborhoods that have been managed by the PLP2K-BK program covers 165 acres or about 25 percent of the target of the Strategic Plan of the Ministry of Community Housing, with a population amount of approximately 33,000 assisted head of households (KK).

Source: Ministry of Community Housing, 2011

GOAL 8
DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Source: PPN Ministry/Bappenas

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system						
8.6a	Ratio of Exports + Imports to GDP (indicator of economic openness)	41.60% (1990)*	45% (2011)**	Increase	▶	*BPS and The World Bank **Ministry of Trade and BPS
8.6b	Loans to Deposit Ratio in commercial banks	45.80% (2000)	78.80% (2010)*	Increase	▶	BI Economic Reports 2008, 2009
8.6c	Loans to Deposit Ratio in rural banks	101.30% (2003)	107.6% (2011)*	Increase	▶	*Indonesian Banking Statistics, BI (2011)

Status: ●Already Achieved ▶On-track ▼Need Special Attention

CONDITIONS AND TRENDS

International relations implicates phenomenons of interdependence and interconnectedness among countries. This is reflected in the formation of cooperative collaborations that continues to expand. These collaborations are based on geographic proximity or function, in multilateral, regional (sub-regional), or bilateral levels. This phenomenon of globalization has implications for Indonesia's economy that shows a tendency of becoming more open in the longer term.

With the support of reformations made to the trade regulatory framework, openness in Indonesia's economy has improved the performance of global trade and economic growth. Indonesia's Gross Domestic Product (GDP) has experienced a sharp increase during the post-crisis period of 1998. This increase also occurred in value of national exports and imports. An increase in trade surplus also occurred coinciding with the increase of exports which on average are higher than imports.

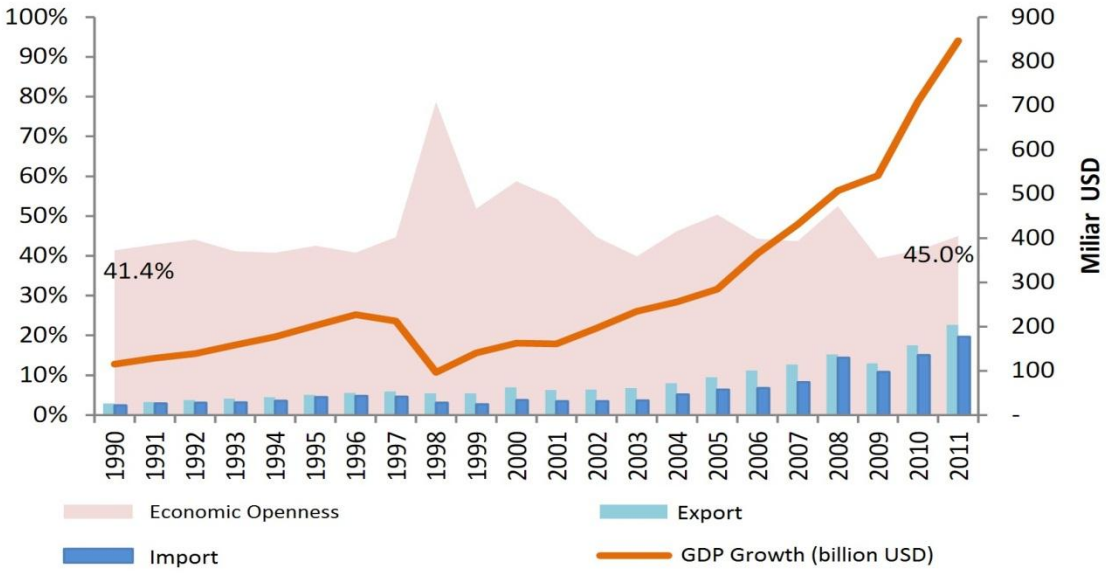


Figure 8.1. Import and export developments, GDP growth and ratio of exports and imports towards the GDP

Indicators of economic openness that have been calculated through the ratio of national exports and imports towrds the GDP shows a significant increase (see Figure 8.1). An assessment of the openness indicator data revealed that during the last decade this indicator amounted 45 percent. However, for the longer term, there was an increase of 41.3 percent in 1990 to 41.4 percent in 2010, and 45.0 percent in 2011. The financial crisis in developed countries that have affected the purchasing power of several countries and increased protectionism poses future challenges in reaching these indicators.

