The Situation of Children and Women in Indonesia 2000-2010

WORKING TOWARDS PROGRESS WITH EQUITY UNDER DECENTRALISATION

unicef

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The Situation of Children and Women in Indonesia 2000-2010

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FOREWORD

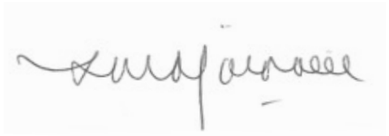
This Situation Analysis of Children and Women was commissioned and completed as a contribution to the growing body of knowledge and information on the situation of children and women in Indonesia.

The process of finalising this analysis has been a comprehensive one, reflecting a wide range of consultations, analysis of data and studies/reports, interviews, and focus group discussions. The findings and recommendations build on the Government of Indonesia's strong commitment to the realization of children's rights, to its own Five Year Development Plan – RPJMN – and other national and international pledges. It also builds on the considerable socio-economic achievements of Indonesia which have had a direct impact on the well-being of its children. In this regard, this particular situation analysis has attempted to be creative and forward-looking for ensuring achievement of the MDGs with equity within Indonesia's policy environment as a decentralized Middle Income Country.

This situation analysis has also identified some of the remaining challenges faced by children, women, and those with a responsibility for their wellbeing, in ensuring the progress made by the country in the past decade is more evenly distributed and reaches the most marginalized and deprived children of Indonesia.

Anchored by the UN Convention on the Rights of the Child, this situation analysis identifies the obligations and potential for action that rest with families, communities, public and private service providers, civil society and government to fully realise the rights of children and women in today's Indonesia.

We truly hope that many different stakeholders and partners – from government officials at national and sub-national level, to NGO and CSO partners and practitioners, the academic and research community, other UN agencies and international financial institutions, the media, private sector and others – will find this situation analysis relevant and useful, inspiring them to greater and enhanced investment in, and with, the children of Indonesia.



Dra. Nina Sardjunani, MA
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National Development Planning Agency (BAPPENAS)

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The development of the 2010 national situation analysis (SITAN) on children and women was implemented within the GoI-UNICEF 2006-2010 Programme Cooperation, under the leadership of BAPPENAS/Ministry of National Development Planning. The National Steering Committee of the SITAN was established in 2009; consisting of all related line ministries and government institutions, to supervise and provide guidance on the development processes for the SITAN development.

The SITAN report titled "Working Towards Progress with Equity Under Decentralisation: The Situation of Children and Women in Indonesia 2000-2010" has been prepared by the Center for Population and Policy Studies, Gajah Mada University (PSKK-UGM), under leadership of Prof. Dr. Muhadjir Darwin, MPA, with technical assistance and support from UNICEF Indonesia and other international researchers.

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- Drs. Wynandin Imawan, M.Sc, Arizal Ahnaf, MA and S. Happy Hardjo, M.Ec who contributed by providing data and information forming the basis of analysis in the SITAN.

Our thanks are also extended to our professional partners their hard work, continuous commitment and dedication on which have contributed to the completion of this report.

- Dr. Saville Kushner; Professor of Public Evaluation, University of West England and Ibunda Yulfita Raharjo who developed the conceptual framework for the SITAN development and supported PSKK in the development of the first draft of the SITAN.
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EXECUTIVE SUMMARY

Within the overall context of Indonesia, this Situation Analysis for Children Report aims to identify, analyse, and explore the available data on the trends and patterns in the major problems affecting children and women in Indonesia over the past decade (2000-2010). It also aims to explore policy initiatives, innovations, and challenges in responding to these problems in the new decentralised governance structures of Indonesia and to provide recommendations for policy makers and practitioners at the national and sub-national levels.

The Situation Analysis comprises five sections: (1) Introduction, (2) Socio-political, Economic and Demographic Context, (3) Analysis of National Indicators on the Situation of Children and Women (4) Children and Decentralization (with a subsection on Voices of Children) and (5) Policy Recommendations.

Section 4 focuses on four very different provinces, namely Aceh, Papua, Central Java and East Nusa Tenggara. For each, an in-depth analysis is conducted on one relevant sector or issue.

1. Aceh: Examining Aceh is useful not only for understanding the vulnerabilities children and women face and how children respond in a context of complex emergencies, but also for appreciating how large scale interventions to rebuild the province have contributed to enhanced social development. Prior to the tsunami, many education facilities were destroyed as a result of the conflict between the Free Aceh Movement (GAM) and the Government of Indonesia (GoI), a situation which was aggravated by the earthquake and tsunami. This rendered it difficult to guarantee access to education. However, in the framework of tsunami relief and investment, large scale interventions in the education sector were made following the signature of the peace agreement between the conflict parties in 2005. As a result, the education situation in the province has vastly improved, albeit unevenly at district level. This provides many lessons in policy innovation and identifies the continued challenges for improving disparities in access and quality to education in the province.
2. Central Java: Compared to other provinces, Central Java has on average a higher standard of living, but its large population, urban and rural poverty mean there are considerable inter-district and inter-income group disparities in terms of child welfare. Rural poverty in the district contributes to the migration of children to urban areas, some of which have ended up living in the streets. The study of children living in the streets, their vulnerabilities, and the policy responses to the problem highlight a number of issues in child (special) protection. They also describe through the pilot of the Child-friendly City of Surakarta how multi-sectoral responses under decentralization have required consistent commitment of the district government to prioritising children in policy formulation, budgeting, and the establishment of a Bureau of Child Protection. All of this has been based on the political will and the commitment of the municipality leadership and support from the provincial level to improve child rights and welfare.

3. East Nusa Tenggara (NTT): The long dry season and absence of a large natural resource base mean that the area is prone to drought, food shortages and other challenges to improving child welfare. The institutions delivering public services are in various stages of development and the capacity of personnel to deliver services in such a difficult context is uneven. Examining the case study of malnutrition and health in NTT is appropriate given the economic difficulties, low education levels, customary nutrition practices, and poor access to health services which are prevalent in the province. It also highlights the challenges under decentralization of improving child welfare in the province.
4. Papua: Despite being rich in natural resources, this province faces enormous challenges with limited human capital and a poor human development index. Papua also suffers from a high prevalence of HIV and AIDS (HIV prevalence: 2.4 per cent) compared to a national prevalence of 0.2 per cent and is classified as experiencing a generalised epidemic in HIV and AIDS. This has been exacerbated by migration, resistance to protective measures in sex practices, and difficulties in changing behaviour due to low education and awareness levels. Papua provides an example of the challenges in combating HIV and AIDS under decentralization and special autonomy in an economically underdeveloped area and in terms of social welfare and infrastructure/ services in Indonesia.

The Situation Analysis demonstrates that the situation of children and women has been improving. For some indicators Indonesia is on track to reach the MDGs by 2015 at the national level (for example in the case of universal primary education). However, the analysis also highlights that despite these improvements there are many disparities, such as geographic, economic, gender or income group discrepancies, requiring further urgent attention of the Government and its development partners. In particular, the Situation Analysis highlights the need 1) to reduce non-income poverty (Sections 2 and 3), 2) to redress socio-economic and regional disparities (Sections 2 and 3), 3) to improve the uneven capacity to deliver services at the district and provincial level, and 4) to better incorporate the needs and voices of children and women into local level decision-making (Section 4).

The evidence presented in this Situation Analysis suggests that some of Indonesia's most vulnerable groups continue to live in dire poverty, with poor access to education, health services, social protection, as well as safe and secure living environments (Sections 2 and 3). However, it also shows, that there are government platforms where these issues are prioritised and can be further integrated in development planning, for example the Government of Indonesia's international commitments, the RPJMN and the National Team for Accelerating Poverty Reduction. UNICEF and other UN agencies also have a mandate to support the GoI in this regard.

More specifically, analysis in Section 2 clearly illustrates the improvements in economic growth and poverty reduction over time in Indonesia. However, it also explains that overall poverty reduction has not been accompanied by equitable social outcomes, with social disparity and inequality being evident between provinces, urban and rural areas, gender and socio-economic groups. Analysis in Section 3 demonstrates that with regard to a range of indicators of child and women's welfare it is very important to enhance policy attention towards pro-poor growth and improving human development, as well as achieving MDGs with equity. The need of tapping into the current "demographic window" through strengthened systems of governance and public administration is also noted.

Due attention is given to MDGs in that the analysis presented is centred on children and women, but at the same time inter-related analysis of the situation of child protection is also considered. In addition, whilst presenting a large number of indicators that correspond to data aggregated at national level, whenever possible the discussion also focuses on evidence of the profound and multiple disparities and inequalities which characterize Indonesia today.

The section on child protection, or special protection as it is known in Indonesia, is distinct from the first three sections in that it relies less on indicators and aggregate quantitative data for the whole country due to data insufficiencies and more on in-depth case studies including quantitative data as well as qualitative data. This analytical approach attempts to best capture and illustrate the challenges and contradictions that accompany the incipient construction of child protection in Indonesia. Whilst this section is divided into five distinct units, it is important to underline that these five components of the analysis are deeply interrelated; outcomes in one area may affect changes in others. Each part of the analysis also identifies the major changes in policies and initiatives which have been undertaken in relation to the themes of this section, although the discussion is not exhaustive given the rapidly changing policy and regulatory environment in Indonesia. Reference to these changes is made in relation to decentralization, while they are further discussed in the sub-national analysis of Section 4.

Section 4 builds on some of the challenges identified in Section 2 with regard to decentralization. These include namely: (1) building the uneven capacity of the district and provincial level arms of the Government to be able to design and administer local-level policies and regulations, (2) improving the quality and performance of the civil service at the sub-national level, (3) the complexities of designing and passing necessary regulations etc. at the provincial and district level to support policies and programmes, and (4) ensuring the even spread of quality of service delivery and assistance. It aims to examine the sub-national context from different perspectives through the four case studies, as mentioned above. These serve as examples of the policy innovations and constraints under decentralization in relation to the resources available and institutional capacity to deliver services and the particular vulnerabilities prevalent in different provinces. These are not exhaustive sectoral reviews but rather aim to elucidate the views of decision-makers and practitioners on issues affecting children's rights and welfare.

Section 4.6, focuses on the Voices of Children and demonstrates that young people do not experience health, educational and other problems in isolation, nor do they seek out ways of linking these things together. They rather experience them in a single context as a multi-dimensional series of life encounters. It focuses on a positive approach to adolescent and child development through sharing children's narratives and stories. These demonstrate the importance of looking at development from a child and adolescent perspective.

The Situation Analysis ends in Section 5 with the below key ten recommendations provided in summary.

Recommendation 1. Harmonising the national and local level legal framework.

Recommendation 2. Mainstreaming the Indonesian Child Protection Law and other legislation related to child rights and welfare and promoting compliance in national and local regulations, guidelines, and policies.

Recommendation 3. Improving evidence-based policing making: Reducing data deficiencies.

Recommendation 4. Improving evidenced-based policy making and monitoring: Strengthening knowledge management, data collection and analysis systems at the national and local level.

Recommendation 5. Improving evidenced-based policy making: Producing biennial thematic SITAN of women and children and other key public documents.

Recommendation 6. Establishing a comprehensive National Child (Special) Protection System to uphold and monitor child rights and welfare as mandated by the Indonesian Child Protection Law.

Recommendation 7. Promoting equitable development for women and children: Targeting interventions on worst performers to improve poverty reduction, pro-poor growth, and MDGs with equity.

Recommendation 8. Strengthening the decentralised system through local level capacity building and support in development planning processes: improving consultative planning processes, regulations, policy formulation, programme design, and service delivery to be pro-child and pro-women.

Recommendation 9. Advocating the scale up specific sectoral interventions to improve child rights and welfare and reduce inequity.

Recommendation 10. Communications for development to assist with knowledge building and behavioural change to support other targeted interventions and improve the situation of women and children in Indonesia.

SECTION 1:
INTRODUCTION

1.1
BACKGROUND

The Republic of Indonesia forms a vast archipelago covering three time zones between the Indian and Pacific oceans. It is the world's fourth most populous country, with an estimated population of 237.6 million in 2010, a figure which, despite declining fertility levels, has grown on average by around 3 million people or 1.49 per cent of the population each year.[1] Indonesia is a country of some 300 ethnic groups scattered across 17,508 islands, with approximately ten islands holding the bulk of the population.[2] The largest ethnic group, the Javanese, are mainly situated on the island of Java, and account for almost half of Indonesia's population.[3] The majority of the population (85.2 per cent) is Muslim, making Indonesia the country with the largest population of Muslims in the world.[4] Nevertheless, there are substantial populations of the different denominations of Christianity, Buddhists, Hindus, and others.[5] In 2010, the country had 31 provinces (and two special regions) within its borders at various stages of economic development.[6] In 2005, the World Bank ranked Indonesia amongst those countries with lower-middle income status.

In this environment of social diversity, this Situation Analysis Report (SITAN) aims to identify, analyse and explore the available data on the trends and patterns in the major problems affecting children and women in Indonesia over the past decade (2000-2010). In a marked departure from past SITAN, it also aims to explore policy initiatives, innovations, and challenges in responding to these problems in the new decentralised governance structures in Indonesia. The SITAN and its recommendations should serve as a policy, programme and advocacy tool for policymakers and practitioners, locally, nationally and internationally.

Although traditionally SITANs are carried out every five years, this is the first SITAN conducted since 2000 owing to the challenges that the Government of Indonesia (GoI) and UNICEF were facing in the middle of the last decade in responding to the devastating effects of the Indian Ocean tsunami in Aceh and surrounding areas, which occurred in December 2004. At the same time, the GoI, with the support of UNICEF, was also compiling the Millennium Development Goals (MDGs) report, which provided an interim situation analysis of the changes in the situation of women and children in the country.

In the years following the tsunami, earthquakes and other natural disasters occurred in other parts of the country including West Java, Padang and Daerah Istimewa Yogyakarta (or D.I. Yogyakarta, to be referred to only as 'Yogyakarta' throughout the remainder of this report). These disasters, and the massive social upheaval in Indonesia which preceded them at the onset of the new millennium, have made improving the situation of women and children in such a large and diverse country a significant challenge. Escalating poverty levels following the Asian financial crisis in 1997, as well as political instability, and sporadic outbreaks of violence during the political restructuring of the county through democratisation and decentralisation (discussed further in Sections 2 and 4), characterised the first half of the decade. These circumstances, coupled with the natural disasters mentioned above, have created both obstacles and opportunities within which policymakers and practitioners have sought to improve the situation of women and children in Indonesia.

1 Badan Pusat Statistik (BPS) – Statistics Indonesia (October 2010) *Laporan bulanan: Data sosial ekonomi*, Vol.5, BPS: Jakarta. This figure is based on estimations from the 2010 Census.
2 Government of Indonesia (2010) available at: http://www.indonesia.go.id/en - Republic of Indonesia (Last accessed 5 October 2010)
3 Badan Pusat Statistik (BPS) – Statistics Indonesia (2010) available at www.bps.go.id (Last accessed 10 October 2010)
4 Government of Indonesia (2010) available at http://www.indonesia.go.id/en (Last accessed 10 October 2010)
5 Ibid.
6 Ibid.

The last SITAN (2000) portrayed the situation of children in the period of political transformation from authoritarianism to democratisation following 32 years of the New Order government under President Suharto. Prior to the financial crisis of 1997, Indonesia experienced a long period of remarkable economic growth (see Section 2), which saw some improvements in education, health, infrastructure development and poverty levels. The situation unwound, however, with the multiple political, fiscal, and economic crises in the late 1990s, which saw devastating effects for much of the Indonesian population, but for women and children in particular. The data presented in this SITAN demonstrate how recovering from these crises has been a slow process that has continued throughout the best part of the last ten years, and that improvements have not always been achieved with equity for the poor. The financial crisis, although devastating, created an opportunity for revising traditional poverty reduction strategies. The GoI introduced a range of measures in the form of health and education social safety net programmes, as well as cash and conditional cash transfer programmes, to offset the worst impacts of the crisis for the poor, and in particular for children.

This SITAN (2010) demonstrates that despite the state of instability in which Indonesia found itself in 2000, the situation of women and children in Indonesia has been improving, and that for some indicators (measured nationally) Indonesia is on track to reach the MDGs by 2015. For example, Indonesia is well on the way to achieving universal primary education (see Table 1.1.1 for an overview of the GoI's assessment of its progress on selected indicators for MDGs 1-7), and the challenge now remaining is to improve education quality (see Sections 3.4 and Section 4.4). On other indicators, such as the Maternal Mortality Ratio, there is still much work to be done.[7]

The analysis in this SITAN also highlights that despite these aggregate improvements, in many sectors there are wide geographic, economic, gender, income group, and other disparities in the improvements of the situation of women and the 83.6 million children and young people[8] in Indonesia. This requires urgent attention from government, donor, and civil society policymakers and programmers, to work towards achieving MDGs and progress with equity. Indonesia's greatest challenges in the future, this SITAN argues, are:

- Reducing non-income poverty (see Sections 2 and 3);
- Redressing socio-economic and regional disparities (see Sections 2 and 3);
- Improving the uneven capacity to deliver services at present at the district and provincial level under decentralisation (see Section 4);
- Better incorporating the needs and voices of women and children into local level strategies, regulations, action plans, budgets, programmes and impacts (Section 4).

The evidence presented in this SITAN suggests that some of Indonesia's most vulnerable groups continue to live in dire poverty, with poor access to education, health services, social protection, as well as safe and secure living environments (see Sections 2 and 3). There are, however, platforms within which tackling such disparities can be prioritised in development policymaking. The GoI, through the ratification of many human rights instruments, under its rights-based and empowerment-based poverty reduction strategy, and in its current National Medium-Term Development Plan *(Rencana Pembangunan Jangka Menengah Nasional, RPJMN 2010-2014)*, has a mandate to protect the vulnerable and redress inequalities. Recognising the

7 Note that while the infant mortality rate (IMR) indicator is on track according to the GoI summary on its progress towards achieving MDGs, it is based on progress where the baseline is set at 1990. In the case that the baseline is set at 2000, far less progress has been achieved with only a two-point reduction in the under-five mortality rate and a one-point reduction in the IMR – see Section 3.
8 Badan Pusat Statistik (BPS) – Statistics Indonesia (August 2010) *Trends of the selected socio-economic indicators of Indonesia, August 2010,* BPS: Jakarta, available at: http://www.bps.go.id/65tahun/Boklet_Agustus_2010.pdf (Last accessed 15 October 2010). Note: This number is calculated for the age group of 0-19 years.

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problem of poverty and disparities in Indonesia, the GoI has also created the National Team for Accelerating Poverty Reduction *(TNP2K, Tim Nasional Percepatan Penanggulangan Kemiskinan)*, chaired by the vice president.[9] The purpose of the inter-ministerial National Team is to develop an overarching policy framework that has the long-term goal of speeding up poverty reduction and reducing the impact of shocks and stresses on the poor and vulnerable.[10] In the medium-term, the goal is to improve the quality of policy advice and to unite all of the GoI's social assistance and poverty programmes.[11] The National Team will design and oversee social assistance and poverty reduction programmes, while consolidating, simplifying, and improving the efficiency of existing programmes.[12]

The National Team will also identify important but troubled social protection programmes and resolve their implementation problems.[13] They will look to create synergies in poverty alleviation activities across ministries.[14] United Nations agencies such as UNICEF, under the Human Rights Based Approach (HRBA), also have the mandate and the commitment to continue seeking to improve the situation of the most marginalised and disadvantaged; groups that are identified throughout this SITAN report. As such, there is considerable policy space to work with the GoI at the national and sub-national level to improve the situation of vulnerable and disadvantaged women and children in Indonesia.

9 Presidential Regulation *(Peraturan Presiden)* No. 15/2010 on Accelerating Poverty Reduction formed an inter-ministerial task force
10 See also the Tim Nasional Percepatan Penanggulangan Kemiskinan (TNP2K) website available at: http://tnp2k.wapresri.go.id/berita/10-siaran-pers/258-press-release.html (Last accessed 15 October 2010)
11 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.

Table 1.1.1: Government of Indonesia's assessment of Indonesia's progress on selected MDGs

MDGs GOAL	STATUS
Goal 1. Eradicate Extreme Poverty And Hunger	
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 (PPP) a day	
1. Proportion of population below US$1 (PPP) per day	Achieved
2. Poverty gap ratio (incidence x depth of poverty)	On track
Target 1B: Achieve full and productive employment and decent work for all, including women and young people	
3. Proportion of own-account and contributing family workers in total employment	On track
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	
4. Prevalence of underweight children under five years of age	On track
5. Proportion of population below minimum level of dietary energy consumption	Needs special attention
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	
6. Net enrolment rate in primary school (NER)	On track
7. Proportion of pupils starting Year 1 who complete primary school	On track
8. Literacy rate for the 15-24 year age group	On track
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	
9. Ratio of girls to boys in primary schools	Achieved
10. Ratio of girls to boys in junior high schools	Achieved
11. Ratio of girls to boys in senior high schools	On track
12. Ratio of girls to boys in higher education	On track
13. Literacy ratio of women to men in the 15-24 year age group	Achieved
14. Share of women in wage employment in the non-agricultural sector	On track
15. Proportion of seats held by women in national parliament	On track
Goal 4. Reduce Child Mortality	
Target 4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	
16. Under-five mortality rate per 1,000 live births	On track
17. Infant mortality rate per 1,000 live births	On track
18. Neonatal mortality rate per 1,000 live births	On track
19. Proportion of one-year-old children immunized against measles	On track
Goal 5. Improve Maternal Health	
Target 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	
20. Maternal mortality ratio (per 100,000 live births)	Needs special attention
21. Proportion of births attended by skilled health personnel (%)	On track
Target 5B: Achieve, by 2015, universal access to reproductive health	
22. Current contraceptive use among married women aged 15-49 years, any method	On track
23. Adolescent birth rate (per 1,000 women aged 15-19 years)	On track
24. Antenatal care coverage (at least one visit)	On track
25. Antenatal care coverage (at least four visits)	On track
26. Unmet need for family planning	Needs special attention
Goal 6. Combat HIV and AIDS, Malaria And Other Diseases	
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV and AIDS	
27. HIV and AIDS Prevalence among total population (per cent)	Needs special attention
28. Proportion of married population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS	Needs special attention
29. Proportion of unmarried population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS	Needs special attention
Target 6B: Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it	
30. Proportion of population with advanced HIV infection with access to antiretroviral drugs	Needs special attention
Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	
31. Incidence rate associated with malaria (per 1,000)	On track
32. Proportion of children under age five sleeping under insecticide-treated mosquito nets	Needs special attention
Goal 7. Ensure Environmental Sustainability	
Target 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	
33. Proportion of households with sustainable access to an improved water source, urban and rural	Needs special attention
34. Proportion of households with sustainable access to basic sanitation, urban and rural	Needs special attention
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	
35. Proportion of urban population living in slums	Needs special attention

Source : Ministry of National Development Planning (BAPPENAS). Report on the Achievement of the Millennium Development Goals Indonesia 2010.
Jakarta : BAPPENAS, 2010

1.2
CHILD RIGHTS AND THE LEGAL AND POLICY FRAMEWORK IN INDONESIA

Pro-child social policy in this SITAN is based on the assumption that the entire policy formulation and implementation process is informed by human rights principles as have been ratified in Indonesia. Child rights have been a major concern at the global level since the ratification of the United Nations Convention on the Rights of the Child (CRC) in 1989. This has produced a variety of social policy changes throughout the world, including child labour laws, the creation of a juvenile court system, mandatory education requirements and child protection laws.[15] Many of these changes are also occurring in the Indonesian context.

Indonesia has established an institutional and legal framework within which to seek to improve child welfare. Prior to this SITAN, the GoI introduced the CRC through Presidential Decree No. 36/1990.[16] In the Presidential Decree, there are seven articles that were ratified with reservations/conditions *(dengan syarat)*. These articles were only then applied when in line with the Constitution.

> "The ratification of the Convention on the Rights of the Child by the Republic of Indonesia does not imply the acceptance of obligations going beyond the Constitutional limits nor the acceptance of any obligation to introduce any right beyond those prescribed under the Constitution. With reference to the provisions of Articles 1, 14, 16, 17, 21, 22 and 29 of this Convention, the Government of the Republic of Indonesia declares that it will apply these articles in conformity with its Constitution."[17]

These reservations were revoked by a Charter on Reservation Revocation signed by the Indonesian Foreign Minister Hasan Wirayuda on 11 January 2005, in D.K.I. Jakarta (Daerah Khusus Ibukota Jakarta, the capital city of Indonesia, to be referred to just as 'Jakarta' throughout the rest of this report). While the CRC (not including the two Optional Protocols) has been ratified by the president, it has to date not been ratified through parliament to form a binding statute which would supersede a Presidential Decree.

Most importantly, the GoI has ratified a number of laws on human rights, including Law No. 39/1999 on Human Rights and Law No. 23/2002 on Child Protection, during the period of this SITAN (for further information on this, see Box 1.2.1). The Indonesian Law on Child Protection (ILCP), and its consequent treatment in the RPJMN, particularly 2010-2014 (approved in January 2010), views child protection holistically (including the rights to health and education) with child protection as it is understood by UNICEF and other agencies being described as 'special protection'. Article 2 of the ILCP states that it is based on the principles of the CRC. Overall, the basic principles underlying the ILCP are: (a) non-discrimination; (b) the best interests of the child; (c) the right to life, continuity of life, and development; and (d) respect for the opinions of children.

15 Miller-Perrin, C. L. and Perrin, R. D. (2007) *Child maltreatment: An introduction*, 2nd ed., Sage publications: Newbury Park

16 Presidential Decrees are ranked lower than Laws/Statutes *(Undang-undang)*. Although the United Nations CRC was ratified by Presidential Decree, the ILCP/2002 doesn't officially mention the CRC as a legal instrument for consideration in the preamble, as Laws in Indonesia may not refer to regulations that are lower in rank.

17 Multilateral Treaties deposited with the Secretary-General (1992) Status as at 31 December 1991, United Nations: New York, p201

Some child rights are mentioned specifically in the 1945 Indonesian Constitution following the four sets of amendments. These include the rights of the child to grow and develop, and to be protected from violence and discrimination. However, the amendments do not recognize the rights relating to child participation, the right to be heard, or for their opinions to be valued. These rights are, however, addressed in the ILCP (Article 10):

> "Every child shall be entitled to speak and have his opinions listened to, and to receive, seek and impart information in accordance with his intellect and age for the sake of his personal development, in accordance with the norms of morality and propriety."[18]

While this right could be somewhat moderated by interpretations of "norms of morality and propriety," it nonetheless provides a legal platform for children to participate in decisions which affect them.

Furthermore, in contrast to the CRC, the ILCP not only outlines the rights of the child but also their obligations/duties. It remains to be explored to what extent interpretation of the obligation-related articles can also be used to restrict child rights in practice.

Finally, the ILCP defines childhood as starting in the womb until the age of 18. Law No. 36/2009 on Health uses the same definition as the ILCP for the provision of health services (up to age 18 years). This is in contrast with other laws, such as Law No. 1/1974 on Marriage, where the minimum age for marriage is 16 for females and 19 for males, and under Law No. 25/1997 on Labour, a child is defined as aged under 15 years, and young people are defined as aged 15-17 years. Childhood comes to an end when a child is married, according to Law No. 12/2006 on Citizenship. These different definitions of the age span for childhood may affect children in terms of child (special) protection.

Overall, however, the protection for human rights and child rights now offered under Indonesian law far is far greater than that proffered by the Suharto regime. Key human rights are now being enforced by Indonesia's recently established Constitutional Court (through Article 24C of the Constitution and Law No. 24/2003). Indonesia also has a constitutional Bill of Rights[19] and the Human Rights Law No. 39/1999, which outlines the range of recognized human rights and elaborates on many of the Bill of Rights articles. These provisions can be overridden by other statutes, if they are more detailed or more recently enacted. Nevertheless, Human Rights Courts have been established permanently in Jakarta, Medan, Surabaya and Makassar. These are the only courts that can impose penalties for breaches against the Human Rights Law for genocide or gross human rights violations.[20] The UNDP *Justice For All* report states that:

> "The Human Rights Law contains more rights specifically related to women, children and other vulnerable groups than does the Constitution. Chapter III Part 9 of the Law regarding children's rights contains more rights than any other of the Law's subject areas, and emphasises that 'children's rights are human rights and, in their interests, are recognised and protected by law even when they are in the womb'. It provides additional legal protections for child defendants, such as disallowing the imposition of the death penalty

18 *"Setiap anak berhak menyatakan dan didengar pendapatnya, menerima, mencari, dan memberikan informasi sesuai dengan tingkat kecerdasan dan usianya demi pengembangan dirinya sesuai dengan nilai-nilai kesusilaan dan kepatutan."*

19 This Bill of Rights is largely based on a 1998 Decree of the People's Consultative Assembly (MPR), which contained a Human Rights Charter. This Charter was essentially replicated in the Human Rights Law (Law No. 39/1999) and the Human Rights Court Law (Law No. 26/2000). Four different sets of constitutional amendments were made in 1999, 2000, 2001 and 2002, with the Bill of Rights contained in the 2000 amendments.

20 UNDP (2006) *Justice for all: An assessment of access to justice in five provinces of Indonesia*, UNDP: New York, pp22-23

or life imprisonment and giving them the right to have their case heard in an impartial Children's Court in a hearing closed to the public. Chapter III Part 9 also deals with women's rights, such as their right to special protection from things that could threaten their safety or reproductive health when working."[21]

The Constitution also outlines, in Articles 28 and 34, obligations of the state with respect to human rights and the protection of vulnerable groups. In particular, it states, "protection, promotion, enforcement and fulfilment of human rights are principally the government's responsibility" (Article 28, clause 4). The Constitution also indicates that the state must develop a social security system for all, to empower the weak and impoverished (Article 34, clause 2), and that the state must provide appropriate healthcare and public service facilities (Article 34, clause 3). Furthermore, contained in the Bill of Rights are articles on achieving equality and justice, equal opportunity in government, and protection against discriminatory treatment, all of which are instruments that can be used to reduce inequality and overcome inequities in Indonesia.

Indonesia has also ratified a number of international instruments which seek to protect human rights and which relate to the rights of children. These include: the International Covenant on Civil and Political Rights (but not the two Optional Protocols); the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (Indonesia has signed but not ratified the Optional Protocol); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (but not the Optional Protocol); the United Nations Convention against Corruption; the United Nations Convention on the Rights of Persons with Disabilities; and the International Covenant on Economic, Social and Cultural Rights. This SITAN recommends that, in the interests of women and children in particular, the Optional Protocols in both the CRC and the CEDAW be ratified.

Many of the principles of the CRC have also been translated into national policy, such as in the National Program for Indonesian Children *(PNBAI, Program Nasional Bagi Anak Indonesia)*, and through the pro-child cross-sectoral approach in the current National Medium-Term Development Plan (RPJMN 2010-2014). See Box 1.2.2 for an overview of the National Program for Indonesian Children.[22] These documents have addressed some of the important child rights, such as the rights to education, health, and the right to child (special) protection. The rights of the child to be heard and for them to participate in decision-making, however, receive less attention in these documents. Nevertheless, a number of social organisations continue to seek to improve the fulfilment of child rights and participation in practice.[23]

21 Ibid.

22 The U.S. spelling of the word 'Program' is retained throughout this report when the GoI uses this spelling for the official English names of its programmes

23 There are a number of social organisations that work on child-related issues in Indonesia. These include: the National Commission for Child Protection (Komisi Nasional Perlindungan Anak, or Komnas Anak)-Jakarta; the Indonesian Child Protection Commission (KPAI, Komisi Perlindungan Anak Indonesia)-Jakarta; the Regional Child Protection Commissions (Komisi Perlindungan Anak Daerah); the Foundation for Child Consumers (KAKAK, Yayasan untuk Kepedulian Konsumen Anak)-Solo; Ina Siswati-Yogyakarta (an NGO for Female Street Children); the Indonesian Child Welfare Foundation (YKAI, Yayasan Kesejahteraan Anak Indonesia); the Communication Forum for Fostering and Developing Indonesian Child Communication (FKPPAI, Forum Komunikasi Pembinaan dan Pengembangan Komunikasi Anak Indonesia)-Jakarta; Plan International Indonesia; and the Foundation for Development of Rights Awareness and Initiative of Teen and Child-Friendly Communities (Lembaga Pengembangan Kesadaran Hak dan Inisiatif Komunitas Ramah Anak dan Remaja)-Gorontalo. Some concrete actions that these organisations have undertaken include the establishment of child parliaments (the implementation of a child congress that publicizes children's voices), and a child forum, both of which are facilitated by the Indonesian Child Protection Commission. Some municipalities in Indonesia have also sought to establish child-friendly cities.

Box 1.2.1: Basic tenets of the Indonesian Law on Child Protection (No. 23/2002) - ILCP

In Law No. 23/2002, the elucidation specifies that child rights constitute part of the overall set of human rights provided for in the 1945 Indonesian Constitution. In particular, the Law states that every child is entitled to live, grow and develop, to participate in society, to be protected from violence and discrimination, and to have his/her rights and liberties upheld in line with the United Nations CRC. While Law No. 39/1999 on Human Rights refers to the rights of children, the specific obligations and responsibilities of parents, the family, the community and the state are further elaborated in the ILCP. In particular, Chapter IV specifies that parents, the family, the community and the state are all responsible for protecting and upholding the rights of children referred to in the law, and will face legal sanctions if they fail to do so. The state is also responsible for providing facilities that are accessible for children, to ensure their optimum growth and development, and for protecting the rights of children to healthcare, social security, education (including special-needs education), play time, and so on. Child rights are to be protected from the time the child is in the womb, until the legal age of maturity; 18 years. Article 2 of the ILCP seeks to protect children according to the principles of:

1. *Non-discrimination*: The ILCP outlines that the state has an obligation to respect and ensure all child rights to all children without distinction, exclusion, restriction, or preferences based on race, colour, sex, language, religion, political or other opinion, social heritage, nationality, poverty, birth or other status. Non-discrimination also means that the state shall provide protection for disadvantaged children, such as disabled or refugee children, children without parents, or children in conflict with the law. The amended 1945 Constitution also adopted the non-discrimination principle in the second amendment (Article 28B, clause 2).
2. *For the best interest of the child*: The ILCP outlines that the state shall guarantee that any action on the part of public or private institutions, courts or administrative authorities should ensure that the best interest of the child is the primary consideration. The state shall guarantee child protection when families or parents fail to perform their duties.
3. *Right to life, survival and development*: The state shall recognize that every child has the inherent right to life and it shall ensure to the maximum extent possible the survival and development of the child. This is the supreme right of the child under the CRC, and more generally under the Universal Declaration of Human Rights (Article 2), and the International Covenant on Civil and Political Rights (ICCPR, Article 6). This principle has been adopted in the ILCP and in the 1945 Indonesian Constitution (Article 28B, clause 1). Furthermore this is also guaranteed under Law No. 39/1999 on Human Rights (Articles 4 and 9).
4. *Respect for the opinions of children*: The child shall have the right to freedom of expression. This right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of barriers, either orally, in writing or in print, in the form of art, or through any other media of the child's choosing. The assumption is that a child is basically capable of forming his or her own views, and has the right to express those views. Yet, the protection for the child to give his or her opinion should take into consideration his or her age and maturity.

Children have the right to protection from discrimination, economic or sexual exploitation, neglect, injustice, harsh treatment, violence or abuse, and other forms of mistreatment (Article 13). There are also provisions in Article 15 for protection against misusing children for political activities, armed conflict, social unrest, violence and war. Article 16 specifies that children should be protected from abuse, torture or inhuman punishment under the Law, and that the arrest, detention, or criminal prosecution of a child shall only be used as a final recourse. In the case that children are incarcerated, they should be separated from adults, receive legal aid and other assistance at every stage of the legal process, and be processed in a children's court (Article 17). In the case that the child is a victim or perpetrator of sexual abuse, he or she has the right to have their identity kept confidential.

The obligations of children are also outlined in the Law in Article 19, including: to respect his parents, guardians and teachers; to love his family and the community, and to respect his friends; to love the homeland, the nation and the state; to practice his religion in accordance with its teachings; to uphold noble values and ethics.

Box 1.2.2: National Program for Indonesian Children (PNBAI) 2015

The National Program for Indonesian Children 2015 emerged after Indonesia's commitment to the declaration on 'A World Fit for Children' (WFC) at the 27th United Nations General Assembly Special Session on Children in 2001. There are four key areas that receive special attention in the WFC declaration and which have been adopted by the national programme: *promoting healthy lives; providing quality education; protecting against abuse, exploitation and violence; and combating HIV and AIDS*. The programme also seeks to translate into practice the principles and rights for children guaranteed under the 1945 Constitution (Articles 28b and 28c) and in the ILCP (Law No. 23/2002), with a clear view towards supporting the CRC and achieving the related MDGs.

The programme is jointly administered by state departments and institutions, and various civil society organisations, and includes child representatives. It has also been integrated into the National Medium-Term Development Plan (RPJMN 2010-2014). The programme has three basic policies:

1. Improve child health, growth and development through community empowerment, strengthening cross-sectoral joint efforts and coordination, improving living environments, and increasing the quality and outreach of health initiatives. This includes increasing the quality, skills and knowledge of health providers, finance staff and managers (including utilization of relevant technologies).
2. Improve child intelligence through widening the accessibility and increasing the quality and efficiency of the education system, as well as increasing the participation of the community in these processes.
3. Improve the protection and participation of children through improving the quality of social services, including legal instruments, and the spread and outreach of services, especially for children in emergencies or difficult situations, by working in local and international partnerships.

In relation to the MDGs, the programme aims more specifically to:

For health: Reduce infant mortality by one third of 2001 levels; reduce maternal mortality by one third of 2001 levels; reduce malnutrition and low birth weight for infants; increase access to clean water and improve household sanitation; develop a national programme for developmental and early learning for children; implement a national health programme for young adolescents; and implement a national programme on reproductive health.

For education: Increase the number of children with access to developmental and early learning services to 85% by 2015; by 2008, complete the compulsory basic education programme that ensures a minimum of nine years of education for every Indonesian child; increase the enrolment capacity of secondary level education facilities; and promote alternative education programmes such as elementary school equivalency programmes (Programme package A), secondary school equivalency programmes (Programme package B) and high school equivalency programmes (Programme package C).

For child protection: Prevent child abuse, violence and exploitation; establish and enforce legal protection for children; strengthen programmes for recovery and social reintegration; strengthen coordination and cooperation; and enhance child participation.

For combating HIV and AIDS: Create a conducive setting for preventing the spread of HIV and AIDS through comprehensive medical therapy and treatment, and cross-sectoral cooperation; integrate preventive measures with medical therapy, treatment and support; empower families and young adolescents (particularly young female adolescents); address AIDS-related stigma and improve general attitudes towards AIDS victims and their families; improve access to antiretroviral therapy (ART); and integrate and mainstream AIDS prevention with the national educational curriculum.

1.3 CONCEPTUAL FRAMEWORK, DATA COLLECTION AND ANALYSIS IN THE SITAN

Along with the previously mentioned changes in the legal framework for the introduction of new policies, policymaking in Indonesia has also had to incorporate a changing institutional environment. During the past ten years, Indonesia has seen three presidents (Wahid, Sukarnoputri and finally Yudhoyono) from different political parties, following the installation in 1998 of interim President Habibie, who began the process of political restructuring in the country. Over time, the political situation has stabilised in Indonesia, with each subsequent election being marked by a reduced level of violence. The presidents, and their respective legislative assemblies, have contributed to strengthening the institutional reforms of democratisation and decentralisation (implemented through Laws No. 22/1999 and 25/1999, and revised through Laws No. 32/2004 and 33/2004), and to improving the skills and the capacity of the civil service throughout the country to deliver services throughout Indonesia. These institutional changes have introduced both deliberative democracy and participatory development in the country.

Legislative elections were held in Indonesia in April 2009 for the 132 seats of the Regional Representative Council (DPD) and 560 seats of the People's Representative Council (DPR). The Democratic Party of President Susilo Bambang Yudhoyono won the largest share of the vote. Presidential elections were then held in Indonesia in July 2009, to elect a president for the 2009-2014 period. President Yudhoyono won more than 60 per cent of the vote in the first round and was declared president by the General Election Commission. Thus, President Yudhoyono has been given the mandate to continue to strengthen democracy, to improve the economic situation and governance - especially with regards to reducing corruption and improving transparency - and to achieve the MDGs with equity, as articulated in the new Medium-Term Development Plan (RPJMN 2010-2014).

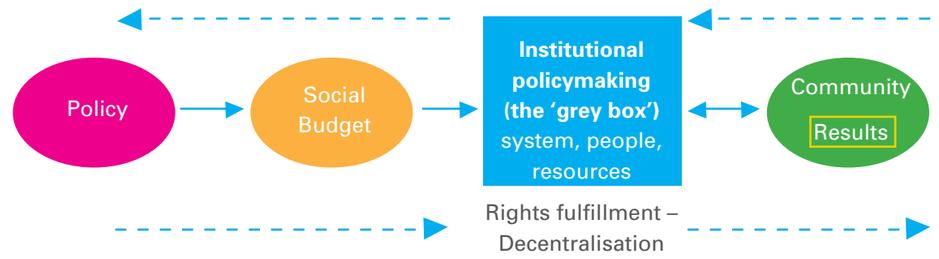
Following ten years of reforms, communities are now more involved not only in political processes but also in social planning. In particular, there is greater civic engagement in five key areas: (1) the formulation of local regulations; (2) local development planning; (3) local budgeting; (4) community-driven development; and (5) public service provision.[24] This SITAN endeavours to explore these processes of institution strengthening and innovative policymaking, as well as the difficulties this entails in Indonesia's new decentralised system.

Conceptually, this SITAN distinguishes two dimensions of child-focused policymaking. First, it involves the official decision-making process and the implementation of responses to child-related problems and issues such as health, education, child freedom and participation, child protection (from violence, neglect and discrimination), defining these as efforts to achieve the larger goals of child welfare and the fulfilment of child rights. Policies are shaped by leaders, as well as laws, government regulations, long- or short-term time frames, professional practices, institutional strategies and action plans.

Second, child-related policymaking also comprises complex informal processes in communities, including interactions between various stakeholders, including between rights-holders (children) and duty-bearers (parents, practitioners), between citizens and those who speak for constituencies or agencies, and between public officials and NGO activists and/or academics. All these stakeholders play important roles in shaping policies and how they are implemented in practice through real actions based on their values, personal identity, and interests. They build collaboration, share visions and values, face problems together and search for more rational agreements.[25] Therefore, this SITAN aims to better explain the 'institutional grey box' of policymaking and implementation, by exploring the data and undertaking analysis from the perspectives of the decision-makers, the policy implementers, and the people who use the services (Figure 1.3.1).

For example, some of the relevant policies created at the national level are also being implemented locally, such as efforts to make pregnancy safer, to reduce malnutrition, and to improve food security. The policy framework and regulations may exist at the national level but these also need to be ratified and enacted in the local level regulatory framework under decentralisation. Enacting national (and local) initiatives relies on local level prioritisation and interpretation of these laws and regulations, which also depends on the knowledge and interests of local government staff and local political leaders, which may result in modifications and changes to such policies in practice. Other policies are the result of local initiatives, such as in the case of the East Nusa Tenggara Maternal and Child Health Revolution (Revolusi KIA). However, the implementation of policies and programmes which affect children depend not only on the stipulation of a policy by both local and national governments, but also on: budgets being prioritised for implementation; the creation of appropriate technical guidelines for government staff to use in implementing these policies; the creation of strategies and action plans by local sectoral offices and agencies, and sometimes inter-office coordination; the availability of infrastructure and service facilities; the number and capacity of local government staff assigned to implement these policies; and (in some cases) partnerships with civil society organisations to get the initiatives off the ground. At every stage, people's priorities, interests, and capacities are involved, which may affect the effectiveness of implementation and actual changes in practice, which in turn affect child welfare. This is the institutional grey box of policymaking. Furthermore, whether these appropriate mechanisms are taken up by local peoples also depends on their needs, understanding, priorities and interests, which - if they are not aligned with a particular policy - may limit the uptake of a programme or service in practice.

Figure 1.3.1: Policy making and policy shaping



Therefore, this SITAN is unique methodologically in that it endeavours to examine the problems evident in child welfare and examples of the response to them in social policy in Indonesia. It examines the situation of children at the macro (national), mezzo (sub-national), and micro (individual) levels. It applies multiple theories and perspectives of analysis and different data sources, including the views of policymakers, practitioners, parents, activists and the voices of children themselves. It uses mixed data collection methods, including desk reviews, focus group discussions (with practitioners, government, children, and reference groups for feedback on findings and triangulation), in-depth interviews with policy stakeholders and community members, and life histories of children. The methods include both qualitative interviews and analysis of policy implementation, as well as use of quantitative data from the National Socio-Economic Surveys (known in Indonesia by the acronym SUSENAS), the Indonesian Demographic and Health Surveys (IDHS, known in Indonesia by the acronym SDKI), Basic Health Research (known in Indonesia as Riskesdas), and use of other data in routine reports from relevant departments. 'Social policy'-making has three different dimensions which this SITAN seeks to explore. First, it relates to the different sectors and agencies responsible for welfare services: education, health, nutrition, housing, water and sanitation, women's empowerment and child protection. Second, from a multi-sectoral perspective on development, it signifies all policies aimed at strengthening society and meeting social rights. Third, it involves participation of and collaboration with institutional practitioners and citizens, especially children, and is influenced by how they interpret and shape the policies that affect them.

24 Darwin, M. (2009) *How participation shapes local development, paper submitted to UNDP as a background paper for Human Development Report 2010*, p12

25 Regarding the discussion on policy shaping as informal policymaking, see: Cronbach, L. J., Ambron, S. R., Dornbusch, S. M., Hess, R. D., Hornik, R. C., Phillips, D. C., Walker, D. S. and Weiner, S. S. (1985) *Toward reform of program evaluation: Aims, methods, and institutional arrangement*, Jossey-Bass Publishers: San Francisco, CA, pp76-151. On the role of practitioner in policy implementation, see: Lipsky, M. (1971) 'Street level bureaucracy and the analysis of urban reform', *Urban Affairs Quarterly*, Vol.6: 391-409. On bottom-up analysis that puts practitioner, citizen or community at the centre of analysis, see: Goggin, M. L., Bowman, A. O'M., Lester, J. P. and O'Toole, Jr., L. J. (1990) *Implementation theory and practice: Toward a third generation*, Scott, Foresman/Little, Brown Higher Education: Glenview, Illinois, pp99-106.

1.4
SITAN STRUCTURE

Based on the data collection methods and the conceptual framework already described, this SITAN is therefore structured as follows:

Section 2 provides an overview of the changes in the political, economic and demographic context over the past ten years, since such changes affect the context in which child welfare policies and programmes are designed and operate. It demonstrates that along a number of socio-economic and welfare indicators there are disparities between income groups, provinces, urban and rural areas, and in some cases gender, illustrating the importance of improving policy attention to pro-poor growth and improving human development, as well as achieving MDGs with equity.

Section 3 examines patterns and trends in the indicators of child welfare and the situation of women, particularly at the national level. This includes a discussion of indicators in health and nutrition, water and sanitation, HIV and AIDS, sexually transmitted infections and adolescent sex practices, education, and child (special) protection in Indonesia. It also includes a discussion of some of the national-level policy interventions in place to improve each aspect of child welfare. The analysis and discussion of each indicator and corresponding policy interventions is not exhaustive, however, as the changes in both the legal and policy framework over the past ten years have been too numerous even for the most comprehensive of SITAN, and data insufficiencies also persist. It is clear from Section 3 that despite overall improvements in some indicators, disparities between regions and groups remain. Furthermore, it is clear that understanding the changes in the situation of children in Indonesia is undermined by data insufficiencies in some key indicators, notably in child protection.

Next, to truly understand the problems children and women face in a country as large and diverse as Indonesia, and the factors that have contributed to vulnerabilities or improvements in their situation, it is important to examine the local contexts. Variations in the situation of women and children in Indonesia - and the complexities of how such situations have emerged - are likely to be disguised by national averages and statistical indicators.

Section 4 therefore, explores case studies of the situation of women and children in four very different provinces in Indonesia: Aceh, Papua, Central Java and East Nusa Tenggara (NTT). This section demonstrates that in different regions of Indonesia there are different vulnerabilities and contributing factors, requiring different kinds of interventions. Section 4 also examines the way children themselves respond in different contexts. It elucidates the synergies between home, school, street and communities, and that despite the different contexts and vulnerabilities they face, children have similar coping mechanisms, and as their skills develop, they use innovative strategies to improve their own situations. This is important for considering how children might be better included in policy- and decision-making regarding their own welfare. Section 4 finally examines the policy framework and responses to the needs of children and women in the new decentralised context in Indonesia. It explores how decentralisation has been institutionalised, how policies are delivered, and how this translates into practice from the views of key stakeholders in the four provincial case studies, including the views of practitioners. This provides a series of lessons learned in both policy innovation and the challenges of improving child welfare under decentralisation.

The four provinces selected for the case studies were chosen to represent very different socio-economic contexts and varied stages of institutional development under decentralisation. They vary in terms of special autonomy status, availability of natural resources, density of the population, experience of natural disasters and conflicts, and proximity to public resources and infrastructure. The case studies within the provinces were also chosen to illustrate particular challenges and policy responses in Indonesia, with regard to education (Aceh), malnutrition and health (NTT), combating HIV and AIDS (Papua), and child (special) protection for vulnerable groups such as children living on the streets in Indonesian cities (Central Java). Section 4 outlines the economic and non-economic factors which shape these vulnerabilities from the perspectives of key stakeholders (policymakers, practitioners, and children themselves). It then examines some (but not all) of the policy responses to these challenges in each province, illustrating the challenges, gaps and innovations in the decentralised context. It is important to remember that these case studies are not exhaustive sectoral reviews in each province, as given the complexities of the sub-national environment in Indonesia and the policy and institutional environment at the national and sub-national level, each would constitute a large-scale SITAN in itself. The features of these provinces and case studies are as follows:

1. Nanggroë Aceh Darussalam (N.A.D., but known as 'Aceh' here and throughout the rest of this report): Located in the northwest of the archipelago on the island of Sumatera, Aceh has implemented special autonomy and *Syariah* law. It has a troubled history of conflict between the state and the Free Aceh Movement (GAM), as well as natural disasters. While the province is resource rich, it has limited human development and high levels of poverty, made worse by the impact of the December 2004 tsunami. Examining Aceh is useful not only for understanding the vulnerabilities children and women face (and how they respond) in a context of complex emergencies, but also how large scale interventions to rebuild the province have contributed to service provision. Prior to the tsunami, many education facilities were destroyed during the conflict, and the situation was made worse by the tsunami. This made it difficult to guarantee access to education. However, large scale interventions in education resulting from tsunami relief, and investment in conflict areas following the signing of the peace agreement between GAM and the GoI in 2005, have resulted in vast improvements in education levels the province (albeit unevenly at the district level), as Section 4 demonstrates. This provides many lessons in policy innovation and identifies the continued challenges for improving disparities in access to education in the province.

2. Central Java: Located in the south of the country on the nation's most densely populated island, Central Java is predominantly Muslim. It has a higher standard of living on average compared to other provinces, but its large population and rural poverty mean there are large inter-district and inter-income group disparities in terms of child welfare. Rural poverty in the district contributes to the migration of children to urban areas, some of whom have ended up living on the streets. The study of children living on the streets, their vulnerabilities, and the policy responses to the problem highlight a number of issues in child (special) protection. They also highlight how multi-sectoral responses to the problem under decentralisation, through the child-friendly city pilot in the City of Surakarta, have required consistent commitment of the district government to prioritising children in policy formulation, budgeting, and the establishment of a Bureau of Child Protection. All of this has been based on the political will and the commitment of the municipality leadership and support from the provincial level to improve child rights and welfare.

3. East Nusa Tenggara (NTT): Located in the far east of Indonesia, NTT is made up of a number of small islands. The long dry season and absence of a large natural resource base mean that the area is prone to drought, food shortages and other challenges to improving child welfare. It has a strong traditional social system and a large number of mainly Christian ethnic groups. The institutions delivering public services are in various stages of development and the capacity of staff to deliver services in such a difficult context is uneven. Examining the case study of malnutrition and health in NTT is appropriate given the economic difficulties, low education levels, traditional nutrition practices and poor access to health services, which are prevalent in the province. It also highlights the challenges under decentralisation of improving child welfare in the province.

4. Papua: Located in the far east of the archipelago, Papua also enjoys 'Special Autonomy' and has a large number of traditional institutions that have been formalised and incorporated into local government structures. Despite being rich in natural resources, Papua has a lack of human capital and a poor human development index. Papua also suffers from a high prevalence of HIV and AIDS compared to other provinces in Indonesia and is classified as experiencing a generalised epidemic in HIV and AIDS. This has been made worse by migration, influx of projects and funds with special autonomy (and the consequent use of sex workers), resistance to the use of protection in sex practices, and the challenges of changing behaviour due to low education levels. Papua provides an example of the challenges to combating HIV and AIDS under decentralisation and special autonomy, and in an area of Indonesia that is underdeveloped economically and in terms of social welfare and infrastructure/services.

In each of the provinces one municipality *(kota)* and one district *(kabupaten)* has been selected where interviews were conducted, as shown in Table 1.4.1.

Table 1.4.1: Research areas

Provinces	City/Municipality	District
Aceh	Banda Aceh	East Aceh
Central Java	Surakarta	Brebes
East Nusa Tenggara (NTT)	Kupang	Sikka
Papua	Jayapura	Jayawijaya

Section 5 makes a series of recommendations for the GoI, UNICEF, other donors and civil society organisations working in child welfare.

SECTION 2:

SOCIO-POLITICAL, ECONOMIC AND DEMOGRAPHIC CONTEXT

INTRODUCTION

Understanding the context within which pro-child social policymaking takes place is important for considering the trends in improvements in child welfare and the limitations and challenges for such initiatives. Only when socio-political conditions are conducive to promoting pro-child social policies can such policies be implemented and have an impact.[1] This section therefore briefly reviews key social, economic, political and institutional reforms that have taken place since the last Situation Analysis Report (SITAN) was conducted in 2000. It demonstrates the achievements Indonesia has made with regard to democratisation and decentralisation, as well as the challenges it has faced. This provides the context for Section 3, which discusses the national-level trends in child welfare in Indonesia across education, health, and other areas. This section also briefly reviews trends in economic indicators at the national level, and sharp disparities between provinces in terms of gross domestic product, poverty levels and the GINI measure of income inequalities. This section also discusses improvements in the human development index (HDI), the gender development index (GDI) and the gender empowerment measure (GEM), again demonstrating that there are significant regional disparities. Finally, this section discusses demographic changes, including fertility rates and the distribution of population by age and gender.

2.1
POLITICAL AND INSTITUTIONAL CONTEXT

Since 2000 when the last SITAN was conducted, Indonesia has undergone large-scale institutional, social, and political reforms. The reform period (commonly referred to as *reformasi*) has been marked most notably by a broader process of democratisation, which began after the resignation of Suharto after 32 years as president in May 1998, and the implementation of decentralisation (discussed further below, and in more detail in Section 4). Reform in Indonesia has also involved a variety of other institutional and legislative changes over the past decade, including: instituting greater political rights and freedom of expression for citizens[2]; the ongoing process of rolling back the role of the military in politics and civilian affairs[3]; passing four sets of amendments to the 1945 Constitution, including articles relating to human rights;[4] and passing legislation which has allowed for freer press,[5] freedom of association,[6] and freedom to form new political parties.[7] It has also involved changing the form and number of seats in legislatures at each level of government, implementing the direct popular elections of the president and vice president, governors, district heads and mayors,[8] and creating the General Elections Commission *(KPU, Komisi Pemilihan Umum)* for elections oversight, no member of which may simultaneously be a member of any political party.[9] Indonesia has also sought to reduce corruption within the framework of improving overall governance, including transparency and accountability.[10] It ratified Law No. 40/1999 on Anti-corruption and created the National Anti-Corruption Commission *(KPK, Komisi Pemberantasan Korupsi)* in 2003. Bessell (2007) also argues that along with these legislative and institutional changes, there have been improvements in terms of child protection and welfare laws during this period, which were discussed in the previous section.[11]

Overall, Imawan (2004) argues that the reform period has been marked by four key changes to the political economy of Indonesia.[12] First, initiatives to shift the control over political decision-making by the executive to the citizenry, through freer elections first held in 1999, and subsequently in 2004 and 2009, with each set of elections being less marred by violence. Centralisation of political power and domination of decision-making were key features of the preceding Suharto government. Second, initiatives during the reform period have included creating greater checks and balances on the distribution and use of power between the legislative and executive arms of government, as well as between central and local governments. Third, rule over the populace has shifted from 'rule through using the law' that characterised Soeharto's New Order government, to building the 'rule of law'. Fourth, reform has also involved efforts to reduce opportunities for corruption and collusive practices within government.[13] Improving accountability and transparency is important, not only for delivering public services that benefit children, but also for effective child budgeting, the delivery of social protection schemes, and for more broadly achieving social equity and cohesion.

1 See Grindle, M. S. (1980), *Politics and policy implementation in the third world*, Princeton University Press: New Jersey; and Mazmanian, D. A. and Sabatier, P. A. (Eds.) (1981) *Effective policy implementation*, Lexington Books: Lexington, MA

2 Political rights were regulated through Law No. 9/1998 on Freedom to Express Opinions in Public Spaces. This law was revised through Law No. 22/2005 on Guarantees for Political and Civilian Rights. The most important change through Law No. 22/2005 is that the state is mandated to protect the right to express opinion *(hak untuk mengemukakan pendapat)*, the right of association *(berserikat/berorganisasi)* such as in trade unions and other organisations, the right to vote and to be elected *(hak untuk memilih dan dipilih)*, and the right to equal treatment under the law *(hak sama di hadapan hukum)*.

3 Depoliticisation *(depolitisasi)* of the military. The separation of the police and military (with the police being responsible for domestic security) is regulated in the People's Consultative Assembly (MPR, Majelis Permusyawaratan Rakyat) Provision *(Ketetapan)* No. VI/2000 on the Elimination of the Dual Function of the Armed Forces. For more information on the impact of these changes see: Kontras, T. (2003) '*Politik militer dalam transisi demokrasi Indonesia*', Komisi untuk Orang Hilang dan Korban Tindak Kekerasan (Commission for Missing Persons and the Victims of Violent Action): Jakarta. Several authors note that this process of reform is ongoing and has yet to be consolidated: Mietzner, M. (2009), *Military politics, Islam, and the state in Indonesia*: From turbulent transition to democratic consolidation, Institute of Southeast Asian Studies: Singapore; Sumarkidjo, A. (2001) 'The rise and fall of the generals: The Indonesian military at a crossroads', in: Lloyd, G. and Smith, S. (Eds.), Indonesia Today, Institute of Southeast Asian Studies: Singapore, pp136-145; Robinson, G. (2001) 'Indonesia on a new course?', in: Alagappa, M. (Ed.), *Coercion and governance: The declining political role of the military in Asia*, Stanford University Press: Stanford, pp226-258; and Rinakit, S. (2005) *The Indonesian military after the New Order*, Institute of Southeast Asian Studies: Singapore. Informed observers have generally noted that the ongoing removal of the military from politics depends upon the quality of civilian governance, political stability and the consolidation of democratic reforms.

4 For a detailed discussion of Indonesia's constitutional amendment process, see: Indrayana, D. (2007) 'Indonesian constitutional reform, 1999-2002: An evaluation of constitution making in transition', *Kompas*, 2008: Jakarta; and Ellis, A. (2007) 'Indonesia's constitutional change reviewed', in: McLeod, R. H. and MacIntyre, A. (Eds.), *Indonesia: Democracy and the promise of good governance*, Institute of Southeast Asian Studies: Singapore, pp21-40

5 Law No. 40/1999 on Freedom of the Press guarantees freedom of the press, as mentioned in Article 4: 1) Freedom of the press is guaranteed as a basic right of citizens; 2) There is no censorship, bans or broadcasting restrictions of the national press; 3) To ensure freedom of the press, the national press has the right to search for, obtain and distribute ideas and information; and 4) To be responsible for reporting, journalists have the right of refusal in court *(Hak Tolak)*

6 Law No. 25/1997 on Manpower

7 Law No. 31/2002 on Political Parties

8 Law No. 22/2003 on General Elections and revised by Law No. 10/2008 on General Election of Members of National Parliament (DPR, Dewan Perwakilan Rakyat), Local Parliament (DPRD, Dewan Perwakilan Rakyat Daerah), and Regional Representatives Council (DPD, Dewan Perwakilan Daerah). For a brief review of the successes and challenges with direct elections, see case studies covering former separatist areas, regions heavily impacted by communal conflicts, national and local legislatures and parliamentary performance: Aspinall, E. and Mietzner, M. (Eds.) (2010) *Problems of democratisation in Indonesia: Elections, institutions and society*, Institute of Southeast Asian Studies: Singapore; Schulte Nordholdt, H. and van Klinken, G. (Eds.) (2007) *Politik lokal di Indonesia*, KITLV and Yayasan Obor Indonesia: Jakarta; Erb, M. and Sulistiyanto, P. (Eds.) (2009) *Deepening democracy in Indonesia? Direct elections for local leaders (Pilkada)*, Institute of Southeast Asian Studies: Singapore

9 Law No. 31/2002 on Political Parties, Law No. 12/2003 on General Election of Members of the National Parliament (DPR, Dewan Perwakilan Rakyat), Regional Representatives Assembly (DPD, Dewan Perwakilan Daerah) and Local Parliament (DPRD, Dewan Perwakilan Rakyat Daerah), and Law No. 23/2003 on General Election of the President and Vice President. The Ministry of Home Affairs is now considering directly appointing provincial governors, which some observers argue will 'roll back' some of the democratic reforms that have taken place over the past decade.

10 Synnerstrom, S. (2007) 'The civil service: Towards efficiency, effectiveness and honesty', in McLeod, R. H. and MacIntyre, A. (Eds.), *Indonesia: Democracy and the promise of good governance,* Institute of Southeast Asian Studies: Singapore, pp159-177; Goodpaster, G. (2002) 'Reflections on corruption in Indonesia', in Lindsey, T. and Dick, H. (Eds.) *Corruption in Asia: Rethinking the governance paradigm*, The Federation Press: Sydney, pp87-108; Supeno, H. (2009) K*orupsi di daerah: Kesaksian, pengalaman, dan pengakuan*, Kreasi Total Media: Jakarta. Though improving its global corruption index ranking, the general consensus among observers is that much work remains to address issues of corruption in Indonesia.

11 Bessel, S. (2007) 'Children, welfare and protection', in McLeod, R. H. and MacIntyre, A. (Eds), *Indonesian democracy and the promise of good governance*, Institute of Southeast Asian Studies: Singapore

12 Imawan, R. (2004) 'Political parties in Indonesia: The half-hearted struggle to look for an identity' (*Partai politik di Indonesia: Pergulatan setengah hari mencari jati diri)*, Inauguration speech for professors in Political Science at the Faculty of Social and Political Sciences, Gajah Mada University, Yogyakarta, 4 September, p3

13 For an overview of patterns and practices of corruption in Indonesia, see: Wilson, I. (2009) 'The rise and fall of political gangsters in Indonesian democracy', in Aspinall, E. and Mietzner, M. (Eds.), *Problems of democratisation in Indonesia* pp199-218; Abdullah, T. (2009) *Indonesia: Towards democracy*, Institute of Southeast Asia Studies: Singapore, pp429-526; Lindsey, T. (2001) 'The criminal state: *Premanism* and the new Indonesia', in: Lloyd, G. and Smith, S. (Eds), Indonesia today: Challenges of history, Institute of Southeast Asian Studies: Singapore, pp283-297

Implementing reform over the past decade, however, has not been without its challenges. For the first part of the decade, the country was recovering from the multiple fiscal, economic and political crises of the late 1990s, which were in part triggered by the 1997 Asian financial crisis. This left unstable exchange rates, escalating levels of poverty, massive unemployment, and economic instability, all of which affected the welfare and rights of children, as discussed later in this section.

As Indonesia overhauled its political system, reduced the subsidies for fuel and food, and sought to simultaneously recover from the financial crisis, social unrest and outbreaks of violence occurred in some places in the archipelago, as is common in countries transitioning from authoritarian to more democratic rule.[14] Beginning in late 1998, communal conflicts broke out in various regions such as Central Sulawesi, Maluku, North Maluku, and Central and West Kalimantan, while tensions continued from the previous decades around demands for self-rule in the restive provinces of Aceh and Papua.[15] Such violence has not only directly been experienced by children caught up in the conflicts and through displacement, but it has also been detrimental to the safeguarding of children's rights to live safely and securely and to access public services (since education, health and other facilities have been destroyed).[16] Elections were also coloured by violence, both in and outside of the communal conflict regions.[17] This was particularly the case in the first rounds of the different elections held in Indonesia, such as the general elections *(pemilu)* in 1999 and, to a lesser extent, in 2004, and more infrequently in the later presidential elections *(pilpres)*, and local head elections *(pilkada)*. In some instances, the more fanatical members of the support groups for different candidates mobilised using violence, sometimes driven by financial incentives.[18]

However, by the time the 2004 general elections were held, many of the inter-group tensions in the communal conflict regions, which characterised the first half of the decade, had begun to dissipate, although this was less the case in Papua and Aceh. Yet, as the country began to stabilise politically and financially, it was hit by a wave of natural disasters. The most serious of these included the devastating tsunami in December 2004, which in Indonesia mainly affected Aceh province (discussed further in Section 4), and the earthquakes in Yogyakarta province in 2006 and in Padang (West Sumatera) in 2009. Similar to the complex emergencies experienced in the conflict zones, children are dramatically affected by the impact of such disasters; they may be injured, lose family members, experience displacement, lose access to basic services (particularly health and education), and experience psycho-social distress.[19]

14 See Bertrand, J. (2004) *Nationalism and ethnic conflict in Indonesia*, Cambridge University Press: Cambridge. For a brief review on the extent of social unrest during the fall of Suharto, see Lane, M. (2008) *Unfinished nation: Indonesia before and after Suharto*, Talisman Publishing Pte Ltd: New York, pp140-176, and Forrester, G. (Ed.) (1999) *Post-Soeharto Indonesia: Renewal or chaos?*, Crawford House Publishing: Bathurst

15 For example: conflict in Poso (Central Sulawesi), which broke out in late 1998, began to de-escalate in 2003, see: Sianturi, E. M. T. (2005) 'Konflik Poso dan resolusinya', *Buletin Balitbang Pertahanan*, Vol.8 No.14, pp1-2; the Maluku conflict, which broke out in 1999, began to deescalate in 2000, and the conflict in North Maluku began to deescalate in 2004, see: Malik, I. (2005) 'Diplomasi perdamaian Malino dalam penyelesaian konflik di Poso dan Maluku', in: Anwar, D. F., Bouvier, H., Smith, G. and Tol R. (Eds.) *Konflik kekerasan internal: Tinjauan sejarah, ekonomi-politik, dan kebijakan di Asia Pasifik*. Yayasan Obor Indonesia: Jakarta, pp317-323; and peace began to take hold in Aceh with the signing of the Memorandum of Understanding between the Free Aceh Movement and the Indonesian Government, which took place on 15 August 2005 in Helsinki, Finland, see: Badan Inisiatif Manajemen Krisis (Crisis Management Initiative) (2006) *Proses perdamaian Aceh: Keterlibatan perempuan*, UNIFEM and CCDE (Pusat Pengembangan Masyarakat dan Pendidikan): Banda Aceh.

16 UNDP (June 2006) *Access to justice in Aceh: Making the transition to sustainable peace and development in Aceh*, UNDP/BAPPENAS: Jakarta, available at: http://www.undp.or.id/programme/governance/ (Last accessed 1 October 2010)

17 See Darwin, M. (2003) 'Freedom from fear: Social disruption and systems of violence in Indonesia', in: Ananta, A. (Ed.) *The Indonesian crisis: A Human development perspective*. Institutute of Southeast Asian Studies: Singapore, pp105-158. See also, Mishra, S. C. (February 2001) *History in the making: A systemic transition in Indonesia*, UNSFIR: Jakarta. For international discussion on the relationship between democratization and escalation of violence, see Snyder, J. (2000) *From voting to violence: Democratization and nationalist conflict*, W.W. Norton & Company: New York. On violence in Poso and its relation to regional head elections, see Sianturi, E. M. T., (2005) '*Konflik Poso dan resolusinya*'; see also, Malik, I. (2005) '*Diplomasi perdamaian Malino dalam penyelesaian konflik di Poso dan Maluku';* on conflict in Maluku and its relationship with elections, see Badan Penelitian dan Pengembangan (Litbang) Departemen Pertahanan (11 August 2009) *Penanggulangan konflik Maluku*, Badan Penelitian dan Pengembangan (Litbang) Departemen Pertahanan: Jakarta

18 Darwin, M. (2009) 'How participation shapes local development', Background paper for Human Development Report 2010, UNDP: Jakarta; Ramdansyah, R. (2009) *Sisi gelap Pemilu 2009: Potret aksesori, demokrasi Indonesia*, Rumah Demokrasi: Jakarta; see also the case studies in Section 4 of this report

2.1.1 DECENTRALISATION

While grappling with these complex emergencies and various forms of instability since the last SITAN was conducted, the country set about decentralising the political system. Indonesia, under President Suharto, had a unitary, centralised system of government, in which policies, laws, regulations and directives were issued by the central government. These were then administered by provincial governments, which represented the central government throughout the archipelago. The district level of government further administered the top-down policies and programmes as directed by the provincial administrations. This system was radically reformed when the decentralisation laws (No. 22 and 25) were passed in 1999. Under decentralisation, the decision- and policymaking powers for many key sectors of governance were transferred to the district level in response to the demands for closer governance and greater self-rule for the diverse regions throughout the country. This presented a challenge for Indonesia, where the capacity to design and create policies and programmes at the district level was uneven in such a large country accustomed to top-down directives (see Section 4 for further discussion of these challenges).

Decentralisation in Indonesia required not only creating the political will to pass the necessary revisions to legal instruments, but also to achieve consensus across a wide range of stakeholders from increasing numbers of political parties, and from various political, ethnic, religious and other social groups, in the large and diverse nation. Since independence was declared in 1945, there has been sustained public debate about the relative merits of a centralised versus a federal state structure, as well as decentralisation. Indonesia has consequently changed its political structures at several key points. While Indonesia had a very short experience as a federal state in 1950, it then shifted to a 'unitary state' with a parliamentary democracy until 1959 when the executive took on greater powers under President Sukarno's 'guided democracy', with a return to the 1945 Constitution (which had and still retains a highly 'special' and romantic position in the minds of many of Indonesia's political elite, including conservative military figures).

Following the economic and political instability of the final years of the Sukarno administration and the anti-communist violence in 1965-1966, Suharto assumed power and implemented a more authoritarian form of military rule through his New Order government until 1998. This period was marked by the establishment of numerous mechanisms and regulations to create a highly centralised bureaucratic state with significant military involvement via its institutional policy of *dwi fungsi* (dual function), which legitimated military participation in society, the economy and civilian politics, together with its responsibility for defence.[20] The system of governance involved centralised authority being administered through a hierarchy of decision-making, from the centre to provincial, district, sub-district and then village level (five tiers of government).

19 Pederson, D. (July 2002) 'Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being', *Social Science and Medicine*, Vol.55 (2), pp175-190; see also the International Council of Voluntary Agencies, *Psychosocial care and protection of Tsunami affected children*, available at: http://www.icva.ch/doc00001316.html (Last accessed 10 October 2010)

20 See Guinness, P. (1994) 'Local society and culture', in: Hill H. (Ed.), Indonesia's New Order, Allen & Unwin: St. Leonards, N.S.W, pp267-304. For example, the Law on Village Government, passed in 1979, standardized the village administration and made village heads paid bureaucrats, upwardly accountable. See: Kahin, A. R. (2009) 'Problems of integration: West Sumatra's place in Indonesia', in: Sakai, M., Banks, G. and Walker, J. H. (Eds.), *The Politics of the Periphery in Indonesia: Social and Geographic Perspectives*, National University of Singapore Press: Singapore, pp101-116.

The passing of the decentralisation laws in 1999 was no easy task, given the long history of debate outlined above. In 2001, however, the new decentralised system began to be implemented. This system essentially reduced the system to three tiers of government: national, provincial and district. District government became autonomous, with decision-making powers equal to provincial level.[21]

Implementing decentralisation has not been without its challenges. Indonesia has endeavoured to build the uneven capacity of the district- and provincial-level executive and legislative arms of government and the civil service across the country, to enable design and administration of local-level policies and regulations. Nevertheless, some authors argue that the promises of improved governance at local level have, on the whole, not materialised.[22] For example, Buehler (2010) has observed that:

> "The few successful reform efforts at the local level have largely been driven by a handful of exceptionally well-performing administrators and are therefore not a reflection of broader trends."[23]

Many local governments have often encountered difficulties in utilizing resources allocated through increased budget allocations, due to "their inability to develop coherent and effective projects [or strategic plans that can be translated effectively into annual work-plans]."[24] At the same time, and perhaps a strongly related point, is that the civil service "continue[s] to provide distorted performance incentives…that preserve old behaviour in defiance of new legislation and new democratic system of government."[25]

One further challenge for governance in Indonesia in a decentralised context is improving bureaucratic efficiency and performance. 'Bureaucratisation' has been common in Indonesia since the 1970s, when it was most extensive in Southeast Asia. By way of comparison, between 1970 and 1980, the number of government officers in Malaysia grew from 293,000 to 550,000 (87 per cent), in Thailand, from 235,000 to 354,600 (50 per cent), and in Indonesia, from 515,000 to 2,047,000 (297 per cent).[26]

Tjokroamodjojo (1988) described the bureaucracy of the time as rich in structure but poor in function.[27] That is, the extensive bureaucratic structure (the number of government units) and the number of government officers was not in line with the role and function of government.[28] This had various implications. First, it hid unemployment, as many government officers were unproductive and had little to do.[29] Second, there was ineffective control of the bureaucracy, which allowed in some cases for the payment of 'illegal fees' to officials *(pungli = pungutan liar)*.[30] This resulted in lengthy and complicated procedures for providing services, and extensive red-tape. Third, this created inefficiencies in the bureaucracy that, in the end, negatively affected investment, production and trade.[31]

The problem of the number of civil servants remains today; despite efforts to control the rising number of government officers, numbers continue to increase. In 2010, the number of government officers reached 4,732,472.[32] While decentralisation has reduced the number of civil servants employed at the national level, the number has increased rapidly at the local level, particularly with the proliferation of new districts and municipalities.[33] In 1993, only 14 per cent of government officers were employed at the local level[34], but in 2003, this proportion had increased to 68 per cent.[35] While the number of national level civil servants fell 70 per cent from 3,505,970 in 1993 to 840,007 in 2003, the number of local government officers (in provinces, districts or municipalities) increased sixfold from 503,374 to 2,807,998.[36]

The number of civil servants creates challenges in improving the quality of human resources. Among all civil servants employed at national and local level, only 47 per cent are considered to have professional skills.[37] Large numbers of civil servants mean that 80 per cent of the budget is allocated for routine government expenses, mainly for civil servants, with only 20 per cent for development expenditure.[38]

Additionally, the complex processes of designing and passing the necessary government regulations, directives and guidelines at the provincial and district level, to provide the supporting regulatory framework, are still ongoing. Indonesia has also sought to work towards achieving an effective and efficient balance between each level of government through several sets of revisions to the 1999 decentralisation laws, including through Law No. 32 and 33/2004 on local governance, and through Government Regulation No. 19/2010 on Regulations for Implementing the Role and Authority and Finance for Governors as Representatives of the Government in the Provinces. To some extent, Government Regulation No. 19/2010 has reinstituted a 'vertical' form of governance from provincial to district level, in contrast to the 'horizontal' and autonomous relationship introduced by the fiscal and administrative decentralisation laws of 1999.[39]

Such a large-scale undertaking of political institutional change has also been coloured by political tensions and competition in some areas. Decentralisation has not only created opportunities for the realignment of local power structures, but has also triggered demands for the creation of new provinces, districts and sub-districts (commonly referred to as *pemekaran*, literally meaning 'blossoming'). In December 2009, the number of districts and municipalities reached a total of 497 (399 districts and 98 municipalities), as well as 77,012 villages/urban villages *(desa/kelurahan)*

21 Holtzappel, C. J. G. (2009) 'Introduction: The regional governance reform in Indonesia, 1999-2004', in Holtzappel, C. J. G. and Ramstedt, M. (Eds.), *Decentralization and Regional Autonomy in Indonesia: Implementation and Challenges*, Institute of Southeast Asian Studies: Singapore, pp1-58

22 Buehler, M. (2010) 'Decentralisation and local democracy in Indonesia: The marginalisation of the public sphere", in: Aspinall, E. and Mietzner, M. (Eds.), *Problems of Democratisation in Indonesia: Elections, Institutions and Society,* Institute of Southeast Asian Studies: Singapore, pp267-285

23 Ibid., p281

24 Ibid., p282

25 Synnerstrom, S. (2007) 'The civil service', in: McLeod, R. H. and MacIntyre, A., Indonesia: *Democracy and the Promise of Good Governance*, Institute of Southeast Asian Studies: Singapore, pp160-174. Synnerstrom goes on to note that this includes the manner in which public institutions are structured, operate and are financed as well as human resource management practices. As of 2007 the number of civil servants was 3.6 million (excluding military and policy), with 2.5 million located in regional governments (provincial and district but mostly district), with the bulk of these comprised of teachers. These figures do not include those working on 'honorarium' positions, most of whom are also found among the ranks of teachers in both madrasah and state schools below district level.

26 Ever, H.-D. and Schiel, T. (1992) *Kelompok-kelompok strategis: Studi perbandingan tentang negara, birokrasi, dan pembentukan kelas di dunia ketiga*, Yayasan Obor Indonesia: Jakarta, p226. On bureaucratization in Indonesia, see also: Thoha, M. (28 January 2010) 'Birokrasi Presiden yang tambun', *Kompas*27 Tjokroamidjojo, B. (1988) *Manajemen Pembangunan*, CV Haji Masagung: Jakarta, p116; Tjokroamidjojo, B. (1986) *Pengembangan sistem dan penyempurnaan administrasi negara dalam pembangunan nasional*, Yayasan Penerbit Administrasi: Jakarta, p50

28 Ibid.

29 Ibid.

30 Ibid.

31 Ibid.

32 Pusat Kajian Manajemen Pelayanan, Lembaga Administrasi Negara/PKMP-LAN (Centre for the Study of Service Management in State Administration) (2010) *Civil servant statistics* 2010, PKMP-LAN: Jakarta

33 Kumorotomo, W. and Widaningrum, A. (2010) *Reformasi Aparatur Negara Ditinjau Kembali*, Jurusan Manajemen dan Administrasi Kebijakan Publik dan Magister Administrasi Publik (Department of Management and Public Policy and Magister Programmes in Public Administration) , Gajah Mada University, Gava Media: Yogyakarta, p85

34 See attachment of the President's Speech on the ceremony of Indonesia's Independence Day, 17 August 1993

35 Data from Pendataan Ulang Pegawai Negeri Sipil, Badan Kepegawaian Negara, PUPNS-BKN (State Officers Board, Re-registration of Civil Servants) (2003) Internal report, Mimeo: Jakarta

36 Data taken from the President's Speech in 1993, and from BKN-PUPNS, *Ibid.*

37 Pusat Kajian Manajemen Pelayanan, Lembaga Administrasi Negara (PKMP-LAN) (2010) *Civil servant statistics 2010*

38 Kumorotomo, W. and Widaningrum, A. (2010) *Review of state apparatus reform*, p35

39 See: Crouch, H. (2010) *Political reform in Indonesia after Soeharto*, Institute of Southeast Asian Studies: Singapore, pp87-114; and Kahin, A. R. (2009) 'Problems of integration: West Sumatra's place in Indonesia', p114

and 33 provinces and special regions.[40] This is compared to 27 provinces and special regions, 341 districts and municipalities (268 districts and 73 municipalities) and 69,065 villages in 1999.[41]

The formation of new administrative regions on the one hand puts pressure on government budgets at the national level, as national revenues need to be distributed across increasing numbers of local administrations. It also puts pressure on local human resources and their capacity to delivery timely and quality services in each newly formed administrative unit, given that there is some delay in building the public infrastructure and institutions necessary to deliver services, and the already small numbers of trained civil servants are spread thinly. Moreover, in some cases the demands to form new administrative regions have also been coloured by violence, such as most recently in Tapanuli, North Sumatera.[42]

On the other hand, creating new administrative regions represents an opportunity to access resources at the local level by creating more local level civil service jobs and political positions, and in terms of raising local revenues when these new administrations introduce taxes and levies. However, often such local taxation laws are in contradiction to national level regulations and/or have created business 'disincentives' at the local level.[43] In some cases this has also worked against children's access to public services such as education, since local governments have sometimes introduced 'user-fees' for accessing school services or for the issuing of identification documents, such as birth certificates.[44] In the case of issuing birth certificates, which should be provided for free, user fees at the local level have been a disincentive for the poor to gain relevant documentation, amongst other reasons (see later discussion in Section 3.5). This has wider implications for citizenship and access to government services. For example, a lack of identity documents has been identified as one of the major reasons that children of single female-headed households do not complete basic education, with 28 per cent of such children never attending school compared with a national average of 8 per cent. The largest proportion of children that do not complete basic education identified not having birth certificates as a reason.[45] What is important here is that, in some cases, decentralisation has not always resulted in improvements in the way services are delivered, particularly for the poor, which has consequences for the welfare of women and children.

Despite the challenges, however, such legislative and institutional changes at the national level have been essential for beginning to create an environment in which broader human rights and pro-child policies can be designed and implemented, including greater respect for child rights and freedom of expression for children.[46] In this context, despite the challenges, decentralisation has created opportunities at the local level to respond to the very specific idiosyncrasies of each region in terms of child welfare. Local leaders, members of parliament, and the district executive now have the space for designing innovations relating to child rights and welfare in their regions, and have the discretion to invest resources to create child-friendly environments at district and provincial levels. Decentralisation has the potential to create 'friendly' competition among districts. Seeing development achievements in neighbouring regions has inspired innovation (as is discussed further in Section 4). This was not the case previously when district governments, in particular, had to rely on top-down directives.

Furthermore, Indonesia has entered into an era of participatory development and deliberative democracy. Citizens are not only involved in the election of national and local political leaders as described above, but also in social planning for the provision of public services. *The Musrenbang* (Consultative Development Planning Forum) system (described further in Section 4), which is unique to Indonesia, involves consultative priority-setting and planning meetings with communities and key stakeholders at the village, sub-district, district, provincial and national levels. This creates the opportunities, especially in the decentralised context, for practitioners, policymakers, community members, youth and even children, to provide continued input into policymaking, service provision and programmes relevant to each level of government administration. In this way, civic engagement and public participation have the potential to shape local development, and ideally to institute pro-child policies.[47] However, as Section 4 of this report demonstrates, there remains some progress to be made in ensuring the voice of these grass-roots stakeholders - particularly women, children and practitioners - do actually make it into policymaking, and there remains a disconnect between national and local regulatory environments, policies, budgets, strategic plans, and processes in practice. Section 4 also outlines the development planning process under decentralisation, as well as the system of budget disbursement and other related matters.

2.2 ECONOMIC CONTEXT

2.2.1 ECONOMIC GROWTH

Sustainable, pro-poor and pro-child economic growth is essential for improving the welfare of children. However, the effects of the financial crisis of the late 1990s have continued to be felt well into the new millennium, and have reversed some of the more positive trends in the economic development of preceding decades, making protecting child welfare a challenging endeavour (see Section 3). To some extent, however, Indonesia has managed to lessen the effects of the crisis, particularly in relation to children, through a number of social protection programmes and initiatives instigated to mitigate what might have been higher rates of early school leavers and poorer health service provision (see Box 2.2.1 on these programmes later in this section).[48]

Overall, during the three decades preceding this SITAN, Indonesia enjoyed rapid economic growth and macro-economic stability. During the 1970s, five major areas of economic reforms contributed to economic growth and poverty reduction in Indonesia: economic stability, taxation, trade, foreign investment, and finance.[49] The results of these reforms were impressive. In 1969,

40 Badan Pusat Statistik (BPS) - Statistics Indonesia (August 2010) *Trends of the selected socio-economic indicators of Indonesia, August 2010*, BPS: Jakarta, available at: http://www.bps.go.id/65tahun/Boklet_Agustus_2010.pdf (Last accessed 15 October 2010)

41 Ibid.

42 Violent demonstrations took place supporting the plan to form Tapanuli Province in North Sumatera, resulting in the death of the Chair of the North Sumatera legislative assembly, Abdul Aziz Angkat. For example, see: '*Golkar: Usut Tuntas Tewasnya Ketua DPRD Sumut', Mahaka Media* (4 February 2009); '*Stop Pemekaran Daerah Baru', Kompas* (6 February 2009), p2.

43 Sandee, H. (2009) 'Small enterprises and decentralization: Some lessons from Java', in Holtzappel, C. J. G. and Ramstedt, M. (Eds.), *Decentralization and regional autonomy in Indonesia: Implementation and challenges*, Institute of Southeast Asian Studies: Singapore, pp206-209

44 Ray, D. (2009) 'Decentralization, regulatory reform, and the business climate', in: Holtzappel, C. J. G. and Ramstedt, M. (Eds.), *Decentralization and regional autonomy in Indonesia: Implementation and challenges*, Institute of Southeast Asian Studies: Singapore, pp150-182

45 See, PEKKA (Programme for Women Headed Households) and AusAID (2010) Access to justice: *Empowering female heads of households in Indonesia, 2010*, PEKKA: Jakarta, pp45-48

46 See for example, Bessel, S. (2007) *Children, welfare and protection*

47 Darwin, M. (2009) *How participation shapes local development*. See also: Program PascaSarjana Politik Lokal dan Otonomi Daerah, '*Keterlibatan publik dalam desentralisasi tata pemerintahan: Studi tentang problema, dinamika dan prospek* Civil Society di Indonesia', Joint research report between BRIDGE, BAPPENAS, UNDP Indonesia, Gajah Mada University: Yogyakarta. These reports explain the role of civil society organisations in making policy at the local level.

48 Sumarto, S., Suryahadi, A., and Widyanti, W. (2010) 'Design and Implementation of the Indonesian Social Safety Net Programs', in: Hardjono, J., Akhmadi, N. and Sumarto S. (Eds.), P*overty and Social Protection in Indonesia*, Institute of Southeast Asian Studies: Singapore, pp111-148

49 Wardhana, A. (2009), '*30 tahun reformasi ekonomi Indonesia: Transisi dari kebergantungan akan sumber daya menuju kemampuan bersaing secara internasional*', in: Abimanyu, A. and Mehantara, A. (Eds.) *Era baru kebijakan fiskal: Pemikiran, konsep, dan implementasi*, Kompas: Jakarta, p24

Indonesia's annual income per capita was only approximately US$70,[50] however, following rapid and sustained economic growth, averaging almost 7 per cent annually, by 1996 the per capita income had increased more than tenfold to US$1,080.[51] The agriculture sector contributed 24 per cent to gross domestic product (GDP) while non-oil industries contributed 20 per cent of GDP.[52] Absolute poverty reduced sharply, from 40 per cent of the population in 1976 to 11 per cent in 1996.[53]

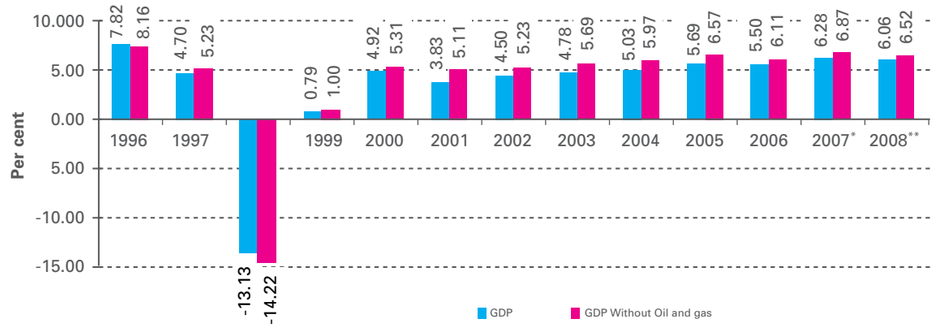
The government also instituted a family planning programme that successfully reduced population growth to an average of 2 per cent annually, which was translated into average per capita income growth of almost 5 per cent annually. Other countries in the region were experiencing similar growth, which was collectively considered to be a part of the 'East Asian Miracle'.[54] During the 1980s, however, Indonesia faced a series of problems. The falling oil prices in 1982 reduced export earnings and budget revenues. At the peak of the oil boom years, 80 per cent of Indonesia's export earnings and 70 per cent of budget revenues came from oil. Consequently, the large decline in oil prices severely affected Indonesia's balance of payments.[55] Between 1983 and 1995, the government introduced some twenty-four packages of economic reforms aimed at increasing economic efficiency and encouraging investment as well as non-oil exports.[56] However, with the onset of the multiple crises in 1997, poverty levels rose sharply as Indonesia entered a period of economic shock, instability and negative growth.

In the period following the SITAN 2000, Indonesia has gradually recovered from the economic crisis. Figure 2.2.1 shows the changes in GDP growth rates (with and without oil and gas contributions) over the past decade. While the country experienced negative growth in 1998, in the period between 2001 and 2004 this situation reversed, whereby growth (without the contribution of oil and gas revenues) steadily increased from 3.83 per cent to 5.03 per cent according to data from *Badan Pusat Statistik (BPS)* - Statistics Indonesia (see Figure 2.2.1). By 2008, growth was at approximately 6 per cent, slightly down from the previous year, and approximately 6.5 per cent if oil and gas revenues are included. Growth estimates used in the National Medium-Term Development Plan *(RPJMN, Rencana Pembangunan Jangka Menengah Nasional)* indicate that in 2009, growth had decreased somewhat to only 4.3 per cent as a result of the global financial crisis, which began in October 2008.[57]

The positive changes in Indonesia's economy are also evident in the improving trends in GDP per capita at current market prices, which has increased steadily to IDR 21.7 million in 2008 from IDR 12.6 million in 2005 (see Figure 2.2.2 below). Annual income per capita, at constant market prices in Indonesia, has also increased steadily over the last decade to IDR 9,111,100 (approximately US$942) in 2008, from IDR 7,655,535 (approximately US$890) in 2004, despite the recent decline in economic growth. Indonesia is also now part of G20.

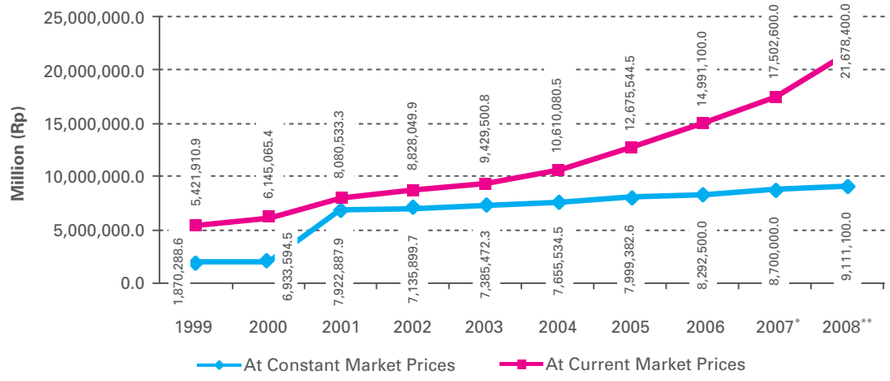
50 Hill, H. (1996) *Transformasi ekonomi Indonesia sejak 1966: Sebuah studi kritis dan komprehensif.*: PT. Tiara Wacana: Yogyakarta, pp23-24. See also, Shahrir (1992) *Refleksi pembangunan ekonomi Indonesia 1968-1992*. PT Gramedia: Jakarta
51 Ibid.
52 Ibid.
53 Ibid.
54 In 1993, the World Bank published the book entitled 'The East Asian Miracle'. Between 1970-1996 (before the 1997 financial crisis) six countries in Southeast Asia showed remarkable GDP growth: Korea (835 per cent), Singapore (690 per cent), Thailand (689 per cent), Malaysia (582 per cent), Hong Kong (560 per cent), Indonesia (432 per cent). Source: Rasyid, A. (2010) *State ownership in banks after the crisis: A new paradigm*, PowerPoint presentation, presented for Financial and Private Sector Development Forum 2010, World Bank Headquarters: Washington, D.C., 2-3 March, p2.
55 Saidi, Z. (1998) *Soeharto menjaring matahari: Tarik-ulur reformasi ekonomi orde baru pasca 1980*, Mizan: Jakarta, pp90-91
56 Hill, H. (1996) *Transformasi ekonomi Indonesia sejak 1966*, p25
57 Government of Indonesia (2010) *Rencana Pembangunan Jangka Menengah Nasional (RPJMN) 2010-2014*, Government of Indonesia: Jakarta, p14

Figure 2.2.1: Gross domestic product (GDP) growth rates, with and without oil and gas (per cent), Indonesia 1996-2008



Source: Badan Pusat Statistik (BPS) - Statistics Indonesia, 1996-2009
Notes: *Preliminary figure; **Very preliminary figure; 1996-2000, at 1993 Constant Market Prices; 2001-2008, at 2000 Constant Market Prices.

Figure 2.2.2: Gross domestic product (GDP) per capita, at constant and current market prices (million IDR), Indonesia 1999-2008



Source: BPS - Statistics Indonesia, Strategic Data, 2009

With such economic achievements, from its previous status as a low income country, Indonesia has now been reclassified as a lower-middle income country, being ranked at 114 out of the 210 countries given economic rankings by the World Bank. Using the Atlas method, gross national income in Indonesia was at USD$1,880 per capita in 2008. In Southeast Asia, Indonesia is now ranked seventh among 10 countries that have adequate economic data available (data on Myanmar is unavailable). See the Table 2.2.1.

Table 2.2.1: Gross national income per capita 2008, ATLAS method and purchasing power parity (PPP) of Southeast Asian countries

Country	GNI per capita, Atlas method (US$)	Purchasing power parity (International dollar)
Upper-middle income (US$3,856-11,905)		
Singapore	34,050	50,800
Brunei Darussalam	27,050	47,970
Malaysia	7,250	13,740
Lower-middle income (US$976-3,855)		
Thailand	3,670	7,770
Timor-Leste	2,460	4,690
Philippines		3,900
Indonesia	1,880	3,600
Low Income (US$975 or less)		
Vietnam	890	2,700
Lao PDR	760	2,050
Cambodia	640	1,870

Source: World Development Indicators Data Base, World Bank, 2010, and the World Bank List of Economies, 2010

2.2.2 POVERTY ALLEVIATION AND POVERTY REDUCTION PROGRAMMES: CHANGING STRATEGIES

Some argue that while the development strategies which began to be introduced through the Five Year Development Plans *(Repelita, Rencana Pembangunan Lima Tahun)* in the late 1960s and throughout the 1970s under the New Order Suharto government focused on economic growth, inflation control, creating an investment climate, and other efforts for political and economic stability (see the discussion above), there were few initiatives which focussed directly on poverty reduction.[58] Over time, however, the focus on poverty alleviation in national development efforts has grown and changed form. With the first Five Year Development Plan (*Repelita I*, 1969-1974), some initiatives were introduced to improve services for poor families such as the Poor Family Welfare Services Program *(Program Pelayanan Kesejahteraan Keluarga Miskin)*, a programme that continued in various forms over the next two decades.[59] The initial Five Year Development Plans used a basic needs approach to poverty reduction,[60] in which the poverty line was established at a minimum of 2100 calories intake per capita per day.

Poverty reduction efforts intensified with *Repelita IV* (1985-1989) and began to be characterised by multi-sectoral approaches aimed at reducing inter-regional inequity through the special targeting of particular disadvantaged regions and provinces. Examples include USAID sponsored Provincial Development Project, CIDA sponsored Sulawesi Regional Development Project, and World Bank sponsored Yogyakarta Rural Development Project.[61] One of the more renowned redistributive development initiatives of the later Suharto period was the Left-Behind Villages Program *(Program Inpres Desa Tertinggal, IDT)*, which was implemented through a Presidential Instruction *(Inpres, Instruksi Presiden)* beginning in 1994 (along with other Presidential Instructions, such as road building in rural areas).

The IDT programme also used a regional targeting and multi-sectoral approach to lift the standard of living in some of Indonesia's more isolated villages. Since 2000, the targeting principles of redistribution and intensified interventions in particular regions have continued to be employed in development efforts in Indonesia, through both the continuation of previous programmes in the earlier part of the last decade and through new programmes implemented by the Directorate for Disadvantaged Regions at The National Development Planning Agency *(BAPPENAS, Badan Perencanaan Pembangunan Nasional)*. This includes development and rehabilitation programmes in conflict-affected areas such as the Support for Poor and Disadvantaged Areas Project *(P2DTK, Percepatan Pembangunan Daerah Tertinggal dan Khusus)*. Targeting disadvantaged regions has also been mainstreamed through the creation of the Ministry for the Development of Disadvantaged Regions in 2004.

Aside from targeting particular regions, poverty reduction efforts began to include the principles of empowerment and improving human capabilities (skills building) in the final days of the New Order, representing a significant departure from the basic needs approach. Such efforts have continued since the last SITAN (2000) was conducted, and have contributed to mitigating the effects of the financial crisis, which triggered spiralling poverty levels. For example, the Kecamatan (sub-district) Development Program *(PPK, Program Pengembangan Kecamatan)* was designed to address the self-defined needs and priorities of poorer groups and women in the country. With technical assistance from the World Bank, the Government of Indonesia (GoI) began implementing the programme in many sub-districts throughout Indonesia in 1998. The PPK proved popular both with the government and in rural Indonesia and was scaled up to combat the effects of the financial crisis. The programme has continued through several iterations over the last decade, becoming the largest community-driven development programme in the world.[62] In April 2007, the GoI launched a revised version of the programme,[63] the National Program for Community Empowerment - '*Mandiri*'[64] (PNPM Mandiri), which, drawing on the national development budget, is now the cornerstone of the national development strategy.

Poverty reduction strategies in Indonesia, particularly in the second half of the past decade, have extended empowerment and human capabilities approaches to also focus on United Nations-supported rights based approaches to development. The National Strategy on Poverty Reduction *(SNPK, Strategi Nasional Penanggulangan Kemiskinan)*, which was officially released by the Coordinating Minister for People's Welfare *(Kementerian Koordinator Bidang Kesejahteraan Rakyat)* in 2005, made poverty reduction and reducing inequality the top priority in the national development strategy. The National Strategy prioritises both the rights of the poor and the obligations of the state to respect, protect, facilitate, and fulfil people's rights in terms of welfare. It aims to: (1) create entrepreneurial opportunities for the poor; (2) strengthen community institutions to improve access to information for the poor and enable them to participate in formal decision-making processes (through, for example, the *musrenbang* system mentioned above); (3) incorporate capacity building, through investment in health, education and training;

58 Shahrir (1986) *Ekonomi politik kebutuhan pokok: Sebuah tinjauan prospektif*, LP3ES (GIVE FULL NAME): Jakarta, pxxi; Dewey, A., Dove, M. R., Retnandari, N. D., Sutrisno, L. (1993) *Suatu tinjauan mengenai usaha-usaha pemberantasan kemiskinan di Indonesia 1968-1993: Realita mikro dan konteks makro* (unpublished draft)

59 Shahrir (1986), 'Political economy of basic needs', p93. This programme became the Family Welfare Support Program (Bimbingan Kesejahteraan Keluarga) in the Second Five Year Development Plan (Repelita II, 1975-1979). As the programme grew, under the Third Five Year Development Plan (Repelita III, 1980-1984) it became The Development of Family Welfare (Pengembangan Kesejahteraan Keluarga). In Repelita IV (1985-1989) and V (1990-1994), the name of the programme was changed to Donation and Alleviation of Poor People *(Penyantunan dan Pengentasan Fakir Miskin)*. Dewey et al. (1993) *Suatu tinjauan mengenai usaha-usaha pemberantasan kemiskinan di Indonesia 1968-1993*, pp29-30

60 The five main basic needs for people to survive and live in dignity were defined as food, health, water and sanitation, education and shelter.

61 These programmes were later merged into the Regional Integrated Development Program (PPWT, Program Pengembangan Wilayah Terpadu), which was designed to minimize the weaknesses of sectoral programming. Other programmes have focused on the urban poor, such as the City Integrated Infrastructure Development Program (Program Pembangunan Infrastruktur Perkotaan).

62 Barron, P., Diprose, R. and Woolcock, M. (2006; 2011) *Contesting development: Participatory programmes and local conflict in Indonesia*, Yale University Press: Ithaca

63 PNPM Mandiri, often known as just PNPM, combines many of the mechanisms and principles of the preceding Urban Poor Reduction Program (P2KP, Program Penanggulangan Kemiskinan di Perkotaan), and the Kecamatan Development Program (PPK, Program Pengembangan Kecamatan).

64 *Mandiri* in Indonesian means to stand alone or be independent

(4) improve social protection, through improving insurance, assistance, savings mechanisms and programmes, and the promotion of traditional social safety nets; and (5) build global partnerships. In line with the Human Rights Based Approach to Development (supported by UNICEF and other UN agencies), the GoI's poverty reduction strategy, which has begun to be implemented in the past five years, is both growth- and equity-oriented, creating a framework within which the needs of the most disadvantaged can be prioritised.

Indonesia, through its efforts to improve the economy, reform its political institutions, and through a number of poverty alleviation programmes and other initiatives at the time of the crisis (including fuel subsidies and later cash transfer programmes, as well as social safety net programmes described in Box 2.2.1) has managed over the past ten years to improve poverty levels. The number of people living below the poverty line had fallen to 14.1 per cent (32.5 million people) by March 2009, compared to 16.7 per cent (36.2 million people) in 2004.[65] Higher poverty levels increase insecurity for children, put enormous pressure on families and limit the opportunities for children and young people to access education, health services, clean water, sanitation, nutrition and the skills required for future employment. Nevertheless, many of those that have recently 'escaped' poverty remain vulnerable to economic shocks and can easily slip back into poverty with, for example, high rates of inflation due to global economic crises.[66]

Though poverty remains a challenge in terms of fulfilling the basic rights of households and children in particular, significant achievements have been made in the last decade through social safety net programmes, cash transfer programmes, rural infrastructure and service improvement programmes (especially in isolated and disadvantaged areas) and other poverty eradication programmes introduced to offset the devastating effects of the 1997 financial crisis (see Figure 2.2.3 below). Based on the poverty headcount index, the percentage of the poor population has decreased from 23 per cent in 1999 to 15 per cent in 2008.[67] Despite the efforts to reduce poverty, of the 32.5 million Indonesian people living under the poverty line it is estimated that at least 14 million of them are children.[68] However, there is currently insufficient information on child poverty, in terms of a composite index of material and non-material indicators of poverty for children. As of July 2010, UNICEF is working with the Social Monitoring and Early Response Research Institute (the SMERU Research Institute) to design and undertake a pilot child poverty study to begin the process of filling the data gaps on child poverty.

Figure 2.2.3 shows an increase in poverty levels in 2006, although this was not as severe as in 1997. It is estimated that poverty increased from 16 per cent in 2005 to 17.8 per cent in 2006. It is likely that the increase can be traced to when Indonesia stopped importing rice, the major staple food in the country, which led to a 33 per cent increase in the price of rice between February 2005 and March 2006. It is also likely that this was linked to the reduction in fuel subsidies in the same year - part of a rolling subsidy reduction which had been implemented over the preceding years. After this, however, the poverty rate declined again to 14.15 per cent in 2009.[69]

65 Government of Indonesia (2010) RPJMN 2010-2014, p15

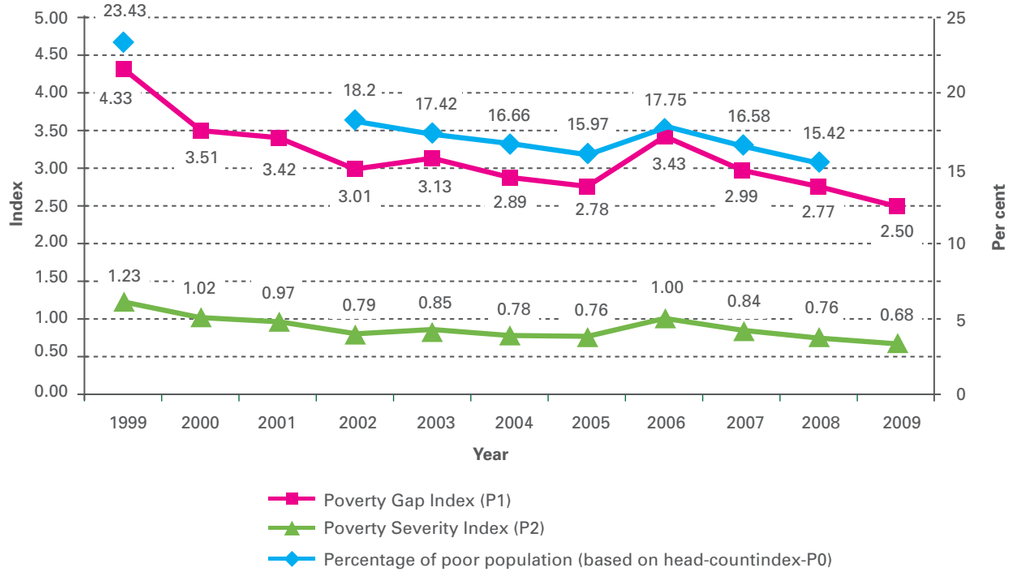
66 Suryahadi, A. and Sumarto, S. (2010) 'Poverty and Vulnerability in Indonesia before and after the Economic Crisis', in: Hardjono, J., Akhmadi, N. and Sumarto, S. (Eds.) *Poverty and Social Protection in Indonesia*, Institute of Southeast Asian Studies: Singapore, pp36-62

67 A poor person is someone who cannot meet his/her basic needs, both food and non-food needs (BPS - Statistics Indonesia, 2000, 2001, 2002, 2003, 2004, 2007). A poor person is someone whose average per monthly per capita consumption falls under the BPS defined poverty line (BPS - Statistics Indonesia, 2008). A new poverty line was introduced in December 1998. The new poverty measure widens the scope of commodities considered a basic need. The resulting method provides a more realistic measure of poverty and is a better tool for poverty comparison across regions through the introduction of a reference population and regional price deflators. The reference population consists of household whose nominal expenditures fall in the second and third deciles. The regional price deflators are expressed as a proportion of the price level in Jakarta. This more dynamic poverty measure also facilitates time series comparisons.

68 From the calculations made by the Centre for Population and Policy Studies, Gajah Mada University, using 2007 National Socio-Economic Survey unweighted data (the 2008 National Socio-Economic Survey does not have data on household expenditure), 46 per cent of the poor population (using BPS – Statistics Indonesia poverty indicators) are aged under 18 years. Assuming that the proportion does not change in 2009, then in 2009 the number of poor children in Indonesia is estimated to be as high as 14,720,000.

69 World Bank (2006) *Era baru pengentasan kemiskinan di Indonesia*, World Bank: Jakarta

Figure 2.2.3: Percentage of poor population (based on P0), poverty gap index, and poverty severity index over time, Indonesia 1999-2009



Source:
- P0: Welfare Indicator 2003 (data 1999 and 2002), 2005 (data 2003), 2006 (data 2004-2005), 2008 (data 2006-2008), BPS - Statistics Indonesia (based on National Socio-Economic Survey)
- P1 and P2: BPS - Statistics Indonesia, Statistical Year-Book of Indonesia 2009

Box 2.2.1: Examples of social safety net programmes

The discussion below describes examples of social safety net programmes in Indonesia. This is not exhaustive, but rather provides examples of scholarships and block grants programmes for schools, health insurance programmes, and conditional and unconditional cash transfer programmes. Other programmes not discussed here include subsidised rice programmes, such as Rice for the Poor *(Raskin)* amongst others.

Scholarships
From the 1998/99 to the 2002/03 academic year, the government provided a large number of scholarships for poor students through the Social Safety Net *(JPS, Jaring Pengaman Sosial)* Education Sector Program. This programme was designed to reduce the impact of the 1997 economic crisis, which threatened the sustainability of education for children of poor families and those who had fallen into poverty as a result of the crisis (i.e., leaving school early and working to support families).

After reducing the fuel subsidy in 2001, the government provided subsidies via the Fuel Subsidy Reduction Compensation Program *(PKPS-BBM, Program Kompensasi Pengurangan Subsidi BBM)*, including an Education Sector Program, which was known as Special Assistance for Students *(BKM, Bantuan Khusus Murid)*. The scholarship programme of JPS was allocated to cover approximately 6 per cent of primary school students, 17 per cent of junior secondary school students, and 9 per cent of senior secondary school students, while

the BKM programme was allocated to approximately 20 per cent of students at the primary, junior and senior secondary school levels. Despite this allocation, research has shown that the percentage of poor households whose children were receiving scholarships was smaller, that is, less than 15 per cent.[70]

The BOS programme

Following the large reduction in the fuel subsidy in March and October 2005, commencing in the 2005/06 academic year, the government made fundamental changes to the PKPS-BBM Education Sector Program concept and design for primary and junior high schools. This BKM programme for primary and junior secondary schools was replaced by the School Operational Assistance programme *(BOS, Bantuan Operasional Sekolah)*. In contrast to the BKM programme, which provided money directly to poor students who were selected by schools in accordance with the allocations they had received, BOS funds were provided to schools to be managed in accordance with the requirements that had been determined by the central government. The size of the fund for each school was determined on the basis of the number of students in accordance with the requirements that had been determined by the central government.[71]

BOS was available for all primary and junior high schools, including *Sekolah Dasar* (Primary School), MI (*Madrasah Ibtidaiya*, Islamic-based primary school), *Sekolah Dasar Luar Biasa* (Primary School for Children With Special Needs), *Sekolah Menengah Pertama* (Junior Secondary School), MT (*Madrasah Tsanawiyah*, Islamic-based Junior High School), and *Sekolah Menegah Pertama Luar Biasa* (Junior Secondary School for Children with Special Needs). Both public and private schools running the compulsory education programme at primary and junior high schools (or equivalent) were entitled to receive BOS. Schools that considered themselves as well-off were, however, allowed to opt out of the BOS programme.[72]

The introduction of the BOS programme was expected to reduce the cost of education borne by students' parents. Under the programme, poor students should receive free education. Although the objectives of the programme as stated in the Operational Guidelines for BOS 2005 did not specify free education for poor students, this has been emphasised in the implementation and regulation of the programme. The programme regulations require the elimination of school tuition for schools that, prior to receiving BOS, had smaller school tuition fees schedules than the BOS funding. Schools that, prior to receiving BOS, had school tuition fees schedules greater than the BOS funding were permitted to collect school tuition fees, but had to exempt poor students from tuition fees and reduce the tuition for other students. In addition to the regulations on school tuition fees, the regulations also allow schools to use the funds to provide transportation allowances as special assistance for poor students deemed to be in need.[73]

70 The SMERU Research Institute (2006) 'Pelaksanaan program Bantuan Operasional Sekolah (BOS)', The SMERU Research Institute Newsletter No. 19, July-September, Jakarta
71 Ibid.; Suharyo, W. (2005) 'A rapid appraisal of the PKPS-BBM Education Sector School Operational Assistance (BOS)', the SMERU Research Institute: Jakarta
72 The SMERU Research Institute (2006) *Pelaksanaan program Bantuan Operasional Sekolah (BOS)*
73 Suharyo, W. (2005) *A rapid appraisal of the PKPS-BBM Education Sector School Operational Assistance (BOS)*

The objective of the BOS programme

"The BOS Program aims to provide assistance to schools in order that they can exempt students from their school tuition. This exemption, however, will not result in decreased quality of the education services provided for the community…The BOS Program is aimed at releasing poor students from education cost and reducing the costs for other students, so they obtain a better quality basic education until the completion of nine years of basic education in order to achieve the goal of the nine year compulsory basic education programme."[74]

Because recipient schools used most BOS funds for operational activities that supported teaching and learning activities, the BOS funds were of benefit to all students, including those from both well-off families and poor families. Most schools also decided to give the same treatment to all students in the school charges that were levied on students.[75]

Health insurance

Indonesia introduced the first phase of its plan to achieve universal health coverage through a mandatory public health insurance scheme in 2004. *Asuransi Kesehatan Masyarakat Miskin*, or *Askeskin*, was targeted to the poor. The key objective of *Askeskin* was to improve access to healthcare and provide financial protection against health shocks and illnesses for poor households that lack access to formal insurance.[76] It initially targeted the poorest 60 million people.[77] In 2008, Askeskin evolved into *Jaminan Kesehatan Masyarakat*, or *Jamkesmas*, a Ministry of Health 'insurance' programme that now covers over 76.4 million poor Indonesians.[78]

The *Askeskin* programme reimbursed providers in two ways: (1) a payment provided to community health centres *(puskesmas)* based on the number of registered poor; and (2) fee-for-service payments covering third-class hospital beds reimbursed through P.T. Askes (a state-owned insurer). All public hospitals were automatically qualified as providers, while *Askes* contracted with private (mostly non-profit) hospitals individually.

Changes to *Askeskin* implemented in 2005 resulted in differences in two major areas. First, rather than being a purely government-run programme, it provided a block grant to P.T. Askes, which then targeted the poor with *Askeskin* cards and reimbursed hospital claims. Second, the beneficiary cards in *Askeskin* were individually targeted rather than the household cards used in previous programmes. By 2008 *Askeskin* had expanded to cover over 70 million people.[79] Then in 2008, *Askeskin* evolved into *Jamkesmas*.