Growth of the national economy also needs to be supported with a reliable financial system. Various efforts have been made in reforming the financial sector entirely, especially the banking sector after the economic crisis led to the increase in resilience of banks, which in turn managed to maintain the public's faith in the banking industry. Resilience in the banking industry is reflected in several indicators, which include the Capital Adequacy Ratio - CAR, which indicates that national banks are generally able to handle potential risks sufficiently in the future. Increased resilience of banks helps to maintain the public's confidence in the banking industry. This is seen in the increase of third party funds and loans (credit) to third parties. Resilience is also evident from the banking intermediate functions which are prudent in managing credit quality as reflected in the increase in the Loan-to-Deposit Ratio (LDR) and a decrease in Non-Performing Loans (non-performing loans/ NPL) in the last 2 years (see Table 8.1).

Table 8.1. Several Selected Indicators of Commercial Bank Conditions in Indonesia, 2010-2011

Indicator	2010	2011
Total Asset (trillion IDR)	3,008.9	3,652.8
Third – Party Funding (trillion IDR)	2,338.9	2,784.9
Loans to Third Parties (trillion IDR)	1,765.8	2,200.1
Loan to Deposit Ratio - LDR (%)	75.2	78.8
Return on Assets - ROA (%)	2.9	3.0
Non-Performing Loans - NPL (%)	2.4	2.0
Capital Adequacy Ratio - CAR (%)	17.2	16.0

Source: Bank of Indonesia

The Loan to Deposit Ratio/ LDR in commercial banks and rural peoples' credit banks (BPR) has increased significantly after the economic crisis of 1998. The increase in LDR of commercial banks is seen in the increase of loans during 2011 by 24.5 percent and the increase of third-party funds in recent years. Apart from being affected by the economic conditions in Indonesia, which are conducive, rapid credit growth is also a result of the GWM LDR[1] policy from Bank Indonesia, which has been effective since March 2011. This policy sets the banking loan to deposit ratio within a range that is considered able to drive intermediation (lower limits of 78 percent and upper limits of 100 percent). With these developments, the LDR of commercial banks continued to increase to 75.2 percent by the end of 2010 and 78.8 percent by the end of 2011, while BPR loan ratio increased to 107.6 percent in 2011. From financing aspects, a credit growth of 21.44 percent was recorded in 2011 with a current nominal value of IDR 41 trillion.

SIGNIFICANT EFFORTS TO ACCELERATE THE GOALS ACHIEVEMENT

Various steps have been taken to increase the ratio of exports and imports to the GDP, among others: through policies that increase the competitive strength of non-oil exports through market diversification as well as increasing the diversity and quality of products, supported by strategy and encouraging diversification of export markets to reduce reliance of certain export markets; increasing the diversity and quality of products primarily manufacturing products that add greater value, based on natural resources and large market demand; improvement of the quality of market expansion, promotion and facilitation of non-oil exports in various export destinations through the utilization of trade cooperation schemes in bilateral, regional and multilateral levels; as well as through control of product imports that could potentially reduce the competitiveness of domestic products in the domestic market.

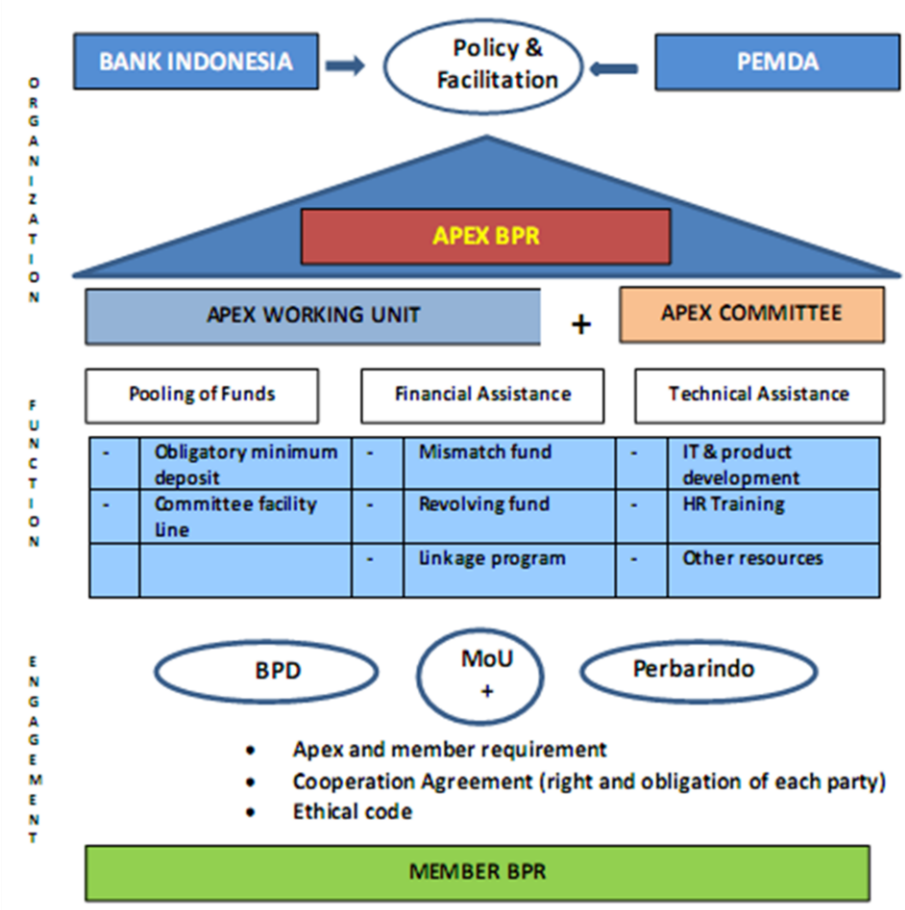
To maintain the stability of the financial sector and strengthen the public's faith in financial institutions, the Government has established several policies, namely: (i) increasing the competitive strength and resilience of the financial sector through measures such as drafting laws on Financial Services Authority (OJK) (ii) increasing banking intermediate function, through establishment of prime lending rates, and (iii) increasing public access to financial services (financial inclusion) through programs such as the People's Business Credit (KUR) i.e. a lending program using assurance models for people who are unbankable as well as the My Savings Program (TabunganKu) that introduces savings "without administrative fees" with an initial deposit that is fairly reasonable (only 20,000).

[1] The GWM LDR is a policy regarding the minimum deposit obligated to be maintained by the Bank in the form of a Current Account balance with the Bank of Indonesia totaling the percentage of the difference between the bank LDR and target LDR.

Box 8.1
BPR Apex Generic Model for Optimization of BPR Roles in Financing Micro, Small, and Medium-sized Enterprises (MSMEs)

The BPR Apex Model (local micro-finance institutions), which has been implemented in Germany, Hungary, Ghana, Brazil, and India, was adopted in Indonesia to strengthen economic growth by optimizing banking contributions in financing as many businesses as possible, especially micro, small, and medium enterprises (MSMEs). MSMEs, with numbers reaching 51.3 million, are business units that dominate the business sector in Indonesia, however only approximately 40 percent are assisted by banks. The banking institution that has prioritized financing for micro and small enterprises is the People's Credit Bank (*Bank Perkreditan Rakyat* or BPR). With limited resources compared to other commercial banks, the BPRs' presence needs to be protected. Therefore, cooperation between BPRs (local micro-finance institutions) and synergy between BPRs and commercial banks are needed to optimize MSME financing.

Figure 8.2 Apex BPR Collaborative Model



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

Indicator		Baseline	Current	2015 MDGs Target	Status	Source
Target 8D: Deal with debt of developing countries through both national and international efforts in order to manage debt over the long run						
8.12	Ratio of International Debt to GDP	24.59% (1996)	8.3% (2011)	Reduce	▶	Ministry of Finance
8.12a	Debt Service Ratio (DSR)	51.00% (1996)	21.1% (2011)*	Reduce	▶	BI Annual Report 2009 *External Debt Statistics, BI (2011)

Status: ●Already Achieved ▶On-track ▼Need Special Attention

CONDITIONS AND TRENDS

Indonesia's foreign debt consists of government debts, debts of the central bank (Bank Indonesia), and private sectors. As shown in Figure 8.2, since 2006, Indonesia's total foreign debt has increased. However, Indonesia's foreign debt since 1998 has actually lessened over time. This is evident from the ratio of Indonesia's foreign debt to the Gross Domestic Product (GDP), which has decreased by 151.2 percent from in 1998 to 26.6 percent in 2011.