Many district governments have followed the lead of *Jamkesmas* and established district-based insurance schemes (typically called *Jamkesda*) that cover the near-poor or those not covered under *Jamkesmas*. These schemes take different forms. Some *Jamkesda* are designed as extensions of *Jamkesmas*, with the goal of covering an additional population of near-poor, on top of those covered by *Jamkesmas*; other schemes focus on specific services, such as in Yogyakarta, where maternal and child health services for 104,500 children and pregnant women are covered under a district-led scheme.[80]

74 Ministry of National Education (Departemen Pendidikan Nasional) (2005) *Buku Petunjuk Pelaksanaan BOS*
75 Ibid.
76 Sparrow, R., Suryahadi, A. and Widyanti, W. (2010) *Social health insurance for the poor: Targeting and impact of Indonesia's Askeskin program*, The International Institute of Social Studies of Erasmus University Rotterdam and The SMERU Research Institute: Jakarta
77 Ibid.
78 Ibid.
79 Ibid.
80 Ibid.

There are several important differences between the prior *Askeskin* programme and the *Jamkesmas* programme. *Jamkesmas* is managed by the Ministry of Health and P.T. Askes is no longer involved, except in managing the enrolment of members and the distribution of Jamkesmas cards. In addition, district health offices now directly manage contracting and claims processing. And *Jamkesmas* now contracts with many private hospitals whereas *Askeskin* utilised mainly public providers. A report from the SMERU Research Institute finds that the programme is "indeed targeted on the poor and those most vulnerable to catastrophic out-of-pocket health payments. Askesin has improved access to healthcare in that it increases utilization of public outpatient care. We do not find evidence of substitution effects from private to public care." As of January 2010, the *Jamkesmas* programme is being implemented throughout the country and will serve as one of the key building blocks of the government's proposed universal coverage agenda.

Unconditional cash transfers

Unconditional cash transfers *(BLT, Bantuan Langsung Tunai)*, as a form of compensation to poor households for domestic fuel price increases, started to be made by the GoI in August 2005. The programme was implemented against a background of high price inflation accentuated by major fuel price increases, which were increasing the financial stress on low income households. The programme ended in September 2006. The amount of funds allocated per family was approximately US$120 in four instalments over the course of one year.[81]

Conditional cash transfers

In 2007, the unconditional cash transfer programme was replaced by a household conditional cash transfer programme (*Program Keluarga Harapan*; the Family Hope Program). Conditional cash transfers under this programme have two aims: short-term poverty alleviation and investment in long-term human capital.[82] In July 2007 the government launched pilot programmes in seven provinces (West Java, East Java, West Sumatera, North Sulawesi, Gorontalo, East Nusa Tenggara, and Jakarta). The target groups to receive conditional cash transfers have been poor households with pregnant women and children up to 15 years of age. Eligible households must be classified as very poor *(rumah tangga sangat miskin)*, with children aged 1-6 years with lactating mothers. These households receive cash for a maximum period of six years. Unlike the previous programme, the receipt of the cash benefits is payable as long as certain conditions regarding health and education are met.[83]

There are 12 health and education conditions for the continuation of conditional cash transfers:

Health indicators:

(1) Four prenatal care visits for pregnant women; (2) Taking iron tablets during pregnancy; (3) Delivery assisted by a trained professional; (4) Two postnatal care visits; (5) Complete childhood immunizations; (6) Ensuring monthly weight increases for infants; (7) Monthly weighing for children under three and biannually for under-fives; (8) Vitamin A twice a year for under-fives

81 World Bank (2008) *Conditional cash transfer in Indonesia: Program Keluarga Harapan and PNPM Generasi baseline survey report*, World Bank: Jakarta
82 ILO (2008) *Social security in Indonesia: Advancing the development agenda*, ILO: Jakarta
83 World Bank (2008) *Conditional cash transfer in Indonesia*

Education indicators:

(9) Primary school enrolment of all children 6-12 years old; (10) Minimum attendance rate of 85 per cent for all primary school aged children; (11) Junior secondary school enrolment of all children 13-15 years old; (12) Minimum attendance rate of 85 per cent for all junior secondary school aged children.[84]

If a mother is pregnant and/or has children aged 0-6 years, she will receive IDR 1,000,000 per year or IDR 250,000 per quarter regardless of the number of children aged under five that she has. If a mother has two primary school aged children (6-12 years) and one secondary school aged child (13-14 years) and these children are attending school, she will receive IDR 1,800,000 per year or IDR 450,000 per quarter. A mother with children aged 0-6 years and three primary school aged children will receive IDR 2,200,000 per year.

The government has also launched Community Conditional Cash Transfer, namely PNPM Generasi Sehat dan Cerdas (also known as *PNPM Generasi*). PNPM Generasi builds on the project infrastructure and capacities developed through the experiences of the *Kecamatan* Development Program (PPK). PNPM Generasi is implemented as part of the government's new flagship programme, PNPM Mandiri.[85]

PNPM Generasi differs from household conditional cash transfers in that cash transfers are allotted to communities and not to households. The condition for participating in community conditional cash transfers is community commitment to increasing health and education standards. PNPM Generasi places strong emphasis on lagging health and education outcomes. In order to get funding, communities have to submit a proposal for certain activities and investments, such as:

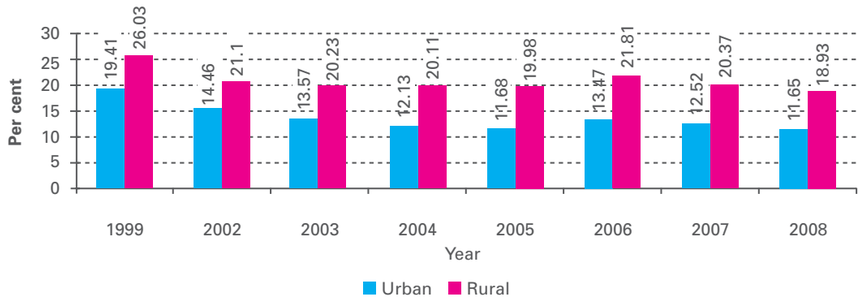
- Transportation costs for midwives and nurses to provide outreach services
- Increase services of integrated health service units *(posyandu, pos pelayanan terpadu)* or village health posts *(pustu, pukesmas pembantu)* to ensure timely delivery of immunization, vitamin A and weighing
- Procurement of scale and height measurement tools
- Build infrastructure for health posts
- Contracting private providers or NGOs to provide health services in villages
- Contracting nurses and midwives to deliver health services in villages
- Increase access to education and health services through building or improving the quality of roads and bridges.[86]

The size of block grants provided to communities in conditional cash transfers in sub-districts are pre-determined by the population size of sub-districts and poverty levels. The average grant amount during the 2007 programme was US$8,400 (equivalent to IDR 76,440,000, using exchange rate US$1 = IDR 9,100) per village. All participating villages also receive technical assistance in the form of facilitators and training.[87]

84 Government of Indonesia, Tim Penyusun Pedoman Umum PKH, Lintas Kementrian dan Lembaga (2007) Pedoman Umum Program Keluarga Harapan (PKH), Tim Penyusun Pedoman Umum PKH: Jakarta
85 Ibid.
86 World Bank (2008) *Conditional cash transfer in Indonesia*
87 Ibid.

However, despite the improvements in poverty levels overall, urban/rural disparities remain. Based on the poverty head-count index, Figure 2.2.4 shows that while poverty levels are falling in both rural and urban areas, they remain significantly higher in rural areas.

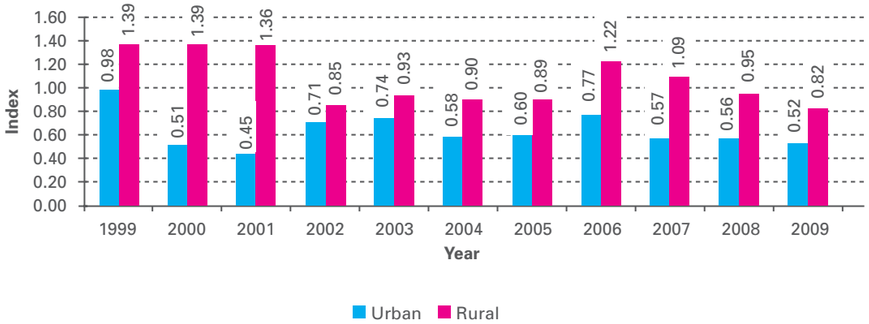
Figure 2.2.4: Percentage of poor population (based on head-count Index) by area, Indonesia 1999-2008



Source: Welfare Indicators, processed by BPS - Statistics Indonesia, based on National Socio-Economic Surveys 1999-2008

It is also evident that the severity of poverty is higher in rural areas, and that rural areas were more likely to be affected by both the impacts of the financial crisis (for which interventions seem to have reduced poverty levels in urban but not rural areas) and the impacts of increasing rice prices in 2006. The poverty severity index increased by 0.29 points in urban areas between 2005 and 2006, but by 0.45 points in rural areas. The trends in the poverty severity index indicate that only in 2009 did the situation in rural areas return to the level prior to the increase in the price of rice. The poverty severity index is basically a measure of the gap between the poverty line and the average income of poor people.

Figure 2.2.5: Poverty severity index by area, Indonesia 1999-2009



Source: BPS - Statistics Indonesia, Statistical Year-Book of Indonesia 2009

Table 2.2.2 below also demonstrates, using 2007 *National Socio-Economic Survey* data, that much of Indonesia's poverty is concentrated in rural areas and the features of households living in poverty. The table shows that most poor households remain in rural areas although the share of urban poverty is on the rise. Poor households tend to be concentrated in the agricultural sector and poverty is highly associated with working in the informal sector. Poor people tend to have less education and poor households are larger in terms of household members. Poor people in rural areas are less likely to have access to health services in which more poor pregnant women are less likely to be helped by skilled health professionals and after birth many babies in poor households are not breastfed.

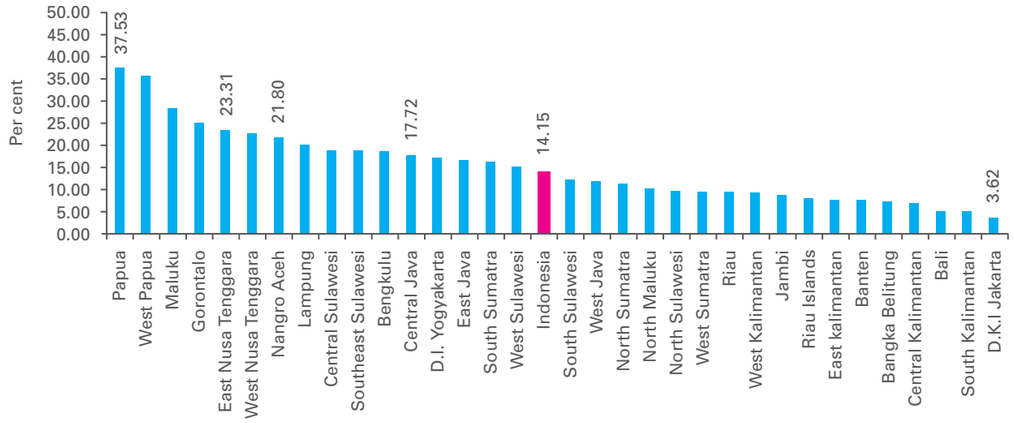
Table 2.2.2: Number of poor people by social indicators, 2007

Of every 100 Indonesians	But for every 100 POOR Indonesians
64 live in a rural areas	72 live in a rural areas
42 do no have access to safe water	52 do no have access to safe water
57 do not have access to decent sanitation	80 do not have access to decent sanitation
32 have households with more than 5 members	54 have households with more than 5 members
31 have less than primary education	41 have less than primary education
10 are illiterate	17 are illiterate
49 work in agriculture	69 work in agriculture
66 work in informal sector	76 work in informal sector
23 work as a unpaid workers in the household	31 work as unpaid workers in the household
42 live in villages without secondary high school	55 live in villages without secondary high school
61 live in villages without access to telephone	72 live in villages without access to telephone
Of those aged below five, 32 births were delivered by unskilled midwife	Of those aged below five, 49 births were delivered by unskilled midwife
Of those aged below five, 5 are not breastfed	Of those aged below five, 3 are not breastfed

Source: National Socio Economic Survey 2007 (unweighted data for national averages), poverty line calculated by BPS - Statistics Indonesia based on minimum expenditure for consumption of 2,100 calories per day. Percentages calculated by the Gajah Mada University.

Disparities are also evident in poverty levels when provinces are compared. Many of the provinces in eastern Indonesia, such as Papua, Maluku, East and West Nusa Tenggara, have the highest poverty levels in the country, some ten times higher than in Jakarta, the capital.

Figure 2.2.6: Percentage of population below the poverty line by province, Indonesia 2009



Source: BPS - Statistics Indonesia, Statistical Year-Book of Indonesia, based on National Socio-Economic Survey, 2009

Poverty is devastating for children and often results in lower performance at school, early leaving (dropouts) and lower standards of living. The case of Budi outlined in Box 2.2.2 below demonstrates how poverty, together with the chance for independence and earnings, can result in children working from an early age in hazardous conditions.

Box 2.2.2: Budi the scavenger[88]

Budi is 15 years old. He is from a poor family who scavenge through rubbish for their livelihood in a poor rural village in Central Java. When other children are busy with school, Budi spends his time picking through rubbish. He lives with his parents and six siblings in a room 5 by 6 meters with a bamboo wall, which is 30 meters from the river and frequently floods in the wet season.

Budi is actually a smart boy. In his first and second years of primary school he was ranked first. However, the school was closed due to low enrolment, so he had to attend a school farther away and was often absent. He thought his parents wouldn't notice and he preferred to hang out at the riverside with his friend, Andi. They just used to sit, have a chat, smoke and sometimes go swimming until school was over. Budi said, "I couldn't escape from the previous school, because it was close to home."

Consequently, his school performance declined dramatically. His teachers noticed his absence and that he never did his homework, so it was reported to his parents, for which he was "not only scolded but also beaten."

Because of his absenteeism, Budi has had to repeat the class. Feeling embarrassed, he finally decided to drop out of school. Since his father and siblings only ever went to primary school and some did not manage completion primary school, he too was reluctant to prioritise school. Instead he preferred to help his dad, and has been scavenging through rubbish since Year 5 of primary school. After he dropped out, he started scavenging full-time on his own. He gets the shortest route to the rubbish site as he is the youngest scavenger in his family. Their employer provided bicycles to reach their work areas easily.

Budi was excited the first time he earned his own money, so he encouraged his peers to work like him, and taught them how. Budi manages his money to cover his daily expenses such as cigarettes and billiards. Budi's parents use their wages to pay for food and school for his younger siblings. Budi seldom gives his money to his parents. Budi has been smoking since before he was in kindergarten. When he was younger, his grandpa who is a smoker would roll cigarettes for his small crying grandson who was upset that his mother was busy with his younger sibling. When he was in kindergarten, he stopped smoking because his teacher warned him to quit. The teacher said that if he didn't quit his smoking, he would not be able to study at the school. But when he quit school he took up smoking again, using much of his earnings for this. Budi usually gives his sister, Putri, pocket money of IDR 10,000 (US$1) per week. He rarely saves his money, and has now started buying alcohol. An NGO offered to support him to go back to school, but he doesn't want to - he is reluctant and embarrassed to go to school since his peers would be much younger than him.

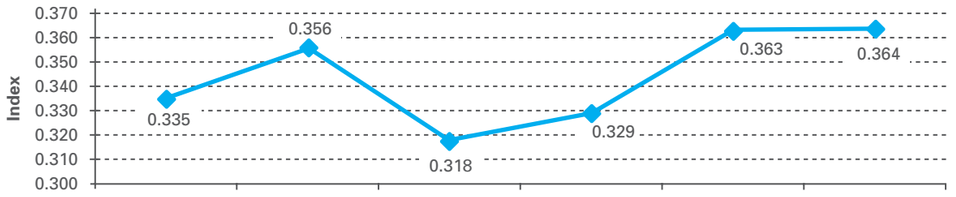
Source: Based on repeat interviews with Budi, rural Central Java, 2009

2.3
INEQUALITIES AND HUMAN DEVELOPMENT

As the discussion above on regional disparities in poverty levels has demonstrated, economic growth has not always been accompanied with equity for the poor in terms of wealth and human development. Several summary measures capture inequalities and development over time. Wealth gaps among individuals is measured by the Gini coefficient, with a value of 1 indicating high inequality between individuals. The HDI captures multiple aspects of welfare by combining the indicators of life expectancy, educational attainment and income into a composite index. The GDI shows the comparative development of women.

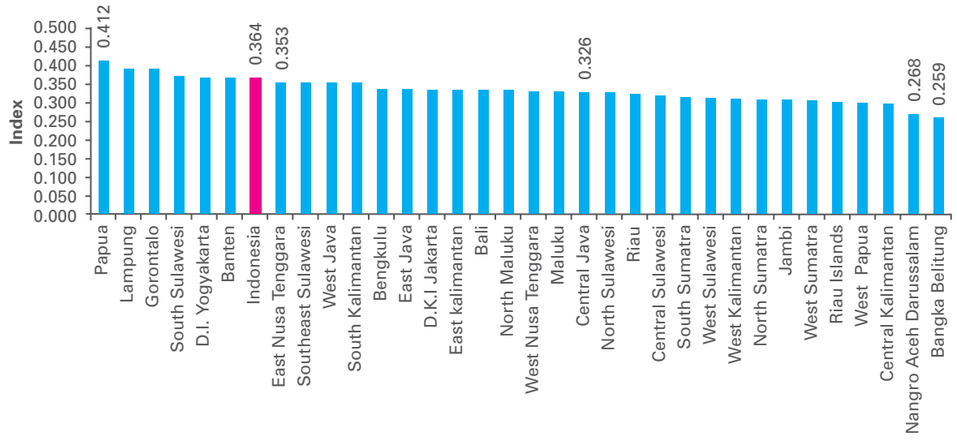
Figure 2.3.1 highlights that income inequalities have been rising over the past decade, in contrast to data presented earlier in this section that highlighted improvements in economic growth. Figure 2.3.2 demonstrates that wealth gaps are greater in some provinces than in others.

Figure 2.3.1: Gini coefficent over time, Indonesia 1993-2007



Source: BPS - Statistics Indonesia, Welfare Indicators; Income and Consumption Indicators, based on National Socio-Economic Surveys 1993, 1996, 1999, 2002, 2005 and 2007

Figure 2.3.2: Gini coefficient by province, Indonesia 2007

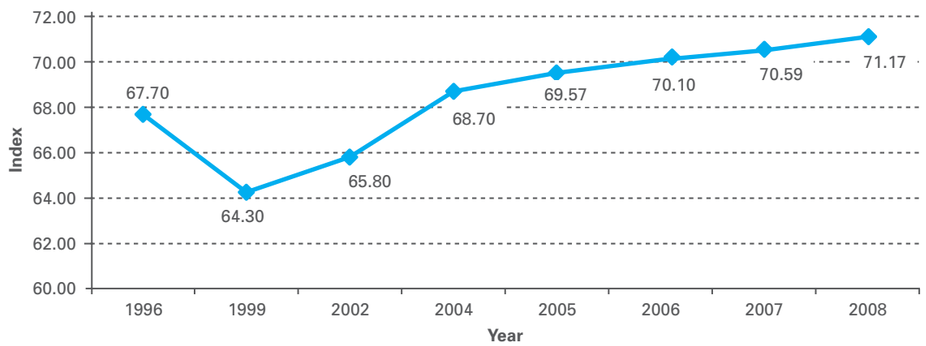


Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2002, 2005 and 2007

88 Name changed

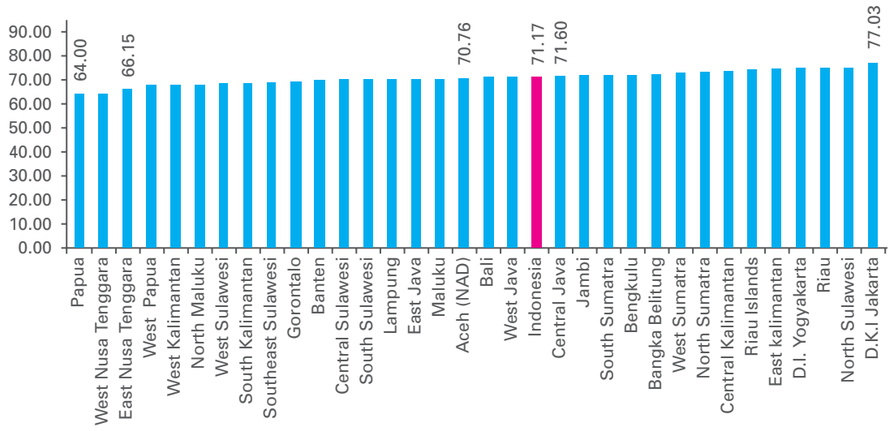
The impact of the economic crisis saw the HDI fall by 3.4 points between 1996 and 1999. It has been rising slowly ever since (see Figure 2.3.3). Yet, as Figure 2.3.4 demonstrates, rates are far lower than the national average in some provinces, mainly in eastern Indonesia, including Papua, and East and West Nusa Tenggara, and rates in the national capital, Jakarta, are far above the average for Indonesia; 77.03 compared to 71.17, in 2009. Table 2.3.1 shows that there have been improvements over time in the provinces, with the selection from our cases showing that this has been occurring even in the worst performing province, Papua, where in 2008 the index had almost reached the same level as the lowest national average score, which was recorded in 1999 (i.e., 64.00).

Figure 2.3.3: Human development index (HDI) over time, Indonesia 1996-2008



Source: BPS - Statistics Indonesia, 1996-2008

Figure 2.3.4: Human development index (HDI) by province, Indonesia 2008



Source: BPS - Statistics Indonesia, 2008

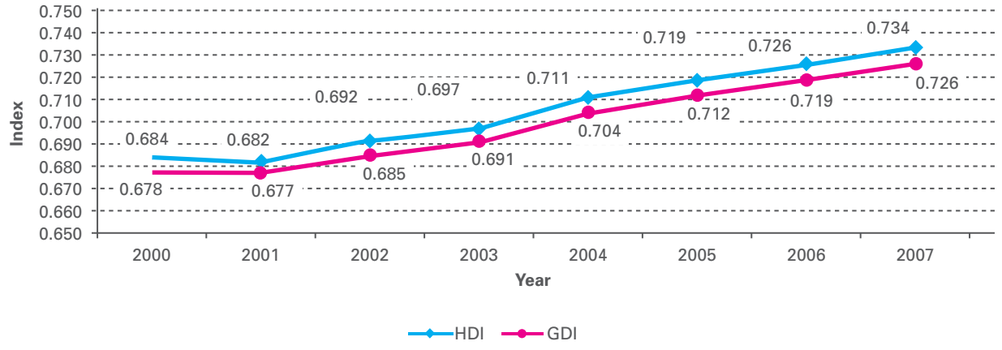
Table 2.3.1: Trends in the human development index (HDI) over time in selected provinces and national average, Indonesia 1996-2008

Area	1996	1999	2002	2004	2005	2006	2007	2008
Indonesia	67.70	64.30	65.80	68.70	69.57	70.10	70.59	71.17
Aceh	69.40	65.30	66.00	68.70	69.05	69.41	70.35	70.76
Central Java	67.00	64.60	66.30	68.90	69.78	70.25	70.92	71.60
East Nusa Tenggara (NTT)	60.90	60.40	60.30	62.70	63.59	64.83	65.36	66.15
Papua	60.20	58.80	60.10	60.90	62.08	62.75	63.41	64.00

Source: BPS - Statistics Indonesia, 1996-2008

Along with human development, there have been some positive improvements in gender development as measured by the GDI and GEM, as demonstrated by Figure 2.3.5. Significant progress was made through Presidential Decree No. 9/2000 on Gender Mainstreaming, which instructed all ministers, heads of state institutions, commanders of the armed forces, governors, district heads and mayors, to mainstream gender considerations in all government processes (from planning, to implementation, monitoring and evaluation), in all development policies, programmes, and government action. Presidential Regulation No. 7/2005 on the National Medium-Term Development Plan 2004-2009[89] also stipulates that improving the quality of life and the welfare and protection of children is imperative to establishing justice and democracy in Indonesia and should be implemented through the national medium-term development plans and government work plans (RKP). In the 2006 government work plan, gender mainstreaming was to be adopted by all government sectors to assure that all development policies, programmes and actions are responsive to gender issues: "All of the implementations of national development shall always use the principle of mainstreaming of good governance, sustainable development, community participation, decentralisation, and gender."[90]

Figure 2.3.5: Human development index (HDI) and gender development index (GDI) over time, Indonesia 2000-2007



Source: UNDP, 2000-2007 (UN Human Development Reports 2002-2009)

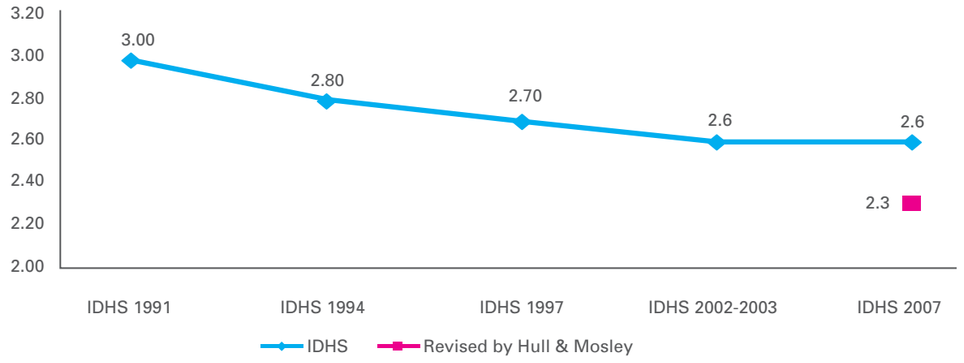
89 Presidential Regulation No. 7/2005 on the National Medium-Term Development Plan 2004-2009
90 Presidential Regulation No. 39/2005 on the 2006 Government Work Plan, p20

Figure 2.3.5 shows that the GDI has been improving alongside the HDI. However, the 2010 survey of the World Economic Forum on the global gender gap index found that Indonesia is still ranked 87 out of 134 countries. It is in a better position than Malaysia (rank 98) and Cambodia (97), but performing worse than other Association of Southeast Asian Nations (ASEAN) such as the Philippines (9), Thailand (57), Vietnam (72) and Singapore (56).[91] In 2009, Indonesia was ranked at a level similar to Saudi Arabia, Pakistan, Yemen, Benin, Chad and Turkey.

2.4 CHANGING DEMOGRAPHICS

One challenge for improving welfare and distributing resources is the challenge of population growth. An intensive family planning programme began in Indonesia in 1971. In the 30 years prior to the period covered in this SITAN (1970-2000) Indonesia underwent a major transition from high to low fertility. Through a combination of delayed marriage, and the increased use of contraception to prolong the time between births and to reduce the number of births, population growth has slowed. The total fertility rate was 2.3 in 2000 and has remained at that level.[92] The annual growth rate on average between 2000 and 2009 was 1.35 per cent.[93]

Figure 2.4.1 Total fertility rate (TFR) over time, Indonesia 1991-2007

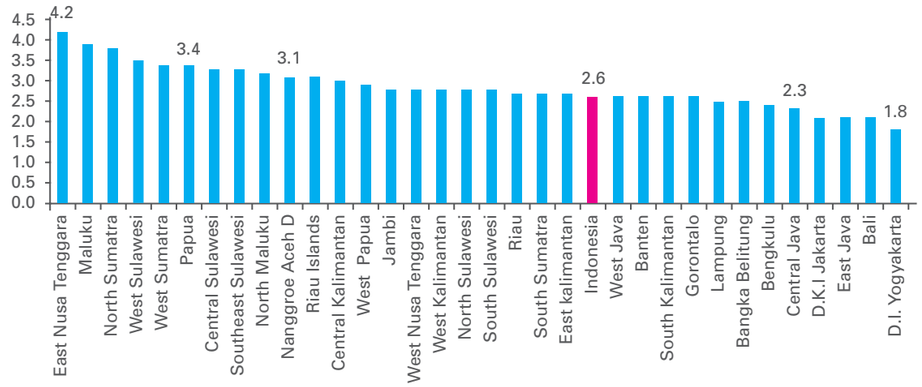


Source: BPS - Statistics Indonesia and Macro International, Indonesia Demographic and Health Surveys (IDHS) 1991, 1994, 1997, 2002-2003 and 2007

It is evident from Figure 2.4.2 below, that there is higher fertility rates in many of the provinces in eastern Indonesia (which were also areas that were poorer, as discussed previously) compared with many of the provinces on Java and Sumatera islands. The *2007 Indonesia Demographic and Health Survey (IDHS)* data demonstrates that fertility rates are also higher in rural areas, and amongst the poor.[94]

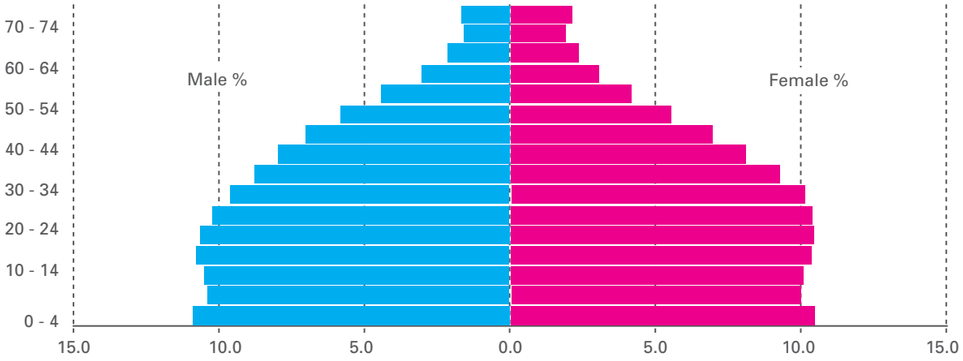
91 Hausmann, R., Tyson, L. D., Zahidi, S. (2010) *The global gender gap report 2010,* World Economic Forum: Geneva
92 The TFR based on IDHS Data 2002-2003 and 2007 is constant at 2.6. However, the characteristics of the sample of these two surveys is not comparable with other survey samples *(National Socio-Economic Survey, the Intercensal Survey and the 2000 Census)*. Unmarried women are underrepresented in the *IDHS* sample. After Hull and Mosley (2008) adjusted the denominator of the formula to make it comparable with the characteristics of the other surveys and census, the resulting TFR is similar to that from the Census 2000, which is 2.3. See Hull, T. H. and Mosley, H. (2009) *Revitalization of family planning in Indonesia.* BKKBN (Family Planning Coordinating Board): Jakarta. Hartanto, W. and Hull, T. H. (2009) *Fertility estimates of Indonesia for provinces: Adjusting under-recording of women in 2002-3 and 2007 IDHS*, Australian National University: Canberra
93 BPS - Statistics Indonesia (2009) Statistical Year-Book of Indonesia 2009, BPS - Statistics Indonesia: Jakarta
94 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic Health Survey (IDHS) 2007*, BPS and Macro International: Calverton, Maryland

Figure 2.4.2 Total fertility rate (TFR) by province, Indonesia 2007



Source: IDHS 2007

Figure 2.4.3: Indonesia population distribution, 2009



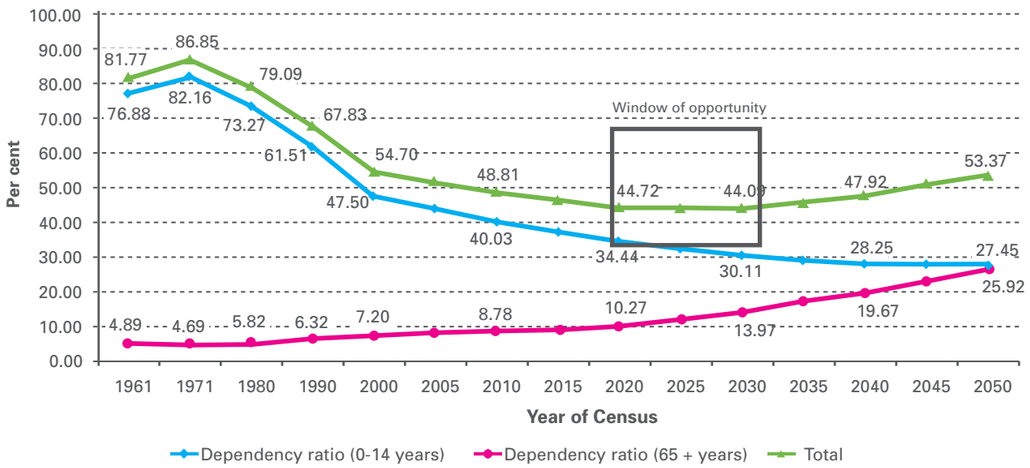
Source: BAPPENAS, BPS - Statistics Indonesia, UNFPA Indonesia (2008) 'Proyeksi Penduduk Indonesia (Indonesia Population Projection) 2005-2025'

However, Indonesia has an opportunity to take advantage of what is known as the 'demographic bonus'. Figure 2.4.3 shows that the population distribution of Indonesia in 2009 was skewed towards younger age groups. If fertility rates remain similar in the future, by 2025 the population will reach approximately 275 million people, and the working population will increase from 64.6 per cent to 68.8 per cent of the total.[95] This means that as more younger people enter the labour market, this will decrease the dependency ratio of the older population on the younger population. This creates a window of opportunity to promote development and social services before segments of the working population become dependent as they age. The window of opportunity opens up between 2020-2040, with the lowest levels of dependency predicted to fall between 2020 and 2030, when the dependency ratio will fall below 45 per 100 head of population of working age. Following this, the dependency ratio will increase as the population ages.[96] If

95 Adioetomo, S. M. S. (30 April 2005) '*Bonus demografi: Menjelaskan hubungan antara pertumbuhan penduduk dengan pertumbuhan ekonomi*', Speech given at the Inauguration Ceremony for Professors in Demography Economics, Faculty of Economics, University of Indonesia, p66
96 Ibid., pp65-66

social services and development are not maximised during this period, not only will this be a loss for Indonesia, it could result in a demographic crisis in the following years, especially if a large percentage of the aging population after 2040 is reliant on social welfare.[97] In order to benefit from the demographic bonus, the sustainability of the family planning programme is essential, as is investing in building the skills and employability of the Indonesian youth.[98]

Figure 2.4.4: Dependency ratio ages 0-14 year, 65+ years and total, Indonesia 1961-2050



Note: Compiled by the Centre for Population and Policy studies (CPPS), Gajah Mada University, based on demographic indicators for 1950-2050 using various BPS - Statistics Indonesia census data and surveys, in Adioetomo (2005)

2.5 CONCLUSION

This section outlines the progress and institutional change that has taken place in Indonesia over the past decade. An institutional framework has been created which provides for greater freedoms for Indonesians. There has also been growing policy attention to children's and women's welfare and that of the poor. Decentralisation presents both challenges and opportunities for giving greater attention to the specific needs of women and children in sub-national environments, which is discussed further in the case studies in Section 4.
Analysis in this section clearly shows the improvements in economic growth and poverty reduction over time in Indonesia. However, overall poverty reduction has not been accompanied by equitable social outcomes, with social disparity and inequality being evident between provinces, urban and rural areas, gender groups and socio-economic groups. In Section 3, discussion on a range of indicators of child and women's welfare shows similar trends, indicating the importance of improving policy attention to pro-poor growth and improving human development, as well as achieving Millennium Development Goals (MDGs) with equity.

97 Herutomo, R. (2008) 'Harvesting Demographic Bonus', *Globe Asia*, Vol.2(4): 22-24
98 Hull, T. H. (26 October 2008) *Correcting Indonesia's fertility estimates: Problems with the sample of the demographic and health surveys*, Unpublished paper

Furthermore, one challenge over the long-term for Indonesia will be the problem of population growth, especially if attention is not given to improving the skills of Indonesian children and youth now. This is so that by the end of the next decade Indonesia will have a productive population during the demographic window of a low dependency ratio, which can support improvements in social services and infrastructure. This will also require the continued efforts of policymakers and planners to ensure that Indonesia strengthens its system of governance and public administration. If not, the pressure on public services will grow and may reach crisis levels by the middle of the century as the population ages.

SECTION 3:

ANALYSIS OF NATIONAL INDICATORS ON THE SITUATION OF WOMEN AND CHILDREN

INTRODUCTION

This section provides a general overview about key aspects of the situation of children and women in Indonesia. There are five broad clusters of analysis: health and nutrition (focusing on trends in outcomes relating to mortality rates and nutrition); water and sanitation; HIV and AIDS and adolescent health practices relating to sexually transmitted infections (STIs); education (focusing on attendance, early leaving rates, access and quality); and finally, child protection (including citizenship and birth registration, protection from violence, abuse, and exploitation, alternative care systems, and child freedom and participation). The first subsection on health and nutrition, and the second on water and sanitation, relate to Millennium Development Goals (MDGs) numbers 1, 4, 5, 6 and 7.[1] The third subsection, on HIV and AIDS, relates to Goal 6. The fourth part, on education, relates to Goals 2 and 3.

Due attention is given to MDGs in that the analysis presented here is centred on children and women, but we also consider inter-related analysis of the situation of child protection. In addition, while presenting a large number of indicators that correspond to data aggregated at the national level, whenever possible the discussion also focuses on evidence of the profound and wide-ranging disparities and inequalities which characterize Indonesia today. The fifth subsection, on child protection - or 'special protection' as it is known in Indonesia - is distinct in that it relies less on indicators and aggregate quantitative data for the whole country (due to data insufficiencies) and more on in-depth case studies (some of which include quantitative data), as well as qualitative data. The approach in the analysis is intended to capture and illustrate the challenges and contradictions that accompany the incipient construction of child protection in Indonesia. Whilst this section is divided into five distinct subsections, it is important to underline that these five areas of analysis are deeply interrelated, such that outcomes in one may affect changes in others. Each section of analysis also identifies the major changes in policies and initiatives that have been undertaken in relation to the themes of the section, although the discussion is not exhaustive given the rapidly changing policy and regulatory environment in Indonesia. Some mention is made of these changes in relation to decentralisation, although further discussion takes place in the sub-national analysis in Section 4.

The following analysis highlights that, in terms of almost all the indicators and available data, considerable progress has been made towards improving the situation of women and children over the past decade, both in terms of the regulatory framework and national aggregate figures in health, nutrition, water and sanitation, and education, although much work remains to be undertaken in the area of HIV and AIDS prevention and child (special) protection. However, across these indicators, there are consistent inequalities and inequity between the provinces, such that in many cases a few more successful provinces serve to raise the national average. Furthermore, the poorest quintiles and people in rural areas tend to be left behind in terms of the gains for women and children in recent years. Moreover, on some indicators gender inequities remain. These results underline the importance of policy initiatives that aim to achieve the MDGs with equity and to ensure that growth in Indonesia is pro-poor and seeks to remedy regional, socio-economic and gender inequities. The National Medium-Term Development Plan (*RPJMN*) 2010-2014 of the Government of Indonesia (GoI) and the corresponding sectoral Strategic Plans (Renstra, Rencana Strategis) and government actions also place importance on reducing inequalities and inequities and focussing on improving the situation of the poor. As such, the policy space exists to continue to strive for progress with equity in the coming decade.

1 These MDGs are as follows: Goal 1: Eradicate extreme poverty and hunger; Goal 2: Achieve universal primary education; Goal 3: Promote gender equality and empower women; Goal 4: Reduce child mortality rate; Goal 5: Improve maternal health; Goal 6: Combat HIV/AIDS, malaria, and other diseases; Goal 7: Ensure environmental sustainability.

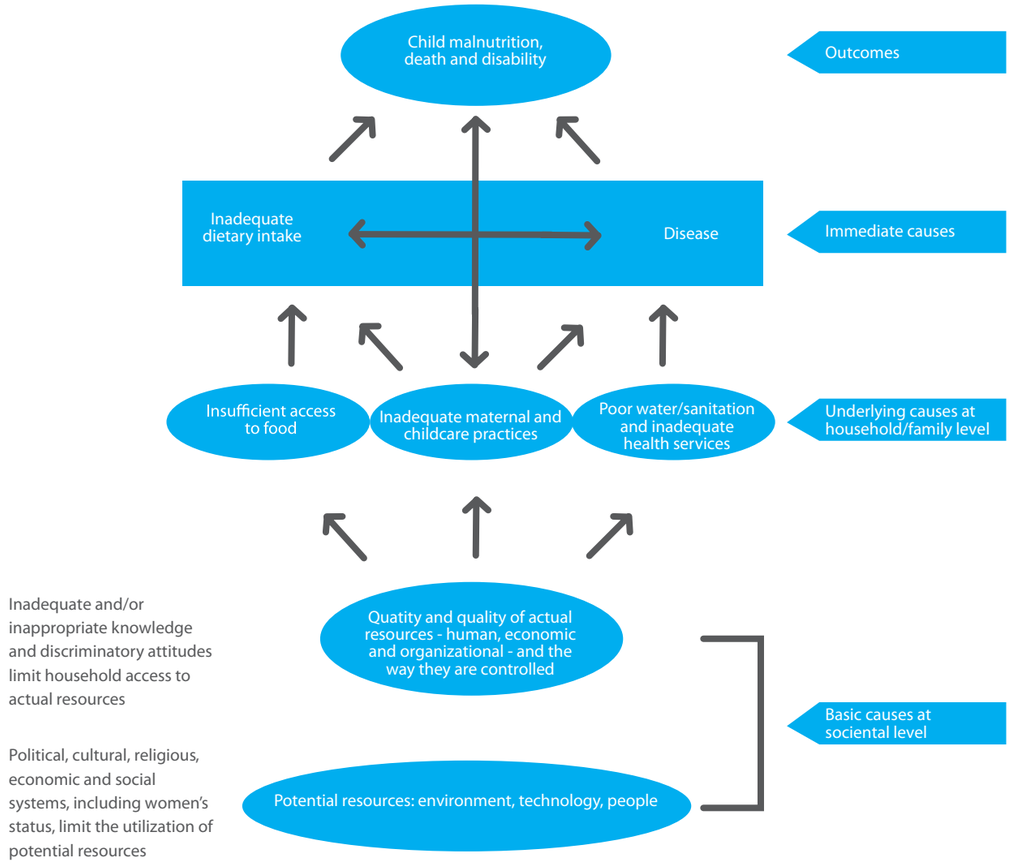
3.1 HEALTH AND NUTRITION

Appropriate health and nutrition, as well as access to clean water and adequate sanitation are vital for the welfare and wellbeing of children and women. Three of the eight MDGs (Goal 1: Eradicate extreme poverty and hunger; Goal 4: Reduce child mortality, and Goal 5: Improve maternal health) have been specifically targeted at improving outcomes in the welfare of women and children through reducing malnutrition rates, infant and child mortality rates, and maternal mortality rates. Other interrelated MDGs and sub-targets pertaining to assisted births, the use of birth control, reductions in malaria and tuberculosis rates, HIV prevention, improved water and sanitation etc., contribute to improving health and nutrition outcomes overall, as well as to child survival and development. The examination in this report of health and nutrition in relation to children and women in Indonesia comprises three subsections: mortality, nutrition, and some related determinants including, access to water and sanitation. These various aspects of health are deeply interconnected, as shown by the conceptual framework on determinants of malnutrition and mortality in Figure 3.1.1.[2] The diagram shows that malnutrition, for example, is not just attributed to a lack of available food or income to buy food, but also to caring practices (such as breastfeeding or hygiene practices) and living in unhealthy environments (for example, with poor access to clean water and sanitation). Good hygiene practices and nutrition can also help to prevent the spread of common diseases and resilience to other illnesses such as diarrhoea, which can all in turn increase the risk of child and infant death. The provision and access of services are essential for improving health and the likelihood of child and mother survival during childbirth. Information and education that promote healthy hygiene and sexual practices are vital too, to prevent illness and the transmission of diseases. However, as Figure 3.1.1 demonstrates, improving nutrition and decreasing child and infant mortality rates also relates to the policy and institutional environment, as discussed further in the case studies in later sections of this report.

© UNICEF/2004/Rachel Donnan

2 UNICEF (1998) *State of the world's children 1998*, Oxford University Press: Oxford

Figure 3.1.1: UNICEF conceptual framework on understanding child malnutrition, death and disability



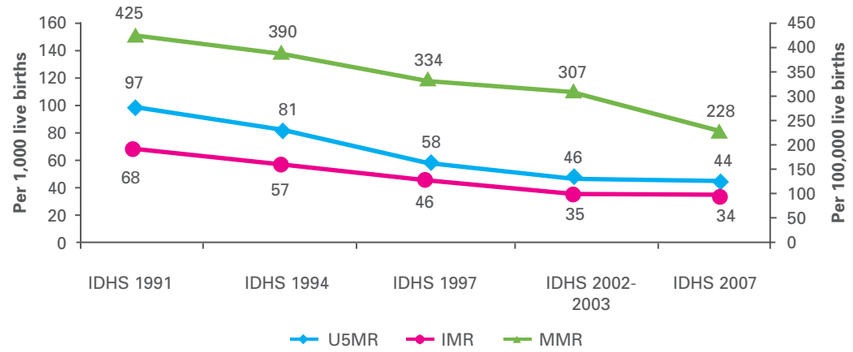
Source: Adapted from UNICEF, State of the world's children 1998

As we will see, Indonesia has made significant progress with respect to a large number of indicators on child survival and development at the national level, but there are some remaining and ongoing challenges, not only with regards to the provision of services and inter-provincial disparities, but with the promotion of healthy practices too. Since the last SITAN in 2000, Indonesia has undergone a number of drastic political and institutional changes, not least a deep and complex process of decentralisation, which has had a profound impact on the delivery of services, including health services in Indonesia. The impact of decentralisation is not always clear or evident. In some cases it has allowed for better responses to community needs, while in others it has created gaps where service provision is uncertain. The context of decentralisation is important for the evenness of service provision across a country as large, diverse and complex as Indonesia. One of the key aspects of this section is to provide in-depth information about the nature, extent and general trends of inequalities and disparities relating to key health issues in Indonesia. In some cases, substantial improvements evident from aggregated data at the national level can be deceptive and can obscure the fact that women and children - especially those living in rural areas, underdeveloped provinces and poor households - still live very precarious lives.

3.1.1 MORTALITY RATES: MATERNAL MORTALITY RATIO (MMR), INFANT MORTALITY RATE (IMR) AND UNDER-FIVE MORTALITY RATE (U5MR)

Since the 2000 UNICEF Indonesia SITAN, there have been significant improvements with respect to a number of health and nutrition indicators, notably the infant mortality rate (IMR), under-five mortality rate (U5MR) and maternal mortality ratio (MMR), as well as the prevalence of malnourished children, as discussed later in the section (data from *2002-2003 IDHS and 2007 IDHS*). Figure 3.1.2, which summarises key mortality rate data captured in the *Indonesia Demographic and Health Surveys (IDHS)* since 1991, shows the general decline of mortality rates in Indonesia. The general improvement of these key indicators over time has taken place prior, during and following the decentralisation of the provision of key health services.

Figure 3.1.2: Infant mortality rates, under-five mortality rates, and maternal mortality ratios, Indonesia 1991-2007



Source: Badan Pusat Statistik (BPS) - Statistics Indonesia and Macro International, Indonesia Demographic and Health Surveys (IDHS) 1991, 1994, 1997, 2002-2003 and 2007

After two decades of significant improvements in IMR and U5MR, progress is ongoing but at a much slower rate: a two-point reduction in the U5MR and a one-point reduction in the IMR between 2003-2003 and 2007 (see Figure 3.1.2). Furthermore, while the MMR has decreased to 228, the rate is still far above that of neighbouring countries in Southeast Asia (in 2007, the rate for Viet Nam was 160; Thailand was 12; Malaysia was 28; and 160 for the Philippines).[3] An examination of the annual reduction rate (ARR) suggests a slowing down of the rate of decline of IMR and U5MR following decentralisation in Indonesia, from 3 per cent to 1 per cent.[4] The

3 UNICEF (2008) *State of the world's children 2009: Maternal and newborn health*, UNICEF: New York

4 According to *IDHS* data (see BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007*, BPS and Macro International: Calverton, Maryland, USA, p118), "The decline in childhood mortality indicated by the IDHS 2007… may be exaggerated. Comparison of the last three IDHS surveys (1997, 2002-2003 and 2007) shows a different pattern of mortality decline. Infant mortality declined from 46 deaths per 1,000 live births in 1993-1997 to 34 per 1,000 in 2003-2007, with an annual reduction rate (ARR) of 3 per cent. The ARR between 1998-2002 and 2003-2007 is less than 1 per cent (from 35 deaths per 1,000 live births to 34 per 1,000). In the same period, under-five mortality declined from 58 deaths per 1,000 live births in 1993-1997 to 44 per 1,000 in 2003-2007, with an annual reduction rate (ARR) of 3 per cent. The ARR in under-five mortality between 1998-2002 and 2003-2007 is also less than 1 per cent (46 deaths per 1,000 live births in 1998-2002 to 44 per 1,000 in 2003-2007)…the three most recent IDHS surveys tend to give lower 0-4 year period mortality estimates and higher 5-9 year period mortality estimates. The infant mortality estimate for the 0-4 year period preceding the survey for the 2007 *IDHS* therefore should be higher than 34 deaths per 1,000 live births, and for the 2002-2003 IDHS it should be higher than 35 deaths per 1,000 live births. Using estimates for infant mortality rates in the 5-9 year period preceding the survey, the ARR for the last two *IDHS* surveys is 3 per cent. Assuming this ARR is correct, the 0-4 year period estimate for the 2002-2003 IDHS is 41 deaths per 1,000 live births, and for the 2007 *IDHS* it is 37 deaths per 1,000 live births. This means that in the 2002-2003 *IDHS*, the IMR estimate 35 per 1,000 for the period 0-4 years preceding the survey should be inflated by 17 per cent, giving an estimated infant mortality rate of 41 deaths per 1,000 live births; for the 2007 *IDHS*, the IMR should be inflated by at least 10 per cent, giving an estimated infant mortality rate of 37 deaths per 1000 live births…"

2007 IDHS data also highlight that IMR reductions may be overestimated.[5] However, whether the slowing down of the ARR can be attributed to the decentralisation process or whether other factors are at play is unclear.

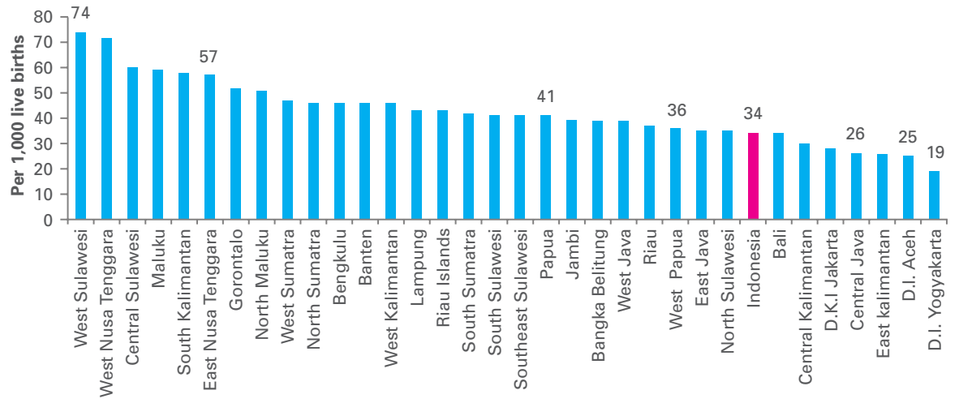
In addition, detailed data on infant and child mortality - in this case the contribution of neonatal deaths (i.e., the death of a child born alive before 28 days) and post-neonatal deaths (i.e., the death of a child born alive after 28 days but before one year old) to the overall mortality rates - require further attention. The World Health Organisation (WHO) has estimated that globally, almost 40 per cent of deaths of children under five occur in the first month of life, and three quarters of neonatal deaths take place in the first week (early neonatal deaths).[6] According to WHO (2006) most of these are preventable.[7] Data from the *2007 IDHS* indicate a similar pattern in Indonesia, with over two thirds of under-five deaths taking place within the first month after birth (77 per cent), and 80 per cent of these deaths taking place within the first week of life.
The reduction of neonatal deaths is therefore essential to further reduce child mortality; one of the main MDGs. The post-neonatal mortality rate has reduced by 40 per cent and the neonatal mortality rate has declined more slowly, by 32 per cent over the past 10 years.[8] However, the proportions of infants who died in the first day, in the first week and in the first 28 days after birth, have all increased during the same period.[9] The increasing proportion of neonatal deaths as a part of infant deaths has been attributed to several factors. In particular, the ongoing difficulties in reaching the many babies who are born at home without effective and timely neonatal interventions, as also discussed later in this section.[10] This is a particular challenge, as close to 60 per cent of births still take place at home in Indonesia.[11]

3.1.1.1 An overview of disparities: Patterns in mortality rates

Whilst the general progress and improvements in infant and child mortality rates have to be acknowledged, a more detailed examination of disaggregated data provides a more nuanced picture, within which gaps, disparities and uneven achievements can be observed. Disparities in Indonesia are multifaceted; they occur between and within provinces (within-province disparities are detailed in the case studies chapters), between urban and rural areas, between age and gender groups, and among groups of different socio-economic status. These disparities need to be noted both by national and international actors, to inform policymaking and facilitate the delivery of appropriate services where they are most needed.

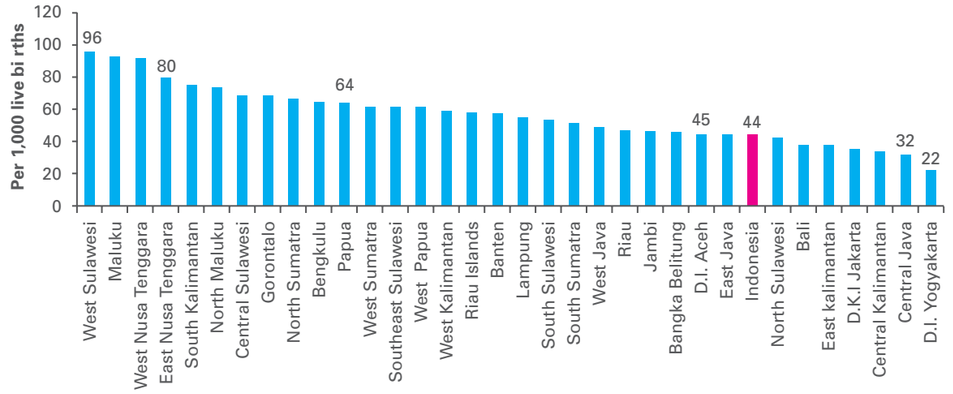
The breakdown of IMR and U5MR by provinces is consistent with general patterns of regional disparities in Indonesia. At a national level, the IMR stands at 34 per 1,000 live births and the U5MR at 44 per 1,000 live births, but at a provincial level these rates are as low as 19 (IMR) and 22 (U5MR) for Yogyakarta and as high as 74 (IMR) and 96 (U5MR) for the newly formed province of West Sulawesi. It is notable too that the majority of provinces underperform compared to the national average (26 out of 33 provinces, both for the IMR and the U5MR) while only a handful of better developed (East and Central Kalimantan, Jakarta, Bali) and populous provinces (typically Yogyakarta) consistently perform very well. It is interesting to note that by 2007, Aceh had a low IMR, indicating that following the tsunami, the province has managed to ensure that many of the direct causes of the IMR outlined earlier in this section have been addressed. There is an absence of comparable provincial level data on the MMR and hence disparities cannot be ascertained. While there have been notable improvements in MMR, IMR and U5MR, there is a danger that a handful of high-achieving provinces are driving up aggregate indicators, leaving under-achieving provinces far behind.

Figure 3.1.3: Infant mortality rate (IMR) by province, Indonesia 2007



Source: IDHS 2007. Note: The figures presented here are for the ten-year period preceding the survey

Figure 3.1.4: Under-five mortality rate (U5MR) by province, Indonesia 2007



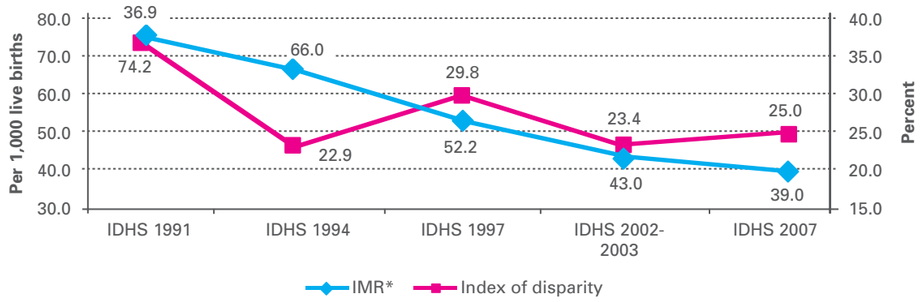
Source: IDHS 2007

As has been illustrated in the section above (and will be discussed again below), there are multiple and multidimensional aspects to some key areas of mother and child health in Indonesia, and disparity indices allow us to observe the general trends of disparities in IMR and U5MR in Indonesia over the past decade. An index of disparity (ID) is a summary measure of disparity

5 Ibid.
6 WHO (2006) *Making a difference in countries: Strategic approach to improving maternal and newborn survival and health*, WHO: Geneva
7 Ibid.
8 Badan Pusat Statistik (BPS) - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS)* 2007
9 Ibid.
10 Ibid.
11 Ibid.

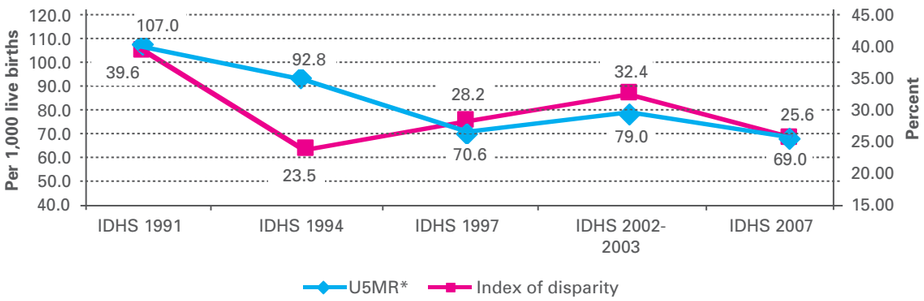
across population groups. Groups may be defined by education, gender, and/or income.[12] In Figures 3.1.5 and 3.1.6, inter-province disparity is shown for the IMR and U5MR, respectively.[13] It is clear that while there has been an overall trend of decreasing mortality rates, disparities among provinces have increased for the IMR between 2002-2007.

Figure 3.1.5: Infant mortality rate (IMR) and provincial index of IMR disparity over time, Indonesia 1991-2007[14]



Source: Processed by the Gajah Mada University based on data from IDHS 1991, 1994, 1997, 2002-2003 and 2007

Figure 3.1.6: Under-five mortality rate (U5MR) and provincial index of U5MR disparity over time, Indonesia 1991-2007[15]



Source: Processed by the Gajah Mada University based on data from IDHS 1991, 1994, 1997, 2002-2003 and 2007

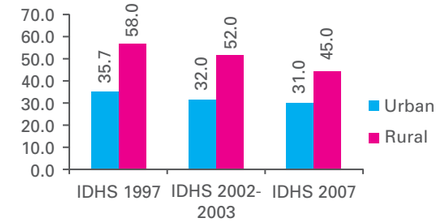
Whilst the general trend of the disparity index for the IMR decreased somewhat early in the decade, recent data point towards an increase in disparities in 2007 (Figure 3.1.5), meanwhile for the U5MR disparities have been reducing since 2002-2003 along with aggregate rates (Figure 3.1.6). The introduction of safety net programmes in health with the onset of the financial crisis may have had some impact on the decline of disparities in the IMR between 1997 and 2003.

12 Pearcy, J. N. and Keppel, K. G. (2002) 'A summary measure of health disparity', *Public Health Reports*, May-June, Vol.117: 273-280
13 The ID is defined as the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage. Index of disparity = ($\sum$ Ir (1-n) – Rl / n) / R * 100, r = group rate, R = total population rate. Pearcy, J. N. and Keppel, K. G. (2002) 'A summary measure of health disparity'.
14 Ibid.
15 Ibid.

Ariasih (2003) reported on a study in Purworejo District in Central Java, which showed that mothers who owned social safety net cards were more likely to choose skilled birth attendants for assistance during childbirth.[16] In multivariate analysis conducted by Ariasih (2003), there was a significant association between the health component of the social safety net programme and the choice of birth attendants.[17] However, the more recent increasing disparities between provinces indicate that current health interventions related to the IMR are not effectively reducing provincial disparities. At the same time, they are managing to slowly reduce disparities between provinces for the rate of mortality among children under five.

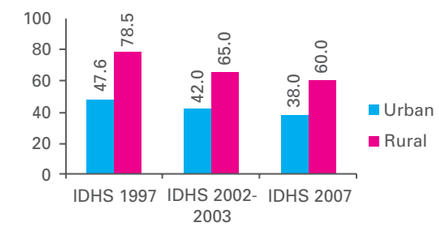
Rural and urban locations are an important source of disparities within provinces, but also contribute to broader inter-provincial disparities. As indicated in Figures 3.1.7 and 3.1.8, both the IMR and U5MR are substantially higher for children living in rural areas when compared to those living in urban households. Urban/rural disparities with regards to IMR and U5MR are longstanding, but the gap appears to be reducing for the U5MR whereas it remains unchanged for the IMR, confirming the previously mentioned trend that health interventions are not impacting on IMR or inter-provincial disparities over time. Finally, additional data on post-neonatal mortality in *IDHS* surveys shows a similar pattern of rural/urban disparities (Figure 3.1.7). Data from the *2007 IDHS* survey indicates that post-neonatal mortality rate in urban areas stood at about half that the rate in rural areas (12 per 1,000 live births, compared to 21 per 1,000 live births).

Figure 3.1.7: Infant mortality rate (IMR) by area, Indonesia 1997-2007



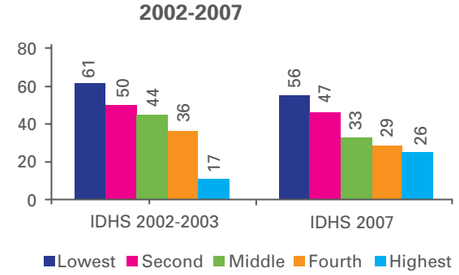
Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.8: Under-five mortality rate (U5MR) by area, Indonesia 1997-2007



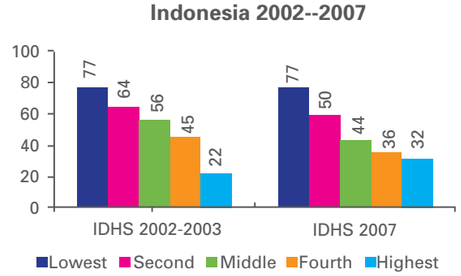
Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.9: Infant mortality rate (IMR) by wealth quintile, Indonesia 2002-2007



Source: IDHS 2002-2003 and 2007

Figure 3.1.10: Under-five mortality rate (U5MR) by wealth quintile, Indonesia 2002--2007



Source: IDHS 2002-2003 and 2007

16 Ariasih, I. N. (2003) *Pemilihan penolong persalinan oleh peserta program jaring pengaman sosial bidang kesehatan (JPS-BK) di Kabupaten Purworejo,* Gajah Mada University: Yogyakarta
17 Ibid.

Figures 3.1.9 and 3.1.10 provide both some expected and unexpected results regarding social disparities in mortality rates, considered by wealth quintile. On the one hand, both the IMR and U5MR are significantly higher amongst the poor, with the highest IMR and U5MR concentrated amongst the lowest wealth quintile of the population. Whereas for the wealthiest quintile of the population, both rates are less than half the rates of the poorest group. When compared to 2002-2003, the 2007 figures point to a slow reduction of the IMR amongst the lowest quintile and the largest reduction amongst the third and fourth quintiles. Disappointingly, the U5MR shows no improvement for the lowest quintile of the population between 2002-2003 and 2007, but some significant reductions for the middle three quintiles of the population. However, it is of some concern that both the IMR and the U5MR have increased for the wealthiest quintile during the period between 2002-2003 and 2007, requiring further research into what may underpin this trend.

The results above indicate that despite some improvements in aggregate mortality rates over time in Indonesia, particularly compared to the early 1990s, disparities remain between provinces, with poorer and rural populations being most vulnerable. This highlights that while Indonesia is making substantial progress towards reaching MDGs, considerable attention needs to be given to ensuring that these are reached with equity.

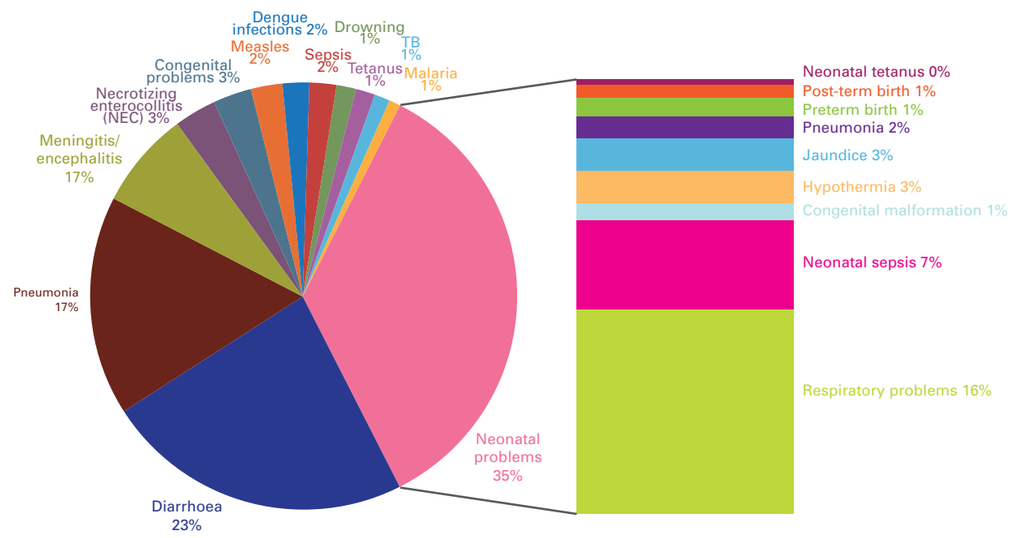
3.1.2 DIRECT CAUSES OF CHILD AND MATERNAL MORTALITY

Most childhood mortality in Indonesia takes place in infancy, and especially during the neonatal period, due to problems such as respiratory problems, neonatal infections, etc. There is also high mortality in early childhood, due to diarrhoea and pneumonia. As is highlighted in Figure 3.1.11 below, these are the three most common causes of death both in infancy (aged 1-11 months) and in early childhood (aged 1-4 years). According to the Indonesian Ministry of Health (2008), in neonates (0-28 days of life), 78.5 per cent of deaths happen in the first week of life, highlighting the problems in health care and other service coverage, as well as quality of life-saving interventions for newborns.[18] Undernutrition during pregnancy and childhood also contributes to the disease burden, and to more than one third of child mortality globally.[19] Higher and lower prevalence rates in some of these direct causes at the provincial level and between income and rural-urban location groups may go some way to explaining disparities, which require further attention by policymakers.

The leading immediate causes of maternal mortality in Indonesia, as demonstrated in Figure 3.1.12, are haemorrhage (28 per cent), eclampsia (24 per cent) and infections (11 per cent). Haemorrhage, often due to retained placenta, is an indication of poor medical support during labour. Eclampsia reflects inadequate care and management during pregnancy and delivery. Death by infection is due to poor prevention and management of infections, unsafe abortions (the majority among married women) and lack of clean delivery.[20] Indirect contributing factors relating to maternal mortality are discussed later in this subsection and are likely to be related to prenatal care, birth assistance by skilled health professionals, giving birth in health facilities to reduce the likelihood that death results in complicated births, and level of maternal nutrition (discussed in Section 3.2), among others.

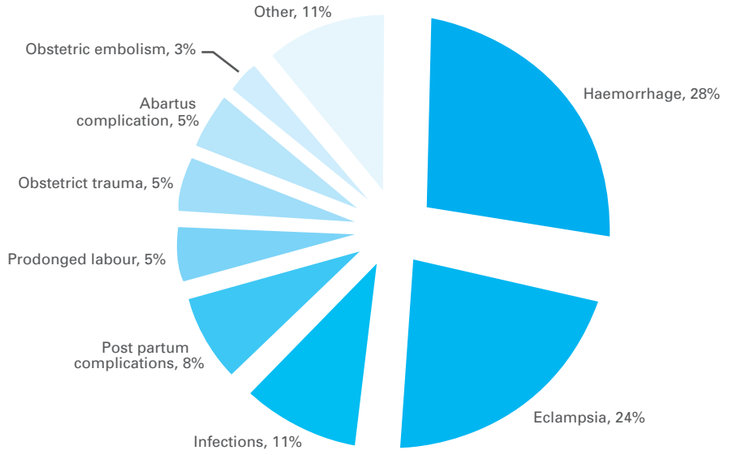
18 Ministry of Health (2008) *Health profile* 2007, Ministry of Health Republic of Indonesia: Jakarta, Indonesia
19 Countdown to 2015 Core Group. (2008). 'Countdown to 2015 for maternal, newborn, and child survival: The 2008 report on tracking coverage of interventions', The Lancet, Vol.371: 1247-1257
20 Ministry of Health (2008) *Health profile* 2007

Figure 3.1.11: Causes of under-five deaths, Indonesia 2007



Source: Indonesian Ministry of Health, Health Profile 2007[21]

Figure 3.1.12: Immediate causes of maternal death: Obstetric complications, Indonesia 2007



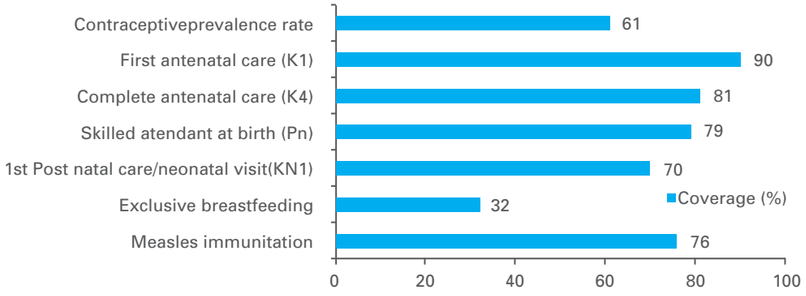
Source: Ministry of Health, Health Profile 2007

21 Ibid.

3.1.3 POLICY CHALLENGES: IMPROVING HEALTH SERVICES AND CARE IN THE DECENTRALISED ENVIRONMENT

The 'continuum of care' is a health care concept involving an integrated system of health care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care. This includes health care for adolescent girls and women, which contributes to their health and nutritional status during pregnancy, and to the health of their newborns, infants and children. Ekman, Pathmanathan and Liljestrand (2008) highlight that safe childbirth is critical to the health of both women and newborn children, and that a healthy start in life is an essential step towards a healthy childhood and a productive life.[22] Maternal and child health status, as indicated by their mortality rates, may therefore be reflected in their access to this continuum of care and their health practices. Figure 3.1.13 shows aggregate results for the coverage of a continuum of care in Indonesia. Most of these indicators are discussed further later in this section. However, there are mixed aggregate results in health coverage for the continuum of care, with lower rates of first postnatal care and exclusive breastfeeding rates, but higher rates of first antenatal care and skilled attendance at birth. Furthermore, as WHO (2009) demonstrates, the rate of infant mortality and neonatal death is high due to a number of factors: low nutritional status of pregnant women, low rates of exclusive breastfeeding for infants under age 6 months, high incidence of diseases such as diarrhoea, asphyxia and respiratory infections, non-optimal use of the *posyandu* system (integrated health service posts), and other socio-cultural and behavioural factors.[23]

Figure 3.1.13: Health coverage along the continuum of care, Indonesia 2007



Source: IDHS 2007

General improvement of the aggregate mortality rates over time has taken place prior, during and following the decentralisation of the provision of key health services. However, it is unclear whether the more recent slowing down of improvements in the trends of mortality rates has been due to the changes in the institutional environment under decentralisation, indicating that further research into the impact of decentralisation on health services is required. There is likely a lag due to the time needed to strengthen the sub-national institutional environment and subsequent service provision.

22 Ekman, B., Pathmanathan, I. and Liljestrand, J. (2008) 'Integrating health interventions for women, newborn babies, and children: A framework for action', The Lancet, Vol.372: 990-1000

23 WHO (2009) Improving child health and development in South-East Asia region: A strategic framework for action, WHO - SEARO: New Delhi

3.1.3.1 Antenatal care

Aside from usage of the community level health services offered by *posyandu*, there are other essential health services and practices that improve child and maternal health and nutrition. Antenatal care (ANC) is important for pregnant women, providing a number of interventions essential to their health and well-being, and that of their infants. In Indonesia, ANC by a skilled provider has seen significant growth and achievements during the last decade. While there are some regional disparities, the majority of provinces achieve over 90 per cent coverage among pregnant women for at least one ANC visit with a skilled provider. However, there are some specific underperformers requiring special attention, particularly in Papua, West Papua, and Maluku (Figure 3.1.14). Rural/urban disparities do exist but are diminishing over time. According to data from the *IDHS* between 1997-2007, there has been steady improvement in rural areas, with coverage now reaching 90 per cent for at least one visit (Figure 3.1.16). However, other social disparities are quite clearly marked with the poorest quintile of the population being the only quintile not to reach 90 per cent on this indicator (Figure 3.1.17).

The Indonesian Maternal Health Programme recommends that pregnant women have at least four ANC visits during each pregnancy, according to the following schedule: at least one visit in the first trimester, at least one visit in the second trimester, and at least two visits in the third trimester.[24] The number of people receiving ANC has been increasing over time between 1997 and 2007, with most receiving more than four ANC visits (Figure 3.1.18). However, there has been no change over time between rural and urban areas, with three quarters of women in rural areas receiving more than four ANC visits compared with nearly 9 in 10 women in urban areas (Figure 3.1.19).

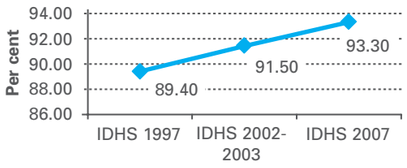
Please note, for Figures 3.1.14 through 3.1.19, showing data on ANC from *IDHS* from 1997 to 2007, antenatal care is defined as pregnancy-related health care provided by medical professionals (doctors, nurse, or midwife), excluding traditional birth attendants and friends.

Figure 3.1.14: Percentage of pregnant women receiving at least one antenatal care visit from a skilled health provider by province, Indonesia 2007

Source: IDHS 2007

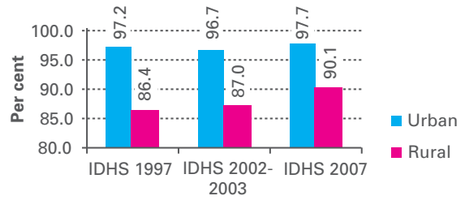
24 Ministry of Health (2001) *Rencana strategis nasional Making Pregnancy Safer di Indonesia 2001-2010*, Ministry of Health Republic of Indonesia: Jakarta

Figure 3.1.15: Percentage of pregnant women receiving at least one antenatal care visit from a skilled provider over time, Indonesia 1997-2007



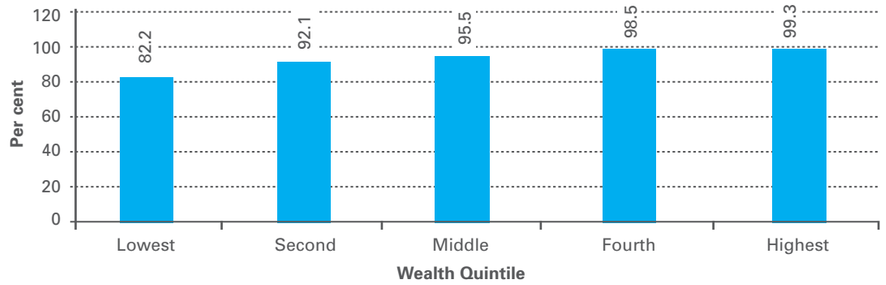
Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.16: Percentage of pregnant women receiving at least one antenatal care visit from a skilled provider by area, Indonesia 1997-2007



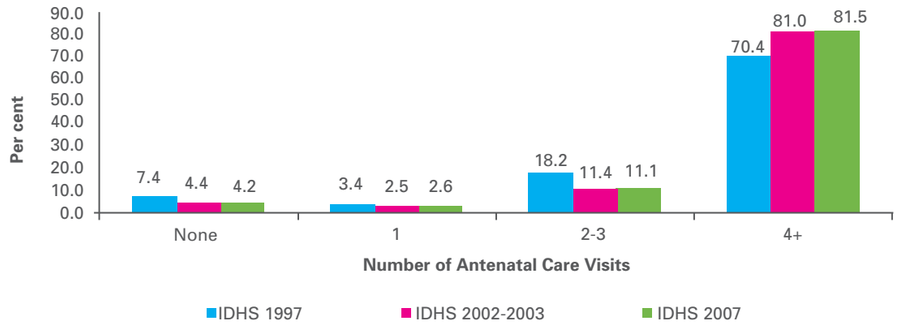
Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.17: Percentage of pregnant women receiving at least one antenatal care visit from a skilled provider by wealth quintile, Indonesia 2007



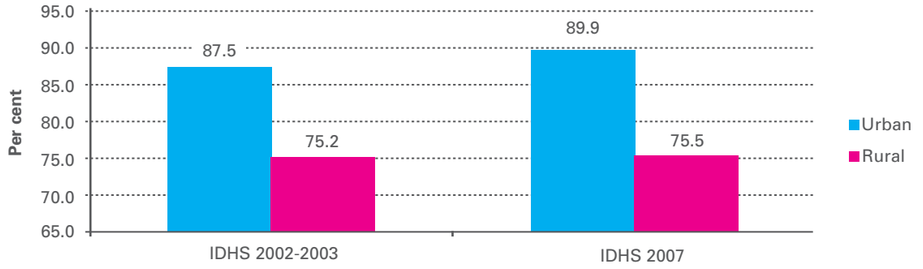
Source: IDHS 2007

Figure 3.1.18: Percentage of pregnant women receiving antenatal care visits by number of visits, Indonesia 1997-2007



Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.19: Percentage of pregnant women with four antenatal care visits (ANC-4) by area, Indonesia 1997-2007



Source: IDHS 2002-2003 and 2007

3.1.3.2 Assisted births

Assistance from skilled health personnel during delivery plays a significant role in reducing both maternal and child mortality rates. In 2000, the GoI focussed its efforts on reducing maternal and neonatal mortality by launching the 'Making Pregnancy Safer' (MPS) National Strategic Plan. This plan builds on the WHO MPS approach and previous GoI programmes (among others, the National Safe Motherhood Programme). MPS focuses on strengthening the capacity of the health system, securing the provision and utilisation of interventions that target the major causes of maternal and neonatal morbidity and mortality.[25] Indonesia's MPS strategy is an effort to reach the MDGs, and as such, its goals are to reduce by 2015 the maternal mortality ratio by 75 per cent from the 1990 levels and to reduce the infant mortality rate to below 35 per 1,000 live births. The key messages of MPS in Indonesia are:

- Every delivery should be assisted by a trained health provider.
- Every obstetric and neonatal complication should be managed adequately.
- Every woman of reproductive age should have access to services for prevention of unwanted pregnancy and management for complications of unsafe abortions.[26]

As outlined previously, there has been some progress towards achieving maternal and child health-related MDGs, however a large proportion of under-five deaths and infant deaths in Indonesia continue to occur during the newborn period, pointing to critical problems in service delivery and quality during pregnancy and delivery. As outlined above, according to the MPS strategy, every delivery should be assisted by a trained health provider. WHO (2004) defines these trained health providers as accredited health professionals - such as midwives, doctors or nurses - who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.[27]

Considering the importance, then, of skilled birth attendance and the GoI goals of 'Making Pregnancy Safer', it is important to highlight that there has been a steady increase in birth assistance by skilled health personnel in Indonesia (hospital, health centre staff or village

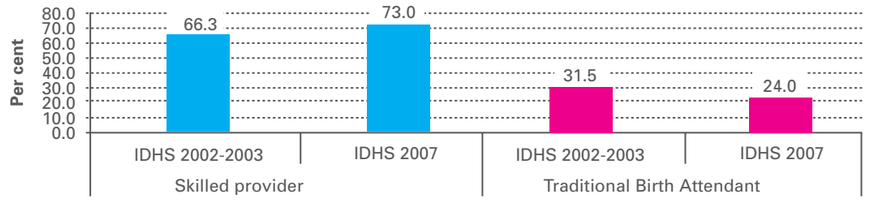
25 Ministry of Health (2001) *Rencana strategis nasional Making Pregnancy Safer di Indonesia 2001-2010*
26 Ministry of Health (18 March 2009) *Percepatan Penurunan AKI, AKB, Prevalensi Gizi Kurang melalui Revitalisasi Sistim Pelayanan Kesehatan Dasar Tahun 2009* (Accelerating the reduction of maternal mortality, infant mortality and the prevalence of undernutrition through primary health care system revitalisation 2009), available at: http://www.depkes.go.id/downloads/newdownloads/rakerkesnas_2009 (Last accessed 19 April 2009)
27 WHO (2004) *Making pregnancy safer: The critical role of the skilled attendant*, A joint statement by WHO, ICM and FIGO, WHO: Geneva, p333

midwives) from 40.7 per cent in 1992 to 66.3 per cent in 2002 and 73 per cent in 2007 (Figure 3.1.20). However, these figures are still some way from reaching the GoI target of 90 per cent of births assisted by skilled personnel.[28]

Although it is beyond the remit of this work to provide the reader with a comprehensive explanatory analysis of disparities in Indonesia across all health indicators, nevertheless, by focusing on key health indicators, it is evident that a series of structural (i.e., developmental, geographic and economic factors), social and cultural/behavioural factors (discussed in later sections of this report) all contribute to the production and reproduction of disparities. One important aspect is the provision of services and the readiness of the population to use those health facilities which are likely to play a critical role in reducing the MMR, IMR and U5MR. Critical services, with regards to these key indicators, include antenatal care (discussed previously), birth/delivery assistance, postnatal care and immunization programmes.

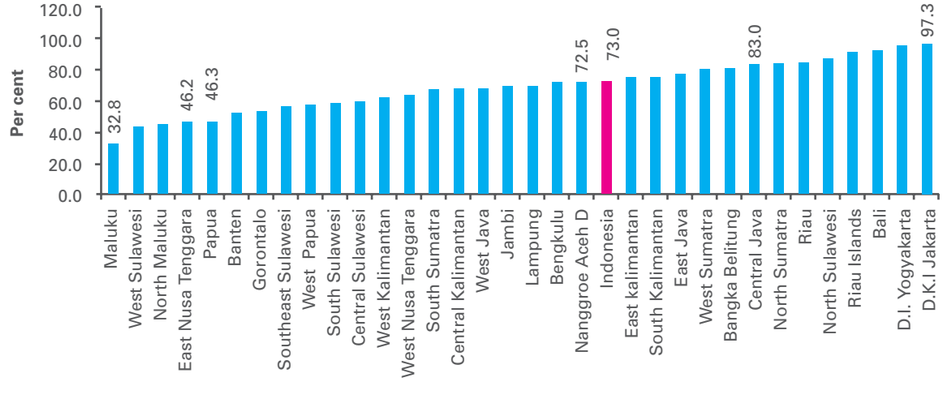
Unsurprisingly, there are some notable differences in the use and availability of these services. For instance, at a national level 46 per cent of births take place at a health facility. At the province level, this ranges from 91 per cent in Bali to just 8 per cent in Southeast Sulawesi, according to 2007 *IDHS* data. A clear pattern of inter-provincial disparities emerges from the data with only four of Indonesia's 33 provinces achieving the government target of providing 90 per cent of births with skilled assistance.

Figure 3.1.20: Percentage of assisted births, Indonesia 2002-2007



Source: IDHS 2002-2003 and 2007

Figure 3.1.21: Percentage of births assisted by skilled providers (most qualified persons), Indonesia 2007



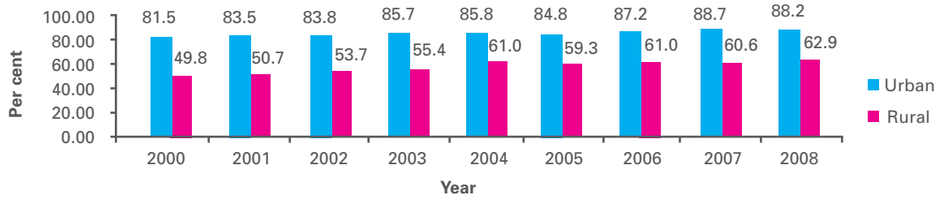
Source: IDHS 2007

28 BPS - Statistics Indonesia and Macro International, *Indonesia Demographic and Health Surveys (IDHS)* 1991, 2002-2003 and 2007

On the whole, the more rural provinces and particularly those in eastern Indonesia are the least likely to use the assistance of skilled health personnel at childbirth. Furthermore, many of the same provinces with high infant mortality rates are those that have the lowest proportions of births assisted by skilled health personnel. As would be expected, data on assisted birth/delivery confirms the existence of rural/urban disparities, but more detailed data from the *National Socio-Economic Surveys (SUSENAS 2000-2009, BPS - Statistics Indonesia) and from the Ministry of Health (2007 Riskesdas, Basic Health Research)* provide some further insights. Data from the National Socio-Economic Survey (Figure 3.1.22) indicate that the rural/urban gap decreased between 2000 and 2004 (from a gap of 31.7 per cent in 2000 improving to an all-time best of 24.8 per cent in 2004), but has remained consistent since then at approximately 25 per cent.

Furthermore, in a study in the Serang and Pandeglang districts in Banten province on Java, as cited in National Development Planning Board *(BAPPENAS)* and Ministry of Health's *The Landscape Analysis*, Makowiecka et al. (2009) found a higher density of midwives working in urban areas as compared to remote areas, and also found that those assigned to remote areas were less experienced and managed fewer births, compromising their capacity to maintain professional skills.[29] Furthermore, 2007 *IDHS* data indicates that in those provinces where there are lower rates of skilled birth attendance, there is a preference for the use of traditional birth attendants *(dukun bayi)*. For example, traditional birth attendants were commonly used in Maluku (67.5 per cent), West Sulawesi (63.2 per cent), Southeast Sulawesi (67.3 per cent), Gorantalo (69.6 per cent), Banten (52.1 per cent) and Bengkulu (50.6 per cent), amongst others. These results indicate issues of preference for traditional birth methods, as well as problems of coverage of skilled birth attendants.

Figure 3.1.22: Percentage of women with children under age five who used trained health personnel during their most recent delivery by area, Indonesia 2000-2008



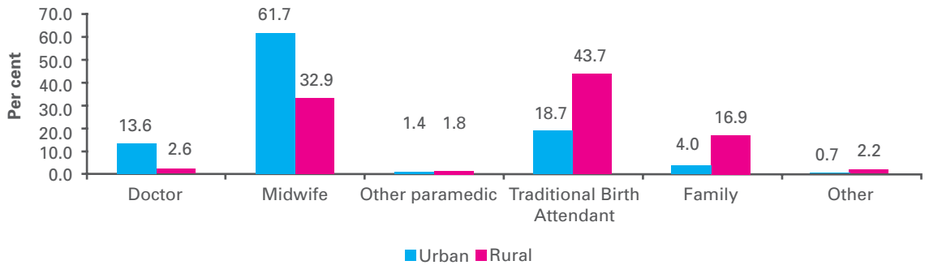
Source: BPS - Statistics Indonesia, Welfare Statistics based on National Socio-Economic Surveys 2000-2008

Figure 3.1.23 from 2007 *Riskesdas* data sheds further light on the nature of the delivery assistance which rural and urban women use.[30] Very few rural women give birth with the assistance of qualified health professional. Only 2.6 per cent of rural women give birth with the assistance of a doctor, and while a significantly larger proportion of rural women give birth assisted by a midwife (32.9 per cent) this figure is still only about half that of urban women (61.7 per cent). It is also in rural areas that women are more likely to use traditional birth attendants and infant mortality rates are higher, particularly amongst poorer groups.

29 BAPPENAS (National Development Planning Board)/Indonesian Ministry of Health (2010) *The landscape analysis: Indonesian country assessment*, BAPPENAS: Jakarta, p61

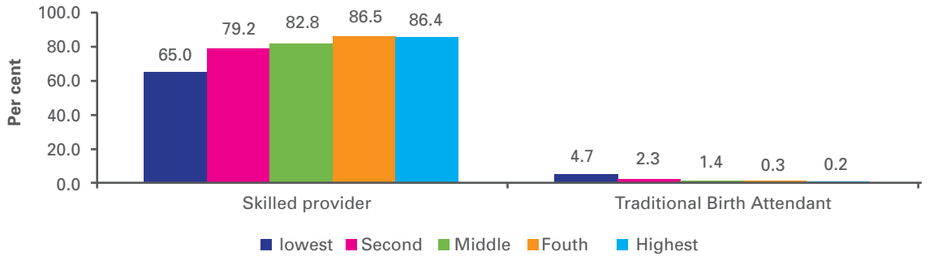
30 Ministry of Health (2008) *Laporan Nasional, Riset Kesehatan Dasar (Riskesdas) 2007*, National Institute of Health Research and Development: Jakarta

Figure 3.1.23: Percentage of mothers with assisted childbirths, most recent birth by area and type of assistance, Indonesia 2007



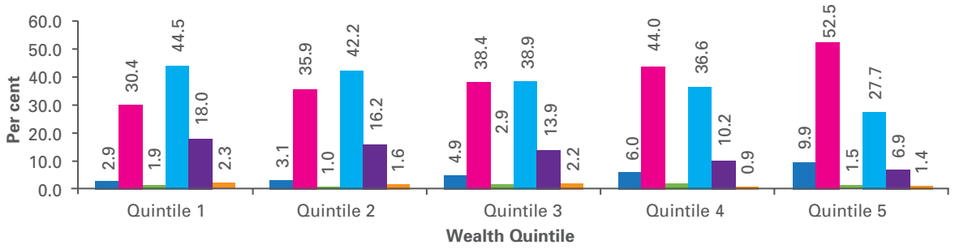
Source: Ministry of Health, Riskesdas 2007

Figure 3.1.24: Percentage of births assisted by skilled providers, by wealth quintile, Indonesia 2007



Source: IDHS 2007

Figure 3.1.25: Percentage of mothers with assisted childbirths, most recent birth by wealth quintile, Indonesia 2007



Source: Riskesdas 2007

Figures 3.1.24 and 3.1.25 provide some information relating to assisted delivery. Figure 3.1.24, showing *IDHS* data, indicates relatively high proportions of deliveries assisted by skilled health personnel across the wealth quintiles in Indonesia. However, while the rates range from 79.2 per cent to 86.4 per cent across the four wealthiest quintiles, the least wealthy quintile lags far behind, at only 65 per cent of the women's most recent deliveries. The more detailed data from the *2007 Riskesdas* regarding the nature of the assistance provided during delivery shows a distinct set of disparities across the social strata (Figure 3.1.25). Birth assistance provided by doctors remains low throughout Indonesian society, ranging from 2.9 per cent amongst the poorest and just under 10 per cent amongst the wealthiest. Midwives are clearly an important source of skilled support, being the main source of assistance for the two highest quintiles of society. In contrast, traditional birth attendants remain the main source of support for the three poorest quintiles, and in the provinces with the lowest rates of skilled birth attendance. Additional data based on the *2005 Intercensal Survey (SUPAS)* underline wealth-based inequalities, including the estimate that 83 per cent of women in the highest wealth quintile give birth at a health facility whilst only 14 per cent of women in the lowest quintile do so.

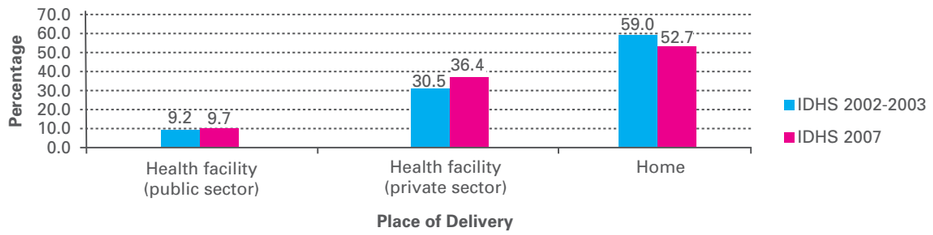
To measure the achievement towards MDGs, health experts have argued that the proportion of births attended by skilled health attendants is not as closely associated with maternal death as much as the capacity to manage the direct causes of maternal death. Interventions addressing maternal death should be implemented both through providing skilled assistance and creating an 'enabling environment' for managing cases of post-partum haemorrhage, severe infections, eclampsia, prolonged labour and also abortion complications, as well as known cases of obstetric emergencies or complications.[31] Furthermore, WHO (2006) demonstrates that maternal mortality remains high in countries where a large proportion of health professionals are not able to manage obstetric emergencies (either due to lack of training or lack of an 'enabling environment') and where referral systems do not facilitate timely life-saving interventions.[32] Other research indicates that assisted births in hospitals and other health-care institutions are likely to reduce maternal and infant mortality associated with complicated deliveries.

Such findings seem relevant for explaining, at least in part, the only marginal decreases in infant and maternal mortality rates. Facility-based delivery is incredibly important for decreasing deaths from complicated births, but there has been little change in use of health facilities for delivery during the same time period when decline in infant and maternal mortality rates have been stagnating in Indonesia. Figures 3.1.26, 3.1.27 and 3.1.28 demonstrate that the number of births in public health-care facilities has changed little between 2002-2003 and 2007, but births in private health facilities have increased and births in the home have decreased slightly. While many of the figures mentioned earlier indicated an aggregate increase in the uptake of assisted births by skilled professionals in recent years, this has not been accompanied by significant reductions in infant and maternal mortality rates. At the same time, there has not been a similar uptake of using public health-care facilities for assisted births. Therefore, the marginal change in mortality rates over time may also be related to the underutilization of health-care facilities for delivery. Furthermore, the number of births at home in rural areas has only decreased marginally compared to urban areas, with very little difference in the use of public health facilities for assisted births in both urban and rural populations - in rural areas in particular mortality rates remain high. Urban populations tend to be less likely in 2007 to give birth at home, tending to be using private health facilities. The breakdown of the *2007 Riskesdas* data demonstrates that as wealth increases, so too does the likelihood of using private health providers instead of giving birth in the home, but that there is very little difference by wealth quintile on the use of public facilities, with the poorest quintiles being least likely to use public or private health facilities (see Figure 3.1.28).

31 Bailey, P., Paxton, A., Lobis, S. and Fry, D. (2006) 'Measuring progress towards the MDG for maternal health: Including a measure of the health system's capacity to treat obstetric complications', *International Journal of Gynaecology and Obstetrics*, Vol.93: 292-299

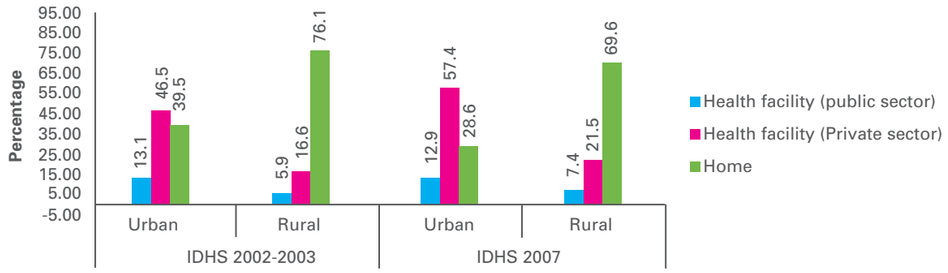
32 WHO (2006) *Making a difference in countries*

Figure 3.1.26: Percentage births by place of delivery, Indonesia 2002-2007



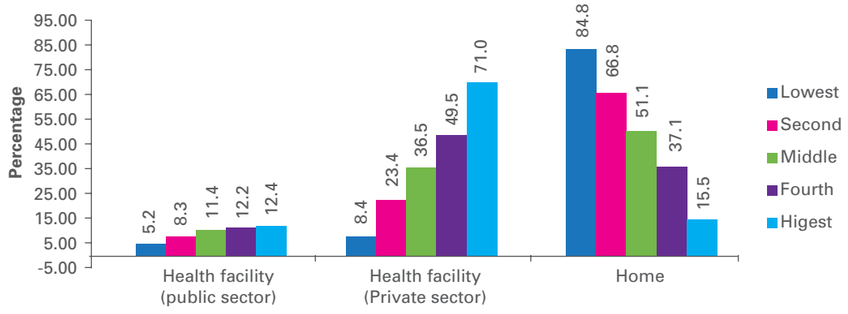
Source: IDHS 2002-2003 and 2007

Figure 3.1.27: Percentage births by place of delivery and by area, Indonesia 2002-2007



Source: IDHS 2002-2003 and 2007

Figure 3.1.28: Percentage of births by place of delivery and by wealth quintile, Indonesia 2007



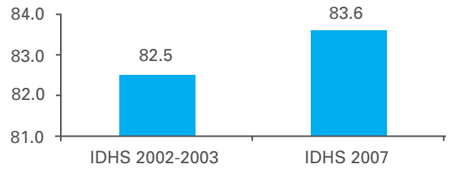
Source: IDHS 2007

Overall, it is clear that public services for assisted births by skilled personnel for the rural poor are either not accessible or are underutilized. This may have some bearing on higher IMR and MMR for these populations. These results also indicate that improving the enabling environment and improving access to and the use of public health-care facilities for assisted births may be key to reducing mortality rates and to achieving the GoI goal in the 'Making Pregnancy Safer' strategy that every obstetric and neonatal complication should be managed adequately.

3.1.3.3 Postnatal care

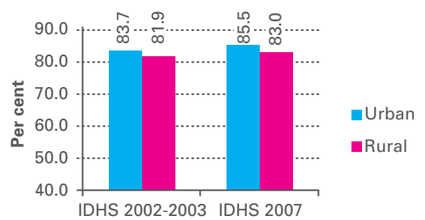
Postnatal care (PNC) is important for the welfare of both mother and child. It provides an opportunity to treat complications arising from the delivery, and provides the mother with important information on how to care for herself and her infant. The postnatal period is defined as the time between delivery of the placenta and 42 days (six weeks) following delivery. The timing of postnatal care is important because the first two days after delivery are critical; most maternal and neonatal deaths occur during this period. The following figures on PNC demonstrate that there has only been a very slight increase over time. Marked provincial disparities also exist. While the majority of provinces have rates of PNC exceeding 60 per cent, there is almost universal coverage in Yogyakarta for example, but only 34 per cent of women in Papua receive PNC (Figure 3.1.31). Disparities also exist among in terms of wealth, whereby approximately 90 per cent of pregnant women in the highest three wealth quintiles receive PNC, but poorer women lag far behind. While inter-provincial and wealth disparities exist, disparities are less pronounced between urban and rural areas with similar levels of care.

Figure 3.1.29: Percentage of post-partum women with postnatal care, Indonesia 2002-2007



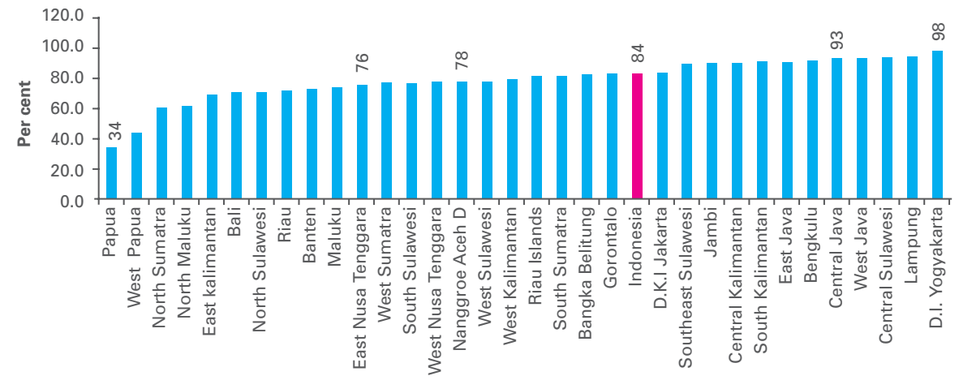
Source: IDHS 2002-2003 and 2007

Figure 3.1.30: Percentage of post-partum women with postnatal care by area, Indonesia 2002-2007



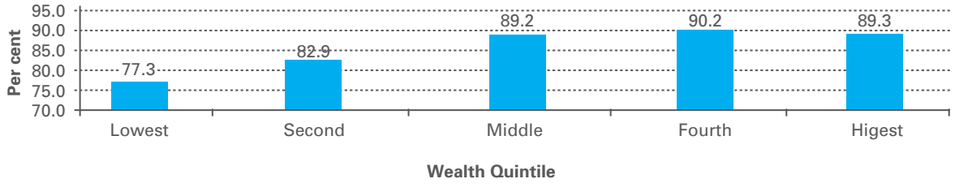
Source: IDHS 2002-2003 and 2007

Figure 3.1.31: Percentage of post-partum women with postnatal care by province, Indonesia 2007



Source: IDHS 2007

Figure 3.1.32: Percentage of post-partum women with postnatal care by wealth quintile, Indonesia 2007



Source: IDHS 2007

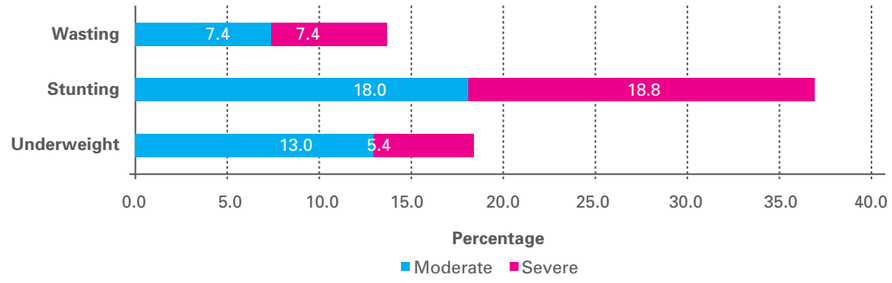
3.1.4 MALNUTRITION

Nutrition status is a key outcome and indicator of the state of child welfare. As was illustrated by the conceptual framework on the determinants of child mortality and nutritional status earlier in this section (Figure 3.1.1), for children to grow adequately, or for adults to have an adequate nutritional status, several conditions must be met. Their dietary intake and their health status - which act in synergy - are the immediate determinants of their nutritional status. Dietary intake in turn, will be affected by the food available and accessible to the household (or its food security), while health status will depend on the access to health services as well as to safe water and appropriate sanitation. Food security, access to care, as well as health status result themselves from determinants operating at the underlying level of their family and community as well as at the more fundamental levels of society. They relate to the availability and control of human, economic and organisational resources in the society, themselves the results of previous and current technical and social conditions of production, together with political, economic and ideological-cultural factors. Malnutrition is often seen amongst the poorest segments of the population.[33]

Malnutrition is a generic terms that refers to undernutrition and overnutrition. In this report, only undernutrition will be covered. Undernutrition means being underweight for one's age, too stunted or short for one's age, and wasted or thin for one's height. Undernutrition also refers to being deficient in vitamins and minerals (micronutrient malnutrition).[34] Undernutrition is associated with 60 per cent of deaths among children under five years of age.[35] The impacts of undernutrition are enormous. Malnutrition erodes human capital by impairment of cognitive and physical development. It leads to lower productivity and wage return in adulthood. It also affects the chances of a child going to and staying in school, and learning well. Malnutrition is associated with maternal health and mortality and it increases the risks associated with HIV and tuberculosis, compromises treatment, and hastens the onset of AIDS.[36]

Unequivocally, undernutrition remains a key issue in Indonesia. Indonesia currently ranks fifth in the world in terms of number of stunted children. Although over the last decades, the number of underweight children has been reduced, 18 per cent of Indonesian children remain affected based on 2007 data (Figure 3.1.33). Data on the prevalence of stunting (36.8 per cent) and wasting (13.6 per cent) among Indonesian children 0-59 months (under-fives) indicate high public health problems as per WHO definitions and cut-offs (stunting >40 per cent, wasting >10 per cent).[37] Child stunting is widely accepted as one of the best predictors of the quality of human capital, influencing potential academic performance and future earning capability of a nation.[38] Related data from the Riskesdas 2007 are shown in Figures 3.1.33 through 3.1.41. Once again, aggregate national indicators are complemented by disparity indicators wherever the data are available.

Figure 3.1.33: Percentage of children under five suffering from wasting, stunting and underweight, Indonesia 2007



Source: Riskesdas 2007

Riskesdas 2007 data (Figure 3.1.34) shows that the prevalence of undernutrition is higher in rural areas. It is likely that access to food, appropriate care and to a healthy environment and health services is less than in urban area thus, impacting on child nutritional status. Poverty likely constitutes one of the major basic causes of undernutrition, with the poorest quintiles being the most likely to suffer from stunting, wasting, and to be underweight (Figure 3.1.36 - 3.1.38). Although, further research needs to be undertaken into why there is less difference between wealth quintiles in regards to wasting when compared with stunting and children being classified as underweight. In Indonesia, such problems are also compounded by, inadequate care, gender inequality, poor health services, and environmental degradation.[39] The prevalence of undernutrition is also higher amongst boys (Figure 3.1.35). Data from regional assessment[40] as well as some international studies (Caputo et al. 2003[41]; and Svedberg et al. 1996[42]) have shown a similar pattern. Because girls represent an asset for the future of household farming activities, they might have been prioritised in terms of care practices and, in particular, in regards to feeding practices.

33 Gwatkin, D. R., Rutstein S., Johnson K., Suliman, E., Wagstaff, A., Amouzou, A. (2007) *Socio-economic differences in health, nutrition and population within developing countries*, World Bank/Government of the Netherlands/ Swedish International Development Cooperation Agency

34 UNICEF (2006) *Undernutrition*, available at: http://www.unicef.org/progressforchildren/2006n4/undernutritiondefinition.html (Last accessed 22 February 2011)

35 Pelletier D. L., Frongillo E. A. Jr., Habicht J-P. (1993) 'Epidemiologic evidence for a potentiating effect of malnutrition on child mortality', *American Journal of Public Health*, Vol.83: 1130-1133

36 World Bank (2006) *Repositioning nutrition as central to development: A strategy for large-scale action*, World Bank: Washington, D.C.

37 WHO (1995) *Physical status: The use and interpretation of anthropometry*, Technical report series, Report of the WHO Expert Committee No. 854: Geneva, Switzerland, available at: http://www.who.int/childgrowth/publications/physical_status/en/index.html (Last accessed 17 June 2010)

38 Victora, C. G., Adair, L., Fall, C., Hallal, P. C., Martorell, M., Richter, L., Sachdev, H. S., for the Maternal and Child Undernutrition Study Group (2008) 'Maternal and child undernutrition: Consequences for adult health and human capital', *The Lancet*, Vol.37: 340-357

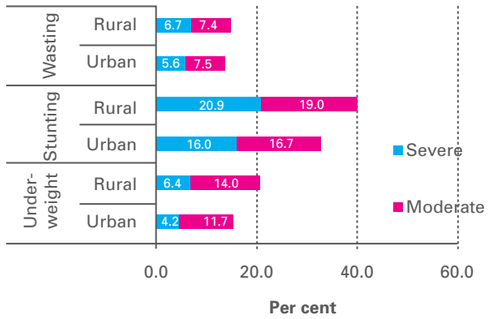
39 Setboonsarng, S. (2005) 'Child malnutrition as a poverty indicator: An evaluation in the context of different development interventions in Indonesia', *Asian Development Bank Institute Discussion Paper No. 21*, available at: http://www.adbi.org/discussion-paper/2005/01/14/869.malnutrition.poverty.indonesia/data.sources.on.child.malnutrition.in.indonesia/ (Last accessed 6 October 2010)

40 Government of Indonesia/WFP/UNICEF/FAO (2010) *Nutrition security and food security in seven districts in NTT province, Indonesia: Status, causes and recommendations for response*, Government of Indonesia: Jakarta

41 Caputo, A., Foraita, R., Klasen, S., Pigeot, I., (2003) 'Undernutrition in Benin - An analysis based on graphical models', *Social Science and Medicine* Vol.56(8): 1677

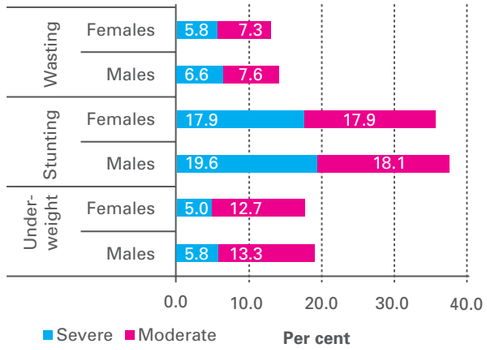
42 Svedberg, P. (1996) 'Gender bias in Sub-Saharan Africa: Reply and further evidence', *Journal of Development Studies*, Vol.32: 933

Figure 3.1.34: Percentage of children under five suffering from wasting, stunting and underweight by area, Indonesia 2007



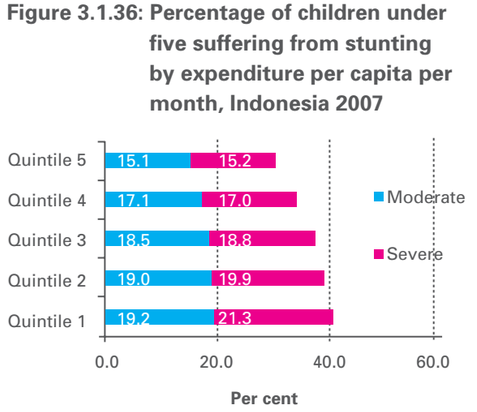
Source: Riskesdas 2007

Figure 3.1.35: Percentage of children under five suffering from stunting, wasting and underweight by sex, Indonesia 2007



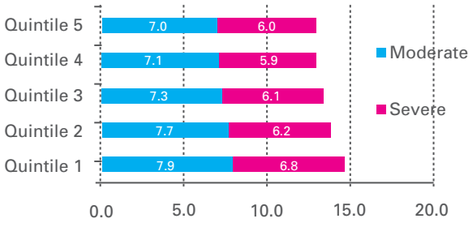
Source: Riskesdas 2007

Figure 3.1.36: Percentage of children under five suffering from stunting by expenditure per capita per month, Indonesia 2007



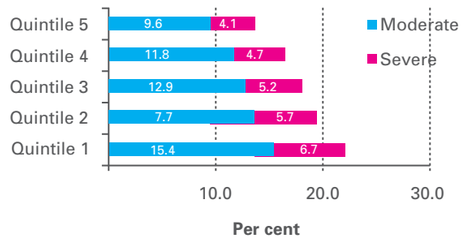
Source: Riskesdas 2007

Figure 3.1.37: Percentage of children under five suffering from wasting by expenditure per capita per month, Indonesia 2007



Source: Riskesdas 2007

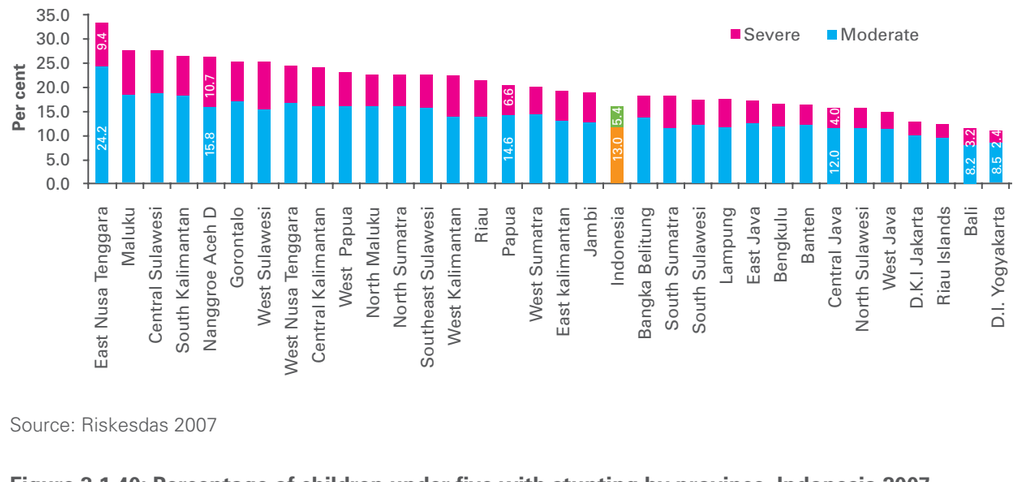
Figure 3.1.38: Percentage of children under five suffering from being underweight by expenditure per capita per month, Indonesia 2007



Source: Riskesdas 2007

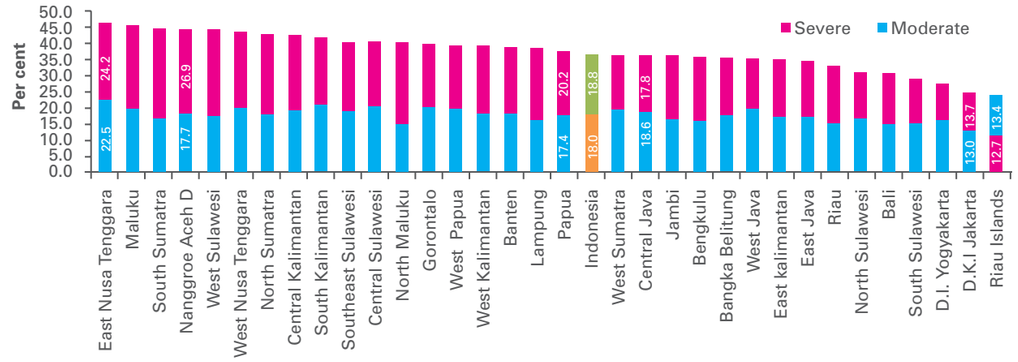
As shown in Figures 3.1.39, 3.1.40 and 3.1.41, East Nusa Tenggara, Central Sulawesi, Maluku, South Kalimantan, Aceh, and Gorontalo are the provinces where the rates of underweight and stunted children are highest, and well above the national average. Wasting is high in East Nusa Tenggara, Riau, Jambi, and Aceh. The link between the poverty levels of each province and the prevalence of undernutrition needs to be highlighted. Aceh, for instance, despite a wealth of natural resources, has high levels of poverty and undernutrition, as well as a lower human development index (HDI).

Figure 3.1.39: Percentage of children under five who are underweight by province, Indonesia 2007



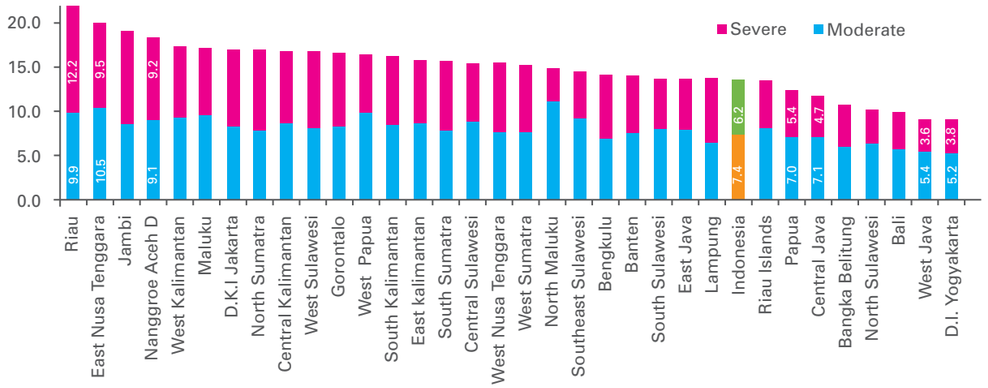
Source: Riskesdas 2007

Figure 3.1.40: Percentage of children under five with stunting by province, Indonesia 2007



Source: Riskesdas 2007

Figure 3.1.41: Percentage of children under five with wasting by province, Indonesia 2007



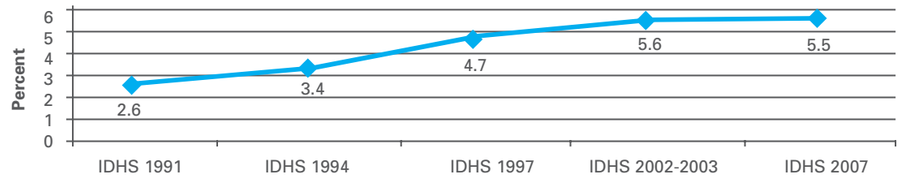
Source: Riskesdas 2007

Maternal nutrition is also of concern. Riskesdas 2007 data indicate that 14 per cent of women have chronic energy deficiency (mid-upper arm circumference <23.5 cm). According to WHO[43], a prevalence rate between 10-19 per cent is considered to be medium prevalence, indicating a poor nutrition situation. *Riskesdas 2007* data shows that in general urban areas 20 per cent of women of reproductive are anaemic, and 25 per cent are anaemic in pregnancy. Maternal undernutrition increases the risk of low birthweight (see next subsection). Low birthweight is associated with a higher risk of mortality and childhood undernutrition and, in particular with stunting. Given the situation, reducing undernutrition is a top priority for the Government of Indonesia, as emphasised in the 2010-2014 RPJMN.[44]

3.1.5 LOW BIRTHWEIGHT

A low birthweight is strongly associated with increased risk of death for children. Research at the global level indicates that infants born at term weighing 1,500-1,999 grams are eight times more likely to die during the neonatal period.[45] Children weighing between 2,000 and 2,499 grams are three times more likely to die from all causes during the neonatal period compared to those weighing at least 2,500 grams at birth.[46] It is important to stress that a low birthweight alone is rarely a direct cause of death, but rather an indirect cause of neonatal deaths, particularly in cases of death from asphyxia and infection (sepsis, pneumonia and diarrhoea), which together account for about 60-80 per cent of neonatal deaths.[47] Children with low birthweight are also more likely to be stunted in early childhood.[48] The *IDHS* data presented in Figure 3.1.42 indicate that the incidence of low birthweight in Indonesia is 5.5 per cent, and that the rate did not reduce significantly between 2002-2003 and 2007. The *2007 IDHS* did not provide birthweight data by province. *Riskesdas 2007* data on birthweight, however, indicated a higher incidence of low birthweight for the same year, placing it at 11.5 per cent.[49] Figure 3.1.43, based on *2007 Riskesdas* data, gives a clear picture of the disparity among provinces, indicating that the incidence of low birthweight at the provincial level ranges from 5.8 per cent in Bali to 27 per cent in Papua. Fifteen of the 33 Indonesian provinces perform worse than the national average of 11.5 per cent, with over 20 per cent of children born with low birthweight in three provinces (Papua, West Papua and East Nusa Tenggara).

Figure 3.1.42: Incidence of low birthweight (percentage), Indonesia 1992-2007

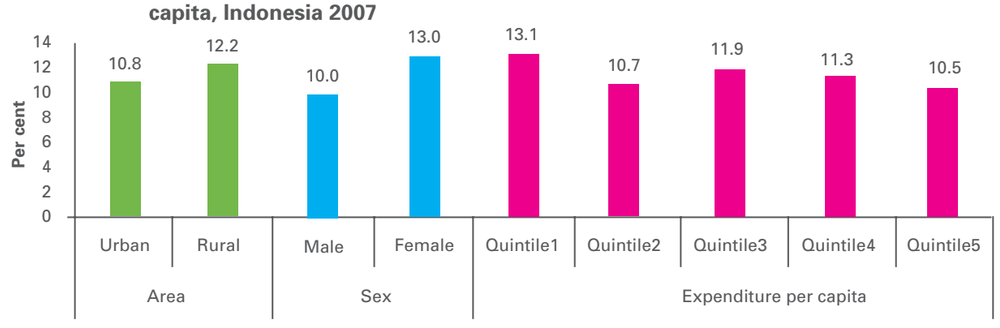


Source: IDHS 1991-1997, 2002-2003 and 2007
Note: In accordance with WHO recommendations, a low birthweight is defined as children born at term weighing <2,500 grams

Figure 3.1.43: Percentage of infants with low birthweight by province, Indonesia 2007

Source: Riskesdas 2007

Figure 3.1.44: Percentage of infants with low birthweight by area, sex, and expenditure per capita, Indonesia 2007



Source: Riskesdas 2007

43 WHO (1995) *Physical status: The use and interpretation of anthropometry*
44 Government of Indonesia (2010) *National medium-term development plan (RPJMN) 2010-2014*, Government of Indonesia: Jakarta
45 Black, R. E., Allen, L. H., Bhutta, Z. A, Caulfield, L. E., de Onis, M., Ezzati, M., Mathers, C. and Rivera, R. for the Maternal and Child Undernutrition Study Group (2008), 'Maternal and child undernutrition: Global and regional exposures and health consequences', *The Lancet*, Vol. 371:243-260
46 Ibid.
47 Thapar, N. and Sanderson, I. R. (2004) *Diarrhoea in children: an interface between developing and developed countries*, University of London: London
48 Victora, C. G., de Onis, M., Hallal, P. C., Blossner, M., Shrimpton, R. (2010) 'Worldwide time of growth faltering: Revisiting implications for intervention', *Pediatrics*, published online
49 Ministry of Health (2008) *Laporan Nasional, Riset Kesehatan Dasar (Riskesdas) 2007*

Data from the 2007 Riskesdas underline some of the general patterns of undernutrition in Indonesia (Figure 3.1.44). The incidence of low birthweight is more prominent in rural areas, affects female infants more often than male infants, and, as would be expected, is more concentrated amongst the poorest quintile of the population.

3.1.6 DETERMINANTS OF CHILD NUTRITIONAL STATUS AND MORTALITY

It is well known that the most effective interventions for reducing mortality in children under five is exclusive breastfeeding up to six months, and timely appropriate complementary feeding from six months onwards, with continued breastfeeding up to two years of age. As such, if all children (90 per cent) were exclusively breastfed for the first six months of life and if they (99 per cent of them) received appropriate complementary feeding from six months onwards, with continued breastfeeding until two years of age, almost 20 per cent of deaths among children under five could be prevented[50]. Similarly, if 99 per cent of children up to 36 months of age were receiving appropriate feeding, stunting could be reduced by at least 15 per cent[51]. The results of the Lancet series have also shown that micronutrient interventions for children and pregnant women can reduce the rates of mortality and stunting by an additional 12 per cent among children up to 36 months of age.[52] Moreover, a balanced energy protein supplementation provided to pregnant women can reduce child death and stunting by around 3.6 per cent and 1.9 per cent, respectively, among children up to 12 months of age.[53] The association between failure to breastfeed and malnutrition have been acknowledged by the GoI since 2003, after researchers reported that the deaths annually of 30,000 children under five years old could be averted through exclusive breastfeeding during the first six months of a child's life.[54]

In the next sections, available data on the aforementioned effective interventions will be presented to help explain disparities and how to tackle them. Moreover, a summary of the findings of *The landscape analysis: Indonesian country assessment*[55], which aimed to better explain the challenges and opportunities for the implementation of effective nutrition interventions to accelerate the reduction of maternal and child undernutrition, will be presented.

3.1.6.1 Feeding practices (breastfeeding, complementary feeding and maternal nutrition)

In 2003, the GoI changed the recommended duration of exclusive breastfeeding from four to six months.[56] The *2007 IDHS* data indicates that only 32.4 per cent of Indonesian children under six months of age are exclusively breastfed (Figure 3.1.42). This represents a net decrease from 40 per cent in 2002, and is likely due to the sharp increase of bottle-feeding practices from

50 The relationship between child mortality and breastfeeding in a number of countries was first published in the early 2000s (see: Jones, G., Steketee, R. W., Black, R. E., Bhutta, Z. A., Morris, S. S., and the Bellagio Child Survival Study Group (2003) 'How many child deaths can we prevent this year?', Child Survival Series, *The Lancet*, Vol.362: 65)

51 Bhutta, Z. A. Ahmed, T., Black, R. E., Cousens, S., Dewey, K., Giugliani, E., Haider, B. A., Kirkwood, B., Morris, S. S., Sachdev, H. P. and Shekar, M.; Maternal and Child Undernutrition Study Group (2008) 'What works: Interventions for maternal and child undernutrition and survival', Maternal and child undernutrition series, *The Lancet*, Vol.371: 417

52 Ibid.

53 Ibid.

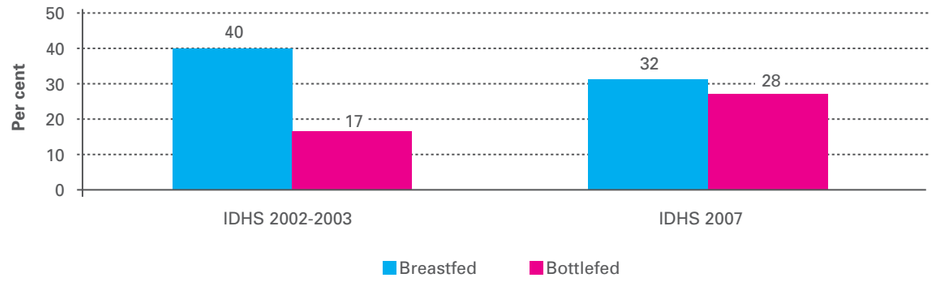
54 The prevention of 30,000 deaths a year based on the Jones et al. (2003) study published in The Lancet has become a focal point of several campaigns seeking to encourage breastfeeding in Indonesia, see: UNICEF (8 March 2006) *Breastfeeding saves lives of 30,000 Indonesian children yearly*, available at: http://www.unicef.org/indonesia/Breastfeeding_release_English__(1).pdf (Last accessed 22 February 2011)

55 BAPPENAS/Ministry of Health (2010) *The landscape analysis: Indonesian country assessment*, BAPPENAS: Jakarta, Indonesia

56 Ministry of Health (2002) *Balanced nutrition for under five healthy living children*, Ministry of Health Republic of Indonesia: Jakarta

17 per cent to 28 per cent among children under six months of age during the same period (Figure 3.1.45). The 2002-2003 and 2007 *IDHS* data indicate that median duration of exclusive breastfeeding dropped from 3.2 months in 2002 to 2.7 in 2007. The median duration of any breastfeeding in Indonesia has been steadily decreasing, from about 23.9 months in 1997 to around 22 months in 2002-2003 to about 20.7 months in 2007, according to *IDHS* data.

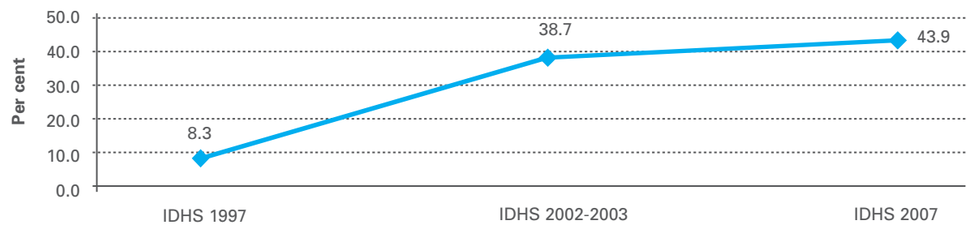
Figure 3.1.45: Percentage of children under six months by exclusive breastfeeding or bottle-feeding, Indonesia 2002-2007



Source: IDHS 2002-2003 and 2007

It is likely that optimal support is not provided to the mother at delivery to start breastfeeding. In Indonesia, only approximately 44 per cent of children are breastfed within an hour of birth (Figure 3.1.46). This represents a net improvement over the last decade. Although early initiation of breastfeeding was higher in rural areas, the median duration of exclusive breastfeeding is similar in rural and urban settings, according to *2007 IDHS* data. The data per province also indicate that early initiation of breastfeeding was the lowest in North and West Sumatera, Jambi, Jakarta, Southeast Sulawesi, Gorontalo and Maluku. However, the rates in East and West Nusa Tenggara (NTT and NTB) provinces were amongst the highest. On the surface, it seems that there is an encouraging trend towards an increase in the number of children who start to breastfeed early (Figure 3.1.46). However these positive figures are somewhat isolated and the general trend seems to be towards declining rates and durations of exclusive breastfeeding.

Figure 3.1.46: Percentage of children who started breastfeeding within one hour of birth over time, Indonesia 1997-2007



Source: IDHS 1997, 2002-2003 and 2007

Complementary food should be given from the age of six months, and breastfeeding should continue well into the second year of life.[57] In 2007, only 41.2 per cent of children aged 6-23

57 WHO (2005) *Guiding principles on feeding nonbreastfed children 6 to 24 months of age*, WHO: Geneva

months were receiving appropriate feeding. Appropriate complementary feeding practices among children aged 6-23 months appear to be lower in rural than in urban areas, according to *IDHS 2007* data. *IDHS* data on infant and young child feeding from ages 6-23 months indicate poor practices, particularly in Aceh, Riau and Riau islands, Lampung, Banten, North, South and Southeast Sulawesi, Gorontalo, North Maluku, and Papua and West Papua provinces.

Overall, *2007 IDHS* data indicate that children born to mothers with secondary or higher education, children of mothers who were assisted by a health professional during delivery and born in a health facility, and children from more prosperous families are those more likely to receive a pre-lacteal feeding. However, the poor level of exclusive early breastfeeding and the general declining trend in breastfeeding are key sources of concern in Indonesia and play a significant part in Indonesia's ongoing child malnutrition problems. It is also interesting to note from the *2007 IDHS* data, that despite girls being born with lower birthweights, they are marginally more likely to have any breastfeeding and to be exclusively breastfed.

Very little data are available on general maternal nutrition. Data from the *2007 IDHS* indicate that about 75 per cent of women with a child under three years old ate meat or fish within the past 24 hours; consumption of iron-rich foods is similar.

3.1.7 POLICY, PROGRAMMES AND SERVICES

3.1.7.1 Micronutrient interventions

Vitamin A is important for a well-functioning immune system. In Indonesia, 68 per cent of children aged 6-59 months were fully protected against vitamin A deficiency according to *2007 IDHS* data; a decline from 75.1 per cent in 2002. The latest data from the *2007 Riskesdas* also show that children in rural areas and in the poorest quintiles are the least likely to receive vitamin A supplementation and are most likely to develop vitamin A deficiency. Coverage of vitamin A supplementation is below 60 per cent in the provinces of North Sumatera, Riau, Maluku/North Maluku, Papua/West Papua for children aged 6-59 months.

Iodine deficiency can be easily prevented by ensuring that households consume adequately iodized salt. Although there has been a steady trend of improvement since 2003 (increasing from 44 per cent up to 53 per cent in 2005 and to 71 per cent in 2007), yet in 2008 data highlighted that only 63 per cent of households were using adequately iodized salt.[58] Data from 2008 also show that the consumption of adequately iodized salt is higher in urban areas and in the highest wealth quintile of the population.[59]

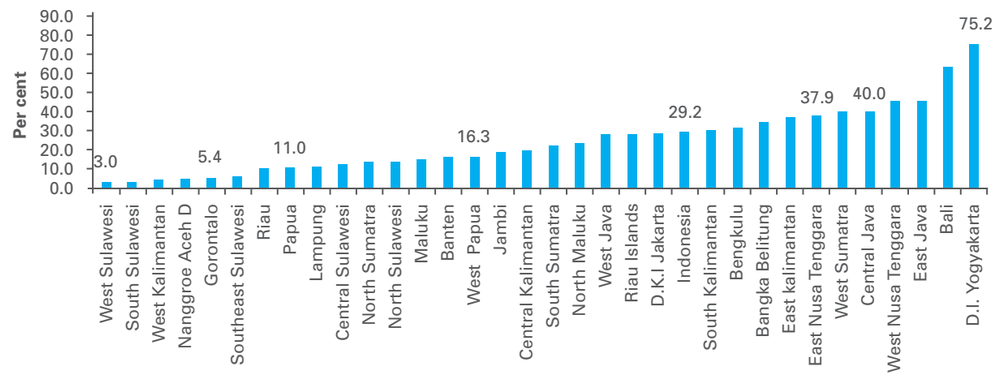
According to WHO, anaemia is a "widespread public health problem with major consequences for human health," and approximately 50 per cent of all anaemia can be attributed to iron deficiency.[60] Severe anaemia is known to increase the risk of maternal and child mortality, as well as contribute to other negative consequences in terms of cognitive and physical development. Both UNICEF and WHO have promoted interventions based on the provision of iron supplements

58 UNICEF-funded Universal Salt Iodization, USI assessment (iodized salt coverage, iodine status and levels of salt iodization) as part of the *Riskesdas (Basic Health Research)* survey conducted by the Ministry of Health in 2007-2008. The results presented in this document exclude data from 6 provinces, and are used for the assessment purposes only.
59 Ibid. *Riskesdas 2007*
60 WHO-UNICEF Joint Statement (2004) *Focusing on anaemia, towards an integrated approach for effective anaemia control*

to vulnerable populations (such as pregnant woman) as an approach to tackle the problem of iron deficiency anaemia (IDA).[61] The policy of the Ministry of Health in Indonesia is to promote the consumption of a minimum of 90 tablets of iron folate by women during pregnancy.[62] Ensuring that iron supplements are made accessible to pregnant women and are consumed by pregnant women is therefore essential to tackle IDA and address a major factor contributing to IMR, MMR and U5MR. However, comparisons of *IDHS* data from 2002-2003 and 2007 show that only approximately one third of women are likely to comply with the 90 tablets of iron folate guidelines, and that this has not changed over time.

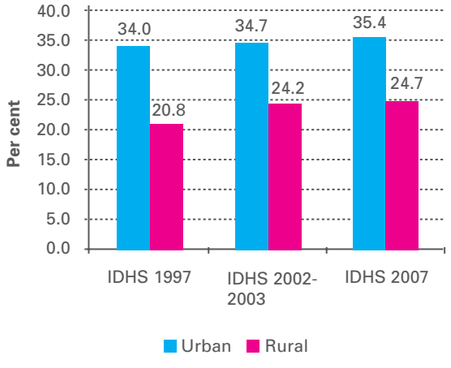
Figure 3.1.47 shows wide disparities in the percentage of women who receive at least 90 tablets of iron folate by province. The difference between the best- and worst-performing province (Yogyakarta and West Sulawesi, respectively) is more than 72 per cent. In addition, a majority of provinces (22 out of 33) perform below than the national average.

Figure 3.1.47: Percentage of pregnant women who receive iron tablets (≥90 tablets) by province, Indonesia 2007



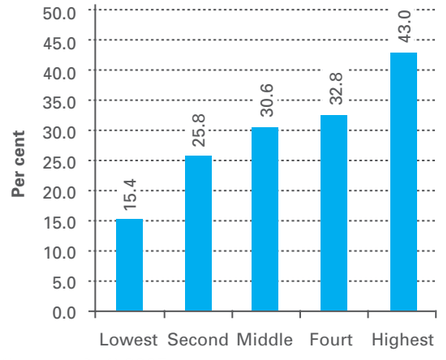
Source: IDHS 2007

Figure 3.1.48: Percentage of pregnant women who receive iron tablets (≥90 tablets) by area, Indonesia 1997-2007



Source: IDHS 1997, 2002-2003 and 2007

Figure 3.1.49: Percentage of pregnant women who receive iron tablets (≥90 tablets) by wealth quintile, Indonesia 2007



Source: IDHS 2007

61 Ibid.
62 Ministry of Health (2001) *Yang perlu diketahui petugas kesehatan tentang kesehatan reproduksi*, Ministry of Health: Jakarta

Figures 3.1.48 and 3.1.49 show rural/urban and wealth disparities in the percentage of women who receive at least 90 iron folate tablets. Urban areas are once again better served than rural areas, but the rates have stagnated in both places. Pregnant women in the poorest quintile of the population are least likely to receive adequate iron supplementation, whereas those in the highest quintile (and presumably best placed to access supplements privately) do in fact receive the best coverage.

3.1.7.2 Child illnesses

As stated previously, child illness is one of the immediate determinants of nutritional status. In Indonesia, diarrhoea and acute respiratory infection (ARI) are the main causes of death for infants and children under five years of age.[63] Prevalence of these illnesses is also high. It is estimated that 11 per cent and 31 per cent of children had ARI and a fever, respectively, in the two weeks preceding the 2007 IDHS, while 13.7 per cent of children had diarrhoea. Yet, only 66 per cent had received treatment or advice from a health facility or provider for ARI, according to *2007 IDHS* data. Moreover, only approximately 61 per cent received some form of oral rehydration in the presence of diarrhoea. For rates of ARI, the differences between urban and rural settings was minor, however, the lower the education of the mother, the higher the likelihood of ARI among her children, according to IDHS data. Again, the 2007 IDHS data demonstrate that for diarrhoea there was a difference in the prevalence between urban and rural areas (12.0 per cent in urban areas versus 14.9 per cent in rural areas), and again as education levels of the mother and household wealth increased, the prevalence of diarrhoea amongst children decreased. Immunization rates are also low - only 46.2 per cent of children aged 12-23 months have completed their basic childhood vaccinations, based on *Riskesdas 2007* data.

3.1.8 PROGRESS AND CHALLENGES RELATED TO THE REDUCTION OF MATERNAL AND CHILD MORTALITY AND UNDERNUTRITION

Aside from the programmes and policies discussed above on 'Making Pregnancy Safer' through assisted births, antenatal and postnatal care, there are a number of other issues and policy gaps that require further attention.

What is clear from the discussion on mortality above is that stagnation in reductions of maternal mortality and neonatal mortality may relate to the poor uptake of assisted births in public facilities, rather than home births, as this is one of the main indicators where little progress has been made over the last decade in Indonesia. Strategies which encourage mothers to give birth if possible in a health facility where there are trained health personnel may go some way to improving mortality rates.

With regard to the challenges for reducing maternal and child undernutrition, overall the findings of *The Landscape Analysis* (2010) are that although the commitment to act for improved nutrition is reasonably strong, the capacity to act still needs to be strengthened.[64] The existing strong commitment to act for nutrition is misdirected at trying to resolve acute nutrition problems rather than putting into place systems and interventions to prevent children and women becoming malnourished, largely because the latter is not generally recognised as a problem. Commitment to resolving the problem of stunting is growing at the national level, but at the provincial and district levels - where all the action is decided and implemented - the nutrition problem is still largely equated with severe undernutrition *(gizi buruk)* and/or lack of food.[65] Mechanisms for policy coordination, identification of priorities and setting of goals and targets are weak or non-existent at all levels. The capacity to act for nutrition needs to be strengthened if stunting reduction is to be achieved. Service provision largely revolves around child growth monitoring and is misdirected to the under-five age group rather than focused on children under two years, where nutrition interventions can have a greater effect. Less priority is given to preventive activities, such as counselling of mothers on infant and young child feeding, than to the curative functions of detecting and treating wasting.[66] Inter-sectoral coordination of implementation needs to be reinforced. Although a sufficient number of nutritionists are being trained, the curricula are outdated or incomplete, and the nutritionists are under employed in the system, and especially in service delivery.[67] Little or no in-service training in nutrition occurs.[68] The use of monitoring data for decision-making, or of evaluation data to learn from programme experience, is very uncommon.[69]

3.1.8.1 Minimum standards and the decentralisation of services

Since decentralisation was adopted in 1999, responsibility for delivery of public health services has been devolved to district level. However, Minimum Service Standards (SPM) have been issued under the Ministry of Home Affairs' Regulation on Technical Guidance on Formulating and Establishing Minimum Service Standards for Government Departments. The SPM aim to ensure that local governments provide basic services and ensure consistency among districts. The 2008 Ministry of Health Regulation on Obligatory Minimum Service Standards specified the following basic services and required local authorities to monitor whether the standards were being met:

- Coverage of ANC for pregnant women (at least four visits), including iron and folic acid supplementation: 95% by 2015
- Coverage of post-partum health services, including vitamin A supplementation: 90% by 2015
- Universal child immunization: 100% by 2010
- Coverage of infant health services, including vitamin A supplementation: 90% by 2010
- Coverage of child health services, including vitamin A supplementation and growth and development monitoring): 90% by 2010
- Coverage of supplementary feeding of 6-24 month old children from poor families: 100% by 2010
- Coverage of treatment of severely malnourished children: 100% by 2010

However, district and provincial level governments have most of the responsibility for implementing interventions, which may result in the uneven provision of services where there are institutional and capacity challenges.

For example, a key aspect of the decentralisation of maternal and child health services has been support for the *polindes* (village maternity posts), *posyandu* (the integrated health service posts) and *puskesmas* (sub-district level community health centre) institutions. The *posyandu*, which operates at the sub-village/hamlet level, is particularly important for current policy initiatives to improve maternal and child health and nutrition under the RPJMN 2010-2014[70], through

63 Ministry of Health (2008) *Laporan Nasional, Riset Kesehatan Dasar (Riskesdas) 2007*
64 BAPPENAS/Ministry of Health (2010) *The landscape analysis*
65 Ibid.
66 Ibid.
67 Ibid.
68 Ibid.
69 Ibid.
70 Government of Indonesia (2010) *RPJMN 2010-2014*

community empowerment in the health sector. Community-Based Health Efforts (CBHE), which aim to empower communities in the health sector, use the posyandu and village health posts (poskesdes) which focus on curative services.[71] These posts offer community-based services ranging from general health promotion, food supplement distribution, and antenatal care, to family planning as well as immunization, growth and development monitoring for under-fives, non-dysentery diarrhoeal disease management, and community health education. *Posyandu* services tend to be offered on a monthly basis, coordinated by health staff from the sub-district supervisory structure (based at the *puskesmas*), and in particular are aimed at monitoring the progress of children aged under five. According to the 2007 Riskesdas, 98.4 per cent of households are located within five kilometres of CBHE[72].

However, results from *The Landscape Analysis* (2010) indicate that uptake of services provided by posyandu is slow[73], which may relate to the implementation of decentralisation and the resulting uneven provision of health services. For example, one policy is that all children under five should be regularly weighed at the posyandu, preferably once per month[74], that the weight is plotted on the 'Road to Health' *(KMS, Kartu Menuju Sehat)* growth charts or in the chart in the mother and child health (KIA) book, and that mothers of faltering children should be counselled. In 2007, only 45.4 per cent of children under five were weighed at least 4 times in the six-month prior.[75] In some provinces such as East Nusa Tenggara and Yogyakarta the percentage was much higher (i.e., above 65 per cent), but in others such as North Sumatera and Jambi it was only 30 per cent or below.[76] In the past six months, 25.5 per cent of children under five had not been weighed at all.[77] *The Landscape Analysis* (2010) argues that, at best, a community-based growth monitoring approach is more curative than preventive.

Moreover, within the 'continuum of care' and under the CBHE, some interventions can be delivered at home or in the community, such as the management of pneumonia which remains one of the leading killers of children under five years of age, requiring prompt identification and antibiotic treatment. While interventions can often effectively be provided through community health workers, in Indonesia community-based health workers are not authorised to identify and manage pneumonia at home.[78] The *posyandu* strategy emphasises more health promotion and curative services administered by registered midwives and nurses, instead of implementing community-based case management for common childhood illnesses. The strategy is more aimed at empowering individuals, families and communities in order to maintain their health status, rather than at prevention.[79]

3.1.8.2 Political commitment to improving health and nutrition

There is political commitment to improving health and nutrition, some of which is outlined in the Health Law No. 36/2009, which recognises health as a basic human right. The Health Law stipulates the kinds of services governments must provide as well as the rights and obligations

71 Under the RPJMN 2010-2014, the GoI aims to establish a *Poskesdas* in each village with trained health staff
72 Ministry of Health (2008) *Laporan Nasional, Riset Kesehatan Dasar (Riskesdas) 2007*
73 BAPPENAS/Ministy of Health (2010) *The landscape analysis*
74 80 per cent of all preschoolers are to be weighed at *posyandu*, according to the *Rencana aksi pembinaan gizi masyarakat 2010-2014.*
75 Ministry of Health (2008) *Laporan Nasional, Riset Kesehatan Dasar (Riskesdas) 2007*
76 Ibid.
77 Ibid.
78 Countdown Working Group on Health Policy and Health Systems (2008) 'Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn and child health', *The Lancet* , Vol.371: 1284-1293.
79 Tim Penggerak PKK Pusat (2009) *Pertemuan Kader Posyandu 3 October 2009*, from the official web site of the Tim Penggerak PKK Pusat, available at: http://tp-pkkpusat.org/index.php?option=com_content&view=article&id=58:temu-kader-posyandu-tahun-2009&catid=1:artikel-terbaru&Itemid=85 (Last accessed 29 January 2010)

of citizens. Under the new law, abortion is outlawed except in cases of pregnancy resulting from rape and medical emergencies.

The new law also legislates that mothers must breastfeed their babies exclusively from birth until six months old (stipulating that it is the right of the child to exclusive breastfeeding for six months unless there are medical reasons to prevent this). The law stipulates that all levels of government, employers and communities must support lactating mothers by providing time and space for them to breastfeed their babies in workplaces, and imposes severe penalties for violations. With the ratification of the Law, the Ministry of Women's Empowerment and Child Protection has issued regulations on the Implementation of the Ten Steps to Successful Breastfeeding in every facility providing services and care for newborn infants. Among these steps is one which states that every such facility should inform pregnant mothers of the benefits and management of breastfeeding, and show mothers how to breastfeed.

The continued political will to improve maternal and child health and nutrition is also evident in the RPJMN 2010-2014. In particular, it highlights the need to improve nutrition of pregnant women. The treatment of severe cases of undernutrition among children aged 6-24 months is also a priority for the government, as outlined in the Minister of Health Decree No. 741/2008 on Minimum Service Standards in Districts/Cities. The National Action Plan for Food and Nutrition (RANPG) for the five-year period 2011-2015 is currently under development. It will be based on the RPJMN at both national and provincial levels. Its main objective is to reduce stunting by five per cent in the next five years, from 37 per cent to 32 per cent.

However, there is also emerging evidence of the need to focus policy assistance for provincial and district level governments on harmonizing the Food and Nutrition Action Plans based on the national plan, decree and guidelines, and to develop inter-sectoral coordination mechanisms to oversee and monitor their implementation.[80] In many provinces and districts these action plans do not exist at all.

3.1.8.3 Coordination

The Landscape Analysis (2010) outlines some weaknesses in efforts to improve nutrition across sectors, within sectors, at all levels of government, and in the UN. At the central level, the National Development Planning Agency (BAPPENAS) has established a Directorate of Health and Nutrition, which oversees activities under UNICEF-GoI cooperation and aims to improve coordination. There is also a Food Security Council, chaired by the president of Indonesia with ministers from the related ministries as members. Similar boards exist at the sub-national level, chaired by the provincial governors and district heads. Moreover, several task forces and committees have been created for the purpose of improving coordination. There is a Nutrition Task Force under the Food Security Council at the central, province and district levels. However, The Landscape Analysis (2010) argues that the roles and responsibilities of these various bodies need to be clearly defined, and work-plans need to be developed to improve efficiency.

3.1.8.4 Programmes

Moreover, as has been discussed above, the GoI has a variety of nutrition programmes in place that seek to improve child and maternal health and nutrition including amongst others:

80 BAPPENAS/Ministry of Health (2010) *The landscape analysis*

- ‘Making Pregnancy Safer’ strategy
- Ten steps to successful breastfeeding
- Vitamin A capsules supplementation for children under five and post-partum women
- Iron folate supplementation for pregnant women
- Food fortification including universal salt iodization
- Promotion/protection/support for breastfeeding
- Treatment of severe malnutrition
- Growth monitoring, particularly through posyandu

This is covered by a variety of legal instruments, decrees and guidelines, which are too numerous to mention here.[81] However, as is evident in the analysis above, coverage is uneven among provinces and between rural and urban areas. Furthermore, the poorest quintiles consistently underperform in terms of access to and the uptake of many of the services and practices promoted through these policies and programmes.

As mentioned above, the findings of The Landscape Analysis (2010) have shown that although the commitment to act for nutrition is reasonably strong in Indonesia, the capacity to act for nutrition still needs to be strengthened. The existing strong commitment to act for nutrition is misdirected at trying to resolve acute nutrition problems, namely severe wasting, rather than putting into place systems and interventions to prevent children and women becoming malnourished, largely because the latter is not generally recognised as a problem. There is little recognition of stunting or maternal undernutrition as important problems, although at the national level there is a more widespread and growing understanding of the stunting problem.

The Landscape Analysis (2010) findings also reveal that commitment to resolving the problem of stunting is growing at the national level, but at the provincial and district levels - where all the action is decided and implemented - the nutrition problem is still largely equated with severe undernutrition (gizi buruk) and/or lack of food. In addition, many ‘nutrition activities’ are implemented or controlled outside of the health sector, and targeting, implementation and coordination aspects may not be happening optimally in order to achieve the best nutrition outcome. The concepts of ‘packages of interventions’ and of a ‘continuum of care’ from conception to two years of age are not also well understood in spite of the fact that the minimum standards and the technical guidelines represent a valuable effort to provide such information and guidance in that direction. Another bottleneck to implementation of a package of effective nutrition interventions through a continuum of care concept seems to be the lack of awareness by health providers of its importance and effectiveness.

Recommendations from The Landscape Analysis (2010) on how to reduce maternal and child undernutrition emphasise the following: nutrition coordination and responsibilities; budget and funding; planning and design of programmes; human resources; service provision; and nutrition information systems. Furthermore, as mentioned previously, attention should be given to creating mechanisms which promote the development of harmonised Food and Nutrition Action Plans at province and district levels, based on the national plan, decree and guidelines, as well as to developing inter-sectoral coordination mechanisms to oversee and monitor their implementation. In order to increase cost-effectiveness of funding, guidance and incentives should be provided to districts encouraging them to prioritize evidence-based interventions targeted at vulnerable groups of pre-pregnant, pregnant and lactating women, and at children under two years of age. Length of children under two and maternal anaemia should be given increasing emphasis and prioritised for measuring the effectiveness of both nutrition as well as poverty reduction programmes at all levels. In parallel to this, job descriptions need to be updated to reflect new programme directions (i.e., measurement of stunting and maternal health/anaemia) for all staff involved in nutrition at all levels of the system. A human resource map for nutritionists and other health workers should be developed in order to identify deployment gaps and competencies, and develop a national plan for a training approach to teach nutritional competencies for volunteers, nurses and midwives, and to provide technical updates for doctors in the nutrition sciences. Also, the implementation at scale (as appropriate, depending on local conditions), of the package of Essential Nutrition Interventions (ENI) should be progressively implemented, starting in a few districts and provinces and gradually expanding so that within five years most mothers and children are covered by ENI as a continuum of care from pre-conception to two years of age. Monitoring and evaluation guidelines should be modified to reflect the new programme focus and relevant indicators.

81 For example, see: Minister of Health Decree No. 741/2008 on Minimum Service Standards in Districts/Cities; Minister of Health Decree 237/1997 on the Distribution of Breastfeeding Substitutions; Draft Government Regulation on Increasing Exclusive Breastfeeding; and Ministry of Women’s Empowerment and Child Protection Regulation No. 23/2010 on the Implementation of the Ten Steps to Successful Breastfeeding

3.2 WATER AND SANITATION

Adequate water and sanitation play a vital role in child and maternal health, as poor conditions increase susceptibility to diarrhoea, skin disease, intestinal and other waterborne diseases, generating high health costs and putting pressure on health services and resources.[82] It is also important for achieving other MDGs as, for example, poor access to water, sanitation and hygiene contributes to increased morbidity, health problems and therefore reduced productivity and income levels, as well as time lost in long-distance water collection and in poor health, which could have been spent on income-generating activities.[83] Improved health and reduced water collection burdens improve school attendance, especially among girls.[84] Having separate sanitation facilities for girls and boys in schools also increases girls’ attendance, especially after they enter adolescence.[85]

The provision and use of clean water and the safe disposal of waste products are therefore key to improving child health, dependent both upon the provisions of key services (clean water, for instance) and good hygiene practices. There are a number of key diseases known to particularly affect children and which are closely associated with water and sanitation, such as diarrhoea, typhoid and hepatitis.[86] Around 10 per cent of the total burden of disease worldwide could be prevented by improvements related to drinking water, sanitation, hygiene and water resource management.[87]

According to the 2007 IDHS data, 14 per cent of children under five years of age had diarrhoea in the two weeks before the survey. The prevalence of diarrhoea is highest among children

82 Prüss-Üstün, A., Bos, R., Gore, F., Bartram, J. (2008) *Safer water, better wealth: costs, benefits and sustainability of interventions to protect and promote health*, WHO: Geneva
83 WHO/UNICEF (2010) *Progress on sanitation and drinking water: 2010 update*, WHO: Geneva
84 Ibid.
85 Ibid.
86 Prüss-Üstün, A. et al. (2008) *Safer water, better health*; Badan Pusat Statistik (BPS) - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007*
87 Prüss-Üstün, A. et al. (2008) *Safer water, better health*

aged 6-35 months[88], presumably because of the protection extended to breastfed babies, many of whom are weaned off breast milk around the age of six months. A number of factors such as wealth and education of the mother play an important part in the prevalence of diarrhoea[89], but exposure to diarrhoea-causing agents is related to the use of contaminated water and to unhygienic practices in food preparation and the disposal of excreta.[90] In general, the prevalence of diarrhoea is lower among children living in households that use piped water or water from a protected well than among children living in households that use an open well or surface water for drinking.[91] Furthermore, fewer children living in households with a private toilet facility with a septic tank suffer from diarrhoea than children living in households with other types of toilet facilities.[92]

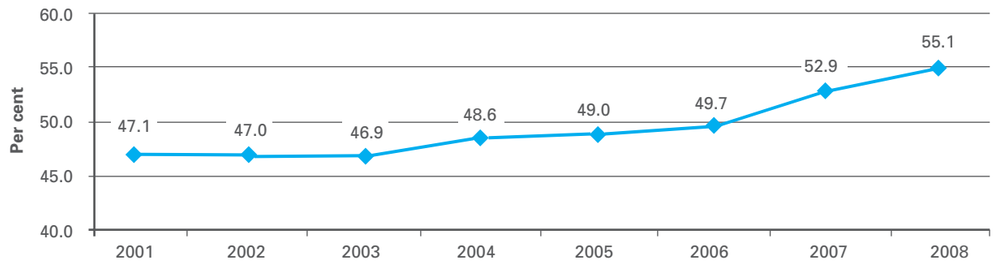
Children's stools are much more likely to be disposed of safely in urban areas than in rural areas (82 and 64 per cent, respectively).[93] The disposal of a children's stools varies substantially by maternal level of education and socio-economic status. Mothers with secondary or higher education are much more likely to dispose of their children's stools safely (86 per cent) than are mothers with no education (48 per cent).[94] Similarly, mothers in the highest wealth quintile are much more likely to dispose of their children's stools safely (93 per cent) than mothers in the lowest wealth quintile (47 per cent).[95] Almost all women reported that they washed their hands before preparing the most recent family meal (97 per cent).[96] Finally, the mother's level of education and the socio-economic status of the household are related to whether young children receive treatment for diarrhoea. The higher the mother's level of education and the higher the household wealth quintile, the more likely it is that children with diarrhoea will be taken for treatment to a health facility or provider.[97]

Based on 2007 Riskesdas data, there are several problems associated with sanitation and hygiene problems, such as typhoid, hepatitis, and diarrhoea. The 2007 Riskesdas data show that the national prevalence of typhoid is 1.6 per cent (ranging from 0.3 to 3 per cent across provinces), and there are 12 provinces with a prevalence rate above the national level including two of the case study provinces in this report: East Nusa Tenggara and Papua. Clinical hepatitis is detected across all the provinces with a prevalence rate of 0.6 per cent (ranging from 0.2 to 1.9 per cent), and is highest in Central Sulawesi and in East Nusa Tenggara. Clinical diarrhoea has a prevalence rate of 9 per cent (ranging from 4.2 to 18.9 per cent) and is highest in Aceh and lowest in Yogyakarta.[98]

3.2.1 ACCESS TO CLEAN WATER

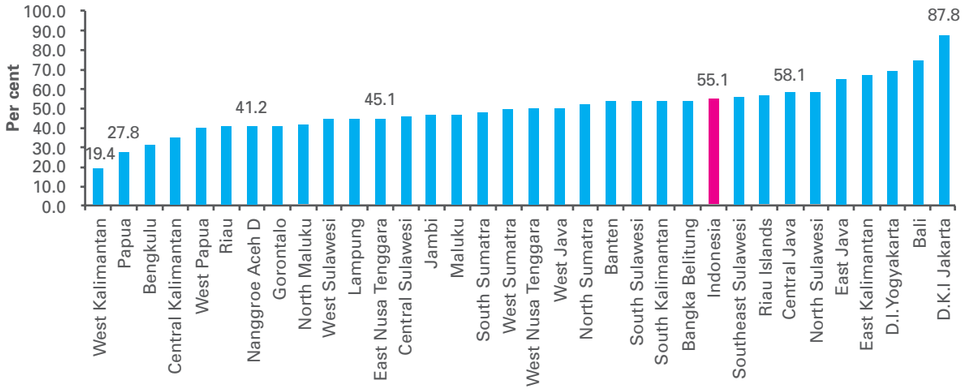
Access to clean water in Indonesia has increased steadily since 2001, according to National Socio-Economic Survey data through 2008 (Figure 3.2.1). Provincial level data, however, indicate that only a relatively small number of provinces are performing well and that the majority of provinces (24) underperformed compared to the national average (Figure 3.2.2). As with IMR and U5MR, a handful of better developed and populous provinces (chiefly those in or close to Java) perform substantially better than the national average. Both rural and urban access to clean water is improving, but on the whole rural households and deeply rural provinces are at a significant disadvantage compared to urban households and more urbanised provinces (Figure 3.2.3), in line with global trends[99]. The overall index of inter-provincial disparity in accessing clean water has slightly improved over the past ten years, from 24 per cent in 2000 to 21 per cent in 2009. Additional data from the National Socio-Economic Survey indicate that 14.6 per cent of Indonesian households have access to piped drinking water, a slight fall from 14.7 per cent in 1992.[100]

Figure 3.2.1: Percentage of households with sustainable access to clean water, Indonesia 2001-2008



Source: Badan Pusat Statistik (BPS) - Statistics Indonesia, based on the National Socio-Economic Surveys 2001-2008
Note: clean water includes filtered water, piped and non-piped water (pumps, protected wells and springs) that are more than 10 meters away from excreta disposal sites.[101]

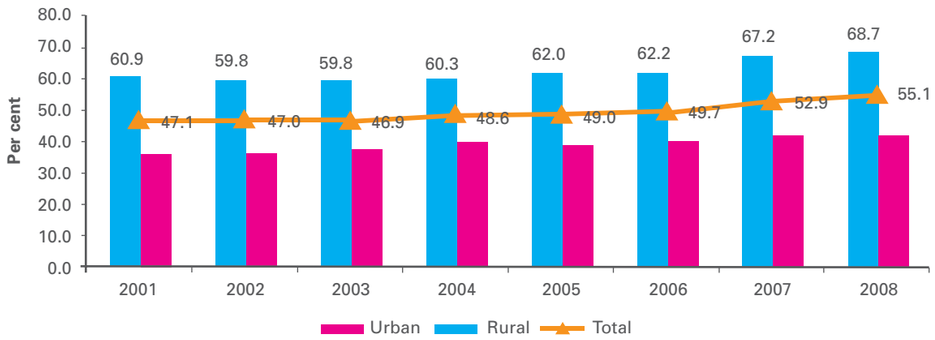
Figure 3.2.2: Percentage of households with sustainable access to clean water by province, Indonesia 2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2008

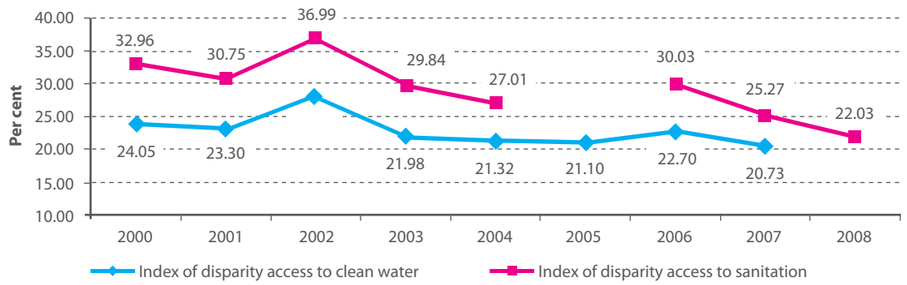
88 BPS - Statistics Indonesia and Macro International (2008) *IDHS 2007*
89 Ibid., p16
90 Ibid., p16; Prüss-Üstün, A. et al. (2008) *Safer water, better health*
91 BPS - Statistics Indonesia and Macro International (2008) *IDHS 2007*, p16
92 Ibid., p16
93 Ibid., p15
94 Ibid., p16
95 Ibid., p16
96 Ibid., p167
97 Ibid., p162
98 Ministry of Health (2008) *Riskesdas 2007*
99 WHO/UNICEF (2010) *Progress on sanitation and drinking water: 2010 update*
100 BPS - Statistics Indonesia (2009) *Survei Sosial Ekonomi Nasional (SUSENAS) [National Socio-Economic Survey]*, BPS: Jakarta
101 *"Termasuk air bersih adalah air kemasan, leding, (pompa, sumur dan mata air terlindung dengan jarak >10 m dari penampungan kotoran/tinja)"* - BPS definition of 'clean water' in the *National Socio-Economic Survey*

Figure 3.2.3: Percentage of households with sustainable access to clean water by area, Indonesia 2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2001-2008

Figure 3.2.4: Index of disparity of access to clean water and sanitation, Indonesia 2000-2008[102]



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008
Note: A number of provinces were missing in the 2005 National Socio-Economic Survey, therefore the index is not calculated for these years.

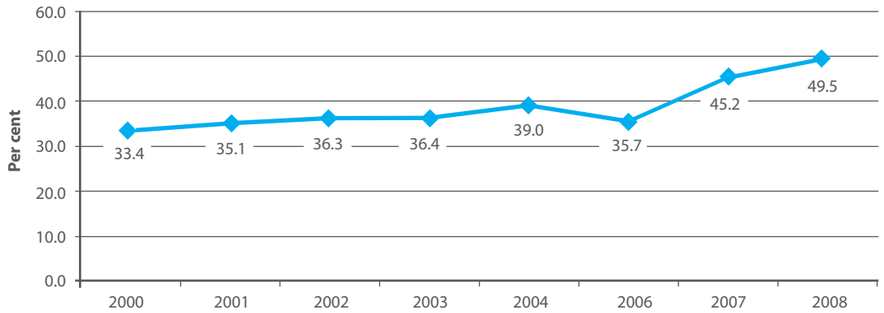
Although the 2008 National Socio-Economic Survey data indicate that Indonesia is on track to achieve the MDGs in terms of access to clean water, using United Nations Joint Monitoring Programme (JMP) measurement methods[103], Indonesia is unlikely to meet the MDGs[104] despite the improvements in access to clean water outlined in the discussion above. The difference is due to: (1) different baselines are used, with one using the Demographic Household Survey (DHS) and the other using the National Socio-Economic Survey; and (2) different definitions are used for classifying pit latrines as either 'improved' or 'unimproved'. Use of JMP methods results in a count of 50 per cent of pit latrines as 'improved'.

Water supply in Indonesia is characterised not only by poor and socially inequitable levels of access as demonstrated above, but also by poor water quality. Over 46 million people in Indonesia lack access to improved water sources.[105] Households in Indonesia are known to use one or more of several mitigation strategies when local water sources are polluted. For many households, especially in urban areas, pipelines supply water, which is usually purchased on a metered basis at a cost of about US$0.17 per cubic meter.[106] This is generally the preferred option, as it costs less than other mitigation options such as bottled water or water sold by vendors.[107] In 2007, 90 per cent of Indonesian households treated water at home, the majority by boiling.[108] This adds considerably to the cost of water for drinking purposes. Many households that purchase water still treat it for drinking, which suggests the water is, or is perceived to be, not directly potable.[109] For Indonesia the price per cubic meter of piped water is US$0.17, from vendors (refill) US$5.4, home boiled is US$21.3 and bottled water (branded) is US$53.[110]

3.2.2 ACCESS TO ADEQUATE SANITATION

According to data from the National Socio-Economic Survey, with regards to basic sanitation facilities there is a trend of ongoing and steady progress at the national level, yet coverage of such facilities still failed to reach a majority of the population in 2008 (Figure 3.2.5). As with access to clean water, a majority of provinces are underperforming compared to the national average (49.5 per cent), with just over 78 per cent of households having access to adequate sanitation in Jakarta, compared to just 18 per cent in East Nusa Tenggara (Figure 3.2.6). A majority of the provinces lag behind the national average, with 20 provinces underperforming and 13 provinces performing better. In these 13 provinces, a majority of the population (over 50 per cent) can access adequate sanitation. The pattern of rural/urban disparities is once again very strong with less than half the number of rural households accessing adequate sanitation compared to urban ones (Figure 3.2.7). However, the trend in the index of disparity with regard to sanitation is more encouraging than for clean water access, pointing towards a steady reduction from 33 per cent in 2000 to 22 per cent in 2008 (Figure 3.2.8).

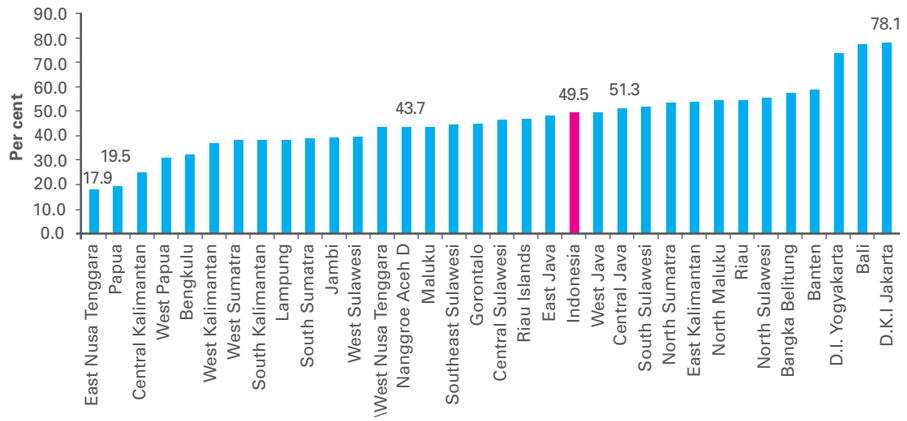
Figure 3.2.5: Percentage of households with sustainable access to adequate sanitation (pit latrines and septic tanks), Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008

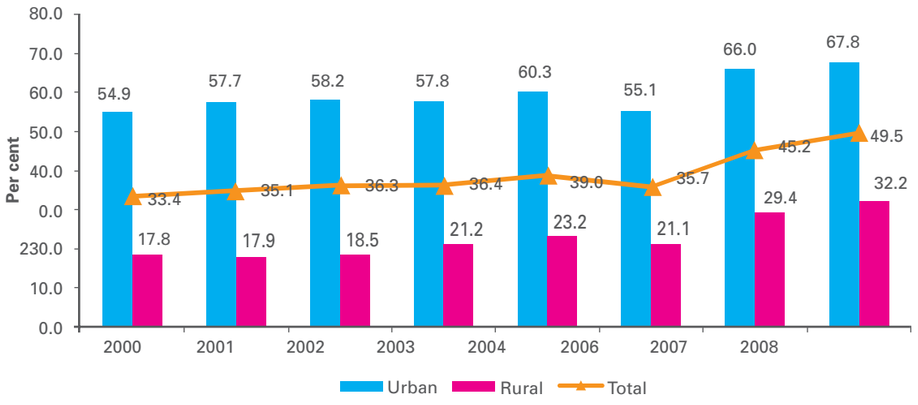
102 The Index of disparity (ID) is defined as the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage. ID = (∑ |r (1-n) – Rl / n) / R * 100, r = group rate, R = total population rate. Pearcy, J. N. and Keppel, K. G. (2002) 'A summary measure of health disparity', *Public Health Reports*, Vol.117: 273-280.
103 Ibid.
104 UNICEF (2010) *Indonesia country profile: Water, sanitation and hygiene (WASH)*, UNICEF: Jakarta
105 Based on United Nations Joint Monitoring Programme (JMP) measurement guidelines, see: WHO/UNICEF (2010) *Progress on sanitation and drinking water: 2010 update*, p34
106 Ibid.
107 Ibid.
108 World Bank (2007) *Economic impacts of sanitation in Southeast Asia summary*, World Bank: Water and Sanitation Program: East Asia and the Pacific (WSP-EAP), available at: http://www.wsp.org/wsp/sites/wsp.org/files/publications/411200810059_EAP_ESI_summary.pdf (Last accessed 10 October 2010)
109 Ibid.
110 Ibid.

Figure 3.2.6: Percentage of households with sustainable access to adequate sanitation (pit latrines and septic tanks) by province, Indonesia 2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2008

Figure 3.2.7: Percentage of households with sustainable access to adequate sanitation (pit latrines and septic tanks) by area, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008

There have been a number of improvements in the provision of water and sanitation in Indonesia, but within a context of ongoing high inequalities and disparities. Although these disparities have declined somewhat over the past 10 years, it is evident that rural areas and a number of key provinces require substantial attention (East Nusa Tenggara and Papua, for instance). Similar to the case for access to clean water, based on National Socio-Economic Survey data, Indonesia is on track to reach MDG targets, albeit without equity. However, based on JMP measurement methods, which use a narrower definition of sanitation, reaching the MDGs is less likely.[111] Yet the fact remains that according to 2009 National Socio-Economic Survey data half the population do not have access to basic sanitation. Open defecation is still widely practiced by some 60 million people, with rates being higher in rural areas (36 per cent) than urban areas (16 per cent).[112] These rates have changed little with time since 2000 (42 per cent and 17 per cent, respectively).[113] Open defecation not only creates problems of security for women in particular (lacking facilities to defecate in private at night), but it also contaminates water supplies, making access to clean water more problematic and increasing the likelihood of associated disease and health problems. The GoI has, in its 2010-2014 development plan, made the elimination of open defecation by 2014 a major national target.

111 UNICEF (2010) *Indonesia country profile: Water, sanitation and hygiene (WASH)*

3.2.3 PROGRESS AND CHALLENGES FOR IMPROVING WATER AND SANITATION

However the provision of facilities and services is only one of the key constituent parts for improving water and sanitation. Knowledge, information and the promotion of good hygiene practices need to be consolidated in order to generate sustainable behavioural change.[114] Behavioural change has become part of the strategy of the Ministry of Health that is elaborated through Ministerial Decree No. 852/2008 on National Strategy for Community-Based Total Sanitation (STBM, Sanitasi Total Berbasis Masyarakat). This strategy is to be implemented by local government agencies, non-government organisations and externally funded projects, and is considered as one of the key strategies to help reach the MDGs on sanitation. Furthermore, in the strategy, schools are considered as important vehicles for behavioural change through hygiene education coupled with the improvement of hand washing, latrines and water supply facilities.

To improve access to water and sanitation, the GoI has adopted national water and sanitation goals. These include achieving 75 per cent access to improved sanitation by 2015 under the National Action Plan on Sanitation (in line with the MDGs) and the eradication of open defecation by 2014 under the National Medium-Term Development Plan (RPJMN) 2010-2014. However, as yet no national strategies or financing plans have been adopted for achieving these targets.[115]

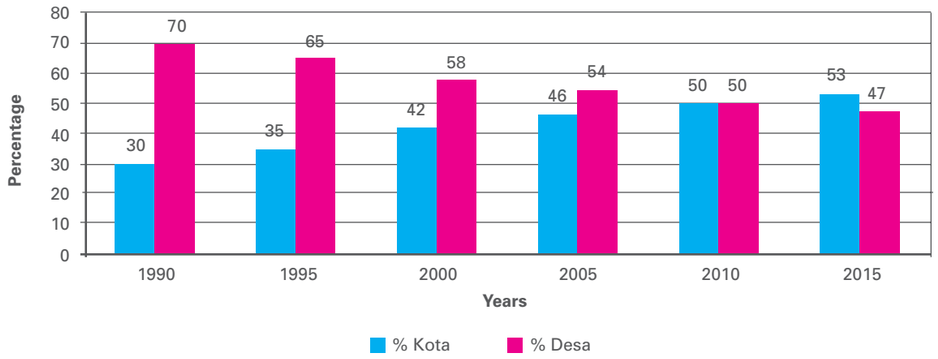
While water and sanitation services, especially in urban areas, have been decentralised to local government, specific responsibilities and funding mechanisms have not been defined in sufficient detail. As a result, municipalities are under little pressure to improve sanitation services and rationalize institutional arrangements, and do not know how to access capital funds. Where improvements are undertaken, especially in urban areas, they tend to be piecemeal and unconnected to any strategic plan for the city as a whole.[116]

However, the development of the National Policy for Community-Based Water Supply and Environmental Sanitation (Kebijakan Nasional Pembangunan Air Minum dan Penyehatan Lingkungan Berbasis Masyarakat) has provided an enabling framework, especially in rural areas. It is following sound principles of demand-responsive, community-based approaches, emphasizing the need for women's involvement, attention to sustainable operation and maintenance, and applying cost-recovery principles. In addition, the government has for the first time included targets for poor people's access to safe water and sanitation services in its National Medium-Term Development Plan and has firmly committed itself to achieving the MDGs.[117]

112 Ibid., p43
113 Ibid., p43
114 Prüss-Üstün, A., et al. (2008) *Safer water, better health*
115 World Bank (2009) *Urban sanitation in Indonesia: Planning for progress*, World Bank - Water and Sanitation program (WSP): Jakarta, available at: http://www.wsp.org/wsp/sites/wsp.org/files/publications/Urban_San_Indonesia.pdf (Last accessed 10 October 2010)
116 World Bank (2009) Urban sanitation in Indonesia: *Planning for progress*
117 UNICEF (2010) *Indonesia country profile: Water, sanitation and hygiene (WASH)*

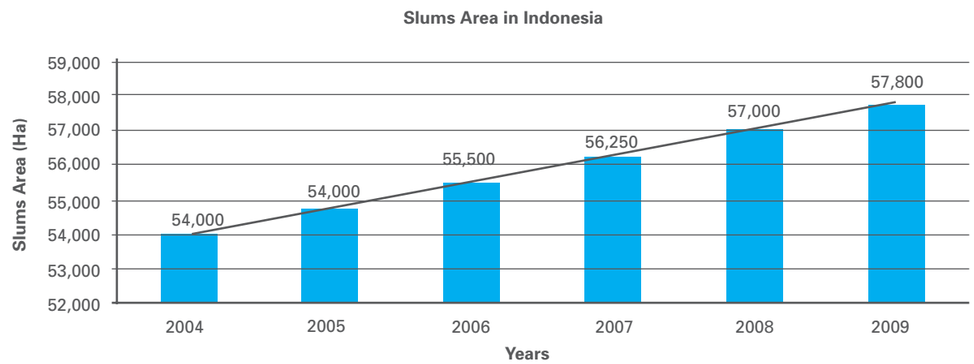
A further challenge for the GoI is the changing nature of population distribution. There is an emerging trend towards increasing urbanization of the population, as demonstrated in Figure 3.2.8. At present, half of Indonesia's population is urban and this is expected to increase to 60 per cent by 2025, along with the challenge of developing essential water, sanitation and hygiene (WASH) infrastructure and services.[118] Along with this, is the growing size of slum areas in some of Indonesia's larger cities (see Figure 3.2.9). If this trend continues, there will be even greater pressure on water and sanitation facilities. Recognising these trends and developing strategies to ensure there are adequate water and sanitation facilities for the urban poor in particular requires the urgent attention of policymakers.

Figure 3.2.8: Projected changes in percentage of urban and rural populations, Indonesia 1990-2015



Source: BAPPENAS, National Action Plan Study, 2009
Note: Kota = city/urban areas; Desa = village/rural areas

Figure 3.2.9: Slum areas in Indonesia, by hectare (Ha) over time, Indonesia 2004-2009



Source: BPS - Statistics Indonesia, based on Village Potential Data Collection (PODES) 2004-2009

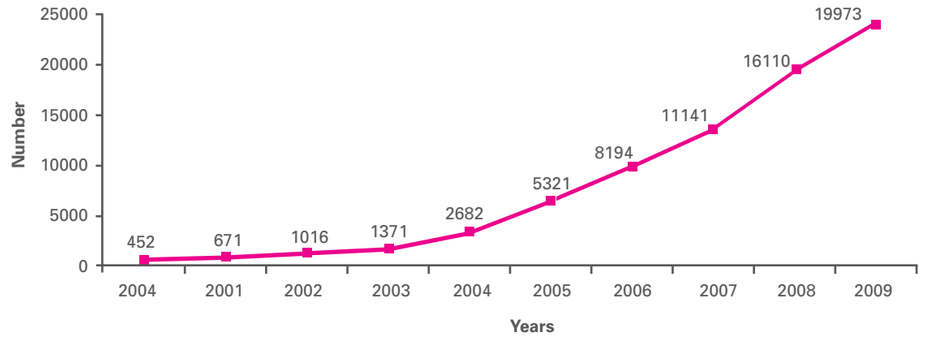
[118] World Bank (2009) *Urban sanitation in Indonesia: Planning for progress*

3.3 HIV AND AIDS

According to Indonesian National AIDS Commission's 'Country Report on the Follow-Up to the Declaration of Commitment on HIV/AIDS' (the 'UNGASS' report), Indonesia has one of the fastest growing HIV epidemics in the region.[119] In 2006 it was estimated that there were 193,000 adults living with HIV in Indonesia, 21 per cent of whom were estimated to be women.[120] By 2009, the estimated number of people living with HIV (PLHIV) increased to 333,200, 25 per cent of whom were estimated to be women.[121] These figures indicate a feminization of the AIDS epidemic in Indonesia.

Since the first case of AIDS was reported in Indonesia in 1987, the number of reported cases has increased steadily. By 2006, 8,194 AIDS cases had been reported (Figure 3.3.1).[122] According to the Indonesian National AIDS Commission (KPA, Komisi Penanggulangan AIDS Nasional), the number of reported cumulative AIDS cases in 2009 was 19,973 cases, 25 per cent of whom were women.[123] It is important to note that these are only reported cases and the data may be showing not only increased infection rates but also improved reporting tendencies and methods.

Figure 3.3.1: Cumulative AIDS cases reported over time, Indonesia 2000-2009



Source: Ministry of Health (MoH), Directorate General of Communicable Diseases Control and Environmental Health (CDC and EH), 2000-2009

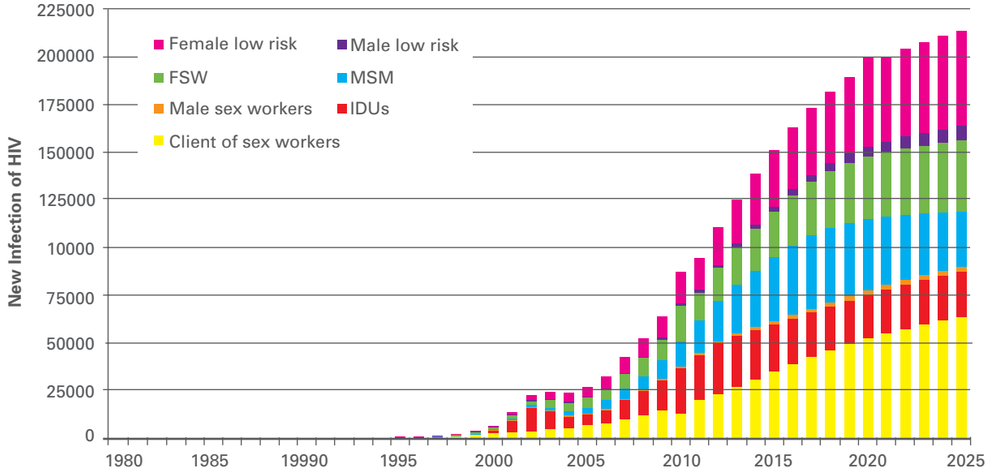
By 2009, 15,608 of reported cases (78 per cent) were for people of productive age (15-49 years). Between 2004-2009, the number of provinces reporting cases of HIV infection also increased, from 16 to 32 (out of a total of 33 provinces).[124] Whilst, the 'UNGASS' report (2009) points towards a relatively low national adult prevalence of AIDS, at 0.22 per cent,[125] concentrated amongst high-risk populations (injecting drug users, men who have sex with men, sex workers and their clients, and the sexual partners of all of the members of these groups), the general trend towards increases in the numbers and prevalence of HIV and AIDS cases is a source of concern.

[119] Komisi Penanggulangan AIDS (KPA, Indonesian National AIDS Commission) (2009) *Country report on the follow-up to the Declaration of Commitment On HIV/AIDS (UNGASS)*, National AIDS Commission (KPA), Republic of Indonesia: Jakarta pVIII; See also UNAIDS/WHO 2009 AIDS Epidemic Update, available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp (Last accessed 1 September 2010)
[120] Komisi Penanggulangan AIDS (KPA, Indonesian National AIDS Commission) (2009) *UNGASS report*, p13
[121] Ibid., p13
[122] Komisi Penanggulangan AIDS (KPA, Indonesian National AIDS Commission) (2010) *National HIV and AIDS strategy and action plan 2010-2014*, KPA: Jakarta, p14
[123] Komisi Penanggulangan AIDS (KPA, Indonesian National AIDS Commission) (2009) *UNGASS report*, pvii
[124] Ibid., pvii
[125] Ibid., p2

Since the year 2000, HIV prevalence has been consistently over 5 per cent in several key populations including injecting drug users (IDUs), sex workers, transgenderists (waria), and men who have sex with men (MSM), leading to classification of the epidemic in Indonesia as a 'concentrated' one.[126] Specifically, the Integrated Bio-Behavioral Surveillance (IBBS) on HIV[127] among key populations found HIV prevalence as follows: direct sex workers 10.4 per cent; indirect sex workers 4.6 per cent; waria 24.4 per cent; clients of sex workers 0.8 per cent[128]; MSM 5.2 per cent; and IDUs 52.4 per cent.[129] IDU and sexual transmission remain the main modes of HIV transmission in Indonesia.[130]

However, there are indications of changes in the types of infected populations, with growing numbers of women - particularly the partners of IDUs and of male clients of sex workers - being increasingly exposed to HIV infection.[131] Reported cumulative AIDS cases among women up to 31 December 2009 indicate that housewives make up the highest proportion of infected women (58.8 per cent).[132] Nationally, the transmission of HIV infection is also rising among MSM (Figure 3.3.2), an alarming trend, according to the 'UNGASS' report (2009).[133] Analysis of the trends in the development of the AIDS epidemic in Indonesia demonstrates the present pattern of infection and the projected future course of the epidemic (Figure 3.3.2). Improving the use and reliability of condoms amongst the population most at risk of infection remains a key priority as current figures indicate the use of condoms is worryingly low: 35 per cent amongst female sex workers, 35 per cent amongst waria (transgenderists), 30 per cent amongst IDUs and only 15 per cent amongst MSM.[134] In order to tailor the response to the epidemic it is important to monitor trends in HIV transmission in all settings.

Figure 3.3.2: HIV trends and projections in Indonesia, 1980-2025



Source: Indonesian National AIDS Commission (KPA), National HIV and AIDS strategy and action plan 2010-2014, 2010

126 Komisi Penanggulangan AIDS (KPA, Indonesian National AIDS Commission) (2010) *National HIV and AIDS strategy and action plan 2010-2014*, p14
127 Carried out by the Ministry of Health and BPS - Statistics Indonesia, in 2007. Ministry of Health and Badan Pusat Statistik (BPS) - Statistics Indonesia (2008) *Integrated Bio-Behavioral Surveillance on Most at Risk populations in Indonesia (IBBS-MAR) 2007*, BPS: Jakarta
128 Data from a survey conducted in six cities among clients of sex workers including truck drivers, ship crews, longshoremen and motor taxi drivers with prevalence ranging between 0.2-1.8 per cent
129 KPA (2010) *National HIV and AIDS strategy and action Plan 2010-2014*
130 Ibid.
131 BAPPENAS (National Development Planning Board), KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, UNAIDS: Jakarta p17
132 Ministry of Health (2010) 'Cumulative AIDS cases among women up to 31 December 2009, by type of work', Presentation by the Directorate General of Communicable Diseases Control and Environmental Health (Dirjen P2PL), Ministry of Health: Jakarta
133 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*; see also KPA (2009) *UNGASS report*, p18
134 Ministry of Health and BPS - Statistics Indonesia (2008) *IBBS-MAR 2007*

Projections from the Ministry of Health (MoH) based on modelling of the HIV epidemic in Indonesia (2008) estimate that the projected HIV infection prevalence in the population aged 15-49 years would increase from 0.22 per cent in 2008 to 0.37 per cent by 2014.[135] The MoH estimates that without increased efforts to expand and strengthen prevention, treatment, care and support services across the country, Indonesia will have almost twice the number of people living with HIV and AIDS in 2014 as compared to 2008, rising to 541,700.[136] Furthermore, it is estimated that of this figure a cumulative 185,700 people will die of AIDS, or an average of 23,000 per year.[137] Based on the projections in Figure 3.3.2, the MoH expects that aside from the rising levels of infection amongst the 15-49 year age group, and MSM, new HIV infections will increase among women leading to a rise in infections among children. Therefore, special attention is needed to the potential for an increase in HIV infections among sexual partners (intimate partners) of people in key high-risk populations. The MoH also expects that without the interventions mentioned above, the need for antiretroviral therapy (ART) will increase from 50,400 (2010) to 86,800 people (2014).

Furthermore, in the two worst affected provinces of Papua and West Papua, the epidemic, which is driven almost completely by unsafe sexual intercourse, is categorised as a low level generalized epidemic with HIV prevalence of 2.4 per cent among 15- to 49-year-olds in the general population.[138] The prevalence rate for the 15-49 year age group is almost 11 times the national prevalence rate of 0.22 per cent.[139] There are some plausible explanations for the severity of the epidemic in that region, but as the 2010 'UNGASS' report conceded, "It is not entirely clear why the infection is so much higher than elsewhere."[140]

The case of Papua will be reviewed in detail in the Section 4, but the root causes of the high rate of infection in that region are complex and rooted in a converging set of mutually reinforcing structural, social and behavioural factors. The patterns of HIV transmission are somewhat distinct in Papua, with over 90 per cent of HIV transmission taking place through unprotected sex and the frequent changing of partners.[141] The early onset of sexual activity in those provinces, lack of knowledge about reproductive health, sexually transmitted infections (STIs) and means of protection, accompanied by a low usage and a low availability and accessibility of condoms, all play a part in the rapid spread of the infection.[142] Various studies also point to gender status issues - notably that women and girls tend to lack information and lack a voice in sexual decision-making, which increases their vulnerability to infection.[143] Finally, the broader development context in Papua also provides a fertile ground for the spread of infection. The provinces of Tanah Papua have experienced a rapid and uneven pattern of development, where widespread poverty remains the norm in the midst of an accelerated expansion of the explanation of natural resources. The GoI/UNICEF Education Sector Response report on the problem of HIV in Papua and West Papua (2009) also highlights the problems of poverty, levels of education and knowledge about HIV, isolation in rural highland communities and the decreasing age of sexual debut as some of the root causes and challenges for tackling HIV and AIDS infection in Papua.[144]

135 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*
136 KPA (2010) *National HIV and AIDS strategy and action plan 2010-2014*, p11
137 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, p18
138 BPS - Statistics Indonesia and Ministry of Health (2007) *Risk behavior and HIV prevalence in Tanah Papua*, BPS: Jakarta. Data for this report were collected in 2006.
139 KPA (2009) *UNGASS report*, p2
140 Ibid., p24
141 UNDP (2005) Papua needs assessment: An overview of findings and implications for the programming of development assistance, UNDP: Jakarta (Indonesia), cited in: KPA (2009) *UNGASS report*, p25
142 KPA (2009) *UNGASS report*, pp24-24
143 Ibid.
144 GoI/UNICEF (2009) *Averting new HIV infection in young people in Papua and Papua Barat: An education sector response, January 2010-December 2013*, GoI/UNICEF: Jakarta

More detailed information on HIV and AIDS such as data collected in prisons and detention centres is still unavailable, and data on orphaned children has yet to be published.[145] There are a number of other data gaps requiring further attention, such as rates of mother-to-child transmission, where even in high-risk areas data are severely limited, as are data on most at-risk adolescents.[146] Some of the available data in these categories is presented below.

3.3.1 INFECTIONS AND TREATMENT OF PREGNANT WOMEN AND CHILDREN

As of 2010 it is estimated that there are 14,228 cumulative cases of children living with HIV, and this is expected to increase to 34,287 cases by 2014.[147] Although data on the incidence of mother-to-child HIV transmission are still limited, the number of HIV-positive pregnant women is increasing. There were an estimated 5,170 pregnant women who were HIV-positive in Indonesia in 2009.[148] Of that number only 196 (3.8 per cent) received antiretroviral (ARV) drugs to reduce the risk of mother-to-child transmission (MTCT), indicating limited prevention of mother-to-child transmission (PMTCT) services.[149] It is projected that the number of HIV-positive women needing PMTCT services will increase from 5,730 people in 2010 to 8,170 people in 2014.[150] Furthermore, the number of children infected by their HIV-positive mothers at birth or through breastfeeding is expected to double from estimates of 2,470 in 2008 to 6,240 in 2014.[151] Finally, it is estimated that 1,070 babies were born with HIV in 2008 and that this will rise to 1,590 in 2014.[152]

The National HIV and AIDS Strategy and Action Plan 2010-2014 highlights that since 2007, PMTCT programmes have been available on a limited scale, particularly in areas with high HIV prevalence. The same report identifies that by 2008, 30 PMTCT service units[153] were integrated into antenatal care units. While from the 5,167 pregnant women tested for HIV in those centres 1,306 (25 per cent) were found to be HIV-positive, only 165 (12.6 per cent) are known to have received ARV prophylaxis from the 30 service units. Furthermore, the number of Voluntary Counseling and Testing (VCT) centres has increased from 24 in 2004 to 527 in 2009[154], which has led to an increase in actual reported cases of HIV-infected pregnant women across 19 provinces, up from 211 in 2008 to 289 in 2009.[155] However, the implementation of PMTCT services at provincial and district levels varies greatly.

Other data also show the inter-provincial variation in testing for HIV and preventive treatment. According to Indonesian Ministry of Health data for 2008 and 2009 on 30 districts/municipalities, the proportion of HIV-infected pregnant women was 4.5 per cent (i.e., 211 out of 4,674 tested) in 2008, and 55.5 per cent of those testing positive received ARV prophylaxis.[156] In 2009, from the same districts, the proportion of HIV-infected pregnant women was 2.9 per cent (i.e., 289 out of 10,026 tested), and 67.82 per cent of those testing positive received ARV prophylaxis.[157]

145 KPA (2009) *UNGASS report*, p84
146 Ibid p26
147 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, p38
148 Indonesian National AIDS Commission (KPA) (2009) *UNGASS report*, pix
149 Ibid.
150 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*; see also National AIDS Commission (KPA) (2010) *National HIV and AIDS strategy and action plan 2010-2014*
151 BAPPENAS, KPA, UNICEF and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, p20
152 Ibid., p18
153 37 PMTCT units were in operation by November 2009, see: Indonesian National AIDS Commission (KPA) (2009) *UNGASS report, p15*
154 KPA (2009) *UNGASS report*
155 Ministry of Health (2010) *Quarterly reports of HIV infections, Ministry of Health*: Jakarta
156 Data from the Ministry of Health, Directorate for Direct Transmitted Disease Control (Direktorat Pengendalian Penyakit Menular Langsung) (2009) Internal report, Ministry of Health: Jakarta
157 Ibid.

Table 3.3.1: Pregnant women receiving PMTCT services in 30 districts/municipalities in 19 provinces, Indonesia 2008 and 2009[158]

No	Province	2008					2009				
		Pre–tested	Tested	Post tested	Positive	Prop ARV	Pre-tested	Tested	Post tested	Positive	Prop ARV
1	North Sumatera	293	9	9	5	3	72	66	66	15	11
2	Riau	752	38	34	12	1	304	4	4	4	5
3	Riau Islands	2,041	2,040	2,036	14	5	3,299	3,296	3,288	16	8
4	South Sumatera	5	5	5	0	0	128	128	128	5	5
5	Banten	0	0	0	0	0	2	2	2	2	3
6	Jakarta	1,628	458	439	46	26	1762	647	633	44	37
7	West Java	192	184	163	21	17	250	218	209	20	13
8	Central Java	169	169	169	6	2	409	462	407	19	7
9	Yogyakarta	3	3	1	1	1	9	10	6	8	4
10	East Java	18	19	17	7	6	13	13	10	7	27
15	East Kalimantan	0	0	0	0	0	0	0	0	0	0
16	North Sulawesi	2	2	2	2	2	7	7	7	2	18
17	South Sulawesi	437	427	425	39	7	474	473	473	31	9
18	West Papua	0	0	0	0	0	283	275	275	5	0
19	Papua	1,289	716	689	12	15	5,316	3,030	2,885	58	13
	Total	**7,436**	**4,674**	**4,580**	**211**	**117**	**13,915**	**10,026**	**9,780**	**289**	**196**

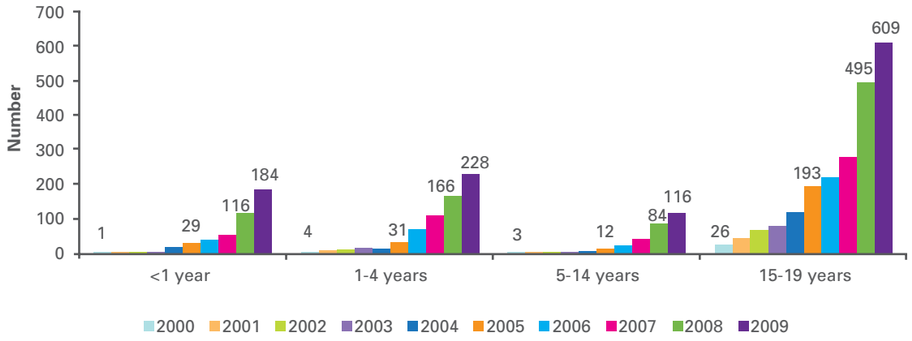
Source: MoH, Directorate for Direct Transmitted Disease Control, Internal report, 2009

3.3.2 HIV AND AIDS AND STIS: INFECTIONS, TREATMENT, KNOWLEDGE AND PRACTICE AMONG ADOLESCENTS

3.3.2.1 Adolescent HIV and AIDS infections and treatment

Data on the cumulative percentage of reported AIDS cases indicates that those aged 20-29 years are the most affected, but after dipping during the mid-2000s, the proportion of the population aged 19 years and younger who are infected has been increasing rapidly again in 2008 and 2009 (see Figure 3.3.3). It is particularly concerning that the rate of reported infection among 15- to 19-year-olds is increasing.

Figure 3.3.3: Cumulative AIDS cases by age groups, Indonesia 2000-2009



Source: MoH, Directorate General of CDC and EH, 2000-2009

158 Ibid.

Only approximately one quarter of children infected with HIV under age 15 were receiving ART and monitoring in 2006.[159] When the 2007 IBBS data from the Indonesian Ministry of Health was disaggregated by age, it showed that young people under age 25 were less likely than other age cohorts in the most at-risk populations to have had HIV testing in the last 12 months and to be reached by HIV prevention programmes (Table 3.3.2). Furthermore, data from the Indonesian Young Adult Reproductive Health Survey (IYARHS) collected in 2007 demonstrated that only 14.3 per cent of young people aged 15-24 years both correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission, up only slightly from 11.5 per cent in 2002-2003.[160] The rate in 2007 was higher among girls (15.1 per cent) than boys (13.7 per cent).

Table 3.3.2: HIV testing and outreach to most at-risk populations, by age, Indonesia 2007

Most-at-risk population	Per cent who have had a HIV test in the last 12 months		Per cent reached by HIV protection programmes	
	Age < 25	Age > 25	Age < 25	Age > 25
Sex workers	27.3	35.2	25.7	30.6
Men who have sex with men (MSM)	31.4	35.1	37.6	47.9
Intravenous Drug Users (IDUs)	36.6	47.6	36.8	46.3

Source: MoH and BPS - Statistics Indonesia, Integrated Bio-Behavioral Surveillance Most at Risk Populations in Indonesia (IBBS-MAR) 2007

3.3.2.2 Adolescent knowledge and practice: STIs and reproductive health

Knowledge and information about sexual health, reproduction and sexually transmitted infections (STIs) constitute an essential aspect of HIV and AIDS policies - they are essential both to reduce the likelihood of infection as well as the fear and stigma that surround STIs in general and HIV and AIDS in particular. Data from the 2007 IDHS and the 2007 IYARHS provide a comprehensive picture of reproductive and sexual health knowledge, awareness and behaviours. Across these surveys and on most indicators, the younger the respondents the less knowledge they displayed about reproductive and sexual health, and on the whole better educated and urban respondents appear better informed than their less educated or rural based peers.

Knowledge about HIV and AIDS among young people seem more substantive than about other STIs, with 84 per cent of the young women surveyed in the 2007 IYARHS reporting having heard of AIDS (but not necessarily know how to prevent it, as knowledge of this is low - see above), but with only 33 per cent reporting knowledge of gonorrhoea, and only 5 per cent reporting knowledge of genital herpes.[161] Young men's knowledge tended to be considerably lower, with only 77 per cent of young men having heard of AIDS, 19 per cent having heard of gonorrhoea and 2 per cent having heard of genital herpes.[162] Alarmingly, over 62 per cent of young men and just over 70 per cent of young women had no knowledge of STI symptoms one might expect in men or women.[163]

159 KPA (2009) *UNGASS report*, p40
160 BPS - Statistics Indonesia and Macro International (2008) *Indonesia young adult reproductive health survey (IYARHS) 2007*, BPS and Macro International: Calverton, Maryland, USA; BPS - Statistics Indonesia and Macro International (2003) *Indonesia young adult reproductive health survey (IYARHS) 2002-3*, BPS and Macro International: Calverton, Maryland, USA
161 The *IYARHS* surveyed unmarried people aged 15-24 years. BPS - Statistics Indonesia and Macro International (2008) IYARHS, p64 and p71
162 Ibid.
163 Ibid.

The survey also identifies schools/teachers, televisions and newspapers/magazines, rather than health professionals, as the main sources of information about HIV and AIDS and STIs.[164] More than a half of the young women interviewed correctly identified the modes of transmissions from mother to child (55-56 per cent) and 42-45 per cent of men reported that HIV could be transmitted from mother to child during pregnancy, delivery and through breastfeeding.[165] Knowledge about protection from HIV infection is still limited, including knowledge of that fact that condom use is one important factor in prevention of transmission. Only 55 per cent of females and 54 per cent of male respondents identified condoms as a method of prevention.[166] Crucially in the case of condoms, the possession of knowledge is necessary but not sufficient to guarantee their use. Data from the IBBS reveal that less than 10 per cent of the young people having knowledge about HIV prevention were consistently using condoms.[167] The issue of testing remains extremely sensitive, not least because of the ongoing fears and stigma attached to HIV and AIDS status. While important efforts have been made to develop HIV and AIDS testing facilities and, crucially, to guarantee confidentiality, at the time the IYARHS survey took place in 2007, only 16 per cent of young women and 10 per cent of young men knew about VCT, a very low figure. However, recent efforts to better develop VCT between 2004 and 2009 as discussed above may have resulted in the increase in the number of young people tested in these facilities, but more data are needed.

In 2009, the University of Indonesia conducted a survey on the situation of adolescents in Indonesia. The survey was conducted in eight districts in four provinces: Aceh, Central Java, East Nusa Tenggara (NTT) and Papua. The survey sampled 1,500 adolescents aged 10-18 years, through a probability proportional to size (PPS) sampling method at the sub-district and village level, and a simple random sampling method at the hamlet and household level across the research areas. Questions were asked to all adolescents in the selected households. The results in the following discussion are drawn from the University of Indonesia survey.[168]

The earliest age of first sexual intercourse reported amongst male respondents was at nine years in Jayawijaya district (Papua) and amongst female respondents at 10 years in Solo district (Central Java). The lowest mean age of first sexual intercourse ranged from 13.7 for boys in Jayawijaya district (Papua) and Aceh Timur district in (Aceh), and 14.4 for girls in Solo district (Central Java) to its highest 16.8 for boys in Banda Aceh municipality (Aceh) and 17.3 for girls in Sikka district (East Nusa Tenggara, NTT). Table 3.3.3 below indicates that on average, most children have sex for the first time during adolescence, and the mean age of first sex was not above 18 in any district.

In order to assess further risks to reproductive health, particularly in terms of risk of exposure to STIs, respondents were then asked how many sexual partners they had had and whether they had experienced any of a described set of STI symptoms (or had these diagnosed). The results varied by district and province with males, particularly in the age group of 16-18 years being more likely to have had multiple sexual partners, particularly in eastern Indonesia (in NTT and Papua). Males were more likely too to report experiencing symptoms of STIs across all districts, which is concerning given that according to the results of the 2007 IYARHS survey mentioned above, young males have the least knowledge of STI symptoms and safe sex practices.

164 Ibid., p65 and p67
165 Ibid., p66
166 Ibid.
167 BPS - Statistics Indonesia and Macro International (2008) *IDHS 2007*
168 University of Indonesia (2010) *Situation analysis of adolescents 2009*, Mimeo: Jakarta

Table 3.3.3: Age at first sex by gender and district, Indonesia 2009

Province	District and gender		Age at first sex (years)		
			Mean	Youngest	Oldest
Aceh	Banda Aceh	Male	16.8	15	17
		Female	17.9	17	18
	Aceh Timur	Male	13.7	10	16
		Female	16.0	15	17
Central Java	Solo	Male	14.5	13	16
		Female	14.4	10	17
	Brebes	Male	15.6	10	18
		Female	16.2	14	18
East Nusa Tenggara (NTT)	Kupang	Male	16.3	11	18
		Female	17.3	17	18
	Sikka	Male	15.0	12	17
		Female	16.8	15	18
Papua	Jayapura	Male	15.5	13	17
		Female	15.0	15	15
	Jayawijaya	Male	13.7	9	18
		Female	14.8	11	18

Source: University of Indonesia, Situation analysis of adolescents 2009

In order to assess further risks to reproductive health, particularly in terms of risk of exposure to STIs, respondents were then asked how many sexual partners they had had and whether they had experienced any of a described set of STI symptoms (or had these diagnosed). The results varied by district and province with males, particularly in the age group of 16-18 years being more likely to have had multiple sexual partners, particularly in eastern Indonesia (in NTT and Papua). Males were more likely too to report experiencing symptoms of STIs across all districts, which is concerning given that according to the results of the 2007 IYARHS survey mentioned above, young males have the least knowledge of STI symptoms and safe sex practices.

Respondents were also asked if pregnancy[169] or births had resulted from sexual intercourse. In general for all age cohorts (10-12, 13-15 and 16-18 years) between 5-10 per cent of respondents reported pregnancy resulting from sexual intercourse whether directly (girls), or indirectly (the partners of boys), with the exception of Central Java where rates were under 3 per cent overall. The highest rates were found in Aceh and Papua provinces. What is also interesting is that in many districts, pregnancies were more likely to be reported in children aged 10-12 years or those aged 16-18 years than they were in children aged 13-15 years. While the higher rates of pregnancy amongst 16- to 18-year-olds may be explained by greater frequency of sex, the higher rates of pregnancy amongst 10- to 12-year-olds is more likely related to lower knowledge of reproductive health and lack of access to contraception. This is evident in the University of Indonesia 2009 survey results, which show that across the age cohorts, as age increased so too did knowledge of reproductive health. Knowledge of reproductive health was highest in Central Java, particularly in Solo district, where rates of pregnancies and STIs were the lowest, rates of multiple sex partners were amongst the lowest, and rates of use of contraception was amongst the highest. However, if we compare the two districts in the study in Papua, where rates of pregnancies were amongst the highest across the districts for the 10- to 12-year-old cohort in Jayapura district, the use of contraception was higher in the Jayawijaya district where pregnancies were lower overall compared to Jayapura. In Aceh, the likelihood of using contraception decreased marginally with each age cohort in both districts (with younger groups being slightly more likely to use contraception than older groups), particularly amongst adolescent girls. Furthermore, it was in Aceh, particularly in Aceh Timur district, where there were higher rates of pregnancy in girls compared to all other districts, and one of the lowest mean ages of first sex, and rates of pregnancy were at similar levels to Jayapura, which had higher rates of pregnancy compared to most districts. In most other districts, as age increased amongst adolescents, so too did the use of contraception (with the exception of Jayawijaya mentioned above where the use of contraception amongst 10- to 12-year-olds was amongst the highest rates for all districts and all age cohorts).

The results of the University of Indonesia 2009 survey indicate that there are links between knowledge of sexual health, the use of contraception, mean age of first sex, and incidence of pregnancy and STIs, although the linkages and trends are complicated, depending on context and a number of different factors. There is one clear message, however, that adolescents as young as nine have had sex in Indonesia, and that where there is little knowledge of reproductive health, low use of contraception and a low first age of sex, then the risks of pregnancy and STIs are higher. However, the results of each twin pair of districts show that the results are all relative to practices overall in the provinces. In places where contraception was most likely to be used (Solo, Sikka and Jayawijaya districts) there were also slightly lower rates of pregnancies compared to their counterparts in the twinned pairs of districts, but not always compared to other districts in other provinces. Furthermore, these findings were not uniform across all age cohorts in Solo, Sikka and Jayawijaya, and these areas did not necessarily have better knowledge of reproductive health than their counterpart districts in the twinned pairs. These findings on the use of contraception also did not necessarily correspond with rates of STIs, indicating that there is a disconnect between safe sex practices and the use of contraception.

3.3.2.3 Other adolescent practices: Smoking, drinking and drug-taking

In terms of other health issues, as age increases, in all districts, so too does the likelihood of smoking, where the rate of having smoked in the 30 days prior to the survey amongst 16- to 18-year-olds ranged from approximately 25-35 per cent across district[170]. Smoking is more likely amongst boys than girls, and rates were higher in Central Java province and Sikka district (NTT), with little difference between rural and urban areas. Furthermore, young adolescents do smoke: between 10-15 per cent of 10- to 12-year-olds reported having smoked in the last 30 days. The likelihood of smoking is reportedly driven by the influence of friends, and curiosity, again particularly amongst boys. On average, for those young males who smoke, they begin at 14 across the districts, with greater variation for girls, ranging from 13-14 years. Age 13-14 years is also when adolescents begin to experiment with alcohol, and there was larger variation for drug usage, ranging from average first use at age 10 in Kupang district in NTT, up to 17 years in Banda Aceh. Although, the ages for first use of drugs were lower in most districts than the ages of first consuming alcohol (12-13 years).

Adolescent drinking is also prevalent, with between 10-20 per cent of adolescents across the districts having drunk alcohol in their lifetime, with higher rates in NTT (around 20 per cent), and similar levels in other districts. However, in Aceh there are lower rates of having been drunk (the lowest rates overall were for Aceh Timur) and similarly high rates in Central Java and Papua, and marginally higher rates again in NTT. This was again most likely amongst boys. The comparison of regional results were the reverse for drug-taking during the adolescents' lifetimes (ranging from 1-3 per cent of adolescents having used drugs). Rates were higher in Aceh and Papua than

169 Adolescent pregnancy refers to both male adolescents (whose girlfriends fell pregnant) and female adolescents who fell pregnant as a result of his/her engagement in sexual intercourse

170 University of Indonesia (2010) *Situation analysis of adolescents 2009*

most other districts in other provinces, indicating that there may be a link between the availability or prohibition on drugs and alcohol, cultural practice, and what adolescents will experiment with. Most are influenced by friends or experiment with drugs or alcohol to release stress (particularly in Jayawijaya, Aceh Timur and Sikka, the rural areas where rates were highest for drug use). The influence of family was particularly important in NTT where alcohol consumption was most prevalent.

3.3.3 PROGRESS, STRATEGIES AND CHALLENGES

Indications are that transmission of HIV is likely to increase, as the number of HIV-positive women continues to increase. The trend of Indonesia's HIV epidemic up to 2025 shows a significant increase of new HIV cases among clients of sex workers and their partners as a reflection of the trend towards a feminized HIV epidemic, as mentioned above.[171] One of the implications for interventions required to respond to this feminization is the need to set up comprehensive integrated PMTCT services within maternal, neonatal and child health (MNCH) programmes, in particular in selected areas where the HIV epidemic has become generalized in the population, and accessible to members of the high-risk populations experiencing a concentrated HIV epidemic. This will help to ensure universal access for women and children for prevention, care, support, treatment and protection as part of the continuum of care.

Major limitations hampering a successful PMTCT response, identified in a rapid assessment conducted by the Ministry of Health, are as follows[172]:

- Lack of integration of PMTCT into the maternal and child health programmes, and consequently, limited availability of PMTCT services - VCT is only available in hospital settings and referral mechanisms within hospital departments and from community health centres are not operating optimally to maximise the use of this service.
- Inadequate quality of existing PMTCT services, especially in terms of routine provider-initiated testing and counselling (PITC).
- Lack of continuum of care and treatment for mother/infant pairs, including a comprehensive 'PMTCT Plus' package.
- Inconsistent reporting.
- Stigma associated with HIV infection.

Research, data and policy towards and about AIDS and HIV in Indonesia have tended to be tightly focused on high-risk groups rather than on the general population. This is not an unwarranted approach considering the nature of the epidemic in the country, but there are limits and some dangers associated with this narrow focus. The latest report from the Indonesian National AIDS Commission (KPA) acknowledges this and has taken steps to encourage and broaden data collection and policy.[173] This is particularly important and critical with regards to women and children. Although 25 per cent of the accumulated AIDS cases in Indonesia are female, data and research on HIV and AIDS and how they relate to women and children in Indonesia remain scant.[174] One urgent measure advocated by the KPA is to include intimate partners of most at-risk population members into the 'high-risk group' from which they are currently excluded.[175]

171 KPA (2010) *National HIV and AIDS strategy and action plan 2010-2014*
172 Ministry of Health (2007) *PMTCT Rapid Assessment*, Mimeo supported by UNICEF: Jakarta
173 KPA (2010) *National HIV and AIDS strategy and action plan 2010-2014*
174 KPA (2009) *UNGASS report*, p25
175 Ibid., p26

The new national strategic plan also added 'most-at-risk' adolescents as one of their priority groups.[176]

The KPA has introduced a new HIV and AIDS Strategy and Action Plan 2010-2014. There is continuity in programming, but also acknowledgement that the trend of the epidemic is changing. Accordingly, the new targets are as follow:

1. 80 per cent of key populations are to be reached by comprehensive and effective prevention programmes.
2. Behavioural change to prevent transmission of HIV infection will to be achieved including (a) consistent and correct condom use in 60 per cent of high-risk sexual transactions, and (b) increase in use of sterile injection equipment to 60 per cent of injecting drug users.
3. Comprehensive services will be available including assurance that all eligible PLHIV receive ARV treatment in a setting where they receive professional and humane treatment, support and care, provided without discrimination, and including provision of effective referrals as well as adequate guidance and case monitoring, as needed.
4. All HIV-positive pregnant women and their children will receive ARV prophylaxis as appropriate.
5. Every person infected and/or affected by HIV, especially orphans and needy widows, will have access to and utilise social and economic support, as needed.
6. Enabling environments are established that empower civil society to have a meaningful role in the response to HIV and AIDS, and where stigma and discrimination towards PLHIV and people affected by HIV and AIDS are eradicated. Progress in this area will need to be measured by observing the degree to which the situation of positive people and other key populations has improved.
7. Increases in government commitment to the national response and in budget allocations at all levels, thus assuring an adequate, self-reliant, and sustainable Indonesian response to HIV and AIDS.

Despite the progress made through the previous national action plans, the KPA's 2010-2014 Action Plan has identified specific areas which need additional attention including[177]:

1. Weak leadership in several government departments and regions, which has led to inadequate support policies as well as severely limited programme implementation.
2. Improvement is needed in management, including, budget design more sharply focused to facilitate achievement of targets, as well as more transparent budget management.
3. Strengthening of logistics management, particularly for ARV and methadone, to ensure sufficient stock is reliably available at treatment service sites when needed.
4. Improvement of coordination and partnership at provincial and district levels to overcome difficulties experienced by some local AIDS Commissions (KPA-D) in their efforts to coordinate with government departments, implementing agencies, local NGOs and other stakeholders in the response to HIV and AIDS.
5. Increased involvement of key populations, particularly for prevention programmes.
6. Improvement of monitoring and evaluation, particularly at the local level (province and district), with regard to the work of government departments.

176 KPA (2010) *National HIV and AIDS strategy and action plan 2010-2014*
177 Ibid., p35

The data gaps and indications of poor knowledge of adolescents on HIV and AIDS and STIs, and weak outreach services providing HIV testing and protection for young people aged 15-25 years, as mentioned above, also highlight that there is a need to pay more attention to most-at-risk adolescents, as at present there is an absence of policy and programming tools specifically designed for this group.

Furthermore, it is important to ensure that social welfare systems are HIV-sensitive and that more data is collected on the situation of children and young people living with HIV and AIDS as well as on PMTCT, all of which is crucial for proper planning. Current indications discussed above show there is a need to revise PMTCT policy to reach more pregnant women and newborns and ensure there is greater uptake of ART. An important challenge for the national response is how to increase domestic support for Indonesia's response to the epidemic. Strong political will is required to reduce dependency on overseas financial assistance to combat HIV and AIDS.

On the whole, there appear to be significant gaps in the knowledge and information about HIV and AIDS and other STIs and reproductive health more generally (including contraception) amongst Indonesian youth. One possible response is to enhance the coverage of these topics within the school system. Some steps in that direction are being taken, targeting three key dimensions: knowledge about safe sex, fostering attitudes more tolerant of others' rights and safe behaviour. However, the integration of reproductive health into the national school curriculum is currently incipient.[178]

3.4 EDUCATION

3.4.1 EXPANDING ACCESS TO EDUCATION

It is commonly accepted that higher education levels not only increase the likelihood of employment and provide better life skills, but are also related to other aspects of child welfare such as health (including HIV and AIDS prevention), nutrition, hygiene, and child protection. With this understanding and a stronger focus on the promotion and fulfilment of children's rights, working towards universal basic education (six years of primary education and three years of junior secondary education) has been a major goal of the Government of Indonesia (GoI). The expansion of access to basic education over the past two decades has been impressive. The National Medium-Term Development Plan (RPJMN) 2010-2014 uses three pillars of education policy: (1) the equality and expansion of education access; (2) the enhancement of quality, relevance and the competitiveness of education outputs; and (3) the strengthening of accountability, and the image of public education. There have been significant improvements in certain indicators in recent years but less improvement on other indicators, particularly in terms of disparities in rural areas, and among the poorer quintiles of the population. As mentioned in the discussions in the previous subsections of Section 3, education levels impact on health practices. For example, higher levels of education among mothers increase the likelihood of pre-lacteal feeding, hygienic cooking practices, hand washing, and increase the likelihood of seeking skilled birth attendants to provide assistance for a safe delivery. Furthermore, knowledge of reproductive health from school can lead to safer sex practices and potentially reduce the risk of HIV and STI infections.

178 KPA (2009) *UNGASS report*, p37

Gradually, education on various issues related to child (special) protection are being introduced into the education system and through ministerial regulations. The Indonesian Law on Child Protection (ILCP) legislates "…against violence and abuse from teachers, school managers, and schoolmates both in schools and other educational institutions" (ILCP, Article 54). For example, Ministerial Regulation No. 2/2010 on the National Action Plan for Prevention and Response to Violence Against Children specifies the responsibilities of the Ministry of National Education and the Ministry of Religious Affairs to socialise the prevention of violence against children, through such means as campaigns, workshops for all education stakeholders, and training for teachers.

As part of the GoI's goal to increase children's access to education, since 1994 it has worked steadfastly to introduce compulsory nine years education (wajib belajar), which itself was an increase from the six years compulsory education first introduced in 1984. As noted by Sharon Bessell (2007),

> "The expansion of universal education remains a policy priority. Scholarship programs and efforts to enhance community involvement in, and commitment to, education are examples of the ongoing policy focus on education. However, the low quality of education and issues around punishment and violence in schools has yet to be adequately addressed. To date the important linkages between these issues and low retention rates have not been recognized."[179]

Schools are also responsible for developing 'healthy' schools. According to Ministerial Regulation No. 57/2009, selected schools are provided with a block grant to develop 'healthy' school models and to provide facilities for physical education and health care (e.g., first aid facilities for children), among others. It is evident that child protection and child health issues must, by law, be addressed and be mainstreamed in educational practice. The challenge for the government's development partners is to support current government policies which includes addressing these issues alongside key strategic development goals outlined in the Ministry of National Education's Strategic Plan 2010-2014, which primarily focuses on issues related to increasing access to quality education and improving the governance of the education sector (through initiatives such as School Based Management, the roll-out of Minimum Service Standards, Teacher Certification, and strengthening Quality Assurance Mechanisms, to list but a few). Considering the synergies between education and other sectors related to child welfare, improving inter-department cooperation is important. The following discussion focuses on some of the trends in education in Indonesia and the challenges for the future. It is by no means an exhaustive sectoral review, but instead aims to highlight both achievements and areas for improvement.

In relation to access to education specifically, many of the government's objectives have yet to be fully realized. For example, between 1994 and 2007, children's universal education had still not been achieved with the net enrolment ratio (NER) for junior secondary school at 65.2 per cent in 2004[180], and approximately 76 per cent transitioned from primary to junior secondary school in 2009.[181] On a somewhat positive note, while still below 100 per cent, this marked

179 Bessel, S. (2007), 'Children, welfare and protection', in McLeod, R. H. and MacIntyre, A. (Eds.), *Indonesian democracy and the promise of good governance*, Institute of Southeast Asian Studies: Singapore p152. It is worth noting that UNICEF has for at least the past decade recognized the linkages between punishment, violence and low retention rates. UNICEF's education programme, has among other things promoted School Based Management and Active, Joyful, Effective Learning environments, which have directly addressed issues of violence in schools. This is clearly implied by the goal of creating 'joyful' learning environment in schools and a common slogan used in schools of '*Guru ramah, murid bahagia dan percaya diri*' (Friendly teacher, happy and self-confident student). In other words, students will not be happy if punished physically or bullied, which often results in higher rates of early school leaving, particularly in contexts where access, quality and relevance of education is low and rates of poverty are high.

180 Bessel, S. (2007) 'Children, welfare and protection', p150

181 Based on data from: Departemen Pendidikan Nasional (Ministry of National Education), *Statistics of National Education*, available at: http://www.depdiknas.go.id/ (Last accessed 10 October 2010). Based on National Socio-Economic Survey (2009) data, the net attendance rate at junior secondary school was 67 per cent.

increase between 2007 and 2009 when compared to earlier time frames can be partly attributed to the government's introduction of the School Operational Assistance (BOS) programme in 2005 (discussed in Section 2), one objective of which was to target assistance to disadvantaged children. This progress also suggests that Indonesia is set to achieve its MDG goal of achieving universal primary education by 2015.

Other important initiatives launched by the GoI include teacher certification programmes for developing key competencies and minimum qualifications, student scholarship programmes targeting disadvantaged and/or gifted children to ensure they are able to access education services, and developing standards for the quality of education services.[182] However, as with efforts to achieve universal primary education, these initiatives as yet have not been fully achieved. This is demonstrated by early school leaving rates, high rates of class repetition, relatively low transition rates to junior secondary school, and even lower rates for transition from junior secondary school to senior secondary school, as well as participation in early childhood education, which are discussed below. Additionally, it is widely accepted that much work is still required to improve the overall quality of education for children in line with Education For All (EFA) goals and, importantly, to reduce issues of violence in schools, which is also discussed further below.

The GoI prides itself on having more ambitious targets for universal basic education than those set out globally in MDG No. 2 which calls for universal primary education. According to recent evaluations, Indonesia is on target to achieve MDG No. 2 on universal primary school education by 2015, as well as MDG No. 3 on gender equality for girls' enrolment in schools. In this section on access to education, first the general trends in terms of participation at kindergarten, primary and junior secondary level schools are summarised. National aggregate data is provided and, wherever possible, disaggregated data is presented to demonstrate inequalities and disparities based on rural/urban residence, province, and gender, as well as composite indices of disparity.

3.4.2 EARLY CHILDHOOD EDUCATION (ECE)

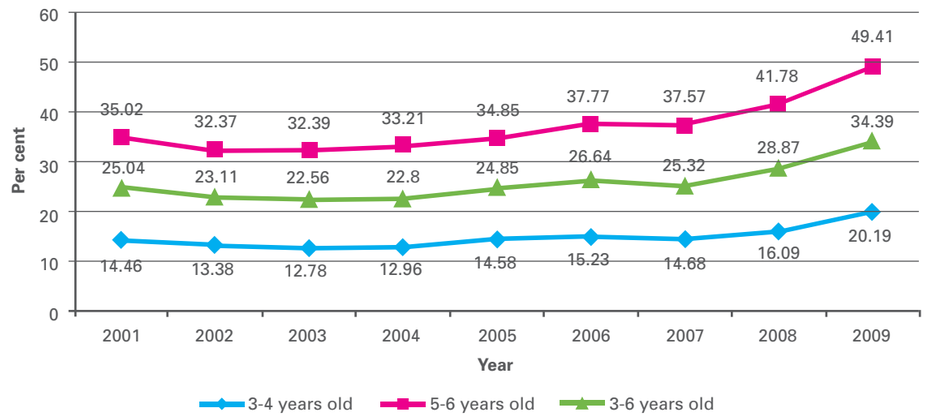
The importance and multiple benefits of early childhood education (ECE) are increasingly being recognized and promoted, not least because good quality early education contributes positively to a child's overall growth and development and increases their school preparedness.[183] The mid-decade assessment of EFA in Indonesia has also indicated that ECE has positive impacts on levels of academic achievement.[184] In Indonesia, ECE is dispensed by a variety of institutions including kindergartens, faith-based organisations, playgroups, day-care centres, holistic integrated early childhood development (ECD) services, ECE posts (pos PAUD, pendidikan anak usia dini), and faith-based ECD centres. The GoI considers early childhood education within the wider framework of early childhood services that also comprises child and maternal health services (i.e., Integrated Service Posts and Mother's programmes - see Section 3.1).

182 GoI (2010) RPJMN 2010-2014; Minister of National Education Ministerial Regulation No. 63/2009 on Education Quality Assurance;
183 See Bachrudin, M. (2007) *Early childhood care and education in Indonesia: Current practice and future policy directions*, UNESCO: Jakarta, p38. For details of impact on children and for an exploration of the broader benefits of early education to development processes and society, see: Samuelsson, I. and Yoshie, K. (Eds.) (2008) *The contribution of early childhood education to a sustainable society*, UNESCO: Paris, available at: unesdoc.unesco.org/images/0015/001593/159355e.pdf (Last accessed 1 September 2010)
184 Education For All Secretariat, Ministry of National Education (2007) *Education for all (EFA): Mid-decade assessment Indonesia*, EFA Secretariat: Jakarta

At the beginning of the 2000s, Indonesia was ranked low among other low-income countries with an ECE participation rate in kindergarten just over 21 per cent.[185] While the GoI now has a target of providing 75 per cent of Indonesian children aged 0-6 years with ECE services, even with the inclusion of frequently undercounted religion-based ECE centres and schools, the overall rate of children aged 0-6 years accessing ECE was still just under 47 per cent according to EFA estimates in 2007; still some way off its target.[186] Moreover, the rate of children aged 3-6 years accessing ECE services was only approximately 34 per cent in 2009, according to BPS - Statistics Indonesia enrolment figures (Figure 3.4.1). The RPJMN 2010-2014 acknowledges that in general in 2010 the overall provision of early childhood education services is still poor.

The data presented in Figure 3.4.1 demonstrates ECE service gross attendance rate[187] for children aged 3-6 years taken from the National Socio-Economic Survey 2009, showing a slowly increasing trend in attendance.

Figure 3.4.1: Early childhood education, 3-6 years old attendance rate over time, Indonesia 2001-2009



Source: National Socio-Economic Survey 2001-2009, processed by BPS - Statistics Indonesia. Note: The National Socio-Economic Survey report provides data on pre-school attendance (ages 3-6 years)

Data published in the mid-decade report of EFA also point towards significant urban/rural disparities for the enrolment of children aged 3-6 years old, standing at 25.4 per cent and 15.4 per cent, for urban and rural areas respectively.[188] Furthermore, data from a study of ECE financing demonstrates that around 30 per cent of children of Indonesia are excluded from a set of services that are critically important for early childhood development, which is strongly related to poverty.[189] It must be noted that one reason for low ECD participation rates is that that support for early childhood education in Indonesia is relatively new and the Directorate of Early Childhood Education was created as recently as 2001.[190] A 2005 report by UNESCO underlined that there was an almost complete absence of government investment in early childhood education and that kindergarten education was supported almost entirely by private sources, with parents

185 UNESCO (2005) *Education for all: The quality imperative*, Education For All (EFA), Global Monitoring Report: Paris, p5, available at: www.unesco.org/education/gmr_download/chapter1.pdf (Last accessed 10 October 2010)
186 Education For All Secretariat (2007) *EFA: Mid-decade assessment Indonesia*, p13
187 The term 'gross attendance rate' is used here rather than 'enrolment' as this is based on survey data
188 Education For All Secretariat (2007) *EFA: Mid-decade assessment Indonesia*
189 UNICEF (2009) *Holistic and ECD for all in Indonesia: Supporting communities to close the gap*, UNICEF: Jakarta
190 UNESCO (2005) *Education for all: The quality imperative*, p5

making the greatest contribution.[191] As a result, under these circumstances children benefiting from early education services have tended to be from higher income groups, thus fuelling inequity and disparity with regard to access to services.

The RPJMN 2010-2014 has also identified the importance of children's 'school readiness' for primary school, based on the current high repeat rate for Year 1 in primary school. Recognizing the important link between school readiness and student performance, the government has made improving both the quality and availability of early childhood education a priority in the RPJMN 2010-2014.[192] Particular challenges that have been identified as improving access to and quality of ECE services include: urban/rural divides, income group disparities, the low quality of facilities, restricted hours of service, and low qualifications of early childhood teachers.[193] The GoI's commitment to extend early childhood services to 75 per cent of children is laudable. However, perhaps as a result of the challenges outlined above, early childhood education, though experiencing improvement over the past several years due to strong advocacy and increasing public/private partnerships, continues to develop at a slower pace compared with other government initiatives in access to education.

Provision of formal ECE and other ECD services is a cross-sectoral issue involving the Ministries of Health, National Education, National Family Planning, Home Affairs, Religious Affairs, Social Welfare, Women's Empowerment and Child Protection, and the Coordinating Ministry of Community Welfare. Each of these ministries have children as a target group, but a comprehensive country policy was needed to guide the ministries on how to provide holistic services for the benefit of children in Indonesia aged 0-6 years. Therefore, two key documents were developed by BAPPENAS (the National Development Planning Agency), with the support of UNICEF. The first is a holistic and integrated ECD national strategy developed in 2008, and the second is the resulting integrated ECD policy guidelines developed in 2009 to support the national strategy.[194] These two documents now function as the national references and umbrella for sub-national governments to develop ECD and EDE programmes and as guidelines on how to translate the strategy into operational action. Since 2005, there have been more speedy improvements in ECE enrolments, based on partnerships between the GoI and the private sector and community-based non-government organisations (NGOs), which are responsible in many cases for implementing ECD and ECE.[195]

Following the initiation of these policies at the national level, a national 'holistic and integrated ECD centre' was established jointly by the line ministries (using their own budgets) working together with provincial governments in Bogor and, Yogyakarta (Java) and Jambi (Sumatera) in early 2010. This initiative was based on the ECD national strategy and implementation guidelines. It is expected that these models can inspire other sub-national governments to replicate them, and develop their own models to support the implementation of holistic ECD programmes. The following ECD policies are now key to Indonesia's ECD strategy:[196]

191 Ibid.
192 GoI (2010) *RPJMN 2010-2014*, Chapter 2, p10
193 In fact, there remain no regulations/guidelines on teacher training for ECD
194 UNICEF (2009) *Holistic and ECD for all in Indonesia: Supporting communities to close the gap*
195 Ibid.
196 BAPPENAS (2008) *The national strategies for holistic-integrative Early Childhood Development* BAPPENAS (National Development Planning Agency): Jakarta

- Improvement of accessibility, coverage and comprehensive ECD services, which address the fulfillment of the young child's holistic needs, through coverage and quality of services.
- Quality improvement of ECD services, which addresses the provision of holistic services by coverage, human services quality, materials, infrastructure and equipment.
- Improvement of inter-sectoral coordination and partnership among stakeholders at local, national and international levels. This policy addresses the promotion of sustainable service provision, service efficiency, and integration of management at all stages and levels.
- Strengthening of institutions; basic legal and community institutions, and partnership with the private sector and mass-media.