The same condition is seen in government foreign debt. Government foreign debt consists of foreign loans and state securities (SBN) in the form of foreign exchange (SBN FX). A decline in the ratio of foreign debt to the Gross Domestic Product (GDP) also occurs in government foreign debt, from 47.3 percent in 1998 to 10.9 percent in 2011, comprising 8.3 percent of foreign loans, and 2.6 percent of SBN Foreign Exchange. The decline indicates an increase in the government's ability to maintain fiscal sustainability. This decline in ratio among others is contributed to the government's efforts in directing the use of loans for expenditures that can drive economic growth. The government has consistently made efforts to control the growth of debts and manages debt with an emphasis on conscientiousness, accountability, efficiency, and effectiveness.

For the central bank, Bank Indonesia's foreign debt continues to decline. This decrease is primarily due to reduced foreign ownership of the Bank of Indonesia debt certificates (SBI) as one of the policies of Bank Indonesia in setting SBI holding periods of least 6 months (six months holding periods). This policy aims to curb capital inflows to short-term securities.

Improvement in Indonesia's ability to manage its foreign debt is also seen from the decrease in the ratio of principal debt payment and external debt interest to export revenue (debt service ratio/ DSR). Along with the drop in Indonesia's external debt position, the DSR in total has declined from its peak level of 59.0 percent in 1998 to 21.1 percent in 2011. DSR figures are constructed from principal obligation payments and debt interests of the government, Bank Indonesia, and the private sector, whereas, specifically for the government, the DSR has dropped to 3.8 percent in 2011.

In line with the progress of the national economy which continues to improve and confidence of international creditors towards Indonesia continues to increase, the foreign debt of the private sectors has also increased from time to time. However, the increase in debt of the private sector is

also accompanied by a decline in risk, as seen in the increase of foreign companies and joint ventures in the foreign debt structure of private debtors. In 2011, foreign debt from private sectors comprised of foreign and joint venture companies accounted for 49.3 percent, an increase from 2006 that amounted 42.0 percent. This reflects an increase in flexibility of external debt of the private sector.

Capital inflow is expected to continually increase, potentially increasing foreign debt of the private sector. This increase is firstly due to push factors, which are influenced by the unresolved debt crisis in Europe, the U.S. fiscal crisis, the political and social conditions in the Middle East and slowdown of the global economy, which resulted in investors shifting their funds into emerging markets. A second, pull factor, is the trust of investors/ creditors in the domestic economy, which tends to increase in line with positive economic growth, increasing foreign exchange reserves, banking conditions, which are secure and stable political and social conditions, as well as investment grade acquisitions.

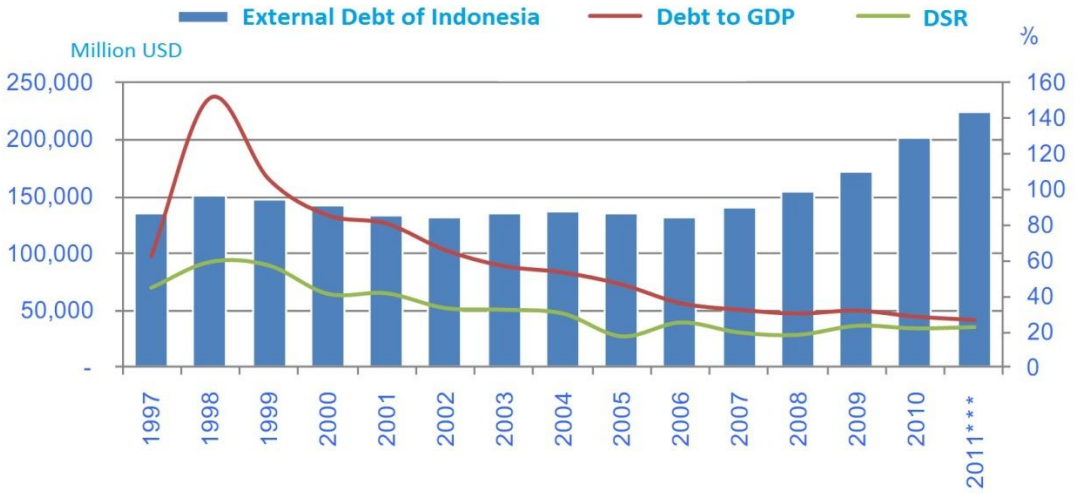


Figure 8.3. Progress of total debt, debt to GDP ratio, and ratio of principal debt and external debt interest payments to export revenues (DSR).