Furthermore, to support the above policies, pro-poor ECD cost and financing recommendations have been developed through a national study completed in 2009.[197] As the results of many global research and longitudinal studies have indicated[198], investing in ECD would gain a return at least seven times higher than the investment (that is, for every US$1 invested in ECD, a return of US$7 can be expected), if these services are targeted at the poor.[199] The UNICEF-sponsored study (2009) recommends that the GoI provides subsidies for each child of IDR 75,000 per month, particularly for people living in the poorest districts in Indonesia, to be paid preferably directly to the ECD centre to reduce costs for poor parents in providing their children with ECD. Investment in ECD would improve the quality of basic education and reduce early school leaving rates and repetition rates in primary school. The subsidy should cover ECE teacher salaries, operational costs, supporting materials and provision of healthy food for children attending ECE. While the gaps in terms of buildings or locations of schools should be addressed by community contributions, the capacity building of all stakeholders can be addressed by inputs from international agencies, central government or NGOs.[200]

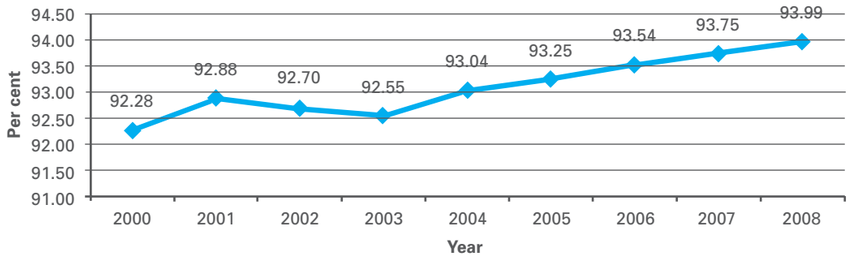
UNICEF has sought to assist the GoI in improving the quality of basic education through promoting good practices in ECD centres. These good practices have been drawn from government programmes supported by UNICEF across 23 districts in 122 provinces since 2006. Between 2006-2008, these models have been adopted by local governments using their budgets in 23 districts. In addition, with UNICEF's assistance, 4 of the 23 districts (Aceh Besar, Sukabumi, Wonosobo and Banyumas) have already developed a District Head Decree, which refers to the national ECD strategy and guidelines, and regulates ECD mechanisms to ensure that every child in each district receives holistic, integrated ECD services.

3.4.3 PRIMARY SCHOOL EDUCATION

In sharp contrast to early child education, striving for universal primary education has long been a key policy of the GoI - it is a commitment that predates the development of the MDGs. Figure 3.4.2 summarises the net attendance rate[201] between 2000-2008, showing that the rates are not only very high, but have also been steadily increasing throughout the 2000s, to reach almost 94 per cent by 2008.

197 UNICEF (2009) *Holistic and ECD for all in Indonesia: Supporting communities to close the gap*
198 Ibid.
199 Ibid.
200 Ibid.
201 This attendance rate is based on survey data, as opposed to the net enrolment rate (NER) which is based on enrolment lists. The net primary enrolment rate in primary education is the number of children of official primary school age who are enrolled in primary education as a percentage of the total children of the official school age population. For a full definition, see: UNSTATS available at: http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=589 (Last accessed 4 September 2010). *IDHS* also rely on net attendance rate data.

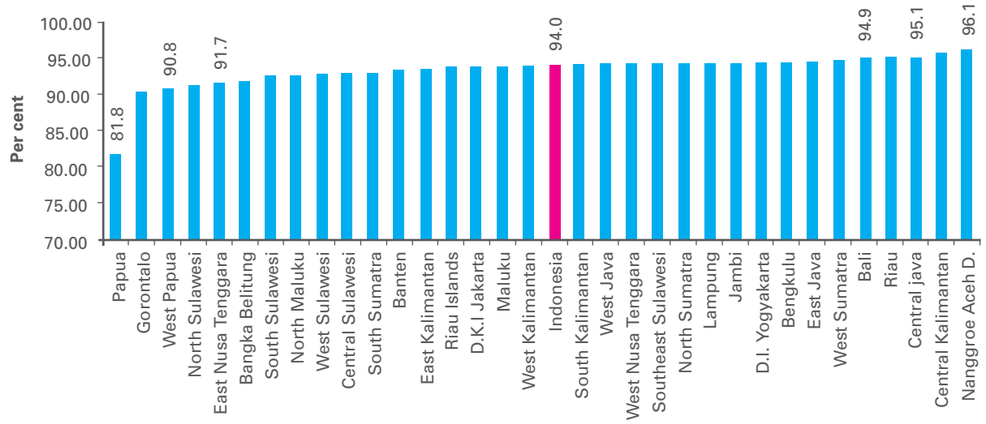
Figure 3.4.2: Net attendance in primary school, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008

Figure 3.4.3 shows that there is an almost equal number of provinces that perform better than the national average (16) and provinces that underperform (17). As expected, within the context of achieving near universal access disparities in accessing primary school are not prominent. However, whilst 32 of the 33 provinces achieve attendance rates above 90 per cent, Papua lags far behind with a primary school attendance rate of 81.8 per cent.

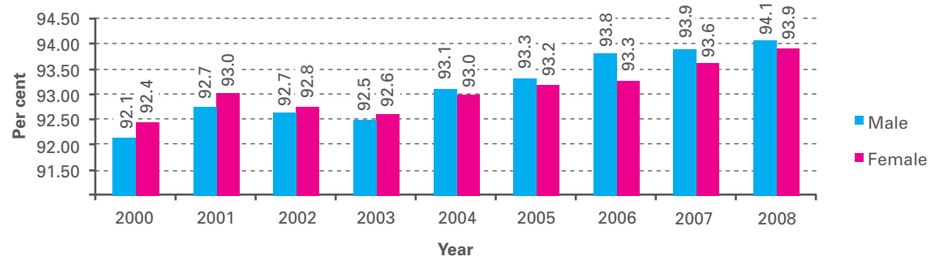
Figure 3.4.3: Net attendance rates in primary school by province, Indonesia 2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2008

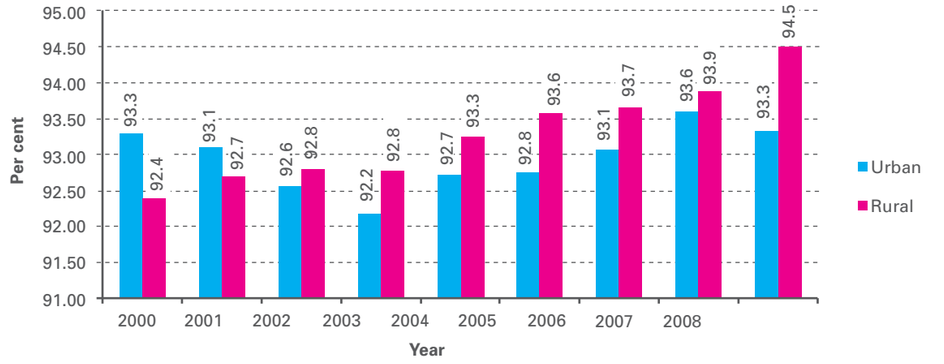
Figures 3.4.4 to 3.4.6 confirm that disparities in accessing primary education are currently extremely small. There are virtually no disparities in male/female attendance (Figure 3.4.4) and Figure 3.4.5 shows that rural/urban disparities are not only small, but that they have in fact reversed. The attendance ratio for primary school in urban areas has remained largely stable at around 93 per cent between 2000 and 2008, but the same ratio has improved in rural areas from 92.4 per cent to 94.5 per cent over the same period, with the rural areas attendance exceeding that of urban ones since 2002. Finally, Figure 3.5.6 shows an index of disparities in primary attendance, confirming that overall inter-provincial disparities are diminishing.

Figure 3.4.4: Net attendance rates in primary school by sex, Indonesia 2000-2008



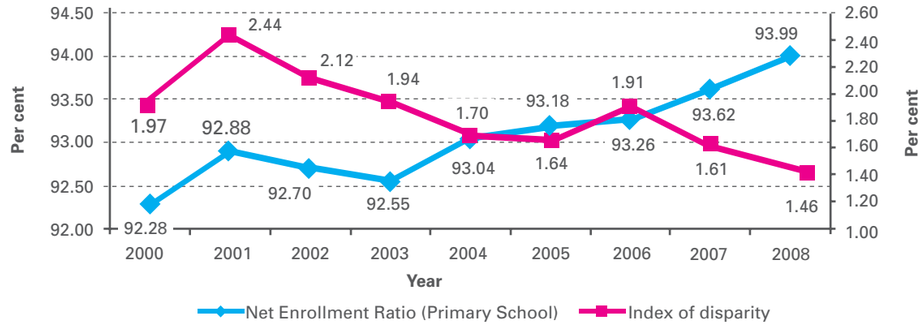
Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2000-2008

Figure 3.4.5: Net attendance rates in primary school by area, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, Welfare Indicators, based on the National Socio-Economic Surveys 2000-2008

Figure 3.4.6: Net attendance rates in primary school and index of disparity, Indonesia 2000-2008[202]



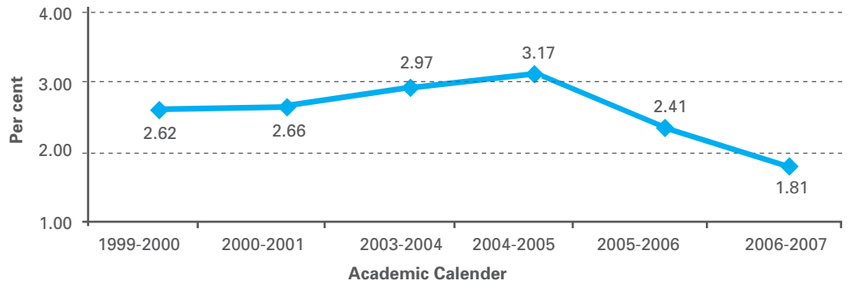
Source: Gajah Mada University, based on the National Socio-Economic Surveys 2000-2008

202 The index of disparity (ID) is defined as the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage. ID = (∑ Ir (1-n) – Rl / n) / R * 100, r = group rate, R = total population rate. Pearcy, J. N. and Keppel, K. G. (2002), 'A summary measure of health disparity', *Public Health Reports*, Vol.117: 273-280.

The last set of indicators summarised here with regards to primary education considers a distinct set of data: the early school leavers[203] (which the GoI labels as 'dropout' rates). The early leaving rate for state-run primary schools in Indonesia is low, and declined from 2.62 per cent in the 1999/00 academic year to 1.81 per cent in the 2006/07 academic year (see Figure 3.4.7 below). In the same vein, according to Ministry of National Education data, the primary school completion rate[204] has also increased from 95.05 per cent in 2005 to 96.86 per cent in 2008.[205]

Impressive completion rates (both at primary and junior secondary levels, see below) have been supported by the introduction of the BOS programme in 2005[206], as discussed previously in Section 2. The BOS programme is a system of financial assistance introduced to compensate for a sudden increase in fuel prices. The BOS programme is designed to target poor students at schools both in rural and urban areas. In contrast to previous scholarship mechanisms, BOS funds were set up to be disbursed at school level, with the funds allocated on the basis of the number of students per annum, which in theory should encourage schools to work towards the retention of students.[207] The BOS programme is substantial; in its initial year the BOS budget disposed of funds that represented an eightfold increase over that of the previous scholarship-based programme.[208]

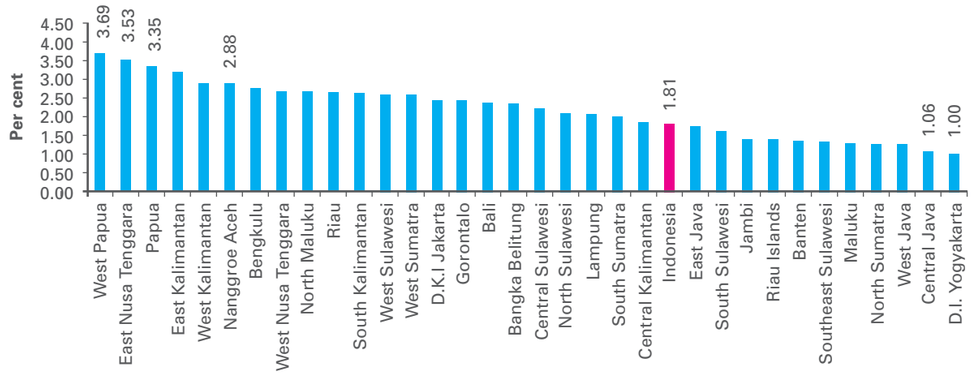
Figure 3.4.7: Trend in early school leaving (dropout) rates from public primary schools, over time, Indonesia 1999/00-2006/07



Source: Indonesia Ministry of National Education, data for academic years 1999/00-2006/07 (available at: www.depdiknas.go.id/statistik, accessed 1 July 2009)
Note: The dropout rate is the percentage of students that leave school definitively in a given academic year[209]

203 For a discussion on the importance of framing 'dropouts' as 'early school leaving', see: Cannon, R. and Arlianti, R. (2007) *Transition to and participation in junior secondary school: A research report for decentralised basic education - 3*, USAID: Jakarta
204 A completion rate is the percentage of students completing the last year of cycle of education (in this case primary school). It is calculated by taking the total number of students in the last class year of the education cycle, minus the number of repeaters in that class, divided by the total number of children of official graduation age. See definition on the World Bank Development Indicators database, available at: http://data.worldbank.org/indicator/SE.PRM.CMPT.ZS
205 Ministry of National Education (2009), *Statistics of National Education*, available at: http://www.depdiknas.go.id/ (Last accessed 10 October 2010)
206 Suharyo, W. (2005) *A rapid appraisal of the PKPS-BBM education sector School Operational Assistance (BOS)*, The SMERU Research Institute: Jakarta
207 Ibid
208 Ibid.
209 Definition from the UNESCO Institute for Statistics, available at: http://www.uis.unesco.org/glossary/Term.aspx?name=Dropout&lang=en (Last accessed 5 September 2010).

Figure 3.4.8: Public primary school early leaving (dropout) rates by province, Indonesia 2006/07

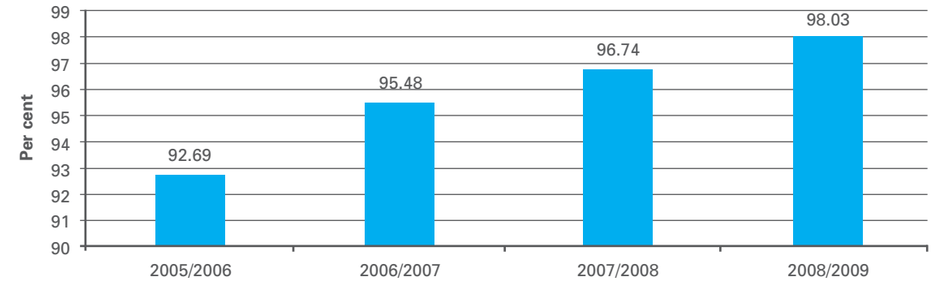


Source: Ministry of National Education, data for academic year 2006/07 (available at: www.depdiknas.go.id/statistik, accessed 1 July 2009)

3.4.4 JUNIOR SECONDARY SCHOOL EDUCATION

As with primary school, the GoI seeks to achieve universal access to junior secondary education (i.e., universal basic education for Years 1-9). However, between primary and secondary school, a significant number of children cease to attend school, a phenomenon demonstrated by transition rates from primary to junior secondary levels. The trend in improving transition rates can be seen in Figure 3.4.9 below. However, data on transition rates compiled by Cannon and Arlianti (2007) from the Ministry of National Education show it to be highly volatile, and the authors questioned the reliability of some of the data, since at the provincial level both Bali and Papua exhibited transition rates over 100 per cent.[210] Furthermore, there tend to be high levels of fluctuation in rates between years, which may be due to either educational issues or to unreliable data and processes of data collection.[211]

Figure 3.4.9: Trend in transition rates from primary to junior secondary school, Indonesia 2005/06-2008/09

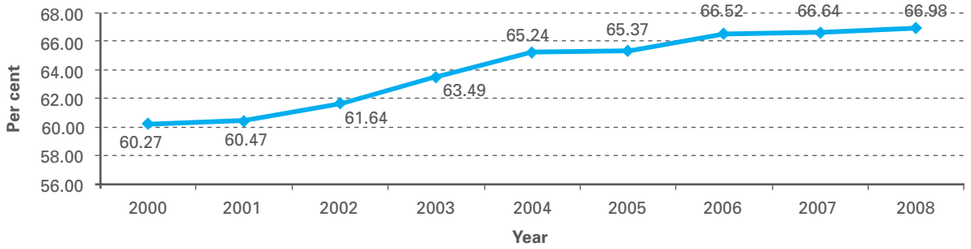


Source: Ministry of National Education, Educational Statistics in Brief, 2005/06-2008/09 (available at: http://www.depdiknas.go.id/ Last accessed 1 July 2009)

210 Migration flux and confusions over the repeat of certain grades can account for transition rates above 100 per cent, but data collection errors cannot be discounted either. Cannon, R. and Arlianti, R. (2007) *Transition to and participation in junior secondary school*, USAID: Jakarta, p15.
211 Cannon, R. and Arlianti, R. (2007) *Transition to and participation in junior secondary school*

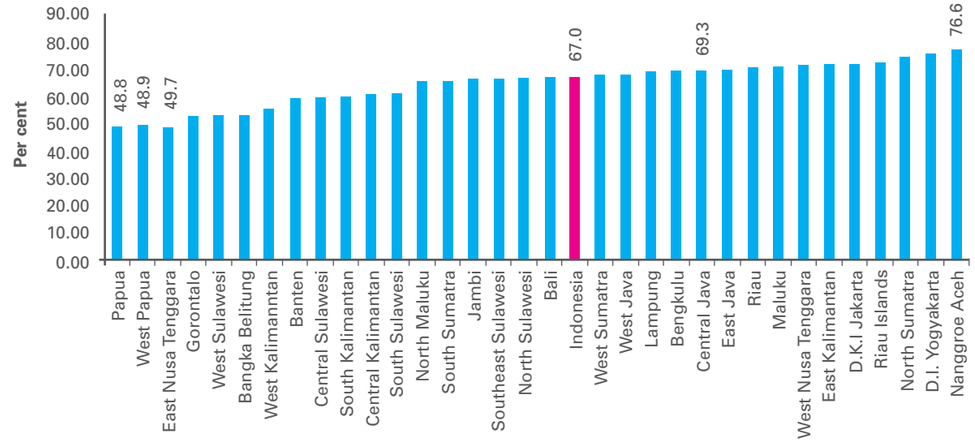
Targets for junior secondary school enrolment were set at by the Ministry of National Education at 75 per cent in 2005 and this rate was officially achieved in the 2007/08 academic year using Ministry of National Education figures.[212] Viewed from the perspective of meeting targets, this is a significant achievement, but viewed from the perspective of the 24 per cent of children who graduated from primary schools and who failed to enrol into junior secondary school, there is cause for some concern. Smooth transitions are a complex phenomenon deriving in part from accessing information, good teachers and good schools, as well as household conditions (such as poverty and parental support) and negative school experience (repeat of class years).[213]

Figure 3.4.10: Trend in net attendance rates, junior secondary school, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008

Figure 3.4.11: Net attendance rate, junior secondary school by province, Indonesia 2008

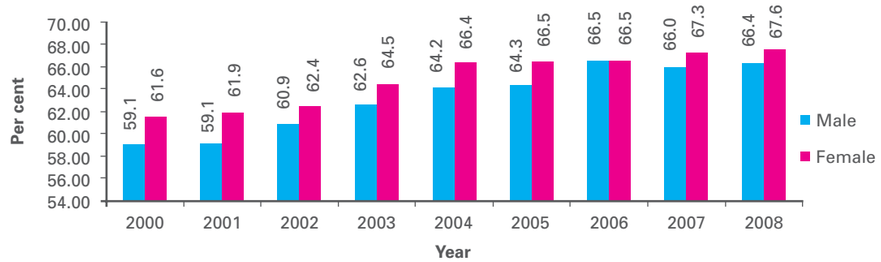


Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2008

Data in Figure 3.4.10 on the net attendance rate for junior secondary education point towards more significant challenges for the GoI in achieving its goal. Whilst the attendance rates for junior secondary schools are substantially lower than for primary education, the trend nonetheless shows a continuous and substantial increase between 2000 and 2008, from 60.27 per cent to 66.98 per cent (using National Socio-Economic Survey data). Figures 3.4.11 to 3.4.13 focus on disparities and inequalities in accessing junior secondary education. Based on National Socio-Economic Survey data presented in Figure 3.4.11, a substantial number of provinces are performing better than the national average (15) suggesting some success in improving access to secondary schools nationwide. However, these advances are more limited than those for primary schools, with 18 provinces underperforming compared to the national average and 14 of the provinces having an attendance rate more than 10 per cent below that of the best performer. In the case of primary education all provinces have an attendance rate within 6 per cent of the best performer, with the notable exception of Papua.

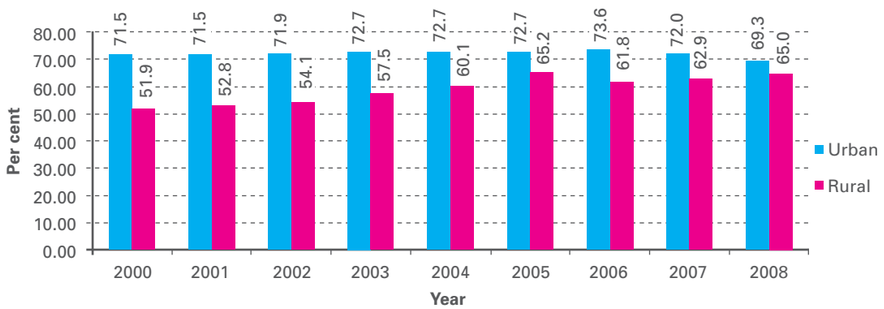
In contrast to primary school where disparities in the male/female attendance rate have virtually disappeared (0.15 per cent in favour of males in 2008), females have maintained a slight advantage over males in terms of access to junior secondary education between 2000 and 2008. Figure 3.4.12, which shows a breakdown of the secondary school attendance rate by sex, confirms this advantage. However, the differential has halved from 2.5 to 1.2 per cent between 2000 and 2008. At the same time, there is more evidence of rural/urban disparities at the junior secondary school level than at the primary school level. As with primary school, the net attendance rate for urban areas has remained relatively stable, this time oscillating around the 70 per cent mark for the 2000-2008 period (Figure 3.4.13). However, the attendance rate for rural areas was low at 51.9 per cent in 2000, but rapidly increased during the decade to reach 65 per cent by 2008. Rural areas are therefore catching up with urban areas, and whilst the rural/urban attendance rate difference remains quite substantial at around 5 per cent, it is however the lowest that it has been during the past decade. This suggests effective targeting towards areas most in need of improving access to secondary schools.

Figure 3.4.12: Net attendance rate, junior secondary school by sex, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2008

Figure 3.4.13: Net attendance rate, junior secondary school by area, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, Welfare Indicators, based on the National Socio-Economic Surveys 2000-2008

212 Ibid., p1
213 Ibid.

The data necessary to construct a disparity index were not available for the junior secondary school attendance rate. However, there is sufficient data to construct an index of disparity (ID) for the junior secondary school gross attendance rate. The gross attendance is a more approximate indicator of enrolment figures but is used here for the insight it provides in terms of the trend of disparities. Figure 3.4.14 shows greater fluctuations of the gross rates than the net attendance rate, which was steadily rising. Whilst there was an overall decrease from 10.13 to 8.01 per cent between 2000 and 2008, the ID seems to have reached a plateau around the 8 per cent mark. It is noteworthy that the ID for the junior secondary school gross rate is significantly higher than that of the net primary school attendance rate (8.01 per cent in 2008 and 1.46 per cent, respectively) reflecting that addressing provincial inequalities remains a priority if the junior secondary school attendance rate is to further improve.

Figure 3.4.14: Trend over time and index of provincial disparity of gross attendance rates for junior secondary school, Indonesia 2000-2008[214]

Source: Gajah Mada University, based on the National Socio-Economic Surveys 2000-2008

3.4.4.1 Early school leaving (dropout) and completion rates

According to data released by the Ministry of National Education in 2009, the completion rate for junior secondary school is high and has shown remarkable improvement between 2000-2008, increasing from 93.79 per cent to 98.17 per cent.[215] Once again, the BOS programme is identified as having played a key role in supporting this increase. This is attributed to improvements in education quality as outlined in government EFA targets, and a range of policy initiatives that have aimed to increase community participation in schools and school-based management, as well as the release of school-based management regulations that have promoted governance reforms at school level, and greater accountability to communities and students. Many of these initiatives have been supported by large amounts of international donor assistance.

Furthermore, as the Cannon and Arlianti (2007) study highlighted, the commitments to improve completion rates and achieve universal basic education, as well as to minimise early school leaving, are set out in the National Strategic Plan for Education (the Education Renstra) and include:

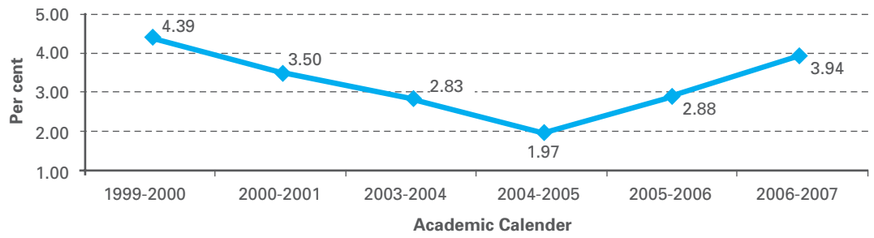
214 The index of disparity (ID) is defined as the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage. ID = (∑ Ir (1-n) – RI / n) / R * 100, r = group rate, R = total population rate. Pearcy, Jeffrey N. and Kenneth G. Keppel (2002), A summary measure of health disparity.

- Eliminate cost barriers by providing operational aid to schools (the BOS programme)
- Establish 'one roof basic junior high school' for isolated areas
- Expand access via the non-formal system, through NGOs and open junior high schools
- Integrate inclusive education for children with special needs
- Integrate 'global issues' such as gender, education for specific services, in conflict and border areas, etc., into programmes
- Advocate and educate in communities concerning the importance of education, ensuring attendance and eliminating early school leaving
- Make use of technology for distance learning as an alternative facility in isolated regions, regions facing transportation obstacles, and regions that are sparsely populated

The authors note that particular achievements have been made through the implementation of the BOS programme and the establishment of 'one-roof' schools, which are considered important strategies that do assist in improving participation by addressing obstacles to participation especially by poor children and children in remote communities.

Although the completion rate at the junior secondary school level is high, overall it must be noted that the transition to senior secondary school is disappointing: over a third of the children who complete junior secondary school (36 per cent) fail to enrol at senior secondary school.[216] When this is combined with the number of early school leavers from primary and junior secondary school, nearly half of students never complete senior secondary school. The rate of early school leaving at the junior secondary level, whilst remaining relatively low (3.94 per cent in 2006/07), is a source of some concern, since it is substantially higher than that for primary school (1.81 in 2006/07). Also, in sharp contrast to the primary school dropout rate, which peaked in the mid-2000s and has consistently improved since, the junior secondary school dropout rate after reaching an all time low of 1.97 per cent in the mid 2000s has steadily climbed since, reaching 3.94 per cent in the 2006/07 academic year.[217] The provincial breakdown of the school dropout rate shows very marked regional disparities; the best performer has a dropout rate below 1 per cent and the worst was 18 per cent. Fourteen of the 33 provinces perform better than the national average but the majority of provinces (19), lag behind the national average, four of which have a dropout rate above 10 per cent (Gorontalo, West Maluku, West Sulawesi and Central Kalimantan), mainly in eastern Indonesia.

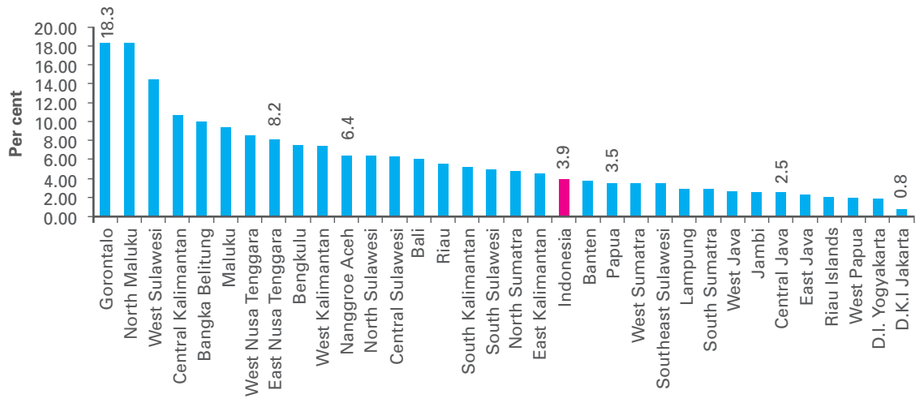
Figure 3.4.15: Trend of early school leaving (dropout) rate for junior secondary school, Indonesia 1999/00-2006/07



Source: Ministry of National Education, data for 1999/00-2006/07 academic years (available at: www.depdiknas.go.id/statistik, accessed 1 July 2009)

215 Ministry of National Education (2009), Statistics of National Education, available at: www.depdiknas.go.id (Last accessed 10 October 2010)
216 Ministry of National Education (2009) Statistics of National Education, available at: www.depdiknas.go.id (Last accessed 10 October 2010)
217 Ibid.

Figure 3.4.16: Early school leaving (dropout) rate by province, Indonesia 2006/07



Source: Ministry of National Education, data for 2006/07 academic year (available at: www.depdiknas.go.id/statistik, accessed 1 July 2009)

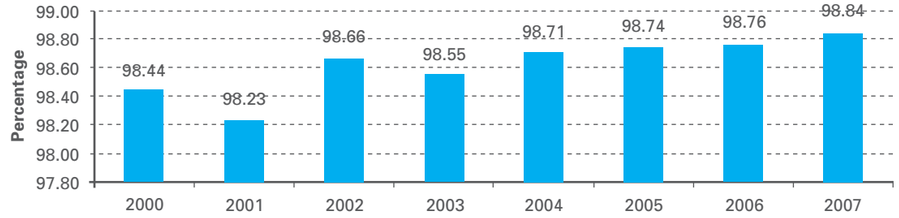
3.4.5 SENIOR SECONDARY SCHOOL EDUCATION

It is also important to briefly examine the data on senior secondary school attendance, as the GoI aims to increase the quality and coverage of senior secondary education in the 2010-2014 development period. The net attendance rate of senior secondary schools, according to data from the 2008 National Socio-Economic Survey, is 44.75 per cent, with similar rates for males and females (44.98 and 44.51 per cent, respectively). This has improved since the 2000 National Socio-Economic Survey, when the net attendance rate was 39.8 per cent. Gross rates were 57.87 per cent for males and 56.95 per cent for females in 2008 in the same data sets. However, provincial disparities do remain (other data breakdowns are unavailable), and the worst performers have rates just under 35 per cent, including West Sulawesi, and East Nusa Tenggara. This is compared with rates just above 55 per cent in North Sulawesi, Yogyakarta, Bali and Maluku, with Aceh having the highest rate at 62.02 per cent, which is no doubt due to the post-tsunami education drive in the province.

3.4.6 YOUTH AND ADULT LITERACY

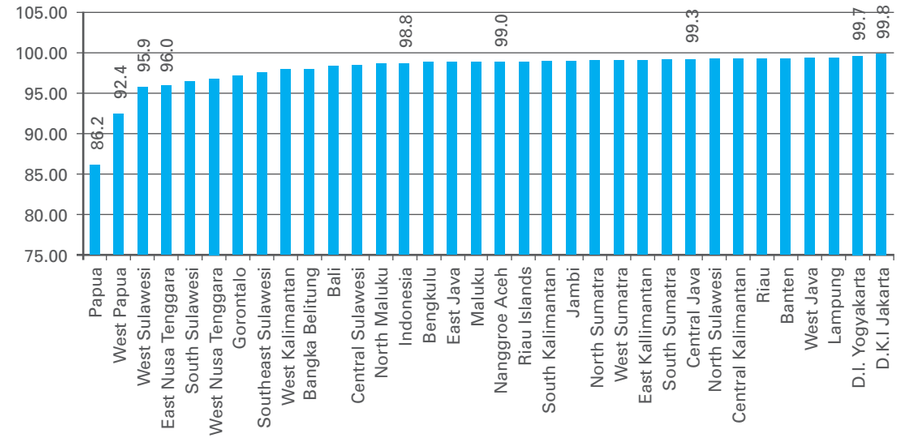
The final set of data regarding education that we consider in this section focuses on a basic outcome of the education process: youth and adult literacy. The youth literacy rate (referring to those aged 15-24 years) is high and has ranged between 98-99 per cent over the past 10 years (Figure 3.4.17). The breakdown of the data at provincial level provides a picture showing some notable contrasts. On the one hand, a large number of provinces are performing well and 20 of the 33 Indonesian provinces have youth literacy rates above 98 per cent (Figure 3.4.18). Amongst the disadvantaged provinces, 13 provinces have youth literacy rates below the national average, although most have rates above 90 per cent. Once again Papua stands out with a low youth literacy rate of 86.21 per cent (see the Figure 3.4.18 below).

Figure 3.4.17: Trend of youth literacy rate (15-24 years), Indonesia 2000-2007



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2000-2007

Figure 3.4.18: Youth literacy rate (15-24 years) by province, Indonesia 2007



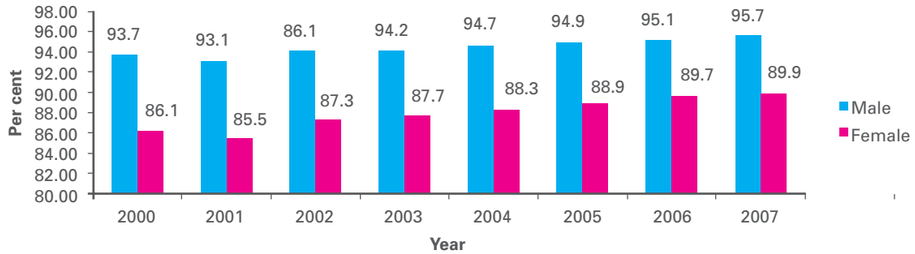
Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2007

Standing at over 92 per cent in 2008, the overall old adult literacy rate for ages 10+ years (not presented here) is high and has increased slowly but steadily throughout the 2000s.[218] The breakdown of the data at provincial level provides a contrasted picture. On one hand, a large number of provinces are performing well and 23 of the 33 Indonesian provinces have adult literacy rates above 90 per cent and 27 of the provinces have literacy rates no less than 10 per cent below that of the best performer (North Sulawesi with 99.12 per cent).[219] Amongst the disadvantaged provinces, ten provinces have adult literacy rates that fail to reach 90 per cent and once again Papua stands out with an adult literacy rate that falls short of 73 per cent.[220] The data on adult literacy rates for those aged 10 years and above (age 10+) shows similar patterns to that for those aged 15+ years, but an encouraging sign is that the provincial data show signs of improvement, particularly for those aged 10+, hopefully indicating that the continuing expansion of basic education throughout the country is bearing fruit.[221] In the case of the age 10+ adult literacy rates, 25 provinces have adult literacy rates above 90 per cent, with just 8 provinces having rates less than 90 per cent.[222] However, again Papua stands out badly with a very slightly improved but nonetheless worrisome adult literacy rate not quite reaching 75 per cent.[223]

218 BPS - *Statistics Indonesia (2009) National Socio-Economic Survey 2008*
219 Ibid.
220 Ibid.
221 Ibid.
222 Ibid.
223 Ibid.

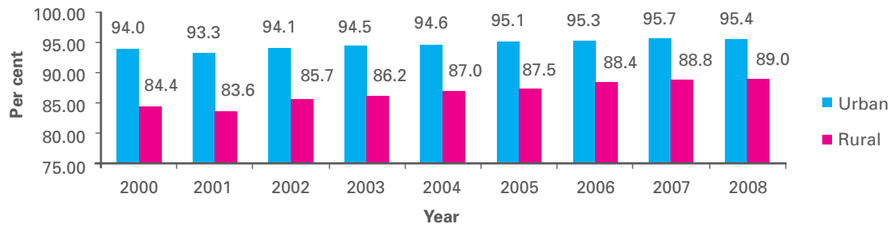
Given that youth literacy rates are high in most cases, and adult literacy (age 10+) rates are improving, it is also important to examine the gender and urban/rural breakdowns for adult literacy. Figures 3.4.19 and 3.4.20 provide additional information on the existence and dimensions of disparities in adult literacy. Whilst the data on attendance rates in basic education showed either parity or a relative advantage for females, the adult literacy figures show female to be at a distinctive disadvantage. Gender disparities are diminishing in the trend for adult literacy (15+ years) since they decreased from an 8.66 per cent difference in 2000 down to a 6.28 per cent difference in 2008. In addition the data amongst those aged 10+ years are only marginally better, with a disparity of 7.59 per cent in favour of males in 2000 decreasing to 5.78 per cent in 2007 (see Figure 3.4.19, below). Furthermore, as with attendance rate data, urban areas have much better adult literacy rates than rural areas, but whereas the urban adult literacy rates have remained stable between 2000 and 2008 around the 95 per cent mark, the adult literacy rates in rural areas have improved from just over 84 per cent to 89 per cent in 2008, decreasing the gap between urban and rural areas from 9.66 per cent in 2000 to 6.4 per cent by 2008.

Figure 3.4.19: Adult literacy rate (age 10+ years) by sex, Indonesia 2000-2007



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2000-2007

Figure 3.4.20: Adult literacy rate (age 15+ years) by area, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, Welfare Indicators, based on the National Socio-Economic Surveys 2000-2008

3.4.7 WEAK DATA AND MONITORING: INFORMAL EDUCATION INSTITUTIONS AND THE PROVISION OF STATE EDUCATIONAL FACILITIES FOR DISABLED CHILDREN

It is important to highlight how very little data there is on disabled children and the challenges they face in accessing education, particularly state-run education. Box 3.4.1 below outlines the story of a resilient disabled child named Slamet, who is one of those few fortunate enough to have a place in a disabled school run by an NGO that is also able to provide him with access to health care. In order to attend this school, he has to live several hundred kilometres away from his parents. However, it is evident that despite fairly informal, low-paid employment, Slamet's parents have prioritised schooling for their children; his sister finished senior high school, which, given the discussion in the previous section, is less likely in poor families like Slamet's. Living in a special institution and with the support of the foundation, Slamet is able to access the health care he needs, although - as later discussion in the section on child protection points out - there is very little monitoring or accreditation of such alternative education and care institutions. As Slamet himself points out, there is limited support in mainstream education for disabled children. All Slamet wants is his independence, and he has identified a number of forms of support that the government might provide to assist the disabled in terms of providing disabled-friendly buildings, public transport and better provisions for disabled children in mainstream schools. As is discussed later in Section 4, vulnerable children such as Slamet, despite extremely challenging circumstances (in his case a debilitating disease), tend to be not only aware of the support they need, but they have extraordinary coping mechanisms and strategies to approach and solve their problems.

Box 3.4.1: Searching for independence despite disability

Slamet is a 15-year-old disabled child. His sister is 20 years old and has finished senior high school. His dad has a mobile street stall from which he sells meatball soup (bakso keliling) and his mum sells traditional medicines and remedies (jamu gendong) in West Java. Slamet lost the ability to use both legs and hands when he was a young child and he is bow-legged. He has been having treatment since 1996 for the disease that resulted in his disability. He recently had surgery to straighten his legs. However, Slamet says that this seems not to have helped and he needs a wheelchair.

Fortunately, Slamet has been studying at a special non-government school for disabled, blind and deaf children in Solo city, called the Disabled Child Foundation (YPAC, Yayasan

Pembinaan Anak Cacat). Slamet lives in the school dormitory, which means he can also access health care treatment nearby. This, he says, would not be possible if he remained with his family, whom he only sees in the holidays. Although he is a disabled, Slamet values his independence and tries to live as independently as possible, but this is difficult as he can't put his clothes on by himself, so his friends help him get dressed. He can't use public transport so he has to rely on people to ferry him around. As he sees it, the only way to get his independence is to recover from the disease.

Slamet says that when he was a small kid, he was a naughty boy who behaved badly, never obeyed the rules, and was undisciplined. Sometimes his parents would smack him on the bottom if he was naughty. However, as he sees it, the main punishment he received was that his parents would treat him as a 'normal child' (non-disabled child) when he was naughty and they made him do things for himself. For him, however, being treated as a normal child "made him feel good and confident," and it upset him that his parents considered this to be punishment. Slamet thinks that if he makes a mistake his parents should be gentle with him and inform him of the difference between right and wrong.

Slamet says when he was younger, he used to get upset easily, but now he is far happier and more adaptable. He doesn't like it when people look at him as though he is abnormal. Once he was even followed by someone, which made him feel uncomfortable, desperately

unhappy and annoyed. So he reprimanded the person. It makes him unhappy to be labeled as a disabled child and he dislikes being pitied. On one occasion, he was so disappointed with one friend that he punched his friend. He regretted it when his friend was wounded and bleeding - he knew he was wrong and tried to help his friend get cleaned up.

Slamet is confident in making friends and has friends inside and outside the dormitory, and he likes having non-disabled friends, he says. He sometimes invites these friends to come to the dormitory to encourage his disabled friends to be more self-confident and feel equal with other non-disabled children.

Slamet thinks it would be hard for children with disabilities to study at mainstream schools, but he hopes that disabled children will be not only be accepted in special schools (SLB, Sekolah Luar Biasa) but also in mainstream school, as he thinks that disabled children will get more experience in mainstream schools. However, according to Slamet not all schools will accept disabled children. Slamet says:

"The government is not paying attention to the disabled. There are some schools that accept disabled children and some that don't. What does it mean? If it is possible, schools should give the same access to the disabled as non-disabled children. So the buildings and the construction too [should be accessible to disable students]. I've suggested this to the City Mayor… Transportation [should be] accessible to disabled children…motorcyclists should not use the pedestrian lanes, and public facilities should not only have staircases."

Source: Based on an oral history provided by Slamet over several 90-minute sessions. His name has been changed to protect his identity.

A 2002 JICA report[224] has highlighted that while there are special schools for people with disabilities, those who live in remote areas have limited access to these educational facilities, particularly outside of Java. While the same report did indicate there has been a trend towards including and integrating children with disabilities into the nine-year compulsory education curriculum[225], in the absence of data and monitoring of the facilities for disabled children over time, it is difficult to ascertain the extent to which schools can accommodate disabled children.

3.4.8 POLICY CHALLENGES: QUALITY, RELEVANCE AND COMPETITIVENESS IN THE DECENTRALISED CONTEXT

On the whole, access to basic education has markedly improved in Indonesia over the past decade and the increasing rate of adult literacy suggests that it is delivering some key benefits to large sectors of the population. However, increasing access and increasing the number of pupils is of limited benefits if the education imparted is of poor or dubious quality.[226]

224 Japan International Cooperation Agency (JICA) Planning and Evaluation Department (2002) *Country profile on disability: Republic of Indonesia*, available at: http://siteresources.worldbank.org/DISABILITY/Resources/Regions/East-Asia-Pacific/JICA_Indonesia.pdf (Last accessed 15 October 2010)
225 Ibid.
226 UNESCO (2005) *Education for all: The quality imperative*

Quality of education is a notoriously elusive concept; what it consists of, how it can be delivered and how it can be monitored are hotly debated in the specialist literature.[227] In a 2000 paper, the UNICEF approach to quality of education proposed the following five dimensions of quality: learners, environments, content, processes and outcomes, founded on 'the rights of the whole child, and all children, to survival, protection, development and participation'.[228] Some of these very disparate dimensions are not easily quantifiable (notably, those that focus on learners and assisting cognitive development). Elsewhere, there are debates about how educational outcomes may be best measured and whether data about exam scores constitute an appropriate indicator. Even in this area, however, data can be hard to find. The 2000 SITAN stated that there is considerable evidence of poor learning achievements in Indonesia, but that the paucity of data and limited indicators rendered monitoring and analysis difficult.[229] Whilst the issue of poor learning achievements has gained prominence in Indonesia, data deficits have not been wholly addressed. Thus, a national system of assessment based on benchmark indicators (basic literacy and numeracy) has still not been implemented.[230]

However, there are several broad areas relating to the quality of education that have been identified by the GoI, including: learning achievement; the quality of teachers; and the need to improve the structure, responsiveness and the coherence of the educational system (RPJMN 2010-2014). As noted above, poor learning achievements have repeatedly been reported in Indonesia. For instance, in 2003 Indonesia ranked 34 out of 45 countries in the Trends in International Mathematics Science Study (TIMSS) and ranked last out of 40 countries in both mathematics and language in the Program for International Student Assessment.[231] At the national level, the limited data available indicate that average national exam scores have improved very slightly from 6 to 7 between 2004-2008, making progress towards RJPMN 2010-2014 targets.

One issue central to the quality of education is the quality and qualifications of teachers. In a policy brief on education quality published in 2005, the World Bank identified a number of issues regarding teachers and the teaching profession.[232] In the brief, the Word Bank underlines a general lack of qualifications amongst teachers, shortcomings in teacher training and accreditation, poor allocation/deployment strategies (i.e., some areas are overstaffed whilst there are acute shortages in others) and poor career path (shortcomings in the systems of promotions and appointment, and poor attention to career development).[233] Elsewhere, a USAID reports underlined the ongoing predominance of antiquated teaching methods, notably through teacher-centred approaches in the classroom.[234] Similar to the case of health and nutrition discussed in an earlier section of this SITAN, the Ministry of National Education is also subject to the Minimum Service Standards (SPM) that have been issued under the Ministry of Home Affairs' Regulation on Technical Guidance on Formulating and Establishing Minimum Service Standards for Government Departments. Thus Ministry of National Education issued Ministrial Regulation No 15/2010 on minimum service standard for basic education.

227 For a summary of the debates, see UNESCO (2005) *Education for all: The quality imperative*, Chapter I
228 UNESCO (2005) *Education for all: The quality imperative*, p3
229 UNICEF and Government of Indonesia (2000) *Challenges for a new generation: The situation of children and women in Indonesia, 2000*, UNICEF: Jakarta, p101
230 Weston, S. (2008) *A review of the implementation of nine years universal basic education. Report to USAID, Decentralized Basic Education - 3.* USAID: Jakarta, p4, cited in: Cannon, R. and Arlianti, R. (2007) *Transition to and participation in junior secondary school*
231 Santika, M. and Cahyanto, J. (2009) *Indonesia's innovative teacher training program for investing in the future*, presented at the 4th World Teacher's Day in Thailand, and at the 12th UNESCO APEID Conference 2009
232 World Bank (2005) 'Improving education quality', *Indonesia Policy Briefs: Ideas for the Future*, The World Bank: Jakarta.

The GoI introduced a number of policies to address some of these shortcomings, chiefly by increasing the number of qualified teachers and ensuring that teachers at secondary level teach the subjects in which they are competent. Qualified teachers in Indonesia are defined as those who have obtained standard educational qualifications and who possess competency in pedagogy, teaching, professional and social skills.[235] The Law on Teachers and Lecturers (No. 14/2005) now mandates that teachers must be in possession of bachelor's degree as well as be in possession of a professional certificate.[236] Table 3.4.1 summarizes data on the number of qualified teachers at the time the law was introduced and indicates that their numbers have increased sharply across the pre-school, primary and junior secondary school cycles in recent years.

Table 3.4.1: Percentage of qualified teachers, Indonesia 1999-2005

Academic year	Per cent of qualified kindergarten teachers	Per cent of qualified primary school teachers	Per cent of qualified junior secondary school teachers
1999/00	9.7		
2000/01	9.8	7.92	42.22
2001/02	9.4	8.35	42.35
2002/03	9.4	9.01	54.87
2003/04	29.9	15.24	60.59
2004/05			

Source: World Bank/Ministry of National Education, 1999/00-2004/05

The number of qualified teachers is highest in secondary schools, currently reaching 60.59 per cent, but remains unacceptably low amongst primary school teachers (15.24 per cent). More recent data published in a USAID report (2009) indicate that 84 per cent of primary school teachers did not meet the degree requirements set by law. A further study by the World Bank (2009) finds teachers to be poorly paid, and noted an ineffectively managed teaching service, both at the district and school level, which it argues is affecting school performance.[237] Moreover, it argues that previous efforts to improve this situation through salary increases, professional development courses, improvement in training, promotion possibilities, and other strategies have largely failed to achieve their goals, mainly due to being implemented in a piecemeal fashion. Instead, the report argues that key to improving quality is the teacher certification process now mandated by the Law on Teachers and Lecturers (No. 14/2005), which is currently being implemented. Certification is now a requirement for both in-service and pre-service teachers in order to guarantee the standards of training and competency of teachers. The Law aims to address the abovementioned issues of teacher quality comprehensively by linking a varied range of strategies to significant salary increases. In particular, the law outlines a series of competencies for teachers:

- Pedagogical competency (such as designing and implementing learning methods)
- Personal competency (character, leadership)
- Professional competency (theoretical and practical knowledge)
- Social competency (moral values, good behaviour)

233 Ibid.
234 USAID (2009) *Teacher education and professional development in Indonesia: A gap analysis*, USAID: Jakarta
235 Law on Teachers and Lecturers (No. 14/2005)
236 USAID (2009) *Teacher education and professional development in Indonesia*
237 Jalal, F., Samani, M., Chu Chang, M., Stevenson, R., Ragatz, A. B., and Negara, S. D. (2009) *Teacher certification in Indonesia: A strategy for teacher quality improvement*, The World Bank and the Indonesian Ministry of National Education: Jakarta

The changes in the system to promote teacher quality are outlined in the Ministry of National Education Strategic Plan (Renstra) 2010-2014, to provide competent teachers in all provinces and districts.[238] The Ministry of National Education Renstra aims to provide competent school management equally in all provinces and districts, through providing competent school principals, supervisors and administrative staff.[239] It collectively addresses classroom teachers and teaching-related staff such as supervisors, principals, technical and administrative staff, reflecting the Ministry of National Education National Standard for Teachers and Teaching Staff.[240] Cannon and Arlianti (2010) argue that this inclusive approach to the 'teaching workforce' is a distinctive and distinguishing characteristic of the National Standard and of Renstra and has clear implications for the continuation of 'whole school' development approaches.[241]

One challenge for improving the quality of education more generally is ensuring that the sub-national governments are equipped to implement the national strategy and standards as outlined in the Ministry of National Education Renstra, and regulations on education. The Renstra 2010-2014 clarifies the functions of the three levels of government in Indonesian education as follows:

- Minister of National Education - responsible for the management of the national education system, including national policy and national education standards;
- Provincial governments - coordination of the implementation of education, developing teaching staff and providing facilities for basic and secondary education across districts;
- District and city or municipality governments - responsible for managing basic and secondary education and educational institutions that are based on local 'superiority or excellence'.

The Renstra 2010-2014 priorities include: (1) new instruments and processes are needed to strengthen mutual accountability between executive and parliamentary arms of government; (2) measures to increase the results orientation of financial planning and budgeting systems are also critical; (3) key capacities also need to be strengthened or extended, especially personnel management, performance monitoring, quality assurance and internal audit systems; and (4) the current fragmentation of financial and information systems also needs to be addressed.

Government Regulation No. 38/2007 allocates responsibilities for planning whereby the central government develops a national strategic plan, the provincial government a strategic plan for education in the province, and district government develops an operational programme for education in the district. However, planning laws that require both provincial and district offices to prepare strategic plans requires close monitoring to ensure that capacity building in planning is consistent with laws and regulations prevailing at any given time. The Cannon and Arlianti (2010) 'Education Policy and Practice' report identifies a number of issues that make implementing education standards and regulations at the sub-national level challenging. The following points are adapted from Cannon and Arlianti, which identifies the challenges as, amongst others[242]:

- Complexity: The implementation of new laws and regulations across finance, decentralization, education, child protection and health, the introduction of the new Renstra, the impact of international agreements on external development assistance, in addition to changes in society and technology; all of these create a very complex

238 Cannon, R. and Arlianti, R. (2010) *Education policy and practice: A study of changes in government of policy and practice since MGP-BE Project Inception*, UNICEF: Jakarta
239 Ibid.
240 Ibid.
241 Ibid.
242 Ibid., pp6-8

environment for project implementation. The challenge for projects is to correctly interpret this complexity to address the needs and conditions in schools, which are often relatively simple in nature.

- Change: The policy environment within which projects operate is constantly changing. This is illustrated by the implications of the Law No. 9/2009 on Education Legal Entities, which was repealed on 31 March 2010. That law had profound implications for school-based management, among others, by creating schools as separate legal entities, no longer 'owned' by government agencies or private providers. The overall objective of the law was to guarantee true autonomy at the school level.
- Uncertainty: As of mid-May 2010, there has been considerable uncertainty around changes in the national governance of education that are in process. This means, for example, that planning proposals in the present Renstra may not be actionable when there is uncertainty about important administrative and technical arrangements in organisational structures and responsibilities. Uncertainty implies that donors and projects need to very closely monitor developments in the areas of their special interest to manage the risk of implementing strategies that are possibly out-of-date or inconsistent with the regulations.
- Balance: The 'Education Policy and Practice' report reveals an imbalance in the content of the regulatory environment between an emphasis on educational administrative, legal, financial and decentralization matters on the one hand, and child, teacher and curricular[243] matters on the other. The implication is that education and child protection specialists must work hard to ensure that learning and teaching matters - and the interests of children - are not neglected at each stage of the development assistance cycle. The importance of balance is also noted in the conclusions of the 2007 review of EFA. That review concluded that it is essential to ensure an effective balance between quality of teaching and learning and efficiency improvements.

The current development of standards and quality assurance and improvement systems in education comes with risks that have been identified in the Good Practices for Mainstreaming in Basic Education 2009 report released by UNICEF:[244]

- The approaches to quality improvement and the burdens they introduce, may overwhelm schools and districts.
- Quality improvement approaches may be poorly aligned with Renstra, and particularly with the educational purposes of schools. They may also be poorly integrated with other quality assurance requirements leading to duplication and waste, as happens now with multiple data collection in districts.
- Quality improvement systems risk leading to over-regulation of schools, with a focus on inputs and outputs at the expense of the more complex, and ultimately more important, learning processes.
- Educational lessons learned about the detrimental impact of 'teaching to the test' and 'what gets rewarded gets done' are at risk of being ignored in the design of quality improvement systems, leading to potential distortions in the learning process.
- There is a risk of resistance. Schools and teachers committed to supporting children's learning may begin to resist these well-intentioned quality improvement strategies when they see them diverting their time and resources away from learning and teaching.

243 'Curricular' is used in the broad sense to refer to concepts that are generally integral components of the whole 'curriculum process': educational aims and objectives, curriculum and lesson planning, learning and teaching methods, assessment of student learning and curriculum evaluation.

244 UNICEF (2009) *Good practices for mainstreaming in basic education*, 3rd revised ed., UNICEF: Jakarta

In spite of these ongoing challenges, a number of initiatives of the GoI and the Ministry of National Education/Ministry of Religious Affairs are underway with the support of international donors. For example, the World Bank is assisting the Ministry of National Education with initiatives to improve education and teacher quality, and to improve monitoring and evaluation systems.[245] Furthermore, the Asian Development Bank (ADB) has worked with the GoI to develop Minimum Service Standards to better 'equip schools', which in theory will increase funding to schools.[246] AusAID, through the Australia-Indonesia Partnership (AIP) also supports the GoI in its commitment to achieving nine years compulsory free schooling through the Basic Education Project (BEP), which commenced in 2006 to increase equitable access to basic education, improve quality and standards, and strengthen education governance and accountability mechanisms. The programme especially targets disadvantaged areas in Indonesia.[247] Other initiatives, such as the AusAID-funded Communities and Education Project in Aceh (CEPA), have sought to improve access to schools in poor and isolated conflict-affected areas in Aceh. The aims are to: rehabilitate schools; assist with improvements in curriculum in line with national standards; and improve schools-based management, accountability and community participation in education. CEPA used conflict-sensitive approaches to development through a high level of programme-provided facilitation and negotiation with communities to support joint ownership of education initiatives.[248]

Based on many of the findings discussed above on what is needed to achieve quality education, UNICEF, together with a number of other international donors and organisations, have supported Ministry of National Education through the Mainstreaming Good Practices in Basic Education (MGP-BE) project which aims to enhance district, municipal, sub-district and school capacity to govern, manage and implement basic education services, following the national regulations, strategies and guidelines.[249] This is just one example of the many joint programmes between the GoI and other international agencies operating in Indonesia to improve education outreach, quality, and management. A brief examination of the changes slowly being achieved through this project is illustrative of the returns on programmes aiming to improve education quality.

MGP-BE began in 2006, and was designed to work with 12 districts in six provinces. It has target areas where capacity development assistance is provided with the ultimate aim that good practices will be replicated in non-target areas. Capacity development assistance is provided at three institutional levels (individual, organisational and regulatory), for schools, government and for education practitioners and sector managers at these respective levels. Areas covered include: schools-based management (SBM) and community participation and oversight of schools; supporting Active, Creative, Effective and Joyful Learning (PAKEM, Pembelajaran Aktif, Kreatif, Efektif dan Menyenangkan); understanding, enacting and implementing government regulations and many of the principles of the national strategies and standards outlined above; and working towards improving the quality of education at the sub-national level.[250] Moreover, the MGP-BE includes strengthening the regulatory environment (between different levels of government and between related line ministries and government agencies), between practitioners/managers, and creating successful 'models of change' upon which to base future dissemination and replication of good practices. It also endeavours to work with sub-national governments to incorporate good practice approaches into budgeting processes and strategic development plans at district, provincial and national levels.[251]

245 The World Bank (2010), Indonesia - projects and programs, available at: http://web.worldbank.org (Last accessed 1 November 2010)

246 Asian Development Bank (2010), Indonesia - Project, available at: http://www.adb.org/indonesia/ (Last accessed 1 November 2010)

247 The Australia-Indonesia Basic Education Programme, available at: http://www.bep.or.id/ (Last accessed 1 November 2010)

248 AusAID (2010) Communities and Education Project in Aceh (CEPA), available at: http://www.indo.ausaid.gov.au (Last accessed 1 November 2010)

249 UNICEF/GoI (2007) *Basic education sector capacity support programme in Indonesia: Mapping good practices for mainstreaming in basic education*, UNICEF: Jakarta

250 Ibid.

251 Ibid.

Figure 3.4.21 below shows the overall level of good practice replication to non-target schools in all the project's target sub-districts (two per district, i.e., 24 sub-districts), levels of replication for all non-target sub-districts across all 12 partner districts, and a combined level of replication to non-target schools across all the 12 MGP-BE target districts.[252] The data demonstrate that by the end of 2009, the overall level of replication of good practice is 25.25 per cent of all schools. Compared to a baseline figure of 5.98 per cent, this is a 19.27 per cent increase in the number of schools that have adopted good practice. However, there is a striking difference in the levels of replication between target and non-target sub-districts. Overall, 81.4 per cent of schools in target sub-districts have adopted good practice compared to only 17.2 per cent of schools in non-target sub-districts. The speed at which schools are adopting good practice in target versus non-target areas is also markedly different, as indicated by year-to-year changes (33.6 per cent compared to 10.4 per cent). Yet, the figure indicates that there can be spillover effects of targeted assistance to other districts and sub-districts not participating in this or similar programmes to improve education quality.

Figure 3.4.21: MGP-BE good practice replication in non-target schools, Indonesia 2008-2009

Source: UNICEF (2010), Preliminary Result Replicating Good Practices, Trends from 2008-2009, UNICEF: Jakarta

One of the good practices that the MGP-BE partner schools promote is having active, functioning school committees and community support for schools, which has increased consistently since the baseline of the project.[253] Under decentralisation, improving schools management will be an important part of improving education quality. By 2010, in the MGP-BE project, it was evident that there has been consistent improvement in schools management since the baseline conducted in 2009[254], particularly for school planning and budgeting. This indicates that the programmes working in improving education quality would benefit from working with government and schools to improve school management processes.

In terms of learning and teaching in schools, particularly at the primary school level, the results related to early school leaving (dropout) and transition rates at primary school and junior secondary school levels were positive from MGP-BE studies. Data gathered jointly by UNICEF and the Ministry of National Education show that student early school leaving rates have decreased by 9.09 per cent at primary school and by 20.21 per cent at junior secondary school level.[255]

252 UNICEF (2010) *Preliminary result replicating good practices, Trends from 2008-2009*, UNICEF: Jakarta
253 Ibid.
354 Based on a representative sample of 180 (or 39 per cent) of the project's target schools
255 UNICEF/GoI (15 July 2009) *News note: Quality of basic education improved due to good practices*, UNICEF/GoI: Jakarta

3.5
CHILD (SPECIAL) PROTECTION IN INDONESIA

Child protection is essential for the fulfilments of rights enshrined in the United Nations Convention on the Rights of the Child (CRC). Indonesia, a signatory of the CRC since 1990[256], has taken some important steps towards fulfilling its obligations, most noticeably with the introduction of important instruments relating to child rights and child protection, including the improvement of legal frameworks (ratification of international treaties, legislation and guidelines, see Section 1: Introduction), through key aspects of development policies (i.e., key rights to health and education, see preceding sections), and with the drafting of specific National Action Plans to tackle the worst forms of child labour, trafficking, commercial exploitation of children, and on the prevention and response to violence against children (see subheadings below for details of the National Action Plans).

However, working towards child protection in Indonesia is a vast undertaking that entails a profound commitment to normative and institutional change, both across the state/governance apparatus and within the wider society, without the support of which child protection is unlikely to be effective. Initial steps have been taken in Indonesia towards child protection, but those steps are incipient and challenges remain. This subsection first provides of general overview of specific child protection issues, including: citizenship and birth registration; protection from violence, abuse and exploitation; inappropriate alternative care systems; and, lastly, child freedom and participation. In many cases there is very little information on the socio-economic features of the most vulnerable populations, such analysis by wealth quintile, age group or gender is not always possible, which seriously inhibits efforts to determine where the greatest needs lie. Furthermore, the general overview shows uneven responses and progress, and indicates that whilst moving in the right direction, much remains to be done with regards to child protection in Indonesia. This general message is further underlined in the second part of this subsection, which focuses on the child protection system in Indonesia, highlighting how some of the key challenges of child protection might best be met by the GoI in the future.

Before beginning however, it is important to reiterate that child protection (as defined by UNICEF and other agencies) under the Indonesian Law on Child Protection (ILCP) and its consequent treatment in the 2010-2014 RPJMN, views child protection holistically as protection of children's rights (beyond the rights to protection from abuse, violence, neglect and exploitation, and inclusive of rights to health, education and other services). Child protection as it is understood by UNICEF and other agencies is described as 'special protection' in Indonesia.[257]

The 2000 UNICEF SITAN dedicated a chapter to the issue of 'Children in Need of Special Protection'. That chapter focused on key vulnerable groups (children living on the streets, children with special needs, children in armed conflict or emergencies, exploited children, abused children and children in conflict with the law) and key sources of vulnerability (weak legislative framework, birth registration and harmful social and cultural practices).[258] Some of these themes and issues are revisited in this SITAN and there are descriptions of a number of positive steps that have been taken, but most of the previously identified issues remain salient issues in urgent need of coordinated responses. In addition, new issues have emerged or gained visibility since the last SITAN, notably those relating to trafficking. Finally, whilst the issues considered in this section are treated individually, there are many important cross-cutting aspects (notably in the nexus between abuse and migration, trafficking, violence and exploitation) which are considered throughout the subsection.

256 Also, the CRC was ratified through Presidential Decree rather than through legislation enacted by parliament.
257 Government of Indonesia (2010) *RPJMN 2010-2014*
258 UNICEF (2000) *Challenges for a new generation: The situation of children and women in Indonesia*, UNICEF: Jakarta, pp139-159

3.5.1 CITIZENSHIP AND THE RIGHT TO IDENTITY: BIRTH REGISTRATION

Birth registration is a legal acknowledgement of existence, name and nationality, and it is essential for the full realisation of citizenship. Birth registration plays a key role in ensuring adequate access to and provision of key services such as health care, including immunization. In addition, birth registration provides an important record of age, which is central to some aspects of child protection, such as timely enrolment in schools, and the enforcement of minimum age of employment or eligibility for marriage.

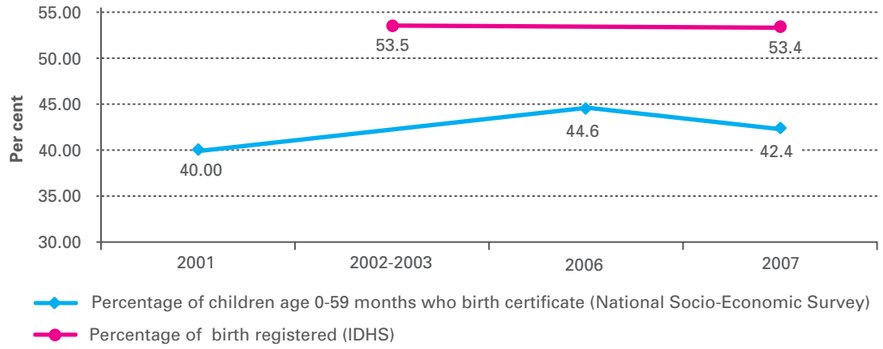
The GoI recognizes the importance of birth registration, which by itself is a substantial improvement over the situation at the time of the 2000 SITAN.[259] The GoI has set ambitious targets for ensuring that all children are in possession of a birth certificate by 2011 and a national target of 100 per cent birth registration for the whole population by 2015.[260] A number of provisions seeking to facilitate the process have been introduced in the past decade. Officially, birth registration was made free of charge with the adoption the ILCP, and new guidelines on the process and requirements of birth registration were issued by the Indonesian Ministry of Home Affairs in 2005.[261] On one hand, the number of local governments that issue birth certificates for free has increased substantially, from 16 districts in 2005 to more than 300 districts in 2009.[262] Yet, decentralisation has posed new challenges and free birth certificates are not available uniformly throughout Indonesia - some districts and provinces prioritise the revenue-making potential of birth registration and still charge a fee.[263] Birth registration rules also vary substantially from district to district, notably with age limits ranging from 60 days to 18 years old.
In addition, according to a review conducted in 2010 by Save the Children, obtaining a birth certificate as underlined in Presidential Regulation No. 25/2008 remains a cumbersome process that requires presenting a certificate by a birth attendant (doctor, midwife, etc.), the name and identity of a witness to the birth, the family registration card, the identity cards of the parents and a copy of their marriage certificate.[264] There are no clear provisions as to what might happen if one of these documents is lacking.[265]

Finally, there are some key weaknesses in the capacity of some local governments to compile statistics on birth registration, as well with the integration of the various birth registration systems. Few district governments have birth registration systems that are coordinated with hospitals, health centres or village midwives, which would make the service more simple and accessible.[266] A key weakness at the national level is the lack of integration between the registration system of the Ministry of Home Affairs and other key registrations systems, notably those recording marriage and death or issuing family cards and identity cards.[267] The lack of integration between the systems for identity cards and birth certificates has important consequences in terms of child protection as it facilitates the falsification of identity cards, which in turn are used to mask the actual age of children to circumvent crucial minimum age requirements.[268]

259 UNICEF (2000) *The situation of children 2000*
260 Save the Children (2010) *Review report: The implementation of the convention on the rights of the child, Indonesia 1997-2009*, Save the Children: Jakarta, p42
261 UNICEF (June 2010) *Children in Indonesia: Birth registration*, UNICEF: Jakarta, available at: http://www.unicef.org/indonesia/UNICEF_Indonesia_Birth_Registration_Fact_Sheet_-_June_2010.pdf (Last accessed 7 October 2010)
262 Save the Children (2010) *Review report Indonesia*
263 Ibid.
264 Ibid.
265 Ibid.
266 Plan International website on *Universal birth registration*, available at: http://plan-international.org/birthregistration/resources/country-case-studies/indonesia (Last accessed 9 October 2010)
267 Save the Children (2010) *Review report Indonesia*
268 Ibid., pp42-43

Reliable data relating to birth registration and the issuance of birth certificates is still hard to find and the data presented here are derived from national surveys. The National Socio-Economic Survey data are based solely on birth certificates whereas data from the IDHS data are based on collection of a range of official documentation relating to births (both sets of data are presented in Figure 3.5.1 below). The broader definition of birth registration used by the IDHS accounts for the higher figures presented below.

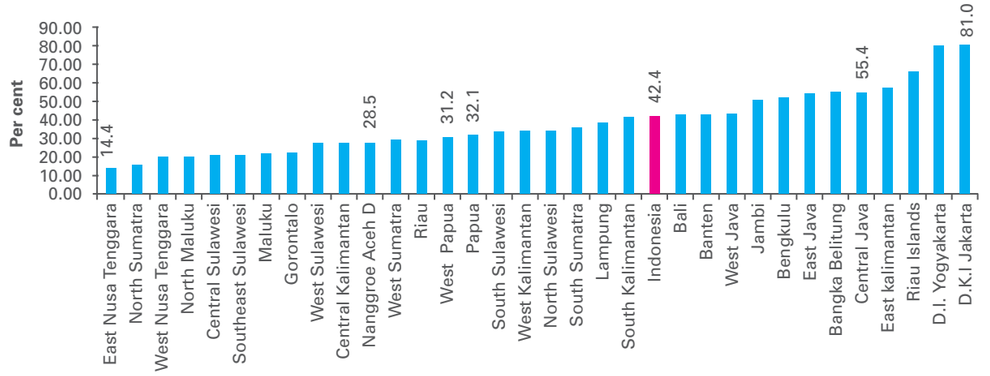
Figure 3.5.1: Percentage of children aged 0-59 months whose births have been registered, Indonesia 2001-2007



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2001-2007; Indonesia Demographic Health Survey (IDHS) 2007. Note: The IDHS data are based on collection of a range of official documentation about births including letters from hospitals, letters reporting births at the village level, as well as birth certificates; the National Socio-Economic Survey data refer solely to birth certificate data.

Figure 3.5.1 shows that birth registration in Indonesia in 2007 was just above 42 per cent, with a marginal improvement from 40 per cent in 2001, and that the target of achieving a record of 100 per cent registration of children by 2011 is unlikely to be achieved. The majority of children in Indonesia therefore have no legal identity. Indonesia currently ranks among the bottom 20 countries in the world in its registration of children.[269]

Figure 3.5.2: Percentage of children aged 0-59 months who have birth certificates by province, Indonesia 2007

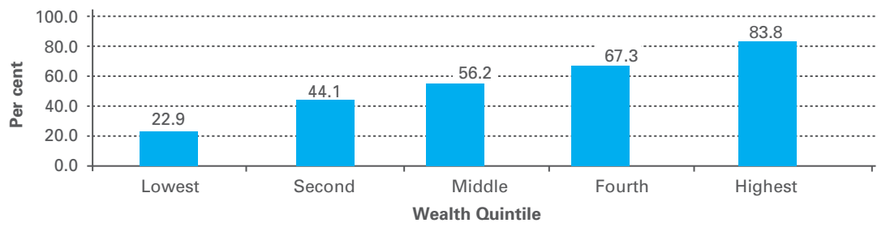


Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2007

269 UNICEF (2010) *Children in Indonesia: Birth registration*

Figure 3.5.2 breaks down the data on possession of birth certificates by province, indicating significant disparities across provinces, ranging from just 14.4 per cent of children under 60 months old being in possession of a birth certificate, up to 81 per cent in the capital city Jakarta. Twelve of Indonesia's 33 provinces achieved a better record than the national average, but the majority of the provinces underperformed. Additional data both from the IDHS and the National Socio-Economic Survey indicate that there are no significant gender-based disparities in issuing birth certificates (based on the 2009 National Socio-Economic Survey 42.61 per cent of male children and 42.12 per cent of females possess a birth certificate). However, more detailed data from the IDHS show significant disparities according to wealth, and between rural and urban areas.

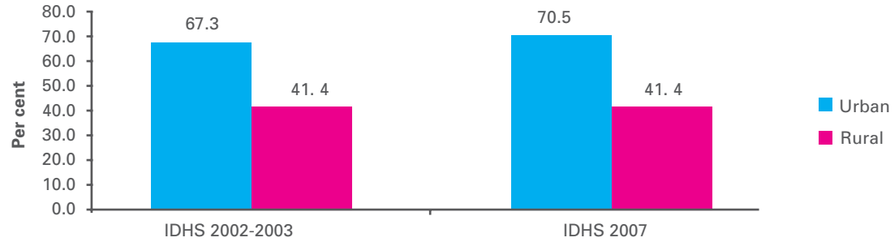
Figure 3.5.3: Percentage of births registered by wealth quintile, Indonesia 2007



Source: IDHS 2007

Figure 3.5.3 shows a very strong association between wealth and birth registration, with the majority of children in the two poorest quintiles remaining without legal identity. Finally, Figure 3.5.4, which details the registration of birth according to area, shows that the rural population are at a clear disadvantage. The disparity between rural and urban birth registration in Indonesia is among the highest in the world.[270] These data further indicate that no changes in the birth registration figures occurred in rural areas between 2002-2003 and 2007, and the little improvement that took place was concentrated in urban areas.

Figure 3.5.4: Percentage of births registered by area, Indonesia 2007



Source: IDHS 2007

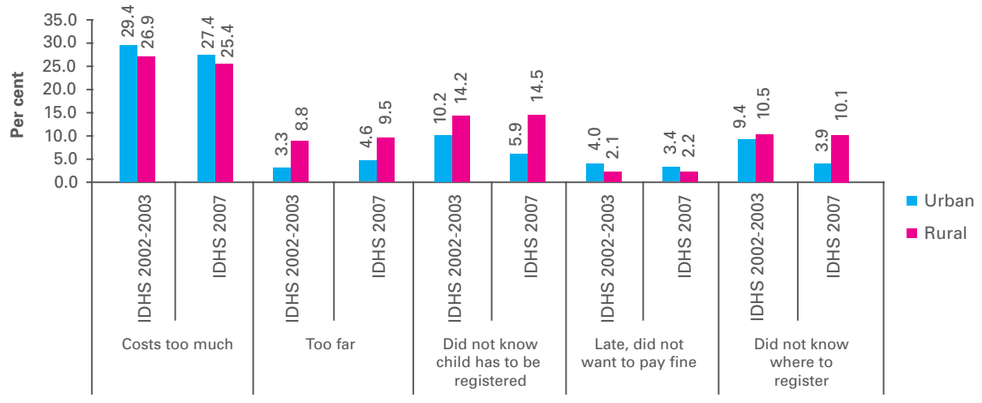
The final two figures (Figures 3.5.5 and 3.5.6), also derived from IDHS data, summarize the reasons given for not registering a birth. Unfortunately, information about the procedural aspect of birth registration (notably with lack of supporting documentation) was not listed in the dataset.

270 UNICEF (2010) *Children in Indonesia: Birth registration*

The data from the IDHS indicates that cost remains overwhelmingly the most commonly cited reason for failing to register birth, both in rural and urban areas and regardless of economic status (including among the wealthiest quintile of the population). The shift towards free birth registration has not entirely addressed the issue of cost. In part this is because some districts continue to charge a fee, but indirect costs are also involved in the process (e.g., cost of transport, needing to take time off work to register the birth, etc.).

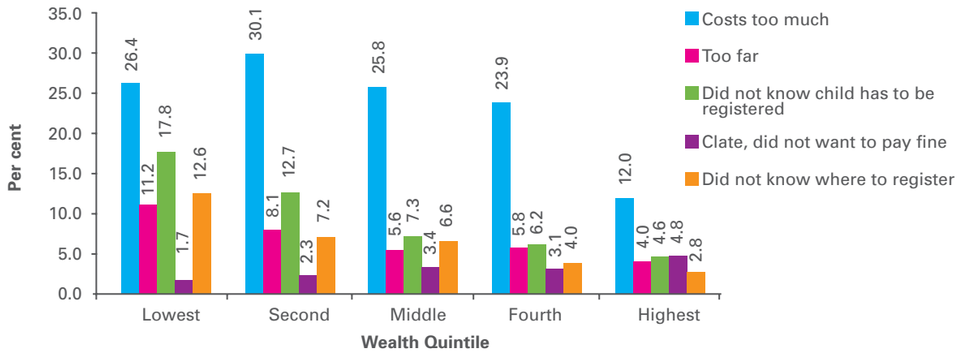
The second and third most cited reasons reflect a lack of information; the respondents reported either not knowing they had to register the birth or not knowing where the registration could be done. However, information about birth registration clearly reached urban populations better than it did rural ones. Between 2002-2003 and 2007, the number of urban respondents who cited not knowing that a child had to be registered fell almost by half from 10.2 to 5.9 per cent, whereas it slightly increased over the same period for rural dwellers, from 14.2 to 14.5 per cent. The proportion of respondents reporting that birth registration facilities were 'too far' also increased between 2002-2003 and 2007, this time for both rural and urban dwellers. Not knowing about the need to register birth was also the second most reported reason across wealth groups, bar the wealthiest quintile where it was the third most common reason. Lack of knowledge about where to register birth was the third most commonly cited reason among the three poorest quintiles, but not the wealthier two. Finally, the introduction of a fine for not registering a birth appears to have had little impact. Fine avoidance is the least cited reason for not registering a birth and this reason is more commonly reported amongst urban dwellers (i.e., when already late to register, the existence of a fine for late registration deters some from registering). Counter-intuitively, fine avoidance is also more common amongst wealthier groups than amongst the poorest quintiles of the population (1.7 per cent amongst the lower quintile and 4.8 per cent amongst the wealthiest, see Figure 3.5.6).

Figure 3.5.5: Reason for not registering birth by area, Indonesia 2007



Source: IDHS 2007

Figure 3.5.6: Reason for not registering birth by wealth quintile, Indonesia 2007



Source: IDHS 2007

The data presented here provide evidence of significant disparities in birth registration among provinces, between rural and urban areas, and according to wealth. In addition, in spite of significant reforms brought by the GoI since the 2000 SITAN, birth registration in Indonesia remains stubbornly low. The introduction of fees levied against parents who fail to register the births of their children has not yielded positive results and should be reconsidered by the GoI. The issue of cost has not been successfully addressed. Direct costs through fees still levied in some provinces and districts, and indirect costs (e.g., transport costs or the need to take time off work) still constitute a significant barrier to birth registration for the poorer sectors of Indonesian society. Lack of information and poor awareness of the importance of birth registration, as well as cumbersome bureaucratic procedures, also contribute to poor birth registration rates. The issues of costs, bureaucratic procedures and access to information need to be addressed by the GoI. Elsewhere, it is essential that birth registration procedures be harmonized across districts and that population records across different institutions be better integrated.

3.5.2 PROTECTING CHILDREN FROM VIOLENCE, ABUSE AND EXPLOITATION

Violence and poverty are amongst the most commonly found root causes in the violation of children's rights, and both need to be addressed in order for effective child protection to take place. In this subsection, first the multifaceted manifestations of violence against children are examined, followed by a focus on abuse and exploitation of children and consideration of current responses by the GoI.

3.5.2.1 Violence against children

While data are scarce, there are indications from a number of targeted in-depth studies of violence in Indonesia that violence against children in homes, on the street and in schools is pervasive in Indonesia, requiring urgent policy attention. The GoI has provided the legal and policy framework to improve child (special) protection, which includes protecting children from violence and abuse and holding responsible parties accountable. However, there are tensions between child protection policies and prevalent attitudes and practices regarding the upbringing of children in general, and corporal punishment in particular. Inevitably, these tensions are reflected in the school environment as well. There is a lack of reliable data available on violence against women and children in Indonesia, systematically collected using the same definitions across all provinces. Nevertheless, data from in-depth and targeted studies show that this is a common phenomenon. At a global level, data on violence against women and children is often threadbare, not least because its documentation is only a recent phenomenon. In addition, reliable data on violence against women and children is difficult to obtain (under-reporting is rife) and notoriously difficult to analyze (for instance, rising numbers often reflect increased reporting rather than rising incidence).

Following the adoption of the ILCP in 2002 and Law No. 23/2004 on the Elimination of Domestic Violence, the Central Bureau of Statistics (BPS - Statistics Indonesia) conducted a survey on violence against children and women in 2006. After piloting the survey in four provinces (North Sumatera, West Java, East Java and South Sulawesi), the survey was implemented as part of the National Socio-Economic Survey (Socio-Cultural and Education Module).

The survey found that 63.8 per cent of respondents knew about the actions of violence against women and children (tindak kekerasan terhadap perempuan dan anak). The report highlights that in 2006 there were three million acts of violence against women (tindak kekerasan terhadap perempuan), with 2.27 million women (or 3.1 per cent of all women) being victims of these acts, although based on data from other studies mentioned below, this figure would likely be higher if violence against children in the home were included. Reportedly, 50.6 per cent of the women in the sample had experienced such violence several times. Experience of physical violence/cruelty (penganiayaan) was reported by 23.3 per cent of the sample, 65.3 per cent had experienced psychological violence in the form of verbal abuse (penghinaan), 11.3 per cent had experienced sexual violence or sexual abuse (pelecehan), and 17.9 per cent had experienced neglect or abandonment (penelantaran). The report found that around 68 per cent of violence against women occurred at home. This figure climbs to 71.2 per cent in rural areas. Most perpetrators were husbands (55.1 per cent) and neighbours (19.6 per cent). Most cases (54.9 per cent) went unreported, with 32.2 per cent being reported to family members. Only 1.9 per cent of cases were reported to the police, and 2.5 per cent to community leaders. Economic reasons were cited as the main reasons for violence against women, cited in 33.1 per cent of cases in urban areas and 35.1 per cent in rural areas.

The survey found that in 2006 there were 2.81 million incidents of violence against children and that around 2.29 million children (or around 3 per cent of all children) had been the victims. Reports of violence against children in rural areas (3.2 per cent) were higher than in urban areas (2.8 per cent). Cases of violence against male children were higher (3.1 per cent) than against female children (2.9 per cent). More than half (53.7 per cent) of the sample had experienced physical violence/cruelty, with this being more frequent for boys. More than one third (36.7 per cent) had experienced psychological violence in the form of verbal abuse (penghinaan), with this being more frequent for girls. Experience of sexual abuse (pelecehan) was reported by 3.9 per cent and 10.3 per cent had experienced neglect/abandonment (penelantaran), in roughly similar proportions for girls and boys.

Most of this violence took place at home (73.1 per cent). More than half (55.9 per cent) of children had experienced such violence several times. The most frequent cause cited by respondents was disobedience and bad behaviour. Almost half of cases (48.3 per cent) went unreported, with 38.3 per cent being reported to family members. Most perpetrators were parents (61.4 per cent), especially in rural areas (64.6 per cent). These figures on violence against children indicate that, in Indonesia, violence at home is a pervasive problem faced by women and children in particular.

A more recent household survey undertaken in 2009 by the University of Indonesia in four provinces confirms unacceptably high levels of neglect, abuse and violence towards children. The survey was conducted in eight districts in four provinces: Aceh, Central Java, East Nusa Tenggara and Papua.[271] As stated in Section 3.3 on HIV and AIDS, the survey sampled 1,500 adolescents aged 10-18 years old through a mixed sampling methodology.[272] Results showed that around 20 per cent of adolescents reported experiencing some form of parental neglect. The most frequently reported form of parental neglect was failing to seek health care when able to do so, ranging from 1.4 per cent of males in Banda Aceh district (Aceh) to 14 per cent of males in Jayawijaya district (Papua). The second most frequently reported forms of neglect was being left alone without adult supervision, ranging from 2.3 per cent of males in Banda Aceh district (Aceh) to 7.5 per cent of males in Brebes district (Central Java). The third most commonly reported form of parental neglect was being emotionally ignored by parents (ranging from 0.9 per cent of males in Banda Aceh district to 9.6 per cent of females in Solo (Central Java).

Furthermore, the same survey reveals that unacceptably high numbers of adolescents report experiencing violence or physical abuse.[273] Violence at home (perpetrated by a family member) was reported by no less than 40 per cent of respondents in Aceh, around 60 per cent in Papua and Central Java, and just under 80 per cent in East Nusa Tenggara. A similar pattern emerged for violence at school, affecting 40 per cent of respondents in Aceh and Central Java, rising to 60 per cent in Papua. Reported violence in the community, perpetrated by friends or employers, was even higher, with over 80 per cent of respondents having experienced this in Central Java and East Nusa Tenggara, and over 60 per cent in Papua and Aceh. However, it is when all these forms of violence experienced by Indonesian children become summarised in a single indicator that the extent and the severity of the problem is laid bare: across the four provinces surveyed, 88 per cent of the children had experienced violence (76.5 per cent in Aceh, 83 per cent in Papua, 96 per cent in Central Java and 98 per cent in East Nusa Tenggara). The survey also points towards significant issues with child sexual abuse.[274] Sexual abuse is perpetrated primarily in the family and the community, but is rarer in schools (across provinces less than 5 per cent of respondents reported having experienced sexual abuse in schools). Sexual abuse in the family was least reported in Aceh (just above 4.5 per cent) and most reported in Papua where it affected over 23 per cent of the survey respondents. Central Java and East Nusa Tenggara had similar levels, at around 15 per cent. Once again, however, the shocking extent and severity of the problem becomes more apparent when all forms of sexual abuse are summarised in a single item: 26 per cent of the children surveyed had experienced one or more kinds of sexual abuse (13 per cent in Aceh, 24 per cent in Central Java, 31 per cent in East Nusa Tenggara and 36.5 per cent in Papua).

These results indicate that violence, neglect and sexual abuse were quite frequent across the research sites, and interventions to prevent violence against children and adolescents should be the focus of future child (special) protection strategies. Violence in schools was more frequently reported in East Nusa Tenggara and Papua, particularly in the more rural districts. Violence in the home or perpetrated by family members was reported most frequently in East Nusa Tenggara (more than one third reported this) but this was reported by nearly a quarter of cases in the other provinces, with the exception of in Aceh. Violence in the community or workplace was reportedly most frequent in East Nusa Tenggara and Central Java.

271 University of Indonesia (2010) *Situation analysis of adolescents in Indonesia*, Mimeo: Jakarta
272 The sampling methodology is detailed in Section 3.3 on HIV and AIDS
273 The survey questions relating to physical abuse asked the respondents if they had been subjected to a range of physical attacks including being pinched, slapped, shaken, kicked, choked, burned, beaten, thrown, or having their arms twisted
274 The survey questions relating to sexual abuse ask respondents if they had been subjected to verbal sexual abuse (harassment), touched or forced to touch someone else, forced to show their naked body, rape, or used as an object of child pornography

A comparative study of 10,073 children aged 9-17 years across East Asia and the Pacific by UNICEF and Research International Asia (Thailand) in 2001 found that 34 per cent of those surveyed in Indonesia reported having been beaten by their parents, and about 50 per cent said that they did not find it easy to talk to their teachers because teachers shout at them or beat them, further indicating that violence is frequent in homes and in schools.[275] In 2005, a large-scale comparative study into the views and experiences of 3,322 children and 1,000 adults in eight countries in Southeast Asia and the Pacific (Cambodia, Fiji, Hong Kong, Indonesia, Mongolia, Philippines, Republic of Korea and Viet Nam) was carried out by Save the Children and also found that violence against children was a common form of punishment.[276] The research in Indonesia involved 813 children from urban, rural and remote areas, and 16 adults. Study methods included use of research diaries, drawings, body maps, attitude survey, and discussions. The kinds of physical punishments mentioned by children in Indonesia included being hit with implements, kicking, slapping, punching, ear twisting, hair pulling, pinching and throwing objects. Of those who were hit, 32.4 per cent were hit with an implement, 23.6 per cent slapped with the hand, 23.6 per cent punched with the fist, and 20.4 per cent kicked. Of those children who mentioned body parts where they were hit, 73 per cent reported being hit on the head and neck, 75 per cent on the limbs, 10 per cent on the back, 15 per cent on the chest and 15 per cent in the stomach.

A key finding from these reports is that various forms of violence against children are interrelated. For instance, a child who is sexually abused has usually also experienced several other forms of violence. Girls and boys who have run away from home often state parental violence and abuse as the main reason. Once a child has left home, she or he becomes vulnerable to additional violence and sexual abuse in the community, on the streets, in institutions and at work. This secondary effect of violence, neglect and sexual abuse should not be underestimated as it leaves girls and boys with no protection at all against sexual exploitation (discussed further below). Members of child-headed households are also at particular risk.

3.5.2.2 Violence in schools

The issue of violence at school is becoming an area of increasing attention and concern as pervasive violence at school has a deeply harmful impact on the school experience of children and it can further hamper their overall growth and development.[277] Working towards the prevention of violence at school forms an integral part of Indonesia's commitment to child protection. Article 54 of the 2002 ILCP makes this commitment unequivocal: children attending school must be protected against violence and abuse from teachers, school managers and schoolmates both at school and in other educational institutions.[278]

Save the Children UK carried out research at schools in North Maluku, surveying 541 children in two sub-districts as part of a project developing non-violent forms of classroom management. Children completed survey forms as follow-up to classroom discussions on discipline. Nearly one quarter of the children reported having been hit by the teacher on their legs, hands, ears, cheeks and buttocks, at least once, with the teachers using their hands, a stick, a ruler or a bamboo switch.[279]

275 UNICEF (2001) *Speaking out! Voices of children and adolescents in East Asia and the Pacific,* UNICEF: New York
276 Beazley, H., Bessell, S., Ennew, J., and Waterson, R. H. (2006) *What children say: Results of comparative research on the physical and emotional punishment of children in Southeast Asia and Pacific, 2005*, Save the Children Sweden: Stockholm
277 UNICEF (2006) *Child-friendly school initiative as prevention of child abuse in school*, UNICEF: Jakarta available at: www.unicef.org/indonesia/Child_Friendly_School_SEminar__English_.pdf (Last accessed 1 October 2010)
278 Ibid.
279 Save the Children UK, Indonesia (2004) *Violence in schools: Report on a survey conducted by the Save the Children Education Programme in North Maluku,* Mimeo: Jakarta, cited in: Save the Children (2005) *Discipline and punishment of children: A rights-based review of laws, attitudes and practices in East Asia and the Pacific*, Save the Children Sweden, Southeast Asia and the Pacific, regional submission to the UN Secretary General's Global Study on Violence against Children, Save the Children Sweden.

Violence in schools comes from distinct sources, which must be addressed through very distinct policies. Violence emanates from adults (teachers and other adults working in the school environment) and from other children, usually through bullying. Research undertaken by Semai Jiwa Amini Foundation in 2008 in three large Indonesian cities (Yogyakarta, Surabaya and Jakarta) examined bullying.[280] The research shows that students reported high rates of violence amongst students in secondary schools, and 67 per cent reported that bullying was taking place in their schools.[281] Psychological violence in the form of isolation was cited as the most prevalent type of violence, verbal abuse the second most common, and physical violence as the least common type of violence. A survey of 1,200 children in 11 secondary schools undertaken by the NGO Plan International Indonesia found similar patterns, with verbal and psychological bullying reported as the most frequent forms of violence taking place in Indonesian schools.[282] Finally there is evidence of bullying taking place in primary schools too, where a study found that 31.8 per cent of students reported having been bullied.[283] The forms of violence are similar to those reported in secondary schools, with a predominance of psychological violence (77.3 per cent) followed by verbal abuse (40.1 per cent) and physical violence (36.1 per cent).

Peer violence at school appears to be endemic in Indonesia, yet so far there is little evidence of any nationwide attempts to tackle the issue. Furthermore, private initiatives to bring attention to and address the issue of bullying have reported that most schools display a negative attitude to anti-bullying campaigns.[284]

Violence in schools is also perpetrated by adults (teachers and other school staff). Research undertaken by Atma Jaya University in three provinces (Central Java, South Sulawesi and North Sumatera) revealed that forms of violence in school included physical, sexual, verbal and emotional.[285] The children interviewed during the research also reported a number of abusive sexual contacts, 19 of 344 children in Central Java were forcefully hugged by their teachers, 11 out of 276 children had their genitals touched by their teachers in South Sulawesi, and 69 out of 413 children reported being improperly touched by their teachers in North Sumatera.[286] Verbal abuse (shouting and yelling at children) as well as public humiliation (forcing children to stand in front of the class, forcing children to clean toilets) are commonly used in the class room (73-80 per cent of teachers across provinces admitted yelling at students, and 90 per cent forced children to stand up).[287]

Several sources of data indicate that adults in the education sector, principally teachers, have accounted for a large proportion of the reports of violence and/or child abuse. According to data from the Indonesia Child Protection Commission (KPAI, Komisi Perlindungan Anak Indonesia), of the 95 reported acts of violence committed against children during the first six months of 2009, 39 per cent were attributed to teachers.[288] Additionally, BPS - Statistics Indonesia data indicate that the reporting of violence committed by teachers increased by 39.6 per cent between 2007-2008.[289] The data on school violence are still tenuous and disparate but indicative of a pervasive culture of fear and violence in the classroom. The pervasiveness of school violence, especially if it is tolerated by society at large, will be a significant challenge for the GoI. Both the GoI and UNICEF have identified training teachers in alternative approaches to discipline as a key way to assist in the prevention of violence in schools. In 2006, the then Minister of Education, Bambang Sudibyo, stated, "[C]ulturally, violence is still conceived as an effective way to enforce discipline and to educate a child. It is therefore crucial that teachers should be trained on alternative ways of discipline."[290]

Box 3.5.1: School violence still prevalent

Bullying and school violence in Yogyakarta remain prevalent. Violence among students is found at nearly every school, and at every level of education. However, school awareness in anticipating such violence is still low

Sari Murti Widiyastuti, head of the Lembaga Perlindungan Anak (LPA) Yogyakarta province, likens bullying in Yogyakarta to a hard-to-detect tip of the iceberg. "Cases are hard to prove, yet are acutely felt by students," she states after speaking at a discussion on 'Learning without Fear' organized by Sekolah Budi Utama in Yogyakarta, Saturday (28 November). The event, which included the participation of 73 schools throughout Yogyakarta, ended with an anti-bullying declaration and collection of signatures on a 6-meter long cloth banner.

According to Sari, the most common form of bullying in Yogyakarta is verbal abuse, ranging from insults, and mockery to threats. Other forms of bullying observed include isolation, intimidation, physical violence and extortion.

Operational Manager Budi Utama Christina HS adds that bullies often come from similar backgrounds of having commonly absent parents and having had prolonged exposure to violence.

The head of Laboratorium Dinamika Edukasi Dasar (Laboratorium of Basic Education Dynamics), Nasarius Sudaryono, also adds that bullying across school boundaries can lead to larger scale school brawls.

Source: Kompas, Monday, 30 November 2009[291]

280 Yayasan Semai Jiwa Amini (2008), Bullying: Mengatasi Kekerasan di Sekolah dan Lingkungan Sekitar Anak, Grasindo, Indonesia.
281 Ibid.
282 Plan International (2009) *PLAN's global campaign to end violence in schools*, p7, available at: www.plan-international.org/learnwithoutfear/files/lwf-progress-report (Last accessed 4 September 2010)
283 Khairani, A. (2009) *Modul program pendidikan: Pencegahan perilaku bullying di sekolah dasar*, available at: http://garuda.dikti.go.id/jurnal/detil/id/0:11977/q/pengarang: percent20Ani percent20/offset/0/limit/15 (Last accessed 16 October 2010)
284 Plan International, cited in: Rachman, A. (27 January 2009) *Education experts warn that teachers and parents play a role in school bullying*, The Jakarta Globe: Jakarta, available at: http://thejakartaglobe.com/national/education-experts-warn-that-teachers-and-parents-play-role-in-school-bullying-/305944 (Last accessed 22 February 2011)
285 Ibid.
286 Ibid.
287 Ibid.
288 Indonesian Child Protection Commission data, cited in: Akbar, A. (15 January 2010) *Menakar kekerasan di sekolah*, Harian JogloSemar: Surakarta, available at: http://harianjoglosemar.com/berita/menakar-kekerasan-di-sekolah-6847.html (Last accessed 21 February 2011)
289 Badan Pusat Statistik (BPS) - Statistics Indonesia data, cited in: Editorial (10 November 2009) *Stop kekerasan di Sekolah* Tempo Interaktif, available at: http://www.tempointeraktif.com/hg/opiniKT/2009/11/10/krn.20091110.181517.id.html (Last accessed 21 February 2011)
290 Sudibyo, B., cited in: UNICEF (2006) *Child-friendly school initiative as prevention of child abuse in school*, UNICEF: Jakarta, available at: www.unicef.org/indonesia/Child_Friendly_School_SEminar__English_.pdf (Last accessed 4 September 2010)
291 Kompas (30 November 2009) *Tingkat kekerasan di sekolah masih tinggi*, Kompas: Yogyakarta, available at: http://www.gugustugastrafficking.org/index.php?option=com_content&view=article&id=1112:tingkat-kekerasan-di-sekolah-masih-tinggi&catid=156:info&Itemid=197 (Last accessed 21 February 2011)

3.5.2.3 Child marriage

The 2000 SITAN reported a high prevalence of child marriage in Indonesia, which then referred to all persons under 16 years of age, occurring in all provinces.[292] The impacts and consequences of child marriage are known to be harmful. A UNICEF (2005) report on this subject throughout the world considered child marriage to be a violation of human rights that compromised the development of girls, often resulting in early pregnancy (and associated health risks for young women), social isolation and the abandonment of education.[293] The same report considers young married girls to be a "unique, though often invisible group…required to perform heavy amounts of domestic work…responsible for raising children and facing constrained decision-making and reduced life choices."[294] Child marriage severely compromises the right to a 'free and full' consent to marriage as recognised in the Universal Declaration of Human Rights, as well as the rights of children to express their views freely. The Pan-African Forum against the sexual exploitation of children considered child marriage to constitute a type of commercial sexual exploitation of children.[295]

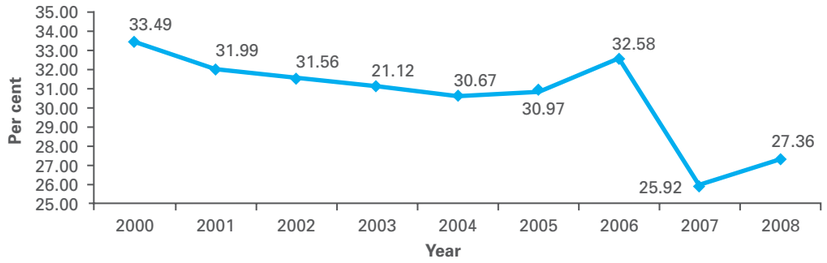
Following the adoption of the ILCP in 2002, adulthood is considered to start when a person reaches the age of 18. Consequently, in this SITAN, child marriage is understood to refer to marriage or union/cohabitation of persons under 18 years of age. However, the legal provisions that regulate marriage in Indonesia and the practices surrounding marriage contradict the age stipulations of the ILCP. Even though the ILCP should take precedence, in practice Law No. 1/1974 on Marriage - which has distinct definitions of childhood - remains a key reference. First, the provisions of Law No. 1/1974 establish that by virtue of marrying, a young girl legally becomes an adult, regardless of her age. Elsewhere, Law No. 1/1974 on Marriage also establishes that marriage before the age of 21 is subject to parental approval and at the same time introduces a minimum age for marriage of 16 years for girls and 19 years for boys. Furthermore, there is a system of dispensation requests whereby parents can approach courts or other officials to allow underage marriage, i.e., before the age of 16 or 19, respectively.[296] The system of parent-initiated dispensation goes against Article 26 of the ILCP, which stipulates that parents have an obligation and responsibility to prevent child marriage. In practise, the current laws, regulations and practices regarding child marriage are somewhat in a state of flux, with contradictory rulings taking place. There have been some attempts by the GoI to clarify and amend marriage laws to bring them in line with the provisions of Law No. 23/2002 (ILCP), but there is strong opposition to changing this traditional harmful practice in Indonesian society and so far these efforts have remained unsuccessful.[297]

3.5.2.4 Current trends in child marriage in Indonesia

Figures 3.5.7 and 3.5.8 summarize some recent data on the prevalence, trend and provincial distribution of child marriage.

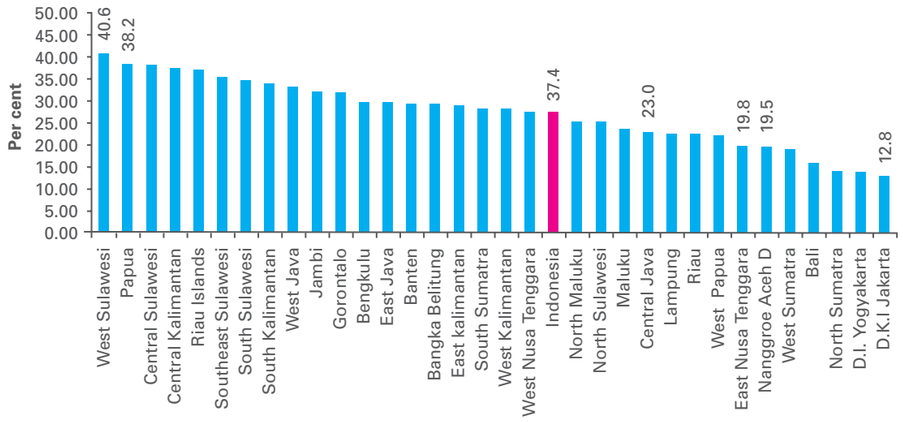
292 UNICEF (2000) *The situation of children 2000*, p127
293 UNICEF (2005) *Early marriage: A harmful traditional practice*, UNICEF: New York, available at: www.unicef.org/publications/files/Early_Marriage_12.lo.pdf (Last accessed 7 October 2010)
294 UNICEF (2005) *Early marriage*, p1
295 Ibid.
296 Save the Children (2010) *Review report Indonesia*, p21
297 Ibid.

Figure 3.5.7: Percentage of women 20-24 years old who were married or in union before the age of 18, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2000-2008

Figure 3.5.8: Percentage of women 20-24 years old who were married or in union before the age of 18 by province, Indonesia 2008



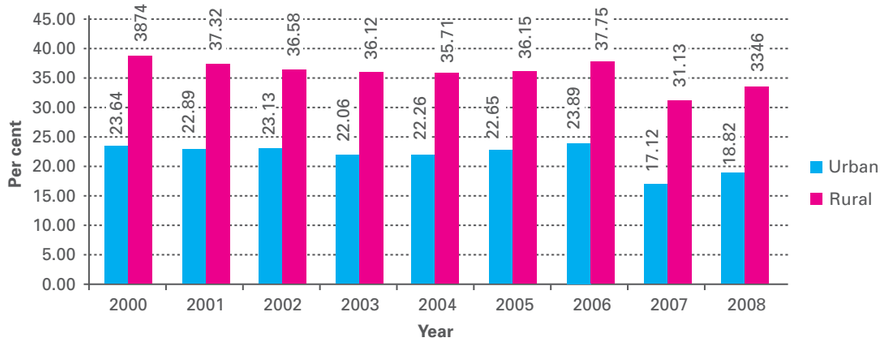
Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2008

Figure 3.5.7 indicates that the trend for child marriage is decreasing, from 33.49 per cent of women aged 20-24 years old having been married before the age of 18 in 2000, down to 27.36 per cent in 2008). However, the figures remain quite high at a national level. The data on provincial incidence shows very clear disparities, from a low rate of 12.79 per cent in the capital, Jakarta, to above 40 per cent in the newly-formed province of West Sulawesi. It is also evident from Figure 3.5.8 that a majority of provinces have a percentage of child marriage above the national average, and that over 30 per cent of women 20-24 years old experience child marriage/union in 11 of Indonesia's provinces.

Figure 3.5.9 underlines that child marriage has long been more prevalent in rural than urban areas, and remains so to this day. Encouragingly, the percentage of women experiencing child marriage has diminished by approximately 5 per cent between 2000-2008 both in rural and urban areas, but girls from rural areas remain at a profound disadvantage compared to their urban counterparts. The rural/urban gap in terms of age of marriage is attributable to the greater availability of choices and better education facilities in urban areas. In urban settings, parents encourage their daughters to complete secondary education or beyond, and in turn educated people tend to marry later.

The National Socio-Economic Survey data (not presented here) demonstrate that for all age cohorts, urban women marry at least two years later than rural women. The median age at first marriage for urban women aged 25-29 years is 22.7 years compared to 18.9 years for rural women in the same age group. While for women with some secondary education the median age at first marriage is 22 years, for women with less than primary education it is just 17 years or younger. The gap is larger among younger women than older women. As the age at marriage has increased, the proportion of single males and females aged 15-24 years has increased. Nevertheless in rural areas, as marriage continues to occur at very young ages, the proportion of single adolescents is lower. In 2000, 95.6 per cent of teenage girls aged 15-19 years in urban areas were single, compared to 84.6 per cent of those in rural areas.

Figure 3.5.9: Percentage of women 20-24 years old who were married or in union before the age of 18 years by area, Indonesia 2000-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Survey 2000-2008

The data on child marriage in Indonesia as presented in this section indicate that whilst decreasing, the practice remains worryingly commonplace, especially in rural areas. In implementing policies that increase access to education and in the enactment of the 2002 ILCP, the GoI has taken important initial steps in tackling child marriage, but these initiatives need to be pursued and strengthened for a further significant decline to take place.

3.5.2.5 Child labour

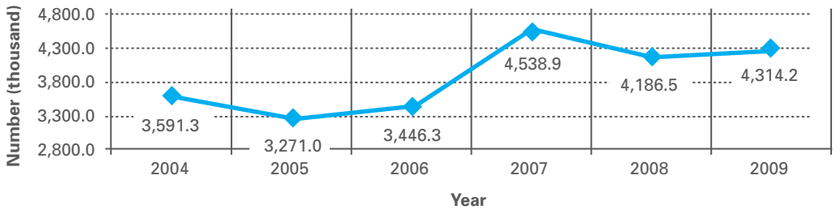
Here an overview of the situation of child labour in Indonesia is provided, presenting some data that examines the prevalence of child labour as well as data on the nature of the work undertaken by children, and some information about the socio-economic profile of children in employment. Child labour can be problematic for a number of distinct reasons. First, it contravenes a number of key rights (such as the right to education, the right to play and recreation), and second children in Indonesia are often employed in hazardous or illicit occupations that are detrimental to their health and well-being. However, it is important to note that societal attitudes tend to be tolerant and accepting of child labour, especially that which takes place within family businesses.

The GoI ratified a number of ILO conventions (No. 105/1999 on Forced Labour, No. 138/1999 on the Minimum Age for Admission to Employment, and No. 182/2000 on the Worst Forms of Child Labour). In addition, the GoI set up a National Action Committee on the Eradication of the Worst Forms of Child Labour in 2001, and the 2003 Manpower Law has provisions relating to child labour. The worst forms of child labour relate to forced labour, recruitment in armed conflicts, prostitution and pornography, illicit trade and activities, and - in broader terms - activities likely to harm children.[298] Those are treated separately below.

There are some question marks about the regulation and monitoring of child labour provisions in Indonesia. On one hand, all forms of hazardous work and 'worst forms of labour' are prohibited by law for those under the age of 18. Some forms of labour, however, are permissible and once again the contradictions and lack of clarity that surround definitions of children in Indonesia become an issue with regards to child labour. The Law on Manpower (No. 13, 2003) initially defines children as persons below the age of 18 who are not allowed to be hired by employers. Further sections of the law, however, then stipulate that employers can hire 13- to 15-year-olds for 'light work as long as it does not hamper their physical, mental and social development'.[299] The lack of clarity is not helped by the fact that there is no legal definition of what constitutes 'light work' and further family enterprises are exempted from a large number of provisions, thus creating uncertainty and potential loopholes. Other aspects of the Law on Manpower have more potential to contribute to child protection, notably in setting up a maximum number of three hours of work per day, as well as important regulations concerning (safe) working conditions and environments for children in employment.[300] Whilst improved, the legal provisions regarding child labour are not satisfactory, and the lack of monitoring and enforcement lead to poor compliance with the limited protection afforded by the law.

The data presented on child labour comes from the National Labour Force Survey (SAKERNAS, Survei Angkatan Kerja Nasional), which is carried out twice a year. The survey is not designed specifically to capture child labour information, and the data is not comprehensive (for instance there is little data about children under 10 years old). However, the longitudinal aspects of National Labour Force Survey make it an important source of information. The second source of data presented here is a specific module designed in conjunction with the ILO: the Indonesia Child Labour Survey (ICLS). The ICLS was incorporated into the 2009 National Labour Force Survey. Although only available for one year, the data from the ICLS provides in-depth information about working children at that specific point in time.

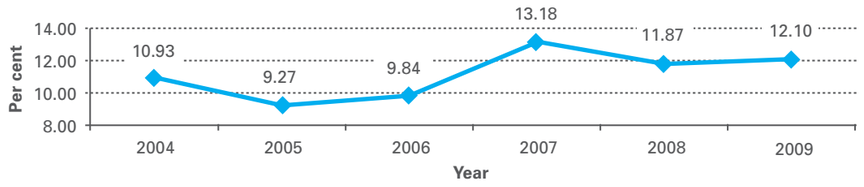
Figure 3.5.10: Working children aged 5-17 years, Indonesia 2004-2009 (thousands)



Source: BPS - Statistics Indonesia and ILO, National Labour Force Survey 2004-2009[301]

298 Ibid., p151
299 Ibid., pp22-23
300 Ibid., pp151-154
301 BPS - Statistics Indonesia and ILO (2010) *Working Children in Indonesia 2009*, BPS and ILO: Jakarta (based on the *National Labour Force Survey; SAKERNAS, Survei Angkatan Kerja Nasional*). The *National Labour Force Survey* uses the term 'working children', a term used to refer to 'children in employment' or children who engage in any activity within the production boundary of the System of National Account. The term 'working children' corresponds to 'children in employment', a standard terminology used by ILO. The *National Labour Force Survey* focuses on children aged 10-14 years. In 2001, with support from UNICEF, BPS - Statistics Indonesia also collected and published information about children aged 5-17 years.

Figure 3.5.11: Labour force participation rates of children aged 10-17 years, Indonesia 2004-2009



Source: National Labour Force Survey 2004-2009 Note: Labour force participation rates indicate the percentage of the total population of children aged 10-17 years who are in the labour force.

Figures 3.5.10 and 3.5.11 provide data about the labour force trends in Indonesia. Labour force data relate to all persons between the age of 5-17 years who are legally employed as well as those engaged in the worst forms of child labour and those employed below the minimum age for employment.[302] Figure 3.5.10 shows the labour force trend in numbers between 2004 and 2009; the data indicate a steady increase in the total number of working children, including those engaged in hazardous or 'worst forms' of labour. Although limited to the 10-17 years old age group, the general trend in child labour force participation rates reflect the trend in Figure 3.5.11, that child labour peaked in 2007 where it comprised 13.18 per cent of the age 10-17 population. By 2009, over 12 per cent of 10- to 17-year-olds participated in the labour force, a two per cent increase over 2004. The increases in numbers and participation rates among children as young as 10 in the labour force is a worrying trend in Indonesia. The remainder of the data presented are derived from the ICLS and provide more detailed insights into the nature of the working activities undertaken by children (aged 5-17 years old).

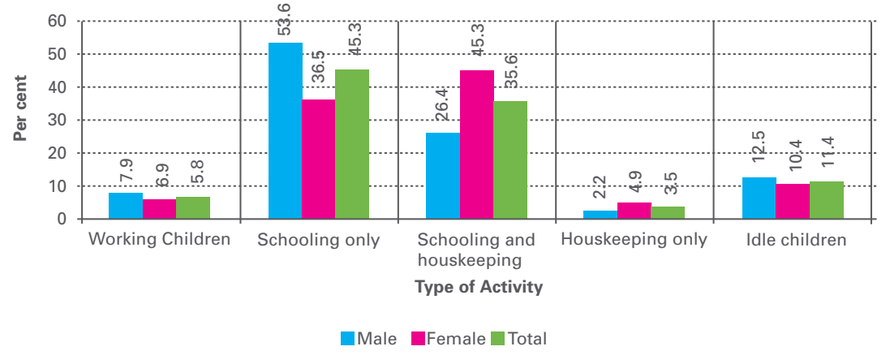
Table 3.5.1: Children aged 5-17 years by type of activity and sex (thousands), Indonesia 2009

Type of Activity	Male	Female	Total
Children in economic activities	2,612.6	1,915.8	4,528.4
Working	2,391.3	1,661.5	4,052.8
Seeking work	221.4	254.2	475.6
Children not in economic activities	27,517.7	26,791.1	54,308.9
Total	30,130.3	28,706.9	58,837.3
Working only	585.0	101.6	686.6
Working and schooling	1,147.4	988.1	2,135.5
Working and housekeeping	1,433.1	1,423.6	2,856.8
Working, schooling, and housekeeping	774.3	851.8	1,626.1
Schooling only	16,159.9	10,491.5	26,651.4
Schooling and housekeeping	7,941.4	13,014.8	20,956.2
Housekeeping only	651.6	1,417.6	2,069.2
Idle children	3,760.5	2,973.2	6,733.7

Source: Indonesia Child Labour Survey (ICLS) 2009, part of the National Labour Force Survey 2009

302 In 2009, the *Indonesian Child Labour Survey (ICLS)* was incorporated into the *National Labour Force Survey* (SAKERNAS). In addition to providing an overview of 'working children', the survey also obtained information about 'child labour'. The operational definition of 'child labour' used is "working children who engage in any kind of presumably hazardous works as indicated by working hours," and it consisted of all working children 5-12 years old (regardless of their working hours), children 13-14 years old working more than 15 hours per week, and children 15-17 years old working more than 40 hours per week.