Sources: External Debt Statistics of Indonesia
Joint Publication of the Ministry of Finance and Bank Indonesia

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

In order to manage debt correctly, the government has established a medium-term debt management strategy in order to achieve long-term debt management goals, to minimize the cost of debt at controlled risk levels. The National Debt Management Strategy for 2010-2014 contains public debt management strategies as follows:

a. Optimizing debt financing potential from domestic sources through the issuance of government bonds (SBN) and domestic loans and withdrawals;
b. Developing debt instruments in order to obtain flexibility in selecting various appropriate instruments, that are cost-efficient and minimal risk;
c. Foreign loans are conducted as long as it is used to fulfill priority needs, provide reasonable terms and conditions for the Government, and without a political agenda from the creditors;
d. Maintaining a policy of reducing foreign loans for the medium term;
e. Improving coordination with the monetary and capital market authorities, especially in efforts to encourage financial market deepening; and
f. Improving coordination and communication with various parties in order to increase the efficiency of credit management and sovereign credit rating.

In addition, the government has also consistently made efforts in controlling debts to maintain the government's fiscal sustainability by setting a target total debt ratio to the GDP (debt to GDP ratio) of 22 percent by the end of 2014. As for loans, debt is managed by implementing net negative flow policies for foreign loans or loans drawn are less than loans due. In addition, another measure to manage debt is made by establishing a foreign loan limit as part of the mandate of Government Regulation 10/2011 concerning Procedures for Procurement of Foreign Loans and Grants.

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

Indicator		Baseline	Present	2015 MDGs Target	Status	Source
Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications						
8.14	Proportion of the population with fixed-line telephones (teledensity in population)	4.02% (2004)	3.60% (2010)	Increase	▶	Ministry of Communications and Information
8.15	Proportion of population with cellular phones	14.79% (2004)	103.90% (2010)	100.00%	▶	
8.16	Proportion of households with access to internet	-	26.21% (2011)	50.00%	▼	BPS, Susenas
8.16 a	Proportion of households with personal computers	-	12.30% (2011)	Increase	▼	BPS, Susenas

Status: ● Already Achieved ▶ On-track ▼ Need Special Attention

CONDITIONS AND TRENDS

In the era of globalization and free trade, which is followed by a knowledge-based economy and society, mastery of information and communication technology is an absolute necessity. Knowledge acquisition is greatly influenced by the ability to obtain information, which in turn is affected by mastery of information and communication technology.

Utilization of new technologies, especially information and communication technology, in several sectors has been successfully implemented through collaborations with the private sectors. Utilization of information and communication technologies is indicated by the proportion of the population that have access to the Public Switched Telephone Network (density of telephone facilities per total population), the proportion of the population who own mobile phones, the proportion of households with internet access, and the proportion of households with personal computers.

The percentage of the population with access to the PSTN network has decreased slightly from 2004 amounting 4.02 percent to 3.6 percent in 2010. PSTN network access in 2010 reached 8.35 million subscribers. When calculated from the penetration rate of PTSN network access to households, numbers reached about 15 percent in 2010, whereas in 2011 the penetration rate of PTSN network access to households reached 25.2 percent.

The proportion of the population who own mobile phones have increased rapidly over the past six years from 14.79 percent in 2004 to 103.9 percent in 2010. This data is calculated based on the total numbers issued by telecommunication providers. In line with the easy and affordable access to acquire starter packs (new mobile phone numbers), as well as providers that do not retract mobile numbers that are no longer active, the total numbers that are circulating are outstanding. As a result, the percentage of the population who own mobile phones is above one hundred percent. However, according to the Susenas, BPS in 2011, the proportion of the population who own mobile phones amounted to 78.96 percent.

In keeping up with global trends, development of wireless based access, which are progressing faster and are more affordable than cable-based (wired) access is increasing rapidly. As a result, PSTN targets for 2015 are expected to decline, however total telecommunications access of PSTNs and mobile phones, will increase.

Utilization of information and communication technology can also be seen from the proportion of households with personal computers and proportion of households with internet access. The percentage of households with personal computers reached 10.2 percent in 2009 and increased in 2011 to 12.30 percent. The low numbers of personal computer ownership by households indicates that we are still not prepared to enter a knowledge-based economy and society. On the other hand, disparities in distribution of personal computer ownership between regions are quite large. As an illustration of the proportion of households with personal computers, in Jakarta, figures reached 25.69 per cent while in the province of East Nusa Tenggara (NTT) only amounted 5.34 percent.