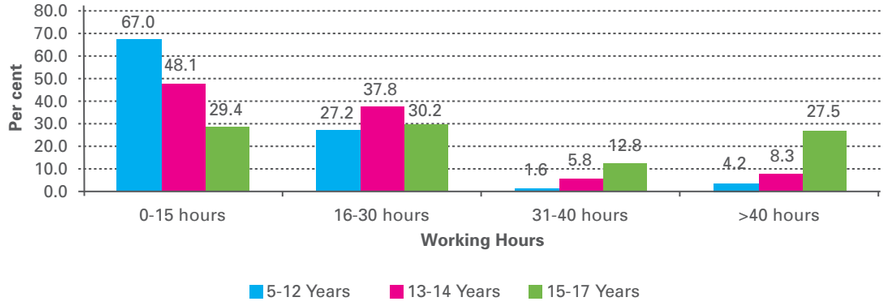
Figure 3.5.12: Percentage of children aged 5-17 years by type of activity and sex, Indonesia 2009



Source: Indonesia Child Labour Survey 2009

Based on data from the 2009 ICLS, Table 3.5.1 and Figure 3.5.12 indicate that children whose sole occupation is work account for 6.9 per cent of all children aged 5-17 years. Attending school is the main and sole occupation for 45.3 per cent of Indonesian children, followed by attending school and contributing to household activities (the four main housekeeping duties include: cleaning, laundry, cooking and shopping). There are, however, some important gender disparities. More than half (53.6 per cent) of boys attend school as their main and sole occupation, but only 36.5 per cent of girls are in the same category. Girls, however, are clearly expected to contribute to housekeeping, sometimes as their sole occupation (4.9 per cent compared to 2.2 per cent for boys), but mostly in addition to schooling (45.3 per cent compared to 26.4 per cent for boys). Finally and most worrying of all, from the perspective of rights to play and recreation, 2.8 per cent of children go to school, work and contribute to household duties (2.8 per cent in total, 3 per cent of girls and 2.6 per cent of boys, 2009 ICLS).

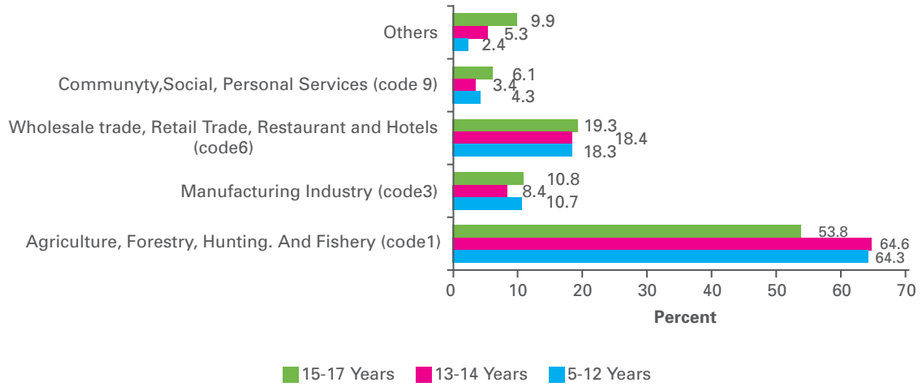
Figure 3.5.13: Percentage of working children by age group and total work hours, Indonesia 2009



Source: Indonesia Child Labour Survey 2009

Figure 3.5.13 provides data on the number of hours children work, and these data indicate that Indonesia's working children work very long hours indeed. Children under 13 years old are not supposed to work at all, but 4.2 per cent of those who work do so for more than 40 hours a week. Additional data from the survey indicates that children in this group attend school as well as work over 40 hours a week.

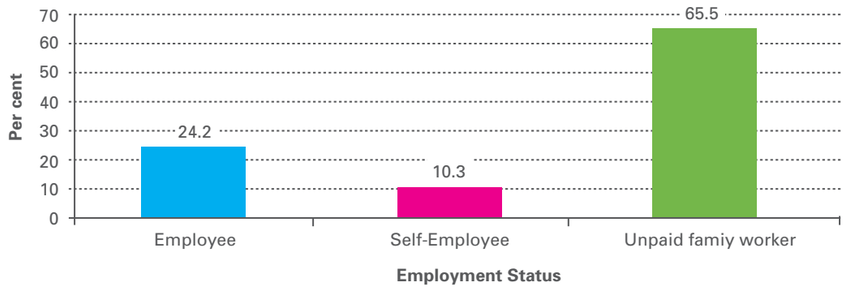
Figure 3.5.14 Percentage of working children by industry and age group, Indonesia 2009



Source: Indonesia Child Labour Survey 2009

Figure 3.5.14 indicates that the majority of working children, across all age groups, are employed in the agricultural sector, followed by commerce and manufacturing. There are, however, some important gender differences. The overwhelming majority of boys work in the agricultural sector (66 per cent) compared to 44.6 per cent of the girls who work. Girls, however, have more diverse occupations, with substantial numbers working in trade and commerce (28 per cent for girls, compared to 12.8 per cent boys) and 16.7 per cent of girls working in manufacturing, compared to 6.1 per cent of boys, according to the 2009 ICLS data.

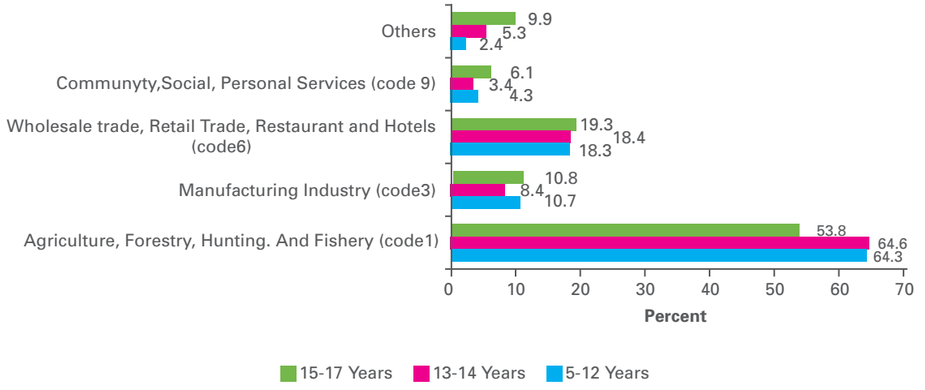
Figure 3.5.15: Percentage of working children aged 5-17 years by employment status, Indonesia 2009



Source: BPS - Statistics Indonesia and ILO, based on Indonesia Child Labour Survey 2009

Figure 3.5.15 reveals that the overwhelming majority of working children are unpaid family workers (65.5 per cent) and that only 34.5 per cent are remunerated for their labour. Additional data indicate that the proportion of unpaid workers diminishes amongst the higher age groups: 82.5 per cent of those aged 5-12 years are unpaid workers, as are 81.5 per cent of those aged 13-14 years and 57.8 per cent of those aged 15-17 years old.

Figure 3.5.16: Percentage of working children aged 5-17 years by place of work, Indonesia 2009



Source: BPS - Statistics Indonesia and ILO, based on Indonesia Child Labour Survey 2009

Finally, Figure 3.5.16 indicates that although child workers are primarily unpaid family workers, they nonetheless work mainly on plantations and farms rather than at family dwellings. Additionally, substantial numbers of children work in environments that are often associated with hazardous work: 7.7 per cent work in mines, construction sites and quarries, while 8.2 per cent work in mobile places, streets or traffic lights.

The information on child labour and working children in Indonesia paints a troubling picture where large numbers of children are working, often combining work with other chores or activities, and that these numbers have been increasing since 2004. Other troubling facts include that Indonesia's child labour laws are hardly stringent but in addition, they are clearly poorly enforced. Under these conditions, the potential for exploitation and abuse under the guise of unpaid family work is clear.

A specific dimension of child work that deserves special consideration is that of domestic workers. Throughout the world, domestic work is mostly informal, mostly undertaken by women and with few protections or regulations. There are approximately three million domestic workers in Indonesia.[303] Several studies on domestic work indicate that the majority of domestic workers are women, and that a large proportion of these workers are under the age of 18 (estimates range from approximately 25 per cent to approximately 50 per cent).[304] The ILO estimated the total number of child domestic workers to be approximately 700,000.[305] A report on domestic work in Indonesia by the ILO (2006) showed a marked reluctance by Indonesian society to regulate domestic work, not least because domestic work is often approached and understood as pertaining to the domestic/private sphere and therefore out of bounds from state interventions.[306] There is no data and little information about the prevalence of abuse amongst domestic workers but according to Amnesty International, "economic exploitation, poor working conditions and gender-based discrimination" does take place, and "many [domestic workers] are subjected

303 BPS - Statistics Indonesia (2007) *National Labour Force Survey 2006*, BPS: Jakarta
304 Rosenberg, R. (Ed.) (2003) *Trafficking of Indonesian Women and Children*. ICMC and ACILS: Jakarta, p18
305 ILO, cited in: Human Rights Watch (2005) 'Always on call: Abuse and exploitation of child domestic workers in Indonesia', Human Rights Watch, Vol.17, No. 7C, available at http://www.hrw.org/en/reports/2005/06/19/always-call-0 (Last accessed 9 October 2010)
306 ILO (2006) *Domestic Workers in Southeast Asia, A Decent Work Priority*. International Labour Office: Jakarta, p9

to physical, psychological and sexual violence."[307] As with other forms of 'domestic' violence, abuses which take place behind the closed door of the private sphere often go unreported and mostly unpunished. Lack of regulation and effective protection are combined with societal attitudes that child domestic workers are vulnerable to harm and have little prospect of accessing redress through formal or legal mechanisms.

Overall child labour remains a source of concern in Indonesia, but the setting up of the National Action Plan (NAP) on the Elimination of the Worst Forms of Child Labour (2002-2007), accompanied by the establishment of a national committee to oversee its implementation, showed an important commitment by the GoI to tackle some of the worst aspects. The implementation of this NAP involved stakeholders at national, provincial and district/ municipality levels. The central government developed the policy of institutionalising the coordination at provincial and district/municipality levels. Currently, two provinces have enacted Provincial Regulations on the Worst Forms of Child Labour, 21 provinces have established Provincial Action Committees and 72 districts/municipalities have established District/Municipality Action Committee. The NAP also included information and awareness campaigns widely disseminated through the media, the provision of family empowerment services, and capacity building through local programme development trainings and institution building. Lastly, the NAP also comprised direct interventions through the provision of assistance to 45,111 children with non-formal training, vocational education programmes and rehabilitation.

The National Action Plan has produced some important advances, but an internal evaluation of the NAP activities identified ongoing challenges. First, data on child labour remains poor and this in turn makes it difficult to allocate budget, devise and implement appropriate policies and responses.[308] Second, although coordination and cooperation between national and sub-national levels have improved, this is nonetheless a work in progress which needs further strengthening. Capacity building and allocating sufficient budget for the fight against the worst forms of child labour remain priorities.[309] The same report further recommends the development of integrated sustainable programmes, the mainstreaming of child labour issues in education, and poverty alleviation programmes to prevent child labour.

3.5.2.6 Sexual exploitation and trafficking

The sexual exploitation of children in Indonesia relates to the prostitution of children and/or using children for the production of pornographic materials. The sexual exploitation of children is categorised amongst the 'worst forms of child labour' and represents a fundamental violation of child rights.[310] The causes of child prostitution are complex, often deeply rooted in poverty and family economic pressures, but a wide range of risk factors also play a role such as migration and displacement, inequality, discrimination, persecution, violence, armed conflicts, HIV and AIDS, dysfunctional family environments and criminal networks.[311] The expansion of the sex industry and demand factors also play important roles.[312]

307 Amnesty International (n.d.) *Indonesia: Exploitation & abuse - the plight of domestic workers*, AI: Asia Pacific, available at: http://asiapacific.amnesty.org/apro/aproweb.nsf/pages/DW (Last accessed 22 February 2011)
308 Secretariat of the National Action Committee on the Elimination of the Worst Forms of Child Labour (2008) *Report on the implementation of the national action plan on the elimination of the worst forms of child labour stage one (2002-2007) and stage two*, Secretariat of the National Action Committee on the Elimination of the Worst Forms of Child Labour: Jakarta
309 Ibid.
310 UNICEF (2004) *The commercial sexual exploitation of children in Surakarta (Central Java) and Indramayu (West Java), Indonesia*, UNICEF: Jakarta, pxii
311 UNICEF (2010) *Children in Indonesia: Sexual exploitation*, UNICEF: Jakarta, available at: www.unicef.org/indonesia/UNICEF_Indonesia_Sexual_Exploitation_Fact_ Sheet_-_July_2010.pdf (Last accessed 9 October 2010)
312 Ibid.

The harmful impacts of prostitution on children are multiple, including physical and emotional stress, early school leaving, increased susceptibility to HIV and AIDS and other STIs, unintended pregnancy, as well as violence and social rejection.[313] The risk of HIV and AIDS infection is a particular source of concern since the 6-16 per cent of female workers who are HIV-positive are usually infected within the first six months after initiating sex work, and young girls have less knowledge about HIV and AIDS and methods of protection than their older counterparts.[314] Prostituted children are also more likely to use alcohol and develop smoking habits.[315] Unsurprisingly, considering the underground and illicit nature of the sexual exploitation of children, it is difficult to evaluate the number of children who are prostituted in Indonesia. Adult female commercial sex work in Indonesia is legal providing that it takes place in registered establishments. However informal and illegal forms of prostitution operate in parallel to legal and regulated forms. Karaoke bars, massage parlours and street prostitution also exist. Data on the illegal forms of commercial sex work are difficult to establish. An in-depth analysis dating from the late 1990s estimated that 30 per cent of women involved in prostitution were below the age of 18.[316] Since the same study estimated the number of commercial sex workers to be between 140,000-230,000, using 30 per cent as a benchmark this indicates that the number of children victims of sexual exploitation ranges between 40,000-70,000.[317] There has been no new or updated data since this study was published in 1999.

There are some complex societal attitudes and behaviours towards commercial sex work in Indonesia, where some forms of adult prostitution are legal but also deeply morally reprehensible. As was already flagged in the 2000 SITAN, silence about this 'taboo' subject tends to be the norm. Beyond silence, however, it is difficult to escape the notion that the prevalent views about sex work and sex workers are negative, if not wholly hostile.[318] In a recent report by Save the Children (2010), attention was drawn to abusive practices towards commercial sex workers (including children who have been forced into prostitution) during police raids seeking to clamp down on illegal prostitution.[319] On one hand, it is relatively well known that 30 per cent of sex workers are children, but there seems to be no policy of differentiating between children forced into prostitution and adult sex workers, let alone efforts to attend to the needs of these sexually exploited children during these operations. Raids and the decision to clamp down on prostitution tend to emanate from district governments seeking to 'clean up' and improve the moral standards of their localities.[320] The latter may be understandable, but abusive practices and the criminalisation of sex workers and children sold into prostitution far less so. This once again underlines some of the challenges associated with efforts to introduce coherent child protection policies in the context of a decentralised country.

The complexities of attitudes and practices towards sex work and the sexual exploitation of children are also rooted in legal provisions that do not always promote the best interests of children. It has already been noted that commercial sex work is legal for adult females provided it takes place within certain establishments. However, the system of legal protection is not as

313 UNICEF (2004) *The commercial sexual exploitation of children in Surakarta*
314 National AIDS Commission (KPA) (2009) *UNGASS report*
315 UNICEF (2004) *The commercial sexual exploitation of children in Surakarta*, pxviii
316 Irwanto, M. F., Anwar, J., Hendirati, A. and Sunarno, N. (1998) *Situational analysis of children in need of special protection*, Centre for Societal Development Studies, Atmajaya Catholic University, Department of Social Affairs and UNICEF, Jakarta, cited in: UNICEF (2000) *The situation of children 2000*, p158
317 Save the Children (2010) *Review report Indonesia*, p141
318 There are some important local differences and in some areas sex work is more tolerated than in others, see: UNICEF (2004) *The commercial sexual exploitation of children*
319 Save the Children (2010) *Review report Indonesia*
320 Ibid.

solid as it should be. On one hand, the prostitution of children whilst punishable by law remains poorly defined (Article 81 and 82, 2002 ILCP). On the other hand, the failure to systematise and harmonize the legal definitions of childhood and adulthood once again becomes problematic. As previously discussed, child marriage signifies the loss of legal status of child for females who marry before they are 18, creating a grey area where it becomes unclear whether a married young girl can legally be prostituted or not. These legal grey areas are subject to varied or localised interpretations of the law, which weaken child protection. Finally, in the field of legal protection, the GoI signed the Optional Protocol to the CRC on the sale of children, child prostitution and child pornography, but has yet to ratify it. Ratification is essential to clarify and harmonize current policies as well as to strengthen protections where they are very weak, for instance with regards to child pornography.[321]

The stigmatisation and criminalisation of sexually exploited children is particularly harmful to children themselves as well as to the consolidation of child protection in this particularly sensitive field. However, as elsewhere in the word, long-standing challenges in dealing with sexual exploitation are being reprised and revisited and reformulated through the prism of human trafficking. In this approach, those who are trafficked tend to be identified as victims and moral condemnation is extended to those who benefit, organise, facilitate or buy into trafficking. In Indonesia, there is an emerging focus on two important aspects of the sexual exploitation of children: sex tourism and the trafficking of Indonesian children both inside and outside of the country. According to the Directorate General of Tourism Destination Development of the Ministry for Culture and Tourism, there were nearly 14,000 child victims of sexual exploitation in tourist destinations in 40 villages and six provinces of Indonesia.[322] The Directorate also identifies that Bali, West Nusa Tenggara, Central Java, Riau Islands, West Java and East Java have been identified as 'top' destinations for child tourism in Indonesia. So far, whilst there is evidence of child sex tourism taking place in Indonesia, this is not yet identified as a significant issue. Rather the potential for Indonesia to become a child sex tourism destination is flagged, and this calls for preventative measures.

Although available data are insufficient, the trafficking of Indonesian adults and children is known to take place to countries such as Malaysia, Singapore, Japan and the Middle East, and it is known that some of the victims of trafficking are coerced into prostitution. There are known factors that facilitate human trafficking and sexual exploitation, such as poverty, social acceptance of child labour, child marriage and low education, as well as a poor record of birth registration (as described earlier in this section).

As with child labour, the GoI adopted and implemented National Action Plans (NAPs) to elaborate and coordinate responses. In 2002 the GoI established two distinct NAPs by Presidential Decree, one on the Eradication of Trafficking of Women and Children 2002-2007 (Presidential Decree No. 88/2002) and one on the Elimination of the Commercial Sexual Exploitation of Children 2002-2007 (Presidential Decree No. 87/2002).

The Ministry for Women's Empowerment commissioned an evaluation of these National Action Plans.[323] The findings of the evaluation indicate a failure to allocate sufficient funds and that most of the programmes attached to the NAPs failed to be implemented. In addition, some important

321 ECPAT International (2004) *Report on laws and legal procedures concerning the commercial sexual exploitation of children in Indonesia*, ECPAT: Bangkok
322 UNICEF (2010) *Children in Indonesia: Sexual exploitation*
323 Marshall, P. et al. (2008) *Evaluasi pelaksanaan rencana aksi nasional pertama indonesia untuk penghapusan perdagangan perempuan dan anak (P3A) dan penghapusan eksploitasi seks komersial anak (ESKA)*, unpublished report.

advances were realised with trafficking but not with the elimination of the sexual exploitation of children. In terms of advances, the adoption of Law No. 21/2007 on the Eradication of the Criminal Act of Trafficking Persons was a significant step forward. Further, national and sub-national task forces on the Prevention and Response to the Criminal Act of Trafficking in Persons have been set up to implement programmes. Provincial and district task forces have started to become established in some provinces and districts. In addition, most of the provinces and some districts have adopted regulations on trafficking, and outreach education work has been conducted in all 33 provinces of Indonesia.[324]

Similar progress however, was not shown with regards to the Elimination of the Commercial Sexual Exploitation of Children. The GoI did little to underline the issue and it was clear that the implementation of the NAP and related programmes was not a priority. One of the chief recommendations of the evaluation was that both trafficking and the elimination of the sexual exploitation of children be combined to ensure better coordination, avoid overlapping or the duplication of programmes, and if possible to even out attention between the two issues. The two NAPs have not only been renewed but the recommended combination has taken place through the setting of the NAP on the Elimination of the Criminal Act of Trafficking in Persons and the Sexual Exploitation of Children. Important steps towards tackling the commercial sexual exploitation of children and trafficking have taken place in Indonesia, but these still fall short of constituting a solid base for effective child protection initiatives. Legal protection needs to be strengthened (notably with the ratification of the UN Optional Protocol) and data both on trafficking and the commercial sexual exploitation of children need to be gathered more systematically. The development of preventive programmes alongside responsive ones is another area of priority (not least through information and awareness raising, as well as through supporting the economic security of vulnerable households).[325] Finally, the National Action Plans need to be suitably funded and better implemented to enable coordinated responses, notably at the sub-national level.

3.5.3 MIGRATION AND DISPLACEMENT

3.5.3.1 Children of illegal migrants overseas

Indonesia provides a number of migrant workers, mainly women, to other countries in the region (primarily Malaysia and Singapore) and in the Middle East. In 2007, the World Bank estimated that as many as 4.3 million Indonesian citizen worked overseas, the second largest provider of migrant workers in the region after the Philippines.[326] However, some migrant workers either unknowingly or deliberately do not have legitimate work visas, particularly in Malaysia. It is estimated, for example, that there are now more than 800,000 illegal workers in Malaysia.[327] They work on plantations or construction sites, or as domestic workers or prostitutes.[328] This creates problems for Indonesian children born overseas to illegal migrants in terms of child protection, as they have no formal documentation, legal status, or recourse to legal protection, or education, and no access to other public services. Furthermore, the process of gaining formal documentation in Indonesia on return is complicated, leaving many children of illegal migrants

324 UNICEF (2010) *Children in Indonesia: Trafficking*, UNICEF: Jakarta, p2
325 UNICEF (2010) *Children in Indonesia: Sexual exploitation*, p3
326 Silva-Leander, A. (2009) *Report on children and migration for UNICEF Indonesia*, Unpublished report
327 Bruynsm, N. (2004) 'Introducing Southeast Asia's children who 'don't exist', Pattayamail, Vol.12. No. 39, available at: http://www.pattayamail.com/582/features.shtml (Last accessed 16 October 2010)
328 Ibid.

stateless. In Malaysia, official documents (namely birth certificates and national identity cards) are prerequisites for all dealings with the state as well as the private sector. It is estimated that there are around 240,000 undocumented children of these illegal workers in Malaysia alone.[329]

Undocumented migrants in Malaysia are targets for arrest and deportation. In the case that a child's parents have suddenly been deported and they have no other family ties in Malaysia, it may be difficult for them to trace their heritage back to their parents' country of origin in order to apply for a passport. This has increased children's vulnerability to living on the streets and the other vulnerabilities this necessarily entails.[330]

3.5.3.2 Displacement

Between 1999-2002 social unrest and violence erupted throughout Indonesia (Maluku, North Maluku, Central Sulawesi, Central Kalimantan, West Kalimantan, West Timor) and tens of thousands of people were killed and more than 1.4 million displaced. A further estimated 500,000-700,000 people were displaced by the conflict in Aceh between 1999-2004, while tens of thousands of people have since 2001 been forced from their homes by military operations in Papua. Since 2005, there have been no reliable estimates of the number of people still displaced by conflict. At the end of 2004, estimates ranged from 342,000-600,000.[331] In July 2003, it was estimated that 740,000 people remained displaced. About 70 per cent of internally displaced persons (IDPs) in Indonesia are women and children.[332]

Some five years after communal and state-society tensions have begun to settle in many conflict areas (although tensions remain in Papua), the information available in early 2009 suggested that the combined number of those still displaced and those who have returned or resettled (but who continue to face barriers to living normally and securely and to exercising basic human rights) ranges from 70,000-120,000. Challenges still faced by these people include lack of access to services, economic hardship and inadequate material assistance, political and social segregation from the larger community, a previous loss of land and property, and a number of other constraints.[333] This is, however, a rough approximation, given the absence of any systematic monitoring of return and resettlement conditions and the difficulties in defining who is still an IDP.

In addition to those still displaced, there are three broad categories of 'former conflict IDPs': (1) IDPs who continue to live in camps or informal settlements with little or no access to basic services, who cannot buy the land they are living on (Central Sulawesi, West Timor); (2) IDPs who have been resettled in collective sites far from urban areas, with poor access to markets, health services, education and no access to agricultural land (West Kalimantan, West Timor, Maluku and Central Sulawesi); (3) IDPs who have returned to their homes but who have not been able to reclaim their property or livelihoods (Aceh, Central Sulawesi, West and Central Kalimantan, and Maluku).[334]

329 Ibid.
330 Ibid.
331 Internal Displacement Monitoring Centre (2010) *Between 70,000 and 120,000 people still displaced by conflict in Indonesia in 2009*, available at: http://www.internal-displacement.org/idmc/website/countries.nsf/percent28httpEnvelopes percent29/5347032E6CECCB46802570B8005A70E2?OpenDocument (Last accessed 16 October 2010)
332 Penanggulangan Bencana dan Penganganan Pengungsi Badan Koordinasi Nasional (PBP Bakornas) and the Office for the Coordination of Humanitarian Affairs (OCHA) (2003) *Follow-up workshop on the management of IDPs in Indonesia*, Sukabumi, 19-23 June and 20 July, p3
333 Internal Displacement Monitoring Centre (2010)
334 Ibid.

Despite significant differences in the situation facing each of these groups, there are a number of common problems preventing them from enjoying their rights to the same extent as the rest of the population. These include poor housing conditions, lack of access to land, lack of economic opportunities, food insecurity, limited or no access to basic services (such as clean water, health care or education), and limited social integration with surrounding communities.[335]

3.5.3.3 Children living and working on the streets

Children living on the streets form a major group of vulnerable or at-risk children and are identified as in need of special protection in Indonesia. This constitutes an important shift from the recent past when suspicion and punitive approaches towards children living on the streets predominated. As will be shown, whilst the shift in public discourse is welcome, the legacy of suspicion has not been wholly superseded, neither amongst public officials nor across society.

First, the UN defines a 'street child' as: "any boy or girl...for whom the street in the widest sense of the word...has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults."[336] The ILO makes a further and broadly accepted differentiation between children who live in the streets to undertake economic activities and those who live off the streets with little or no contact with family environment.[337] It is now broadly accepted that the term 'street child' is both insensitive and stigmatizing for children who are exploited and living and working on the streets.

Whilst all children living on the streets have limited access to essential basic services such as health and education, are exposed to risks of violence and exploitation and experience stigmatisation, marginalisation and discrimination, the deprivations and risks are more acute and severe for children living off the street. Often fleeing violence, with little or no protection, they are intensely vulnerable to violence, abuse and exploitation as well increased risk of exposure to STI, substance abuse and incarceration. However, Kemensos, the Ministry of Social Affairs (formerly known as DEPSOS), which is broadly responsible for assisting neglected children and children living on the streets, currently defines children living and working on the streets surprisingly narrowly, referring to: "children 5-18 years of age who spend most of their time on the street to earn money or just hang around." Similarly, in the current GoI National Program for Children (PNBAI, Program Nasional Bagi nak Indonesia), 2004-2015, children pushed onto the street primarily for economic reasons and living off the streets also seem to be the central concern, with little or no mention of children living in the streets: "the state of the family economy is apparently the main factor pushing the children onto the streets where they become an economic asset to the family, with this family dependence on their income making it difficult to get them off the streets and into a more appropriate environment children." In practice, children living in the streets have not always been overlooked by the GoI responses, but a more comprehensive understanding of children living on the streets is essential to ensure that the most vulnerable and neglected children of Indonesia do no fall by the wayside.

The factors pushing children to live off the streets and in the streets are varied, often related to poverty, including unemployment, rural/urban migration and failures to provide families with safety net programmes.[338] Other factors include violence and/or the breakdown of families

335 Ibid.
336 UNICEF (2009) *Child protection information management mapping: Towards a data surveillance system in Indonesia*, UNICEF: Jakarta, pp30-31
337 Ibid.
338 UNICEF (2000) *The situation of children 2000*, pp144-146

notably through divorce and remarriage. The identification of children living on the streets as a specific group requiring attention can be traced back to the late 1990s, when the visibility of such children increased, especially in Java and Sumatera.[339] The sudden increase in the number and visibility of children living on the streets has been linked with wider economic crises, both in the late 1990s and in the late 2000s.[340] Once again, reliable data are scarce but the trend seems to be towards substantial increases in the number of children living on the streets in Indonesia. Estimates gathered by the Ministry of Social Affairs put the number of children living on the streets at around 50,000 in the late 1990s[341], and that number increased to 60,000-75,000 in 2004 and increased yet again to an estimated 230,000 in 2008.[342]

The issue of children living on the streets is given very little consideration in the child protection related material published and produced by the GoI. In spite of the severity of the problem with children living on the streets in Indonesia, the response of the GoI has been disappointing and lacking the leadership and substance that characterizes other child related interventions and policies of the GoI.[343] As already noted elsewhere, the GOI approach to children living on the streets has shifted over the years from punitive approaches that criminalised children living on the streets and considered them as delinquents, to recognizing that they constitute a vulnerable group requiring special protection.

However tensions remain and in practice the conversion from criminalizing children living on the streets to child protection remains incomplete. The relatively low priority and mixed attitudes towards children living on the streets are still much in evidence in the current National Program for Children 2004-2015 (PNBAI) formulated in 2004: "Due to the difficult situations and conditions they find themselves in, street children often resort to criminal activity and become integrally involved with the criminal elements of the city, which has an extensive impact on public security." According to a Save the Children report, initial approaches to children living on the streets in the late 1990s were consistently punitive 'public security' led interventions, mostly taking the form of raids designed to clear the streets of 'undesirables', including children living on the streets.[344] These raids constitute arbitrary mass arrests and were often accompanied by violence, all of which directly contravenes basic human rights provisions. The shift towards child protection did lead to a retreat from these abusive and punitive approaches and more appropriate responses were adopted.

In the late 1990s, the UNDP, NGOs and the GoI through the Ministry of Social Affairs collaborated in setting up a number of shelters and 'safe houses' designed to host and rehabilitate children living on the streets.[345] In 2006, the Ministry of Social Affairs developed a network of social development centres for children.[346] Other initiatives have included setting up mobile schooling programmes to work towards fulfilling educational needs and the provision of vocational training for children living on the streets who have dropped out of school.[347] Whilst these programmes

339 Ibid.
340 Ibid.; Dursin, K. (11 February 2010) *Mobile classes offer hope to Indonesia's street children*, OneWorld South Asia: available at: http://southasia.oneworld.net/globalheadlines/mobile-classes-offer-hope-to-indonesia2019s-street-children (Last accessed 1 October 2010)
341 UNICEF (2000) *The situation of children 2000*, p144
342 UNICEF (2000) *The situation of children 2000*, pp144-146; and Ministry of Social Affairs (2008) Government of Indonesia National Program for Children (PNBAI) 2004-2015, cited in: UNICEF (2010) *Who are children without parental care?*, UNICEF: Jakarta, available at: www.unicef.org/indonesia/UNICEF_Indonesia_Children_Without_Parental_Care_Fact_Sheet_-_June_2010.pdf, (Last accessed 1 October 2010)
343 Save the Children (2010) *Review report Indonesia*
344 Ibid.
345 UNICEF (2000) *The situation of children 2000, pp144-146; and Save the Children (2010) Review report Indonesia*
346 UNICEF, Save the Children and Ministry of Social Affairs (2007) *Someone that matters: The quality of care in childcare institutions in Indonesia*, UNICEF: Jakarta, p29
347 Child Frontiers (2009) *Child and family welfare services in Indonesia: An assessment of the system for prevention and response to abuse, violence and exploitation against children*, Child Frontiers: Jakarta, p59

and initiatives provide important services, it is notable that they are essentially reactive rather than preventative. Considering the recent trend towards rapid increase in the numbers of children living on the streets, the paucity of responses and the weaknesses of the alternative care system, the setting up of preventive measures and programmes ought to be amongst the priorities of the GoI. More worrying still, the Save the Children report underlines that although shifts have taken place in terms of national level policies and discourse regarding children living on the streets, at the local level there has been an unwelcome resurgence of raids and punitive approaches, including arrests and fines.[348] A number of cities and districts have enacted draconian regulations seeking to better control streets and public spaces, for instance prohibition of begging activities, busking or selling of goods in the streets.

The regulations are problematic in several respects, first because they erode the capacity of the urban poor to earn a living without providing suitable alternatives, and second there are numerous reports that the enforcement of these regulations by public order officials frequently results in violence.[349] In this particular instance, there seems to be a contradiction between child protection as conceived by central government, and child unfriendly local regulations and initiatives undertaken at the sub-national level. It is important to take note of these tensions and of the need to harmonize the concept of child protection between national and sub-national levels, but decentralisation can also be made to work in favour of child protection. In Section 4, the setting up of 'child-friendly' cities in Central Java focusing on children living on the streets is examined in detail. This is an example of best practice towards children living on the streets in Indonesia indicating that comprehensive child protection measures - incorporating appropriate responsiveness and preventive measures - can and do take place in decentralised Indonesia.

The issue of children living on the streets in Indonesia remains a pressing one because the trend is towards increasing rather than decreasing numbers of children living on the streets. In spite of the severity of the problem, responsive policies are still very limited and preventative ones virtually absent. The issue of children living on the streets has received comparatively little attention at almost all levels. Legal and social protection provisions are inadequate and need to be strengthened, and fundamental new approaches of the type depicted in the 'child-friendly' city initiative in Central Java are in urgent need of consideration.

Box 3.5.2: Pram: A child living on the street

Pram is a 16-year-old boy from Papua (Jayapura) who ran away from home, dropped out of school and was living on the streets at the time of the interview. One of six children from a poor family, Pram nonetheless recalls a happy childhood. Though not academically inclined, Pram was a highly motivated young boy who hoped to become a professional football player or join the army. Once a favoured child by his father, Pram's world came crashing down in his third year of primary school when he caught his father having an affair with another woman. Pram reports that his father would hit him as a form of punishment if he missed school, but the discovery of the affair first by himself and then by his mother led to even more severe episodes of violence. His father beat his mother black and blue with a wooden stick and beat Pram too when he was trying to protect his mother: "I shouted, 'Mum run away! Mum run away!' But she couldn't…and I gave in to my dad, if he hit mum then he would inevitably hit me too [for challenging him]."

348 Save the Children (2010) *Review report Indonesia*, pp135-140
349 Ibid., p136

Pram was stripped naked by his father, hung upside down from a tree and left in the sun for an entire afternoon until after sunset. His father then put ants on Pram's naked body and left him to be bitten. The feelings of Pram and his siblings towards their father developed into bitterness, fear, loathing and ultimately, feelings of betrayal. Pram was hurt physically but was also left deeply scarred emotionally: "I am bitter, really… Especially when I remember how Dad hit my mum."

Following the violent episode, Pram ran away from home and dropped out of school. Pram reports that he understood that this was a risky option for a small child but he nonetheless felt compelled to run away. His decision was partly derived from a desire to flee from violence and partly from wanting to exercise some control over his relationship with his father. From Pram's perspective, living in the streets remained his only avenue to shame and punish his father for his violence and betrayal of his son and family. Pram acknowledges that even now he wants to hurt his father's feelings. His father had once been proud of him and Pram now wants his father to feel responsible for his [Pram's] loss of status and shattered life ambitions. Pram feels that his earlier goals and life ambitions are now out of reach. Pram has developed a deeply ambivalent attitude towards school and education and any putative reintegration remains linked to his father behaving responsibly towards his family: "My father loved me when I was small, but now he has remarried. I am angry…the problem would be solved if my dad left his affair…but dad is not willing to."

Whilst he still has contact with siblings and relatives, there are deep family tensions relating to his living in the streets and the issue of school and education: "All of them are angry, my relatives, uncle and aunty are willing to send me back to school but I don't want to go. They have enrolled me to study at informal school [kejar paket C] but I never attend the school. Even If I went to school, I would be self-conscious [because of] my mucky clothes."

Living in the streets is a harsh experience but Pram also notes that he has developed a network of friends who are in circumstances similar to his and who helped him find some shelter in a crowded building. His friends also encouraged him to take on his job as a car park attendant, which helps him to subsist, and some also encourage him to take up his schooling again. On this point Pram is aware that it would be in his best interest to go to school but he remains adamant that it is too late and that school is no longer really an option for him: "I don't know how to solve my problem, it may not be a solution."

Source: Child interview conducted by PSKK, UGM in Jayapura, 2009; Pram is not his real name

Pram's[350] experience outlined in Box 3.5.2 underlines how violence and the breakdown of a family can be viewed through the eyes of a child. It demonstrates the devastating effects of trauma and how running away, dropping out of school and living in the street is perceived by children themselves as the only way to exercise control over otherwise unmanageable circumstances. Pram is resisting returning to school and potentially improving his opportunities for better employment and a better standard of living over the long-term in response to the emotional hurt and physical violence he has experienced. He does this knowingly, but also because he has no sense of justice for what he and his mother have experienced, and no knowledge of alternative means of addressing his trauma. Furthermore, it also demonstrates how violence in the home has larger consequences for child development, child rights and opportunities.

350 Name changed

3.5.4 ALTERNATIVE CARE

Children can find themselves without parental care for a wide number of reasons, as the result of natural disaster or conflict, or as the result of parental illness, disability or poverty. The CRC emphasises the importance of family as being the most favourable environment to support a child's interests, and that if children find themselves without parental care then the extended family, alternative families (e.g., fostering and adoption) and - as a last resort - institutional care are possible alternatives.[351] The role of the state is conceived essentially in supportive terms, first enabling parents to fulfil their role and ensuring that alternative care solutions are found if the parents cannot fulfil their role. In December 2009, the 65th UN General Assembly issued guidelines that reiterate and enhance the general provisions of the CRC.[352]

There is a lack of data on children without parental care in Indonesia and little official data on children living in institutions. However, the 2000 census and research undertaken by UNICEF in conjunction with Save the Children and the Ministry of Social Affairs (then DEPSOS, now known as Kemensos) shed some important light on the issue.[353] Data on children under 15 years of age from a national population survey carried out in 2000 indicate that over 2.15 million children lived without parental care but that 90 per cent of these children were cared for by their extended families. A major finding of this collaborative research was that the majority of children who are in childcare (90 per cent) had at least one parent alive and more than 56 per cent had both parents alive with less than 6 per cent of the children in care having lost both parents.[354] There is still no official data on the total number of childcare institutions operating in Indonesia, but estimates vary from 5,250-8,610 and these are overwhelmingly in the private sector (the Ministry of Social Affairs runs three facilities and local governments approximately 32, while the remainder are in private hands).[355] Some partial data about these institutions are available because some (though not all) of these institutions receive funding from the Ministry of Social Affairs (over 4,000 institutions).[356]

Historically, childcare institutions in Indonesia (even those in receipt of government funding) have been allowed to operate largely unregulated without licensing or mechanisms of oversight. There are bureaucratic standards for the management of childcare institutions but the focus is on budgets and staffing levels.[357] The types, standard and quality of services offered by childcare institutions have not been given due consideration. Unsurprisingly, the lack of regulation and oversight has meant that these institutions are not always run with the best interests of children in mind. Alternative care in Indonesia remains problematic for distinct sets of reasons: because of the prevalence of institutional care as a response to children without parental care and because of the quality of care within these institutions.

As was mentioned above, the majority of children in childcare institutions in Indonesia have both parents alive. Poverty and/or access education therefore appear to be the prime motives for the institutionalisation of children. A corollary of this state of affairs is that children also tend to stay for long periods of time in these institutions (typically the length of education cycles). Even though separation from family is known to be detrimental to the development of children, the

351 Save the Children (2010) *Review report Indonesia*, p43
352 UNICEF (2010) *Children in Indonesia: Children without parental care*, UNICEF: Jakarta
353 UNICEF, Save the Children and Ministry of Social Affairs (2007) *Someone that matters*, pp4-5. Note: The Ministry of Social Affairs was known as DEPSOS in 2007 but is currently known as Kemensos.
354 Ibid.
355 Ibid., pp18-19
356 Ibid., p3
357 Save the Children (2010) *Review report Indonesia*, pp42-43

majority of children in childcare institutions have little contact and interaction with families and communities during prolonged institutionalisation.[358] Institutional childcare in Indonesia appears to primarily be the result of economic vulnerability and a mechanism to ensure education, indicating that a possible alternative to residential childcare would reside in supporting access to education.[359] The provision of education is the central priority of these institutions and this has a detrimental impact on the quality of care they provide. For instance, few childcare institutions provide services that address the needs of children who have experienced violence, neglect or trauma.[360] In almost all cases, placement procedures into childcare institution were not followed. Virtually no assessments of the children's need for care were carried out either before or during the placement, and children are expected to leave once they have completed their education, not before.[361] The criteria for the selection of children into a childcare institution has little to do with protection needs - instead criteria tend to focus on whether they are of school age, from a poor background, and old enough to take care of themselves.

The 2007 UNICEF, Save the Children and the Ministry of Social Affairs report also underlines serious issues in the running and operation of childcare institutions, including low ratio of staff per child, lack of personnel with knowledge of or background in social work, and extensive practices of using the children as a source of free labour. Children are largely left to look after themselves and each other, including cleaning, washing and contributing to the running of the institution, but the children's contribution is often in lieu of adults rather than complementing the work of adults. Other questions relate to the strict daily regimen in operation at childcare institutions, where the maintenance of order and discipline take priority over ensuring the welfare and emotional development of the children. The military-style discipline of these institutions also frequently descends into violence, both physical and emotional. Punishments, public humiliations, hitting, caning and the shaving of children's heads are all used as disciplinary methods at childcare institutions.[362]

The 2007 report also drew a bleak picture of alternative care in Indonesia, and the Ministry of Social Affairs was in the final stage of drafting new regulations (National Standard on the Care of Children in Institutions) at the time the report was being completed. The new regulations seek to address some of the issues that have been highlighted here, such as introducing licences for institutions, compliance mechanisms and shifting from a primary focus on residential care towards providing support for children and their families.[363] The reform of the current alternative care system in Indonesia is an important step that should assist the GoI to fulfil its obligations underlined in the CRC and in the 2002 law on child protection (ILCP). Follow-up research and data collection and analyses are needed, as this overview indicates. However, the reform of the current alternative care system is a major undertaking that will require sustained coordination between local and central government bodies, as well as substantial financial support.

3.5.5 CHILDREN IN CONTACT/CONFLICT WITH THE LAW

In this section, the situation of children in conflict with the law is examined, referring to persons under the age of 18 years who are suspected or accused of committing an illegal offence. This is a particularly sensitive area of child protection, as upholding the rights of those who are in conflict with the law can clash with local beliefs and practices as well as raise difficult questions about the role and behaviour of state actors involved in the juvenile justice system.

With many aspects of child protection, the GoI has adopted positive measures, notably through legal provisions, incorporating child-friendly approaches to development planning, and through the drafting of national action plans. However, these positive steps have not been reflected in the area of the juvenile justice system for the 2000-2010 period. The Juvenile Justice Act (No. 3/1997) was the only legislative step dealing with children in conflict with the law, and on the whole the juvenile justice system remained stubbornly 'child-unfriendly'.[364] For instance, the 2000 SITAN flagged the issue of the age of criminal responsibility which had been set at eight years old, stating that this is far too low, but this issue remains unaddressed at the time of writing this report.[365]

There are multiple concerns about children in conflict with the law in Indonesia that arise from almost all aspects of their treatment in the justice system, and there is evidence of pervasive denials of children's rights. The CRC and Indonesia's Law No. 23/2002 on Child Protection stipulate that detention should only be used as a last resort, and the CRC emphasizes restorative approaches and rehabilitation.[366] Official data are sorely lacking but the available evidence suggests that harsh punitive approaches, including incarceration, are commonplace in Indonesia. Officially, only children over 12 years of age can be sent to jail, but UNICEF staff have reported cases where younger children have been detained and even sent to jail.[367]

These reports are supported by evidence from the household survey undertaken by the University of Indonesia for the 2009 Situation Analysis of Adolescents in Indonesia.[368] The survey of 1,500 adolescents (aged 10-18 years) across four provinces (Aceh, Central Java, East Nusa Tenggara and Papua) shows that just under 7.5 per cent of all the respondents had experienced imprisonment. The breakdown of this figure by age group reveals that a considerable number of children under 12 years old are imprisoned, with the exception of Central Java where virtually no children 10-12 years old report imprisonment. In Papua, however, over 10 per cent of 10- to 12-year-olds report having experienced imprisonment (4 per cent in Jayapura and 16 per cent in Jayawijaya districts). In Aceh, there is a disproportionately high number of 10- to 12-year-olds report imprisonment which was 6.4 per cent for that age group compared to 4 per cent overall for the 10-18 year age group report imprisonment, while in East Nusa Tenggara (NTT) they are 5 per cent and 5 per cent, respectively. Furthermore, research undertaken by the University of Indonesia in 2006 estimated that 96 per cent of child cases that came to court resulted in custodial sentences and that 60 per cent of these sentences exceeded one year.[369]

Data from the 2009 survey by the University of Indonesia further substantiate these worrying findings by estimating that approximately 7.5 per cent of children aged 10-18 years old report having experienced imprisonment. The survey, however, also points towards significant disparities between provinces with reports of imprisonment ranging from 1.5 per cent in Central Java, followed by 4 per cent in Aceh and 6 per cent in NTT, up to 18 per cent in Papua. Two of

358 UNICEF, Save the Children and Ministry of Social Affairs (2007) *Someone that matters*, pp5-6
359 Ibid., p12
360 Ibid., p8
361 Ibid.
362 Ibid.
363 Save the Children (2010) *Review report Indonesia*, p45
364 Ibid., p125
365 UNICEF (2000) *The situation of children 2000*
366 Save the Children (2010) *Review report Indonesia*, pp125-127
367 UNICEF (June 2010) *Children in Indonesia: Juvenile justice.* UNICEF: Jakarta, p2, available at: www.unicef.org/indonesia/UNICEF_Indonesia_Juvenile_Justice_Fact_Sheet_-_June_2010.pdf (Last accessed 22 February 2011)
368 University of Indonesia (2010) *Situation analysis of adolescents 2009*, Mimeo: Jakarta. The survey and sampling methods are detailed in Section 3.3 on HIV and AIDS.
369 Ibid.

the provinces NTT and Papua show considerable intra-provincial disparities. In NTT, almost twice as many adolescents report imprisonment in Kupang (7.8 per cent) as compared to Sikka (4 per cent). In Papua the disparities are even wider, with 5.5 per cent of respondents reporting imprisonment in Jayapura compared to 38.6 per cent in Jayawijaya.

Indonesia's Directorate General for Corrections estimates that some 5,000 children are incarcerated at any one time (either awaiting trial or serving their sentences) and as noted in the 2000 SITAN, many are incarcerated for petty crimes and minor offences, such as theft, vagrancy, truancy or drug misuse.[370] Worryingly there are indications that in some cases children are treated more harshly than adults by the justice system, since some of these offences are categorised as 'status offences' and are not considered criminal offences when committed by an adult.

Harsh sentences result in part from the predominant view within the criminal justice system that formal judicial processes and even imprisonment are appropriate punishments for young offenders.[371] It derives in part too from the fact that children put under arrest are processed through the justice system without legal counsel. There is little or no legal aid available for children who come into contact or conflict with the law, whether as offenders or victims.[372] In addition, in a number of cases, children have been intimidated into waiving their rights to legal representation.[373] The only commonly acknowledged path to avoiding harsh and/or prison sentences is currently through bribery, principally in police stations.[374]

One of the most worrying aspects of the experience of children in conflict with the law in Indonesia is the incarceration of children with adults. Failing to separate children from adults during incarceration leaves children vulnerable to emotional and sexual abuse and physical violence. The 2006 study by the University of Indonesia indicated that 85 per cent of children detained were incarcerated with adult inmates.[375] There are currently only 16 special juvenile detention centres throughout Indonesia and these house only 11 per cent of detained children. The lack of provisions for juvenile detention also means that incarcerated children have no access to basic services such as education, which weakens rehabilitation efforts and the likelihood of successful reintegration into society.

However, the experience of physical abuse and violence by children in conflict with the law is not restricted to contact with adult inmates but also comes from police and prison officers.[376] A number of reports and studies have pointed out that some children in conflict with the law are frequently subjected to physical violence and degrading treatments at the time of arrest, in police stations and whilst in detention and prison.[377] Special offices for women and children, where staff are better trained in women and child rights, have been established, but in practice they work with specific groups such as child victims and perpetrators of sexual violence rather than with the wider group of young offenders.

Finally, the little available data and research on the interaction between children and the justice system have tended to focus on children in conflict with the law, but the situation of children

370 Ibid., p1; UNICEF (2000) *The situation of children 2000*, p150
371 UNICEF (2006) *A situation analysis of juvenile justice in Indonesia*, UNICEF: Jakarta
372 Ibid.
373 Save the Children (2010) *Review report Indonesia*, pp130-131
374 Ibid.
375 UNICEF (2010) *Children in Indonesia: Juvenile justice*, p2
376 Save the Children (2010) *Review report Indonesia*, pp131-132; see also UNICEF (2006) *SITAN Juvenile justice*
377 Ibid.

who come into contact with the law either as victims or witnesses requires further attention and currently there are few specific measures to protect the interests of these children.

There have been numerous calls for initiatives to render the juvenile justice system more child-friendly. These include ending the policy of systematic lengthy prison sentences, and improving the environment and safety of incarcerated children, notably through ensuring that they are sent to dedicated facilities. More substantively still, UNICEF is supporting diversion schemes that entirely bypass the court system. These schemes work best when set up in close collaboration with community-based programmes involving the families of offenders, and seek to emphasise the rehabilitation of children, avoid stigmatisation and minimise the rate of repeat offences.[378] The lack of data and research on children in conflict with the law also means that little is known about their background and the causes and conditions that lead to their committing offences. Collection of such information is important in order to develop non-judicial interventions (notably by social workers) that seek to prevent rather than punish offences.

Whilst the overall situation of children in conflict or in contact with the law remains rather bleak, there are however some signals that more positive approaches to juvenile justice are underway. The GoI is currently drafting a new law on juvenile delinquency that may potentially emphasise restorative rather than retributive justice.[379] The draft raises the minimum age of criminal responsibility to 12 years old and seeks to end the policy of harsh punishment for non-serious offences (i.e., decriminalizing status offences and emphasising diversion to the community at all stages of the juvenile justice process for non-serious offenses).[380]

Finally, some of the more recent information about children in conflict with the law, notably from the 2009 survey by the University of Indonesia, raises important questions about provincial and intra-provincial disparities, showing a troubling inequality of treatment of children based on their place of residence. The variations in the reported rates of imprisonment in children under 12 years old, for instance, show that districts and provinces act in direct contravention of national level laws, showing that the challenges of harmonizing and implementing child protection across national, provincial and district levels have so far not been met.

3.5.6 CHILD PARTICIPATION

The Convention on the Rights of the Child (CRC) underlines child participation in a number of articles, including the right of all children to free expression and the opportunity for their views to be respected (Articles 12 and 13), access to information (Article 17) and freedom of association (Article 15). The term 'participation' has a variety of meanings, but in the context of child rights and child protection it is usually associated with the process of sharing in decisions which affect children's lives and their communities.[381] There is therefore a profound interaction between freedom and participation rights. The fulfilment of those rights entails both awareness and empowerment on the part of children as well as their families, communities and government. In this subsection, child participation issues are explored from two distinct perspectives. First some traditional views about children and families in Indonesia are examined, indicating the profound challenges facing the fulfilment of children's rights to participation. Second, some issues relating

378 UNICEF (2010) *Children in Indonesia: Juvenile justice*, pp2-3
379 Ibid.
380 Ibid.
381 Hart, J. (1992) 'Children's participation: From tokenism to citizenship,' *Innocenti* Essay No. 4, UNICEF-IDC: Florence

to the legal normative framework are examined, which, it is suggested, also impede the full realisation of children's freedom and participation rights.

Some traditional views and concepts about children are based on a very distinct understanding of children as being (and supposed to be) politically powerless, without independent status or rights, and generally regarded to be the property of their parents, who are in turn allowed to treat their 'property' as they see fit.[382] There is an underlying assumption too that children by definition lack the maturity to exercise rights to freedom of expression. A child who holds views distinct from adults (parents, guardians, and/or teachers) is automatically in the wrong. In effect, adults often respond negatively or punish children who express views or opinions different from their own. This stand is legitimised on the grounds that it is in the best interest of the child. In focus group discussions set up to prepare this SITAN, practitioners reported some of the most commonly held views regarding key children's rights, notably that whilst in the process of development children should have no rights to freedom ("A child should not be treated as an adult for he/she is still in the process of personal development; he/she should be under parents' or teachers' guidance and does not deserve absolute freedom"). Other commonly held views emphasise the rights of parents to discipline their children though corporal punishment ("A father has the right to discipline his child with a good hard smacking. It is even taught in Islam") and finally that notions of children's rights are alien and contradict local morals and values ("We should fight against Western liberal culture. Don't use that culture to fight against Islamic shariah. The role of the parent is to build good morals for children. We have to do so for the sake of our children. If not, our younger generation will suffer from moral degradation").[383]

These views are revealing of certain beliefs about children and families in certain sectors of Indonesian society. These beliefs include:

- That parental rights supersede children's rights and that parents can and should have control over the development of their children;
- That family members will act in the best interests of children who are not capable of caring for themselves;
- That families rooted in traditional cultures are 'strong families', even though some of their cultural customs justify child maltreatment; and
- That families have the right to privacy and autonomy, even though this right often results in harm to vulnerable members.

In families that hold these views, decisions concerning child affairs remain wholly in the hands of parents. An interview with Wavan, a 15-year-old boy from Yogyakarta, illustrated this lack of freedom and participation in decision-making. Wavan's father decided that Wavan would major in Science rather than Social Science, his own favoured option, and Wavan felt compelled to accept his father's choice. Similarly Rahman, a 13-year-old girl from Surakarta hoped to continue her studies at the prestigious secondary school in a town where her close friends enrolled. However, her father decided that as a future mother, she should have a strong religious background and she was therefore sent to a nearby pesantren (an Islamic boarding school) after she graduated from primary school. Although the decision was made without her consent, she accepted her father's choice as she did not want to be labelled a 'naughty girl'. The latter reflects the importance of

382 Walker, C. E., Bonner, B. L., and Kaufman, K. L. (1988) *The physically and sexually abused child: Evaluation and treatment*, Pergamon Press: New York
383 Focus group discussion results from Aceh, East Nusa Tenggara (NTT), Papua and Central Java

labels that characterise children as 'good children' (who comply with their parents' decisions) or 'naughty children' (who oppose or disagree with their parents, and who are subjected to punishment). Children's responses to these pressures vary. Some internalise and accept the harsh treatment, opting to believe that although senseless, the punishments are in their best interest: "I don't mind being hit by my parents or teacher when I am wrong. Maybe they hit me because they want me to be a better child." Other children express deep frustration and discontent: "How can I enjoy freedom, when I cannot even ask for my favourite food without my parents getting mad at me" (Maria, 14-year-old girl from Papua). For others, however, harsh discipline and corporal punishment becomes intolerable and triggers flight or escape mechanisms. Marcus, a 15-year-old boy from Kupang, chose to drop out of school and flee from his home in search of work: "Sometimes I don't understand why he was always mad at me." Although Marcus was able to find work as a driving assistant and so far has no regrets about his decision, fleeing home renders children vulnerable to harm and exploitation.

These short excerpts illustrate that Indonesian children are a long way away from being in a position to exercise their rights to freedom and participation. Although the GoI has made an important commitment towards the fulfilment of the CRC, the recognition of children's rights to freedom and participation by the GoI has been somewhat lukewarm. The provisions of the 2002 ILCP, in keeping with the provision of the Indonesian Constitution, recognize children's rights to participation on the grounds of 'decency and propriety'. According to Save the Children, this constitutes a diminution of the rights as envisaged by the CRC. These 'reduced rights' are, according to Save the Children, very much in evidence during divorce proceedings or during the processes of placing children in alternative, foster care or adoption, where the views of children are neither heard nor considered.[384]

3.5.7 POLICY RESPONSES AND CHALLENGES: NATIONAL CHILD PROTECTION SYSTEM IN INDONESIA

3.5.7.1 Child protection information management system

The review above of specific issues related to child harm and vulnerabilities (birth registration, trafficking, violence and exploitation, etc.) has consistently underlined the paucity of data relating to child protection in Indonesia. According to an in-depth analysis of child protection information management in Indonesia, data are necessary for evidence-based programming and budgeting that delivers sufficient resource allocation towards preventative and protective services.[385] Three kinds of data critical to efficient information systems are identified as lacking: data on the prevalence of cases, data on the prevalence of risk factors and evaluation information. The same report argues that critical factors underpinning this endemic lack of data include the absence of a lead actor for child protection at the national level and the absence of agreement on data collection priorities, procedures and methods, leaving each ministry to gather their own data. Failures in data sharing across government agencies, but also with and between major NGOs working in the field of child protection, further weaken data compilation, management and analysis.[386] Additional dimensions at the sub-national level include poor data collection and transfer, notably from the district to the province level.[387]

384 Save the Children (2010) *Review report Indonesia*, p10 and p30
385 UNICEF (2009) *Child protection information system*, p6
386 Ibid.
387 Ibid., piv

3.5.7.2 System building approach to child protection as a strategy to build a protective environment

Since signing the CRC in 1990, Indonesia has acknowledged that all children are subject to their developing capacities, and therefore are in need of special safeguards and care, and are entitled to certain fundamental rights. By ratifying the CRC, the GoI has made a legally-binding commitment to respect, promote and fulfil children's social, economic, cultural, civil and political rights. This requires the creation of an environment where all girls and boys are free from violence, exploitation, abuse, neglect, inappropriate judicial responses, and unnecessary separation from their families.

As discussed in earlier subsections of Section 3, in general the situation for Indonesian children has considerably improved, particularly with regard to access to health care and education. However, tangible gains for child protection are not keeping pace with progress in other areas. Children continue to face grave protection violations, such as sexual exploitation and abuse, neglect, detention as a first response, the worst forms of child labour, trafficking, corporal punishment, unnecessary institutionalisation and violence in their homes, schools and communities. Such violations have persisted over time, despite ongoing efforts.

Global analysis, clear evidence, and systematic practices in other countries demonstrate that it is indeed possible to establish effective strategies to address child protection violations. Many child protection systems in other countries have proven to be more cost-effective and of greater benefit to the diverse range of child protection concerns, in contrast to other development approaches that have focused on individual problems or specific child protection issues. Thus, the global evolving strategic approach to child protection concentrates on developing comprehensive national child protection systems.

An effective national child protection system strengthens the protective environment to safeguard children against all forms of abuse, exploitation, neglect and violence, and should consist of three interlocking components: the social welfare system for children and families, the justice system, and an integrated social behaviour change component. Such systems and components should be structured in a way that both prevents and responds to all child protection concerns in an integrated manner. Thus, the national child protection system should prevent violations from happening and protect children in all situations regardless of the nature of the violation or the context in which it occurs, including in emergencies, conflicts, and in periods of transition. The work of the national child protection system should promote attitudes, beliefs, values and behaviours that ensure children's well-being and protection, and affirm children's human rights, as set forth in the CRC, its Optional Protocols, and other international instruments.

Social welfare and justice systems, structures and services are the 'who' and the 'what' of the national child protection system. These structures refer to the organisation of institutions, including the different ministries, departments and agencies, as well as their mandates, lines of accountability, responsibilities, capacities (human, financial and physical), and services provided, including for children, and the supporting monitoring and coordinating bodies. Social welfare and justice structures support different strategies, which include prevention of and response to and mitigation of child protection violations.

Social welfare systems for children and families should be mandated in law to ensure that children's rights to protection are fulfilled by those who have a role in their care, welfare, protection and guidance, ensuring justice for children. Actors in the social welfare systems are accorded the authority and responsibility to undertake actions to prevent, respond to and mitigate the impact of any significant harm occurring to children, whether by their parents or relatives, other children, individuals, groups of individuals, or by officers of the State itself, such as teachers, police officers, and government institutional care providers. Social welfare systems within a national child protection system should prevent and respond to such violations, in all situations regardless of the nature of the violation, or the context in which it occurs, including in emergencies, conflicts, and periods of transition. Social welfare systems should provide a continuum of services from prevention to response through comprehensive primary, secondary and tertiary services.

A well-functioning national child protection system also needs an integrated child protection information management system. A commitment to collecting and analysing accurate information, along with ongoing development work on child protective systems, implementation capacity and building solid policy and practices at all levels, will ensure country systems are better able to respond to protection concerns on a daily basis, as well as those that emerge in emergencies. Successful implementation of child protection programme interventions as well as child protection services in Indonesia is in part contingent upon the availability and timely use of good quality information. Availability of good quality strategic information is fundamental for guiding policies and for designing, monitoring and evaluating programmes.[388]

3.5.7.3 The Indonesian child protection system

UNICEF works in close collaboration with the GoI in the process of building a comprehensive Child Protection System at both national and sub-national levels. The UNICEF approach to child protection focuses on building a safe environment where "girls and boys are free from violence, exploitation, and unnecessary separation from family; and where laws, services, behaviours and practices minimise children's vulnerability, address known risk factors, and strengthen children's own resilience." This approach is human rights-based, and emphasises prevention as well as the accountability of governments.[389] In addition, since 2008 the UNICEF strategy towards child protection has focused increasingly on the establishment of systems of child protection. This is an acknowledgement of the fact that child protection spreads across national and sub-national government institutions and actors, as well as across non-government ones (NGOs and community groups) and that it requires "coordination, integrated referral mechanisms and a strong normative legal framework…"[390] This strategy is singularly appropriate in the context of a country as large and complex as Indonesia.

Child protection represents a significant challenge because it requires coordinated intervention by multiple actors across a large number of fields and sectors, both at national and sub-national levels.[391] Decentralisation has tended to multiply challenges from the perspective of coordination, but also because capacity for child protection work at the district and sub-district levels is currently low.[392] Yet provided that capacity building takes place at the sub-national level, decentralisation also offers opportunities for rapid, appropriate and well-targeted responses, which need to be maximised.

388 UNICEF (2009) *Child protection information system*, p1
389 UNICEF (2008) *Child protection strategy*, available at: http://www.unicef.org/protection/files/CP_Strategy_English.pdf (Last accessed 11 September 2010)
390 UNICEF (2009) *Child protection information system*, piv
391 Ibid., p6
392 Ibid., p3

As noted above, the GoI has acknowledged the importance of child rights and child protection. The GoI commitment and efforts towards achieving the MDGs, notably in the field of health, education and poverty reduction, as already reviewed in the preceding subsections of this SITAN, are essential contributions to child rights and child protection. It is notable too that some important steps have taken place towards making development planning child-friendly (notably in the RPJMN 2010-2014). Aside from ratifying the ILCP and adopting the necessary legislation for its enactment (i.e., Law No. 23/2002 on Child Protection), other activities of the GoI include drafting and implementing National Action Plans (NAPs) that address specific issues as and when they emerge, including NAPs against the worst forms of child labour (2002-2007), trafficking (2002-2007), and against the commercial sexual exploitation of children (2002-2007). More recently, the GoI has also adopted the NAP on the Eradication of Criminal Act of Trafficking in Persons and the Sexual Exploitation of Children (2009-2014), as well as set up a the National Task Force on the Prevention and Response to the Criminal Act of Trafficking in Persons (by Government Regulation No. 69/2008). At a sub-national level, regulations on trafficking have already been adopted in most of the provinces and in some districts, and it is intended for NAPs and task forces to be set up at provincial and district levels. However, previously mentioned, the NAPs are not always well funded or well implemented (e.g., the NAP Against the Commercial Sexual Exploitation of Children).

In effect, the commitment of the GoI on child protection has been consolidated over the past decade and this is an essential starting point to ensuring child rights and welfare. However, much remains to be done not least in ensuring that the GoI is equipped with the necessary normative and institutional framework to address the multifaceted challenges of child protection. So far the impact of interventions in the field of child protection have not always been easy to evaluate, and whilst laudable they constitute ad-hoc responses which can supplement but cannot replace the establishment of preventative approaches that identify vulnerabilities.[393]

3.5.7.4 Child protection legal and policy framework

From the perspective of the legal normative framework, considerable progress has taken place since the 2000 SITAN (see Section 1 for a general introduction and review of the adoption of key legal instruments). The 2002 ILCP was an important step forward, but questions are increasingly being raised about whether it provides a sufficiently solid basis for child protection. To a degree this point has been acknowledged by the GoI, with recognition that legal instruments are weakened by a general failure to accompany the ILCP with related Government Regulations.[394] More broadly, a recent review of the implementation of the CRC in Indonesia by Save the Children has highlighted a series of important issues.[395] First, it pointed out that the CRC was ratified with three reservations, one of which was subsequently withdrawn but the remaining two reservations considerably weaken some general principles of the CRC, notably those relating to freedom and participation (as described previously).[396] Second, the ILCP has not been accompanied by a review of existing legal provisions, some of which remain decidedly child-unfriendly. There are currently contradictory provisions, notably those relating to the definition of children and minimum age requirements that create de facto loopholes, which weaken child protection. This lack of harmonization not only takes place within the body of national laws but also between national law and legislation at the district/municipal level.[397] Third, technically there

393 Ibid., pp6-7
394 Sardjunani, N. (2009) *Human resources development in Indonesia national medium term development*, Jakarta, p28
395 Save the Children (2010) *Review report Indonesia*
396 Ibid., pp8-10
397 Ibid., p10

are mechanisms that allow for the judicial reviews of national and regional legislations to ensure that they are in line with the CRC (through the supreme and constitutional courts). In practice however, these are cumbersome procedures with little guarantee of success (for instance the constitutional court rejected the review of the Law on Manpower). Some of the mechanisms, notably the Supreme Court's power to bring legislation and regional laws in line with upper laws such as the CRC principles, are not well known. On the whole, whilst there are avenues to pursue judicial reviews to bring national and regional laws in line with the CRC, they are in effect of limited use, rarely pursued and rarely used. Lastly, as signalled above, the ratification of the Optional Protocol to the CRC on the sale of children, child prostitution and child pornography remains a priority to strengthen child legal protection in Indonesia.

Indonesia has developed a fairly progressive legal framework for the promotion of children's rights. However, the legal framework for prevention and response to violence, abuse, neglect, exploitation and abandonment of children remains less developed. An effective legal framework for child protection is one that: designates a government agency with a clear mandate, authority, and accountability for the management and delivery of child protection services; stipulates a continuum of prevention, early intervention and response services to prevent and respond to all forms of child maltreatment; stipulates the standards, criteria, authority and procedures for making decisions about which interventions are appropriate in individual cases, including the standard for when compulsory protective services may be used; requires that all decisions regarding compulsory protective services, the separation of a child from his/her family, and out-of-home care are made by a designated government authority, subject to judicial review; and includes a binding regulatory framework for compulsory registration, accreditation, monitoring, and inspection of all government and non-government service providers.

While the ILCP guarantees children's right to be protected from all forms of violence, abuse, neglect and exploitation, it currently lacks several essential provisions of a comprehensive legislative framework for the delivery of prevention and response services. Significant progress has been made in developing detailed guidance and regulations with respect to integrated medico-legal services for victims of violence and exploitation, which provide a solid legal framework for inter-agency collaboration. However, the provision of broader child and family welfare services is governed primarily by non-binding guidance documents issued by the Ministry of Social Affairs (Kemensos, previously known as DEPSOS), which are not widely known, even amongst service providers.[398]

Overall, the laws, guidelines, and regulations present an approach to child protection that is primarily community-driven and charitable, responsive and forensic (medico-legal), primarily victim-centred (rather than family focused), and largely centred upon institution-based services. There is no clear designation of authority to make decisions regarding protective services, and guidelines and criteria for making decisions about what interventions are necessary to protect a child are limited. Instead, authority for reporting, risk assessment, intervention planning, decision-making and case management has been delegated broadly to any individual, community organisation, NGO or childcare institution engaged in providing child welfare services. Interventions and services have not been conceptualised as a continuum of options, with priority given to family preservation, and there are broad grounds for removing a child from parental care.[399] While there are relatively clear procedures for the selection and appointment of legal

398 Ibid.
399 Throughout this report, the term 'family preservation' means the process by which parents/caregivers and children are supported to live together in a safe and appropriate family unit. At a minimum, the term means that a child is enabled to live with a family member, perhaps extended family, and is not sent to stay in an institution.

guardians and adoptive parents, there are no similar standards or approval procedures for foster care or placement of a child in a childcare institution.

A recent report on child and family welfare services in Indonesia commissioned by the Ministry of Social Affairs recommended a series of interventions in order to address these issues.[400]

1. Comprehensive guidelines for the prevention and response to violence, abuse, neglect and exploitation of children should be issued, preferably through a strengthening of the 2002 ILCP or (if not feasible) through the issuance of comprehensive and binding government regulation. Whilst a new Law on Social Welfare should lead to improvements on the general delivery of social services, those provisions are currently too broad to address the specific needs of children and families.
2. Measurable standards for the quality of care in relation to child and family services should be set up through binding ministerial regulations. A licensing system linked to the national standards of care will require service providers to fulfil at least minimum standards.
3. Protocols for inter-agency coordination should be developed, and roles, responsibilities, information sharing, processes and procedures for referral should be defined. The child welfare authority should have a central decision-making role especially with regards to protective interventions (in contrast to punitive procedures against perpetrators).
4. Finally, the protocols for inter-agency coordination should emphasize integrated service centres, but should not be dependent on a physical location.

In the justice sector, Law No. 3/1997 on the Juvenile Court is not fully in line with international standards, which has pushed the GoI to draft a completely new juvenile justice bill in line with the CRC and other international standards. The current Juvenile Court Law sets the minimum age of criminal responsibility unacceptably low (at the age of eight years), as the Committee on the Rights of the Child has stated. It furthers criminalizes status offences such as child misbehaviour, fails to set sufficient guarantees to make detention a measure of last resort in practice, and does not incorporate mandatory diversion schemes at the different stages of the justice process.[401]

3.5.7.5 Coordination in child protection

Coordination and harmonization are important aspect of child protection system and these demands are particularly challenging in the context of a country as large, diverse and bureaucratically and institutionally as complex as Indonesia. There are several entities that are dedicated to aspects of child protection. These specific entities include the Indonesian Commission of Child Protection set up in 2004, which is responsible for the socialisation of child rights in the law as well as for reporting on Indonesia's progress with the implementation of the CRC.[402] Another key institution is the Ministry for Women's Empowerment and Child Protection (KPPA) where the Directorate on Child Protection is located.[403] The Directorate is headed by a Deputy, at Echelon 1 level. The central remit of the KPPA is to coordinate, monitor and evaluate the implementation and protection of child rights. The KPPA is involved in policy development, data collection and monitoring, but not in the delivery of services.

400 Child Frontiers (2009) *Child and family welfare services in Indonesia*
401 Ibid.
402 Ibid,. pp24-25
403 Ibid., pp23-23; Note: The Ministry changed in 2009 from the Ministry of Women's Empowerment to the Ministry of Women's Empowerment and Child Protection. Some offices at the provincial and district levels have also changed the nomenclature.

KPP structures are located in the centre of the state apparatus. Similar structures are established at the provincial and district levels.[404] While in the past the structures were formed mostly for the Bureau of Women's Empowerment, the offices in most provinces have been transformed into a Badan (agency) often combining women's empowerment and child protection with other tasks.[405] However, as the case studies in Section 4 will demonstrate, these are still in incipient form.

Several key ministries and departments have critical responsibilities in child protection, such as the Ministries of Social Affairs, Health, National Education, and Justice and Human Rights. However, given the number of actors, this general structure is proving insufficient to tackle the challenges of child protection because it is weak in providing a lead actor, coherence and coordination, which weakens the prospects of effective coordination and harmonization throughout the field of child protection, and not solely with regards to data. These institutions and entities have been depicted as being insufficiently developed and funded to be in a position to fulfil their remit.[406]

3.5.7.6 Service delivery

Social welfare systems should provide a continuum of services from prevention to emergency response through comprehensive primary, secondary and tertiary services. Studies have shown that Indonesia has made good progress to develop tertiary services for children who have experienced various violations of child protection, while secondary services are inadequate. In general terms, effective child protection in Indonesia requires the continued development of the resilience of the family, through social work functions with vulnerable families and the strategic use of social cash transfers to decrease a family's vulnerability to various shocks.[407]

Indonesia has not yet developed comprehensive, focused national or provincial level strategies for the prevention of violence, abuse and exploitation of children through, for example, systematic programmes on parenting skills or targeted behaviour change. There are some creative media-led awareness campaigns, generally focused on prevalent issues such as trafficking and child labour. However, the more common approach to 'socialisation' and 'advocacy' has been the distribution of informational materials and presentations to communities on new legal provisions and policies. During the interviews for the study by Child Frontiers (2009), the scope and impact of these campaigns were questioned by some respondents. They felt that traditional, more spontaneous methods of imparting information (such as through village meetings and religious discussion) were more effective than organised campaigns. Whatever the method, it was suggested that campaigns need to be more sustained and reach the wider population, rather than a few targeted marginalised communities.[408]

Secondary prevention, or early intervention services, are those directed at children and families who have been identified as vulnerable or at risk of maltreatment or neglect. Early intervention services target families that are already at risk of engaging in abusive behaviours, in order to change those circumstances before they result in actual harm to a child.

404 The Bureaus are divisions in the provincial or district governments, which report to the head of the secretariat of the provincial or district government. These coordinate policy but do not implement programmes.
405 A *Badan* is a technical agency that supports the head of the region, notably with the development and implementation of specific provincial or district policies.
406 Save the Children (2010) *Review report Indonesia*
407 Child Frontiers (2009) *Child and family welfare services in Indonesia*
408 Ibid.

Secondary level services designed to identify families and children at risk remain limited in all three provinces studied in the Child Frontiers study (2009)[409]. It is hoped that the establishment of community social workers will help to address this important gap. At present, community social workers, supported by Dinas Sosial (the district-level institutions responsible for the delivery of services under the Ministry of Social Affairs), have concentrated on ensuring children's basic rights and have relied upon cash transfers and economic empowerment to remedy family conflict and breakdown. While financial assistance to poor families is an essential component of a welfare system, this cannot be prioritised at the expense of family strengthening services. In all three provinces, there are customary mechanisms in place to support parents and protect children. These need to be maintained in changing community environments, and good practices formalised.

Tertiary interventions are those use to respond to circumstances where a child is at serious risk of, or is already being abused, exploited, neglected, or harmed in any way. This requires a continuum of interventions, including both voluntary/community-initiated interventions in less serious cases (mediation, counselling and advice giving, and community monitoring), as well as compulsory state interventions which must be used where children have experienced or are at risk of serious harm. This includes structured supervision and family support services, such as parenting programmes, family and individual counselling, therapeutic treatment programmes, and/or temporary or permanent removal of the child and placement in alternative care. Decisions regarding the use of compulsory measures are generally made through a formal administrative or court process, based on the assessment and recommendations of the social welfare authority.

In Indonesia, tertiary responses have focused primarily on the development of integrated medico-legal services for responding to reported cases of violence, abuse and exploitation, and in the development of specialised residential rehabilitation homes (RPSA, Rumah Perlindungan Sosial Anak). Through the establishment of specialised police units and hospital-based integrated service centres (PPT, Pusat Pelayanan Terpadu), child victims of the most serious forms of violence, sexual abuse, and trafficking now have access to medical care, psycho-social support, legal advice, and child-sensitive investigative procedures. However, as a hospital-based, crisis intervention model, PPTs generally address only the most serious cases of violence and exploitation; predominantly sexual abuse and physical violence causing injuries warranting medical attention.

While these new services provide temporary sanctuary and care, they should be considered as elements in a wider continuum of tertiary services, rather than a comprehensive solution. The PPTs, for example, are able to provide essential medical and forensic services for abused and exploited children. They do not, however, have the mandate or capacity to case manage or assess the family environment before a child is returned home, or to ensure that children receive appropriate care and protection after they leave the centre. These limited prevention strategies are symptomatic of a broader reactive approach to family and child welfare. Without early identification mechanisms, services provided by government agencies and NGOs tend to respond when a family or child is already in crisis. This partially explains the over-reliance on the emergency response services of the PPA (pelayanan petirahan anak), PPT and RPSA. The UNICEF and Child Frontiers report (2009) drafted four recommendations that are critical to making the current welfare system more responsive to the needs of women and children:

409 Ibid.

1. Promotion of behavioural change through the elaboration of comprehensive strategies to promote changes in public attitudes towards child protection issues (reinforcing the importance of family-based care and introducing standardised approach to parenting skills education through organisations such as the PKK and women's empowerment clubs).
2. The development of a continuum of services between prevention and response services both through voluntary community measures (e.g., family mediation) and more formal protective interventions, up to compulsory measures such as supervision orders or the removal of the child from the home for the more serious cases.
3. The clarification of decision-making processes and authority, which includes both the setting up of standardised procedures and criteria (reporting, assessment, intervention planning and case management) and the development of designated institutions and processes in cases of interventions relating to childcare and prevention. The report highlights the importance of accountable government agencies, and that all decisions regarding the removal of a child from the care of parents should be made/approved by designated government officials (subject to judicial review).
4. The gradual development of specialised community-based services to support children who are vulnerable, neglected or victims of violence or exploitation. The report emphasises the need to set up effective referral networks through government, community and NGO providers, as well as the need for the Ministry of Social Affairs and the Dinas Sosial (the district-level institutions responsible for the delivery of services under the ministry) to develop more specialised child protection services (parenting skills programmes, parenting support groups, counselling services, temporary respite care, therapeutic interventions for drug and alcohol abusers, structured family supervision, and kinship and foster care arrangements).

3.5.7.7 Ongoing challenges to child protection advancements: A summary

Since the last Indonesian SITAN in 2000, Indonesia has made considerable advances with child protection. The signing of the CRC and its subsequent ratification through the adoption of the 2002 ILCP are foundational events for child protection in Indonesia. However, throughout the 2000s it has become slowly apparent that the ILCP in its current guise is not as solid or as far-reaching as once envisaged. The overview on child protection in Indonesia shows uneven progress in the consideration of various aspects of child protection. For instance, the issue of children with special needs is still badly neglected and information, data and research are scarce. However the situation of children with special needs, especially those living in poor rural households, needs attention. Few rehabilitation or appropriate access facilities exist. This contravenes the 2002 ILCP, which stipulates that children with special needs have a right to access basic services. Thus child labour trafficking or birth registration have received considerable attention but this has not been replicated with other vulnerable children such as children living on the streets, children forced into prostitution, children in conflict with the law, or children with special needs. In these cases, not only are key vulnerable group being left behind but legal protection is insufficient and the judicial system and security forces are frequently part of the problem rather than participating in the construction of child protection.

Furthermore, even in areas that receive considerable attention, impact is uneven. For instance, the issue of trafficking has mobilised attention and led to the enactment of a National Action Plan, but this was then poorly funded and implemented. By contrast, child labour also received considerable attention and implementation of a National Action Plan, but in that case, implementation and impact were far more satisfactory. Uneven child protection reflects in part prioritisation by the GoI and in part capacity issues. In some cases there are clear contradictions between national and local level institution's approaches to child protection (as with birth

registration - an area of substantial and energetic intervention by the GoI at the national level but neither harmonized nor well implemented at provincial or district level). Elsewhere, child protection can be weakened too by some societal beliefs and practices, for instance with the issue of child marriage, where change sought by the GOI has failed to take place. However, the picture is not altogether bleak and it is important to note too that notions of child rights and child protection are becoming increasingly disseminated and accepted both across society and state institutions. For instance, a damning report by UNICEF, Save the Children and the Ministry of Social Affairs (2007[410]) on alternative care has led to positive reactions by the GoI in addressing the issue, rather than ignoring or rejecting the findings.

At present, child protection in Indonesia, whilst progressing, is still incipient and further improvement requires addressing a complex blend of systemic, institutional and attitudinal changes. It has been shown throughout this subsection that legal protection needs to be strengthened. In cases, this means ensuring that legal provisions be adopted to address specific concerns, and in other cases harmonization across the national body of law need to take place as well as harmonization between national and provincial/district levels, to ensure that all are in line with child protection. This overview has also underlined the central importance of improving data and information management if appropriate policies are to be conceived, appropriately funded and then implemented. For child protection to take root and become increasingly effective in Indonesia, there is a need to move from ad-hoc and uneven responsiveness towards the adoption of comprehensive, coordinated and holistic approaches that are both responsive and preventive. As detailed here, the setting up of a child protection system across the national territory is a significant undertaking for the GoI, but it is a precondition to Indonesia meeting its international commitments, and its commitments to ensuring the welfare and well-being of Indonesian children.

410 UNICEF, Save the Children and Ministry of Social Affairs (2007) *Someone that matters*

SECTION 4:

SUB-NATIONAL CHALLENGES AND INNOVATIONS: CHILD WELFARE UNDER DECENTRALISATION

INTRODUCTION

Section 2 provided an overview of some of the major institutional changes which have taken place over the last decade. One major institutional change discussed in Section 2 was the introduction of decentralisation, which has involved the transfer of decision- and policymaking powers (and budgetary control) for many key sectors of governance mainly to the district/municipal level in response to the demands for closer governance and greater self-rule for the diverse regions throughout the country. To reiterate, decentralisation was introduced through Laws No. 22 and 25/1999, and was implemented in 2001, and later revised through Laws No. 32 and 33/2004. During the same period, these new laws and other laws allowed for the popular election of the president, governors, district heads and mayors (and village heads). Section 2 argued that decentralisation provided the opportunity:

- To better address child welfare at the provincial and district levels, in that local government can now respond to the very specific characteristics of each locality in terms of child welfare;
- To design innovations relating to child rights and welfare at the sub-national level through greater discretion to invest resources in creating child-friendly environments at district and provincial levels; and
- To improve public participation in sub-national policymaking through the musrenbang system (musyawarah perencanaan pembangunan, or consultative development planning forums), where practitioners, local leaders, community members, youth and even children can be involved in priority-setting and development planning, which have the potential to shape local development and, ideally, to institute pro-child policies.

However, Section 2 also argued that decentralisation presents a number of challenges including:

- Building the uneven capacity of the district and provincial level executive and legislative arms of government and the civil service across the country, to enable better design and administration of local level policies and regulations;
- Improving the quality and performance of the growing number of civil servants at the sub-national level;
- The complexities of designing and passing necessary government regulations, directives and guidelines at the provincial and district levels, which provide the supporting regulatory framework for policies, programmes and action at the sub-national level;
- The pressure on budgets, resources and revenues with the creation of a plethora of new provinces, districts, cities, sub-districts and villages, and in these new places the challenge of creating the new institutional structure for government; and
- Ensuring an even spread of quality of service delivery and administration.

Section 4 aims to examine the sub-national context under decentralisation for different aspects of child welfare through four provincial case studies. The section begins with further discussion of the decentralisation and planning processes. Following this, health and nutrition are examined in East Nusa Tenggara (NTT). Special Autonomy and HIV and AIDS are the focus of the case study on Papua. In Aceh, both Special Autonomy and education are examined, and finally, in the case study on Central Java, there is discussion of child protection and policy responses to the problem of children living on the streets. These case studies should serve as examples of the practical implementation of decentralisation (and Special Autonomy) in different contexts, illustrating examples of the policy innovations and constraints under decentralisation in relation to the resources available, institutional capacity to deliver services, and the particular vulnerabilities prevalent in different provinces.

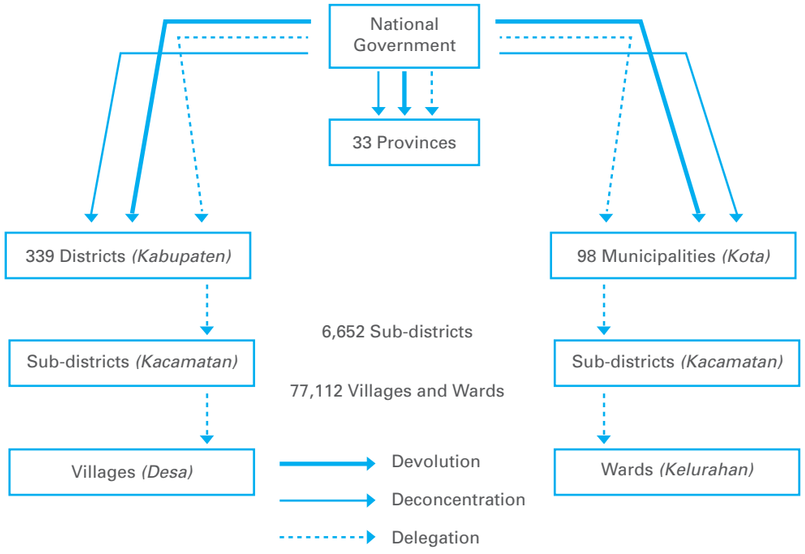
These case studies are not exhaustive sectoral reviews. Instead, they aim to elucidate the views of government policymakers and practitioners on the innovations they use to improve child welfare and the challenges they face under decentralisation in relation to the particular theme of each case study. Each case study begins with a very brief overview of provincial and district indicators, similar to the main indicators discussed at the national level (also provided in further detail in annexes 4.2-4.5), before a larger discussion of the theme of the provincial case study. In terms of the study of policy innovations and constraints at the end of each subsection, these discussions builds on the former subsections, rather than replicating the discussion of the entire process in cases where the findings are similar. For example, the case study of NTT examines the complications in the processes of decentralisation for malnutrition and health policy, planning and implementation, with a detailed examination of the planning and institution building process. While the fieldwork in Papua also examined the same aspects and the case study on Papua does illustrates similarities and differences, this subsection instead focuses on the added complications in planning and institutional building processes under the Special Autonomy Laws in that province. By the end of the four case studies, readers should have a clear understanding of the policy innovations and challenges under decentralisation, as well as the factors that contribute to the vulnerability examined in each province, in the areas of health and nutrition, HIV and AIDS, education and child protection. Throughout the case studies, life histories of children are included, and the relevant issues are further elucidated at the end of the section, in the subsection that explores child agency in difficult contexts (Section 4.6, The voices of children). Section 4 also demonstrates not only that disparities exist at the sub-national level, but also that each province has a unique set of constraints and challenges in terms of child welfare.

4.1
FURTHER ELABORATION ON DECENTRALISATION

The 1999 decentralisation laws have drastically devolved central government functions to local governments, mainly to the district/municipal level but also, in some aspects, to the province level. District/municipal governments are now responsible for budgeting and policymaking in relation to the provision of infrastructure, education and culture, health, agriculture, communications, industry and trade, capital investment, environment, land and tenure, cooperation and labour. Meanwhile, the scope of central government authority is similar to that of a federal system, in that it is responsible for foreign affairs, defence and security, the judiciary, monetary policy, religious affairs and other affairs which are national in scope such as macro-economic policy, the national standardisation of the provision of government administration, state-owned corporations and government human resource development.

Law No. 22/1999 abolished the former hierarchical relationship between the central government, provinces and districts/municipalities. Provincial and district/municipal governments are now autonomous, with, in most cases, the districts/municipalities having greater authority. The provinces of Aceh and Papua also have Special Autonomy, which provides them with a greater share of their oil and gas revenues than other provinces, and wider powers (discussed in the subsections below). Figure 4.1.1 below shows the dispersion of power under decentralisation. Box 4.1.1 outlines the division of responsibilities between the central and local governments in Indonesia.

Figure 4.1.1: Transfer of power and authority under decentralisation[1]



In the early years of decentralisation, the introduction of decentralisation was not always followed by a clear division and description of authority and responsibility for each level of government. In some instances this created problems in the implementation of decentralisation. For example, in 2001 in South Kalimantan and North Sulawesi, local regulations on the same subject were issued by both provincial and district assemblies.[2] This created implementation challenges in terms of the division and clarity of responsibilities.[3]

Furthermore, with the introduction of decentralisation, local government also faced tremendous challenges in terms of the capacity of personnel and local assets management.[4] Various studies argue that the creation of new regions has often been accompanied by problems of insufficient local government capacity and resources to carry out economic and social development.[5] Moreover, public services in new regions are generally poorer compared to other places where institutions were already established.[6] This, some argue, has resulted in adverse effects on the economies and welfare of the new regions.[7] Furthermore, the putra daerah (meaning literally 'sons of the region') phenomenon also took hold in the first years of decentralisation, where there were demands from local officials that important regional civil service and political positions should be reserved for 'local people', independent of skills.[8]

1 Source for information on distribution of powers: Dirjen Pemerintahan Umum, Kementerian Dalam Negeri (May 2010) Law No. 32/2004. Source for numbers of administrative units: Badan Pusat Statistik (BPS) – Statistics Indonesia (August 2010) *Trends of the selected socio-economic indicators of Indonesia, August 2010*, BPS: Jakarta, available at: http://www.bps.go.id/65tahun/Boklet_Agustus_2010.pdf (Last accessed 15 October 2010)
2 SMERU Research Institute (2001). *Indonesia's Decentralization Policy (2001): Initial Experiences and Emerging Problems*, SMERU Research Institute: Jakarta, p9.
3 Ibid.
4 Ibid.
5 BAPPENAS and UNDP (2008) *Studi evaluasi dampak pemekaran daerah 2001-2007*, Building and Reinventing Decentralised Governance: Jakarta, available at: http://www.undp.or.id/pubs/docs/pemekaran_ID.pdf (Last accessed 13 June 2010)
6 Ibid.
7 Ibid.
8 SMERU Research Institute (2001) *Indonesia's decentralization policy*, p15

The 1999 decentralisation laws were revised through Laws No. 32 and 33/2004. These new laws sought to solve problems related to conflicts between the executive and legislative (DPRD) arms of government, political instability and unclear distribution of functions among different tiers of government.[9] Further clarification of the functions of the different levels of government was laid out in Government Regulation No. 38/2007 (see Box 4.1.1). However, challenges remain in consolidating decentralisation and good local governance[10]. Moreover, despite national efforts to curb the creation of new regions, demands continue. In early 2007, for instance, the proposals to form 114 new districts/cities and 21 new provinces were filed with the national parliament (DPR-RI).[11] The Advisory Service Support for Decentralisation (ASSD) stated, "Law No. 32/2004 has failed to create a strong base for developing new healthy, prosperous, and effective local governments as indicated by the fact that most of the 170 new regions established since 1999 have had negative impacts on administrative terms and on service delivery."[12] As of October 2010, the law is now under review, responding to a widespread consensus among government officials, members of parliament, community leaders and civil society groups.[13]

While most of the power and authority sits with the district/municipal level of government, according to Government Regulation No. 19/2010, the main role of the governor as the head of the provincial government is one of coordination between districts/municipalities within the province, and coordination between provinces (Article 3). Article 3 also specifies that the governor must support and monitor district/municipal governments and safeguard the political stability (Article 3). More specifically, the governor is responsible for providing support, advice, facilitation and consultation for district and municipal governments as well as undertaking efforts to improve the even spread of the quality of public services between districts and municipalities in the province (Article 9). Amongst others, the role of the governor also involves: coordinating meetings between district heads/mayors; requesting district heads/mayors to handle emergency situations and important issues that require speedy resolution; evaluating draft local regulations on budgets, taxes, levies at the district and municipal levels; resolving disputes between districts/municipalities in terms of administration; providing both appreciation and sanctions for district heads/mayors on performance, implementation of responsibilities and violations of oaths/promises; appointing district/municipal secretaries; and ratifying the election of district and municipal legislatures (Article 4). The governor is responsible specifically for resolving disputes between districts/municipalities in relation to boundaries, resources, assets, transport, waste/rubbish and land/layout (Article 10). Furthermore, the governor manages the provincial level development coordination and priority setting through the provincial musrenbang.

9 Advisory Service Support for Decentralization (ASSD), *Briefing paper on the current revision of Law 32/2004: New developments in Indonesia's decentralization policy*, GTZ-Mendagri: Jakarta
10 Ibid.
11 BAPPENAS and UNDP (2008) *Studi evaluasi dampak pemekaran daerah 2001-2007*
12 Ibid., p1
13 Ibid.

Box 4.1.1: Division of responsibilities between the central government and local governments in decentralised Indonesia

The division of responsibilities between the different levels of government in decentralised Indonesia is explained in Government Regulation No. 38/2007 on the Division of Functions between the Central Government, Provincial Government, and District/Municipal Government. Government functions include the rights and responsibilities of every level of government to protect, serve, empower and increase the welfare of the populace (Article 1). Government functions handed over to the sub-national level must also consider provisions for funding, infrastructure and staffing needs (Article 3). The division of responsibilities must take into account factors of externality, accountability and efficiency, while also ensuring complementary relations between different levels and units of governance (Article 4, clause 1). Further stipulations on the working technicalities for each sub-sector are to be governed by Ministerial/Institutional Decrees after sufficient coordination with the Ministry of Home Affairs (Mendagri) (Article 4, clause 2).

Government functions relating to foreign policy, defence, security, justice, national fiscal and monetary policy and religion are the functional responsibility of the central government (Article 2, clause 2).

Government functions consist of obligatory functions and discretionary functions (Article 6, clause 2). Provincial and district/municipal governments must implement obligatory functions (Article 7, clause 1), in the following sectors (Article 7, clause 2): education; health; the environment; public works; spatial planning; development planning; housing; youth and sports; investment; cooperatives and 'small and medium enterprises'; population and civil registration; labour; food security; women's empowerment and child protection; family planning; transportation; communications and information; land; national unity and home affairs; regional autonomy, regional budgets, regional government apparatus, staffing and cryptology; village and community empowerment; social affairs; cultural affairs; statistics; archives; and libraries.

The administration of obligatory functions must adhere to minimum service standards set by the government (Article 8, clause 1). If a regional government is unable to perform an obligatory function, the central government will take over the implementation using funding from the regional budget (Article 8, clause 2). Further directives on this matter are provided through a Presidential Regulation (Article 8, clause 4).

Discretionary functions are those functions that exist in practice and can improve the public welfare and correspond to the condition, uniqueness and potential of the region concerned (Article 7, clause 3). These functions are to be set in regional government regulations (Article 7, clause 5) and may include (Article 7, clause 4): maritime affairs and fisheries; agriculture; forestry; energy and minerals; tourism; industry and trade; and transmigration.

Ministerial/institutional heads set the norms, standards, procedures and criteria for the implementation of obligatory and discretionary functions (Article 9, clause 1). This process must include stakeholder participation and coordination with the Minister of Home Affairs (Article 9, clause 3).

In carrying out affairs of foreign policy, defence, security, justice, national monetary and fiscal policy and religion, the central government can choose to become the sole implementer, or to devolve a portion of the functions to governors as a means of deconcentration, or to delegate a portion of the functions to regional/local government, in line with the principle of assistance with tasks delegated among various levels of government (Article 16, clause 2).

Provincial governments can fully and solely implement their functions or choose to assign a portion of these functions to the district/municipal or village governments, also in line with the above-mentioned principle of assisting with tasks (Article 16, clause 3). Likewise, the district/municipal government can assign selected functions to the village government under the same principle (Article 16, clause 4).

The central government provides guidance and capacity building assistance to facilitate regional government implementation of its functions (Article 18, clause 1). If the regional government is still deemed unable to implement its functions after these efforts, then the central government will temporarily perform those functions (Article 18, clause 2). The functions will be transferred back to the regional government when it has established adequate capacity (Article 18, clause 3). Further directives on this matter are provided through a Presidential Regulation (Article 18, clause 4).

One of the administrative objectives of decentralisation is also to reduce social and economic disparities[14], identified in Section 3 as pervasive across most indicators in health, education, water and sanitation, HIV and AIDS, adolescent health, and (where evidence was available) child protection. Meanwhile the political objective is to enhance local democratic governance through direct accountability of heads of local governments to their local constituents.[15]

4.1.1 THE DEVELOPMENT PLANNING PROCESSES

The development planning and policymaking processes in Indonesia are both top-down and bottom-up. Top-down planning and priority setting begin with the formulation of the RPJMN (National Medium-Term Development Plan) every five years, which underpins the Renstra (Strategic Plans) of each line ministry. These strategic plans are then translated into annual work plans. This process is also followed at the provincial and district/municipal level, and at each level it involves both line ministries/offices and the national/sub-national Development Planning Agencies (BAPPENAS/BAPPEDA). BAPPENAS (national) and BAPPEDA (sub-national) play an important role in coordinating the planning and budgeting processes through facilitating relevant agencies in a forum to ensure coherence between the long-term, mid-term, and short-term development plans.

Supporting the top-down planning process is the musrenbang, which involves government supported public consultation, as outlined in Government Regulation No. 40/2006 on national development planning procedures. The regulation stipulates that the formulation of government annual work-plans should incorporate community participation through musrenbang forums

14 UNDP (2009) 'The missing link: The province and its role in Indonesia's decentralization', *Policy issue paper* No. 1(1), UNDP: Jakarta
15 Ibid.

held at the village, sub-district, district/municipal and provincial levels. At each level, priorities and goals are set through these musrenbang and are then considered by district/municipal and provincial governments. At district level, the final 'list' is meant to be incorporated into the local government strategic plans and work-plans, which should be reinforced through local level regulations, guidelines and budgets. The work-plan must also be approved by the local legislature/parliament (DPRD). BAPPEDA facilitates the musrenbang and policymaking process to ensure the coordination and synchronisation of local government development plans with national priorities and goals. See annex 3 for further elucidation of this process and the relationship between long-term (20-year) development plans, medium-term (five-year) development plans, and annual work-plans, according to Law No. 25/2004.

Law No. 25/2004 emphasises that the National Development Planning System aims:

1. To support coordination of development among the stakeholders;
2. To ensure that there is good integration, synchronisation and synergy across regions (antarwilayah), across spaces (antarruang), across time (antarwaktu), across functions of government (antarfungsi pemerintah), as well as between the central and local levels of government;
3. To ensure there are linkages and consistency between planning, budgeting, implementation and monitoring;
4. To optimise community participation; and
5. To ensure the utilisation of resources efficiently, effectively, justly and sustainably.

The second point implies that local planning is not an absolute form of a decentralised system, but local governments should also refer to the centre-local hierarchy. Furthermore, this law also reiterates that Local Government Work-Plans (RKPD, Rencana Kerja Pemerintah Daerah) and Local Medium-Term Development Plans (RPJMD, Rencana Pembangunan Jangka Menengah Daerah) should also refer to national annual Government Work-Plans (RKP, Rencana Kerja Pemerintah) and National Medium-Term Development Plans (RPJMN, Rencana Pembangunan Jangka Menengah Nasional). The planning process is outlined further in annex 3.

As a technical guide on conduct of the musrenbang, the Ministry of Home Affairs and the BAPPENAS annually issue a Joint Circular (Surat Edaran Bersama) on the implementation of local development planning forums (musrenbangda). Based on Law No. 25/2004 and Law No. 32/2004, the compilation of local government work-plans (RKPD) begins with the preparation of a preliminary draft (Rancangan Awal RKPD) by BAPPEDA. Following this, the heads of the local government agencies, offices, bureaus and other sectoral and technical units (SKPD, Satuan Kerja Perangkat Daerah) prepare their own work-plans (Rencana Kerja SKPD), corresponding to the main tasks and functions outlined in preliminary draft. This also guides the formulation of each office's strategic plan (Rencana Strategis SKPD).

Once the work-plans for each sectoral office have been compiled, the heads of BAPPEDA offices use these to coordinate the formulation of a Draft Local Government Work-Plan. The Draft Local Government Work-Plan prepared by BAPPEDA is then used in the musrenbang, in which community stakeholders and government administrators participate, to formulate the final Local Government Work-Plan. The musrenbang for preparation of the Local Government Work-Plan coordinated by BAPPEDA should be carried out no later than March every year. Village level musrenbang are generally held in January, sub-district level musrenbang are held in February, and district level musrenbang and other planning forums are held in March, and finally provincial level musrenbang are held in April. Based on the results of musrenbang, the heads of each BAPPEDA office prepare the final draft of the District and Provincial Government Work-Plans. These Work-Plans are then enacted through District/Provincial Government Head Regulations (Peraturan Kepala Daerah), which are also approved by local parliaments and provide the guidelines for the preparation of Draft District/Provincial Budgets (RAPBD, Rencana Anggaran Pendapatan dan Belanja Daerah).

Based on the system outlined above, it is evident that the development planning system goes through four processes. First, development planning undergoes a process of political negotiation. Local planning actually begins with the political process of electing the direct district/provincial heads, and then incorporating the visions and missions of these elected leaders. In addition, the Local Government Work-Plans, the General Budget Policy (KUA, Kebijakan Umum Anggaran), and the local budget formulation also undergo a political process based on communication and consultative meetings between executive and legislative branches (district/provincial parliaments) of the local government. Second, there is a technocratic process, in which planning is carried out according to specific functions by professional planners or by government agencies. In the context of Law No. 25/2005, this technocratic aspect of the process is carried out by BAPPEDA and the local agencies, offices and bureaus in local government. Third, development planning is a participatory process, involving local stakeholders, among others through village musrenbang. Fourth, there are top-down and bottom-up processes in terms of the government hierarchy. Top-down processes encompass the aspects of local planning that must also reference national planning processes. At the same time, bottom-up processes refer to the preparation process of annual planning that starts from musrenbang at the village level, from which the results are directed to the sub-district (kecamatan), district/municipality (kabupaten/kota), province and national levels.

In these four processes of development planning, BAPPEDA (at the district/municipal and provincial levels) has a strategic and influential role as regulator and facilitator of the interactions between local actors in the planning process. BAPPEDA must follow the local planning sequence as directed in the Joint Circulars from the Ministry of Home Affairs and BAPPENAS, as outlined below:[16]

1. Facilitate the management of village/ward (desa/kelurahan) musrenbang together with the Village Community Empowerment Agency (PMD, Pemberdayaan Masyarakat Desa) in the district/municipality;
2. Facilitate the management of sub-district (kecamatan) musrenbang together with the Village Community Empowerment Agency in the district/municipality;
3. Coordinate all district/municipal offices/agencies/bureaus and other work units (SKPD, Satuan Kerja Perangkat Daerah), especially in facilitating the management of district/municipal SKPD forums to discuss the proposed programmes and activities submitted from village and sub-district levels;
4. Conduct district/municipal musrenbang to discuss the local government work-plans.

16 Minister of National Development Planning (Head of BAPPENAS) and Minister of Home Affairs (Mendagri) (12 January 2007) Joint Circular No. 0008/M.PPN/01/2007-050/264a/sj, on 'Technical guidance on holding *musrenbang* 2007'

4.1.2 BUDGET ALLOCATION

The main provision of Law No. 32/2004 on local government is to delegate fiscal responsibility to the district level sectoral offices (Article 11). The budget allocation for district government is stipulated by Law No. 33/2004 on the Fiscal Balance between the Central Governments and the Regional Governments.

Following the implementation of Laws No. 32 and 33/2004, which revise the original decentralisation laws, provincial and district/municipal revenues are derived from:

- The central government general allocation fund (DAU, dana alokasi umum) is a block grant to local governments forming the basis for payments for civil servants and the general provision of services. It is designed to partially equalise the fiscal capacity among districts. Twenty-six per cent of net central government revenue should, according to the law, be allocated to the DAU (Article 27). The amount of DAU allocated to provinces and districts is calculated based on the number of local civil servants (Article 27), and on the discrepancy between the size of the population and geographic size, gross regional domestic product per capita and the construction cost index, the human development index, and the levels of income and natural resource endowments at the local level (Article 28).
- The central government special allocation fund (DAK, dana alokasi khusus), is earmarked for specific purposes in particular regions (Article 39). It is often allocated for development of infrastructure needs. The DAK is allocated based on general criteria (i.e., fiscal capacity of the local budget), specific criteria (i.e., related laws and local socio-demographic characteristics), and technical characteristic (i.e., determined by related ministries/department) (Article 40).
- Local government revenues (PAD, pendapatan asli daerah) such as taxes, revenues, levies, profits from properties, etc. (Article 6).
- Natural resources and tax revenue sharing from the central government. These are called revenue sharing funds (DBH, dana bagi hasil). Between 15-80 per cent of natural resource revenues, such as from forestry, mining, fishery, and gas and oil, are now distributed to regional governments (Article 11). Districts/provinces rich in oil and gas such as Aceh and Papua have especially gained from this reform.
- Grants (hibah) from foreign countries made through the central government (Article 44).
- Emergency funds (dana darurat) from the national budget are allocated in emergency situations created by natural disasters or extraordinary events that cannot be handled by local budgets (Article 45).
- Deconcentration funds (dana dekonsentrasi) are provided from the central government to the governor for functions associated with delegated (deconcentrated) authority from the central government to the governor (Article 87).
- Co-administered task funds (Dana tugas Perbantuan) are funds for jointly implemented activities between the central and local governments (Article 94).

Special Autonomy regions also have a Special Autonomy Budget Allocation (Dana Otsus) for a defined time period from the central government, based on the Special Autonomy Laws enacted in Papua and Aceh.

Most local budgets at the district/municipal level comprise general and special budget allocations, and local revenues. Most provincial budgets comprise general and special budget allocations, and deconcentrated funds. Local level budgets are jointly approved by the executive and legislative branches of local government and are enacted through local regulations according to Law No. 33/2004.

4.1.3 OFFICES RESPONSIBLE FOR DIFFERENT ASPECTS OF CHILD WELFARE

Under decentralisation, a number of different offices of government (Dinas) are responsible for improving particular aspects of child welfare.

The Office of Health (Dinas Kesehatan) at the provincial and district/municipal level handles most aspects of maternal care, child nutrition, disease and sanitation.

The Office of Education (Dinas Pendidikan) is responsible for ensuring children complete nine years of compulsory education, as well as improving graduation rates, continuation rates, and improving quality of education.

The Office of Social Affairs (Dinas Sosial) is tasked with improving the welfare of abandoned children and protecting children from serious social welfare problems. This includes child labour, children living on the street, children in orphanages, disaster victims and children with special needs. Children who suffer from domestic abuse are also the responsibility of the Office of Social Affairs.

Alongside the Office of Social Affairs, the Office of Manpower (Dinas Ketenagakerjaan) is also responsible for dealing with child labour. This Office is authorised to monitor and ensure that companies and factories do not employ children.

Children who are in conflict with the law are the responsibility of the police department (Polda, Kepolisian Daerah), the prosecutions office and the courts.

Birth registration is the responsibility of the Bureau of Population and Civil Registration. In most provinces and districts/municipalities, such as in Yogyakarta, this bureau is structurally responsible to the district and municipal Secretariats (Sekda) and does not fall under a technical implementing unit/office. The bureau must ensure that every child born is registered.

In each provinces and district/municipality with a functioning Bureau of Women's Empowerment, Child Protection and Family Planning (BP3AKB, Badan/Biro Pemberdayaan Perempuan dan Perlindungan Anak dan Keluarga Berencana), child victims of human trafficking are the responsibility of that Bureau. The Bureau is responsible to the district/municipal/provincial secretariat and coordinates with the Office of Social Affairs to run an integrated services centre (PPT, Pusat Pelayanan Terpadu) to deal with cases, such as child trafficking and early marriages.

4.2
TACKLING MALNUTRITION IN EAST NUSA TENGGARA (NTT): A LARGE, DISPARATE AND POOR PROVINCE

4.2.1 INTRODUCTION

Section 4.1 discussed the regulation of the processes of development planning and policymaking under decentralisation. This case study focuses on malnutrition in East Nusa Tenggara (NTT) within the decentralised context. The impacts of malnutrition are enormous and have broad effects on the health and social welfare, both of individuals and of society as a whole. The case study examines the current status of malnutrition in NTT and endeavours to understand some of the contributing factors in context, as well as policy responses to the problem. This is not an exhaustive sectoral review, but rather the discussion endeavours to highlight the challenges and space for innovation in the decentralised context.

Malnutrition is a particular problem in NTT, exacerbated by the geography and climate, particularly the unreliable agricultural yields, the difficulty in accessing health care in remote areas, and local behaviours and cultural practices relating to the use of health facilities and consumption of nutrients. Examining the case study of malnutrition and health in NTT highlights other contributing factors such as poor economic status, low education levels, customary nutrition practices and poor access to health services, which are all prevalent in the province. In relation to the Millennium Development Goals (MDGs) on health and nutrition, NTT is well behind the national average, particularly in terms of underweight and wasting in children and, related to this, child mortality. Not only are these indicators worse than at the national level but they have also seen little or no improvement in recent years. Disparity is key when studying the issue of malnutrition in NTT, not only the disparity of the region as a whole compared to the national level but also the disparities between rural and urban areas, among districts and across social strata.

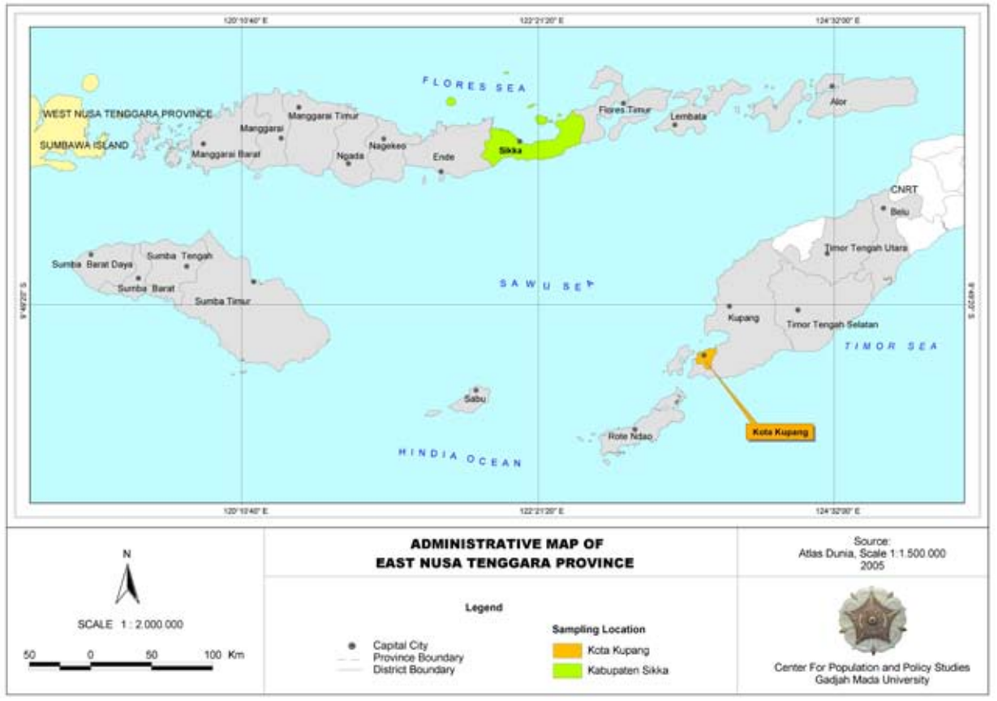
Secondary data sources were used for quantitative analysis[17] (see annex 4.2), supplemented by qualitative data from focus group discussions (FGDs) and in-depth interviews with children and their parents, medical practitioners and those working on the administrative side of health-care provision (including civil servants and development agency employees). Two districts were chosen for in-depth study to provide insight into the issues of malnutrition in NTT: more urbanised Kupang municipality and more rural Belu district. This allowed for comparison between an urbanised and a remote community, as well as one in transition from conflict. In the discussion, in-depth interview and FGD data are useful for further elaborating on the relationship between direct and underlying causes of death and malnutrition in the province in terms of diet, disease, household practices and living environment, as well as institutional service delivery as it relates to the UNICEF conceptual framework for understanding malnutrition and mortality problems, as discussed in Section 3.1.

17 Most notably data from: Badan Pusat Statistik (BPS) - Indonesia (2008) *National Socio-Economic Survey (SUSENAS, Survei Sosial Ekonomi Nasional) 2008*; BPS - Statistics Indonesia (2007) *Indonesia Demographic and Health Survey (IDHS) 2007*; and Ministry of Health, National Institute of Health Research and Development (2008) *Basic Health Research (Riskesdas, Riset Kesehatan Dasar) 2007*.

4.2.2 BACKGROUND

4.2.2.1 Geography and livelihoods

Figure 4.2.1: East Nusa Tenggara (NTT) location map



Source: Center for Population and Policy Studies, Gajah Mada University, 2010

The province of NTT covers an area of approximately 2.49 per cent (47,349.90 km^2) of the whole of Indonesia, and the landscape is comprised almost entirely of limestone mountains and hills.[18] The province consists of more than 550 islands, including the larger islands of Flores and Sumba, and the western portion of the island of Timor (West Timor). Kupang municipality is the provincial capital, which is located in West Timor. NTT has a dry, semi arid climate that is affected by the monsoon. The dry season is longer than in most other parts of Indonesia, lasting seven months of the year (May-November). The topography of NTT is hilly and mountainous, with very few flat or sloped areas appropriate for farming. These conditions make the region less fertile and drier than other parts of the country, which impacts on agriculture and in turn on diet and nutrition levels, as well as economic output of the region.

The regional topography also shapes the customs and life choices of the population, including settlement patterns. People tend to build houses high on the rocky mountains, above the erosion prone soils, but far from water and food sources. This in turn presents development challenges, since the difficult geographical terrains are an obstacle to providing accessible public services, such as schools, sub-district community health centres (puskesmas) and hospitals, and lack of

18 BPS - Statistics Indonesia (2009) NTT *Province in figures 2008*, BPS NTT: Kupang

access to these facilities directly impacts on health and nutrition. This is reflected, for example, in low attendance by health professionals during delivery (see Figure 4.2.13 later in this subsection for the proportion of institution-based deliveries, and see also the detailed examination of this issue nationwide in Section 3 of this document).

NTT's economy is dominated by agriculture, which accounts for 35 per cent of GDP and is based almost entirely on smallholders.[19] The vast majority (89 per cent) of NTT's population are farmers; 79 per cent of them are dryland farmers who cultivate corn as their main crop. These farmers are vulnerable since their income generating activities rely on infertile soil, which is susceptible to draught, placing the entire province at high risk of food insecurity.[20] Agriculture in NTT is largely based on subsistence farming and ground crops, with the majority of farmers cultivating maize, followed by wetland rice, cassava, and dryland rice. Other food crops include dry season vegetables, which grow well in much of NTT. Tree crops are largely grown as cash crops. These consist primarily of coconut, cashew nut, candlenut and coffee. Forests in NTT occupy an extensive 1,800,000 hectares, but this is mainly for conservation purposes, with sparse growth in the dry climate.[21] The average yields per hectare of all food and tree crops are low, and there is great potential for enhanced production[22]. This should certainly be addressed in long-term development projects, and represents a promising opportunity for economic and nutritional improvement.

Subsistence agriculture is highly susceptible to the frequent price increases for staple foods and for oil that occur in Indonesia, following national and global market trends. This has had a substantial impact on transportation costs and non-staple food prices during the last decade, deepening the state of poverty of rural people who live in the more remote districts, such as Sumba Barat, Timor Tengah Selatan, Timor Tengah Utara, Lembata and Manggarai.

Livestock are also a significant source of income and food, with widespread farming of cattle, pigs, goats and poultry. Cattle are largely farmed for cash and other livestock are kept partly for domestic purposes, partly for income generation.[23] Here too, production efficiency is low, and there is major potential for improvement with obvious implications for improving nutrition in the region, both directly and via economic means.

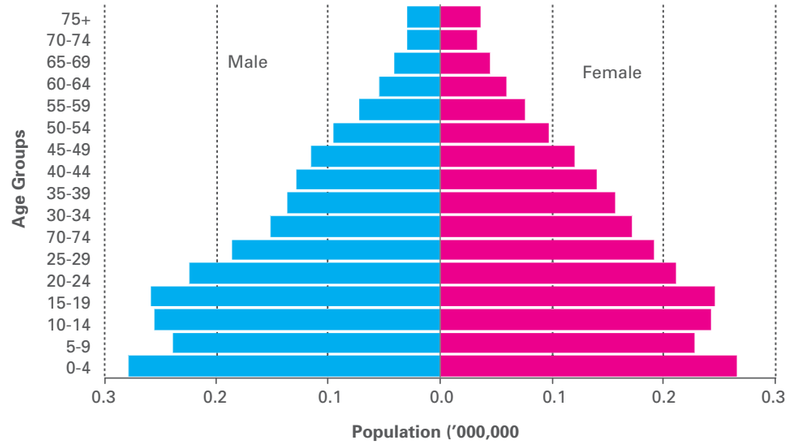
All crops and livestock are sold for cash once domestic needs are met, and key cash crops each have specialised marketing facilities. Not recognised by those living in NTT as nutritious, foods like beans, eggs, fruits and vegetables are often sold, the money being used primarily to purchase rice, adding little nutritional value to the usual existing food stocks of corn and cassava.[24] Programmes to educate communities about the nutritionional value of such products could prove a valuable means of boosting nutrition using existing resources. Crops and livestock are sold in local periodic markets, which are often hard to access. Barter is also common and farmers may, for instance, exchange corn for chickens or vice versa. While competitive pricing often prevails, the potential for raising producers' market returns are a concern for economic development.

19 Muslimatun, S. and Fanggidae, S. (2009) *A brief review on the persistence of food insecurity and malnutrition problems in East Nusa Tenggara province, Indonesia*, Oxfam Working Paper (No. 12): Kupang, NTT
20 Ibid.
21 Kana Hau, D. et al. (2007) *Pengkajian pengembangan teknologi konservasi lahan untuk peningkatan halis usaha tani di lahan kering Kabupaten Ende: Laporan akhir*, Balai Besar Pengkajian Dan Penengembangan Teknologi Pertanian, Badan Penelitian dan Pengembangan Pertanian, Departemen Pertanian: Kupang, NTT
22 Barlow, C. and Gondowarsiot, R. (2007) *Economic development and poverty alleviation in Nusa Tenggara Timur,* Working Paper, Department of Political and Social Change, RSPAS, Australian National University, Canberra and Nusa Tenggara Association: Canberra and Kupang
23 Ibid.
24 Stuttard, J. (2008) *Nutrition assessment report: NTT Province, TTS District*, Action Contre le Faim Indonesia: Timor Tengah Selatan, NTT

4.2.2.2 Demography

The population of NTT province is estimated to be 4,534,319, with the vast majority living in rural areas (83 per cent).[25] As shown in Figure 4.2.2, the population is characterised by a relatively large proportion of people under the age of 30, and in particular is skewed towards the under-15 age group, reflective of the high birth rate in this region, clearly a region in a phase of population growth. For NTT, having a large 'productive population' (aged between 15 and 50 years) to support a relatively small older population is economically beneficial. However, to counter this, the particularly large group of children under age 15 years does put a high burden of care and support on this productive segment of the population. Lots of mouths to feed mean that the limited food stocks are spread thin, often limiting calorie and nutritional intake to such an extent that there are serious health implications, particularly for young, growing bodies.

Figure 4.2.2: Population pyramid, NTT 2005



Source: Badan Pusat Statistik (BPS) - Statistics Indonesia, Intercensal survey 2005

The population of NTT continues to grow year on year. The rate of growth, however, has been decreasing slightly over the past five years, from 1.97 per cent in 2005 to 1.84 per cent in 2009.[26] Related to this, the total fertility rate[27] (TFR) is also high and has being steadily decreasing, albeit slowly, from 2.99 in 2005 to 2.8 in 2009.[28] These are above the national TFR levels for those years, which were 2.2 and 2.16, respectively.[29]

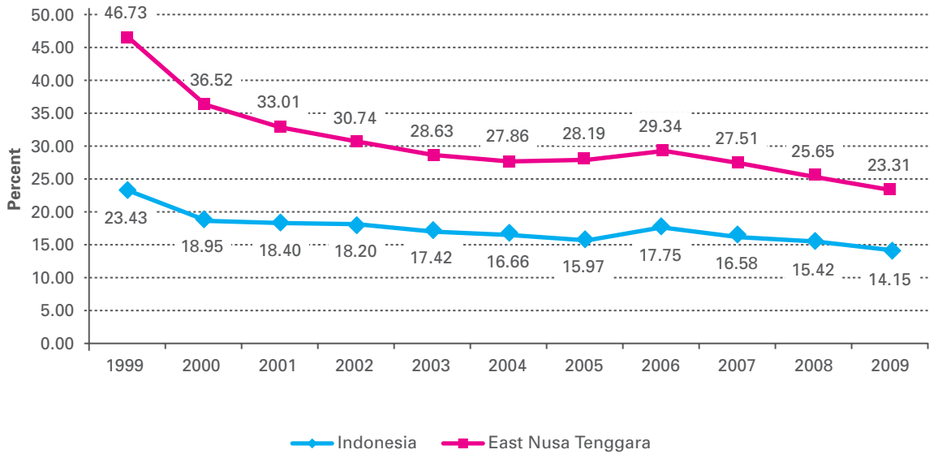
The religious make up of NTT is atypical of Indonesia, with a predominance of Christians living in the province. There are about 56 per cent Catholics, 35 per cent Protestants, 8 per cent Muslim, 0.6 per cent Hindu and Buddhist, and the rest still follow their traditional systems of belief, most notably Marupu.[30] Customary systems and practices strongly influence the way of life of those living in NTT, including customs surrounding nutrition and food, which will be outlined more in the subsection on the contributing factors to malnutrition (Section 4.2.3.2).

25 BPS - Statistics Indonesia (2009) *Report based on the Intercensal Survey (SUPAS) 2005*: Jakarta
26 Ibid.
27 Children born on average to one woman over the course of her reproductive life
28 BPS - Statistics Indonesia (2009) *Intercensal survey 2005*
29 Ibid.
30 Ibid.

4.2.2.3 Economic context

Malnutrition breeds a poverty cycle by lowering productivity and income in adulthood, in turn feeding back into the likelihood of malnutrition for the next generation. It is not surprising, therefore, that NTT is one of the poorest regions in Indonesia. Based on data from the NTT Provincial Bureau of Statistics (BPS)[31], the number of poor people in NTT in March 2009 was 1,010,000 people, or 23.31 per cent of the provincial population, far higher than the national average (see the Figure 4.2.3). Poverty was at its most severe during the period 1993-1999 due to the economic crisis affecting Indonesia at that time, and since then the percentage of those living below the poverty line has been decreasing. The trend took a definite turn for the better after 2006 following a recovery from the removal of fuel subsidies and the ban on rice imports. While the percentage of the population living below the poverty line in NTT is considerably higher than the national average, the gap has been closing somewhat over time.[32]

Figure 4.2.3: Percentage of population below the poverty line, NTT versus Indonesia 1999-2009

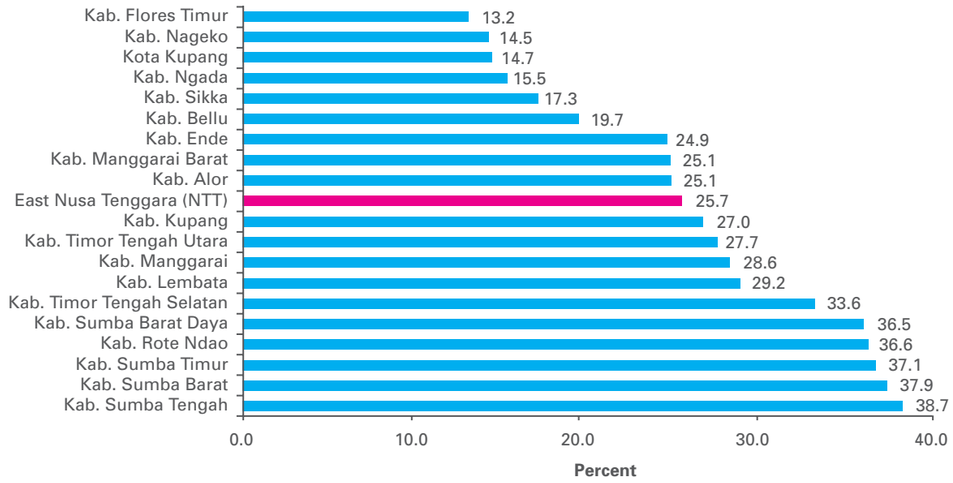


Source: BPS - Statistics Indonesia, Statistical Yearbook 2010, based on the National Socio-Economic Survey 2009

In general, there is a considerable disparity between the relative sizes of rural and urban populations living below the poverty line: 25.35 per cent in rural areas versus 14.01 per cent in urban areas.[33] According to the study by Barlow and Ria (2007)[34], the GDP per capita in NTT varied greatly among districts/municipalities, with that in the provincial capital, Kupang, and several other towns being over three times the average of other districts. In general, areas with the largest poor populations are those with high dependency on subsistence farming activities such as cultivation of corn and other basic foods for consumption rather than income. These include Sumba Barat, Kupang, Timor Tengah Selatan and Timor Tengah Utara, Lembata and Manggarai. Development initiatives to relieve poverty and malnutrition should focus on the poorest districts of NTT with the aim of closing this gap.

31 BPS - Statistics Indonesia (2009) *Statistical Yearbook 2009 (based on the National Socio-Economic Survey, SUSENAS, 2008)*, BPS: Jakarta
32 Ibid.
33 BPS - Statistics Indonesia (2009), *Statistical Yearbook 2009*, based on the *National Socio-Economic Survey 2008*
34 Barlow, C. and Gondowarsiot, R. (2007) *Economic development and poverty alleviation in Nusa Tenggara Timur*

Figure 4.2.4: Percentage of poor population by district, NTT 2008



Source: BPS - Statistics Indonesia, based on National Socio-Economic Survey 2008[35]

4.2.2.4 Human development

Figure 4.2.5: Trends in development indices, NTT 1999-2007

Source: HDI from BPS/BAPPENAS/UNDP, Indonesia Human Development Reports 1999-2007; GEM and GDI from BPS - Statistics Indonesia and The Ministry of Women's Empowerment, Gender Based Human Development 1999-2007

35 BPS - Statistics Indonesia (2009) *Data dan Informasi Kemiskinan 2008 (Buku 2: Kabupaten/Kota) (based on National Socio-Economic Survey, SUSENAS, 2008)*, BPS: Jakarta

In general, human development in NTT is far behind the national average, reflected by the human development index (HDI). Between 2000-2007 the HDI of Indonesia has been constantly increasing to reach a level of 73.4 (see Section 2). NTT, however, remains far below the national figure despite increasing from 60.4 in 1999 to 65.8 in 2007 (see Figure 4.2.5). Significant improvements were made in the second half of the 2000s indicating there has been some improvement in life expectancy, education levels (mainly at the primary school level) and income (the contributors to the HDI). Even so, the HDI disparity among districts in NTT is considerable, with districts in rural areas generally on the lower end (see annex 4.2). In 2007, the lowest HDI was attributed to Sumba Timur district with a score of 58.6, while the highest level achieved was in Kupang municipality, at 75.9 - higher than national HDI. Also shown in Figure 4.2.5, the gender development index (GDI) follows a similar pattern, increasing over time but continuing to sit at a level well below the national figure, and with rural/urban and inter-district disparities. The 2007 GEM (gender empowerment measure) of NTT is more of a highlight for NTT, currently at 61.0. A strong increase between 2002-2004 in the GEM and consistent increases since then mean that the level reached by NTT is higher than that of other larger provinces in Java, for instance Central Java where the 2007 GEM stood at 59.7. This accomplishment reflects the fact that in NTT, women's participation in the workforce, women's average wage in non-agriculture sectors, and woman participation in politics and decision-making (women as professional workers, high rank officials, and managers) are relatively good. Again the inter-district disparity can be observed with low figures in rural districts - the lowest being Manggarai Barat (46.8).

4.2.2.5 Basic education

Annex 4.2 shows the trends in education in NTT. Early childhood education attendance rates according to the National Socio-Economic Survey have fallen from 10.21 per cent in 2004 to 6.6 per cent in 2007. From a low point in 2002, the primary school level net attendance rate[36] for NTT has experienced some considerable increases from 87.07 per cent in 2002 to 91.72 per cent in 2008, with attendance rates for girls and boys almost equal, again based on National Socio-Economic Survey data. However this remains below the national average, and since 2005, the trend has been flat. The relatively low attendance rates have been exacerbated by an increasing rate of early school leaving (dropout) for primary school - now standing at 3.53 per cent of students (the second highest provincial rate in the entire country). Another concern is the low rate of transition to junior secondary level, 89.61 per cent in 2007/08, which has fallen in recent years from 99.4 per cent in 2005/06. Junior secondary school attendance now sits at 49.7 per cent. This correlates with the timing of the removal of fuel subsidies and the ban on rice imports, as well as policy changes in education, which are discussed in more detail below. This highlights the need for renewed initiatives to boost enrolment and retention levels to reach the target set in the MDGs for 2015 - 100 per cent net enrolment rates, in line with Education For All, which should not differentiate on the basis of gender.

While levels of primary school attendance were not that dissimilar to the national average, there was greater disparity between the junior secondary school net attendance rate and the national average in 2008 (49.7 per cent in NTT versus 67 per cent nationally). Again, following steady increases in attendance in the initial years of the 2000s, gains have tailed off in the latter years of the decade. Girls have slightly higher attendance rates than boys (64.44 per cent versus 61.84 per cent), but this minimal disparity is much smaller than at the beginning of the decade when girls' attendance was 64.16 per cent while boys' attendance was only 45.55 per cent. Retention rates in NTT are poor, with early school leaving at a rate of 8.24 per cent in 2006/07, well above the national average of 3.94 per cent, for junior secondary school.[37] Early school leaving rates have been climbing sharply since 2003/04 when they were at a low point of 1.65 per cent, even below the national average of 2.83 at that time.[38] In 2007/08, repeat rates for NTT were the highest in the country at 1.55 per cent of secondary level students (compared to the national figure of 0.42 per cent), and have been climbing steadily from their low point of 0.35 per cent at the beginning of the decade.

Reasons for early school leaving shed some light on these indicators. In 2006, 84 per cent (or 19,023) of early junior secondary school leavers cited economic reasons for leaving school.[39] This was followed by 7 per cent who considered the distance to school too far.[40] The third most common reason cited for leaving school was that the family does not prioritise education (5 per cent) and it is not uncommon for parents to use scholarship money provided for students to satisfy their basic needs.[41] Interviews with staff at the provincial Office of Education also stated that with low incomes, many parents cannot afford to advance their children to higher levels of education beyond primary school.[42] Other interview respondents indicated that, coupled with these economic challenges, parents struggle to pay extra fees and charges from schools and the cost of uniforms and books.[43] Finally, many students are expected to help their parents by contributing to household income, by working as newspaper sellers, day labourers on building sites, farms or plantations, or as domestic staff.[44] With some of the worst performance in education indicators in the country in NTT, enrolment and retention at junior secondary level should be a priority for development workers to meet education targets in line with the MDGs.

In Section 2 of this report, the social safety net programmes designed to support education for poor students were examined, in particular the Fuel Subsidy Reduction Compensation Programme (PKPS-BBM) for the Education Sector, which provided money directly to poor students, and the Schools Operational Assistance programme (BOS, Bantuan Operasional Sekolah) which replaced it in 2005/06, whereby money was provided to the schools to be managed in accordance with requirements determined by the central government. Although it is impossible to give a definitive reason as to why almost all the education indicators have reversed their generally positive trend into negative after the middle of the decade, it does call into question the effectiveness of providing money to schools to manage rather than directly to the families of poor students, since the timing of the change of policy correlates with the negative shifts in the education indicators. Office of education staff identified that in some cases BOS funds are used to pay honorariums to teachers due to limited school budgets, which is outside the BOS policy.[45] The low fiscal capacity of the district means that the Office relies heavily on the central government's special budgetary allocation (DAK), scholarship funds, and BOS funds.[46]

36 Since the figures are based on survey data and not actual reported figures from the Department of Education, net attendance rate is used in the place of net enrolment rate as the closest equivalent available.

37 Indonesia Ministry of National Education, *Statistics of National Education*, available at: www.depdiknas.go.id/statistik (Last accessed 1 July 2009)
38 Ibid.
39 East Nusa Tenggara (NTT) Provincial Office for Education, Youth and Sport (2009) *Data collection report on children at secondary school, within the framework of compulsary of 9 years basic education*, Center for Women's Studies, Cendana University: Kupang, NTT
40 Ibid.
41 Ibid.
42 Interview with Kindergarten and Basic Education Section Staff, NTT Provincial Office of Education, Youth and Sport, Kupang (25 November 2005)
43 Interview with coordinator of the women's division, local NGO, Sikka district (19 September 2009)
44 Interview with Kindergarten and Basic Education Section Staff, NTT Provincial Office of Education, Youth and Sport Office, Kupang (25 November 2009)
45 Interview with Head of Basic Education Section, Office of Education, Youth and Sport, Sikka District, NTT (21 September 2009)
46 Ibid.

Education quality is also a problem in NTT. Staff from the Early Education and Primary School Section of the Office of Education in Sikka (21 September 2009) stated, for example, that aside from the problem of the scarcity of teachers, many teachers in villages do not have adequate education themselves - there are still primary school teachers who only completed junior secondary school, and junior secondary school teachers who only completed high school. Furthermore, many schools have limited facilities, lacking libraries, for instance. Many villages do not have electricity, so children rarely study at night.[47] Staff in the Office of Education argued that institutional capacity is also a problem. Given the high rotation levels of civil servants, many government officials in senior positions in the Office don't have a background in education to manage the challenges of educational policy and services in NTT.[48] For example, in the Office of Education in Sikka, only three government officials have a background in education.[49]

4.2.2.6 Child protection

While data on child protection are scarce, annex 4.2 outlines some basic figures on child marriage, birth registration, neglected children and children living on the streets. The proportion of children aged under 18 years who were married was 19.8 per cent in 2008, and rates have actually increased since 2000 when the rate was 18.1 per cent, according to National Socio-Economic Survey data. The same data set revealed that only 14.4 per cent of children aged 0-59 months in 2007 had a birth certificate, with this being only marginally more likely for boys, and rates have been decreasing since 2000 when 18.2 per cent of children that age had birth certificates. Data from the Office of Social Affairs indicate that the number of neglected children has grown substantially to 492,519 in 2009 (up from 58,776 in 2008), with 84,376 of these children aged under five years. The same office puts the number of children living on the streets at 12,397 in 2009 (with little change since 2008).

4.2.2.7 The voice of a child in context

Mawar is an average adolescent in NTT. Her case is not particularly extreme given the high levels of poverty discussed above, but her case illustrates the multiple levels of insecurity that children from poor families face in terms of health, nutrition, education and child protection in NTT, and also underlines the importance of viewing the experience of children holistically. Her case illustrates the challenges of accessing health care despite health insurance programmes, and the challenges for children to stay in school in the face of poverty, and the ways that children avoid violence in school through absenteeism. Moreover, her story demonstrates how children make choices in challenging contexts as they strive for improved conditions and well-being.

47 Interview with Kindergarten and Basic Education Section Staff, NTT Provincial Office of Education, Youth and Sport, Kupang (25 November 2005)
48 Interview with Head of Basic Education Section, Office of Education, Youth and Sport, Sikka District, NTT (21 September 2009)
49 Ibid.

Box 4.2.1: Mawar's experience: Multiple insecurity for children in NTT

Mawar is a confident and happy child of Alor ethnicity who is 16 years old. She was born in Kupang municipality. She has one older sister who completed primary school and now works in Osmo (in another district) as a domestic servant. Mawar's parents did not complete primary school. When Mawar was eight years old, her father, who was a fisherman, drowned after falling from his boat while fishing. Since then, her mother has been a single parent, and she has a small kiosk at Osmo.

When Mawar was four months old, her mother brought her to Rote (a rural district) where she lived with her extended family (grandparents). She studied at a state primary school in Rote where some people, she says, including children, still often suffer from malnutrition because of drought and famines. "[There is] a scarcity of vegetables, vitamins and meats in the dry season in Rote," she explained. "If there is a lack of food to eat, they will only eat rice or sometimes mix it with sap [sugar liquid that is obtained from palm trees]". Mawar understands the importance of vegetables, protein and vitamins in people's diets and thought that the government should help people in areas suffering from famine by giving them 'charity' so that they are able to eat. Recognizing these circumstances, she felt compassion for the life of poor people in Rote village.

Mawar, was unable to sit her primary school exams when she was in Rote. Her grandfather (who works as a 'palm sap seeker', selling the sap he gets by tapping palm trees, which is used to make palm sugar) could not afford to send Mawar to school anymore.

After moving to Kupang city area, Mawar and her mum have rented a small room of 4 by 4 meter space, with a wooden wall and sheet-metal roofing that costs IDR 90,000 (US$10) per month to rent. There are no appliances in the room, only a small lamp hanging from the ceiling that is turned on from 5 p.m. until 5 a.m. There is one bed, a wardrobe, a stove, and a draining-board which holds cups, plates and cutlery (all plastic). She observes that people in their neighbourhood are often drinking, stealing, gambling, robbing people and playing billiards. Her neighbours earn money in diverse ways - some even by using force and violence.

In Kupang, she enrolled at an informal school, through a non-profit organisation, called the Purnama Kasih Foundation. "Mum said the formal school is too costly, so [you] just have to study at Purnama Kasih." Mawar finally was able to sit the national examination and completed primary school. She enjoyed it so she decided to undertake Kejar Paket B (equivalent to junior secondary school). Each student has to pay IDR 16,000 (US$1.60) every month. However, poor households are entitled to free monthly education fees and this includes Mawar's family. The school also provides several free study kits for the poor, including text books and note books, but not pencils or pens.

Mawar's mother now works as a trader at a traditional market (Pasar Oeba), though she doesn't have a permanent stall. Mawar often helps her mum at the market selling spices. They get the products from a wholesale distributor and then retail them directly to consumers at the roadside. If they are lucky, they will earn profits of around IDR 10,000 (US$1) per day. Studying at school two or three days a week, Mawar wakes up in the morning before 6 a.m., helps her mother do domestic chores, and goes to the school at 7:30

a.m. by public transport. When she doesn't go to school, she helps her mother in the stall. On those days, having finished the domestic chores like cooking and cleaning, at 6 a.m. they walk together to the market. They rest from 12-3 p.m. and return to the market where they work until 5 p.m. At noon they come back home to take a rest and then go back to the market from 3-5 p.m.

Categorised as poor, Mawar and her mother receive the Direct Cash Transfer (BLT, Bantuan Langsung Tunai) although payments are haphazard for reasons she doesn't understand. They also get Raskin (a subsidised rice programme for poor families which provides 10 kilograms of rice per poor household at the price of IDR 1,000 per kilogram), as well as Jamkesmas (free health care provision for the poor). Mawar says that the Jamkesmas is government assistance for the poor when they are sick, for which they use a health-care card. Mawar says her mother is very often sick. Her body is weak, and so she is susceptible to illness, so she often has the flu, nasal congestion, coughs and fevers. Only when she is really really sick, do they buy medicine at the little kiosk nearby. They don't go to the puskesmas as it is too far away.

Mawar often witnesses crime in the market, such as pickpocketing and robbery. She takes steps to prevent these things happening to her by giving all the money she earns to her mum once her goods are sold. "I don't want to keep the money and prefer to give it to my mum. I am afraid of losing it," she says.

Mawar says she often experiences violence at home and at school. Her mum reprimands her and hits her if she makes a mistake. One thing that she still remembers is giving a consumer the wrong change by mistake that turned a day's profit into a loss. Her mum hit her across the back, making Mawar cry with pain. "Mum often hits me when she is angry," she says.

At school, Mawar says that there are two bad-tempered teachers who often hit students as well as tweaking their arms or ears. Mawar's ear was tweaked roughly when she was not able to answer the teacher's questions. Mawar never reports these teachers, but she rarely attends school on Wednesdays because this is when those teachers are scheduled to teach. Because of her absence, she often receives school warnings: "If you dislike school, we'll just expel you. Are you not afraid of that?"

Mawar is very keen to continue her studies and move on to senior high school and to be a supermodel. Even though her mum and grandfather once said that Mawar doesn't need to go to school, she doesn't agree with them. "'You don't have to go to school, just learn to hold a cooking pot, in the morning, afternoon and at night,' they said to me. But I think it will enlighten me, give me advantages and knowledge. School is an education so that we can read, calculate and achieve a better future. That's the goal."

Mawar feels blessed by what she has achieved. She's lucky, she says, because even though she lives a life of scarcity, she survives.

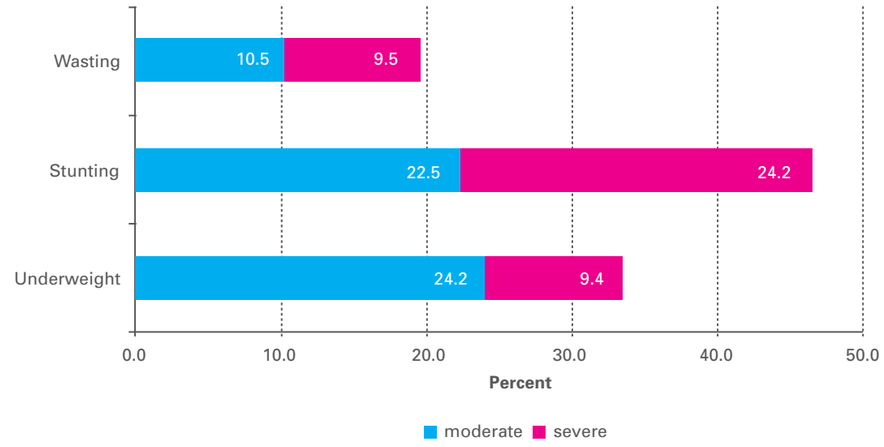
Source: Child interview conducted by PSKK, UGM in NTT, 2009; Mawar is not his real name

4.2.3 THE CASE STUDY: HEALTH AND MALNUTRITION IN A GEOGRAPHICALLY LARGE BUT POOR PROVINCE

The discussion earlier in this subsection has already highlighted the improving but stubbornly high levels of poverty, lower than average education levels, lagging HDI, growing numbers of neglected children and difficult agricultural and economic conditions in NTT. Child marriages are also fairly common, and few children have birth certificates. This is in stark contrast to the indicators of child welfare in Central Java, discussed in a separate case study. The case of Mawar (see Box 4.2.1) demonstrates the linkages between poverty and multiple levels of insecurity for children in NTT. Amidst these challenges, indicators of health and nutrition, while improving, are also concerning. The following discussion examines child welfare in a difficult context in terms of health and malnutrition and related factors, drawing on survey data and in-depth interviews from NTT.

4.2.3.1 Malnutrition

Figure 4.2.6: Percentage of children aged under five suffering from wasting, stunting and underweight, NTT 2007



Source: Ministry of Health (MoH), Report on the results of the National Basic Health Research (Riskesdas) 2007

Despite efforts to reduce the malnutrition levels in NTT discussed later in this section, the number of severely and moderately malnourished children still remains high, as seen in Figure 4.2.6. When it comes to the percentage of severely underweight[50], stunted[51] or wasted[52] children under age five, NTT is one of the worst affected provinces in the country. Of all 33 provinces in Indonesia, NTT has the third highest level of severely underweight children (9.4 per cent in NTT versus 5.4 per cent at the national level), third highest for severe wasting in children (9.5 per cent

50 Measured by comparing the weight-for-age of a child with a reference population of well nourished and healthy children, see: World Food Programme (WFP), *Hunger Glossary*, available at: http://www.wfp.org/hunger/glossary (Last accessed 30 September 2010)

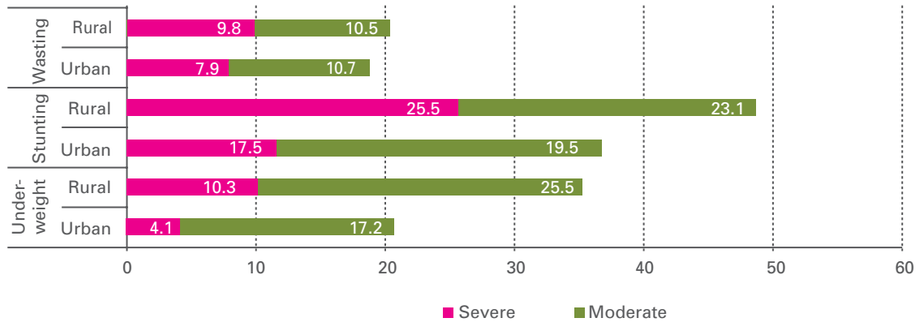
51 Reflects shortness-for-age; an indicator of chronic malnutrition and calculated by comparing the height-for-age of a child with a reference population of well-nourished and healthy children. According to the UN Standing Committee on Nutrition's *5th Report on the World Nutrition Situation* (2005), almost one third of all children are stunted. See: WFP, *Hunger Glossary*, available at: http://www.wfp.org/hunger/glossary (Last accessed 30 September 2010)

52 Reflects a recent and severe process that has led to substantial weight loss, usually associated with starvation and/or disease. Wasting is calculated by comparing weight-for-height of a child with a reference population of well-nourished and healthy children. Often used to assess the severity of emergencies because it is strongly related to mortality. See: WFP, Hunger Glossary, available at: http://www.wfp.org/hunger/glossary (Last accessed 30 September 2010)

NTT versus 6.2 Indonesia), and seventh highest for severely stunted children (24.2 per cent NTT versus 18.8 per cent nationally). Even when moderate and severe rates are combined, the rates in NTT are far worse than the national average: wasting (20 per cent in NTT versus 13.6 per cent nationally); stunting (46.7 per cent in NTT versus 36.8 per cent nationally); and underweight (33.6 per cent in NTT versus 18.4 per cent nationally). There are wide disparities among districts in NTT, most of which are explained by rural/urban comparisons (see annex 4.2).

Rural areas are much worse affected than the urban areas in terms of moderate and severe malnutrition, most likely due to their dependence on unreliable agricultural yields as well as local attitudes towards the consumption of different types of foods (see discussion later in this section). From a gender perspective, the nutrition indicators are slightly higher for boys than for girls across the board. This pattern has also been observed at the national level and could be attributed to the phenomenon explained, for example, by Svedberg (1996)[53], who explains that because girls represent an asset for the future of household farming activities, they might be prioritised in terms of care practices and, in particular, feeding practices. Whatever the reason, malnutrition policy needs to take this gender disparity into account.

Figure 4.2.7: Percentage of children aged under five suffering from being underweight, stunting or wasting, by rural versus urban area, NTT 2007

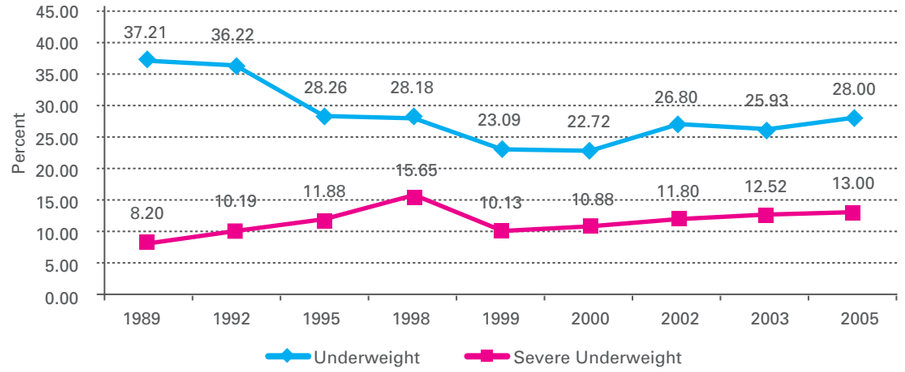


Source: Ministry of Health, Riskesdas 2007

As is evident from Figure 4.2.8 below, the prevalence of severely and moderately underweight children has been stagnant over time. The prevalence of underweight children in each district in NTT is also high across the board, with more than 30 per cent of children underweight in 13 of the 16 districts. This highlights the depth of the problem in this region. There is, however, a high disparity among districts with the highest proportion of underweight children in Rote Ndao (40.8 per cent), and the lowest in Kupang municipality (14.3 per cent).[54] Combined with poor agricultural conditions, NTT has the highest TFR in the country (4.2)[55], making tackling malnutrition increasingly difficult.

53 Svedberg, P. (1996) 'Gender bias in Sub-Saharan Africa: Reply and further evidence', *Journal of Development Studies*, Vol.32: 933
54 Ministry of Health (2008) *Riskesdas 2007*
55 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007*, BPS - Statistics Indonesia and Macro International: Calverton, Maryland, USA

Figure 4.2.8: Trends in prevalence of moderately underweight and severely underweight children, NTT 1989-2005



Source: Gizi.net (2009) in Working Paper#12: A Brief Review on The Persistent of Food Insecurity and Malnutrition Problem in East Nusa Tenggara Province, Indonesia, Siti Muslimatun and Silvia Fanggidae, Institute of Indonesia Tenggara Timur Studies and Oxfam, February 2009 (Based on Susenas)

Perhaps most alarming is that 20 per cent of children in NTT are suffering from wasting (moderate and severe).[56] In general, inter-district disparity is not as great as for some other indicators. However one district - Manggarai - stands out as particularly bad with levels of wasting at 33 per cent of children under five years old, with 19.6 per cent of them suffering severe wasting (compared to the national rate of 9.5 per cent). Wasting is an acute condition suffered by undernourished children, and children with severe wasting require additional nutrition and immediate rehabilitation of their nutrition status because this condition can be fatal, highlighting a situation of chronic and acute malnutrition in NTT.

Furthermore, 20 per cent of all babies are born with low birthweight (<2,500 grams), which is an indicator of maternal undernutrition (gizi buruk). Again this rate is the third highest among Indonesia's provinces, and much higher than the national level of 11.5 per cent.[57] Low birthweight is associated with a higher risk of mortality, childhood undernutrition and, in particular, stunting.[58] A low birthweight is strongly associated with increased risks of death for children, which goes some way to explaining why child mortality is high in NTT. Research at the global level indicates that infants born at term weighing 1,500-1,999 grams are eight times more likely to die during the neonatal period. Children weighing between 2,000-2,499 grams are three times more likely to die from all causes during the neonatal period than are those weighing more than 2,499 grams at birth[59]. Furthermore, neonatal deaths among low birthweight babies are often related to conditions such as sepsis, pneumonia and diarrhoea.

56 Ministry of Health (2008) *Riskesdas 2007*
57 Ministry of Health (2008) *Riskesdas 2007*
58 BAPPENAS/Ministry of Health (2010) *The landscape analysis: Indonesian country assessment*, National Development Planning Board (BAPPENAS), Indonesia: Jakarta
59 Black, R. E. et al. (2008) 'Maternal and child undernutrition: Global and regional exposures and health consequences', *The Lancet*, Vol.371: 243-260

4.2.3.2 Contributing factors to malnutrition in context

The micronutrient status[60] of the population in NTT shows a high prevalence of anaemia among preschool children - over 40 per cent. The anaemia prevalence among children aged 6-23 months was 77.2 per cent, while the provincial figure was 68.4 per cent.[61] A study by UNICEF in three districts (Kupang municipality, Sumba Tengah and Sumba Barat Daya), found that at least 24 children had died of malnutrition related causes - including gastroenteritis (2), TB (1), diarrhoea (2), upper respiratory tract infection (1), cancer (1), acute respiratory infection (ARI) and pneumonia (1), pneumonia (4), ARI (1), malaria and pneumonia (1) and marasmus (1).[62]

It is evident from Table 4.2.1 that problems of poor nutrition are more prevalent in NTT compared to Indonesia as a whole, with one third of the province having poor nutritional intake. It is particularly problematic in some of the more isolated and rural districts of the province.

Table 4.2.1: Nutritional status, NTT versus Indonesia 2007

Severe and moderate malnutrition	Percentage	Adequate nutrition	Percentage
Indonesia	18.4%	**Indonesia**	77.2%
NTT	33.6%	**NTT**	64.4%
Districts in NTT		**Districts in NTT**	
Rote Ndao	40.8%	Kupang municipality	80.4%
Timor Tengah Selatan	40.2%	Ngada	71.7%
Kupang district (not municipality)	37.9%	Sumba Timur	70.9%
Timor Tengah Utara	37.5%	Lembata	68.7%
Manggarai	37.3%	Manggarai Barat	67.9%

Source: NTT Office of Health, based on the Riskesdas 2007

Findings from *The Landscape Analysis: Indonesia Country Assessment*[63] highlight a shortfall when it comes to coverage of preventative nutritional interventions, which would help to relieve malnutrition. Instead there is a tendency to focus on 'curative' approaches when serious situations arise. According to this report, effective preventative interventions would include promotion of and counselling on breastfeeding and complementary feeding, iron folate, protein and energy supplementation for women, worming treatment for women and children, treatment of diarrhoea with zinc, and improved coverage of food fortification and home food fortification programmes.[64]

However, there is a lack of data on exclusive breastfeeding practices at the provincial level. While data show that there is a high percentage of under-five children who have been breastfed in NTT at one point during their infancy (97.3 per cent, 2007 IDHS data), it is difficult to ascertain whether they were exclusively breastfed for the first six months of their lives, and whether this was followed by appropriate complementary feeding practices. The results of the focus group discussions discussed in Box 4.2.2 below indicate, however, that exclusive breastfeeding for infants up to six months of age is uncommon in both the districts where the study was conducted, and responses were similar at the provincial level.

60 Adequacy of vitamins and minerals in the diet
61 Sample taken by SEAMO and CRS in their studies in Belu and TTU in 2006: see WFP (December 2006) *Food security assessment and phase classification pilot, Indonesia*, WFP in cooperation with FAO, National Food Security Council (Ministry of Agriculture), Badan Koordinasi Nasional (Bakornas), Ministry of Health, SEAMEO, ACF, SMERU and ECHO: Jakarta
62 UNICEF (2008) *Rapid assessment of malnutrition in NTT, Kupang Municipality, Sumba Tengah and Sumba Barat Daya*, Mimeo: Kupang
63 BAPPENAS/Ministry of Health (2010) *The landscape analysis: Indonesian country assessment*
64 Ibid.

In addition, the 2007 Basic Health Research (Riskesdas) data (see annex 4.2) demonstrate that poor families in NTT in the lowest three wealth quintiles are less likely to consume adequately iodised salt (around one quarter do so) compared to those in the wealthiest quintile (nearly half). Overall, only around one third of people in the province consume adequately iodised salt. This is also less likely in rural and isolated districts. Furthermore, 2007 IDHS data reveal that only 37.9 per cent of pregnant women receive at least 90 iron tablets (albeit an improved rate since 2002-2003 when it was just 25.4 per cent).

As described, the prevalence of anaemia in children is high, exclusive breastfeeding rates are likely low, many poor families don't consume adequately iodised salt, and many pregnant women do not take adequate levels of iron supplementation. All of these factors are likely contributing to poor nutrition and health in the province.

An interview with a staff member of the Office of Health in Kupang municipality revealed that they had identified at least 105 children with severely poor nutritional status (nine of whom subsequently died), and 3,808 children had moderately poor nutritional status in the municipality in 2009 (20 October 2009). The main causes, according to the office staff, were poor understanding of the importance of nutrition in the community and low household incomes. This also highlights that knowledge about nutrition and/or cultural consumption patterns are adding to the problem (see further discussion below).

In order to further explore the context and causes of malnutrition in NTT, FGDs with health practitioners, government staff and community members were conducted at the provincial and district levels[65], and the results are summarised in Box 4.2.2 below. The findings confirm the opinion of the staffmember mentioned above and also add further information on the complexities of malnutrition in NTT. The summary indicates that the opinions among participants are that malnutrition problems must be solved with a multi-sectoral approach and that the problem is underpinned by food availability, poverty, and consumption patterns based on both cultural practices and access to food. Further discussion later in this subsection also demonstrates poor knowledge of the importance of nutrition, the importance of access to clean water and sanitation, and institutional policies that are inadequate to overcome – and potentially contributing to - the pervasive malnutrition problem in NTT.

65 Focus group discussions were held at the provincial level in NTT, and in Kupang municipality and Sikka districts. Participants included representatives from BAPPEDA (District Development Planning Agencies), several civil society organisations (CSOs), midwives, nurses, health clinic staff, and staff from the hospital including doctors. CSO staff and BAPPEDA dominated the discussion on putting forward the issues about the causes of malnutrition in NTT. The midwives, nurses, and hospital staff put forward opinons on problems in service provision and the problems they face in providing services to tackle malnutrition. The CSOs tended to be more critical in terms of proposals put forward and offered their opionons, whereas other practitioners only answered questions when asked. CSOs were more likely to be of the opinion that malnutrition was caused by inadequate services and lack of awareness among parents. Midwives and health clinic staff complained of the lack of awareness and knowledge among mothers regarding the nutrition they provide for their children, in addition to factors relating to disease and culture. Planners, such as staff from BAPPEDA and the Office of Health, focused on the problems of geographic access, poverty and lack of funds.

Box 4.2.2: The causes of malnutrition in NTT - FGD results

a. Health cluster FGDs, provincial level (2 September 2009):

- Socio-cultural factors:
  - The concept of illness (children lose their appetite to eat, common flu is not considered illness; children are considered ill when they have to stay in bed)
  - It is forbidden to eat certain foods in some communities, including chicken, meat and eggs even though they are in abundant supply in rural areas. Pregnant women are also prohibited from consuming nuts because of superstitions that this will cause bad luck.
  - Social expenses (obligatory contributions to cultural festivals/rituals/ceremonies/ celebrations) in NTT are high. Chicken and pigs are not enjoyed on a daily basis by children, but are reserved for funeral ceremonies and events to be enjoyed by the entire clan.
  - Saving money is not common in NTT and in place of this, people are more likely to store food in the barns as a form of saving.
- Direct causal factors:
  - Lack of nutritional intake: the eight-month dry season restricts local food production.
  - Imbalanced nutritional intake (consumption patterns shifting to preference for instant foods such as instant noodles).
  - Infectious diseases (upper respiratory tract infection and diarrhoea) and other illnesses are common, which then contribute to poor nutritional intake.
  - Parenting: many children are not raised by their biological mothers but rather friends and other family members who do not give due attention to nutrition.
- Indirect causal factors:
  - Poverty: low household income means that families do not have the purchasing power to buy necessary food supplies.
  - The fertility rate is the highest in Indonesia, creating a heavy burden on families due to the number of household members. Furthermore, a house may be inhabited by more than one family and food must be divided among many people. This impacts heavily on children as they receive insufficient portions and nutrition.

b. Health FGD, Kupang municipality (8 September 2009)

- Malnutrition is caused by parents' low level of nutrition-related knowledge as well as a lack of food supply in the household.
- Inappropriate eating habits, e.g., taking insufficient amounts of food, or not considering the nutritional value of food consumed. Families endeavour to eat to achieve 'fullness', but do not give adequate attention to the nutritional content of the food they eat.
- Poor families with lower education and a large number of children are more likely to be affected.
- Many mothers do not practice exclusive breastfeeding, and often breastfeed for less than six months.
- Families affected by malnutrition can be divided into two groups: those that are economically stable but their children do not have good eating habits, and those that are too poor to provide enough nutrition to their children.

c. Health FGD, Sikka district (25 September 2009)

- Low birthweight
- Lack of nutritional intake
- Caregiver's parenting style that does not give adequate attention to nutrition
- Low economic status
- Infectious diseases (intestinal parasites, TB, malaria) contributing to poor nutrition as children don't eat when they are sick
- Unhealthy eating behaviours on the part of parents
- Lack of attention to personal and environmental sanitation
- Low health-seeking behaviour (not using health services or health insurance)
- Lack of health care equipment, e.g., inappropriate weighing devices to calculate birth- and other weights
- Short breastfeeding period
- Lack of clean water supply

Source: Problem mapping results of Health Cluster FGDs at provincial level and in Kupang municipality and Sikka district

Summarising the malnutrition problem map generated out of these discussions involving a multitude of health practitioners and policy makers, it seemed that participants had good insights into causes of malnutrition in NTT, and viewed the problem from a multi-sectoral perspective. As described in Box 4.2.2, practitioners believe that malnutrition problems are caused by direct and indirect factors. UNICEF's conceptual framework, as outlined in Section 3.1 (see Figure 3.1.1), can be used to organise FGD inputs as follows:

Direct factors at the household level include:

I. Lack of food and lack of nutritional content in available food
II. High incidence of infectious disease and low birthweight

Underlying causes at the household level include:

I. Cultural practices (e.g., excluding certain nutritional foods from diet for ceremonial or superstitious reasons, storing food rather than consuming it)
II. Low awareness and care given to nutrition on the part of parents
III. Poor personal and environmental sanitation
IV. Non-exclusive or short breastfeeding periods

Indirect or underlying factors at the societal level include:

I. Public health service quality and outreach, especially for mothers and children
II. High levels of poverty
III. High fertility rates (i.e., large families)

UNICEF's conceptual framework described in Section 3.1 also indicates that the institutional environment is important in tackling problems in nutrition. This is examined later in the subsection and is likely a third indirect factor that may be, to some extent, preventing significant inroads being made into tackling malnutrition in NTT.

Stuttard (2008)[66] expands on and confirms some of the issues raised above in her report on nutrition in NTT. According to her findings in relation to low nutritional value of foods consumed[67], people's diets in NTT are predominantly based on staple carbohydrate foods such as rice, cassava, corn and banana. Almost 50 per cent of people in her study had eaten no vegetables or fruit in the last 24 hours, and more than 50 per cent had not consumed protein such as fish, meat or eggs, with many believing that protein rich food are not necessary for a healthy diet. School children's liquid intake was low, less than one litre per day, and 39 per cent reported drinking non-boiled water. Regarding breastfeeding, Stuttard finds that while the majority of mothers do breastfeed their babies, most do not do so exclusively and very few are breastfeeding exclusively to six months of age. Babies are fed complementary foods from as early as one month old. Around a third of women do not feed their babies colostrum.

Based on the results of FGDs with children themselves[68], parents and children do not always acknowledge that malnutrition is a major problem for the general population, and participants said that the problem occurred infrequently in their own neighbourhoods. This attitude potentially highlights the greatest barrier to overcoming malnutrition in the region, and most likely underpins the lack of commitment to addressing the problem both at the community and political level. This finding is reinforced by 'The Landscape Analysis' report[69] which finds that the existing commitment to act for nutrition is misdirected at trying to resolve acute nutrition problems, rather than putting into place systems and interventions to prevent children and women becoming malnourished, largely because the need for the latter is not generally recognised. According to this study, the nutrition problem is still largely equated with severe undernutrition and/or lack of food. Parents also highlighted that malnutrition is stigmatised, and that it carried a lot of shame for parents if their children are classed as malnourished. In many cases where a child was classed as malnourished, the parent would dismiss the diagnosis of the health professional and refuse to visit the health centre again for regular monitoring.

In terms of cultural practices relating to nutritional consumption and childbirth, health practitioners, civil society organisation (CSO) workers and midwives who participated in the FGDs also highlighted in more detail a number of issues that may be preventing improvements in nutrition in NTT, which require concerted efforts to build knowledge and education for behaviour change. Many highlighted the importance of including traditional and religious leaders in this process as they have influence over local communities. Some of the constraints highlighted included:

- Despite wide availability, consumption of some nutritious foods is prohibited by local customs in some villages, e.g., chickens, eggs and fish
- It is a local tradition for women to eat only porridge after birth in some places
- Women are considered unattractive if they put on weight, therefore they are discouraged from eating much food
- Decisions about medicines, treatment and birth are still dominated by men
- Women dispose of colostrum in some places as it is considered dirty
- Busy working women are more likely to give sugared water or sweet tea to babies instead of breastfeeding
- It is frequent practice to give rice to children without vegetables, especially when parents have limited cooking skills or understanding about food

66 Stuttard, J. (2008) *Nutrition assessment report, NTT Province, TTS District*
67 Based on the analysis of the 24-hour dietary intake of almost 150 primary school children and women of reproductive age
68 Focus group discussion with seven children, Kupang (9 September 2009)
69 BAPPENAS/Ministry of Health (2010) *The landscape analysis: Indonesian country assessment*

- Older siblings tend to care for the young while their parents work, and they lack knowledge of how to prepare food and the importance of nutrition

Children themselves understood that it is the rural poor populations that suffer most, especially during a drought, which confirms the findings in this report. One participant, 'Mawar' talked about her experience living in Rote during dry season when food was not only less available, but also lower in nutritional value - typically rice with sweet water.[70] Another key group affected by malnutrition that the children talked about were children living on the streets. A participant told the story of 'Kocar' (not his real name), a 14-year-old male child labourer who lives on the street and works as a transport driver's assistant, having left primary school in Year 4. Children living on the streets are considered to be the 'scum of society' and are afraid of authority figures, such as the police, who intimidate them rather than offer support.

"Kocar uses the little money he earns to purchase cigarettes and alcohol and rent a 'PlayStation', which he considers to be basic needs. He sometimes only eats twice a day and if he wants to eat something special, he will not hesitate to steal it or beg for it. He has six brothers and sisters and they are classed as a poor family." (Interview, 18 September 2009)

Children were aware of programmes that have been put into place to alleviate malnutrition, such as provision of food to families with malnourished children, provided either via midwives or the community health service. They also talked about other poverty and hunger relief programmes such as Direct Cash Transfers (BLT, Bantuan Langsung Tunai) and Rice for the Poor (Raskin, Beras Miskin), which some considered to be very important. The children also talked about problem areas where relief programmes were lacking, such as efforts to change parents' attitudes and understanding of malnutrition, as well as negative attitudes towards children living on the streets.

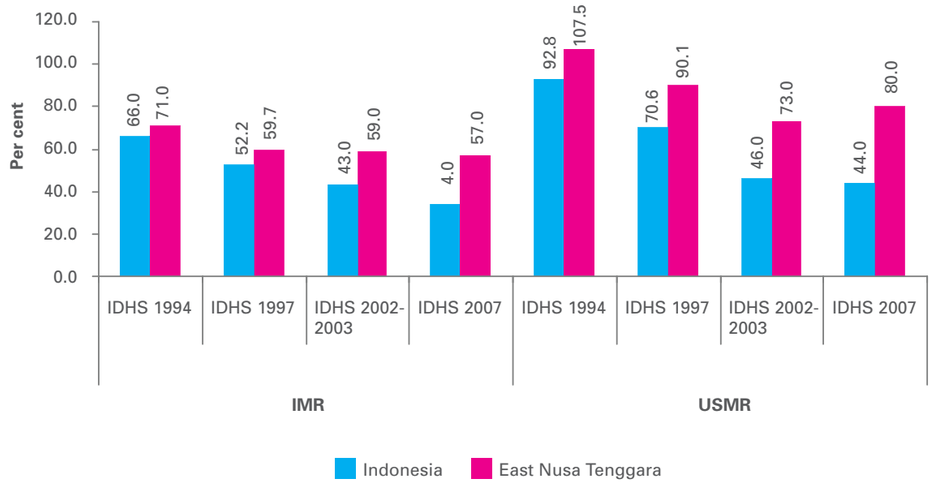
4.2.3.3 Mortality

Undernutrition is associated with 60 per cent of deaths among children under five years of age.[71] So it is not surprising that, as shown in Figure 4.2.9 below, child mortality is a serious problem in NTT and has received attention from various stakeholders. The latest infant mortality rate (IMR) for NTT is 57 per 1,000 live births, compared to 34 in Indonesia overall. Not only has the IMR remained well above the national average between 1994-2007, but the figure has not reduced significantly since 2003, indicating that the efforts to alleviate IMR in this province have not yielded satisfactory results, which has driven the creation of new policies on malnutrition, as discussed further later in this subsection. Much stronger efforts will have to be made to reach the MDG for IMR, which is set at 19 per 1,000 live births by the year 2015. There are three main factors that contribute to infant mortality, according to data from the Provincial Office of Health (2010). These are asphyxia (311), low birthweight (230) and infections (61), followed by a variety of other factors.[72]

In addition, the under-five mortality rate (U5MR) in this province is also significantly higher than the national figure and, more worryingly, has been increasing over time, from 73 per 1,000 live births in 2002/2003 to 80 in 2007. Over the same period, the national figure has been decreasing. This indicator is still a long way from the MDG target of 32 per 1,000 live births by 2015.

70 Sweet water is derived from palmyra trees, especially the fruit
71 Pelletier, D. L., Frongillo, E. A. Jr., Habicht, J.-P. (1993) 'Epidemiologic evidence for a potentiating effect of malnutrition on child mortality', *American Journal of Public Health*, Vol.83: 1130-1133
72 NTT Provincial Office of Health (May 2010) *Infant mortality data, 2009*, NTT Provincial Office of Health: Kupang

Figure 4.2.9: Trends in IMR and U5MR, NTT versus Indonesia, 1994-2007



Source: IDHS 2007

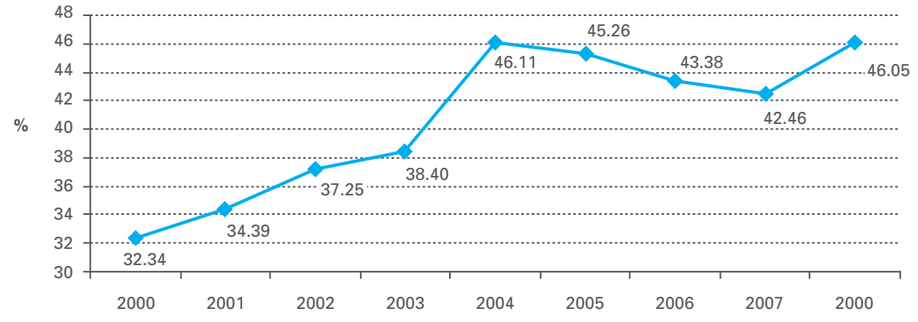
According to Provincial Office of Health data from 2009, 1,377 babies were stillborn, neonatal deaths (0-6 days) accounted for a further 794 deaths, and babies who died between 7-28 days (post-neonatal deaths) constituted 184 cases that year.[73] The worst affected districts for stillbirths were Timor Tengah Selatan, Timor Tengah Utara, Manggarai Timur, Manggarai, Manggarai Barat, Sumba Barat Daya and Flores Timur.[74] There may also be problems of underreporting for stillbirths given that many births take place at home (see further discussion below).

The maternal mortality rate (MMR) is also an issue in NTT, however the trend has been moving in a positive direction between 2004-2007. Based on NTT Office of Health reported figures, the MMR for 2007 was 306 per 100,000 live births, down from 554 in 2004.[75] Although there is still some way to go, if decreases continue along these lines, NTT could reach the maternal mortality MDG of 110 per 100,000 live births by 2015. In the meantime, the government of NTT is aiming for its own target of a decrease in MMR to 150 by 2013.[76] According to data from the NTT Provincial Office of Health, the main direct causes of maternal mortality in 2009 were haemorrhage, infections during pregnancy and infections during birth.[77]

The ability to provide skilled assistance by health personnel during delivery plays a significant role in reducing infant and maternal mortality rates and the elevated MMR and IMR in NTT is associated with low access to skilled delivery assistance (see Figure 4.2.10). This is also discussed in Section 3 of this report in the subsection on assisted births, which outlines the GoI's Making Pregnancy Safer programme that is largely focused on increasing the number of assisted births. Following some good gains in the first half of the decade, the figures from 2004-2008 did not show any significant increase. The 2008 National Socio-Economic Survey data (in line with 2007 IDHS data from the previous year) showed that only 46 per cent of all deliveries were attended by skilled health personnel, and NTT ranks thirtieth out of Indonesia's 33 provinces in this regard. While rates of births assisted by skilled personnel are growing in NTT (see annex 4.2), this is still far below the national average. National Socio-Economic Survey data revealed that in rural areas in 2008, the rate of assisted births by skilled personnel was 40.6 per cent, compared with 76.6 per cent in urban areas of NTT, a wide disparity that indicates the need for a focus on this problem in the rural corners of the province.

73 Ibid.
74 Ibid.
75 NTT Provincial Office of Health (2008) *Health conditions in NTT 2008*, NTT Provincial Office of Health: Kupang
76 NTT Provincial Government (2008) *NTT Medium-Term Development Plan*, NTT Provincial Government: Kupang
77 NTT Provincial Office of Health (May 2010) *Maternal mortality data, 2009*, NTT Provincial Office of Health: Kupang

Figure 4.2.10: Percentage of births attended by trained heath personnel, NTT 2000-2008



Source: BPS - Statistics Indonesia, Statistical Yearbook 2009, based on the National Socio-Economic Survey 2008

The ability to provide skilled assistance by health personnel during delivery plays a significant role in reducing infant and maternal mortality rates and the elevated MMR and IMR in NTT is associated with low access to skilled delivery assistance (see Figure 4.2.10 above). This is also discussed in Section 3 of this report in the subsection on assisted births, which outlines the GoI's Making Pregnancy Safer programme that is largely focused on increasing the number of assisted births. Following some good gains in the first half of the decade, the figures from 2004-2008 did not show any significant increase. The 2008 National Socio-Economic Survey data (in line with 2007 IDHS data from the previous year) showed that only 46 per cent of all deliveries were attended by skilled health personnel, and NTT ranks thirtieth out of Indonesia's 33 provinces in this regard. While rates of births assisted by skilled personnel are growing in NTT (see annex 4.2), this is still far below the national average. National Socio-Economic Survey data revealed that in rural areas in 2008, the rate of assisted births by skilled personnel was 40.6 per cent, compared with 76.6 per cent in urban areas of NTT, a wide disparity that indicates the need for a focus on this problem in the rural corners of the province.

Section 3 discussed the importance of births taking place in institutions such as hospitals and clinics, especially to assist with complicated deliveries. In contrast to national figures, far more people in NTT give birth at home (77.5 per cent compared with 52.7 per cent at the national level) and only 16.1 per cent give birth in a public health facility according to 2007 IDHS data. There have only been marginal improvements since the 2002-2003 IDHS was implemented. Many poor patients who live far from health facilities choose traditional healers instead of doctors to address health issues according to data from the 2007 Basic Health Research (Riskesdas), especially for deliveries. This together with the lower rates of skilled birth attendance may go some way to explaining the stubbornly high IMR in the province. High rates of child marriage (under age 18 years) in the province, at 19.8 per cent of children, according to 2008 National Socio-Economic Survey data, may also be related to mortality rates if girls are becoming mothers when they are very young, underdeveloped or suffering from poor nutrition, all of which can make delivery more risky.

While each district in NTT has a general hospital and there are also a few private and army hospitals, in 2003 there was a total of only 1,994 beds for over 4 million people, or around 1 bed per 2,000 population (BPS – Statistics Indonesia, NTT, 2004), which is a long way from the ideal ratio of 1:500. In 2008, there were 33 general hospitals and 2 specialist hospitals, 284 puskesmas (usually found at the sub-district level), 938 puskesmas pembantu (pustu) and 304 mobile units. Most puskesmas had an attending doctor, albeit not always full-time. During the field research for this report it was evident that in rural areas pustu were often short of drugs and understaffed. Finally, there were 8,304 integrated health posts (posyandu), catering especially for nursing mothers and children, sometimes numbering several per village.[78] These are run by trained volunteers and, according to a study by Barlow and Ria[79], have proved a most effective provider of services. It is admitted, however, that these health facilities have not reached some areas of NTT and that some posyandu are not considered helpful in improving maternal and child health.[80] To address this, an initiative termed 'Revolusi KIA' (maternal and child health revolution) has been launched by the Health Office (Dinas Kesehatan) to reduce MMR and IMR by revitalizing posyandu. The initiative is discussed later in this subsection.

In 2007, the number of health personnel working at various health facilities[81] was 9,133, comprising 772 doctors, 6,675 nurses and midwives, and 1,860 other health professionals.[82,83] This is equivalent to a ratio of 205 health professionals per 100,000 population, and represents a 65 per cent increase from 2005-2006 and a 33 per cent increase from 2006-2007. This figure is still some way from the target of 158 per 100,000. The landscape of NTT and lack of funding are major factors in the province's lacking of medical facilities, and access is particularly problematic for island areas such as Pulau Pura, Ende, Raijaua, Palue and Ndao.[84]

To deal with this issue, one of the goals highlighted in the 2009-2013 Regional Medium-Term Development Plan (RPJMD, Rencana Pembangunan Jangka Menengah Daerah) for the health sector is to develop a health care system for the poor. This has been in place in Kupang municipality since 2008 based on the Mayoral Regulation on Free-of-Charge Health Services in puskesmas and their networks for poor and underprivileged people[85]. To implement this regulation, the mayor of Kupang followed it with a Mayoral Decree.[86] In practice, however, the procedure to get health insurance for the poor is quite complicated and poor people are thus reluctant to access public health services.

This is an even more pervasive problem in rural areas and in areas with large numbers of Internally Displaced People (IDPs). In the case of Belu District and other areas such as Timor Tengah Utara and Kupang, where there are large numbers of IDPs who fled the conflict in what was once East Timor (now Timor-Leste), there is even greater pressure on health resources. As many as 200,000 people fled to West Timor in the province of NTT, living in camps and army barracks.[87] Between 1999-2003, NTT was classed as being in an emergency phase by the GoI and UNHCR. When Timor-Leste became independent, many IDPs remained in Indonesia.

78 NTT Provincial Office of Health (2008), *Health conditions in NTT 2008*
79 Barlow, C. and Gondowarsiot, R. (2007) *Economic development and poverty alleviation in Nusa Tenggara Timur*
80 NTT Provincial Office of Health (2008), *Health conditions in NTT 2008*
81 *Puskesmas*, hospitals, and health personnel at district and provincial levels
82 Pharmacists, nutritionists, medical technicians, community health-care workers.
83 NTT Provincial Office of Health (2008), *Health conditions in NTT 2008*
84 Interview with staff of the NTT Child Protection Commission (21 November 2009)
85 Mayoral Regulation No. 11/2008 on Free Health Services in Puskesmas and Corresponding Network for Poor People at Kupang Municipality
86 No. 78/KEP/HK/2008 on Determining Health Insurance Beneficiaries in Kupang Municipality 2008, and Mayor Decree No. 104.A/KEP/HK/2008 on Determining Free Health Service Beneficiaries for the Poor and Non Jamkesmas (Health Insurance) Beneficiaries in Kupang city
87 Djami, M., Filiana Tahu, M. and Sesilia (2007) *Perempuan pengungsi masih terlupakan. Laporan bersama kondisi pemenuhan HAM perempuan pengungsi Aceh, Nias, Yogyakarta, Porong, NTT, Maluku dan Poso, Komnas Perempuan: Jakarta*

However, this has caused tensions between host and IDP communities.[88] Homes have been burnt down or damaged, and there are violent clashes between IDPs and host communities which have continued beyond the emergency phase.[89] These conflicts are underpinned by disputes over access to resources and employment, as well as the occupation of communal lands and/or indigenous land by the IDPs.[90] The situation is further complicated by individual land conflicts (such as cases where IDPs have been unable to make all payments for land purchases), and disputes over land rights, particularly in Belu district.[91] Resettlement and livelihood assistance for IDPs has also generated tensions in host communities who are less likely to receive such assistance, even though poverty levels are high in Belu[92], as one respondent stated:

> "So, local residents can just watch; wherever there are IDPs, assistance comes. Clean water is provided, toilets, plates, all kinds of things for the kitchen. It continues to be provided by all variety of NGOs. So local residents watch this unfold and it stimulates jealousy, as we don't have toilets, for example. Why is it not given to us?" (Local resident, Belu district, 17 August 2010)

However, one of the great difficulties that IDPs face is organising appropriate letters and documentation of 'poor status' in order to access free or cheap health care. If IDPs are assisted by CSOs and non-government organisations (NGOs) they may succeed in organising the appropriate documentation, but are less likely to be able to do this alone.[93] Staff from the Center for Internally Displaced People argue that the main problem is the 'extra fees' charged by neighbourhood heads and village staff for this documentation, which should be provided for free. This is further complicated by complex and long administrative processes.[94] Maternal and child mortality rates tend to be higher in IDP camps due to these difficulties and other problems, such as domestic violence.[95]

Following advocacy by residents and CSOs to the government, settlements outside the camps have begun to be built by the GoI, funded by CIS, Oxfam and the GoI. However, the contract was given to the Indonesian military armed forces to build the settlements at a cost of IDR 14 million (approximately US$1,500) per home, and problems have emerged relating to the quality of the houses provided.[96] Local CSOs have endeavoured together with Oxfam and the European Union to build further shelters, involving the community directly in this process, using local materials and involving women in the design of these homes, with the cost allocated at around IDR 6 million (approximately US$650).[97] CSOs such as CIS have also begun programmes (2008-2011) to assist with improving relations between IDP and host communities, particularly in villages where conflicts have broken out.[98] They work with women as an entry point to begin the peace-building process through livelihoods programmes and creating farmers' groups, and joint projects to build pipe systems for access to clean water, amongst others.[99] Yet the challenge for providing adequate access to health facilities and free (or cheap) services remains given the administrative problems outlined above.

88 Interview with staff from the Center for Internally Displaced Persons, Kupang Municipality (17 August 2010)
89 Djami, M., Filiana Tahu, M. and Sesilia (2007) *Perempuan pengungsi masih terlupakan*
90 Sunarto et al. (2005) *Overcoming violent conflict: Volume 2, Peace and Development Analysis in Nusa Tenggara Timur*, CPRU-UNDP, LabSosio and BAPPENAS. See also: CIS Staff, Kupang Municipality (17 August 2010)
91 Interview with staff from the Center for Internally Displaced People, Kupang Municipality (17 August 2010)
92 Ibid.
93 Ibid.
94 Ibid.
95 Ibid.
96 Ibid.
97 Ibid.
98 Ibid.
99 Ibid.

4.2.3.4 Diseases and ill health

Good levels of nutrition can help to prevent the spread of common diseases and improve resilience to other illnesses such as diarrhoea, thus reducing the risk of child and infant death. Undernutrition during pregnancy and childhood contributes to the disease burden (and reduced resilience against disease) and to more than one third of child mortality globally.[100] This section explores prevalence of certain common diseases and illnesses in NTT, as well as the quality and reach of some of the preventative measures that exist to combat them. See annex 4.2 for further data and the trends discussed below.

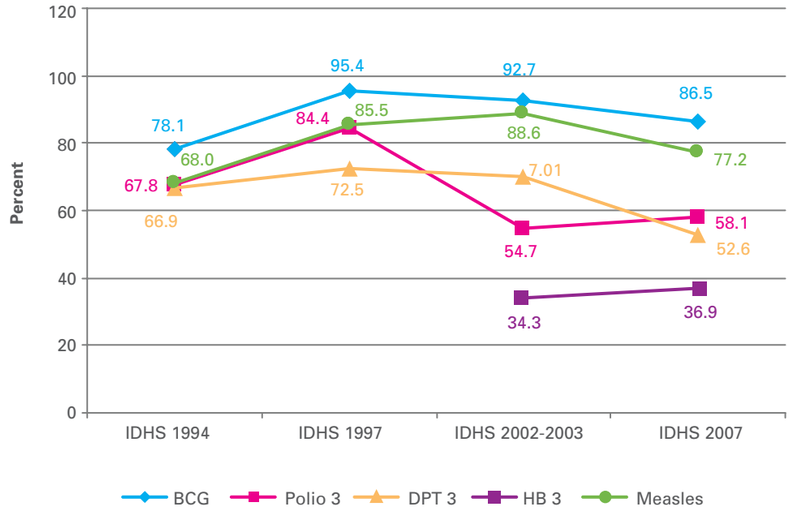
Malaria is endemic in eastern Indonesia and common in NTT. Despite mosquito net distribution drives[101], for families with children and pregnant women, cases have fluctuated between 2004-2008, spiking in 2004 (624,278 cases) and hitting their lowest point in 2005 (70,390 cases). Since then, the incidence of the disease has remained fairly constant[102], indicating that mosquito nets distribution needs to be widened, or community education programmes on effective use of the nets may be necessary, if the initiative is to have a positive effect on reducing rates of malaria. Data from the 2007 IDHS[103] revealed that only 6.7 per cent of children in NTT were protected by insecticide treated mosquito nets.

Child illness is one of the immediate determinants of nutritional status in Indonesia, and diarrhoea and acute respiratory infection (ARI) are the main causes of death for infants and children under five.[104] Prevalence of these illnesses is also high in NTT. It is estimated that 15 per cent and 17 per cent of children in NTT had diarrhoea and ARI, respectively, in the two weeks preceding the 2007 IDHS survey (compared to 11 per cent and 14 per cent at the national level). Yet, only 62 per cent received treatment or advice from a health facility or provider for ARI, and 51 per cent for diarrhoea.[105] However, on a positive note, parents are knowledgeable on basic treatment of diarrhoea when it does arise, with 83 per cent of sufferers having been given some form of oral rehydration, which is substantially higher than the national level of just 61 per cent.[106]

According to district level health information for NTT (see annex 4.2), 84 per cent of villages had achieved universal child immunisation by 2007, having increasing steadily from 77 per cent in 2004. On this basis, NTT would be considered to have reached the WHO/UNICEF Global Immunization Vision and Strategy (GIVS), which set a target for countries to reach at least 90 per cent national vaccination coverage and at least 80 per cent vaccination coverage in every district or equivalent administrative unit.[107] However, the 2007 IDHS data tell a different and more complex story, with only two immunisations reaching above or near to this level of coverage for children aged under two in NTT: HB3[108] (87 per cent) and measles (77 per cent). Progress in immunisation coverage at the end of the 1990s has reversed in the last decade and is down between 9-26 percentage points in 2008 compared to 1997 (polio down 26 per cent, DPT3[109] down 20 per cent, measles down 9 per cent, BCG down 8 per cent).

100 Countdown to 2015 Core Group. (2008) 'Countdown to 2015 for maternal, newborn, and child survival: The 2008 report on tracking coverage of interventions', *The Lancet*, Vol.371: 1247-1257
101 UNDG (2010) MDG good practices: *MDG-4, MDG-5, MDG-6, child mortality, maternal health and combating diseases*, available at: http://www.undg-policynet.org/ext/MDG-Good-Practices/GP_chapter3_mortality.pdf (Last accessed 20 November 2010)
102 Ministry of Health (2008) Indonesia health profile 2004-2008, Ministry of Health: Jakarta; Centre for Health Data, Ministry of Health (2009) *Indonesia health profile 2006-2009*, Ministry of Health: Jakarta
103 BPS - Statistics Indonesia and Macro International (2008) *IDHS 2007*
104 Ibid.
105 Ibid.
106 Ibid.
107 WHO/UNICEF (n.d.) *Global Immunization vision and strategy*, available at: http://www.who.int/immunization/givs/en/index.html (Last accessed 11 October 2010)
108 Hepatitis B
109 Diphtheria

Figure 4.2.11: Percentage of children under age two who were immunised, NTT 1994-2007

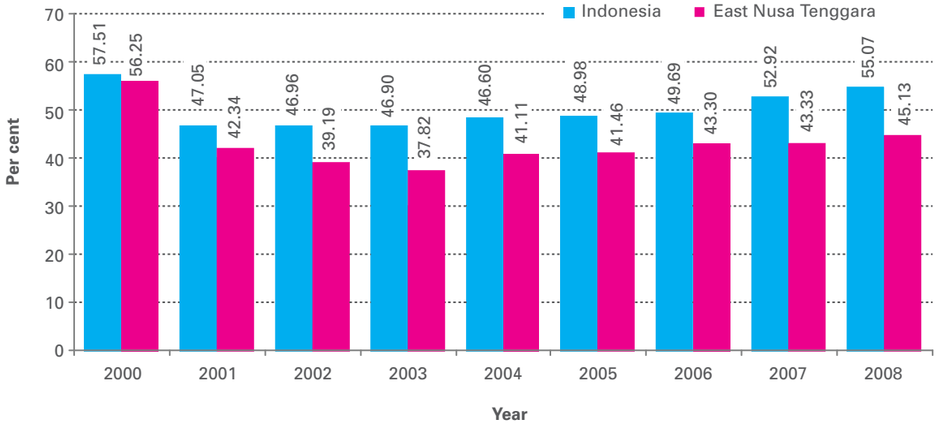


Source: IDHS 2007

4.2.3.5 Water and sanitation

The discussion above outlined the problem of malnutrition and access to health services in NTT. Those problems are further complicated by poor access to clean water and adequate sanitation, which contributes to illness and undernutrition as discussed in Section 3 of this report, and has also influenced the participation of children in schools.[110] Education officials have highlighted that in almost all rural districts, such as Sikka district, students are more frequently sick due to the inter-related problems of malnutrition, ill health, and poor access to clean water and adequate sanitation, and thus school attendance is lower.[111]

Figure 4.2.12: Trends in access to clean water, NTT versus Total Indonesia 2000-2008

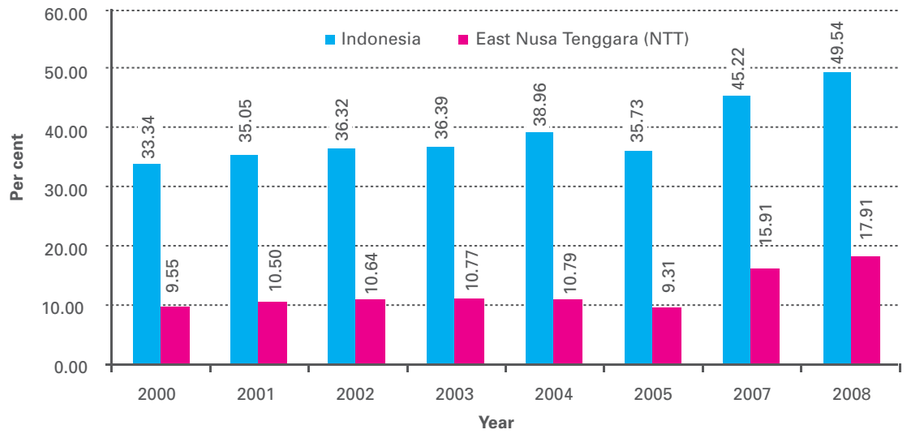


Source: BPS - Statistics Indonesia, Statistical Yearbook 2009 (based on the National Socio-Economic Survey 2008)

110 Interview with the Head of the Kindergarten and Basic Education Section, Office of Education, Sikka District, NTT (21 September 2009)
111 Ibid.

In general, the climate in NTT is semi-arid with dry periods of up to eight or nine months per year. Such long dry periods mean a lack of accessible water springs. Not surprisingly, in a province characterised by rugged terrains, dry temperatures and poor infrastructure, access to clean water and basic sanitation is low compared to national averages (see Figure 4.2.12, based on National Socio-Economic Survey data). At the provincial level in 2008, NTT was 10 percentage points below the national average (45.13 per cent NTT versus 55.07 per cent Indonesia). Moreover, the gap worsened at the beginning of the decade and has only marginally improved since. There is also a huge difference between rural and urban figures, such that in urban areas access to clean water is more than double that in rural areas (80 per cent of the population have access compared to 38 per cent in rural areas; see annex 4.2). Disaggregated district level data (see annex 4.2) show stark disparities between the best and worst affected areas - in Kupang municipality 78 per cent of residents have access to clean water, but in Sumba Tengah and Sumba Barat Daya the rates are only 9 per cent and 5 per cent, respectively.

Figure 4.2.13: Trends in the proportion of households with sustainable access to adequate sanitation (ventilated pit latrine and septic tank), NTT, 2000-2008



Source: BPS - Statistics Indonesia, Statistical Yearbook 2009, based on the National Socio-Economic Survey 2008

Despite considerable improvement in the latter part of the decade, access to sanitation in NTT is substantially below the national average (18 per cent NTT versus 50 per cent Indonesia; see Figure 4.2.13 above). The rural/urban disparity in access to sanitation is even greater than for access to clean water, with the urban population almost four times as likely to have adequate sanitation compared to the rural population (47.58 per cent urban compared with 11.47 per cent in rural areas) (see annex 4.2). Integral to this problem is the issue of lifestyle practices common in rural areas, including the practice of building houses without bathing-washing-toilet facilities and combining living areas with cattle stalls. Furthermore, the 2007 Indonesia MDGs progress report highlights the problem of poor awareness and knowledge about the relationship between unclean water and poor sanitation, and illness.[112]

Barbiche and Geraets (2007)[113] have listed some of the major issues in relation to water and sanitation in NTT based on their study, which focuses on the districts of Timor Tengah Selatan and Alor. Along with the climate and geography, they found that most of the water access indicators are below standard. Wells (often unlined) and water points attached to springs are the most common water sources. Water points are very sensitive to the change of seasons, easily becoming dry in summer, and dirty in the rainy season. In Timor Tengah Selatan, water sources are located on average 710 metres from houses, taking an average of one hour for a round trip to collect water. The average quantity of water consumed per person per day for hygiene and drinking is 14 litres. As discussed in Section 3 of this report, such a low quantity of water consumption can be directly linked to the incidence of water-related diseases, and can represent an underlying cause of infant malnutrition.

Clean water and sanitation are a fundamental problem in NTT and a major contributing factor to the malnutrition and ill health of children and women in particular, as well as the poor more generally in the province. Climate and lifestyles practices in NTT have contributed to this issue. Meanwhile, the local government has not been able to cope with these problems.[114] According to the 2007 MDGs report, this is now one of the top priorities for the GoI[115]. Related to this, the government has incorporated 'Clean and Healthy Living Patterns' into its National Medium-Term Development Plan (Rencana Pembangunan Jangka Menengah Nasional, RPJMN 2009-2014) strategic goals on improving public health. The attainment of this goal will be measured by the 'healthy house' indicators, with a target of 47.26 per cent by the year 2013.[116]

4.2.4 POLICIES AND PROGRAMMES TO ALLEVIATE MALNUTRITION AND ILL HEALTH

Compared to more developed areas of Indonesia, NTT is still highly dependent on the central government for budget and resources and thus the provincial government still plays an important role in formulating overall development policies and, to some extent, in transmitting initiatives from Jakarta, despite the implementation of decentralisation and greater autonomy for districts and municipalities.

The limited authority of the provincial government under decentralisation has had a fundamental impact on development programme implementation in NTT. While the province relies to a large extent on the central government for budget injections and special programmes for disadvantaged areas, decentralisation has changed the way planning and coordination is carried out, as districts can now act independently of the higher levels of government. One implication of this is that at the district level, the elected district heads and mayors (bupati/walikota) have greater influence over government strategies and policy direction, although budget approval is also the responsibility of the district parliaments (DPRD) that can also produce local level legislation. In NTT, the district heads are, in general, members of the same parties that dominate most of the district parliaments. Thus, executive-parliament coalitions are quite strong in NTT, which provides some level of synergy between the different arms of government at the local level. However, the extent to which districts and municipalities coordinate with the provincial government varies across the province.

This subsection next examines three areas of policy development in NTT relating to efforts to reduce child and maternal mortality rates, improve food security, and to tackle malnutrition.

112 BAPPENAS and UNDP (2008) *Laporan pencapaian Millennium Development Goals, Indonesia 2007*, UNDP/BAPPENAS: Jakarta
113 Barbiche, J. C. and Geraets, C. (2007) *Water and sanitation and food security assessment NTT- Dec-2006/Jan 2007*. A report for Action Contre le Faim, available at: http://www.ntt-academia.org/AcF-NTT-Report-v32.34581808.pdf (Last accessed 10 November 2010)
114 Evaluation on indicators of achievment of the RPJMD 2009-2013 presented by the NTT Governor at the Head of Sectoral Office meeting (16 July 2010)
115 BAPPENAS and UNDP (2008) *Laporan pencapaian Millenium Development Goals, Indonesia 2007*
116 Ibid.

4.2.4.1 Strategies and policy innovations: The Maternal and Child Health (KIA) Revolution

In the NTT Medium-Term Development Plan (2008-2013), improving health is the number two priority, which relates to improving child and maternal health.[117] Furthermore, improving the quality of life and the role of women, as well as the welfare of children and the participation of youth is priority number seven.[118] The NTT government aims to reduce the annual number of cases of infant mortality in the province to 593 and maternal mortality to 150 by 2013.[119] The Head of the Community Health Section of the NTT Office of Health argues that these goals were set based on the fact that few inroads were made into the reduction of mortality rates in the preceding years (18 August 2010). He also argued that many of the problems relate to low access to skilled birth attendants, in line with the findings of this report.

One of the ways by which the NTT provincial government aims to tackle the problem of child and maternal mortality rates, and improvements in the health system more generally in the province, is through the Maternal and Child Health (KIA) Revolution policy, which was enacted through NTT Governor's Regulation No. 42/2009. The targets of the policy include ensuring that women give birth in facilities with adequate human resources, equipment, infrastructure, medicine and an adequate budget to support this. The regulation also states that speeding up access to such facilities for mothers during labour and in the prenatal and postnatal periods is essential. This is especially important given that many births take place in the home in NTT, assisted by traditional birth attendants with inadequate training, rather than by skilled birth attendants such as midwives or doctors. In other cases, births take place at health facilities with inadequate resources and equipment, and only when there are complications during birth are patients sent to hospitals. The time lost during this process of transferring patients during emergencies to better equipped health facilities in the islands of this province has meant that maternal deaths are more frequent.[120]

The Head of the Community Health Section of the NTT Office of Health explained that key to achieving the goals of the KIA Revolution is behavioural change in the community, particularly in terms of local customs of giving birth at home with traditional birth attendants.[121]

The Head of the NTT Office of Health highlighted that the indicators of success of the strategy include adequate coverage of health facilities, the creation of appropriate District Head and Mayoral Regulations in all districts and municipalities to increase in the number of pregnant women giving birth in health facilities rather than at home to 80 per cent by 2013, and ultimately reductions in infant and maternal mortality rates, as outlined above, to levels at least equivalent to the national rates.[122] Funds for the strategy are drawn from deconcentration and general allocation funds at the provincial level, as well as supporting funds from AusAID (Australian Agency for International Development), UNICEF and the AIPMNH (Australia Indonesia Partnership for Maternal and Neonatal Health).[123]

117 NTT Provincial Government (2008) *NTT Medium-Term Development Plan (RPJMD NTT)*, NTT Provincial Government: Kupang
118 Ibid.
119 Ibid.
120 Interview with the Head of the Community Health Section of the NTT Office of Health, Kupang, NTT (18 August 2010)
121 Ibid.
122 Interview with the Head of the NTT Office of Health, Kupang, NTT (13 August 2010)
123 Interview with the Head of the Community Health Section of the NTT Office of Health, Kupang, NTT (18 August 2010)

Through the KIA Revolution policy, the NTT provincial government aims to[124]:

1. Assist district and municipal government with KIA planning processes, beginning in 2009.
2. Provide integrated services management training appropriate for treating children aged under five (although this is yet to be implemented).
3. Open a special education and training programme in midwifery to increase the number of trained midwives.
4. Promote knowledge and behavioural change through radio, newspapers and leaflets (angkutas), and the release of songs and CDs on the KIA Revolution (to be played through all forms of public media including on public transport) in both Indonesian and local languages. Furthermore, the government is releasing books on the KIA Revolution and working with journalists to provide adequate information.
5. Develop prototypes of puskesmas with adequate staff and facilities.
6. Develop hospital facilities that are in line with national standards through cooperating with hospitals outside the province that reach this standard (this is underway in several districts).
7. Host socialisation meetings on the technical aspects of the strategy with district government agencies to ensure that the necessary district and municipal regulations are enacted and that they support the strategy.
8. Increase the number of trained specialists, as follows:
   a. Short-term: Increase the number of trained doctors, dentists, midwives and nurses through requests to the central government, other regions and contractors to send trained staff to NTT, as well as requests for individuals to voluntarily relocate.
   b. Medium-term: Request that the central government place specialist doctors in NTT and increase the number of specialist doctors trained locally, including provision of scholarships for people from NTT to study medicine. Also, develop a number of specialist and general training programmes, certification and university programmes for midwives and other health staff in NTT.
   c. Long-term: The NTT government wants to develop the Kupang hospital as an educational facility for general and specialist doctors, to strengthen the recently opened Faculty of Medicine at the University in Kupang, and to have a specialisation in midwifery at existing educational facilities, as well as to open new educational facilities.

4.2.4.2 Challenges to improving mortality rates under the KIA Revolution

Interviews with health practitioners and government staff identified a number of challenges for the KIA Revolution strategy. The greatest challenge to the initiative is the limited human resources, facilities and infrastructure in remote districts. For example, according to the director of the Hospital in Ndao District (20 November 2009), there is not a single doctor trained in obstetrics, and more assistance is needed to actually implement the KIA Revolution, through the provision of infrastructure, trained staff and facilities, although the problem of adequate medicines has already been addressed. He further highlights that incentives of up to IDR 10 million (approximately US$1,100) have already been offered but as yet this offer has not been taken up by trained doctors, indicating that attracting skilled specialists to the province is one of the greatest challenges of the policy. To combat this in the interim, the hospital in Ndao has sent doctors and midwives to specialise and train in the skills they need. However, this is not addressing the short-term goals of the government.

124 Based on interviews with different staff at the NTT Office of Health, Kupang (18 August 2010)

Furthermore, the KIA Revolution policy was made at the provincial level, and requires commitment in the form of strategies, work-plans, and budgets at the district/municipal level. Without such voluntary commitment on the part of districts/municipalities, no matter how well formed provincial level policies are, they may not be implemented at the district level or have any impact on women and children. For example, one respondent from the NTT Office of Health illustrated the tensions between district/municipal governments and provincial level government: "The provincial government does not own the territory; the territory belongs to respective districts/municipalities and many programmes created by provincial government are not adopted by district/municipal governments. For example, the Governor's Regulation on the KIA Revolution. The programme has been implemented at provincial level, but although information has been disseminated at the district/municipal level it does not necessarily mean that they will implement it under regional autonomy. In the past, people were afraid of the provincial offices, but this is no longer the case and the programme has only been adopted in four districts." (19 September 2010)

Wherever there is commitment between district and provincial level leaders, such as the district heads and the governors, there are synergies between policies and cost-sharing of initiatives, which is often the case in NTT when such leaders are from the same party.

Practitioners who participated in FGDs also outlined a number of concerns with implementing the KIA Revolution strategy (19 September 2009). First, they were concerned about the impact of the strategy on health practitioners such as midwives and doctors who are busy providing health services and have minimal time for information dissemination. Second, participants highlighted that in many villages, traditional birth attendants demand financial incentives to bring pregnant women to midwives and health facilities. Third, they argued that implementing such policies require village regulations or other incentives to encourage women to use health facilities for births.

4.2.4.3 Strategies and innovations to improve food security and nutrition

In order to combat the problem of malnutrition and food security, the central GoI has made establishing domestic food security, basic food self-reliance (not relying on imports) and improving the general quality of nutrition a priority in the RPJMN 2010-2014. Food Security Boards have been established at the central and local levels. In NTT in 2000, the Regional Department of Agriculture was transformed into the Food Security and Community Counselling Board[125] (Bimas, Bimbingan Masyarakat). In 2005 the Ministry of Agriculture released Law No. 7/2005 on Food Security, which stipulated that the tasks and information functions of agriculture, forestry and fisheries must be separate, and that a coordinating mechanism should be introduced in the provinces. However, given limited resources, the information dissemination function was added to that of the Food Security Board, which was again transformed to become the Food Security and Information Board (BKPP, Badan Ketahanan Pangan dan Penyuluhan).[126] The NTT Board is responsible for food security at the household level in terms of the type, amount, safety and nutritional content.[127] It is also responsible for detecting basic food shortages, improving the amount and quality of food consumed by the populace, monitoring the availability of food, and disseminating information on agriculture, forestry and fisheries.[128] However, in practice it tends to focus information activities on agriculture and carries out a coordinating function for agriculture, forestry and fisheries at the district level.[129] Supporting budgets are used for operational costs, to fund the Food and Nutrition Vigilance Team (TKPG, Tim Kecukupan Pangan dan Gizi), and to support the Food and Nutrition Vigilance System (SKPG, Sistim Kewaspadaan Pangan dan Gizi).[130]

a) Strategies and innovations to improve food security: The Participative Integrated Development Rural Agriculture (PIDRA) Community Empowerment Programme

Between 2001-2008, the Ministry of Agriculture (Kementerian Pertanian) implemented a joint programme with the International Fund for Agricultural Development (IFAD) to develop the intensification of dry land farming through community empowerment initiatives in three provinces, including NTT, through the PIDRA Community Empowerment Programme.[131] The programme was coordinated in NTT by the Food Security and Information Board in five of the worst affected districts in terms of food security (Timor Tengah Selatan, Timor Tengah Utara, Alor, Sumba Timur and Sumba Barat).[132]

The programme aimed to provide support for communities to increase farming intensification and access to health and education, involving participation of women and children. In each village chosen for the programme, 10 groups were selected, made up of male- and female-headed households that provided support for each other and monitored group member involvement in posyandu (usually run by communities) and participation of the children in these households in education (in line with the nine-years compulsory education programme). In each village, a Village Development Institution (LPM, Lembaga Pengembangan Masyarakat) was established, which aimed to mobilise and manage community funds for infrastructure, facilities, health and education needs.[133] Building infrastructure involved local labour and materials, in particular for improving access to clean water, piping and irrigation systems, among others, in order to allow for farming during the dry season.[134] The programme was a joint initiative between the Food Security and Information Board and CSOs that also provided technical training to group members on farming methods and building infrastructure. By 2006, PIDRA had overcome food security problems in the selected villages, with the establishment of 897 groups across 25 sub-districts. The programme was also replicated in 2006 by the Village Food Self-Reliance Programme funded by the national budget in other districts in the province.[135]

b) Strategies and innovations to improve food security: Food shortage detection system

In order to detect food shortages and problems, the Food Security and Information Board in NTT developed the Food and Nutrition Vigilance System. The indicators used to detect food shortages and problems include[136]:

- In the farming sector: crop failures, puso (harvest failure due to climate problems), etc.
- In the health sector: data on weight of children aged under five from posyandu
- Economic indicators: poverty levels
- Geographical mapping of food shortages (supported by the World Food Programme)

125 Bimbingan Massal Swa Sembada Bahan Makanan – or Mass Guidance for Food Self-Sufficiency
126 Interview with programme staff from the NTT Food Security and Information Board, Kupang (16 August 2010)
127 Interview with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
128 Interview with programme staff – Food insecurity section, from the NTT Food Security and Information Board, Kupang (16 August 2010) and with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
129 Interview with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
130 Interview with staff from the Food Intensification Division (Bagian Rawan Pangan), NTT Food Security and Information Board, Kupang (16 August 2010)
131 Interview with programme staff from the NTT Food Security and Information Board, Kupang (16 August 2010)
132 Interview with the Secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
133 Ibid.
134 Ibid.
135 Interview with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
136 Interview with programme staff from the Food Insecurity Section, from the NTT Food Security and Information Board, Kupang (16 August 2010)

Implementing this programme, the Food and Nutrition Vigilance Team involves staff from the Office of Health (nutrition section), the Office of Settlements (previously Public Works) and other offices.[137] The programme involved a pilot of the SMS Gateway (whereby SMS messages are sent by investigators and other people providing updates via mobile phones) in Kupang and Belu. Staff at the provincial level together with WFP analyse data received through SMS. One of the advantages of the system is that information on crop failures, for example, is received quickly so that the Board can promptly respond.[138] Furthermore, the national SKPG plus pilot programme was established in NTT in five districts (and also in several other provinces) in 2009 to detect food shortages at the household level, using deconcentration funds provided from the central to the provincial governments. Rapid surveys are conducted by the Food Security and Information Boards at the district level on food security and household coping mechanisms.[139]

4.2.4.4 Challenges faced by the Food Security and Information Board

The fieldwork for this report identified a number of challenges faced by the Board in its food security strategies:

1. In making the maps of food shortages and nutrition, staff capacity at the district level is the greatest challenge. The Provincial Food Security and Information Board trained district level staff. However, an evaluation of 21 districts by the Board found that only seven districts had the capacity to make the maps. The Food Security and Information Board carries out meetings with district clusters to collectively review the data collected, but this has not yet been possible in all districts.[140]
2. The number of staff at the district level is often insufficient as there are frequent transfers and staff turnover. This causes blockages in the information system and requires frequent training and retraining by the province.[141]
3. Community and other stakeholders associate food security and undernutrition only with availability of basic foods, and they lack a broader understanding of food shortages and nutrition. However this is being tackled through the creation food reserves.[142] This has been reinforced through Governor's Regulation No. 36/2007, which requires that provincial and district governments provide funds for establishing food reserves to overcome problems of food shortages. When food shortages occur at the village level, district reserves can be used. However, if the problem occurs at the sub-district or district level, provincial reserves can be used. Some related issues include:
   a. Despite the release of the Governor's Regulation in 2007, only in 2010 have several districts created food reserves.[143]
   b. It is also difficult to get district governments to provide funds for food reserves from limited budgets; it involves advocacy to parliaments and budget formulation teams.[144]
   c. The Food Security and Information Board's functions are limited to provision of coordination and information, including analysing data and providing advice for related technical institutions and agencies. It cannot enforce regulations or sanctions, nor can it force villages to report to the Board, and it is often unaware of the extent of the problem or initiatives to overcome this when villages report instead to the Local Development Agencies (BAPPEDA) rather than the Board.[145]

   This discussion highlights the challenges for provincial governments using deconcentration funds for food security initiatives that need to be implemented at the district level, over which they have more of a coordinating and assistance function rather than direct authority. Moreover, district capacity in terms of numbers and capability of staff and budget priorities further complicates the situation.

4.2.4.5 Strategies to improve coordination: The Food Security Council

To overcome some of these problems, the Governor of NTT established the Food Security Council (DKP, Dewan Ketahanan Pangan) to advocate the policies of the Council and other related policies on food and nutrition in 2007, given that the problem is multi-sectoral yet each sectoral agency also has sectoral responsibilities. Members of the Council include all related government agencies and CSOs. The Council is chaired by the governor, and the secretary is the head of the Food Security and Information Board. Within the Council are working groups coordinated by related agencies leading each sector. These consist of the:

1. Food Production Task Force, coordinated by the Food Security and Information Board
2. Distribution Control and Price Monitoring Task Force, coordinated by the Office of Industry and Trade
3. Food and Nutrient Diversification Task Force, coordinated by the Office of Health
4. Quality Monitoring, Food and Nutrient Awareness Task Force, coordinated by the Office of Social Affairs
5. Supporting Infrastructure Task Force, coordinated by the Office of Public Works

4.2.4.6 Challenges to implementation: The Food Security Council

The Food Security Council faces a number of challenges. For example, there is no shared budget from the members of this working group. Coordination takes place in the form of biannual meetings (at a minimum) for evaluation and planning, and meetings every three months for each task force (sometimes monthly depending on the initiative of the coordinating agencies for each task force).[146] According to staff from the Food Security and Information Board, holding council meetings twice a year is insufficient, resulting in weaknesses in the process, and the monitoring function of the Council is difficult as it has no authority over the participating agencies.[147]

Furthermore, some of the task forces are not operating effectively, when the staffmembers from relevant agencies do not participate. The agencies themselves argue that it is a classic model of ineffective coordination, only holding meetings and asking questions on the programmes of the different agencies. For example, a staff member of the Office of Health stated:

> "In terms of joint initiatives, we have put forward ideas, but at the moment it is just discussions over who is doing what, what the budget is and so on… Coordination is like a set of train tracks - separate, we are all working in parallel but heading towards the same destination. It's difficult to coordinate without a single proposal with a single aim to focus on interventions and resources, and we can't do something if there isn't a joint plan which we design together." (Kupang, 18 August 2010)

137 Interview with staff from the Food Intensification Section, NTT Food Security and Information Board, Kupang (16 August 2010)
138 Interview with programme staff from the Food Insecurity Section, from the NTT Food Security and Information Board, Kupang (16 August 2010)
139 Ibid.
140 Ibid.
141 Ibid.
142 Interview with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
143 Interview with programme staff from the Food Insecurity Section, the NTT Food Security and Information Board, Kupang (16 August 2010)
144 Ibid.
145 Ibid.
146 Ibid.
147 Interview with programme staff from the NTT Food Security and Information Board, Kupang (16 August 2010)

There are inefficiencies in the coordination and implementation process within this structure. According to the study by Muslimatun and Fanggidae (2009), there are unclear mechanisms of cross-sectoral coordination, and the goals of each sector and of the Council itself are unclear. The authors also argue that the coordination meetings most often have no clear direction or decision-making authority. The absence of decision-making authority, despite the fact that the Council was chaired by the Governor, led to very limited budget allocated from local district and municipal budgets for its operations, and no budget for programmes of its own.

4.2.4.7 Strategies and innovations: Increasing the consumption of nutrients in the community

The NTT Office of Health aims through its 2009-2013 Strategic Plan to reduce severe malnutrition among children under five years old from 6.7 per cent in 2007 to 4.1 per cent, and to reduce moderate malnutrition from 30.1 per cent to 25.8 per cent by the end of the period. However, in 2009, severe malnutrition had increased to 9.4 per cent, while moderate malnutrition had reduced to 24.2 per cent.[148]

In order to reduce malnutrition, the NTT government aims to:

- Empower communities at the village level to participate in the health-related planning for women and children, including nutrition.[149]
- Strengthen planning processes through providing nutrition specialists and information dissemination staff.[150]
- Develop the surveillance system and the education of the community on nutrition through information dissemination staff.[151]
- Improve the quality of coordination across programmes and sectors relating to nutrition, living environments, community empowerment, health promotion and education, and joint operations between localities to overcome health issues.[152]

Initiatives underway include:

- Strengthening village level planning and community empowerment through health promotion as a part of joint initiatives with UNICEF in Belu and Sikka districts, through the Community Health and Nutrition System Strengthening (Chansys) programme. The Office of Health has already undertaken information dissemination activities with the district level Offices of Health and puskesmas, including information on the relationship between illness, problems in health clinics and cultural practices.[153]
- The implementation of Project Nais, providing villages with funds up to IDR 140 million for health programmes to be spent over two years. The programme is facilitated and supported by the Offices of Health at the district level through technical assistance for the community in writing funding proposals.[154] However, the challenge with this programme is that the NTT Office of Health does not have mechanisms at the village level to monitor and evaluate the implementation of proposed activities following the distribution of funds. Nor does it have the budget for staff who can communicate with villagers, local civil servants, religious leaders or village heads, to monitor implementation.[155] The Office of Health considers meetings and consultation at the village level to be extremely important in overcoming nutrition problems, to optimise the use of funds, and for planning.[156] Some of the staff at the posyandu could be involved in some of the planning activities, but the NTT Office of Health argues that this may be ineffective, as such people are perceived to be the extension of the government which is unrelated to village level activities.[157]
- Other initiatives at the district level include the Konseling Kadarsih programme, which aims to improve community awareness about nutrition and is currently being implemented in Sikka district by working with posyandu staff and village officials. The challenges it faces include the continuing need for awareness raising activities over the long-term and reaching all the isolated villages on the many different islands in the district.[158]

4.2.4.8 Challenges for policy implementation in addressing malnutrition in children and in general

Community perceptions, knowledge and nutrition practices

The FGDs discussed earlier illustrated the problem of community perceptions of malnutrition. The perception in the community that malnutrition is related to blood problems in Sikka, for example, is one indicator that information dissemination strategies are not yet optimal, and Office of Health staff believe this is associated with the lack of involvement of community leaders in socialisation activities, as these actors have extensive influence over communities.[159]

Other interviews revealed that it is problematic for working mothers to prepare a wide variety of food for children even though local cheap foods are available. Furthermore they revealed that some parents have poor knowledge of how to prepare nutritious food for their children using local produce.[160]

Limited budgets in poorer districts/municipalities

Budgets are limited at the district level for health and child-welfare related activities. While district staff argue that with decentralisation they have been able to more quickly respond and implement programmes, there is a problem of sustainability when funds run out.[161] As NTT is a poor province, most of the general budget at the district/municipal level and the provincial level is allocated for civil servants' wages and benefits. Little revenue is raised through local taxes and levies. Hence, local governments rely heavily on deconcentration funds and development assistance paid from the central government to the province, both of which require lobbying by the provincial government.[162] BAPPEDA staff also argue that while general allocation budgets are determined based on geographic size, among other considerations, the island nature of NTT means this budget is still insufficient. Hence there is current lobbying to include ocean distances in the general budget allocation.[163]

148 NTT Provincial Government (2009) *NTT Strategic Plan (Renstra)* 2009-2013, NTT Provincial Government: Kupang
149 Interview with staff from the Nutrition Improvement Section NTT Office of Health (18 August 2010)
150 Ibid.
151 NTT Provincial Government (2009) *NTT Strategic Plan (Renstra)* 2009-2013, NTT Provincial Government: Kupang
152 Ibid.
153 Interview with staff from the Nutrition Improvement Section, NTT Office of Health (18 August 2010)
154 Ibid.
155 Interview with staff from the Nutrition Improvement Section NTT Office of Health (18 August 2010)
156 Ibid.
157 Ibid.
158 Interview with the Head of Nutrition Section, Sikka Office of Health, Sikka (30 September 2009)
159 Ibid.
160 Interview with the coordinator for the Women's Division, Volunteers for Humanity *(Tim Relawan Untuk Kemanusiaan)* Sikka (19 September 2009)
161 Interview with staff from the Office of Health, Kupang municipality (20 October 2009)
162 Interview with programme staff, NTT Food Security and Information Board, Kupang (16 August 2010)
163 Interview with staff from the Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)

Furthermore, health practitioners have highlighted that special allocation funds (DAK) are not always in line with local needs, but rather with central government policies and interests, at times creating a mismatch between priorities and budget allocation:

> "In our region, funds have been allocated for building more puskesmas as the central government prioritises infrastructure, but what we actually need are more midwives and medicine." (19 September 2009)

Based on the budget review carried out by Oxfam (2009), there have been various interventions both by government agencies and NGOs, including short-term interventions (such as emergency food supplement provision), medium-term interventions (such as agricultural assistance, including provision of corn and other non-rice food crop seeds), and long-term interventions (such as providing access to credit, to improve household economic systems and assist with coping with malnutrition problems). However, a report on the accountability and performance released by the NTT Office of Agriculture demonstrated that the budget for food security increased from approximately IDR 30 million in 2004 to above IDR 35 million in 2005, but back to below IDR 30 million in 2006. Muslimatun and Fanggidae (2009) highlight that one third of the government budget for malnutrition problems in NTT was aimed at addressing short-term problems, such as emergency relief in food crises, while two thirds was allocated for long-term strategies, such as welfare. However, the majority of the provincial government budget set aside to combat malnutrition is channelled into curative care rather than prevention; 75.2 per cent of the total funding is allocated by provincial government for curative treatment of malnutrition in the provincial hospital, and the budget is specifically set aside for patients hospitalized for malnutrition. A staff member from the Child Protection Commission stated that:

> "…Seventy-five-point-two per cent of the budget is set aside for the provincial hospital, however, public hospitals are only accessed by the community living nearby the hospital (predominantly the urban population). This means that, although intended for both urban and rural populations, the budget is not actually reaching those living in remote areas. The budget allocation needs to be rebalanced between hospitals and the Office of Health to use it for other areas, especially given that the Office of Health is most effective in reaching the malnourished population." (Child Protection Commission staff, NTT, 16 August 2010)

Puskesmas have limited funds in some areas to reach all villages and convey information on nutrition and health in village consultation and deliberation (musyawarah) meetings, or to monitor improvements. This is only operational in areas where puskesmas have adequate staff. Despite KIA initiatives, there is extensive variation in district budgets. As one provincial Office of Health staff member stated:

> "There are districts that have budgets of IDR 25 million [for information dissemination activities], some that have IDR 50 million, and some that have IDR 200 million, and others up to IDR 700 million. What can you do with IDR 50 million? There is nearly IDR 200 million but it is mainly used for Additional Food Provision (PMT) activities, and if monitoring activities take place they are usually only for PMT activities."[164]

Districts and municipalities have consequently been advocating to access provincial level deconcentration funds, and monitoring and surveillance funds for information dissemination and health promotion, which have been provided by the province, considering the difficulties faced at the district level.[165]

[164] Interview with staff, Nutrition Improvement Section, NTT Office of Health (18 August 2010)
[165] Ibid.

Clear understanding about the appropriate use of funds is sometimes lacking, particularly at the puskesmas level. Provincial Office of Health staff highlighted that other funding such as community health insurance (Jamkesmas, Jaminan Kesehatan Masyarakat) programme funds can also be used for information dissemination, not just for subsidizing medicine costs for poor patients. However, rarely are the staff in puskesmas aware of what different funds may be used for, such as Health Operational Assistance (BOK, Bantuan Operasional Kesehatan)[166]. The provincial government has responded by publishing a book that explains funding guidelines more clearly for puskesmas staff.

Holistic approach to service provision for families with malnourished children

Despite the initiatives outlined above to improve service provision for the poor, including poor children, sometimes the health problems of children are not treated holistically as a problem for the whole household. Support provided at health facilities for poor families whose children are being treated can be problematic. Community CSOs working in the area of health in different districts described several cases of poor mothers travelling long distance to take their children to hospital, but the mothers themselves not being allowed to access food at the hospital. Consequently such mothers discharged their children and took them home, where they also did not have enough food. Meanwhile health staff failed to monitor these cases and the children died of malnutrition.

Strengthening coordination between government, NGOs/CSOs and INGOs/agencies

Based on prior coordination problems among CSOs/NGOs, international NGOs (INGOs), the BAPPEDA and the district/provincial executives prior to 2004 (these agencies tended to interact more with sectoral offices), a Joint Secretariat was formed based on a Governor's Decree in 2004 at the initiative of the provincial Head of BAPPEDA. The Secretariat has members from United Nations agencies, bilateral aid agencies, international multilateral agencies and local CSOs/NGOs. While the Secretariat is mainly administrative in function and is co-located with BAPPEDA, it assists with data gathering and priorities setting, as well as coordination of policies among the institutions.[167] Regular meetings are held and the BAPPEDA budget funds the Secretariat, which has created several posts (e.g., in economics, social work, joint work with international agencies, etc.)

However, CSO and other international agency staff have highlighted that inefficiencies persist as well as confusion about which sectoral agencies the CSOs/NGOs, INGOs and international agencies must work with on particular initiatives, such as KIA - whether through the Secretariat, with particular sectoral offices, with multiple offices, with BAPPEDA, and so on. They have also identified that it is important to create greater cohesion between the Secretariat and the other relevant agencies, for improved sharing of information.[168]

Intra-government coordination of the planning process

Given that food and nutrition are multi-sectoral responsibilities, other interviewees highlighted that political struggles between agencies in coordination of initiatives (both related to the Food Security and Information Board's activities and, more generally, between sectoral agencies at the provincial and district levels) make dealing with food security and malnutrition more difficult. Different agencies have different agendas, particularly when it comes to determining market

[166] Ibid.
[167] Interview with staff, Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)
[168] Interview with UNICEF staff, NTT (18 August 2010)

prices for food and distribution.[169] BAPPEDA has a key role too in the coordination process, especially between national and local medium- and long-term development plans, and in synchronising programmes at each level of government. The role of BAPPEDA was outlined in the overview of decentralisation and in annex 3. One particular problem faced by BAPPEDA for coordinating the planning process is that sectoral reports provided to the agency tend to describe the number and type of activities rather than the outcomes and impacts, making future planning difficult.[170]

Coordination between levels of government (province and district/municipality) is also challenging under decentralisation. The provincial government has endeavoured to ensure that MDG indicators are included in the district and municipal reports, which Governor has the the responsibility of evaluating. Given the limited authority of the provincial government, the involvement of the provincial government in health and education interventions, for example, must be joint initiatives with district and municipal governments. While the provincial governments have set goals as a part of the strategic plans, and have undertaken a number of initiatives to improve health and nutrition, achievement of this is very much dependent on the district level governments agreeing to take up these initiatives, and then implementing them.[171]

Other problems of coordination include:

- Synchronisation: A lack of synchronisation between election times at the local level (winning candidates have their own visions and missions for each region) and the timing of national and local development plans.[172] This creates difficulties in the short turnaround times for the planning process including the consultative development planning forum (musrenbang) at each level, creating local policies involving particular agencies, and creating local development plans in line with national development plans.[173] Law No. 25/2004 regulates that local Medium-Term Development Plans (RPJMD) must be finalised within three months of the inauguration of elected heads, and such plans must include the relevant local policies.
- Oversight and assistance from the provincial government: Government Regulation No. 19/2010 outlines that provinces should oversee district performance. This includes providing assistance in drafting budgets before they are enacted at the district level. However, budgets are quite general, and details are contained in the RKA (Work and Budget Plan), which the provincial BAPPEDA has insufficient manpower and resources to review in detail.[174]
- Local parliamentary approval: While budgets are determined through consultation with sectoral agencies, through musrenbang, and other mechanisms, the local parliaments also have approval authority, and with newly elected parliaments, they are sometimes weak in overseeing or debating the budget since they are not familiar with the field or conditions on the ground.[175]

Rotation of government staff

In the discussion above on education and food security in NTT, it was evident that civil servant staff turnover can be problematic if officials do not have a background in a particular sector.

169 Confidential interview, government staff member, Kupang (18 August, 2010)
170 Interview with staff from the Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)
171 Interview with staff, Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)
172 Ibid.
173 Ibid.
174 Ibid.
175 Interview with staff, Office of Health, Kupang municipality (20 October 2009)

Interviews during the fieldwork for this report also found this to be a problem in the departments concerned with health and nutrition when attention is not paid to the background of staff during rotations.[176] Rotations often occur with the election of new district heads/mayors.[177] In planning meetings with BAPPEDA, new staff members have insufficient knowledge to present proposals and policies and explain why they are high priority, and so they may not be approved by BAPPEDA.[178]

As was discussed previously, programmes such as the 'SMS Gateway' and the surveillance system implemented by the Food Security and Information Board need a level of long-term continuity which is undermined by frequent staff rotation, resulting in delays and problems with information dissemination.[179]

Provincial BAPPEDA staff argue that while staff rotation is unavoidable, there could be better handover mechanisms employed to pass on information to new staff, which to date has only been a formality[180]. Furthermore, this would be assisted by creating manuals explaining processes, as a fallback source of information for new staff.

Data for monitoring improvements

Many stakeholders use different measurements of health status for mapping interventions, which complicates monitoring, evaluation and establishing whether interventions are having impact. In general, the NGOs' baseline studies have come up with figures indicating higher rates of malnutrition and poorer health compared to WFP and National Socio-Economic Survey estimations used by the government. This also creates tensions between government and such organisations. For example, one respondent stated:

> "Monitoring conducted by an international organisation in Maumere Diocese which is in partnership with our organisation reported that there are more than 600 children with malnutrition and thousands of children under-nourished. When this finding was published, the government assumed that I was trying to embarrass them. The Office of Health and the international organisation had different measurements for categorising a child as suffering from malnutrition. Thus, the results were different, despite the fact that monitoring had been conducted with midwives and posyandu workers. Because such health workers are well-trained, it is important that government agencies remain objective and draw on their knowledge. The Office of Health did, however, hospitalise these children, but the hospital did not provide food for the mothers so the mothers took the children home to their villages." (NGO worker, Maumere, Sikka, 25 September 2009)

Minimum standards

Both the government interviewees (cited in much of the discussion above) and Health Cluster FGD respondents (19 September 2009) highlighted that that malnutrition in NTT is also related to institutional and personnel capacities of each office, agency, bureau and board responsible for handling problems associated with malnutrition. Among efforts made by the government of NTT to strengthen institutional capacity has been the issuing of NTT Government Regulation on the

176 Interview with staff, Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)
177 Ibid.
178 Ibid.
179 Interview with programme staff, Food Insecurity Section, from the NTT Food Security and Information Board, Kupang (16 August 2010); Interview with the secretary of the NTT Food Security and Information Board, Kupang (16 August 2010)
180 Interview with staff, Social and Cultural Section, Provincial Office of the Local Development Planning Agency (BAPPEDA) (18 August 2010)

Establishment of SKPD Organisation and Management in line with the national level minimum standards legislation discussed in Section 3. However, time and commitment to building capacity of civil servants in practice is essential to improving service provision.