Even so, internet use has increased rapidly in line with increasingly affordable services and devices for internet access. The percentage of households with internet access reached 11.6 percent in 2009, 23.46 percent in 2010, and increased to 26.21 percent in 2011. Due to increased levels of mobility and smart devices that are becoming more and more affordable, the internet is now not only accessible through fixed access such as in homes, but also through mobile internet via hand phones and laptops. In addition, the initiation of the provision of communal-based Internet access services such as Internet cafes have also been carried out by SMEs and individuals.

SIGNIFICANT EFFORTS TO ACCELERATE THE GOAL ACHIEVEMENT

The information technology and communication sectors are strongly influenced by rapid changes in information and communication technologies. This not only results in high demand for large short-term investment but also the need to possess various efficient technologies. In accordance with Law 36/1999 concerning Telecommunications which contains a clear division of tasks between the government as the sector builder and regulator and enterprises as operators (infrastructure/ services provider), the government uses state budget interventions to ensure the availability of information technology and communication services in non-commercial, communal regions, as well as regulation framework interventions to create a competitive and conducive climate for implementation.

The government has established the construction of a national fiber-optic broadband network (Palapa Ring project) as one of its priorities, which aims to connect all major islands in Indonesia and 497 districts/ cities. In 2010, telecommunication operators had connected all major islands in Indonesia except Maluku and Papua where construction is planned to start in 2012. An extension network has been built which covers 311 district capitals/ cities (63 percent) in 2010 and 328 (66 percent) in 2011. By 2014 broadband infrastructure development is expected to reach 422 district capitals/ cities (85 percent). The government has also provided access to telecommunications and internet services in the Universal Service Obligation (USO) regions with a target of 33,184 Ringing Villages (*Desa Berdering*, infrastructure building program) and 5,748 Village Internet Services Centers (PLIKs). In 2010, the Ringing Villages Program had reached 27,670 villages (83.4 percent) while the PLIK Program reached 4,269 sub-district village capitals (74.3 percent). In 2011, services from the Ringing Village Program were available in 30,413 villages (97.3 percent) and PLIK in 5,706 villages (99.3 percent). Targets are scheduled to be completed in 2012.

In addition, the Government is finalizing radio frequency spectrum allocations especially for support of third-generation mobile communication services (3G) so that providers are able to provide optimal services.

Box 8.2.
The Ringing Village and Smart Village Programs (*Desa Berdering* and *Desa Pinter*).

Ringing Village (Desa Berdering) is a program providing basic telephone services (basic telephony), or phone services and SMS (short message services) in remote areas, emerging areas, border areas, areas with unfeasible economic conditions and areas without access to telecommunication services. Implementation of the Ringing Village program in the Western Region of Indonesia is fully completed, while for Indonesia's Eastern Region (Sulawesi, Maluku, and Papua), its completion is expected by April 2012. The program is intended to provide access to information and communication services in remote areas at affordable prices. The Ringing Village service is currently available in 30,413 villages (97.3 percent) from a target of 33,184 villages. Technology used is neutral technology with minimal devices that are required in telecommunications facilities as follows:

a. FWT (Fixed Wireless Telephone)/ Handset
a. Billing Display/ PDPT Telephone Bill Recording Device
b. Power Supply (PLN-APB/SC)
c. Billboard Signs
d. Yagi Antennas (if signal is weak and uses cellular technology)
e. VSAT Antennas and VSAT Devices (if signal is completely unavailable)

There is also the **Smart Village Program (*Desa Pinter*, villages with Internet access)** which aims to diminish the gap in information and education. Due to the availability of computers with internet access, people are able to access any kind of information, including educational and other types of information. The **Smart Village** service is equipped with computers, computer peripherals and internet access with data transfer speeds (throughput) of at least 56 Kbps from the CPE to operators, Latency: 750 ms Max from the CPE to the IIX and Loss Packet: 2 percent from the CPE (Customer Premises Equipment) to the IIX (Indonesia Internet Exchange).