Authority under decentralisation
Decentralisation gives authority to the district level, which in a poor province like NTT results in a slight mismatch between funds distribution for poorer and disadvantaged provinces (from the centre to the province), provincial level policies, and the implementation authority at the district level. While ultimately decentralisation aims to bring better service delivery to the populace in providing support services through the closest level of government (the district), which is important in a country as diverse and large as Indonesia, in the interim there are problems of institutional capacity at the district level as discussed throughout this and subsequent sections. Improving district level capacity is essential to ensuring both that the districts/municipalities can deliver services and that the province can perform its role of assisting and coordinating.

Furthermore, some agencies responsible for child welfare, such as the Bureau of Women's Empowerment and Child Protection, have been created following decentralisation. Law No. 23/2002 on Child Protection and Government Regulation No. 41/2007 on Local Organisational Structure require provinces to establish a Bureau of Child Protection. However, similar to the province, such bureaus have authority to coordinate and monitor child welfare and knowledge dissemination, but cannot sanction or enforce policies when other sectoral agencies are responsible for implementing services relevant to women and children. For example, the Bureau of Women has administrative authority to coordinate other organisations but does not have authority regarding technical-operational programme implementation. According to the interview with the Chairman of the Bureau of Child Protection in NTT (17 August 2010), weakness in the Bureau results from a lack of technical-operational budget. The Bureau can therefore only create guidelines and cooperate with other sectoral offices. For other offices, cooperation and joint initiatives to implement programmes also result from shared budgets, however, the NTT Bureau only has IDR 35 million (approximately US$4,000) for the operationalisation of initiatives at provincial level and IDR 120 million (approximately US$13,500) for the operationalisation of initiatives across five districts. As a result, other offices often refuse to carry out initiatives and instructions/guidelines from the Bureau, such that child protection initiatives are often ineffective.

4.2.5 COMMUNITY PARTICIPATION IN THE PLANNING PROCESS: THE MUSRENBANG

As described in the introduction to this section, the musrenbang process of consulting with communities at every level on problems, priorities and needs was an important part of the planning process in Indonesia. However, it was evident during the fieldwork that much of this process in NTT was somewhat dominated by elites at each level and rarely were the voices of women and children incorporated into the process. Furthermore, a study by Benu (2008), who studied the musrenbang process in Kupang district in 2007, highlighted that there is little time to properly conduct and prioritise micro-level planning processes such as the musrenbang alongside district medium-term development processes, district strategy formulation, the formulation of work-plans and draft budgets.[181] Hence, the latter tend to be prioritised, which in effect prioritises strategies over needs.

[181] Benu, F. L. and Praingu, A. D. (2008) *Review on development planning processes and documentation of Kupang district government and its commitment to poverty reduction, education and public health agenda*. Hickling: Jakarta, 2008

The Benu study, which illustrates from Kupang district how planning processes can be conducted according to the law, but may not be effectively addressing key problems in a district, drew the following conclusions among others:

1. The discussions of priorities in the musrenbangdes (village level), Musrenbangcam (sub-district level), district level Inter-Office/Agency (SKPD) Forums and Musrenbangkab are not sharply focused because these forums discuss criteria and priorities that are not built on valid supporting data.
2. The execution of musrenbang at each level is often undertaken 'in a hurry' and the outputs are thus not optimum.
3. There is an absence of quality facilitators in the musrenbang process.
4. The voices of women on the subject of malnutrition in the musrenbang process are still very limited. Some women do not perceive themselves as rights holders or duty bearers in relation to malnutrition, as there is a stigma associated with malnutrition, where it is shameful for mothers who have children under five years old that are underweight, which leads them to deny the existence of malnutrition problems in their neighbourhoods, and thus it is not prioritised in the musrenbang.
5. There is a lack of understanding on the part of participants in the SKPD Forum at the district level about how to apply performance-based budgeting principles as required by the Minister of Home Affairs' Regulation No. 13/2006. Almost all SKPDs still focus on budget allocation issues without referring to attainment indicators or target indicators either regarding results (output) or gains (outcomes) (Benu, 2008).
6. So far, BAPPEDA has prioritised Office/Agency proposals in the planning process that are in line with the priorities of the district head, whereas frontline service priorities are ignored if they are outside this agenda.

The problem of mismatch between the musrenbang process, community priorities and district head priorities (and consequently budgets) mentioned by Benu (2008) is also confirmed by FGD participants, where, in the words of one participant who was a health practitioner:

> "Planning made by puskesmas is sent to the Office of Health for consultation with BAPPEDA. However, there are some problems in the process. For example, the number one priority is for malnutrition alleviation, but in some cases the plan has been rejected by BAPPEDA and the budgeting department when it is outside district head priorities. In order for it to be prioritised, it depends on the skills of the person making the proposal to shape it to fit in with the district head's commitments and priorities so that it is included in the district budget." (19 September 2009)

In Benu's review of the Kupang District Medium-Term Development Plan and Strategic Plan he found that:

- Data analysis is weak;
- Principles and priorities are not clear in relation to strategies and programmes;
- While commitment to the MDGs is strong in vision and mission statements, there are weaknesses in strategies and programme priorities;
- Policies are not linked to outputs and outcomes; and
- There is strong consistency between the development plans and strategic plans, but many of the outcomes of musrenbang are not accommodated in these plans.

It is evident that there need to be greater efforts made to ensure that both women's and children's needs and priorities make it into district planning, regulations, budgets, and service provision at the district level, whether through the musrenbang process or other means. The evidence discussed throughout this subsection from FGDs and in-depth interviews demonstrates that women, children and practitioners often know what the key problems are but this does not always make it into policymaking processes and practice. Furthermore, malnutrition and good health are not just factors of food and service availability but also of knowledge and cultural practice. A number of institutional weaknesses under decentralisation presented in the previous subsections demonstrate how there is significant space for institution building and process strengthening to ensure that budgets and priorities are child- and women-friendly and that they result in real improvements in health and nutrition indicators under decentralisation.

4.2.6 SUMMARY CONCLUSION

The case of NTT demonstrates that tackling health and malnutrition problems, in a large and poor province made up of a number of islands such as NTT, is a complex undertaking. The problems related to health and nutrition for women and children are exacerbated by the geography and climate of the province, a large, growing and young population, high levels of rural poverty and unreliable agricultural yields, which affect access to food and food availability, accessing to health care, and access to clean water and adequate sanitation. These challenges are further compounded by low education levels and local behaviours and cultural practices relating to use of health facilities (a preference exists for home births and traditional attendants), poor exclusive breastfeeding practices and inadequate knowledge and practice related to the consumption of nutrients. Nutrition is further affected by disease and ill health resulting from a variety of factors related to the above, which creates a vicious cycle for children, whereby disease and ill health prevent improvements in nutritional status and nutrition itself can increase susceptibility to disease both directly and indirectly. Problems of ill health and nutrition and other vulnerabilities are particularly acute in rural areas and in IDP camps where women and children are subject to multiple vulnerabilities.

The case of NTT also demonstrates that efforts are being made through local policy innovations and the efforts of civil society practitioners to tackle the problems of high rates of mortality, ill health, and undernutrition under decentralisation in NTT. However, at present, inroads in terms of mortality and nutrition are slow, while the institutional environment gradually strengthens under decentralisation. This requires continued efforts on the part of government, international and local organisations.

Weaknesses are evident not only in the provision of services and health facilities, but also the quality and outreach of these services, which need to be improved to ensure that minimum service standards are upheld. The NTT provincial government has introduced a number of initiatives, not all of which are discussed in the case study. First, these include commitment to prioritizing reductions in maternal and child mortality in the Medium-Term Development Plan. Second, they also include policies to improve access to and the provision of skilled birth attendants, more trained professionals in the health sector and campaigns to promote facility-based births to prevent deaths from complicated deliveries. Third, cross-sectoral initiatives have been introduced to improve food security, detect food shortages, and improve coordination between government offices and CSOs/international agencies working on improving health and nutrition, although these are not always as effective as they might be. Fourth, the necessary regulatory framework has been enacted at the provincial level, but given that under decentralisation the province has more of a coordinating role, further uptake and introduction of initiatives are needed in some districts/municipalities.

At the district level, some of the challenges to improving health and nutrition and access to clean water and adequate sanitation include low numbers of trained staff and poor civil servant and practitioner capacity to implement initiatives and actually provide services and facilities. This is further compounded in some places by limited budgets, the frequent rotation of government staff, weak data collection mechanisms for monitoring improvements, and the need for further efforts to ensure that minimum standards are upheld under decentralisation.

Furthermore, the voices of women and children (and the practitioners working to provide relevant services), are needed to ensure that their needs and priorities are articulated and incorporated into district and provincial strategic plans, annual action plans, budgets and programmes/services in the development planning process through the musrenbang. However, in practice there is substantial room for improvement in such processes to ensure that the regulatory and policy framework, as well as the subsequent budgets and services, are pro-child, pro-women and have a positive impact on maternal and child welfare.

4.3 PAPUA: A PROVINCE WITH HIGH LEVELS OF POVERTY, LOW LEVELS OF HUMAN DEVELOPMENT, AND A LARGE NATURAL RESOURCE BASE IN THE MIDST OF A LOW LEVEL GENERALISED HIV AND AIDS EPIDEMIC

The previous subsection on NTT described the multiple insecurities for children and explored the connections among poverty, poor health and malnutrition, and access to health services, clean water and adequate sanitation, as well as low education levels and traditional practices relating to health care and food consumption. The province of Papua, in the far east of Indonesia, presents a similar environment to NTT in terms of poor welfare for children. In fact, Papua has even lower levels of education (particularly at the primary school level) and higher levels of poverty than NTT. In some districts in Papua, health and nutrition indicators are at lower levels than NTT averages, or at least on par with many of the districts in NTT, access to clean water is lower in Papua than NTT, and sanitation levels are similar in the two provinces, although inter-district disparities are far wider in Papua. However, in contrast to NTT, Papua is a resource-rich environment with Special Autonomy status, which means greater authority for the provinces and its districts, and greater access to natural resource revenues, similar to Aceh (discussed in the next case study).

This section extends the discussion from Section 3, in which the generalized epidemic of HIV and AIDS in Papua was highlighted. Here the problem and the policy responses are further examined. The analysis, as in the case study on NTT, draws on a combination of survey data, secondary sources, and in-depth interviews with policy makers, practitioners, academics, community members and children themselves, conducted in Jayapura municipality and Jayawijaya district. Jayapura municipality is more developed in terms of infrastructure and service provision in comparison to Jayawijaya, which is a more rural district located in a mountainous area with relatively limited access to public services, such as education and health care.

4.3.1 BACKGROUND: POPULATION, ECONOMY AND HUMAN DEVELOPMENT

4.3.1.1 Population and environment

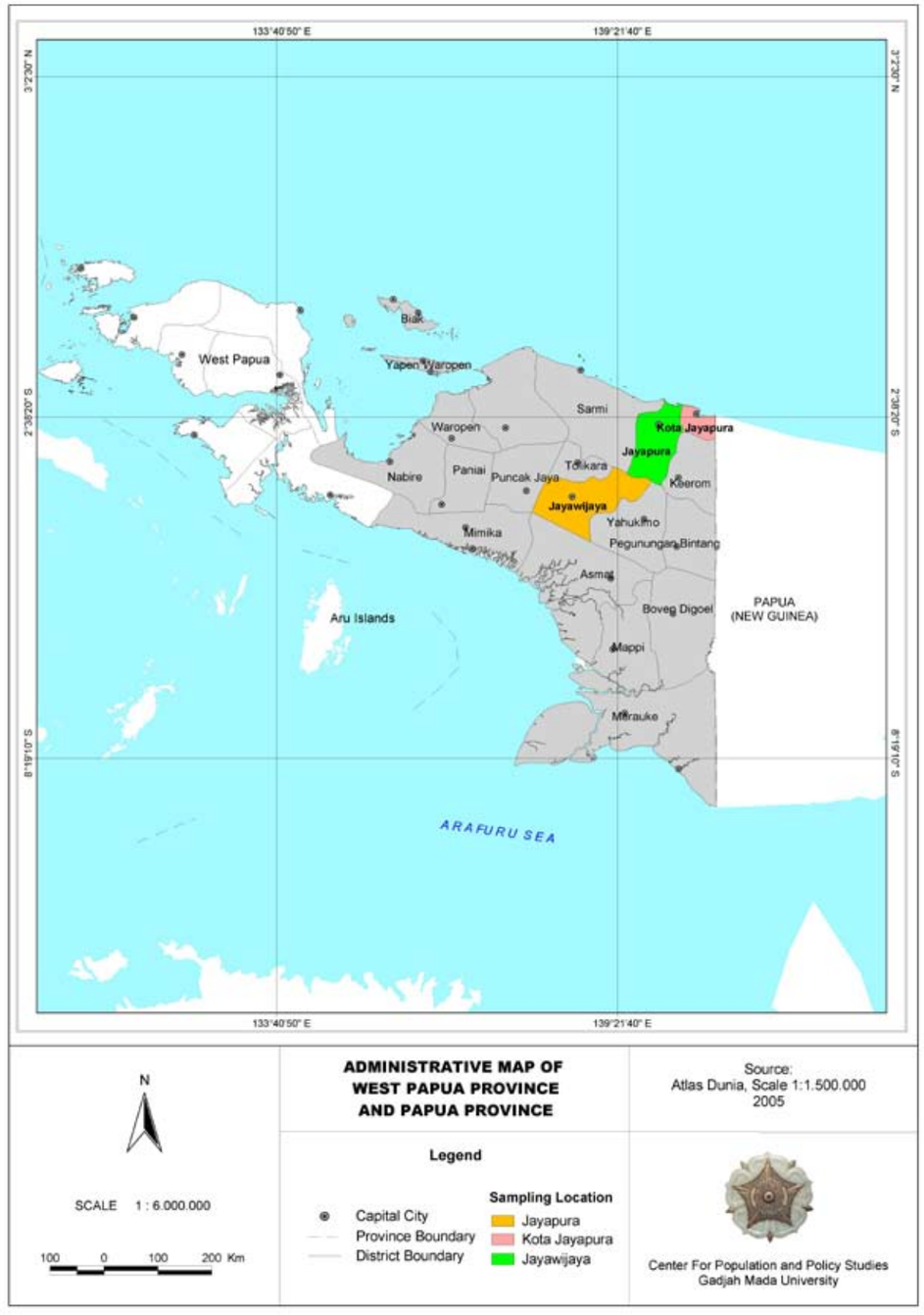
The Indonesian province of Papua covers an area of 319,036 square kilometres, or approximately three times the size of Java.[182] It is one of two provinces, which together are known as Tanah Papua. The population of Papua in 2010 was approximately 2,138,500 people, while the province of West Papua (which was formed in 2003) had a population of some 757,700, such that Tanah Papua has a population of approximately 2,896,200.[183] In 2010, Papua had a population density of only seven people per square kilometre. The two provinces of Tanah Papua are the two least densely populated provinces in the country.[184] Less than a quarter of the population live in urban areas.[185] However, over the past two years the population density has increased sharply as a result of population growth, which was at a rate of 1.95 per cent in 2008, a slight decrease from 2.08 in 2005.[186]

The Papuan population is characterised by a high number of people under the age of 45 years.[187] This is positive in that there is potentially a large population of working age. However, there is also a large number of children, especially under the age of four years.[188] This is indicative of a high birth rate in the province as well as a comparatively high total fertility rate (TFR). The TFR has been declining somewhat over the past five years, albeit very slowly, from 2.73 in 2005 to 2.69 in 2009.[189] The TFRs in Jayawijaya and Jayapura, the two areas of focus for this case study, are considerably lower than in other parts of Tanah Papua, which may be due to Suku Dani (Dani ethnic group) community practices, including sexual abstinence among breastfeeding women during the five-year post-partum period.[190]

The province is ethnically diverse with different systems of leadership and livelihood, closely associated with the different ecological zones. In general, the highlands are populated by people who make their livelihoods from agriculture, while in the lowlands livelihoods revolve around fishing and hunting and growing sago (sagu), a staple food, in the wetland swamps.[191] Papua also has an abundance of natural resources such as gas, oil, gold, silver, marine products and copper. Mining generates nearly three quarters of Papua's revenue and is a priority for the Papuan government.[192] The mining company PT Freeport is thought to have generated over US$1 billion in revenue, primarily for the central government, although under Special Autonomy the province now has greater access to this revenue.[193] The province's forests areas, which span 31 million hectares, also produce highly sought-after timber. Forestry together with other natural resources and revenue from mining, oil and gas, proffer great sources of wealth and employment opportunities.[194]

182 Badan Pusat Statistik (BPS) - Statistics Indonesia (August 2010) *Trends of the selected socio-economic indicators of Indonesia, August 2010*, BPS: Jakarta, available at http://www.bps.go.id/65tahun/Boklet_Agustus_2010.pdf
183 Ibid.
184 Ibid.
185 Projection from BPS - Statistics Indonesia (2009) *Intercensal Survey 2005*, BPS: Jakarta
186 BPS - Statistics Indonesia Papua Province (2008) *Papua in Figures 2007*, BPS and BAPPEDA (Regional Development Planning Board) Papua Province: Jayapura
187 BAPPENAS (National Development Planning Agency)/BPS - Statistics Indonesia/UNFPA (2008) *Proyeksi Penduduk Indonesia 2005-2025*, BAPPENAS: Jakarta (based on *Intercensal Survey 2005* projections)
188 Ibid.
189 Ibid.
190 Heider, K. G. (1976) 'Dani sexuality: A low energy system', *Man, New Series*, Vol.II(2): 188-201; Heider, K. G. (1996) *The Dugum Dani: A Papuan culture in the highlands of West New Guinea.* Aldine Publishing Company: place?
191 Chauvel, R. (2005) *Constructing Papuan nationalism: History, ethnicity and adaptation,* East-West Center: Washington, D.C.; McGibbon, R. (2004) *Plural society in peril: Migration, economic change and the Papua conflict*, East West Center: Washington, D.C.
192 Hedman, E. E. (Ed.) (2007) *Dynamics of conflict and displacement in Papua*, Working Paper Series, Department of International Development, University of Oxford: Oxford
193 Ibid.
194 International Crisis Group (2002) *Indonesia: Resources and conflict in Papua*, International Crisis Group: Jakarta/Brussels

Figure 4.3.1: Map of Papua Province



Source: Center for Population and Policy Studies, Gajah Mada University, 2010

4.3.1.2 Brief history

The integration of Tanah Papua into the Republic of Indonesia has been problematic for some Papuans. After the 1949 Round Table Agreement, which officially ended Dutch occupation over the colony, the Indonesian government argued that according to the Round Table Agreement, 'West Papua' (i.e., all the land west of the country of Papua New Guinea) was part of Indonesia.[195] The Dutch disagreed with Indonesia's position.[196] Numerous bilateral agreements between the two countries failed to produce any agreement. Ultimately in August 1962, the Dutch and Indonesians, under UN supervision, signed the New York Agreement, by which the two countries agreed to transfer the administration of this land from the Netherlands to a United Nations Temporary Executive Authority (UNTEA). The period for the UNTEA would be from 1 October 1962 to 1 May 1963, followed by Indonesian control, with the agreement that an Act of Free Choice would be held within five years.[197]

The relations between Tanah Papua and the central government have long been complex due to a variety of historical causes, which relate back to Tanah Papua (then Irian Jaya) falling under Indonesian control in the 1960s. The complexity of the relations is manifested in the call for secession by some political actors, most prominently leaders of the Organisasi Papua Merdeka (Free Papua Organisation).[198] In 1999, following the end of the Suharto period, President B. J. Habibie implemented decentralisation. Following this, Special Autonomy (Otonomi Khusus) for Papua was adopted during the administration of Habibie's successor, President Abdurrahman Wahid, as a step towards accommodating local demands and providing greater control for Tanah Papua over the revenue from natural resources, including up to 80 per cent of the income derived from the province's extractive industries.[199] The tensions between Tanah Papua and the central government, however, have not simply been a question of rebellion or secessionism, but rather the much more complex issue of justice, human rights, prosperity and economic opportunity.[200] Unequal division of natural resources between central government prior to Special Autonomy, combined with government-sponsored migration (transmigration) of other Indonesians to Tanah Papua, create a sense of marginalization among Papuans.[201] Many feel that they have become strangers in their own land.[202] This is compounded by poorer education and skills on the part of indigenous Papuans.[203]

4.3.1.3 Economic and human development

Despite having plenty of natural resources and greater access to resource revenues under Special Autonomy, resources are not distributed equally and do not always result in improved living conditions for the poor. Instead, development is uneven and there are fluctuations in the number of people living in poverty.[204] While Papua has the fourth highest Gross Regional Domestic Product (GRDP) per capita in Indonesia, this has not yet amounted to better access to public services and infrastructure.[205] One third of the population is living below the poverty line.[206] The percentage of poor people in rural areas is almost eight times as high as in urban areas (6 per cent urban versus 47 per cent rural[207]), partly due to geographical distances and lack of access to transportation, which have proven to be a challenge for the rural poor when it comes to enhancing their ability to earn a living.[208] At the district level, there are also huge disparities, with Merauke and Jayapura having the smallest proportions of poor residents (16 per cent and 19 per cent respectively), and Yahukimo and Supiori having the highest (both 51 per cent) in 2009.[209]

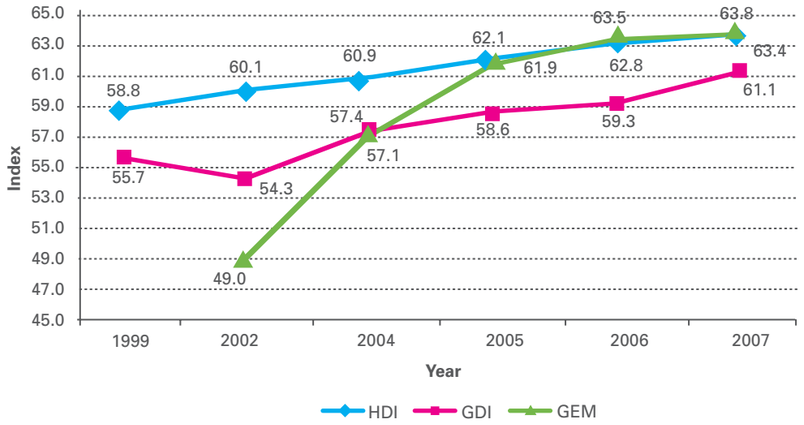
The World Bank (2005) reports that local government revenues doubled after the adoption of new policies on decentralisation in 2001, and that they further increased with the enactment of the Special Autonomy Law. In 2003, the province of Papua was reported to have had the second highest per capita level of development spending of all provinces of Indonesia.[210] It is expected that local government revenues will further increase through 2021[211], providing a considerable period of secure finance during which to plan and achieve local development objectives. The opportunities provided by this apparently high level of productivity are, however, contrasted with considerable challenges to reducing poverty.[212]

Papua has high per capita spending on infrastructure relative to other regions in the country.[213] These expenditures cover the transportation sector, as well as water and irrigation. Papua has the third highest infrastructure spending per capita with around IDR 44,000 per person in 2005.[214] This figure is twice as large as the national average of below IDR 20,000 per person.[215] However, the evidence suggests that this high rate of expenditure is not benefiting the ethnic rural Papuans due to the uneven spread of Papuans in geographically vast Papua.[216] Papua, Nusa Tenggara and Maluku share the lowest rankings in terms of access to infrastructure in the sectors of electricity, piped water and roads. Increasing access to piped water should be a priority, as the share of villages with access to piped water is exceptionally low.[217]

Low income, access to education and life expectancy together are captured in the human development index (HDI). Figure 4.3.2 shows the improving but still low levels for the HDI in Papua. In 2007 the HDI is well below the national average (63.4 in Papua versus 73.4 nationally). Disparity is key when considering this issue, with a high level of inter-district disparity, much of which can be attributed to the rural/urban split discussed earlier (see annex 4.3). Among districts, the HDI ranged from 73.8 in Jayapura municipality to only 47.4 in the highland district of Pegunungan Bintang in 2007. Yet, as Figure 4.3.3 demonstrates, even at the district level the HDI is improving slowly over time. Similarly, while the gender development index (GDI) and the gender empowerment measure (GEM) are improving (see Figure 4.3.2), similar differences to that of the HDI are found among districts (see annex 4.3). As discussed in previous sections of this report, poverty and low human development can have adverse affects on the welfare of the poor, especially women and children in poor families.

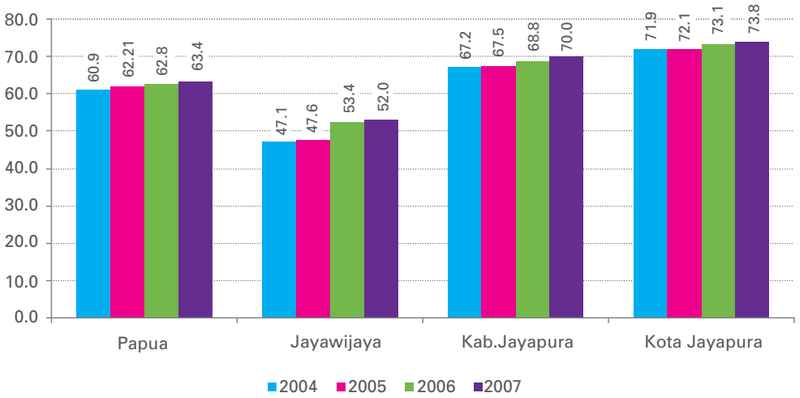
195 Chauvel, R. and Bhakti, I. N. (2004) *The Papua conflict: Jakarta's perception and policies*, East-West Center: Washington, D.C.
196 Vandenbosch, A. (1976) '*Indonesia, the Netherlands, and the New Guinea issue', Journal of Southeast Asian Studies*, Vol.7(1): 102-118
197 Borchier, C. and Vedi R. H. (Eds) (2003) *Indonesian politics and society, a reader*, Routledge Curzon: London/New York; Chauvel, R. and Bhakti, I. N. (2004) The Papua conflict
198 Bachtiar, H. W. (1963) 'Sejarah Irian Barat' in: Koentjaraningrat and Bachtiar H. W. (Eds) *Penduduk Irian Barat*, PT Penerbitan Universitas: Jakarta
199 Blair, D. C. and David L. P. (2003) *Indonesia commission: Peace and progress in Papua*, Council on Foreign Relations: Washington, D.C.
200 Bertrand, J. (2007) 'Papuan and Indonesian nationalisms: Can they be reconciled?' in: Hedman, E.-L. E. (Ed.) *Conflict, violence and displacement in Indonesia*, Cornell Southeast Asia Program: Ithaca, pp32-51
201 Chauvel, R. (2005) *Constructing Papuan nationalism: History, ethnicity and adaptation*: McGibbon, R. (2004) *Plural society in peril*; McGibbon, R. (2004) *Secessionist challenges in Aceh and Papua: Is special autonomy the solution?* East-West Center: Washington, D.C.
202 Ibid.
203 McGibbon, R. (2004) *Plural society in peril*
204 Halmin, M. Y. (2006) *The implementation of Special Autonomy in West Papua, Indonesia: Problems and recommendations*. Naval Postgraduate School: Monterey, California; World Bank (2005) *Papua public expenditure analysis: Regional finance and service delivery in Indonesia's most remote region*, World Bank: Jakarta; UNDP (2007) *Harmonization of human development programme and donors in Papua Province*
205 USAID (2009) *Papua assessment*, USAID: Jakarta; World Bank (2005) *Papua public expenditure analysis*
206 BPS - Statistics Indonesia (2009) *Statistical yearbook 2009 based on the National Socio-Economic Survey (SUSENAS) 2008*, BPS: Jakarta
207 BPS - Statistics Indonesia (2008) *Data dan informasi kemiskinan 2008 (Buku 2: Kabupaten/Kota)*, BPS: Jakarta
208 World Bank (2005) *Papua public expenditure analysis*
209 BPS - Statistics Indonesia (2008) *Data dan informasi kemiskinan 2008 (Buku 2: Kabupaten/Kota)*; BPS - Statistics Indonesia (2009) *Statistical yearbook 2009*, based on the National Socio-Economic Survey
210 World Bank (2005) *Papua public expenditure analysis*
211 Ibid.
212 UNDP (2004) *Indonesia human development report*
213 World Bank (2005) *Papua public expenditure analysis*
214 Ibid.
215 Ibid.
216 Ibid.
217 Ibid.

Figure 4.3.2: HDI, GDI, GEM over time, Papua 1999-2007



Source: HDI - BPS/BAPPENAS/UNDP, Indonesia Human Development Report, 1999-2007; GEM and GDI – BPS/The Ministry of Women's Empowerment, Gender Based Human Development, 1999-2007

Figure 4.3.3: HDI in selected districts, Papua 2004-2007



Source: HDI - BPS/BAPPENAS/UNDP (various years) Indonesia Human Development Report 2004-2007

4.3.2 EDUCATION, HEALTH, NUTRITION, AND WATER AND SANITATION

The low level of education in the province of Papua (captured as a part of the HDI) is indicated by the youth literacy rate (15-24 years), which is much lower than at the national level in 2007 (86 per cent versus 98 per cent, respectively).[218] Figures show that while literacy rates in Papua were decreasing in the first part of the decade, there has been considerable improvement from 2006-2008.[219] However, gender inequalities exist, with the number of illiterate women almost 10 per cent higher than the number of illiterate men (33 per cent versus 22 per cent), according to adult literacy rates (aged 15+ years).[220] While the gender difference among youth is equally wide (young male literacy is 10 per cent higher than for young females), yet literacy rates for each gender are higher overall (91 per cent for young males versus 81.5 per cent for young females) than among adults, indicating that education efforts are starting to make inroads amongst the younger population.

Nonetheless, the net attendance rate at primary schools in Papua was 82 per cent in 2008, and just 49 per cent for junior secondary school (compared to national rates of 94 per cent and 67 per cent, respectively). Again gender differences exist, with girls' attendance rates 2-4 per cent below that of boys.[221] Furthermore, any improvements in these attendance rates at both primary and junior secondary levels have stagnated in recent years.[222]

It is important to note that quality of education is uneven across the province. Teachers' levels of education, presence at schools and ability to teach vary widely, being particularly poor in geographically isolated areas.[223] It is difficult to attract qualified education and health personnel to work in areas without sufficient infrastructure. For example, people in Jayapura enjoy comparatively better education and health facilities than do residents of more rural Wamena. In rural areas, non-government organisations (NGOs) tend to fill in the void of state-run schools. Faith-based organisations provide more than 50 per cent of basic education (primary and junior secondary school) in Papua.[224] Overall, the shortage of buildings, unequal distribution of teachers, low quality of teachers and other factors have slowed down the development of the education sector in Papua.[225]

Special Autonomy has enabled Papua to allocate considerable portions of the budget for the development of various sectors.[226] For example, under the Special Autonomy Law, the provincial government must allocate 30 per cent of the Special Autonomy funds to enhance the development of the education sector.[227] With the enactment of the Provincial Regulation No. 5/2006 on Educational Development in Papua Province, the government has committed to allocating 30 per cent of its budget for education development in Papua. However, later discussion on policy interventions at the end of this subsection demonstrates that this does not seem to have been realised in practice.

Despite considerable improvements in mortality rates over the past 10 years, levels are still higher in Papua than Indonesia as a whole, especially when it comes to under-five mortality rates (U5MR). The infant mortality rate (IMR) was 41 per 1,000 live births in 2007 (versus 34 at the national level) while the U5MR was 64 per 1,000 live births (versus 44 at the national level).[228] Rates were not as high as in NTT in the same year (i.e., 57 and 80 per 1,000 live births, respectively).

218 BPS - Statistics Indonesia (2009) *Statistical yearbook 2009*, based on the *National Socio-Economic Survey (SUSENAS) 2008*
219 Ibid.
220 Ibid.
221 Ibid.
222 ibid.
223 Universitas Cenderawasih (2005) *Papua public expenditure analysis and capacity harmonization: Papua province report*, Universitas Cenderawasih: Jayapura
224 Universitas Cendrawasih (2006) *Studi evaluasi kebijakan dan implementasi Otonomi Khusus di Tanah Papua tahun 2002-2006*, Universitas Cenderawasih: Jayapura
225 Halmin, M. Y. (2006) *The implementation of Special Autonomy in West Papua, Indonesia: Problems and recommendations*; Mollet, J. A. (2007) 'Educational investment in conflict areas in Indonesia: The case of West Papua Province', *International Education Journal*, Vol.8(2): 155-203
226 World Bank (2005) Papua public expenditure analysis
227 Mollet, J. A. (2007) 'Educational investment in conflict areas in Indonesia: The case of West Papua Province'
228 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007*; BPS and Macro International: Calverton, Maryland, USA; See also data from *IDHS 1994 and IDHS 1997*.

Levels of malnutrition in Papua are comparable to the national levels and lower than in NTT, and this is certainly an area that needs further attention nationwide. Proportions of children who are underweight, stunted and suffering from wasting stood at 21.2 per cent, 37.6 per cent and 12.4 per cent, respectively, in 2007.[229] However, in some districts the problem of malnutrition is pervasive and rates are above those of NTT. Inter-district disparity is again key, especially for stunting, which varies from 16.7 per cent in Sarmi district up to 57.4 per cent in Waropen district.

Part of the issue is that preventative measures are not extensive enough in Papua and programmes such as for immunisation have not been as successfully implemented as in other parts of the country. According to the 2007 Basic Health Research (Riskesdas, Riset Kesehatan Dasar), only 32.8 per cent of Papuan children completed their childhood immunisations, while the national average stood at 58.8 per cent. Again, this can largely be attributed to the remote nature of the province, making it difficult to roll out such programmes universally. There is also a problem in Papua of access to clean water and adequate sanitation, which can both affect health and nutrition. Papua is far below the national average in these areas, and while access to adequate sanitation stood at a level similar to NTT in 2008 (19.5 per cent in Papua versus 17.9 per cent in NTT), district disparities in Papua are far greater than in NTT, with only 0.6 per cent of the population having access to a private or public latrine in Tolikara district compared to 95.4 per cent in Merauke district, according to 2008 National Socio-Economic Survey data (see annex 4.3). Similarly, according to the same data set, access to clean water in Papua is also poor compared to national averages, and below that of NTT (27.8 per cent in Papua versus 45 per cent in NTT), and inter-district disparities are similarly wide (see annex 4.3).

Papuan Special Autonomy status is intended to protect and empower the indigenous population, including women and children. The Papuan government has shown a political commitment to address health-related challenges through the enactment of the Governor's Regulation No. 6/2009 on Health Care Provision for Indigenous Papuans. However, providing universal access to health care remains a challenge for the government, particularly when it comes to vulnerable groups such as poor people, women and children in such a large and geographically disparate province with poor basic infrastructure, such as roads, in many remote parts of the province.[230] Long distances from health services and transportation costs constitute the main causes of low rates of accessing quality health and education services[231]. This situation also creates substantial challenges for HIV and AIDS prevention initiatives in the province (discussed later in this subsection). It is important to note that, compared to other provinces, Papua is lagging behind in terms of progress towards achieving the MDGs.[232]

Children in Papua also face a number of other insecurities. The rate of early marriages (under 18 years) is growing in Papua Province (from 33 per cent in 2000 to 38 per cent in 2008) and the rate of birth registration (for children under five years old) has fallen from 37.7 per cent in 2001 to 32.1 per cent in 2007 in both rural and urban areas, according to National Socio-Economic Survey data. Meanwhile, Ministry of Social Affairs puts the number of neglected children in Papua Province at 399,462 (see annex 4.3).

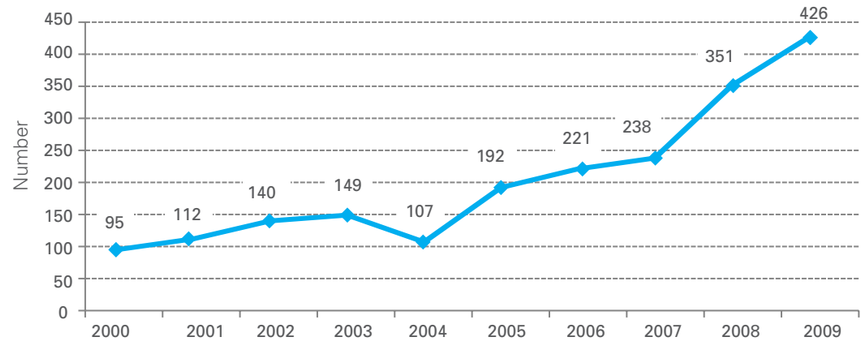
229 Ministry of Health (2008) *Report on the results of the National Basic Health Research (Riskesdas) 2007*, National Institute of Health Research and Development: Jakarta
230 World Bank (2005) *Papua public expenditure analysis*
231 Hutagalung, S. A., Arif, S. and Suharyo, W. I. (2009) *Problems and challenges for the Indonesian Conditional Cash Transfer Programme - Program Keluarga Harapan (PKH)*. SMERU: Jakarta
232 UNDP (2008) *Indonesia human development report*

As is evident in the discussion above, women and children suffer multiple insecurities in Papua in terms of access to education, health services, nutrition, clean water and sanitation and child (special) protection. These factors also interact with adolescent sex practices and the problem of growing HIV infection rates in the province, discussed under the next subheading. The economic development in the province and poor infrastructure, as discussed above, also make it difficult to reach rural and isolated communities with HIV and AIDS interventions and initiatives to improve health and education services, which are inadequate in many parts of the province.

4.3.3 HIV AND AIDS PREVALENCE IN PAPUA

Section 3.3 discussed HIV and AIDS and trends in adolescent sex practices in Indonesia. However, given that the rate of HIV infection has reached a low-level generalized epidemic in Papua Province, much of the discussion in Section 3.3 focused on the problem of HIV and AIDS in Papua where the prevalence rate for the population aged 15-49 years is almost eleven times the national prevalence rate of 0.22 per cent.[233] In a province-wide population-based survey conducted in Papua in 2006, adult HIV prevalence was estimated at 2.4 per cent, and reached 3.2 per cent in the remote highlands and 2.9 per cent in less-accessible lowland areas.[234] These rates are somewhat higher among young Papuans. Among 15- to 24-year-olds, HIV prevalence was estimated to be 3 per cent.[235] HIV prevalence among the ethnic Papuans is higher (2.8 per cent) compared to non-ethnic Papuans (1.5 per cent).[236] However, this difference does not reflect vulnerability based on ethnicity, but rather reflects differences in knowledge levels, particularly related to prevention and safer practices.[237] By 2009, there had been a reported 426 deaths from HIV and AIDS in the province, although the actual number is likely to be higher (Figure 4.3.4).

Figure 4.3.4: Cumulative reported deaths from HIV and AIDS, Papua 2000-2009



Source: Directorate General Communicable Diseases Control & Environmental Health, Ministry of Health

233 Indonesian National AIDS Commission (KPA) (2009) *Country report on the follow up to the Declaration of Commitment on HIV and AIDS (UNGASS)*, National AIDS Commission, Republic of Indonesia: Jakarta, p2. However, provincial level sources put this at 15.4 times that of the rest of Indonesia for Papua province - see Indonesian Ministry of Health (2009) *Laporan triwulan situasi perkembangan HIV & AIDS di Indonesia sampai dengan 31 Desember 2009*, Ministry of Health: Jakarta; Papua and West Papua AIDS Commission (KPA) (2008) *Strategic communication plan for HIV and AIDS: Prevention and management in Tanah Papua, Indonesia*, Papua and West Papua AIDs Commission: Jayapura
234 Papua and West Papua AIDs Commission (KPA) (2008) *Strategic Communication Plan for HIV and AIDS: Prevention and Management in Tanah Papua, Indonesia*,
235 Indonesian Ministry of Health (2009) *Laporan triwulan situati perkembangan HIV & AIDS di Indonesia sampai dengan 31 Desember 2009*
236 BPS - Statistics Indonesia and Ministry of Health (2006) *Situasi perilaku berisiko dan prevalensi HIV di Tanah Papua*, BPS: Jakarta
237 Ibid.

As discussed in Section 3.3, as of 2010, there were an estimated 14,228 cumulative cases of children living with HIV, and this is expected to increase to 34,287 cases by 2014, for Indonesia overall.[238] Although data on the incidence of mother-to-child transmission (MTCT) are still limited, the number of HIV-positive pregnant women is increasing. There were an estimated 5,170 who were HIV-positive pregnant women in Indonesia in 2009.[239] Of that number, only 196 received antiretroviral (ARV) drugs to reduce the risk of MTCT (3.8 per cent), indicating limited prevention of mother-to-child transmission (PMTCT) services.[240] It is projected that the number of HIV-positive women needing PMTCT services will increase from 5,730 people in 2010 to 8,170 people in 2014.[241] Furthermore, the number of children infected by their HIV-positive mothers at birth or through breastfeeding is expected to double from estimates of 2,470 in 2008 to 6,240 in 2014.[242] Finally, it is estimated that 1,070 babies were born with HIV in 2008 and this is expected to rise to 1,590 in 2014.[243] Given that the prevalence of HIV is highest in Papua and accounts for a large proportion of the infection rates mentioned above, it is important that initiatives focus on prevention for both women and children. Yet, in 2009 in Papua Province, 58 women accessing PMTCT HIV services tested positive for HIV but only 13 of these received ARV treatment.[244] Furthermore, there is likely a very high level of underreporting of HIV and AIDS cases given the low knowledge of HIV discussed below. All of this indicates that there is great scope for improvements in the coverage of the initiatives outlined in Section 3.3 for more effective HIV prevention.

4.3.4 CONTRIBUTING FACTORS TO THE GROWING RATES OF HIV INFECTION IN PAPUA PROVINCE

4.3.4.1 General overview

The discussion in Section 3.3 highlighted that in most parts of Indonesia the problem is concentrated in high-risk populations, including intravenous drug users (IDUs), men who have sex with men (MSM), sex workers and their clients, and the sexual partners of all of these groups). It also outlined the changes in the types of infected populations, highlighting that growing numbers of women - particularly the partners of IDUs and of male clients of sex workers - are being exposed to HIV infection, and thus there has been a feminization of the epidemic.[245] This could also lead to higher rates of children born with HIV. Section 3.3 highlighted that according to government reports, the two worst affected provinces in Indonesia are Papua and West Papua, and the generalized epidemic in these provinces is driven almost entirely by unsafe sexual intercourse, with HIV prevalence of 2.4 per cent among the general population aged 15-49 years.[246] Various other reports cited in Section 3.3 found that the patterns of HIV transmission are somewhat distinct in Papua, attributing this to the following factors:

- HIV transmission is largely taking place through unprotected sex and the frequent changing of partners.[247]
- The early onset of sexual activity.[248]
- Lack of knowledge about reproductive health, sexually transmitted infections (STIs) and means of protection.[249]
- Low usage, availability and accessibility of condoms also play a part in the rapid spread of HIV infection.[250]
- Women and girls tend to lack information as well as lack a voice in sexual decision-making, increasing their vulnerability to infection.[251]
- Root causes and challenges, including poverty, low levels of education and knowledge of HIV, and isolation in rural highland communities.[252]

Focus group discussions (FGDs) with government education officials at the provincial level and in Jayapura municipality, and with teachers, principals, civil society organisation (CSO) workers, health practitioners and health officials, also sought to identify what has led to the increase in the HIV epidemic in Papua. In addition to the factors identified in the other reports discussed above, FGD participants also highlighted a range of contributing factors to HIV transmission (and associated vulnerabilities) which they related to poverty, the growing sex industry, sexual practices, unsafe sex, knowledge, stigma, attitudes towards illness, and structural problems with implementing policies, such as the regulatory environment and a lack of district level funding for initiatives (see Box 4.3.1).

Box 4.3.1: Contributing factors to HIV prevalence and emerging efforts to combat this in Papua - FGD results

Views on contributing factors to HIV transmission:

- The vast proportion of HIV transmission is through sexual intercourse.
- It is common practice for men and women to have multiple sexual partners.
- Drunkenness affects judgement and the likelihood that people will engage in unprotected sex.
- The reality is that half of Jayapura's population has never even heard of HIV or AIDS (emphasised by health practitioners).
- Women with low education don't seek out prenatal care (and relevant tests) often until they are eight or nine months pregnant, when it is very late to initiate efforts to prevent transmission to their babies. Even if they know about HIV, if they can't see how they might have been affected they are offended if they are offered Voluntary Counselling and Testing (VCT) services, as they associate it with being accused of having done something immoral.
- HIV and AIDS is still highly stigmatized among those who know about it. When a woman or a child is found to be infected with HIV and AIDS they are often driven out of the house by their families, resulting in increasing numbers of street children exposed to other vulnerabilities.

238 BAPPENAS, National AIDS Commission (KPA), UNICEF, and UNAIDS (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, Jakarta
239 Indonesian National AIDS Commission (KPA) (2009) *UNGASS report*, pix
240 Ibid.
241 BAPPENAS, et al. (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*; see also the National AIDS Commission (KPA) (2010) *National HIV and AIDS strategy and action plan 2010-2014*, KPA: Jakarta
242 BAPPENAS, et al. (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, p20
243 Ibid., p18
244 Ministry of Health, Directorate for Direct Transmitted Disease Control (2009) *Internal report*, Ministry of Health: Jakarta
245 BAPPENAS, et al. (2008) *Mathematic model of HIV epidemic in Indonesia 2008-2014*, Jakarta, p17
246 BPS - Statistics Indonesia and Ministry of Health (2007) *Risk behavior and HIV prevalence in Tanah Papua*, BPS: Jakarta. The data for this report were collected in 2006.
247 UNDP (2005) *Papua needs assessment: An overview of findings and implications for the programming of development assistance*, UNDP: Jakarta (Indonesia), cited in Indonesian National AIDS Commission (KPA) (2009) *UNGASS report*, p25
248 KPA (2009) *UNGASS report*, pp24
249 Ibid.
250 Ibid.
251 Ibid.
252 GoI/UNICEF (2009) *Averting new HIV infection in young people in Papua and Papua Barat: An education sector response, January 2010-December 2013*, GoI/UNICEF: Jakarta

- HIV and AIDS is attributed to various problems from witchcraft to tuberculosis. Despite the prevalence of HIV and AIDS in the highlands, few highlanders compared to lowlanders report knowing people affected by HIV or AIDS.
- Lowlanders tend to seek medical help for illness, while highlanders tend to self-treat; which indicates different availability of and access to medical services in the two regions.
- Papuans' perceptions of sickness compound the problems related to HIV and AIDS. Many people do not get prompt treatment because they do not think they are sick. One FGD participant explained that Papuans don't regard fever as a sign of illness. They will acknowledge that they are sick only when they can no longer get out of bed.
- There are growing numbers of sex workers in the province, accompanying increasing development and industrial expansion.
- Women who are unable to make a living from subsistence production find sex work a way to supplement their meagre incomes.
- There are around 4,000 regulated sex workers. There are another 4,000 'street workers', or sex workers who do not operate from a fixed location. There are almost certainly at least another 4,000 women who are involved in an 'underground' sex industry in rural locations across the province.
- Some are willing to be paid a minimal amount of money for sex; enough to buy credit for their mobile phones. This type of sexual transaction is known as seks pulsa (sex for phone credit).
- Having multiple sex partners in a group context is labelled sequential sex (seks antri). Sequential sex is a negotiated sexual service where a woman allows several men to have sex with her one after the other. This may increase exposure to HIV.
- There are inconsistent and contradictory regional regulations (some yet to passed) relating to HIV and AIDS. Where regional regulations have been passed, none have accompanying technical guidelines and thus have not been implemented. According to one regulation, if a pimp is aware of a sex worker having contracted an STI, they must bar the sex worker from working, and a failure to do so would result in a hefty fine. Yet this regulation has not been implemented.
- Currently NGOs implement the majority of programmes targeting adolescents. The government has no programmes specifically targeting youth.
- Several government programmes were clearly designed without a prior needs assessment. As a result, these programmes do not correspond to the realities in the field.
- One clear planning issue is insufficient funding at the district level. This means that health agency staff are not able to make field visits when forming policies, programmes or action plans - they engage in 'desk planning' that is not based on actual data. This is also a human resource problem - agency staff lack comprehension of the programme planning process.

Impressions about changes beginning to occur and efforts being made to combat the problem:

- The Jayapura AIDS Commission has a programme specifically targeting adolescents aged 12-14 years. The programme aims to educate adolescents on sexual and reproductive health and HIV and AIDS, given the growing risks facing young people.
- The provincial government is leading the mainstreaming of HIV and AIDS and life skills education into the education sector to reach all students.
- Information and education campaigns are beginning to make use of local culture and idioms to increase effectiveness. For example, 'Dare to say No, and nothing ill will come about', 'Healthy dating - remember, dating is for releasing the heart, not for sexual release', 'Protect yourself, use protection', and 'Recklessness can lead to HIV'.
- There is increasing awareness on prevention of mother-to-child transmission of HIV. Expectant mothers are provided with information, advised to have early blood tests, and, if HIV-positive, given drugs to suppress the virus. The mothers are advised to give birth via caesarean section and not to breastfeed.
- Nowadays numerous sex workers do not fear rejecting customers who refuse to wear condoms. Those most reluctant to use condoms tend to be the boyfriends and the regulars.

Source: FGDs conducted at the provincial level with education officials and practitioners (7 September 2009), Jayapura municipality with education officials and practitioners (10 September 2009), and in Jayawijaya municipality with health officials, CSO representatives, and health practitioners (17 September 2009). Follow-up FGDs were also conducted between 11-14 August 2010 with CSO staff and health practitioners in Jayapura.

FGDs were also conducted with children to ascertain how they perceive both the situation of children in Papua in general and the problem of HIV and AIDS in particular. Box 4.3.2 outlines how children themselves perceive their situation and main vulnerabilities.

Box 4.3.2: Voices of children in Papua on the vulnerabilities they face - FGD results

The situation for many is difficult for the following reasons:

- Many children have to work, particularly if their parents are no longer alive, and many quit school.
- One of the largest influences on children is whether their parents are alive, and if they are, whether they are able to live with them or not. There is little assistance from the government or community for children who have lost one or both parents.
- Some parents, particularly poor parents, are very busy with work and struggling for money and material happiness, but children don't just need that. With busy working parents, children feel like they have lost their parents and are therefore unhappy. So they prefer to stay at their friend's houses or on the street since they can't stand to be alone in their houses anymore.
- Home and family should be the main source of support for children's growth and development both physically and mentally. Families should also be the main source for love, attention and protection. In reality, home and family become the main source of verbal, physical and psychological violence. To escape from this situation, children prefer to be away from the home, and one alternative is the church. In such cases, the church is not seen as a place to seek God's love, but to look for love and attention from friends, carers and counsellors.
- There are gaps between the children in immigrant and local ethnic groups. The phenomenon is like an iceberg that could melt and fall apart, endangering social relationships between communities. Violence in the street through 'thuggery' is common among Papuan children; they are allowed to do it against people who have different coloured skin.
- The allocation of Special Autonomy funding has not been fully felt by students in Papua, not when compared to the effects of the Special Autonomy funding for the health sector. The high school fees are still burdensome for poor students, despite the promise of free

schooling. Also, teachers do not carry out their functions and duties properly as educators and instructors. Even worse, some of them are violent towards children, which could lead to children themselves being violent in the future.

Views on sexual practice and HIV transmission:
- What goes on in the neighbourhood has a huge influence over children's way of thinking and lifestyle, like drinking, smoking and 'free sex'. The greatest amount of influence comes from peers.
- Pregnancy out of wedlock is a common thing in Papua since in local customary norms there is no burden of sanctions or paying fines to the pregnant woman's family. Moreover, 'free sex' is also perceived as a prevalent thing, so that HIV is easily transmitted.
- HIV and AIDS is commonly known as the 'three letter disease' (HIV) or 'seven letter disease' (HIV-AIDS). It is a common disease in Papua. Its transmission is uncontrolled since it is difficult to control and monitor people and children who engage in 'free sex'.

Perceptions about problems with government assistance:
- Assistance through health initiatives has been implemented well enough, but progress in education is less monitored. Funding comes from higher levels of government through so many levels of the bureaucracy that by the time it arrives at the school, the funds 'have been cut a lot'. As a result, the students don't feel the benefit of the assistance. Schools only ask the students for their signature without giving the money directly.
- Monitoring and supervision of this assistance doesn't really happen. Corruption cases are difficult to investigate.
- Child forums, which are supposed to be a way for children to help themselves, have not functioned very well. Lots of children are not active in these forums and prefer to focus on their social life, with all its negative effects.
- Political conditions don't really help children. The main problems are the complicated bureaucracy and corruption.

Source: Four FGDs conducted at a local church in North Jayapura (17, 18, 20 and 22 September 2009). Participants were four boys and four girls, both indigenous and non-indigenous Papuans, aged 12-15 years.

During the multiple discussions with children during the FGDs and the in-depth interviews, they explained that HIV and AIDS could be spread by 'free sex' and switching partners, not using protection during sex, blood transfusions, and by injecting drugs with needles. However, almost all children argued that the largest contributing factor is 'free sex'. They said that 'free sex' does not violate cultural norms in many (but not all) communities, and many customary communities (adat communities) consider pregnancy out of wedlock (hamil di luar nikah) to be something that doesn't incur heavy customary sanctions. Usually, they said, men might need to pay a customary fine. Children who are most likely to engage in 'free sex' are those from broken homes, they said, or those experiencing peer pressure. They also explained that partying and heavy drinking contribute to the problem, as children who have 'free sex' when they are drunk are more likely not to use protection and consequently more vulnerable to infection. However, not all of the children participating in the FGDs and interviews agreed about the practice of 'free sex'. Some saw it as meaning that children are not taking care of themselves, while others said it was acceptable when someone gained employment or as long as they were responsible and paid the customary fine, and others said 'free sex' was prohibited by religion.

Nonetheless, not all Papuan children understand the relationship between sexual practice and the risk of HIV infection. For example, Novendi[253], one of the Papuan boys interviewed during the research, didn't know anything about HIV and AIDS. Another child, Ona, who is living with HIV, didn't know about the disease or its treatment. Ona said, "I know there is no medicine for HIV and AIDS. I get some medicines or vitamins that I have to take every day after eating. If I run out I go to the local foundation that gives me this."

Essentially among the government, development workers, service providers and practitioners, CSO staff, and children themselves, there is an understanding of the long list of contributing factors to both vulnerabilities for children in general (such as poverty, poor living conditions, poor education, parent-child relations in the domestic environment, attitudes amongst children towards unprotected 'free sex') and in relation to HIV transmission in particular (such as knowledge, behaviour, resistance to current modes of education and public information campaigns, attitudes towards illness, and the provision of support and treatment services). However, knowledge about the disease among children themselves is varied. A number of other studies and interviews confirm some of the FGD findings on what is driving the HIV and AIDS epidemic in Papua, which are discussed further below to show why current interventions might not be having an optimal impact in the region.

4.3.4.2 Perceptions of illness, knowledge and language of communication: The challenges for preventing transmission

It was repeatedly evident during the fieldwork that preventing HIV transmission in Papua is not simply a matter of basic education about the disease and its effects, although education levels are a problem (as has been outlined by various studies mentioned above and in the FGDs). It is a far more complicated problem of communication between people who are knowledgeable of the disease and local communities. In particular, there is resistance to understanding the manifestations of the disease and its relationship with sexual practice and behaviour, and resistance to changing behaviour when it is painted as immoral or as leading to the spread of the disease. Even when people are informed about the disease and its effects, often because it is communicated in ways that are not culturally sensitive, they resist changing their behaviours. Furthermore, some people in the province are suspicious about the origins of the disease. The discussion below highlights that combating HIV and AIDS in the province through knowledge is not just a matter of mass education drives, but rather information dissemination in a culturally sensitive and appropriate way.

A number of health practitioners and CSO staff highlighted that one of the problems with HIV prevention is that in the initial stages of infection, people don't feel sick, so they don't change their sexual practices to prevent transmission. For example:

> "HIV and AIDS transmission is strongly related to behaviour. It is difficult to get people who are already infected with HIV or AIDS to change their behaviour. This is what makes the virus so effective. When people get infected, they don't feel sick. What's more, they don't believe they are sick even when they are told they have HIV because they don't feel sick. So they don't change their behaviour to prevent transmission." (Participant in FGD with staff from the Jayapura Church and Muhammadiyah organisation, 11 August 2010)

253 All names have been changed to protect the interviewees.

Another FGD participant further highlighted that:

> "The problem with changing behaviour is that it is strongly related with levels of knowledge. For those who don't know about HIV and AIDS it is difficult to get them to change their behaviour, even when they have been infected. This is partly a problem of communication. Often we are lied to [by patients] when we conduct the voluntary counselling and testing. We ask the patients, have you had sex? They say, never. But if we ask [using different terms and language] have you ever 'had it off' (baku cuki) or 'got on top of a woman' they say they have. Indeed, these are slang terms that could be considered crude. But we have to use their language so we can communicate and they understand what we mean." (Director of Waena Hospice, 12 August 2010)

What's more, there is the perception in Papua that HIV and AIDS is some kind of trick. Given the struggles between Papuans and the central government for greater autonomy and ultimately independence over the last four decades, different CSO staff and religious leaders argued that there is a fairly strong perception that HIV has been deliberately brought in from outside to get rid of the Papuan race. The view expressed in the following quote was also articulated in a number of other interviews with practitioners struggling to educate about prevention of HIV transmission:

> "Changing behaviour for people infected with HIV [such as monogamy or condom use], often doesn't happen because many in the community still believe that HIV and AIDS are a trick. Many still believe that HIV is part of an effort to commit genocide by the central government by bringing in commercial sex workers who are already infected with the virus in order to get rid of the Papuan race." (Confidential interview, 12 August 2010)

It was evident in the information gathered during the fieldwork, FGDs and in-depth interviews, that one of the greatest challenges to preventing transmission is getting people to understand how the virus works and that it is a problem throughout the world and not just in Papua. The Head of the AIDS Commission in Papua said:

> "I try to impress on the community here that HIV and AIDS are not just in Papua, but it is a problem across the world. HIV prevention will be effective when the Papuan people are active in its prevention." (10 August 2010)

It is important to bear in mind that talking about HIV prevention in Papua is fraught with tension and contradictions, especially when the practices defined and celebrated by cultural values are implied to be immoral, or the imperative of changing accepted behaviour is pressed on local peoples, or sexuality is framed in terms of 'risk' and 'promiscuity'. Customary practices are often viewed as exotic or immoral and are devalued and discouraged in the discourse of HIV interventions, which thus meets ith resistance in communities.[254] As one medical doctor working in the sector put it:

> "When we talk about Papuan culture, particularly as relates to conjugal relations, non-Papuans tend to focus the discussion on stereotypes of Papuan sexual practices. They are often highlighted as deviant and dangerous. You know, wife swapping, sequential sex and the like. The cultural practices are taken out of context. They are construed as bad. People who work in the field of health point a finger at culture as the underlying cause of the HIV and AIDS epidemic. Then people wonder why Papuans are reluctant to talk about the relationship between culture and HIV and AIDS. Some people even portray Papuans as defensive when they talk about the relations between AIDS and their culture." (in-depth interview, medical doctor, Jayapura, 14 September 2009)

254 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*, Universitas Cenderawasih: Jayapura; Seidel, G. and Vidal, L. (1997) 'The medical, gender and development, and culturalist discourses on HIV/AIDS in Africa, and their implications', in: Shore, C. and Wright, S. (Eds), *The anthropology of policy*, Routledge: London, pp59-87

Cultural understanding of sexual practices in Papua is incredibly important for creating culturally sensitive forms of communication about HIV transmission, particularly since condom use is low in Papua.[255] While condoms are an effective way of reducing the transmission of HIV and they are relatively cheap and accessible, still promoting behavioural change and condoms use is difficult in a context where there are value systems relating to when and where bodily fluid should be discharged.[256]

While research has shown that Papuans have a low level of understanding about HIV and AIDS, there have been few studies that situate knowledge of HIV risk and prevention in a broader context of cultural practice and experience. Studying sexuality in Papua is a complex undertaking. There are over 250 linguistically distinct cultural groups in Indonesia's easternmost province. It is just as difficult to generalize responsibly about Papuan sexuality overall as it is to fully describe the unique practices and beliefs of particular tribal groups.

Being mindful of the diversity within Papua, a Papuan anthropologist gives the following snap shot of Papuan sexual practices. His observations and analysis support some of the findings from the FGDs and other studies discussed above. Furthermore, he also explains how there may be a mismatch between information drives and locally accepted practice:

> "There are several things, some of them may have roots in culture, some may be the result of newer trends or changes, that we have to take into account when we talk about HIV and AIDS in Papua.
>
> "The first thing is age at first sexual encounter. The age seems to be getting younger and younger. Then there is 'secret sex' that happens in social events like parties. It is, well, a secret, so it is clandestine. Somebody will 'hook up' the couple. It involves gifts, either money or goods. This also takes place across cultural boundaries, such as when people travel outside of their local areas. So it related to a high degree of mobility.
>
> "There are some deviations from norms in other places, such as extramarital affairs and multiple sexual partners. A small number of people may have very active sexual lives. In some places some older men have sex with younger girls. There are some cultural roots for this trend.
>
> "There is seks antri (sequential sex), in which a group of men has sex with a single woman, one after the other. It's not gang rape, since this is agreed upon and negotiated. Usually it involves a group of men who don't have enough resources to give gifts to a potential girlfriend. They seek other men in a similar position to pool resources. This places the girl at risk of contracting HIV and AIDS and at risk of facing violence.
>
> "Don't forget social changes that encourage the use of pornography to incite sexual activity. Increasingly, girls and boys may be having sexual intercourse at a very young age.
>
> "Oh, I almost forgot to mention that gift-giving that relates to sexual intercourse is rooted in some local cultures. Bride price is one example. When a woman is exchanged for bride price, people understand that a part of the exchange includes sexual access for the groom.

255 BPS - Statistics Indonesia and Ministry of Health (2006) *Situasi perilaku berisiko dan prevalensi HIV di Tanah Papua*
256 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*

This exchange of goods for sex is already part of the cultural make-up in many Papuan groups. This is important to understand because nowadays some people give cash as a gift. That can be misconstrued as commercial sex by somebody who is not familiar with the Papuan culture. Well, in a lot of cases it is not commercial sex, even when the women have sex with multiple partners.

"Now, having sex with 'friends' and 'acquaintances' in Papua offers a similar level of risk to having sex with sex workers, but the difference between the two is not necessarily clear to the many youth who have sex with members of both groups. Promoting safe sex with friends needs to be a prominent feature of youth-focused campaigns.

"This pattern is also shaped by economic changes, for younger girls may have sex with older men because they imagine older men to be rich and able to easily look after them."

(In-depth interview, Papuan anthropologist, Jayapura, 9 September 2009)

It is evident that understanding Papuan sexual practices is important for those working in health service delivery and HIV prevention, especially concepts of monogamy and multiple sex partners. As one CSO activist in the field put it:

"Now, when we talk about the relations between culture and HIV and AIDS we have to be aware that there are two cultures at play, the Papuan and the non-Papuan cultures. Health providers and health users often belong to different cultures. If the health provider belongs to a culture that adheres to monogamy, don't you think that he or she will look at monogamous relationships from his or her cultural angle? I think there is a possibility that health providers will look down upon the culture that is not their own. As a consequence, the local culture is labeled as being a risk factor for HIV and AIDS infection. While that may be so, a judgmental tone won't sit well with the Papuans." (NGO activist, Jayapura, 13 September 2009)

Understanding of Papuan value systems is crucial for shaping policy regarding HIV and AIDS. In Papua, government and non-government agency employees work together to educate the general population about AIDS, using a simple prevention message based on the ABC approach: A for abstinence (abstinen), B for be monogamous (baku setia), and C for use a condom (kondom). Given the lower age of sexual debut (discussed further below), and what are considered to be locally acceptable sexual practices, there may be a mismatch between the information conveyed in HIV prevention campaigns and local value systems, particularly with regard to abstinence and monogamy. This is especially the case given that a 2009 University of Indonesia survey of adolescents found that males, particularly in the 16-18 years age group, were more likely to have had multiple sexual partners, particularly in eastern Indonesia - in NTT and Papua. Realistically, safe sex may be a more appropriate way to address the risks of HIV and AIDS, albeit with less political viability.[257]

4.3.4.3 Early age of sexual debut

The average age of sexual debut is 19.5 years for males and 18.8 for females, according to 2006 data.[258] However, among youth in Papua (15-24 years) the number with sexual debut before 15 years of age is significantly higher than amongst people in older age groups (25-39 and 40-49 years).[259] In 2009, the University of Indonesia conducted a survey on the situation of adolescents in Indonesia, as discussed previously in Section 3.3. Amongst survey respondents aged 10-18 years old, the earliest age of sexual debut reported was 9 for boys and 11 for girls in the rural Jayawijiya district, and the average age for girls was 14.8 while the average age for boys was 13.7 in this district. However, in the more urban Jayapura municipality, the average ages of sexual debut were higher (15.5 for boys, 15 for girls) with the earliest reported ages among respondents also being higher, at 13 for boys and 15 for girls. These results confirm the findings of 2006 data and also illustrate that the age of first sexual debut may be younger in more rural areas in the province.

Like many teenagers around the world, teenagers have sex for a variety of reasons, but knowledge of safe sex can prevent transmission of HIV. Two children describe their experience in Box 4.3.3 below, where lack of condom use in one case led to HIV infection.

Box 4.3.3: What youths say

What Nita, 16 years old, says...
"Here's how it went. That night he asked me, 'Do you care for me?' I told him I did, and he asked me to prove it. Well, I asked, 'Prove what?' He then told me to close my eyes and it happened blah…blah…blah... and on that night I was introduced to the world of sex. It happened on a Saturday, at midnight on 8 August 2008. At the time I was so afraid of losing him and I didn't want to be apart from him, and I hoped one day to always be with him."

After the incident, Nita suffered a pain in her vagina and had difficulty walking for a week. She also described her feelings after the incident. "I told my boyfriend that I was hurting, and he took pity on me, apologized and felt guilty. I also felt guilty, towards God, because I know it was against religious teachings, because we weren't married. I also felt guilty towards my mother, because she gave birth to me, but now I no longer listen to her words. I'm no longer a trustworthy daughter. Even though my mother doesn't know it, I still feel guilty."

To prevent infection, Nita says, "We always have an umbrella [condom] ready before anything happens." Nita has not told anyone else that she is sexually active. She considers it a secret not to be shared with anyone, because she fears the potential scolding, the guilt, the shame, the mocking, and being cast out. She has not told her relatives, best friends or her dance-group friends, even though her friends often come to her with their secrets. Although, she says, "They often confide in me, telling me that they've had sex with their boyfriends or

with someone else. Often they tell me these things clearly while feeling guilty or sad, and ask that I keep their secrets. I feel for them, I give them advice. Still, even though many of my friends tell me these things, I don't want to tell them my secret, I'm too ashamed and embarrassed. It's my secret. Only I, my boyfriend, and God, knows."

Nita acknowledges that being in her teens makes her very vulnerable and impressionable. Nita confesses to often yielding to peer pressure to smoke, drink alcohol and other reckless activities. Many of her friends like these activities, and Nita often finds herself joining in. She feels that her happiest moments in life are moments spent with her friends. Nita is less comfortable and content at home because of her father's strict parenting and her awareness of the family's less than prosperous economic situation.

257 Ibid.
258 BPS - Statistics Indonesia and Ministry of Health (2006) *Situasi perilaku berisiko dan prevalensi HIV di Tanah Papua*
259 Ibid.

What Natalia, 15 years old, says...
Natalia ran away from home when she was 15 and still has limited contact with her family. She is HIV-positive. She says, "[My ex-boyfriend] said that if we love each other we don't need to use condoms, he said, 'If you get pregnant, I'll take responsibility.' That's what he said the first time we had sex. Initially I was afraid, but he said if I loved him then I have to prove it, and that I'll have to let him take my virginity. My ex-boyfriend infected me with HIV. I'm certain it was him because I went out with him for a long time, and I was still with him when I found out I had been infected."

"After I broke up with my ex-boyfriend, I became a street sex worker. Initially because a friend brought me along. Before that I didn't want to do it. The friend forced me into it, and eventually I wanted to do it, mainly because I need money to live, of course. My friend had nice clothes, could buy nice face powder, and I wanted to have those things too. I always ask [the clients] to wear a condom. If they refuse, then I refuse to service them."

Source: Source: Child interview conducted by PSKK, UGM in Jayapura, 2009; Nita and Natalia are not the real name

4.3.4.4 Knowledge of reproductive health, safe sex and HIV testing

The relatively early age of sexual debut is not accompanied by sufficient knowledge of reproductive health in Papua, such as about STIs, including HIV and AIDS. This lack of information increases sexually active children's vulnerability to infection. A 2006 study found that 48 per cent of the population had never heard of HIV or AIDS.[260] Population groups with low rates of formal education (i.e., many who never attended school or did not complete primary education) had much lower levels of knowledge, with 74 per cent never having heard about HIV or AIDS, compared to 20 per cent of those who have graduated from senior high school or university.[261] However, the 2009 University of Indonesia survey did find that across the age cohorts, as age increased so too did knowledge of reproductive health. Further discussion regarding knowledge of STIs and safe sex practices among adolescents in Indonesia, including Papua, can be found in Section 3.3, which highlighted the infrequent use of condoms and safe sex practices, and the poor knowledge about Voluntary Counselling and Testing (VCT) clinics.

Even when people are aware of the routes of HIV and AIDS transmission and have the intention to protect themselves, gender inequality often undermines these efforts. Women's low status makes it harder for them to demand fidelity from their partner, to insist on condom use or to refuse sex, even if they know their partner is infected.[262] They may face violence, abuse or abandonment. Often local women are expected to be 'unaware' and submissive in sex, which makes negotiating for safer sex more difficult.[263] It is therefore not surprising that the categories of women most affected include sex workers and the wives of IDUs and of clients of sex workers.

260 Ibid.
261 BPS - Statistics Indonesia and Ministry of Health (2006) *Situasi perilaku berisiko dan prevalensi HIV di Tanah Papua*
262 Ledang, V. and Mayabubun, K. (2010) *Situasi perempuan dan anak Papua di era Otonomi Khusus: Catatan untuk satu tahun terakhir*, INFID: Jakarta
263 Butt, L. (2005) '"Lipstick Girls" and "Fallen Women": AIDS and conspiratorial thinking in Papua, Indonesia', *Cultural Anthropology* Vol.20(3): 412-442

4.3.4.5 Rapid development and the growing sex industry: Risks for children and women

The traditional way of life, values and practices in Papua have been transformed by a variety of factors including the introduction of the cash economy and increasing access to resources since implementation of Special Autonomy, the introduction of Christianity, the process of internal migration, and also the influx of transmigrants from other parts of Indonesia, bringing new cultural value systems.[264] Rapid development and the cash economy together have increased the frequency with which people in Papua seek money or goods in exchange for sex, according to Butt et al. (2002a and b).[265] Follow-up interviews in Papua also revealed that with the creation of new regions following the implementation of decentralisation, job opportunities are opening up in other parts of the province, which has led to an increase in internal migration rates. The sex industry, interviewees argued, tends to follow the migration routes.[266] This is important, given that sex workers, their clients, and their clients' partners are among the most vulnerable groups with regard to HIV infection, as discussed above. Interviewees also explained that with the speed of migration and the consequent frequent relocation of the sex industry, particularly to remote areas, information dissemination and health facility provision is failing to keep up, despite efforts to place VCT centres in community health clinics in at least some of these areas.[267]

They also argued that with migration for employment and the use of different sex workers, infected men are spreading the virus to sex workers and to their partners.[268] Many argued that rapid development under Special Autonomy in places like Jayapura has created a growing culture of consumerism, which is attractive to children as they witness the development of new hotels and restaurants, and the increased use of mobile phones, etc.[269] Several different interviewees and participants in different FGDs in various regions also elucidated the problem popularly portrayed as the '3 Ms' (men, mobile phones, money). The 3Ms have led to greater risks for children and women, whose fathers and husbands/partners (men) travel for work (money), and use sex workers who may be HIV-positive, are then infected with HIV and on return later infect their partners. Different interviewees added that increased incomes, the growing cash economy, and growing consumerism with Special Autonomy have led youth (with repeated mention of street children) to exchange sex for money to buy mobile phones.[270] As one child explained:

> "Nowadays there are many kids who have things. They have everything from head to foot. Their clothes are really good quality. I know my parents are only small-scale farmers. They can't buy me things like my friends have. But I get jealous when I see my friends with their good things. My parents know I want good things and they feel sad that they can't buy me a mobile phone… I wanted to see a different world, which was fun! So, I went to Jayapura [city]. When I was on the boat, I did cry because I was a bit scared, then I found Mama Fin [who runs a halfway house for homeless children]. Sometimes, I remember my parents and I miss them, but I have contacted them. They said to me, 'Look out!', if I go home they will hit me. But I am not scared anymore… Jayapura is great." (Ester, 10 August 2010)

264 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*; Butt, L., Numbery, G. and Morin, J. (2002) 'The smokescreen of culture: AIDS and the indigenous in Papua, Indonesia', *Pacific Health Dialog*, Vol.9(2): 283-289.
265 Ibid.
266 A variety of interviewees, Jayapura (11 August 2010)
267 A variety of health practitioners, Jayapura (11-14 August 2010)
268 Ibid.
269 Ibid.
270 Ibid.

Mama Fin, who runs the halfway house, described the situation as follows:

> "Many girls who run away from home take the boat from Serui or Sentani to Jayapura. They are pretty smart kids. When they get on the boat they pretend to be food peddlers [allowed on the boat to sell food to passengers]. But we have investigated this pattern somewhat and found that many kids don't sleep on the deck, but instead they pay for their ticket with their bodies (through sex) making it easy to go back and forth between Serui and Jayapura without buying a ticket. Kids like Ester were lucky because she found her way directly here. But many kids don't know Jayapura at all and they are at great risk of exploitation because they have to survive somehow and meet their daily needs…There are many children who are selling sex on the streets to buy things that they want, mainly mobile phones. But they face so many risks. When they get drunk from the local alcohol or sniff glue, they don't really know what they are doing…often they only understand the risks after they have been infected with HIV." (13 August 2010)

A number of different NGO and health workers in Papua explained that many parents don't know how to parent their children, and some of them use violence to solve problems. Children, especially those from poor families whose parents spend most of their time working in the fields or plantations, don't have time for their children.[271] These problems lead to children feeling abused or neglected and they may either run away or find other forms of entertainment, such as having sex (as was also evident from the discussions with children, as previously described). One World Vision staff member explained that in Wamena, for children in junior or senior secondary school, it was not uncommon that they changed sex partners up to 10 times at teenage sex parties or other festivals (Interview, 14 August 2010).

Rates of domestic violence, forced sex and sex work have increased with the large inflows of money in once remote regions.[272] Women are at increased risk of abuse. Competition between men for money, resources and prestige can lead to increasingly risky sexual behaviour.[273] One teacher made the following argument:

> "We need to understand that many of our young people are caught in two worlds. Many children in the highlands have to travel a long way to go to school. Sometimes the teachers are not there. So the transfer of knowledge is often minimal. At the same time, their understanding about the values of their people has weakened. Well, tradition in general has weakened. Originally sex was strictly regulated in tribal traditions. Now things have changed. Sex is loosely ruled. Punishments that made youth delay having sex are no longer carried out. Life has changed. Youths need more activities to fill in their time, but they don't have a lot of choice. What's left as a source of enjoyment is their bodies. At the same time, they have no knowledge about diseases and infections and how they can get them. This puts them at a high risk for contracting HIV. Clearly, the HIV and AIDS epidemic will not be solved by focusing only on changing the sexual behaviour of youth, but should emphasise their lives in a more complete way." (Jayawijaya, 17 September 2009)

Understanding teenage sexual practices within the larger socio-economic and cultural environment in Papua is important for designing more effective communications programmes to prevent HIV transmission. The above discussion goes some way towards explaining what may be preventing the national campaign and education policies (and their local level equivalents)

271 Ibid.
272 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*; Butt, L., Numbery, G. and Morin, J. (2002) 'The smokescreen of culture: AIDS and the indigenous in Papua, Indonesia'
273 Ibid.

from improving levels of knowledge and safer sex practices in the region. Given the diversity in terms of terrain and culture in Papua, and the larger constraints of poverty, poor health and low education levels in the province, it is clear that even the programmes themselves will need to be flexible enough to adjust to the wide variety of local environments.

4.3.4.6 Stigma of HIV and AIDS

The attitudes of people in Papua who personally know someone living with HIV are highly diverse. According to 2006 data, the highest percentage of survey respondents (34.3 per cent) kept their distance from people living with HIV (PLHIV).[274] PLHIV were shunned by a slightly higher percentage of males than females (36.7 per cent compared to 31.4 per cent), and by those with lower levels of education (57.3 per cent of residents who had not attended school/completed primary school, compared to 43.2 per cent of those educated to primary and junior high school, and 21.8 per cent who those graduated from senior high school and above).[275] Just over one quarter (28.3 per cent) treated PLHIV just like any other people.[276] Females are less likely to stigmatize PLHIV compared to males, as are people with higher education levels compared to those with lower education levels.

4.3.5 STRATEGIES AND CHALLENGES OF COMBATING HIV AND AIDS UNDER SPECIAL AUTONOMY

4.3.5.1 The national policy environment

The following discussion extends the discussion in Section 3.3 and focuses briefly on national level HIV and AIDS prevention efforts, with a greater focus on local HIV and AIDS prevention efforts by local level governments and CSOs, as well as the on some additional challenges in policy implementation, further to those previously discussed.

National HIV and AIDS prevention policy, as discussed in Section 3.3, aims at creating an enabling environment for successful programme implementation. Important policies and documents formulated by the government that support implementation of HIV programmes are:

- Presidential Decree No. 36/1994 regarding the Establishment of the National AIDS Commission (KPA) and Regional AIDS Commissions (KPAD) as the government institutions that will coordinate the fight against AIDS.
- The first National AIDS Strategy (1995-1999 Strategic Plan), the 2003-2007 Strategic Plan, and most recently the 2007-2010 Strategic Plan.
- The adoption of the commitment at the United Nation General Assembly Special Session on HIV and AIDS (UNGASS) in 2001, as a working framework for an expanded response to AIDS.
- The signing of the Sentani Commitment in 2004 by the six provinces with the most serious HIV epidemics (Bali, Jakarta, West Java, East Java, Papua and Riau), as a joint movement to combat AIDS.
- The Memorandum of Understanding (MoU) between the National Narcotics Agency and the National AIDS Commission, which was followed by the Coordinating Minister for Peoples Welfare Decree No. 2/2007 regarding the Reduction of Harm Caused by Drug Use (National Action Plan 2007-2010).

274 BPS - Statistics Indonesia and Ministry of Health (2006) *Situasi perilaku berisiko dan prevalensi HIV di Tanah Papua*
275 Ibid.
276 Ibid.

In addition to these important documents, several efforts have been initiated to strengthen leadership and commitment at the national level. Special cabinet sessions on AIDS were held in 2002 and 2003 and were followed by the announcement of the National AIDS Movement. Also, to strengthen the capacity of the National AIDS Commission at the central level and in the regions, Presidential Regulation No. 75/2006 was issued to restructure the National AIDS Commission in order to promote a more intensive, comprehensive, integrated and coordinated response.

The National AIDS Commission currently has 12 working groups that help formulate technical policies, with each working group responsible for a specific aspect of the HIV response. These working groups are focused respectively on: Papua; Women; Children and Youth; Harm Reduction; Communications and Promotion; Care, Support and Treatment; Monitoring and Evaluation; Estimation and Surveillance; World of Work; Migrant Populations; Law and Human Rights; and Research and Operational Studies. In addition to strengthening of the National AIDS Commission as a leading entity to respond to the epidemic, there has been some progress made in national HIV programmes such as an increased number of services provided to PLHIV, as discussed in Section 3.3.

The national 2010-2014 Operational Plan (Rencana Operasional) for HIV and AIDS Reduction highlights four programme areas: prevention; care, support and treatment; impact mitigation; and conducive environment. The focus of prevention includes different high-risk groups, one of which is youth aged 15-24 years.

Since the Special Autonomy Law was passed in Papua, the provincial government has far more regulatory and policymaking power in the region. Therefore, the provincial policymaking environment is as important as national strategies for HIV prevention initiatives. However, time is needed for capacities to build and the institutional environment to strengthen in the province, as discussed further below.

4.3.5.2 The Special Autonomy regulatory environment: A brief overview

Law No. 99/1999 divided Tanah Papua (the indigenous name which Papuans use to describe the region) into three provinces, but this was then rescinded by Law No. 21/2001 on Special Autonomy for Papua Province in 2001 and the province was returned to a single entity. Two years later, Presidential Decree No. 1/2003 split the province into three parts again, this time dropping the name Papua, and calling the regions Irian Jaya Tengah (Central Irian Jaya), Irian Jaya Timur (East Irian Jaya) and Irian Jaya Barat (West Irian Jaya) instead.[277] The formality of installing the local government in West Irian Jaya took place in February 2003 and a governor was appointed in November. Installing the government for Central Irian Jaya was delayed from August 2003 due to violent local protests. The creation of this separate central province was blocked by Indonesian courts, that declared it to be unconstitutional and in contravention of Papua's Special Autonomy agreement. The other two provinces were allowed to stand as the provincial governments had already been formed.[278] East Irian Jaya is now called Papua and West Irian Jaya is now known as West Papua.[279]

277 King, P. (2004) *West Papua since Suharto: Independence, autonomy, or chaos?* University of New South Wales Press: Sydney
278 Ibid.
279 Kivimaki, T. (2006) *Initiating a peace process in Papua: Actors, issues, process, and the role of the international community*, East-West Center: Washington, D.C.

The Special Autonomy Law No. 21/2001 comprises twenty-seven chapters and seventy-nine articles. It includes greater authority granted to the province to manage its own government and natural resources (Chapter IV, Article 4; Chapter XIX, Articles 63 and 64). It also recognizes and respects the basic rights of indigenous Papuans and emphasises their need for empowerment (Chapter V, Articles 20 and 21). Furthermore, it is in line with the principle of good governance, which promotes participation, transparency and accountability (Chapter V, Articles 10, 14, 18). In addition, the Special Autonomy Law also acknowledges and respects the existence of traditional rights and customary laws (Chapter XI, Articles 43 and 44).

Despite the contested nature of Special Autonomy (there are still demands for independence in some quarters), the law has given extended powers, wide-ranging autonomy and fiscal resources to the Papuan government. It has also allowed for the creation of unique institutions to represent various Papuan groups which are not present in other provinces, such as the Papuan People's Assembly (Majelis Rakyat Papua, MRP), which is intended to represent indigenous Papuan groups and include local customary groups, in addition to religious and women's groups. The MRP was given the mandate of promoting and protecting the rights and customs of Papuan people.[280] It was also given powers of consultation and assent over candidates for the position of governor and over decisions and regulations relating to the basic rights of Papuans.[281]

On one hand, decentralisation, the Special Autonomy Law, and the greater powers these bring (the province has both regulation-making power and can directly implement programmes/policies which differ from other provinces without Special Autonomy) have enabled local governments to customize responses to local issues. One example is addressing issues related to children who migrate alone from mountainous areas to cities such as Jayapura, for higher education or due to the attractions of the city. Some find their way to church-based institutions and halfway houses (such as the examples described above in the discussion on HIV and AIDS) but others end up on the street, in some cases as commercial sex workers (children forced into sex work). The Jayapura municipal government has established dormitories (asrama) for these child migrants, but some argue this is insufficient:

> "It is very good that local government tries to help those kids. However, dormitories alone are not enough. Those kids need mentoring, life skills development...The government needs to build a comprehensive support system for those children. Not one single agency can meet those children's need. The Office of Social Affairs has to work together with the Office of Education, the Bureau of Women's Empowerment and Child Protection, and local NGOs. The government also needs to do something to prevent those children from migrating alone. They need to ask questions. Why do they leave the mountains to come to Jayapura, leaving them vulnerable to all kinds of mistreatment by bad people? Because they want to go to school. Are schools available in the mountains? Do they have sufficient teachers? If not, why? Is teachers' absenteeism high? If so, why? Some teachers have to go to the districts to take care of administrative things. Why doesn't the government establish offices at the sub-district level to help these teachers, who are often poor, to manage their lives more easily? When teachers are often absent, ultimately children suffer." (Teacher, Jayapura, 11 September 2009)

On the other hand, Special Autonomy presents a number of challenges during the institution building and transition process of Papua's development. According to the multiple stakeholders who participated in the FGDs at the provincial level, implementation of Special Autonomy has

280 Blair, D. C. and David, L. P. (2003) *Indonesia commission: Peace and progress in Papua*
281 Ibid.

not always been smooth, especially given that in many cases there is an absence of relevant regulations or accompanying technical guidelines needed by civil servants or district/municipal governments to implement regulations and policies. As one participant put it:

> "The Special Autonomy Law is excellent in spirit and letter. It opens the room for Papuans to govern Papuans in accordance with the perspectives and the needs of Papuans. However, implementation of the law is a whole different matter. Papuan leaders do need to provide explicit and specific instructions on the implementation of the law on the ground. Those instructions should be contained in special provincial regulations. It took the provincial government a long time to draft and enact the regulations necessary to even implement the law." (Government staff, Jayapura, 13 September 2009)

There are a number of other challenges of implementing Special Autonomy, not all of which are discussed here. Many relate to a political environment where, in response to a Papuan sense of marginalisation and government sponsored transmigration programmes, some Papuans have felt they have lost control of their own homeland to the Indonesians and have become marginal to Papua's political and economic life, leading to expressions of Papuan nationalism with a strong ethnic tone.[282] These dynamics - migration and tribal arrangements, local conflicts and the demands for indigenous Papuans to occupy civil servant positions (under the 'sons of the region'/ putra daerah phenomenon) - are discussed in a number of other studies.[283] Suffice to say that such politics and dynamics do impact the implementation of Special Autonomy and complicate the process of achieving consensus in policymaking among the various levels of government, parties, the parliament at the provincial and district levels, and with the Papuan People's Congress. As one respondent put it:

> "Special Autonomy is like a double-edged sword. On one hand, it has afforded many opportunities Papuans never had before, such as access to funds and educational opportunities. On the other hand, its implementation has roused primordial sentiments and regional affiliations within the regional government bureaucracy and the community. The primordial sentiment is partly a consequence of social inequality in Papua in terms of distribution of government positions." (14 September 2009)

4.3.5.3 Weaknesses in the regulatory environment and service provision under Special Autonomy in general

Tackling HIV and AIDS as has been outlined above is challenging in Papua, considering the wide geographic area, underdevelopment, poor education levels, and sexual practices, among others. However, it is further complicated by the weaknesses in the institutional environment as Papua builds governance and new institutions under Special Autonomy. The following discussion alludes to just a few of these challenges, namely passing legislation, budget disbursement, civil servant capacity, and the effectiveness of consultative planning processes. While Papua avoids some of the problems experienced under decentralisation discussed in the case study on the province of NTT (where the provincial government has little authority to instruct district governments or to undertake direct programme and policy implementation), it faces similar problems of poor institutional capacity to deliver services across such a large area, due in part to the regulatory environment and the skills of civil servants.

282 Bertrand, J. (2007) *Papuan and Indonesian nationalisms: Can they be reconciled?*; Chauvel, R. (2007) *Refuge, displacement and dispossession: Responses to Indonesian rule and conflict in Papua*; McGibbon, R. (2004) *Plural society in peril: Migration, economic change and the Papua conflict*; McGibbon, R. (2004) *Secessionist challenges in Aceh and Papua: Is Special Autonomy the solution?*

283 Hoey, B. A (2003) 'Nationalism in Indonesia: Building imagined and intentional communities through transmigration', *Ethnology*, Vol.42(2): 109-126; Brata, A. G. (2008) *The creation of new regions in Papua: Social welfare vs. elite interests*, Atmajaya University: Yogyakarta; McGibbon, R. (2004) *Plural society in peril: Migration, economic change and the Papua conflict*; McGibbon, R. (2004) *Secessionist challenges in Aceh and Papua: Is Special Autonomy the solution?*; Universitas Cendrawasih. (2006) *Studi evaluasi kebijakan dan implementasi Otonomi Khusus di Tanah Papua tahun 2002-2006*

Division of powers and creating legislation

Legislation has been passed in Jakarta for the purpose of refining the original Special Autonomy laws, but it has often exacerbated confusion. The decentralisation laws passed in 1999 devolved power to the district/municipal level, but under Special Autonomy in Aceh and Papua power was devolved to the provincial level instead. This has caused some confusion among some authorities at the district level. As one government civil servant in Jayapura observed,

> "It seems as if we have two masters, the provincial and the national government. Sometimes we don't know who we should listen to, particularly if they have conflicting demands." (Jayapura, 14 September 2009)

Under Special Autonomy, there are several ambiguities in the division of powers between the provincial and district parliaments and the MRP, and the role of the governor includes both representing Papua's interests as well as being responsible for implementing central government policies in Papua.[284] One important difference between the provincial parliament (DPRD) and the MRP, for example, is that the former represents all the people living in Papua, including migrants from other regions who constitute a significant portion of the population. The MRP, however, more specifically represents indigenous Papuans. The process by which the MRP can review legislation affecting indigenous rights is not entirely clear.[285] Aside from being able to voice and formally contest legislation or regulations that infringe on Papuan rights or customs, there are no legal mechanisms by which these measures can be halted.[286] The MRP has only restricted rights of consultation and approval on issues related to native rights and only in relation to special regulations for implementation of the Special Autonomy Law. No such approval is required for normal legislation and regulations of the provincial parliament.[287]

In 2007 the Indonesian government issued Presidential Instruction (Inpres) No. 5/2007 concerning the Acceleration of Development in Papua and West Papua. This Presidential Instruction indicates five priority areas for the provinces' development. They are: (1) food resources and poverty reduction; (2) education quality improvement; (3) health service improvement; (4) basic infrastructure increase for improved access to remote areas, the interior and border areas; and (5) affirmative action in quality development of indigenous Papuan human resources. This has generated confusion in Papua among Papuan local governments since the content of the Presidential Instruction seemed to overlap with the goals of the Special Autonomy Law (which also emphasises the development of health, education, economics and infrastructure), and was perceived to have the potential to undermine Special Autonomy.[288] As one interviewee argued,

> "The Presidential Instruction was made by the central government alone, without input from Papuans. Yes, the priorities are well thought out. But I have to ask this: who are the intended beneficiaries of development in Papua? Papuans, right? How can the government identify Papuan's needs and priorities without consulting Papuans?" (Medical doctor, Jayapura district, 15 September 2009)

284 Halmin, M. Y. (2006) *The implementation of special autonomy in West Papua, Indonesia: Problems and recommendations*; Sullivan, L. (2003) *Challenges to Special Autonomy in the province of Papua, Republic of Indonesia*, Research School of Pacific and Asian Studies, the Australian National University: Canberra; USAID. . (2009) *Papua assessment*.

285 Halmin, M. Y. (2006) *The implementation of Special Autonomy in West Papua, Indonesia: Problems and recommendations*; McGibbon, R. (2004) *Plural society in peril: Migration, economic change and the Papua conflict*; McGibbon, R. (2004) *Secessionist challenges in Aceh and Papua: Is Special Autonomy the solution?*

286 Ibid.

287 Ibid.

288 King, P. (2004) *West Papua since Suharto: Independence, autonomy, or chaos?*

The implementation of the Special Autonomy Law requires the production of Provincial Regulations (Perdasi, Peraturan Daerah Propinsi) and Special Regional Regulations (Perdasus, Peraturan Daerah Khusus). As of January 2010, only eight Special Regulations had been passed in the province to implement the Special Autonomy Law, whereas it was estimated that at least 24 were required in order to specify necessary details for the implementation of the Law.[289] One of the reasons for the delay was the ambiguity in the division of roles between the MRP and provincial parliament.[290] Interviewees working in HIV and AIDS prevention argued that the poor regulatory environment impedes government action and policy development in Papua.

Coordination between different levels of government

One problem identified by FGD participants was that of coordination between each level of government. First, participants argued, if the central government gives the go-ahead for a programme and the programme is to be implemented by the district offices, the provincial authorities are sometimes not informed of this development or involved in coordination, especially because under decentralisation the district has plenty of leeway in executing its duties. This is problematic in all of the case study regions, but in Papua the provincial government does have greater authority than in other areas where Special Autonomy does not operate. In the case that districts do not coordinate with the provincial government in Papua, the provincial offices do not have access to district data, making data-driven planning especially difficult.

Budget allocation and disbursement

Under decentralisation and Special Autonomy, Papua and Aceh receive general budget allocations (DAU, Dana Alokasi Umum) and special allocations (DAK, Dana Alokasi Khusus), and they can raise revenues through local taxes and levies like all other provinces. However, Papua and Aceh also receive a greater share of mining and natural resource revenues (DBH, Dana Bagi Hasil), and a Special Autonomy budget allocation (Dana Otsus) for a temporary period. The Special Autonomy Law does not stipulate in detail how the Special Autonomy funds in particular are to be distributed among districts and municipalities in Papua, stating only that allocations should be decided by Special Regional Regulations, with priority to be given to lagging regions. The law only makes vague references to how the funds should be used, the ultimate goal of Special Autonomy being "to reduce the disparities between Papua Province and other provinces, promote the living standard of people in Papua Province, and give opportunities to the original inhabitants of Papua."[291] The funds for Special Autonomy should be two per cent of the national general budget allocation pool, amounting to IDR 1.8 trillion in 2005. It now accounts for 60 per cent of provincial revenues, and between 7-23 per cent of district and municipal revenues.[292]

A joint Ministry of Home Affairs and Ministry of Finance Decree (KMK160a/2003), issued in April 2003, clarified that districts/municipalities are to receive a larger share of the fund than the province because of their greater responsibilities in delivering education and health services.[293] Consequently, in 2004 the province reduced its own allocation to 40 per cent; in 2002 and 2003 the province had kept 60 per cent of the funds and only allocated the remaining 40 per cent to local governments.[294] However, one complication that added to delays in policymaking and service provision in the province was that disbursement of the Special Autonomy budget allocation from the province to the districts/municipalities did not begin until 15 July 2003. In fact, more than half of the funds were not disbursed until the end of November.[295] Established districts/municipalities receive their entire shares as cash transfers, whereas newly formed district and municipal governments received only 40 per cent of their share as cash transfers, while the remaining 60 per cent stayed under provincial control to fund programmes mutually agreed on by the provincial and district/municipal governments.[296]

According to a 2009 USAID report, development funds have mostly been used to fund the civil service and government administration, followed by infrastructure.[297] Only a very small portion has been allocated for development activities in the villages. There is a widespread realisation that this condition needs to be reversed so that the majority of the budget is available for the people. In an attempt to realize this purpose, the utilization of Special Autonomy budget allocations is focused on increasing public services for people in the districts and villages. Funds are channelled through the Village Strategic Development Plan (RESPEK, Rencana Strategis Pembangunan Kampung).[298] Evaluation of the impact of this strategy as it begins to take hold will be important for ascertaining whether it has been an effective approach to accommodating community needs and providing local level services.

A second problem related to budgets in practice under Special Autonomy is the extent to which they are child-friendly and prioritise children's needs. For example, improving education is important so children will attend schools that mainstream HIV awareness and knowledge of reproductive health in the province. With the passing of the Special Autonomy Law, 30 per cent of central government transfers were to be allocated for education. Some stated during the interviews that despite the promise of free education, the burden on poor families remains (see FGD results discussed earlier in this subsection). Others saw the funds from Special Autonomy as having accelerated education in the province.

> "Special Autonomy funds have been opening doors for educational opportunities to Papuan children. Prior to the Special Autonomy Law, children whose parents were too poor to afford school would probably never have had a chance to obtain a good education. Not anymore. Now all Papuan children can go to school for free, not only here in Papua, but also outside of Papua. Our school has alumni who have attended some of the best universities in Indonesia. They receive full scholarships from the provincial government. Without the Special Autonomy funds that may not have been possible. (High school teacher, Jayapura, 15 September 2009)

However, the provincial government faced serious criticism in 2008 for allocating insufficient funds to education, in breach of the Special Autonomy Law. The disbursement of Special Autonomy funds was arguably not in line with existing regulations. An NGO worker explained that only 4.7 per cent of the provincial budget (APBD, Anggaran Pendapatan Belanja Daerah) in 2008 was actually being spent on education, which was in contravention of the national law on the education system, which stipulated that at least 20 per cent of regional budgets must be spent on education, and of the Provincial Regulation No. 5/2006, which mandates that the provincial government spend 30 per cent of the Special Autonomy funds on education.[299]

289 Mansai, A. (2008) *Perdasus perdasi, penantian tak berujung*, available at: http://taboloidjubi.wordpress.com/2008/07/28/perdasus-perdas-penantian-tak-berujung (Last accessed 15 January 2010)
290 Conoras, Y and Mayabubun, K. (2010) *Efektivitas otonomi khusus Papua butuh political will Jakarta dan Papua: Catatan untuk satu tahun terakhir*, available at: http://www.infid/org/index.php/news/2010/9/08/27/efektifitas-otonomi-khusus-papua-butuh-political-will-yusman-conoras-amp-kenny-mayabubun.html (Last accessed 26 January 2010)
291 World Bank (2005) *Papua public expenditure analysis*, p95
292 Ibid.
293 World Bank (2005) *Papua public expenditure analysis*; USAID (2009) *Papua assessment*
294 Ibid.
295 World Bank (2005) *Papua public expenditure analysis*
296 World Bank (2005) *Papua public expenditure analysis*; USAID (2009) *Papua assessment*
297 USAID (2009) *Papua assessment*
298 UNDP (2007) *Harmonization of human development programme and donors in Papua Province*; USAID (2009) *Papua assessment*
299 Interview, Jayapura (14 September 2009); APBD Papua (2008) *Abaikan Anggaran Pendidikan*, available at: http://www.inilah.com/berita/politik/2008/02/02/10283/apbd-papua-2008-abaikan-anggaran-pendidikan/ (Last accessed 25 January 2010)

Furthermore, in 2009 the education budget gave insufficient funds at the provincial level for the nine-years compulsory education programme, which is a priority programme for the provincial government.[300] Funds for early childhood education were slashed from IDR 6.65 billion in 2008 to IDR 930 million in 2009.[301] Likewise, funds for junior secondary school have fallen from IDR 35.01 billion in 2008 to IDR 2.83 billion in 2009.[302] In contrast, operational fees saw a dramatic increase, from IDR 8.48 billion in 2008 to IDR 28.04 billion in 2009.[303] These additional funds were allocated to cover fees related to coordination, development and monitoring in general.[304]

Others have criticized the provincial government for expanding tertiary education at the expense of basic education.[305] A number of prominent educators in the province have highlighted the shortage of vocational training opportunities for Papuans, a key gap in the educational system.[306] In the absence of a better education policy and a stronger commitment to elementary education, it is difficult to see how Papuans' participation rates in the growth sectors of the economy can be improved.[307]

Consultative development planning processes: The musrenbang

Section 4.1 outlined how the musrenbang (consultative development planning) system was designed as a bottom-up process to incorporate community views on needs and priorities. The case study on NTT highlighted that this process tends to be dominated by elites at each level and that in some districts there is an absence of women's and children's voices both as participants in the forum and as reflected in the priorities which are set, and consequently in the planning process, regulations and budgets.

In Papua various studies have found that community participation in district priority-setting and planning varies widely across districts. There is uneven commitment from regional leadership, partly because the process is new.[308] Participatory development cannot be introduced successfully without the strong political support of local government leaders. The degree of commitment to such ideas and willingness to implement a participatory approach also varies across Papua.[309]

The government at the provincial level and in some districts in Papua does express willingness to involve multiple stakeholders in the decision-making process. However, effective participatory planning in the region faces a number of challenges, especially for women, children and CSOs who often have the best idea of how to improve their situation. In 2006, a study of the policymaking process in Papua by the University of Cenderawasih found that policy impacts on the poor and women are also scarce.[310] Furthermore, it found that CSOs often participate in an evaluation of budgets only after they are spent.[311] Members of these groups still frequently have a limited understanding of the complex steps regional governments take to decide on allocation of regional budgets.[312] The resulting lack of partnerships with local government and legislatures means that the overall influence of CSOs remains limited.[313] This is particularly problematic for HIV and AIDS prevention, given that people in these organisations are often working most closely with affected populations and providing the supporting services that they need.

The needs of women and the poor are often not taken into account in budgeting because these groups are not represented in regional executives or legislatures.[314] There is also a general lack of community confidence that the musrenbang process will satisfy their needs, with many stakeholders viewing the practice as part of window dressing by regional elites to push forward narrow, self-serving agendas.[315] As a result, people's participation is mostly still deemed cosmetic.[316]

Participants in the FGDs in Jayapura municipality, including government workers and NGO activists, asserted that at the sub-district level they are increasingly resigned to the reality that inputs from communities are either not incorporated into the municipal plans, or are not translated into budgeted programmes. As one government worker in Jayapura put it,

> "Musrenbang is just pro forma. It's in place because we have to do it. But we can't say that it represents people voice if people's needs are not taken into account in planning and policy implementation which follows on from the musrenbang." (17 September 2009)

Other participants stated that public participation does not matter much since ultimately those who run the campaign for particular political candidates (tim sukses) will determine policymaking and implementation.

From both secondary data collection and interviews conducted for this report, it is evident that in the two-step process to policymaking, community needs, including those of women and children, are not generally captured in the musrenbang. If these needs are represented, they are not always prioritised when it comes to the formulation of strategic plans, government regulations, action plans and budget processes. Indeed, practitioners working in communities, for example on the issue of HIV and AIDS, are not always consulted in the policymaking process.

Nevertheless, the provincial government has gone some way to trying to elicit community views about widespread needs through the 'Going Down to the Village' (TURKAM, Turun Kampung) programme. This initiative has been undertaken annually by Governor Barnabas Suebu in an effort to talk directly to constituents. For example, between 4 June and 30 August 2007, the Governor visited 34 locations. In each location, the Governor not only met and held dialogues with local authorities, district/municipal, sub-district and village governments, but also with community members in villages. Following the TURKAM, according to Governor Suebu (2007), the provincial government was further alerted to the pervasive poor condition of public health, including nutrition, health services and health seeking behaviour.[317] While this was no surprise, dialogues resulted in not only greater attention to the problems and a closing of the gap between policymakers and beneficiaries, it also encouraged a holistic approach to beginning to address the

300 USAID (2009) *Papua assessment*
301 Ibid.
302 Ibid.
303 Ibid.
304 Brata, A. G. (2008) The Creation of new regions in Papua: Social welfare vs. elite interests; USAID (2009) *Papua assessment*
305 Elsham Papua Barat (2007) *2006 year end report*, available at: http://www.westpapua.ca/?q=en/node/459 (Last accessed 10 November 2010)
306 Ibid.
307 Ibid.
308 Halmin, M. Y. (2006) *The implementation of Special Autonomy in West Papua, Indonesia: Problems and recommendations*
309 USAID (2009) *Papua assessment*
310 Universitas Cendrawasih (2006) *Studi evaluasi kebijakan dan implementasi otonomi khusus di Tanah Papua tahun 2002-2006*
311 Ibid.
312 Ibid.
313 Ibid.
314 USAID (2009) *Papua assessment*
315 Ibid.
316 Ibid.
317 Suebu, B. (2007) *People driven development*, Provincial Government of Papua: Jayapura

problem based on the ideas presented by villagers and local level policymakers themselves.[318] While it is unclear to what extent women's and children's voices were accommodated in the TURKAM, in the future it could provide a useful space for ensuring not only that women's and children's needs are prioritized, but also also it could drive the commitment needed to ensure that policies and budgets will be woman- and child-friendly.

Institutional capacity to deliver services

The 2007-2011 Strategic Plan for HIV and AIDS Reduction in Papua Province is very much in line with the national Operational Plan for HIV and AIDS Reduction. The 2007-2011 Papuan Strategic Plan for HIV and AIDS Reduction attempts to create ownership of the HIV and AIDS problem among Papuans through the motto 'Mari kitorang bertanggung jawab' (Let's be responsible). In light of the severity of HIV and AIDS problem in Papua, the 2007-2011 Papuan Strategic Plan for HIV and AIDS Reduction calls for all districts/municipalities with at least 5 per cent HIV and AIDS prevalence to create strategic plans and work-plans to address HIV and AIDS with comprehensive and sustainable programmes.

The 2007-2010 Papuan Strategic Plan for HIV and AIDS Reduction emphasises the goal of enhancing the independence of people (including children) with HIV and AIDS, and affirms their rights to obtain education, employment, and to access social and health services and alternative care. The focus on children and young people is crucial in planning for HIV and AIDS interventions, given that the previous discussion has highlighted the fact that many young people in Papua are sexually active.

However, implementation of such plans may be weakened by institutional capacity to deliver services, as discussed in the case of malnutrition in NTT and thus will not be further elaborated here. Similar to the case of NTT, the following challenges were identified in Papua based on a number of in-depth interviews and FGDs conducted:

- Uneven and insufficient numbers of staff with the training and capacity to deliver health and education services, particularly in remote regions.
- Problems of interpreting laws and regulations enacted by the province, or absence of such laws and regulations.
- Uneven capacity and insufficient time in some districts to conduct musrenbang and concurrent district planning processes in coordination with local development planning agencies (BAPPEDA), local sectoral/technical offices, the district executive and the parliament. This includes incorporating musrenbang priorities into strategic plans, drafting these plans, designing appropriate action plans, regulations and policies, and drafting local budgets, as well as monitoring progress.
- Staff turnover and greater staff requirements with formation of new districts and administrations.

At the most basic level, some government institutions in Papua are ill-equipped to handle all of their responsibilities under Special Autonomy, especially at the district/municipal and sub-district levels, although this is slowly improving. An important pre-condition for the successful implementation of the Special Autonomy Law and the achievement of Papua's development vision and mission is the development of key capacities within local government and civil society to formulate and implement appropriate, locally-specific and targeted development

318 Ibid.

programmes across Papua.[319] All district/municipal governments have attempted to make adjustments in planning, operations, budgeting and staffing during the transition toward Special Autonomy, to ensure that the provision of public services is not disrupted and that governance reform progresses smoothly. Capacity, however, is still far from adequate to achieve operational efficiency under the Special Autonomy Law and related developmental programmes. For example, schools are often understaffed to the extent that teachers teach multiple grades.[320]

Results from in-depth interviews and FGDs also highlighted the need to strengthen the capacities in data collection, analysis and reporting, policy preparation, planning, programme implementation, and monitoring among local government agencies. This is in line with the similar challenges outlined in the case study on NTT and will not be further elucidated here. Nevertheless, the following quotations from participants in Jayapura are illustrative:

> "The bottom line is that many practitioners are not aware of the importance of data for planning. We need to scale up the socialisation on the importance of data gathering and data management. We also need to collect different types of data for planning different kinds of programmes." (Child protection officer, Jayapura, 15 September 2009)

> "Due to limited human resource capacity in the civil service, allocated budgets often do not correspond to district needs. How can it possibly correspond to needs when 'budget planning' consists mostly of copy/pasting budget figures from other districts' budgets?" (Jayapura, 15 September 2009)

4.3.5.4 Local government initiatives and challenges to combating HIV and AIDS: The scale of the problem within a context of institution building

A number of initiatives are underway to endeavour to reduce the spread of HIV and AIDS in Papua, but they continue to face the complex environmental and institutional challenges outlined above as well as problems of coverage, outreach, quality and availability. These initiatives include the following:

- The provincial government has introduced counselling in schools to increase awareness about HIV and AIDS.
- The National Family Planning Coordinating Board (BKKBN, Badan Koordinasi Keluarga Berencana Nasional) distributes medicines and vitamins for free in cooperation with some NGOs, such as Yayasan Harapan Ibu (YHI, or Mother's Hope Foundation). However, this initiative faces a number of challenges. Often only female sex workers (with knowledge of HIV transmission) are willing to come to mobile clinics for check-ups, and this is difficult due to the limited facilities.[321] Even though infected street sex workers are encouraged to use protection during the sex, this doesn't always take place, especially if they have been drinking with clients or the clients refuse to use protection. Some clients find other sex workers who are willing to not use protection, while others beat the sex workers who refuse to have unprotected sex.[322]

319 UNDP (2005) *Papua needs assessment*; Universitas Cenderawasih (2005) *Papua public expenditure analysis and capacity harmonization: Papua province report*

320 Universitas Cenderawasih (2005) *Papua public expenditure analysis and capacity harmonization: Papua province report*; Universitas Cendrawasih (2006) *Studi evaluasi kebijakan dan implementasi Otonomi Khusus di Tanah Papua tahun 2002-2006*

321 Interview with counsellor, Yayasan Harapan Ibu (15 July 2010)

322 Ibid.

- The 'Jayapura meeting' was held on 19 November 2008 with several goals:
  - To establish commitment and agreement among the national government, provincial and district/municipal governments, 29 district/municipal parliaments, as well as cultural, religious, and community leaders to accelerate and widen efforts to control the HIV and AIDS epidemic in Papua.
  - To develop a strategy and work-plan for prevention and control of HIV and AIDS in 29 districts/municipalities in Papua, to be supported by strengthening and improving public services related to HIV and AIDS throughout Papua.
- The beginning of 2006 saw the establishment of specific budget allocation for prevention and control of HIV and AIDS in the provincial budget. Since 2002, the Papua provincial budget had already made budget allocations for prevention and control of HIV and AIDS in 29 districts and municipalities, as follows[323]:
  - 2002: IDR 490 million
  - 2003: IDR 3,487 million
  - 2004: IDR 4,435 million
  - 2005: IDR 2,162 million
  - 2006: IDR 6,500 million
  - 2007: IDR 28,389 million
- The Special Autonomy fund has enabled some districts, such Jayapura, to build dormitories for homeless children.[324]
- Joint initiatives between regional governments and NGOs such as Family Health International and the Global Fund for an initiative on information, education and communication (IEC, known in Indonesia as 'KIE'). Billboards have been placed along the street in Jayapura promoting safe sex and monogamy. Earlier discussions on the need for culturally appropriate messages have pointed out that mass communication drives without the participation of traditional leaders are less effective. Leaflets have been also been distributed and are available in puskesmas and distributed in schools.[325] Mobile clinics are used by some puskesmas for KIE to spread knowledge and information in isolated areas. Others visit bus terminals, places where motorcycle taxis congregate, schools, and student accommodations. Such initiatives are usually undertaken by CSOs. However, some indicate that they are not always welcome and have been asked to leave because due to embarrassment causes at the target locality, where people think they are being accused of engaging in risky behaviour.
- Free condoms are provided at puskesmas in boxes near the exit. The boxes are placed in a discrete location so that people are not embarrassed to take them.[326]
- VCT services are available at some puskesmas, but not all due to insufficient staff, and at present are prioritised for high-prevalence and strategic areas, for example areas where migration is concentrated. A VCT team should consist of one doctor, two counsellors, two case managers and one laboratory technician. More staff are needed in newly formed regions, which have been created since Special Autonomy.[327] However, similar to the case of poor parents' reluctance to take their children to hospital for treatment for malnutrition (for reasons like lack of provision of food for accompanying parents), some are reluctant to undertake the journey to VCT centres as they cannot afford transport and other associated costs.
- An HIV and AIDS peer education programme was introduced to junior secondary schools in Papua to provide basic information on HIV prevention and transmission. These activities were conducted mainly in grade seven, in seven districts.

323 Researcher at Cendrawasih University and founder of Yayasan Harapan Ibu (16 July 2010)
324 Government staff, Jayapura (9 September 2009)
325 *Puskesmas* staff (13 August, 2010)
326 Staff of different *puskesmas* in the region (10 and 13 August 2010)
327 Health service providers in a variety of *puskesmas* and health clinics (10-13 August 2010)

However, challenges for government initiatives to combat the problems have been identified by a number of different interviewees working in HIV and AIDS prevention, particularly relating to the district level parliaments and some executives. These include:

- Weak political commitment to tackling the problem
- Weak leadership and lack of awareness/concern among bureaucrats
- A tendency to view HIV and AIDS purely as a health issue
- Low technical capacity of programme staff
- A tendency not to view HIV and AIDS as a real threat to the people's welfare

In addition, not all districts/municipalities have set up the legal apparatus and regulations pertaining to the prevention and control of HIV and AIDS.[328] On 2 February 2007, a Special Regional Regulation was passed on Special Autonomy Budget Allocations, mandating a 15 per cent special budget allocation for health. Funding for prevention and control of HIV and AIDS is taken from this health budget. However, to this day the health sector budget allocation remains under 15 per cent of the regional budget.

Newly created regions have added to the need for greater administration capacity, larger numbers of civil servants and more service provision. In some cases, more service provision may have been required previously but larger districts were unable to accommodate these needs. As one puskesmas nurse describes it,

> "District splitting means more services need to be provided. Previously, one institution would have handled one region. Suddenly, there are two regions. Automatically this splits the manpower base. Some stay in the original part of the district, others move to the new district. This leads to high levels of transfers but new staffs are limited in their capacity. At the very least we can try to hold on to staff until their replacements come. We can't avoid transfers, often they are the result of promotions. But it does mean that we lose staff who are trained to handle things such as VCT." (Puskesmas Head, Padang Bulan, 10 August 2010)

Various nurses and medical staff in the interviews described challenges for those who are suffering from AIDS. They are often not able to stay in hospital for an extended period as required. Even if they have health insurance for the poor, it does not cover all of the costs associated with care, such as for prescriptions. Often they end up in hospices or being cared for by CSOs. When hospices are unable to accommodate a patient, relevant organisations working in the region encourage home-based care, and they send voluntary teams (usually from faith-based organisations) to provide support for families.[329] The hospices are often funded by churches, but the voluntary teams represent all five nationally recognized religions.