This program is a pilot project in providing internet access in rural areas, and is intended to determine the level of interest and needs of the community for communication and information. The target of the Smart Village service is the installation of 131 Service Connections (SSL) in 32 provinces in Indonesia. 100 SSLs have been prepared while the remaining 31 are expected to be completed in late 2012. The implementation of these two programs is in line with Regulation of the Minister of Communications and Information 32/PER/M.KOMINFO/10/2008 concerning Universal Obligatory Services.

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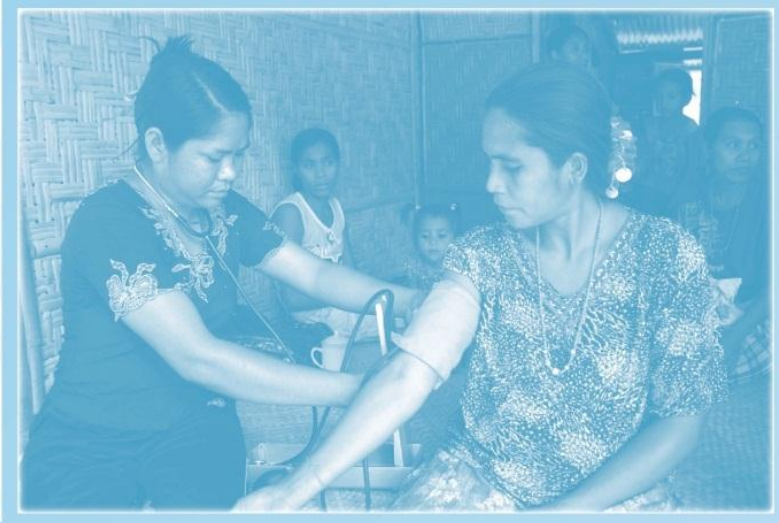

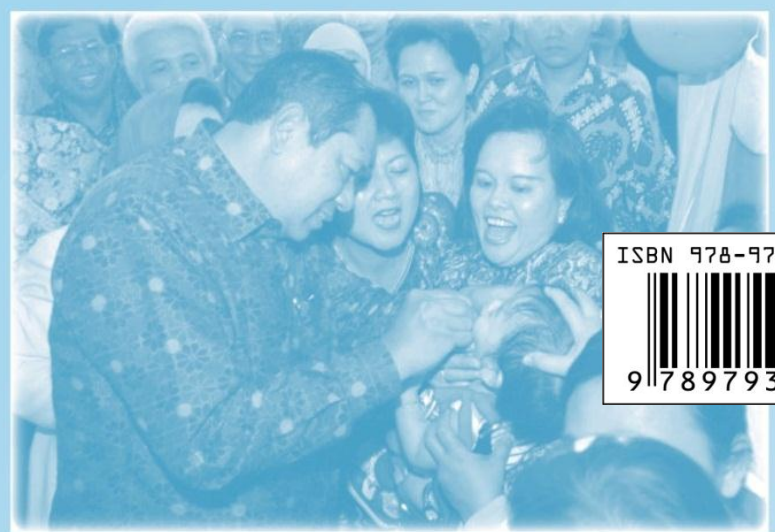

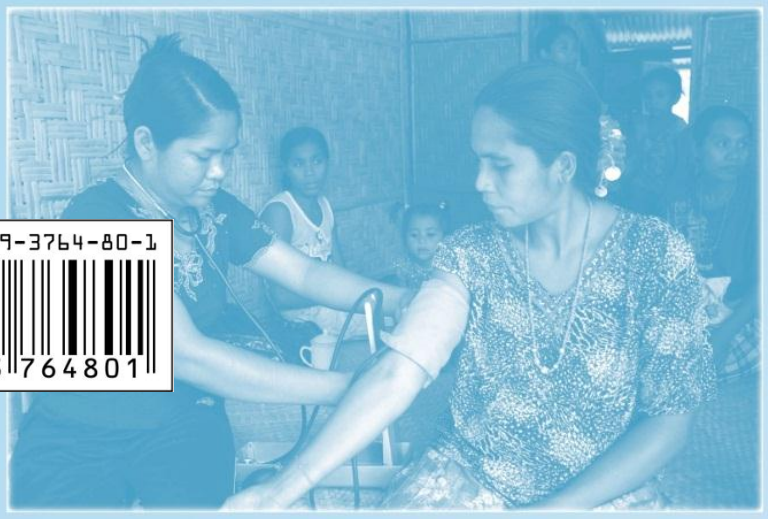

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