The Provincial AIDS Commission has no specific programme targeting children, despite this being a part of the national strategy. The chairman explained:

> "The problem of HIV and AIDS is very complex, particularly because tackling the problem involves changing behaviour which is not easy in populations with low education, let alone in a region which is as large as Papua. So we try and work together with our friends from civil society organisations - divide up the tasks, you know. Indeed, to date we have not begun to talk about the problem in terms of teenagers, because of the scope of the HIV

328 Ibid.
329 Director of the Waena and Abepura hospices (12-13 August 2010)

and AIDS problem. We very much know that preventing HIV infection can be strengthened through educating teenagers. We have high hopes for UNICEF to be able to tackle the problem of educating teenagers." (Chairman of the Provincial AIDS Commission, Jayapura, 10 August 2010)

However, some CSOs (Youth Forum; Life Skill Education, supported by UNICEF) and religious organisations, such as Muhamadiyah, are working in education and information dissemination in the region and work both in partnership with and independently of the Provincial AIDS Commission. Some use peer educators, others work through religious boarding schools, in state schools and in universities, using modules developed by the Provincial AIDS Commission and the Global Fund.[330] However, some parents resist provision of education on reproductive health in religious institutions because they consider it to be in contradiction with religious values.[331] A youth centre was established in Jayapura by the Provincial AIDS Commission using UNICEF funding.

4.3.5.5 CSO and NGO innovations and challenges

It is clear from the discussion above that CSOs and NGOs have played a large role in filling the gaps in government service provision for HIV and AIDS prevention, and care for people living with HIV or AIDS. Some of these receive grants from government (such as from the Office of Social Affairs for staple foods for PLHIV and AIDS sufferers), and others from international agencies including from USAID, Global Fund, UNICEF, HCPI (AusAID) and the Mennonite Central Committee. As has been discussed previously, non-government support includes education and outreach through KIE, providing hospice and home-based care, halfway houses for street children or children forced into sex work, and other forms of care and support for livelihoods.
Many of the HIV and AIDS prevention and education initiatives are implemented by NGOs. However, coverage is uneven, as is the quality of the information and services provided. NGOs face tremendous challenges in their fight against HIV and AIDS in Papua. An in-depth interview with a medical doctor revealed that the NGO community in Papua is small in number and local in focus. Many of the staff are young, and new NGOs that are still 'learning to be NGO'.[332] Despite their efforts to improve HIV prevention, their size and numbers are insufficient to change the direction of the epidemic. Some common issues raised by NGO staff during the interviews for this research include:

- Concern about over reliance on donors and sustainability of their own organisations;
- Difficulty of access to timely technical information, support and skill training;
- Weak but improving collaboration among NGOs; and, perhaps most importantly,
- The continuing urgent challenge of scaling up - either on their own or in collaboration with government - to increase quickly and significantly the coverage and effectiveness of prevention and care services.

According to interviewed sex workers, they need assistance from the state in the form of:

- Housing, especially if they are infected with HIV or AIDS.
- Free ART and related medicines, and easier access to this for PLHIV and AIDS.[333]
- Assistance in skills building and finding alternative employment. (Yayasan Harapan Ibu also focuses on skills improvement in book keeping and crafts.)[334]

330 Variety of CSO practitioners and religious organisation staff working in HIV and AIDS prevention (10-14 August 2010)
331 Ibid.
332 Jayapura (15 September 15, 2009)
333 Interview with Natalia and Sheila (names changed), Jayapura (10 August 2009)
334 Interview with a counsellor, Yayasan Harapan Ibu (15 July 2010)

4.3.5.6 Recommendations for improving HIV and AIDS prevention

The discussion above highlights the institutional challenges for policymaking under Special Autonomy in general, and also specifically as it relates to HIV and AIDS prevention. To improve service provision overall, so that it redresses the multitude of vulnerabilities that women and children face in Papua, the discussion above has identified that greater efforts need to be made under Special Autonomy to:

- Strengthen the regulatory framework;
- Improve coordination among sectoral agencies and between levels of government;
- Increase the disbursement of funds for education and health and related to HIV and AIDS prevention campaigns;
- Increase the number and capacity of civil servants to plan, budget, implement and monitor programmes that redress vulnerabilities for women and children at both the provincial and the district/municipal levels;
- Establish sectoral budget lines for HIV and AIDS in addition to the budget of the AIDS Commission;
- Provide greater facilitation in the musrenbang process to ensure that the voices and needs of children and women are both prioritised and acted upon;
- Build the commitment of government leaders to both prioritise the musrenbang and to incorporate it into district strategies, plans, budgets and programmes; and
- Provide greater guidance and support for district level governments.

FGD participants identified that more effective efforts to combat HIV and AIDS in the province should take into account the following:

- Programme synchronisation and a joint focus are crucial.
- Prevention and control programmes must be in line with initiatives in other sectors to tackle the roots of the problem. A comprehensive approach is needed whereby HIV and AIDS programmes collaborate with prevention and control programmes for other communicable diseases, such as tuberculoses.
- Prevention and control programmes must be better coordinated in order to involve all relevant stakeholders. A comprehensive approach is necessary because the incidence of HIV and AIDS among children shows that the problem must be managed with inter-sectoral cooperation. For example, many children leave home due to parental neglect or because of domestic abuse, and hence the issue is closely related to child protection. In order to make a living, some of these children leave school and enter into prostitution, making this an issue closely related to education. Many are then exposed to HIV and AIDS due to a lack of knowledge on the risks and transmission mechanisms of HIV and AIDS, which is a health and education issue.
- Widespread information and education campaigns on healthy living, prevention of STIs, nutrition, healthy homes, education and the economy are important.
- Prominent cultural and religious figures should play a large role in child development, educating the community on HIV and AIDS transmission in culturally appropriate ways. The World Vision Hope project is one effort to work together with local leaders for prevention.
- School lessons can and should be synchronized with cultural and religious teachings, such as teachings on self-respect and respect for others. However, one challenge to this is convincing religious leaders to not treat the disease as one 'which affects sinners', which has been problematic in the past. This is necessary for reducing the stigma attached to the disease. Furthermore this is problematic in relation to promotion of condom use, as some see such messages as promoting sex outside of marriage, which goes against some religious teachings.

- Interventions need to be targeted in rural areas as much as urban areas, especially in places where migration is taking place, and where education levels are low. So far, most of the KIE activities are targeted at urban areas.

Results of in-depth interviews and FGDs held at the provincial level and in Jayapura and Jayawijaya at the provincial and district levels have revealed that many believe that the single most important priority for Papua Province is to decrease transmission of the HIV virus. This also requires better efforts at targeting both prevention and care initiatives for high-risk groups in the main urban areas, and in and around rural areas that are rapidly developing. The respondents argued that emphasis should be on:

- Increasing the use of condoms among high-risk groups
- Treating and preventing other STIs
- Discouraging the frequent change of sexual partners, or encouraging the practice of safe sex
- Efforts to prevent the sharing of needles by IDUs
- Education on HIV transmission and condom use (aggressively targeting young men and women in both urban and rural sites)
- More services and care need to be provided for PLHIV
- Improving the provision and use of VCT and support and treatment services for pregnant women and youth

They also pointed out that not only have youth been identified as a vulnerable group, but they are the group that carries knowledge, beliefs and practices into the next generation. The impact of a growing HIV prevalence, FGD participants argued, will first increase as people move into towns for treatment and, second, as people migrate home to their villages in the end stages of the disease. This second type of migration will place immense strain on families and communities in coping with sick and dying relatives.

Butt et al. (2002a and b) argue that HIV prevention efforts need to be widespread in rural and urban areas.[335] In particular, rural men and women are highly mobile and frequently visit urban sites where they can engage in sexual behaviour with less fear of repercussions than in their home communities.[336] To be effective, any intervention in an urban centre must have its counterpart in nearby and rural communities.[337] This issue is particularly crucial for Jayawijaya district, which at present has no significant urban or rural HIV education campaigns underway. It is important to bear in mind that youth-specific health services are nonexistent, despite increases in risky behaviour.[338]

It is important to note that Papua is the only province of Indonesia that has embarked on a systematic process to mainstream HIV and reproductive health education into the education sector, to empower young people to take responsibility for their health and to provide them with the necessary skills to achieve this. UNICEF has supported this programme in the implementation of life skills based HIV-related education in junior high schools. HIV and AIDS is integrated into the curriculum and into teaching and learning materials of a variety of different subjects, including biology, religious studies and physical education. However, during the Verification Reference Group discussion held for the research for this SITAN in Yogyakarta about the findings of the studies in the case study provinces, it was clear that even in places such as Yogyakarta, where there are higher levels of education compared with Papua, there is resistance to mainstreaming reproductive health in education for fear that education officials will be accused of condoning sexual activity among students.[339] Papua may face similar challenges in mainstreaming reproductive health in education.

Furthermore, as was highlighted above in the discussion on the transmission of knowledge on HIV in culturally appropriate ways, education efforts need to take into account the local context for communications strategies. Butt (2005) argues in line with the FGD respondents that tribal leaders need to be included in the education process.[340] Not only are they familiar with Papuan culture, but they also tend to stay in a particular location for a long time, providing an anchor for their community. Butt (2005) further argues that both male and female tribal elders should be involved in education and communications efforts so that they can explain their concerns about reproduction and the successful regeneration of the tribal group. Specifically, they need to help design the cultural components of province-wide rural health promotion and HIV communications efforts. Their participation will ensure materials reflect widespread norms and values.[341] AIDS education efforts might consider how indigenous people can act as peer educators within specific tribal groups and communities.[342]

4.3.6 SUMMARY CONCLUSION

The case of Papua contributes to the understanding of the complexities of tackling the multiple insecurities for children and women and a low-level generalized HIV and AIDS epidemic in a province that, despite having an extensive resource base, is geographically large and disparate with low levels of education and human development, and high levels of poverty. The case study demonstrates the depth and scale of the generalized epidemic, particularly amongst high-risk groups. The evidence suggests that, as with the case of malnutrition and poor child health in NTT, it is driven by multiple and concurrent factors, including:

- Poverty, low levels of education and knowledge of HIV, isolation in rural highland communities;
- Rapid development, migration, a growing sex industry and transmission to partners;
- Unprotected sex and the early onset of sexual activity;
- Lack of knowledge about reproductive health, STIs and means of protection[343];
- Low usage and availability of and access to condoms;
- A lack of voice in sexual decision-making for women and girls, which increases their vulnerability to infection[344];
- Local attitudes and sex practices;
- Local perceptions of illness;
- Lack of clear understanding of the problem and resistance to behavioural change, possibly attributed to the type of mass information campaigns and the language used that may not be sensitive to local value systems;
- Knowledge of and access to VCT services; and
- Stigma of HIV and AIDS for treatment.

335 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*; Butt, L., Numbery, G. and Morin, J. (2002) 'The smokescreen of culture: AIDS and the indigenous in Papua, Indonesia'
336 Ibid.
337 Ibid.
338 Ibid.
339 FGD with Verification Reference Group in Yogyakarta, attended by 12 people from NGOs and government workers in the health sector
340 Butt, L. (2005) '"Lipstick Girls" and "Fallen Women": AIDS and conspiratorial thinking in Papua, Indonesia'
341 Butt, L., Numbery, G. and Morin, J. (2002) *Preventing AIDS in Papua*
342 FGD in Jayapura, attended by two people from NGOs, an anthropologist and a government worker (13 September 2009)
343 Ibid.
344 Ibid.

The risks for women and children of HIV infection are growing in Papua, particularly given the feminisation of the epidemic, children migrating alone to cities and being forced into sex work, adolescent sex practices that sometimes involve unprotected sex (with multiple partners), and that there is currently an absence of any government programme or Papua AIDS Commission strategy which is specifically targeting youth. CSOs tend to be providing many of the services in education and care for PLHIV.

While there are multiple efforts underway to try to combat the spread of HIV, Special Autonomy and decentralisation present a number of challenges, including:

- Delays in the enactment of regulations at the district (and sometimes provincial) level
- Coordination between different levels of government
- Poor district capacity in administration, policymaking and service delivery
- Weak prioritization of children's needs in budgets, and delays in disbursement
- Varied levels of community involvement in the planning process
- Unaligned priorities of the community, district executive and legislative
- Weak political commitment to tackling the problem
- Weak leadership and lack of awareness/concern among bureaucrats
- A tendency to view HIV and AIDS purely as a health issue

In order to better combat the problem, efforts need to be scaled up and there needs to be a continued emphasis on:

- Designing interventions and programmes that specifically target youth together with the Papua AIDS Commission, as this is presently lacking;
- Strengthening the local level regulatory framework;
- Improving coordination among sectoral agencies and levels of government,
- Increasing the disbursement of funds for education and health and for HIV and AIDS prevention campaigns;
- Increasing the number and capacity of civil servants to plan, budget, implement and monitor programmes that redress vulnerabilities for women and children at both the provincial and the district/municipal levels;
- Providing greater facilitation in the musrenbang process to ensure that the voices and needs of children and women are both prioritised and acted upon;
- Building the commitment of government leaders to both prioritise the musrenbang and to incorporate it into district strategies, plans, budgets and programmes;
- Providing greater guidance and support for district level governments' HIV and AIDS prevention strategies and services;
- Synchronising programmes between agencies and with civil society initiatives;
- Involving all relevant stakeholders in the design of prevention programmes and strategies;
- Designing far reaching information, education and communication (KIE) campaigns on healthy living, prevention of STIs, nutrition, healthy homes and education;
- Involving prominent cultural and religious figures in educating the community on HIV and AIDS transmission in culturally appropriate ways;
- Mainstreaming HIV education and awareness in the school curriculum;
- Targeting interventions and service delivery and care in rural areas as much as urban areas, especially in places where migration is taking place and where education levels are low;
- Increasing the use of condoms among high-risk groups;
- Efforts to prevent the sharing of needles by IDUs;
- Improving the provision and use of VCT and support and treatment services for pregnant women and youth.

4.4
IMPROVING EDUCATION IN THE SHADOW OF CONFLICT AND THE TSUNAMI: ACEH PROVINCE UNDER SPECIAL AUTONOMY

4.4.1 INTRODUCTION

With the enactment of Law No. 22/1999, the Indonesian central government decentralised the management of its public sector to local governments. While the system of decentralisation can be conducive to democratization and good governance, there are substantial challenges in terms of achieving nationally agreed development targets. These challenges are acute in Aceh, for a number of reasons. First, decentralisation in Aceh has taken its broadest form through the Special Autonomy status of the province (see below), which has allowed the provincial government to set its own priorities and goals. Second, the tsunami of December 2004 deeply impacted on the lives, welfare and livelihoods of people living in Aceh, especially those of women and children. Third, the legacies of the destruction from the prolonged armed conflict and the tsunami have not only impacted on the economy and infrastructure of the province, but also the social, cultural and political environment and the processes of policy formulation and policy implementation. Finally, as is the case elsewhere in Indonesia, substantial achievements in Aceh have been realised against a background of uneven development and deep-rooted disparities within the province, which have important repercussions for the welfare, and well-being of women and children.

Special Autonomy, coupled with large reconstruction programmes supported by international donors, has brought an unprecedented flow of funds into the province. Managing the coordination among numerous and multilevel stakeholders is clearly an issue in itself. However, the enhanced flow of funds - together with the advent of peace - has meant that the challenges of reconstruction and development with equity are taking place in a context of unprecedented opportunities.

The case study on Aceh in this subsection focuses on education. As identified in Section 3.4, education is unequivocally a central focal point in Indonesia's development planning. The National Medium-Term Development Plan (RPJMN, Rencana Pembangunan Jangka Menengah Nasional) 2010-2014 identifies three pillars of education policy:

1. Equality and expansion of access to education
2. Enhancement of the quality, relevance and competitiveness of education outputs
3. Strengthening of the image of public education and of accountability within the education system

Achieving the laudable aims and targets of nationwide education policy in Indonesia is particularly challenging in Aceh. The school system was disputed during the years of conflict and many schools were damaged or destroyed. However, education policy and planning have brought some improvements in the levels of education in the post-conflict and post-tsunami environment, as discussed below. Yet this case study also identifies the ongoing challenges for education and education policy in the province.

4.4.1.1 Background to Aceh: Conflict, the tsunami and Special Autonomy

Aceh is situated on the northern tip of Sumatera Island. Aceh has a tropical, humid climate, encompassing an area of 58,375 km^2 (mostly covered by tropical forests) and has a population

of 4,223,833.[345] The province of Aceh comprises 23 administrative units (5 municipalities and 18 districts), 10 of which were created after 2000. The province is one of the two Indonesian Special Autonomy provinces (the other is Papua, see the previous subsection).[346] The majority of the population lives in rural areas (71.2 per cent versus 28.8 per cent living in urban areas in 2008) and 41 per cent of the population is under the age of 20 years.[347]

Two devastating events have shaped contemporary Aceh and have had an important bearing on the situation of women and children in the province: a prolonged armed conflict and the tsunami of 2004. The historian Anthony Reid described the long history of tense and often violent relations between Aceh and Jakarta in the period preceding independence.[4] In total, Aceh has spent 86 of the past 132 years in armed resistance against Jakarta, and sustainable peace has proven to be elusive.[348] Tensions with Jakarta in the post-colonial period have revolved around three deeply interrelated issues:

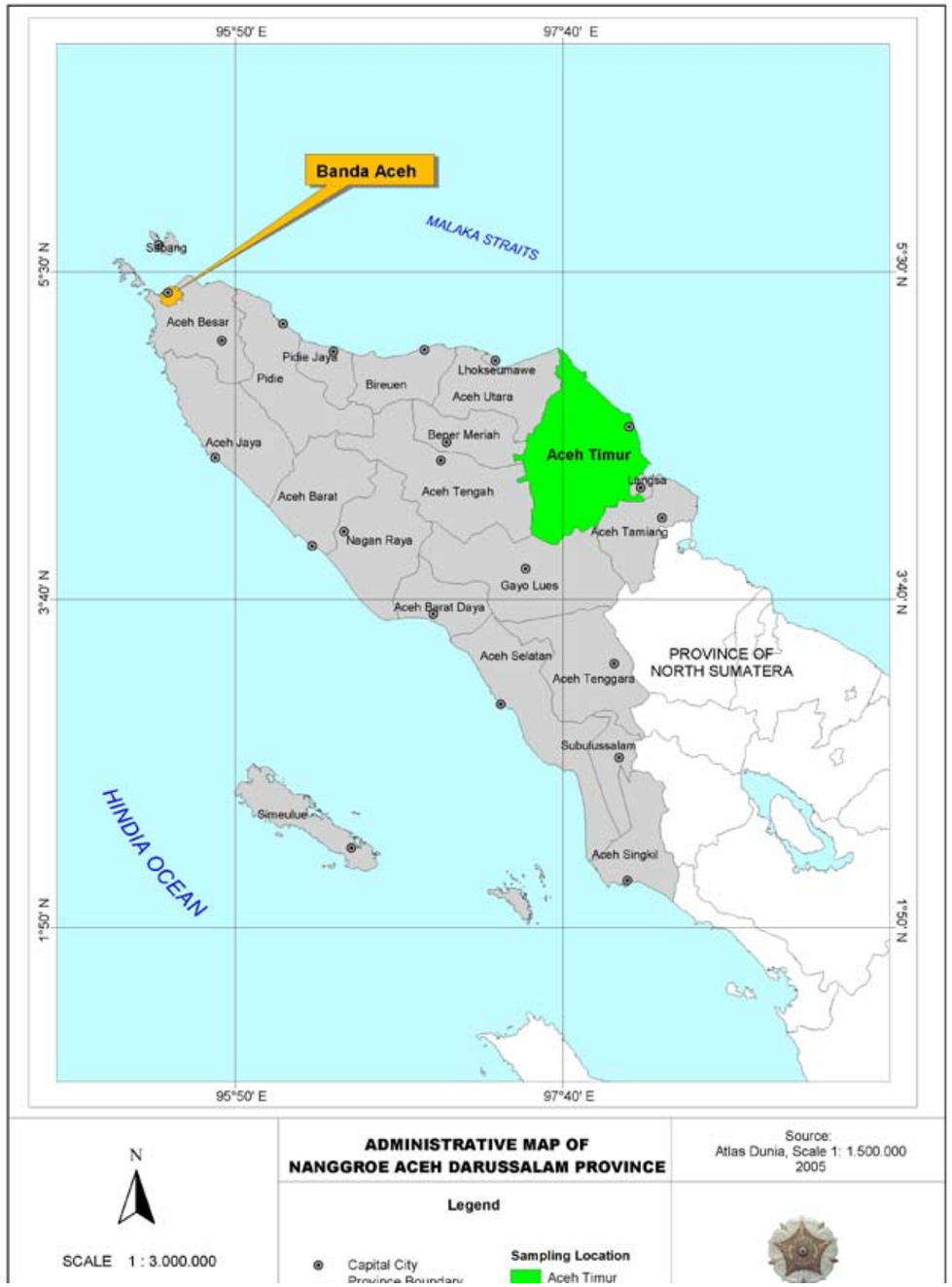
- The Special Autonomy status of Aceh, which started as an unfulfilled promise from Jakarta but which ultimately fell short of the secessionist ambitions of the rebel Acehnese leadership.
- Religion and the creation of an Islamic state.[349]
- The management and sharing of revenue from gas and oil, after these natural resources were discovered in the province during the 1970s.

Issues of autonomy and governance have featured highly in the conflict-ridden relations between Aceh and Jakarta, with natural resources adding to contentions and grievances. The contrast between the abundance of natural resources (oil and gas) and the disappointing performance in terms of poverty reduction have played an important role in fuelling discontent and ultimately armed conflict in Aceh. For instance, poverty levels fell by 47 per cent in Indonesia between 1980 and 2002 but increased in Aceh by 239 per cent over the same period.[350] Armed conflict returned to Aceh in 1976 when the Free Aceh Movement (GAM, Gerakan Aceh Merdeka) proclaimed Aceh's Independence and was met by extensive counterinsurgency campaigns by the Indonesian security forces.

The impact of the armed conflict, which lasted until 2005, was devastating. Over 30,000 persons lost their lives, over 400,000 people were displaced by the conflict and approximately 1.5 million people - or 39 per cent of the population - consider themselves to have been victims of the conflict.[351] The infrastructure damage left by the conflict was devastating, particularly in rural areas where over 50 per cent of infrastructure was damaged, and agriculture and enterprise were severely affected. Education and the school system were deeply affected too, as both GAM combatants and the Indonesian security forces accused each other of using schools as temporary bases or shelters, and schools became a target for both parties.[352] This led to repeated closures of the school system and just under 4,000 schools were damaged or destroyed during the conflict, affecting two thirds of the total number of schools in rural areas.[353] Many children were unable to

345 Badan Pusat Statistik (BPS) - Statistics Indonesia - Aceh Province (2009), available at: http://aceh.bps.go.id/ (Last accessed 25 May 2010)
346 The five municipalities are Banda Aceh, Langsa, Lhokseumawe, Sabang and Subulussalam
347 Estimates are projections based on the *Intercensal survey 2005*, processed by BPS - Statistics Indonesia (2009), BPS: Jakarta
348 Reid, INITIAL. cited in: Multi-Stakeholder Review (MSR, 2009) *Multi-stakeholder review of post-conflict programming in Aceh: Identifying the foundations for sustainable development in Aceh*, GoI: Jakarta, p4
348 Ibid.
349 The demand for an independent Islamic state stemmed from the influence of Acehnese religious leaders (*ulama*) who led the anti-colonial struggles in Aceh. Their views clashed with those of the urban based, Dutch-educated elite in Java, who sought to build an independent modern secular state. See: Reid, A. (2005) *An Indonesian frontier: Acehnese & other histories of Sumatra*, Singapore University Press: Singapore
350 Brown, G. (2005) *Horizontal inequalities, ethnic separatism, and violent conflict: The case of Aceh, Indonesia*. UNDP: Jakarta.
351 MSR (2009) *Multi-stakeholder review,* pxvi
352 Badan Rehabilitasi dan Rekonstruksi NAD-Nias (2009) *Pendidikan, kesehatan, peran perempuan: Menyiapkan generasi bermutu*, BRR: Banda Aceh
353 MSR (2009), *Multi-stakeholder review,* pxvii

Figure 4.4.1: Map of Aceh



Source: Center for Population and Policy Studies, Gajah Mada University, 2010

attend school or undertake the national exams under such circumstances. The tsunami and the armed conflict left dual legacies of devastating infrastructure damage as well as displacement, loss of close relatives and, more generally speaking, violence-related trauma. Children in Aceh were often caught up in the middle of gunfire exchanges in schools, in many cases witnessing the killings of teachers or friends.[354]

In all, it is estimated that the prolonged conflict caused US$10.7 billion in loss and damages - far more than the 2004 tsunami (see below).[355] Finally, countless human rights violations and acts of violence, e.g., killings, rapes, looting, unlawful imprisonments/trials and evictions, were perpetrated both by the Indonesian security forces and GAM combatants, leaving a legacy of trauma, fear and distrust in the population.[356]

By the early 2000s, the prospects for peace in Aceh were unclear. On one hand, the broader process of decentralisation meant that Aceh was granted Special Autonomy through Law No. 18/2001. However, the Special Autonomy status proved controversial and was rejected by GAM leaders. Between 2001-2004, negotiations were interspersed with periods of intense violence between GAM and the security forces that led to heavy losses on both sides. A new uncertain round of negotiation between the protagonists had been initiated in Helsinki when the tsunami of 26 December 2004 struck.[357]

Prior to the tsunami, the conflict in Aceh had received relatively little international attention, not least because access to the province was severely constrained. But the magnitude of the natural disaster brought Aceh to the centre of the world's attention. Both the devastation and the reconstruction efforts that ensued were unprecedented. Over 132,000 casualties (far more than during the armed conflict) were confirmed, but many more have not been accounted for and the total number of people who lost their lives in the disaster and its aftermath is not known. According to a 2006 World Bank expenditure analysis, the total recovery cost in Aceh and North Sumatera stood at US$4.5 billion, 97 per cent of Aceh's Gross Regional Domestic Product (GRDP).[358] The Office of the United Nations Secretary-General Special Envoy for the Tsunami Recovery reported that the funds pledged for the tsunami recovery by multi- and bilateral donors, non-government organisations (NGOs) and the Indonesian government amounted to US$6.1 billion.[359]

The death and destruction wrought by the tsunami, as well as the highly visible national and international responses to the disaster, assisted in creating a new momentum for peace negotiations. A memorandum of understanding (MOU) between the GoI and GAM was signed on 15 August 2005 in Helsinki. The MOU included a clarifying and broadening of Aceh's Special Autonomy status, and was implemented through Law No. 11/2006 on Governing Aceh. The main points of the agreement included broader autonomy in governance (see below), the dissolution of the rebel movement, and the reintegration of combatants into civilian life.[360]

354 Badan Rehabilitasi dan Rekonstruksi NAD-Nias (2009) *Pendidikan, kesehatan, peran perempuan*
355 Ibid., p104
356 MSR (2009) *Multi-stakeholder review*, p4
357 Barron, P. and Clark, S. (2006) 'Decentralizing inequality? Center-periphery relations, local governance, and conflict in Aceh', in *Social Development Papers: Conflict Prevention and Reconstruction*. Paper No. 39, World Bank: Jakarta
358 MSR (2009) *Multi-stakeholder review*, pp103-104
359 Approximately US$3.6 billion from multi- and bilateral donors and international financial institutions, US$2.5 billion from NGOs and the International Federation of Red Cross (IFRC) and US$2.75 billion from the GoI. Office of the Secretary-General's Special Envoy for Tsunami Recovery (2005) *Tsunami recovery: Taking stock after 12 Months*, United Nations: New York
360 MSR (2009) *Multi-stakeholder review*, pp3-4

Law No. 11/2006 on Governing Aceh establishes some key political and fiscal institutional arrangements for Aceh. These include the freedom to set up local political parties, the adoption of Islamic shariah law and the setting up of a distinctive social and political administrative system. The Special Autonomy status, in conjunction with post-conflict and post-tsunami reconstruction efforts (see Box 4.5.1 below), have put Aceh in something of a unique position in Indonesia. Funds and revenues have become available at an unprecedented level to meet the multiple reconstruction challenges, all within the rather untried and untested institutional context of decentralisation and Special Autonomy.

Between 1999-2006, the total regional revenues in Aceh, mostly derived from central government transfers, increased more than five times from IDR 2.4 trillion to IDR 11.2 trillion.[361] There are distinct sources of central government transfers, as follows:

1. The shares in oil and gas revenue in Aceh have been set at 55 and 40 per cent, respectively, since 2001 (compared to 15 and 30 per cent in other provinces). Although the shares of revenue have increased, it is worth noting that the depletion of oil and gas resources in Aceh means that overall revenues are decreasing and are set to decrease further in the future. This has important implications for medium- to long-term development planning in the province. Finally, the Law on Governing Aceh (Law No. 11/2006) has established that 30 per cent of the oil and gas revenues in Aceh must be allocated to education.
2. Between the years 2008-2023, Aceh receives a Special Autonomy Fund (Dana Otsus, or Dana Otonomi Khusus) which consists of an additional 2 per cent from the national general allocation budget fund (DAU, Dana Alokasi Umum). This is a temporary transfer, which will reduce to 1 per cent between 2023 and 2028, after which it will be terminated. According to World Bank estimates, this additional DAU allocation increased Aceh's revenues from IDR 10.4 trillion in 2006 to more than IDR 14 trillion in 2009.[362] The Dana Otsus is a block grant to be used to finance infrastructure development, including community empowerment, poverty alleviation, education, health and other social expenditures.
3. Finally, Aceh receives funds from the Special Allocation Fund (DAK, Dana Alokasi Khusus) for financing specific expenditures not covered by the general allocation fund formula. The DAK is earmarked for national priorities in programming and is transferred to Aceh Province, which is then responsible for distributing it to local governments (districts and municipalities). Since 2003, DAK funds have covered several sectors such as education, health and infrastructure, as well as the setting up of facilities for the new local governments that have been created during the decentralisation process. In addition, throughout the rehabilitation period, Aceh is receiving 'deconcentration' funds designated by the central government to address non-routine or recurrent development spending.[363]

The flow of funds from the central government to Aceh Province is different from other provinces, where most funds are allocated directly to districts. In Aceh the transfers are generally made to the provincial government, which is responsible for the administration and district allocation of the funds. Intra-provincial funds allocation is operated through qanun regulations.[364] For instance,

361 World Bank (2006) *Aceh public expenditure analysis: Spending for reconstruction and poverty reduction*, World Bank: Jakarta
362 Ibid.
363 Law No. 33/2004 specifies that provinces can request emergency funds from the central government to finance extraordinary and urgent needs, such as natural disasters, which cannot be covered by regional government budget (APBD). Although the programme is implemented by the province and local government, deconcentration funds are not recorded in the provincial and local government budgets. Instead, they are recorded in the national budget (APBN).
364 *Qanun* refers to the regulations that are passed by provincial, municipal or district legislative bodies, such as the provincial House of Representatives (DPRA, Dewan Perwakilan Rakyat Aceh). See Law No. 18/2001, Article 1.

Qanun No. 2/2008 stipulates that 40 per cent of the Dana Otsus is to be allocated to the province and 60 per cent allocated to district/municipalities.[365]

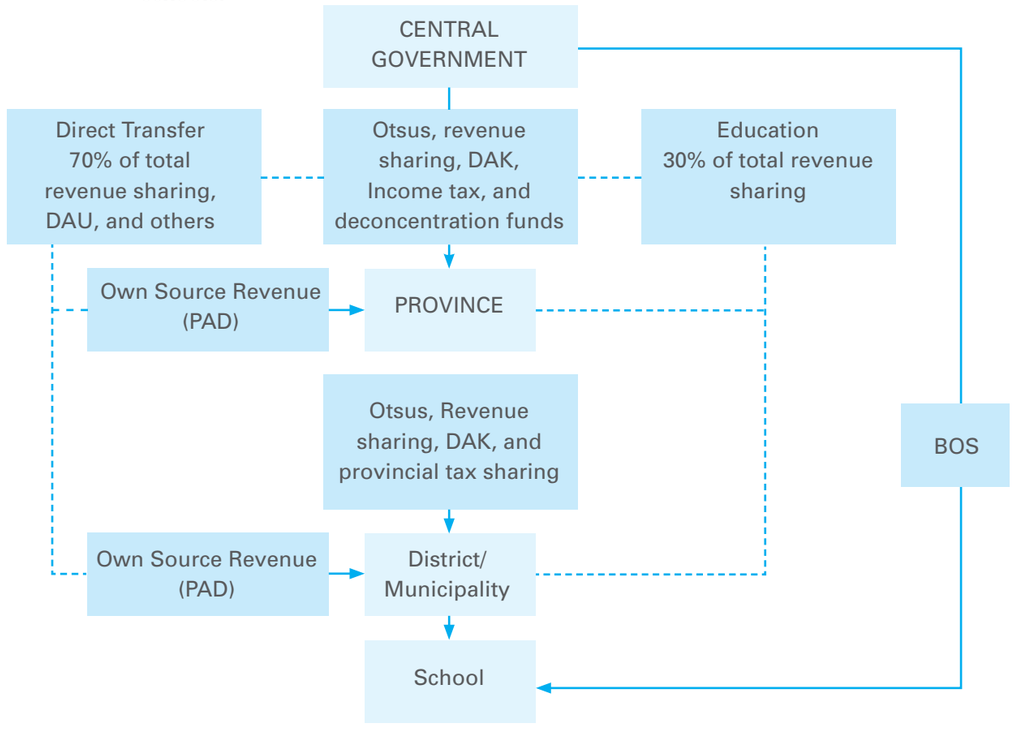
Special Autonomy has led to a dramatic increase in the education budget in Aceh, due in particular to a compulsory allocation to education of 30 per cent of the oil and gas revenue, and a 20 per cent allocation to education of the Special Autonomy funds.

Table 4.4.1: Education budget, Aceh 2002-2009

Year	Amounts IDR	Source
2002	700,000,000,000	TDBHM = oil and gas revenue share
2003	700,000,000,000	TDBHM
2004	700,000,000,000	TDBHM
2005	491,000,000,000	TDBHM
2006	480,000,000,000	TDBHM
2007	650,000,000,000	TDBHM
2008	1,364,835,727,340	TDBHM + Special Autonomy Funds=OTSUS
2009	2,128,157,953,850	TDBHM + OTSUS

Source: Aceh Provincial Development Planning Agency (BAPPEDA), Budget Implementation Reports 2002, 2003, 2004, 2005, 2006, 2007, 2008 and 2009

Figure 4.4.2: Summarizes the general flow of funds in Aceh and illustrates how it relates to schools.



Source: Law No. 11/2006 on Governing Aceh, Qanun No. 4/2002 and Qanun No. 24/2008

365 The transfers are calculated on the basis of a formula that takes into consideration a basic allocation and a fiscal gap. The basic allocation is based on civil servants' salary expenditure and the fiscal gap is obtained from the difference between the fiscal needs - including population, regional area, human development index (HDI), and construction price index (IKK, *indeks kemahalan konstruksi*) - and the fiscal capacity of each region (including own-source revenue and regional percentage of revenue-sharing).

The sudden influx of funds ought to enable Aceh to realise its commitments to improve livelihoods and social welfare in the region. Yet, the challenges of development, post-conflict and post-disaster reconstruction in Aceh, and investing for a sustainable future, when key sources of revenue (e.g., oil and gas and central government transfers) start to decline steeply, are substantial. Poor accountability and poor access to justice remain prevalent in Aceh.[366] As is often the case, the reintegration of ex-combatants is fraught with tensions and has been problematic in some communities, especially when ex-combatants have found it difficult to reintegrate on equal terms with other community members. Elsewhere, disputes over land ownership, usage and inheritance, notably for returnees, are numerous and ongoing.[367] The conflict has also left a deep legacy of mistrust towards the central government, but within Aceh distrust towards the local levels of government also remains high.[368] In addition, past patterns of social tensions leading to sudden outbursts of violence are still dangerously close to the surface and have not yet been replaced by peaceful approaches to conflict resolution.

Box 4.4.1: Tsunami and post-conflict recovery

According to the Multi-Stakeholder Review (MSR, 2009), 38 donors have supported 140 projects implemented by 89 organisations (52 per cent of which were local NGOs) for post-conflict reconstruction, and there are over 563 different projects implemented for post-tsunami reconstruction (p52). Assistance for the post-tsunami reconstruction has dwarfed that of post-conflict reconstruction and peace building assistance by at least 15 times, i.e., US$5.9 billion compared to US$365 million, according to some estimates (p69). Most of the tsunami related programmes made a deliberate effort to avoid conflict affected groups and regions, but the recent Multi-Stakeholder Review (MSR) report estimates that around US$529.5 million of tsunami assistance indirectly assisted post-conflict areas, more than the original budget allocated to post-conflict reconstruction (p69). Unavoidably with interventions of this magnitude, some negative or unforeseen consequences are bound to occur. In Aceh, the MSR reports that the delivery of assistance (post-tsunami and post-conflict) has had "the unfortunate effect of reinforcing an entitlement mentality among ex-combatants, conflict victims and communities in Aceh [which] may hamper the transition from relief to more broad-based development initiatives" (p103).

Source: Multi-Stakeholder Review (2009)

4.4.2 SOCIAL AND ECONOMIC OVERVIEW

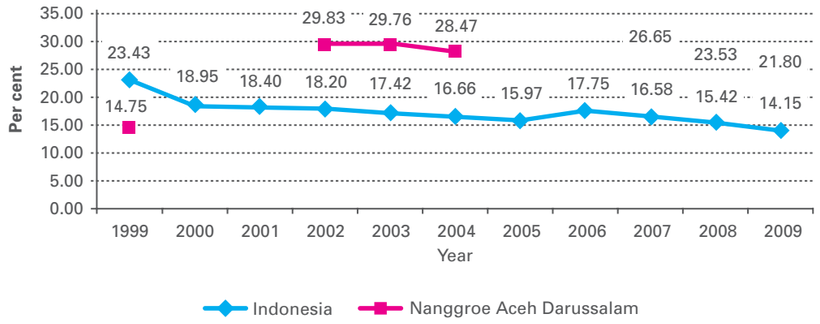
4.4.2.1 Poverty and human development

Data collection during the conflict years was haphazard, often partial and inconsistent. Establishing a reliable picture of social and economic conditions in Aceh is therefore not always possible. Where data exist, however, it is evident that both the conflict and the tsunami impacted negatively on the welfare and well-being of the population in Aceh. As noted above, poverty

366 UNDP (n.d.) *Access to justice in Aceh: Making the transition to sustainable peace and development in Aceh*, UNDP: Jakarta, available at: http://www.undp.or.id/pubs/docs/Access%20to%20Justice.pdf (Last accessed 10 November 2010)
367 Ibid.
368 MSR (2009) *Multi-stakeholder review*, pxix

increased during the conflict years in Aceh whilst reducing elsewhere in Indonesia. In the early 2000s, when the conflict was acute and access to the region was severely limited (including for humanitarian assistance programmes), the proportion of households living below the poverty line doubled from 14.75 per cent in 1999 to 29.83 per cent in 2002 (Figure 4.4.3). However, there has been some improvement since the end of the conflict and the deployment of post-tsunami reconstruction efforts. According to the Multi-Stakeholder Review (MSR, 2009), the economic recovery and, in particular, the resumption of trade and agriculture, have had a positive impact on almost every segment of the population. Key benefits from the resumption of economic activities and economic recovery include economic growth, improved employment levels and poverty reduction.[369] The proportion of the population living below the poverty line declined from 29.83 per cent in 2002 to 21.8 per cent in 2008. However, poverty in Aceh remains both above 1999 levels and significantly higher than in the rest of Indonesia, with a national level of 14.15 per cent in 2008 (Figure 4.4.4). Furthermore, poverty reduction has been attributed to economic growth, which in turn is linked to the influx of post-tsunami aid, which will inevitably start to dwindle in the coming years, making it uncertain whether poverty reduction is sustainable over the long run in Aceh.[370]

Figure 4.4.3: Percentage of population below the poverty line, Indonesia and Aceh 1999-2009[371]



Source: BPS - Statistics Indonesia, Statistical Year-Book of Indonesia, 2000-2009 (based on National Socio-Economic Survey)

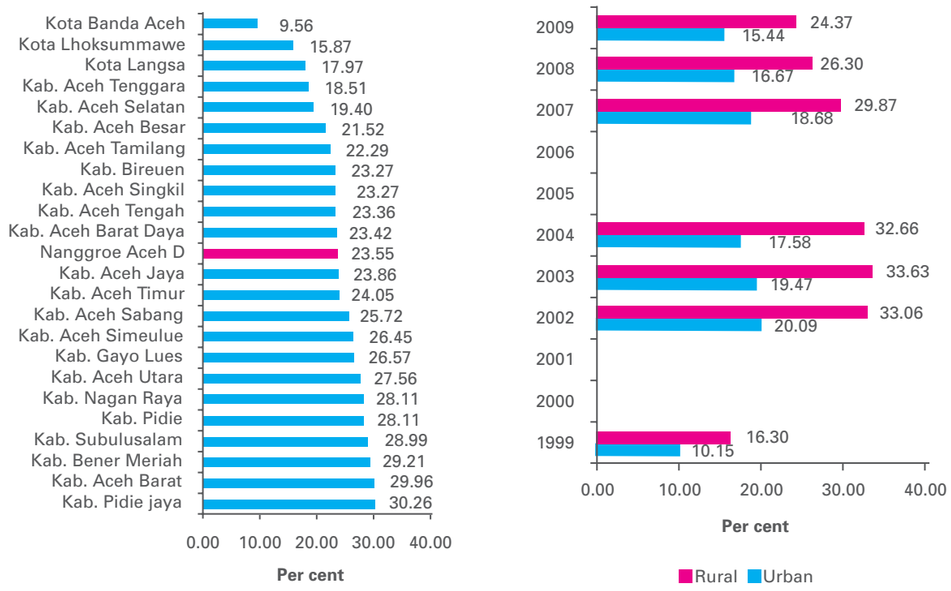
Figures 4.4.4 and 4.4.5 provide further insights into the nature of poverty and disparities in Aceh. Figure 4.4.4 indicates that there are significant disparities between districts and municipalities in Aceh, which in turn reflect the prominence of rural poverty in the province: 10 of the 18 districts register poverty levels above the provincial average and three of Aceh's five municipalities register the lowest percentage of population living in poverty in the whole of the province. This general trend is confirmed in Figure 4.4.5, which identifies the salience of the rural/urban divide in Aceh as a key source of disparities. The population below the poverty line is significantly higher in rural than in urban areas, and has remained consistently so since 1999. The data in Figure 4.4.5 suggest that the rural population was deeply affected by the conflict, with poverty levels increasing from 16.3 per cent in 1999 to 33.1 per cent in 2002 and the differential between urban and rural poverty increasing from 6.15-13 per cent during the same period. Addressing rural poverty and rural/urban disparities remain key development goals: the majority of the population lives in rural areas and more than half of the workforce is currently employed in the rural sector

369 MSR (2009) *Multi-stakeholder review*, pxix
370 Ibid.
371 There are data missing in Figure 4.4.2 due to incomplete data collection in 2000, 2001, 2005 and 2006

(i.e., fisheries, agriculture and small enterprise). However, the rural sectors of the economy remain underdeveloped and highly associated with low income, the expected depletion of oil and gas production in the short- to medium-term renders the improvement of rural livelihoods even more of a priority.[372]

On one hand, the cessation of the conflict and the post-tsunami intervention have not reduced poverty to pre-2000 levels in urban or in rural settings. On the other hand, somewhat encouragingly, the disparities are no longer increasing. Using 2002 and 2009 as benchmarks, the reduction of poverty in rural areas has been marginally faster than in urban areas (reductions of approximately 26 per cent in rural areas compared to 23 per cent in urban areas).

Figure 4.4.4 and 4.4.5: Percentage of population below the poverty line by area (1999-2009) and by district (2008), Aceh



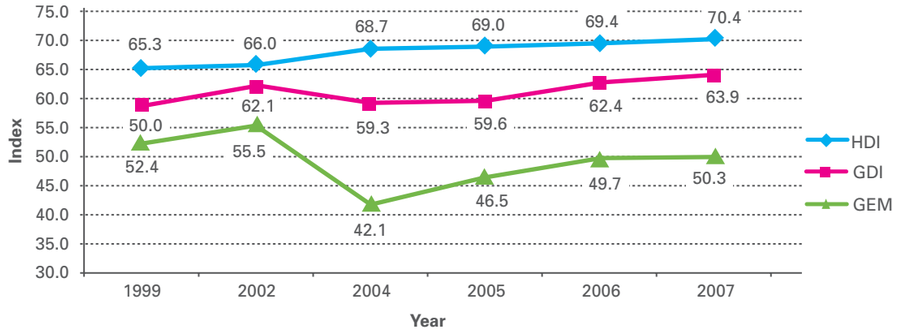
Source: BPS - Statistics Indonesia, Statistical Year-Book of Indonesia, based on National Socio-Economic Surveys 2000-2009[373]

Prior to the 2004 tsunami, Aceh had an above average human development index (HDI), standing at 65.30 compared to a national average of 64.30 in 1999. But the province HDI has been consistently slightly below the Indonesian average since 2004 - the HDI in 2007 stood at 70.59 nationally compared to 70.4 in Aceh (see Section 2). Although the general trend since 1999 has been towards continual improvement of the HDI, Aceh still faces important challenges in terms of tackling prominent HDI disparities across districts. In 2007, there was still almost a 10-point difference between the best performer (urban Banda Aceh; 76.74) and the worst performer (rural Gayo Luwes, 67.17), and 13 of Aceh's 23 districts and municipalities recorded an HDI below the provincial average.

372 World Bank (2006) *Aceh public expenditure*
373 There are data missing in Figure 4.4.5 due to incomplete data collection in 2000, 2001, 2005 and 2006

Elsewhere, as shown in Figure 4.4.6, two gender-based human development indicators lag significantly behind the HDI. The gender development index (GDI) dipped in the middle of the decade and only very slightly increased from 62.1 to 63.9 between 2002 and 2007. More worrying still, the gender empowerment measure (GEM) declined sharply from an all-time high of 55.5 in 2002 to 42.1 in 2004 and stood at 50.3 in 2007. This indicates that gender based inequality in human development still persists in terms of income, human rights, political freedoms and political participation. Whilst women remain under-represented in political and decision-making positions, a number of initiatives and regulations have been established to strengthen the political participation of women, including the qanun on local political parties, which requires that 30 per cent of candidates of political parties be women.[374] Judging by the 2009 election results, the impact of quotas on the formal political participation and representation of women in Aceh is not immediately obvious.[375] However, away from formal arenas of power, some international development agency workers are reporting that the deployment of reconstruction and rehabilitation programmes in post-conflict and post-tsunami Aceh is favouring female participation in public meetings and village meetings, which women rarely attended prior to the tsunami.[376] This is potentially an important development, which remains to be institutionalised, and it is important too to ensure that women's participation is equally fostered across all districts, including those that are not beneficiaries of post-conflict or post-tsunami rehabilitation programmes.

Figure 4.4.6: Human development indicators, Aceh 1999-2007



Source: BPS-BAPPENAS-UNDP, Indonesia Human Development Report 2004 (data 1999 and 2002); BPS-The Ministry of Women's Empowerment, Gender Based Human Development 2005 and 2006

4.4.2.2 Situation of children: Health, nutrition, water and sanitation

With the exception of the IMR, most indicators relating to child survival, health and nutrition indicate that Aceh is performing worse than or similar to national averages. One of the reasons the IMR is particularly low (at 25 per 1,000 live births), is that there is a high level of skilled birth attendance (72.5 per cent, similar to the national average of 73 per cent - see Section 3.1). Rural/urban divides are key to explaining Aceh's other health indicators, such as the under-five mortality rate (currently at 45 per 1,000 live births, similar to the national average, see annex 4.4). On one hand, there is a persistent lack of health-care services in rural areas. In addition, low living standards in rural areas continue to induce health workers to move from rural to urban areas, while health workers who fled from rural conflict areas to the relative safety of urban settings have little incentive to return to their rural postings.[377] As more than 70 per cent of Aceh's population lives in rural areas the low access to quality health care in rural areas has a detrimental impact on the health status of children. Data from the 2007 IDHS show that the health status of children in Aceh is among the worst in Indonesia. The proportion of children fully immunized against all basic antigens is the lowest among all of Indonesia's provinces after Papua, and the percentage is half of national average (23.7 per cent versus 58.6 per cent).[378] Meanwhile, Aceh is among the provinces with the highest prevalence of severe and moderate underweight (10.7 per cent of children in Aceh versus 5.4 per cent nationally), stunting (28.1 per cent in Aceh versus 18.8 per cent nationally) and wasting (9.2 per cent in Aceh versus 6.2 per cent nationally).[379]

The availability of clean water and safe sanitation is critical for improving child survival and improving the health status of children, but only 31.49 per cent of rural households in Aceh had access to clean water compared to 65.33 per cent in urban areas in 2008. Moreover, only 31.23 per cent of rural households had sustainable access to adequate sanitation facilities compared to 74.49 per cent of households in urban areas in 2008.[380] The tsunami badly compromised access to clean water and sanitation. A large number of wells were contaminated in the wake of the disaster. The construction or reconstruction of clean water facilities was a key priority in the tsunami-affected districts, but it is an area where progress has been slow and targets have not been met.[381]

4.4.3 EDUCATION

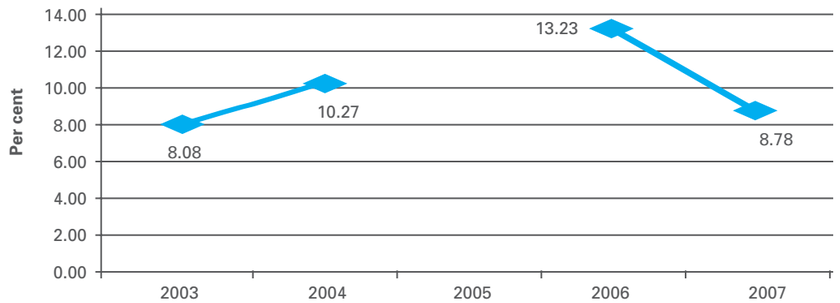
4.4.3.1 Education overview: Access and efficiency

The data on education in Aceh in the 2000s are often lacking and incomplete. As signalled in Section 3, there are a number of issues with the collection of data on education throughout Indonesia, but in Aceh, both the conflict and the tsunami badly disrupted data collection, especially in rural conflict areas. Nonetheless, the available data and information on education indicate a mixed panorama of some achievements (notably in enrolments) and ongoing inequalities and failings in terms of efficiency and quality of education.

As seen in the national overview on education in Section 3, achieving universal basic education (primary and junior secondary school) is a key goal of the GoI and this is the area where most achievements have been realised. Early childhood education is recognised as important in Indonesia, but it is an area of far fewer achievements when compared to basic education. The situation in Aceh strongly echoes this state of affairs. As with national level data, information about early childhood education is sparse but Figure 4.4.7 indicates that Aceh lags far behind the Indonesian national average, which stood at 12.44 in 2007 (see Section 3). However the general trend in Aceh seems to be in keeping with the rest of Indonesia, where attendance rates for 4- to 6-year-olds have been falling during the 2000s. As with national data, further research is needed to identify and ultimately address the causes of this general decline.

374 United Nations Development Fund for Women (UNIFEM) (2010) *Women's political participation*, available at: http://www.unifem-eseasia.org/Governance/Women_Political_Participation.html (Last accessed 2 November 2010)
375 In the 2009 general elections, from a total 652 seats available, only 41 women were elected, 37 in the District Representative Council and four in the Provincial Representative Council. UNIFEM (2010) *Increasing the political participation of women in Aceh*, available at: www.unifem.fi/pdf/SummaryReportWPP_FinlandNC_Final.pdf (Last accessed 2 November 2010)
376 Interview with staff of an international development agency who requested anonymity, Banda Aceh (7 March 2010)
377 World Bank (2006) *Aceh public expenditure*
378 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007*, BPS - Statistics and Macro International: Calverton, Maryland
379 Ministry of Health (2008) *Report on the results of the National Basic Health Research (Riskesdas) 2007*, National Institute of Health Research and Development: Jakarta
380 Based on the *National Socio-Economic Survey (SUSENAS)*, processed by BPS - Statistics Indonesia, Jakarta, 2009. Note: clean water includes filtered water, piped and non-piped water (pumps, protected wells and springs) which are more than 10 meters away from excreta disposal sites
381 Badan Rehabilitasi dan Rekonstruksi NAD-Nias (2009) *Pendidikan, kesehatan, peran perempuan*

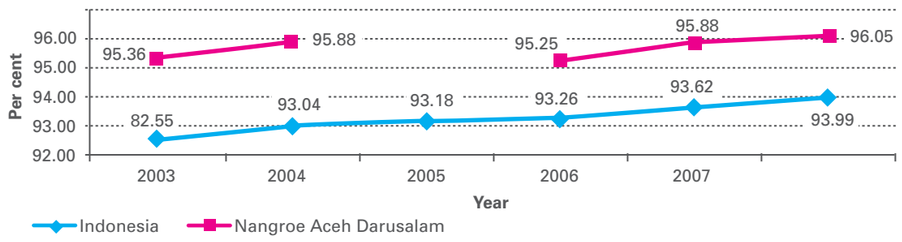
Figure 4.4.7: Attendance rates among children aged 4-6 years in early childhood education institutions, Aceh 2003-2007



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2003-2007

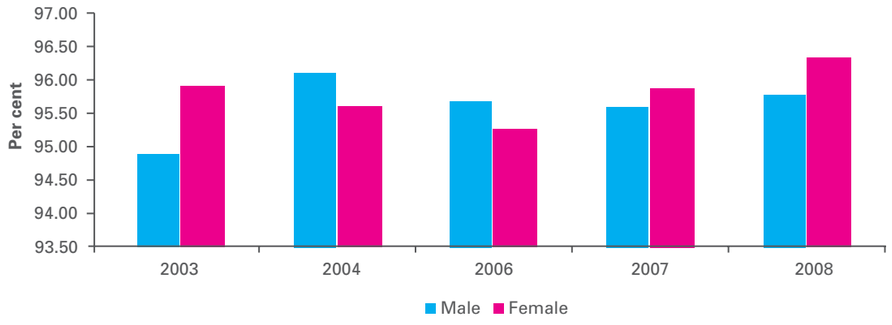
Nevertheless, there have been some remarkable achievements in Aceh in terms of improving education participation at the primary level. These achievements are shown by the increasing net attendance rates (see Figure 4.4.8), which have persistently scored above the national average. In keeping with national level trends, Figure 4.4.9 shows that at primary school level, there are few disparities in male/female attendance. The widest disparity recorded was in 2003 when the female attendance rate was 1.02 per cent above that of males, but the disparity has declined to 0.55 per cent in favour of females in 2008. At the national level, females have maintained a slight advantage over males for most of the 2000s, while in Aceh the advantage has fluctuated between males and females.

Figure 4.4.8: Net attendance rates for primary school, Indonesia and Aceh 2003-2008



Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2003-2008

Figure 4.4.9: Net attendance rates for primary school by sex, Aceh 2003-2008

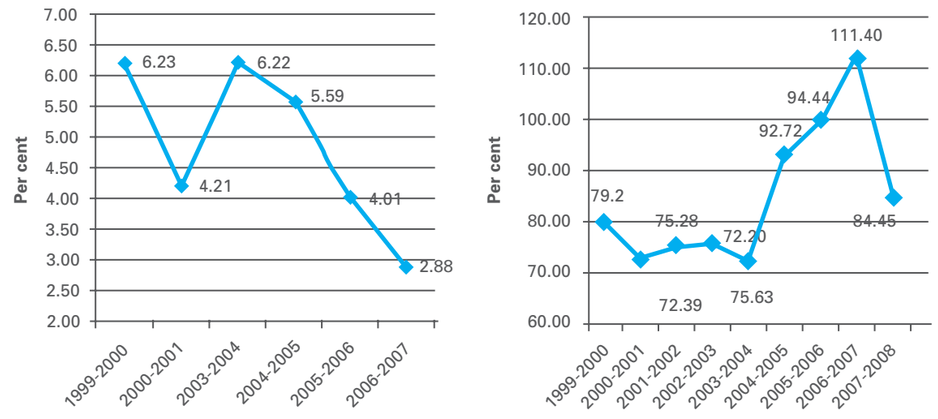


Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2003-2008

The attendance figures in Aceh are impressive but only provide a partial picture of primary education. Figure 4.4.10 on the primary school early leaving (dropout) rate, Figure 4.4.11 on the transition rate from primary to junior secondary school and Figure 4.4.12 on the repeat rate, all reflect the difficult provincial context and raise questions about the efficiency of education. From data in Figure 4.4.10, it is evident that after a sudden spike in 2003/04, the early leaving rate for primary school has been steadily recovering to reach an all-time low of 2.88 per cent in 2007. The national level trend in primary school early leaving rates also shows a slight increase up to the mid-2000s, after which the early school leaving rate declined also to reach an all-time low of 1.81 per cent in 2007. The early school leaving rate for primary school in Aceh has been higher than the Indonesian average, especially in the wake of the tsunami when the rate in Aceh was more than twice that of Indonesia as a whole (6.22 in Aceh versus 2.97 nationally in 2003/04). The transition rate from primary to junior secondary school is a key indicator for evaluating how far Indonesia remains from achieving universal access to junior secondary education. The data in Figure 4.4.11 point towards above average transition rates in Aceh, and the national target of achieving transition rates of 75 per cent has been consistently met since the early 2000s in the province. However, as discussed in Section 3, transition rates are also notoriously volatile and in Indonesia the data are often unreliable. The latter is illustrated here by a reported transition rate of over 100 per cent in 2006/07 in Aceh, indicating either double reporting or over-reporting of transition from primary to junior secondary schools. Finally, the repeat rate for primary school decreased from 6.28 per cent in 2004 to 2.34 per cent in 2006, only to rise again to 3.69 in 2007/08 (Figure 4.4.12).

Figure 4.4.10: Primary school early leaving rates, Aceh 1999-2007

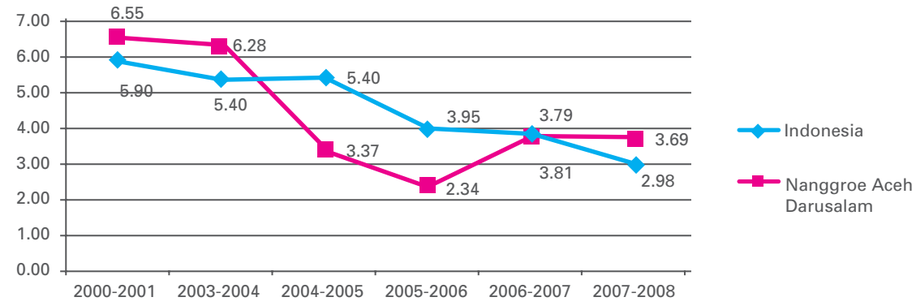
Figure 4.4.11: Transition rates to junior secondary school, Aceh 1999-2007



Source: Indonesia Ministry of National Education, 1999-2007[382]

382 Indonesia Ministry of National Education (2009) *Statistics of National Education*, available at: www.depdiknas.go.id/statistik (Last accessed 1 July 2009)

Figure 4.4.12: Primary school repeat rate, Indonesia and Aceh 2000-2008



Source: Indonesia Ministry of National Education, 2000-2008[383]

The data on participation in junior secondary school are less impressive than at the primary level. The net attendance rate for junior secondary school is substantially lower, standing at 76.56 per cent in 2008 (see Figure 4.4.13). The net attendance rate for junior secondary school in Aceh has consistently been above the national average. However, while the national rate rose steadily from 60.27 per cent in 2000 to 68.98 per cent in 2008 (see Section 3.4), in Aceh, the junior secondary school net attendance rate has, in contrast, declined from a high of 79.98 per cent in 2004 to 76.56 per cent in 2008.

According to a 2006 World Bank report there was a notable increase in the number of women and young people (15-24 years old) employed or seeking employment in Aceh following the disaster.[384] By 2006, 25 per cent of those in the 15-24 age group were actively seeking work.[385] Although research on this subject is currently sparse, this finding nonetheless suggests that declining student participation in junior secondary school may be linked to the tsunami prompting an increasing number of adolescents to seek work instead, in order to contribute to their household income.

Figure 4.4.13: Net attendance rate for junior secondary school

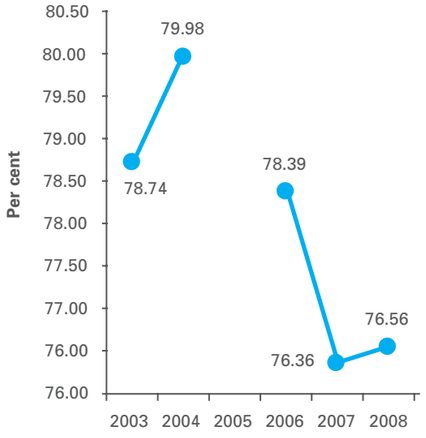
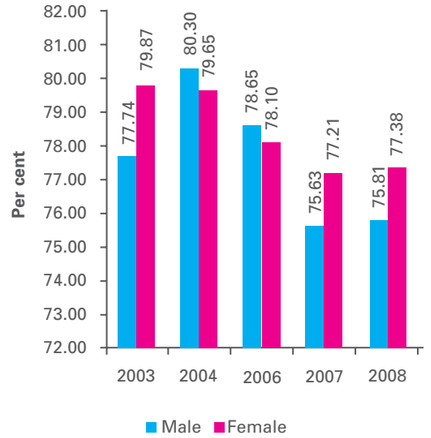


Figure 4.4.14: Gender disparities in junior secondary school participation



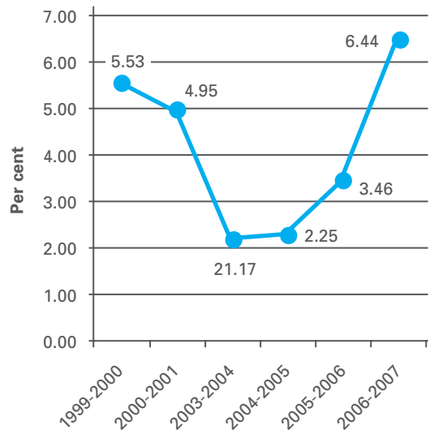
Source: BPS - Statistics Indonesia, based on the National Socio-Economic Surveys 2003-2008

383 Ibid.
384 World Bank (2006) *Aceh public expenditure*, p12
385 Ibid.

Gender-based disparities in junior secondary school participation are slightly more pronounced than for primary school attendance, and have consistently marginally favoured girls (Figure 4.4.14). The gender patterns for junior secondary school participation in Aceh are similar to those at the national level (see Section 3.4).

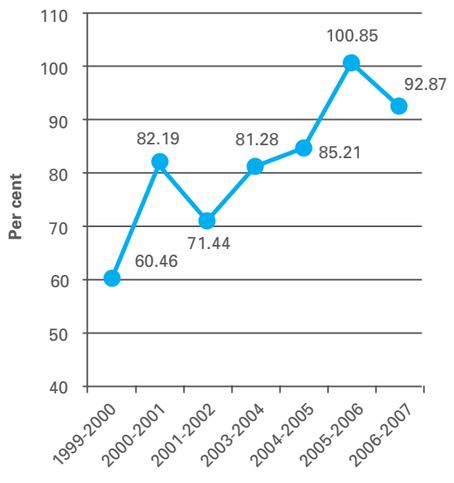
Similar to primary education, a relatively high net attendance rate in junior secondary school is an important achievement, but data on the junior secondary school early leaving rate, the transition rate and repeat rates (Figures 4.4.15 and 4.4.16) again highlight issues with the efficiency of education. The trend in the early leaving rates in Aceh closely follows national patterns of initial decrease in the early 2000s (from 5.53 per cent to 2.17 per cent in Aceh; 4.39 to 1.97 per cent at national level) and steady increases again from the mid 2000s to 2006/07 (from 2.17 to 6.44 per cent in Aceh; 1.97 to 3.94 per cent at the national level).[386] Even though the general pattern of the early school leaving rate in Aceh is similar to the national level, it is notable that the early school leaving rate is above the national average and the recent increase is also more pronounced in Aceh. Between 2003/04 and 2006/07 the rate doubled at the national level but it trebled in Aceh. The latter corresponds to the aftermath of the tsunami when, as was seen above, some children left school to enter the labour force, often to supplement household incomes. The data on the transition rate to senior secondary school once again suggest substantial achievements and improvements over the 2000s with increases from 60.46 per cent in 1999/2000 to 92.87 per cent in 2006/07, yet as with the primary school data, the reliability of the data is questionable with reported transition rates above 100 per cent in 2005/06 (Figure 4.4.16). Finally Figure 4.4.17 shows that the repeat rate for junior secondary school almost doubled between 2000/01 and 2005/06 (from 0.52 per cent to 0.97 per cent) but reduced to 0.62 per cent by 2006/07. Yet overall the repeat rate did increase during the 2000s (from 0.52 to 0.62 per cent) and remain significantly above the national average throughout the period (0.31 per cent in 2000/01 and 0.42 per cent in 2006/07).

Figure 4.4.15: Trend of junior secondary school early school leaving rate, Aceh 1999-2007



Source: Indonesian Ministry of National Education, 1999-2007[387]

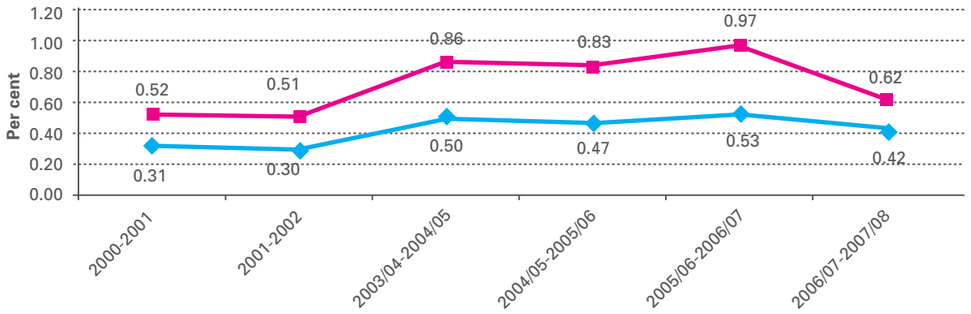
Figure 4.4.16: Transition rate to senior secondary school, Aceh 1999-200



Source: Indonesian Ministry of National Education, 1999-2007[388]

386 Data from: Indonesian Ministry of National Education (2009) *Statistics of National Education*, available at: www.depdiknas.go.id/statistik (Last accessed 1 July 2009).
387 Indonesian Ministry of National Education (2009) *Statistics of National Education* available at: www.depdiknas.go.id/statistik (Last accessed 1 July 2009)
388 Ibid.

Figure 4.4.17: Trend in repeat rates for junior secondary school, Indonesia and Aceh 2000-2009



Source: Indonesian Ministry of National Education, 2000-2008[389]

Figure 4.4.18: Net attendance rate of senior secondary school, Aceh 2003-2008

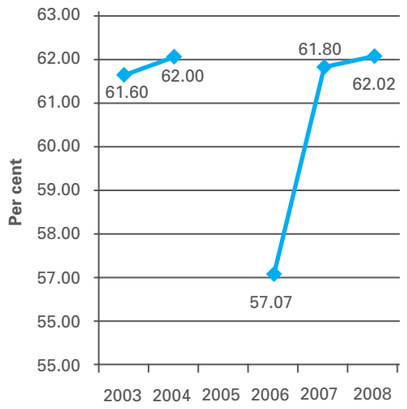
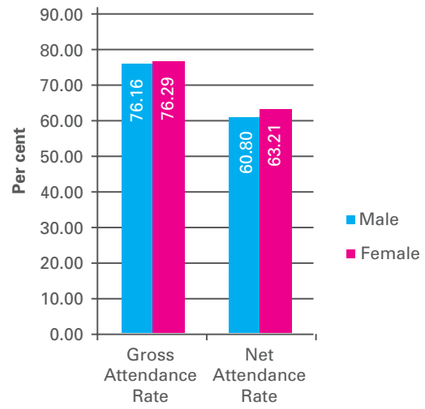


Figure 4.4.19: Gross and net senior secondary school attendance rates by sex, Aceh 2003-2008



Source: BPS - Statistics Indonesia, Welfare Indicators, based on the National Socio-Economic Survey 2000-2008

Figure 4.4.18 and 4.4.19 relate to senior secondary education. As with early education, senior secondary school education is not an integral component of the GoI goal of basic education (i.e., nine years in primary and junior secondary school), and there is a substantial drop in attendance figures at this level. The net attendance rate in 2008 stood at 96.06 per cent for primary school and at 76.50 per cent for junior secondary school, but was low at 62.02 per cent for senior secondary school. The impact of the tsunami on senior secondary school attendance was drastic; between 2004-2006 the rate dropped by over 5 percentage points, only recovering to pre-tsunami levels in 2008. Gender based disparities at the senior secondary school level continue to favour females, even more so than at the primary and junior secondary levels, with female participation rates 2.40 per cent higher than for males.

389 Ibid.

The broad picture emerging from the overview of education data in Aceh points towards a mixed record. On one hand, there have been some considerable successes in maintaining or increasing attendance rates in Aceh above the national average, especially with the core components of basic education (primary and junior secondary school). However, the record with early childhood education are senior secondary education is not as impressive. Significant issues with the efficiency of education remain; notably, in ensuring that children not only enrol in school but remain and complete their education. In many respects, this parallels wider concerns at the national level. A recent UNICEF report on Education For All (EFA) in Indonesia, signals that whilst Indonesia is on track to achieve universal primary education, this progress "conceals major issues that continue to require very close attention in the development process. These issues are early school leaving, grade repetition, transition to junior secondary school and limited participation in early childhood education."[390]

Some of these issues are clearly in evidence in Aceh, but with the added dimensions of post-conflict and post-tsunami impacts within a context of profound but incipient and uncertain institutional change. For instance, retaining children in education and away from the labour market is an issue in most provinces of Indonesia, but the tsunami not only drove many children out of education, but also provided incentives to stay out of education through the increased availability of work in reconstruction programmes. The challenge of retaining children in schools has therefore been difficult to achieve in Aceh. Second, this overview started with an observation that data collection in Aceh had not always been possible in the province and it is impossible to provide an analysis of district disparities. These are broadly acknowledged to exist in Aceh where access to education in rural versus urban areas and in regions with or without a history of conflict vary widely (see below), but to date extensive and reliable data collection on this matter is still lacking. In the following subsection, some in-depth information and data analysis about the nature and peculiarities of the education system in Aceh are examined. The centrality of rural/urban disparity casts a long shadow over access to good quality education in Aceh and this in turn is closely linked and interplays with legacies of violence and disaster in the province.

4.4.4 REBUILDING EDUCATION IN ACEH: THE CHALLENGES OF ACCESS, QUALITY AND ACCOUNTABILITY IN A CULTURALLY SENSITIVE ENVIRONMENT

As elsewhere in Indonesia, the public education system in Aceh consists of six years of primary education (SD, Sekolah Dasar), three years of junior secondary education (SMP, Sekolah Menengah Pertama), three years of senior secondary education (SMA, Sekolah Menengah Atas) and four years of higher education. However, in Aceh the lines between public/secular and religious schools are less prominent than in the rest of the country. Islamic teaching is taught in public schools to a far greater degree than elsewhere in the country.[391] In addition, there is a system of Madrasah, or Islamic schools, that operates in parallel to the public education system. The religious school system has a similar structure to the secular one, including Islamic primary school (MI, Madrasah Ibtidaiyah), junior secondary school (MT, Madrasah Tsanawiyah) and Islamic senior secondary school (MA, Madrasah Aliyah). In addition to the Madrasah schools, there are also Dayah or Islamic boarding schools (pesantren), which are funded and supervised by a government agency - Badan Dayah - rather than being funded and managed by local communities as in the rest of Indonesia.

390 UNICEF (2010) *Education policy and practice: A study of changes in government of Indonesia policy and practice since MGP-BE Project inception*, UNICEF: Jakarta, p28

391 In public junior secondary schools there is a compulsory study of Arabic and the Quran for four hours each week. In comparison, religious teaching accounts for 60 per cent of the curriculum in Islamic junior secondary schools. Interview with a junior secondary school teacher and evaluator, Aceh Timur (17 June 2010)

Box 4.4.2: Islamic teaching in Aceh's education system

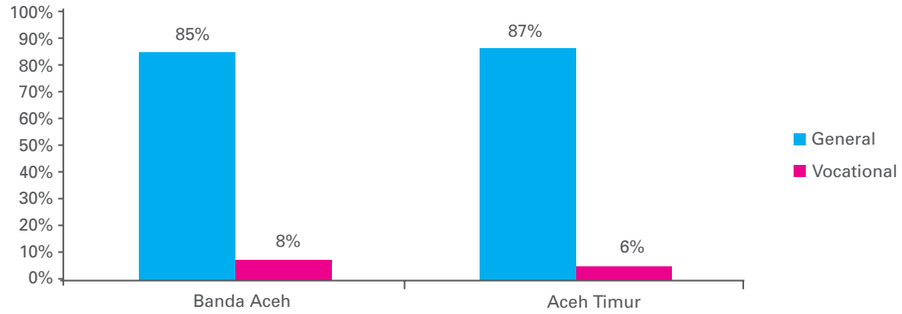
According to Qanun No. 23/2003 on Education, the education system in Aceh must be organic in nature, in that it must be based on the Quran and the hadith, Acehnese socio-cultural values, as well as the Pancasila, which is the philosophical foundation of the Indonesian state. The Aceh Provincial Medium-Term Development Plan (RPJMD 2007-2012) also identifies the development of an education system rooted in Islamic values as one of the core priorities of the education strategy in the province (p47). The Aceh Provincial Government has decreed that all Muslim pupils at the primary school level in Aceh must be fluent in the basics of Islamic teachings, be able to read the Quran, and be able to perfectly perform the salat prayer (RPJMD, p22). As described in Qanun No. 5/2008 on Education, in Aceh the government supplements the National Standard Curriculum - at all levels of education - with a local content curriculum that heavily emphasises Islamic teachings (Article 35, clause 1). The curriculum in every type of school and at every level must include the following subjects (Article 35, clause 3):

Aqidah (belief/faith)
Basic Islamic Law (Fiqh)
Quran and hadith
Moral conduct (Akhlaq)
Civic education
Mathematics
Natural Sciences
Social Sciences
Skills, Information Technology and Communications
Indonesian Language and Literature
Arts and Culture
English
Arabic

Sources: Aceh Provincial Government (2007) NAD Rencana Pembangunan Jangka Menengah (RPJM) 2007-2012, Aceh Provincial Government: Banda Aceh; Qanun No. 5/2008 on Education; Qanun No.23/2003 on Education

Finally, both junior and senior secondary schools have two tracks: a general track (SMU, Sekolah Menengah Umum) and vocational track (SMK, Sekolah Menengah Kejuruan). The development of vocational schools has been assigned as a main priority by the Provincial Government of Aceh in its Regional Medium-Term Development Plan (RPJMD 2007-2012, Rencana Pembangunan Jangka Menengah Daerah). The development of vocational schools with a clear emphasis on professional, rather than solely academic, learning is important to provide education that is relevant and appropriate to children in the province. In a context where child labour remains one of the key obstacles to the universalisation of the basic education policy, vocational schools allow children to remain within the school system whilst learning practical skills that facilitate and enhance their ability to manoeuvre their entry onto the labour market. So far, however, the number of vocational schools in both rural and urban settings remains very limited. A recent survey by the University of Indonesia in Banda Aceh and Aceh Timur shows that general track education remains overwhelmingly the norm.[392] Additional data from the same survey indicate that slightly more males than females access vocational schools, and more children access them in urban areas (Banda Aceh) than rural areas (Aceh Timur). The survey does not elucidate whether this is a matter of choice or a response to the current unavailability of vocational schools, but the data presented in Box 4.4.3 indicate that a lack of facilities is likely to be one of the main contributing factors.

Figure 4.4.20: Type of schools in Banda Aceh and Aceh Timur, 2009



Source: Based on data from: University of Indonesia, Situation analysis of adolescents 2009

Box 4.4.3: Vocational schools in Aceh

The Strategic Plan (Renstra, Rencana Strategis) on Education in Aceh aims to have more than 50 per cent of schools established as vocational schools in Aceh by 2012. According to a Provincial Development Planning Agency (BAPPEDA) staffmember (interview in Banda Aceh, 16 June 2010), the current ratio of vocational schools to general track schools is 1:4 (or 20% versus 80%), and balancing this ratio is a substantial and difficult undertaking. The development of vocational schools requires qualified teachers as well as investment in facilities. In addition, the operational cost per student of vocational school is higher than general track schools and government budgets are limited.

There was a sudden increase in the demand for vocational schools in the wake of the tsunami, but local governments have not responded promptly to the demand. Teachers in vocational schools have expressed a number of complaints about the lack of support for infrastructure and administration, as described by one focus group discussion (FGD) participant:

"There has been an aggressive campaign of promoting vocational schools by the government. Students have responded enthusiastically and the number of students seeking to enrol in vocational schools is exploding because they hope to get a job easily and become financially independent. The central government has been successful in promoting these schools but the local government has not been responsive, and there is no proper preparation for this development. We are pushed to hurry to open vocational schools but we do not have the teachers yet. The local government is also not ready with the budget. The budget for vocational schooling for one student is IDR 2 million per year. It is not the same with general high schools in which the budget per student is only IDR 600,000 per year…but

[392] University of Indonesia (2010) *Situation analysis of adolescents 2009,* Mimeo: Jakarta, p23

we actually get the same funding. The decentralisation of education is a good thing and it is important that the programme be delegated to local governments, but without proper planning it will not result in a good outcome." (FGD participant in Aceh Timur, 14 September 2009)

Elsewhere, a vocational school teacher in Langsa reported that "The Office of Education wants a selection process to get only the best qualified students. But then we received a letter from the General Directorate telling us to accept all the applicants. There are several schools that have had to provide double seats. If we could treble the seats we probably would be told to do so. But we don't have the facilities." (17 September 2009)

Source: FGDs and interviews with participants/places/dates as indicated in text

Whilst the drive to increase vocational schools in Aceh is evidently a positive step, the implementation of the policy is problematic and there has been a lack of coherent planning and coordination between local and provincial governments, resulting in poor service delivery.

4.4.5 QUALITY OF EDUCATION AND DISPARITIES IN ACEH

Aceh is facing a number of challenges to its efforts to improve the quality of education in the province. Table 4.4.2 summarizes some key indicators of the quality of education. The figures reveal improvements since 2007, but at the same time they remain fairly low and in most cases fall short of the targets set in the Aceh Province RPJMD.

Table 4.4.2: Indicators of education quality, Aceh 2007-2009 and target for 2012

	2007-2009 Achievement			Target for 2012
	2007	2008	2009	
Average mark for National Exam:				
Primary public and Muslim schools	5.84	5.83	6.69	6.90
Junior secondary public and Muslim schools	6.15	6.74	7.26	7.50
Senior secondary public and Muslim schools	6.30	6.43	7.16	7.50
Percentage of qualified teachers (≥ bachelor's or diploma level 4):				
Primary public and Muslim schools	29.00	32.37	35.00	50.00
Junior secondary public and Muslim schools	48.00	56.76	60.00	72.00
Senior secondary public and Muslim schools	73.00	80.97	83.00	89.00
Percentage of schools with a library:				
Primary public and Muslim schools	20.00	22.00	23.00	50.00
Junior secondary public and Muslim schools	59.22	60.38	62.00	80.00
Senior secondary public and Muslim schools	45.24	48.72	60.00	90.00
Percentage of schools with laboratory:				
Junior secondary public and Muslim schools	61.55	62.71	65.00	80.00
Senior secondary Public and Muslim schools	33.52	34.98	40.00	70.00

Source: Provincial Office of Education, Internal document: Draft Aceh Education Profile 2008/2009 and Work Plan of the Provincial Office of Education 2010.

Poor infrastructure, low teacher qualifications and financial barriers have been identified as long-standing obstacles to accessing good quality education in Aceh.[393] Historically, these have been most keenly felt in rural areas where the population is poorer, where the distances to reach school facilities are greater, and where transport costs can become prohibitive.[394] Most of these issues are prominent in Indonesia and not particular to Aceh, with the exception of infrastructure damage to schools caused by the conflict and the tsunami. The conflict was damaging to the school system particularly in rural areas where it was at its most intense (see below). The tsunami affected both rural and urban areas along the coast, but the contrast between post-tsunami and post-conflict rehabilitation and reconstruction is stark (see Box 4.4.1). The school building/rebuilding programme is no exception. Most school facilities have been rehabilitated or are under reconstruction in tsunami-affected areas, but progress remains slow in remote conflict-affected areas.[395]

4.4.5.1 Financial burden

Following the granting of Special Autonomy, the provision of free education became a central objective of Aceh's provincial government in its education policy (see policy analysis below). In focus group discussions (FGDs) in Aceh Timur district, the importance of easing the financial obstacles to accessing education was readily acknowledged by the participants. In their view, poor farmers in remote areas had not been able to send their children to school primarily because of the burden of school fees. Ultimately, the removal of the fees makes education not only feasible for poor children but, according to the FGD participants, it also contributes by positively altering rural communities' perceptions about the importance of education.[396]

The task of reducing the financial obstacles to education has been approached from a variety of entry points in Aceh, including the elimination of school fees in some cases, the provision of school buildings or transport, as well as through the provision of scholarships to support orphans and poor children in order to diminish early school leaving rates (see above). As identified in Section 3, the School Operational Assistance programme (BOS, Bantuan Operasional Sekolah) was initially set up to offset the rising cost of fuel (see Section 3) and its impacts on education.[397] BOS funds have played a similar role in Aceh, where they have been complemented by scholarships from the central and provincial governments. The BOS funds aim to finance the operational costs of school in order to make the collection of fees unnecessary. In theory, schools in receipt of BOS funds cannot charge fees from parents.[398] In practice, however, some schools in Aceh, especially at the junior secondary and senior high school levels, do still charge fees and most do so in agreement with school committees. Reports of schools charging fees came from a number of sources, including interviews with government education officials, teachers and students.[399] The BOS funds consist of a standard IDR 400,000 allocated per student per year, but staff from the Aceh Office of Education acknowledge that this is not enough to finance even the most basic school operational costs in the province.[400] The Aceh Office of Education in

393 Aceh Provincial Government (2007) *Aceh Rencana Pembangunan Jangka Menengah (RPJM) 2007-2012*, p47
394 FGD in Aceh Timur (14 September 2009)
395 Interview with staff of an international development agency in Aceh who requested anonymity (7 March 2010). See also MSR (2009) - although the infrastructure damage in the conflict was severe, the relative deprivation of post-conflict reconstruction compared to post-tsunami efforts is one of the central themes of the MSR report.
396 FGD in Aceh Timur (7 September 2010)
397 For a broad description of BOS see Section X, and for a detailed discussion and assessment of BOS see: Suharyo, W. (2005) *A rapid appraisal of the PKPS-BBM education sector School Operational Assistance (BOS)*, The SMERU Research Institute: Jakarta
398 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)
399 From interviews with students, Aceh Besar (30 September 2009), teachers, Banda Aceh (21 April 2010), and government officials, Banda Aceh (22 June 2010)
400 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)

conjunction with USAID developed an alternative formula to work out the actual basic operational cost of schools and found these vary between IDR 570,000 to IDR 600,000 per student per year according to location.[401] Whilst the BOS funds are sufficient to allow the provision of some services, the shortfall forces schools either to charge a fee for 'extra-curricular' and supporting activities or to cut spending in ways that affect the quality of education. A school principal in Banda Aceh illustrates how school fees were reintroduced in his school:

> "Initially the school was free, but we wanted to introduce a marching band and needed to charge IDR 5,000 per student to cover the facilities. Some schools charge hundreds of thousands rupiah, but we only charge IDR 10,000 or IDR 15,000, which is barely enough to cover internet costs. We have no money to pay for the wali kelas [teachers given responsibility for supervising students of a particular class]. We have to find the money ourselves. The Aceh Rehabilitation and Reconstruction Board gave us funds to pay for the wali kelas but this lasted only six months. After that, what could we do? We received no money from the government in Jakarta or in Aceh and this is why we had to increase school fees. This has been done in agreement with the school committee. We do not charge fees just for no reason. [We] consult with all the parents, with the school committee and with the stakeholders. The fee we charge varies between IDR 15,000 to IDR 20,000, and the amount is decided through consultation." (21 April 2010)

Within a context of limited and insufficient BOS funds and school budgets, the levy of school fees becomes essential to the functioning of schools and in turn the amount that is levied in consultation with parents and school committees also varies according to the ability of parents to pay. However, this is becoming one of the mechanisms through which disparities in education are being recycled and reproduced. A senior secondary school principal compares the levying of fees in Yogyakarta and Aceh:

> "If asking for additional services or facilities like schools in Yogyakarta, [schools in Aceh] are not able to do that. In Yogyakarta, parents do cover the costs, while here, it is very difficult to charge the parents." (Interview with a senior high school principal, Banda Aceh, 21 April 2010)

The BOS and scholarship funds have thus had a beneficial impact in easing access to school, through minimising but so far not eradicating school fees. However, the financial burden of education is not limited to school fees and this has important implications for early school leaving rates among children from poor households. Even if a school is free of school fees, children in remote and poor areas experience problems because of distance from and transportation cost to school. Distance to schools, especially secondary schools, is deeply problematic in rural areas such as Aceh Timur, as the district covers a vast geographical area combined with poor transportation infrastructure. Monita's[402] story in Box 4.4.4 illustrates how the post-tsunami context and the high cost of transport led her to leave school, very much against her wishes.

401 Ibid.
402 Name changed, as with the names of all children interviewed.

Box 4.4.4: Leaving school early in Aceh

The NGO Pusaka Indonesia has worked extensively in Banda Aceh, which was amongst the areas worst affected by the tsunami. According to data collected by Pusaka, more than 800 children 'dropped out' of school (from primary to senior secondary school) in Banda Aceh alone. The same data indicate that most children left early for economic reasons and that they entered the labour market.

Monita left school whilst in Year 2 of senior high school. Monita lived in Ulee Kareng, a coastal area of Banda Aceh and was in Year 1 of secondary school when the tsunami hit Aceh. Monita, her father and siblings survived the disaster by climbing onto the roof, but her mother was taken by the wave. After the tsunami, Monita got food aid from Ulee Kareng inhabitants and international agencies. For months, Monita lived in various shelters, barracks and emergency accommodation. Eventually, Monita settled together with some of her siblings and their families in a house provided by UN Habitat house aid. Monita's contribution to the household costs was covered by her father who had remarried and lived with his new wife and stepchildren. Her father's income as a fisherman was small and uncertain but Monita could attend school because she received a scholarship and her secondary school had no fees. However, Monita's school was relocated from Lampineung to Lhong Raya and the cost of transport doubled overnight:

"The transportation costs for a student-return is IDR 3,000. However, I have to change buses and so I have to pay twice - IDR 6,000, return. When the school was still in Lampineung, I didn't have to spend any money on transport since it was close by and my siblings could take me to school."

The transportation cost is beyond Monita's means and her father's means. This forced Monita to quit school although she clearly had no wish to do so.

Source: Interviews with staff of the NGO Pusaka Indonesia and with Monita (name has been changed), Banda Aceh, 30 September 2009

On average, the distance to the nearest senior secondary school is 8.3 kilometres, excluding data from the sub-district of Simpang Jernih, which lies 82.5 kilometres away from the nearest senior secondary school.[403] The transport infrastructure in Aceh Timur district is also insufficient: of the 1,499 kilometres of roads in the district, only 19.9 per cent have asphalt, and only 7.7 per cent of the total are considered to be in good condition.[404]

The policy adopted by the government of Aceh to address the issues of distance and transport has been multifaceted. On one hand, the Aceh Office of Education has adopted the concept of 'one roof' schools, which was developed at the national level and included in the National Medium-Term Development Plan (RPJMN) but which has yet to be implemented nationally.[405] The 'one roof' school refers to concentrating different levels of schooling on one premises, as an alternative to building new premises in remote areas. The teachers working in 'one roof' schools are trained to teach both primary to secondary school levels:

403 BPS Aceh (2005) *Statistik potensi desa Provinsi Nanggroe Aceh Darussalam*, BPS-Aceh: Banda Aceh
404 Badan Rehabilitasi dan Rekonstruksi (2006) *Studi kelayakan kalan lintas Utara-Timur, Lintas Barat-Selatan dan Lintas Tengah Provinsi Nanggroe Aceh Darussalam* (NAD), available at: http://atdr.tdmrc.org:8084/jspui/bitstream/123456789/393/1/Studi%20Kelayakan%20Jalan%20Lintas%20Utara-Timur,%20Lintas%20Barat-Selatan%20dan%20Lintas%20Tengah.pdf (Last accessed 7 June 2010)
405 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)

> "…[T]here are no cases of primary school children graduating and failing to enrol at secondary school because of the lack of school premises. The teachers have to be trained to teach different levels of classes and to have further knowledge. This programme is especially for remote areas like Simpang Jernih." (Interview with staff of the Aceh Office of Education, Banda Aceh, 22 June 2010)

The government of Aceh has provided free means of transport, such as boats for island districts (e.g., Aceh Besar) and school buses for the hinterland districts of the province (such as Pidie). Boats and buses are given to district governments and managed by the Transportation Office[406], but as Monita's story illustrated in Box 4.4.4, free transport is still not available in all rural/isolated areas.

4.4.5.2 Teacher qualification, distribution and teacher welfare

As established in Section 3, the quality of teaching and the qualifications of teachers are key contributing factors to the quality of education. Qualified teachers in Indonesia are defined as those who have obtained standard educational qualifications and who possess competency in pedagogy, teaching, professional and social skills.[407] The Law on Teachers and Lecturers (No. 14/2005) now mandates that teachers must be in possession of a bachelor's degree as well as a professional certificate.[408] The proportion of teachers that graduated with a bachelor's degree (known as 'S1' or a 'level 4 diploma') or above is less than 30 per cent in primary schools and 60 per cent for junior secondary schools in Aceh.[409] Most primary school teachers have got some university level education without completing their degrees. In addition, teachers who were appointed in the 1970s rarely had university level qualifications and graduated instead from the Vocational School for Teachers (SPG, Sekolah Pendidikan Guru).[410] Not only are teacher qualifications quite low but also many are reported to be teaching subjects in which they have no training or expertise.[411]

A lack of qualifications and appropriate pedagogical training impacts on the quality of teaching and on the quality of learning processes in the classroom. Limited knowledge and skills make it difficult to impart the National Standardised Curriculum (KTSP, Kurikulum Tingkat Standar Pendidikan), which is mandated from the central government. The curriculum requires innovative and creative preparation from the teachers and is intended to encourage active learning and participation by the student.[412] Moving away from teacher-centred methods of teaching and imparting the content of the curriculum to students has not been easily understood or well implemented by teachers, as described by one FGD participant in Aceh Timur:

> "Some written policies from central government were not really understood well by the teachers in Aceh Timur district. For example, classroom dynamics are meant to be active, creative and fun, but in practice they are not and classes are boring. There are lots of factors [behind this]. The teachers' capacity to teach and to prepare the syllabus is still low." (14 September 2010)

406 Ibid.
407 Law No. 14/2005 on Teachers and Lecturers
408 USAID (2009) *Teacher education and professional development in Indonesia: A gap analysis*, available at: http://pdf.usaid.gov/pdf_docs/PNADS282.pdf (Last Accessed 10 November 2010)
409 Provincial Office of Education (n.d.) Internal document: Draft of *Aceh Education Profile 2008/2009* and *Work Plan of the Provincial Office of Education 2010*, Provincial Office of Education: Banda Aceh
410 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)
411 FGD in Aceh Timur (14 September 2009)
412 Interview with a senior high school teacher in Banda Aceh (18 April 2010)

A senior high school principal in Banda Aceh municipality recognised that this was an issue especially with teachers from older generations who have failed to adapt and adopt new teaching methods.[413] The curriculum was designed to make learning processes interesting and relevant to the students, yet both teaching and learning often remains boring and this is identified by education staff as contributing to high levels of student absenteeism in classrooms.[414]

In order to improve the quality of teachers, a number of scholarships have been provided for teachers by the provincial government's Quality Assurance Agency (Lembaga Penjaminan Mutu). The scholarship system, which has functioned since 2008, provides financial assistance to teachers to complete a bachelor's degree. The scholarship amounts to IDR 2 million per year. To minimize the possibility of mismanagement of the programme, funding and selection procedures have been kept separate. The district Offices of Education are responsible for determining the shortlists and for the selection of candidates, whilst the scholarship funds are transferred from the provincial government directly to the grantees. The programme has been extremely successful in attracting attention from teachers seeking to gain qualifications, and demand has outstripped the supply of scholarships.[415] In 2009, 300 teachers competed for 179 scholarships.[416] However, most of the grantees have been from the provincial capital (or nearby) and so far little progress has been made towards improving the qualifications of teachers from rural areas. Information about the scholarships is not widely available in rural areas, and even when it is, few rural teachers apply.[417] District governments tend to allocate their education budgets for infrastructure development programmes rather than for professional development of teachers, indicating that the improvement of teacher qualifications is not being prioritised in rural areas where such improvement is sorely needed.[418]

In theory, improving teacher qualifications could be organised by the schools themselves since the new school-based management system now allows school principals to make planning decisions and allocate their budgets in accordance with the priorities they identify and set. However, as described earlier, they operate with very limited budgets that barely cover operational costs. For instance, since 2008 the Aceh Timur district government has not allocated any school budget funds for teaching and learning processes in schools. Hence, the district budget for schools is wholly absorbed by operational activities.[419] If training does take place, then it tends to be on a voluntary basis and teachers who participate are expected to contribute from their income. Unsurprisingly, the curriculum development team in Aceh Timur district, which operates voluntary teacher training schemes, reports a low rate of uptake and advocates that secondary schools should spare IDR 5,000 per student from the BOS fund to finance curriculum development through teachers training.[420] However, there are key competing demands for these funds and (as mentioned previously) such a move would likely encourage the introduction of (or a rise in) school fees, which in turn would negatively impact on school completion and early leaving rates.

However, teacher qualifications and ability to teach are only part of the problem. Education professionals also acknowledge that to impart the knowledge and standards in line with the national curriculum also requires appropriate facilities, infrastructure and supporting facilities,

413 Interview with a senior high school principal in Banda Aceh (21 April 2010)
414 Interview with a senior high school teacher and school inspector/assessor in Aceh Timur (17 June 2010)
415 Interview with the Head of Aceh Timur Office of Education, Aceh Timur (22 June 2010)
416 Ibid.
417 Ibid.
418 Interview with the Head of Aceh Timur Office of Education, Aceh Timur (28 June 2010)
419 Interview with a senior high school teacher in Aceh Timur (17 June 2010)
420 Ibid.

such as libraries and laboratories, which are not commonly available in Aceh (see Table 4.4.2 above).[421] This is particularly the case in rural areas, which tend to have fewer facilities than urban areas.

The unequal distribution of teachers across the districts and municipalities of Aceh is also deeply problematic. It is important to point out that there are no issues with the number of teachers in aggregate and in fact the ratios of teachers to students are quite high overall. In 2009, the ratio of teachers to students for primary school was 1:12.67, and at the junior secondary school level it was 1:8.7.[422] These are far above the ideal ratios of 1:18 at primary secondary school and 1:12 at junior secondary school, which the Office of Education in Aceh is seeking to achieve by 2012.[423] However there are deep imbalances between rural and urban areas with an overabundance of teachers in urban areas and shortages of teachers in rural areas.[424] For instance, 83 per cent of junior secondary school teachers are in urban areas, while only 17 per cent are in rural areas where the majority of the population lives.[425] The shortage of teachers in rural areas is related to the poverty and isolation of these areas as well as lower income as compared to urban areas. In addition the conflict, which was concentrated in rural areas and where schools became targets for attack, further encouraged teachers to move to the urban centres:

> "Normally, teachers don't object to being placed in [rural] districts, but after several months they tend to move away because it is so difficult to get around. Transportation by bus and boat does not always help, as the roads become so bad even with very small amounts of rain, and public transport stops." (Interview with staff of the district BAPPEDA, Aceh Timur, 22 June 2010)

One possible area of intervention to improve teacher numbers in rural areas is to promote the training and allocation of teachers originating from the areas where there are shortages, as they are the teachers who normally find it easier to remain in these areas. With Special Autonomy and decentralisation, each district has tended to appoint teachers from their own location but this has tended to happen without due consideration to qualification standards. Thus, while the selection of education staff (teachers, school principals and supervisors) at the district level has become increasingly sensitive to location, this is more in response to local patronage networks than in order to ensure the efficient selection of qualified personal to run and teach in schools.[426]

To address the issue of teacher allocation and imbalances, the provincial government is adopting a number of initiatives. One approach centres on budget plans with 'equity strategies'. The provincial government has appointed a Working Group on Improving the Quality of Education, which is working out a system of hefty financial penalties for districts that fail to meet specific targets. The provincial government is making full use of its authority to review and approve district level budgets, and is adopting punitive approaches whereby districts that have low scores on education indicators - including teacher-student ratios - will lose their share of the Special Autonomy oil and gas revenues.[427] This approach is a reaction to the severity of the problem and the current lack of innovative approaches at the district level, but such punitive approaches are clearly a double-edged sword and run the risk of further penalising poor districts that lack the capacity to implement policies.

421 Provincial Office of Education (n.d.) Internal documents: Draft of *Aceh Education Profile 2008/2009* and *Work-Plan of the Provincial Office of Education 2010*
422 Ibid.
423 Interview with staff of the Provincial Office of Education (22 June 2010); Provincial Office of Education (n.d.) Internal documents: Draft of *Aceh Education Profile 2008/2009* and *Work Plan of the Provincial Office of Education 2010*
424 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)
425 Badan Rehabilitasi dan Rekonstruksi NAD-Nias (2009) *Pendidikan, kesehatan, peran perempuan*
426 Interview with staff of the Regional Office of Religious Affairs, Banda Aceh (9 September 2009)
427 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)

Another approach has been to address disparities in teachers' welfare, one of the key factors driving the rural/urban imbalance. The standard salaries of teachers are regulated by the government at the national level and salaries are based on grades. However, districts and municipalities can supplement basic salaries with additional allowances and benefits. The decentralisation of education from central to district government has triggered disparities in teachers' benefits, which vary based on local governments' fiscal capacities. In this system, rich districts in Aceh, such as Sabang and Banda Aceh, can afford to give generous allowances and benefits (up to IDR 1,000,000 and IDR 350,000 per month, respectively), whereas the poorest districts, such as Aceh Selatan, Aceh Besar and Pidie, can only afford around IDR 150,000.[428] According to staff at the Aceh Office of Education, some young teachers may be willing to move to rural areas, but the financial packages, living conditions and isolation still deter most of them.[429] To address this imbalance, the Provincial Government of Aceh issued a Governor's Regulation in 2002 that set fixed allowances of IDR 200,000 per month for teachers in urban areas and IDR 400,000 per month for teachers in rural areas. The Governor's Regulation appears to have had an impact on reducing, but so far not eliminating, inter-district and especially rural/urban disparities. The allowances are now financed through the oil and gas revenues.[430] According to staff at the Provincial BAPPEDA office, the salary and benefits of teachers in rural areas are now high enough. By contrast, urban teachers are increasingly struggling with the much higher cost of living in urban areas. These policies and regulations are yet to make a visible impact and it is unclear that they are sufficient to entice teachers away from urban areas. In addition, it is worth noting that the long-term sustainability of equalizing teachers income is in some doubt, as the financing of district-based allowances is dependent on dwindling oil and gas revenues.[431]

4.4.6 VULNERABILITIES IN ACEH: EDUCATION IN THE SHADOW OF THE CONFLICT AND THE TSUNAMI

4.4.6.1 Trauma

As mentioned above, the legacies of the conflict and tsunami have severely affected people's welfare. Communities not only experienced economic and material losses but also experienced fear, violence, personal loss and devastating emotional trauma.[432] A child who spent her childhood in a conflict-affected area in Aceh Timur reports that to this day she is still frightened, and that the memory of bombs planted in the streets still haunts her.[433] When Aceh was declared a Military Operation Region (DOM, Daerah Operasi Militer), gunfire exchanges often took place in front of her house. When it happened, she had to take refuge in her neighbour's or grandmother's house since hers was made of wood and bullets would enter easily. Her uncle was taken by the military because he was accused of being a GAM member and has never been seen since. At the peak of the conflict, most of the inhabitants of her village fled to other areas, but she and her family stayed and she missed school for several months.[434]

428 Yusrizal (2009) *Menata Ulang Pendidikan Aceh*, available at: http://www.serambinews.com/news/view/18423/menata-ulang-pendidikan-aceh (Last accessed 3 September 2010)
429 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)
430 Interview with staff of the Aceh Timur District BAPPEDA, Aceh Timur (22 June 2010)
431 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)
432 FGD with the members of the Child Forum, Banda Aceh (15 September 2009)
433 Interview with Herayanti (name changed), Aceh Besar (4 October 2009)
434 Ibid.

During the 30 years of conflict in Aceh, it was not uncommon for children to be involved in the war, either as informants or to carry food and messages for combatants, and sometimes as combatants themselves.[435] As mentioned previously, the education system became one of the key targets of both the GAM and the military during the conflict, subjecting the school system to destruction, and widespread disruption. The impact of the conflict, however, was not solely one of physical disruptions. Rather, schools and the education system became routinely caught up in the violence. A school teacher who taught in some of the conflict areas of Aceh recalls the routines of intimidation that took place in schools and how this led to a vicious cycle of poor performance, poor management and poor motivation for both teachers and pupils:

> "[I was in Peurelak for seven years]. When I taught in conflict areas, giving students bad marks put your life in danger. There was no student who did not pass class, there was no student who did not graduate, those were the policies from the government Office of Education. This led to a deterioration in motivation and in how students were thinking. Some students were obliged to go to school, because staying in the village would put them in danger. So they went to school, but at school they were exposed to that kind of culture. The teachers also had to hide during the conflict. In Langsa in the west, whenever GAM came [to the village] the teachers would not go to school. I was there from 2000 to 2005, it was still like that. When I was in Peurelak, if we disciplined children, we would be hated, so at nine in the morning students would still be outside… Everything became a 'cover up' to stay safe… so we gave high marks for biology, for mathematics, nines… everybody just wanted to be safe." (Interview with a junior secondary school teacher in Aceh Timur, 17 September 2009)

The tsunami-related traumas are clear. The sudden devastation was pervasive and many children lost parents and/or relatives. The survivors, especially children, have had to face the difficult challenge of rebuilding their lives without parents or other family members. Kalis, age 10 years, lost his parents, grandparents and several siblings alongside his house during the tsunami. Kalis remains frightened when he hears sirens and he cries when there is a gale or a rainstorm. He was mute for a period and although he has now regained his voice, he still stutters when he speaks.[436] The stutter is slowly improving but other children still make fun of him and he ends up fighting.

To address these multiple traumas, the government Office of Social Affairs initiated programmes of psychosocial therapy that have been extended to child survivors of both the tsunami and the conflict. This programme is funded both by the provincial and central government and is still running.[437] In addition, some teachers have received specific training that helps them deal with child survivors of both humanitarian emergencies. It is unclear how many teachers have received such training, but some who have report that it is essential that teachers and staff in education understand that child survivors require special handling. In addition, a senior high school teacher who used to work in conflict-affected areas reports that dealing with conflict-affected children requires special skills since they are often suspicious, rude, may appear slow to learn, and in general require a lot of patience:

> "We have to approach conflict-affected children heart to heart. We shouldn't talk rudely to them, if s/he feels offended, s/he will not be willing to study anymore." (Interview in Banda Aceh, 18 April 2010)

Usman (name changed), a senior high school student who used to live in Lhokseumawe (a major conflict area) illustrates some of these tensions. He went to an Islamic boarding school, but he ran away because of the harsh discipline regime, as he described it:

> "We had to be ready at 7 a.m., on time. It was very strict there. We were not allowed to go out and if we made a mistake we would be beaten by the ustadz [Islamic teacher]. For example, if we went out or smoked we were beaten with a wooden stick, on the legs. After I was beaten, I got out, I escaped." (Interview in Aceh Besar, 6 October 2009)

The Aceh Office of Education provides counselling and therapy training for teachers to provide them with the necessary skills to work productively with children.[438] According to a senior high school teacher who used to teach in a conflict-affected area, there has been an increase in the number of children displaying behavioural problems, for instance through violent behaviour and the consumption of marijuana, as described:

> "…Around three or four children [in a class] consume marijuana … We cannot be too strict with those kids. We have to enter their world…we sit together with them, we ask carefully, if we make any mistakes they could put a knife on the table…" (interview in Banda Aceh, 18 April 2010)

A study on violence in schools was conducted in five districts across Aceh and Nias, including 313 children in Aceh and 285 children in Nias, involving 17 primary schools. This study found that 59 per cent of the students interviewed had been beaten (by hand) and that 83 per cent had experienced some kind of violence or abuse (physical, mental or sexual).[439] The violence took the form of pinching, beating (by hand or with an object), being asked to clean the toilets, slapping, throwing erasers/chalk/brooms at children, and scolding, insulting, reprimanding, shouting, humiliating and threatening children.[440] This study, albeit not based on a representative sample, indicates that violence in schools is pervasive in the region and requiring increased attention from policymakers.

4.4.6.2 Alternative care and education

As elsewhere in Indonesia, alternatives to parental care - notably through the provision of orphanages - are prominent. The conflict and tsunami have further driven the demand for alternatives to parental care in Aceh. This led to the development of an important orphanage programme in Aceh, which is run by the Provincial Office of Social Affairs. There are currently 236 orphanages operatng in Aceh; more than half of those run by the community and the remainder by the government.[441] The budget for orphanages was IDR 200 billion in 2010, originating from both central and provincial government funds. Funds are allocated to orphanages based on the number of children hosted in the establishment, e.g., IDR 6,000 per child per day from the provincial government and IDR 3,000 from the central government. Based on data from the Data and Information Centre (Pusdatin) at the Ministry of Social Affairs, the number of displaced children decreased from 60,197 in 2006 to 15,482 in 2008.[442] This indicates important achievements that took place through multiple interventions undertaken by central and provincial government and with essential support from national and international NGOs operating in Aceh. The setting up of alternative care systems, such as orphanages, has played an important role there.

435 Interview with staff of the Provincial Office of Social Affairs, Banda Aceh (17 June 2010)
436 Interview with Kalis (name changed), Aceh Besar (25 September 2009)
437 Interview with staff of the Provincial Office of Social Affairs (17 June 2010)
438 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)
439 Setyowati, R. et al. (2007) *Violence against children in schools in Nanggroe Aceh Darussalam (NAD) and Nias*, UNICEF: Banda Aceh
440 Ibid.
441 Interview with staff of the Provincial Office of Social Affairs, Banda Aceh (17 June 2010)
442 Data and Information Centre (Pusdatin), Indonesian Ministry of Social Affairs (2008) *Internal report* - Indonesian Ministry of Social Affairs: Jakarta

However, as seen in Section 3, institutional care for children in Indonesia is pervasive and many institutions function as cheap or free boarding schools for children from impoverished families. There are no data available on the proportion of children who are in institutional care in Aceh due to the loss of one or both parents as compared to the proportion who are there because of poverty or neglect. Usman, the child mentioned above who fled the violent disciplinarian regime of a religious boarding school, had also lost both his parents when he was younger and was looked after by his grandmother.[443] He received a scholarship of IDR 600,000 per year, which helped his grandmother, but after he fled the boarding school he stopped attending school for a year. He later joined another Islamic boarding school but also 'dropped out' when it emerged that the school focused almost solely on Islamic teaching at the expense of other subjects that Usman was keen to learn. Eventually, Usman went to an orphanage where he found stability, appropriate schooling, and sports and entertainment activities, which he likes. During interviews with children in Aceh, it emerged that a number of children opted to go into orphanages, as it was the only avenue open to them to secure education without burdening their families financially. The resourcefulness and foresight of these children is remarkable (they are very aware of the importance of education) but it happens at a huge personal, emotional and developmental cost. See Box 4.4.5 for the case of two teenage girls who willingly went to orphanages in order to be able to continue at school.

Box 4.4.5: Tia and Hera, children with parents who live in an orphanage in order to attend school

Tia, is a fatherless 13-year-old girl who lives in the Darussa'adah Orphanage in Aceh Besar. From the time she was in Year 4 of primary school, her mother, who relied on a small and uncertain income, kept moving locations. Because of the frequent moves, Tia never had close friends and she missed her life in the neighbourhood in Langsa. In Banda Aceh, her mother married again to a widower with six children. As a tsunami survivor, her stepfather received housing aid and they all lived in Ujong Bateh. As a fatherless child, Tia received a scholarship of IDR 600,000. Whilst happy with the assistance, the scholarship became insufficient once she started secondary school where the fees and others costs increased. Her stepfather works as a construction worker and has a very small income. In the end, she asked her mother's permission to go and live in an orphanage so that she could keep going to school. Tia is now in the Year 2 of secondary school. She still receives her scholarship, but costs - such as school fees and school materials (worksheets) - are now covered by the orphanage, and she is saving her scholarship for university.[444] Although Tia went to the orphanage voluntarily, she does miss her mother and her house and started crying when speaking of her home life.

Similarly, Herayanti is an 18-year-old senior high school student who has been staying in an orphanage for similar reasons. She comes from a poor family with uncertain income. As primary and secondary schools were free and close by, she was capable of attending school, but this became impossible at senior secondary school level. She received a scholarship from the Aceh Utara District Government but it was insufficient to cover the fees and costs of going to senior secondary school and she asked permission to go to an orphanage in order to be able to carry on going to school.[445] "For sure I would be happier at home because my parents are there. Here [in the orphanage] I feel sad since I am so far away from my parents, but here my basic needs are fulfilled."

Source: Interviews with Tia, Aceh Besar, 5 October 2009, and with Hera, Aceh Besar, 4 October 2009

443 Interview with Usman (name changed), Aceh Besar (6 October 2009)
444 Interview with the administrator/steward of Darussa'adah orphanage, Aceh Besar (5 October 2009)
445 Ibid.

The interviews with children in institutional care reveal a mixed range of experiences. Some, such as Usman, report being happy and fulfilled in that environment, but most of the others have much more mixed experiences in which they report boredom, alienation and loneliness.[446] Whilst the conflict and tsunami make Aceh something of an exceptional case, it still remains, however, that institutional care should be a last resort, that the well-being and welfare of children in care should be improved, and that wherever possible the reunion of children with their families should be promoted.[447]

It is notable, for instance, that in all of the cases reported here the children in orphanages had living relatives and were receiving some form of aid or scholarship. After the tsunami, the Provincial Government of Aceh set up a scholarship fund amounting to IDR 200 billion in 2009, which was disbursed to over 100,000 children.[448] The scholarships targeted displaced children, those living in orphanages, and those who are fatherless or parentless (though not motherless) at the primary and junior secondary school levels. Other scholarships, notably from the Indonesian Red Cross, are available and in some cases are applicable to children attending secondary school. There are no data on the share of scholarships provided by the government versus those provided by other sources, although from the interviews conducted with the Provincial BAPPEDA, in total IDR 294 billion was made available in 2010 across the government agencies, and this is likely higher than that provided by other agencies, which are usually restricted to particular working areas.[449] There is concern that the amount will decrease in 2011 due to declining oil and gas revenues.[450]

There are evidently a number of issues with the scholarships. In several of the interviews, the children acknowledged the importance of scholarships and financial support, but they also reported issues such as not knowing how much they were entitled to receive and delays in the disbursement of funds, which created uncertainty. In addition, the scholarship system seems to work relatively well at the primary school level and in some cases at the junior secondary school level (as long as the school is free or does not charge extensive extra fees), but becomes insufficient at the senior secondary school level.

4.4.7 EDUCATION PLANNING, DECENTRALISATION AND SPECIAL AUTONOMY: INNOVATIONS AND CHALLENGES

4.4.7.1 Education as a development priority

In 2007, the Provincial Government of Aceh promulgated its first Regional Medium-Term Development Plan (RPJMD 2007-2012) since gaining Special Autonomy status.[451] Aceh's RPJMD 2007-2012 provides essential guidance for regional development and for strengthening the provision of services following their deterioration during the conflict and after the tsunami.

The RPJMD 2007-2012 identifies human resource development as a key development priority. It specifically highlights the importance of improving the quality of schooling for children of all socio-economic backgrounds, both in rural and urban areas. Specifically, the Aceh Provincial Government's efforts concerning education include the following aims[452]:

446 Interview with Syakirah, Aceh Besar (8 October 2009)
447 Interview with UNICEF Staff, Banda Aceh (5 September 2009)
448 Interview with staff of the Provincial Office of Social Affairs, Banda Aceh (17 June 2010)
449 Interview with staff of the Provincial BAPPEDA, Banda Aceh (19 November 2010)
450 Ibid.
451 Aceh Provincial Government (2007) *NAD Rencana Pembangunan Jangka Menengah (RPJM) 2007-2012*, p1
452 Ibid.

- To improve the quality of all schools throughout Aceh, both in terms of physical infrastructure and the quality of teaching and administration.
- To provide free education for primary and secondary schooling and eliminate burdensome school fees.
- To provide scholarships for orphaned victims of the conflict and tsunami up to the tertiary level.
- To increase competency standards for teaching staff.
- To give special attention to religious education institutions, such as dayah.
- To develop vocational schools in certain areas.
- To allocate a minimum of 30 per cent of the budget for education.

The importance of human resource development throughout the education sector is further emphasised in the Provincial Strategic Plan (Renstra) for Education 2007-2011, which adopts similar priorities to those at the national level as specified in the RPJMN 2010-2014:[453]

1. **Improving equal access to education.** Approaches include removing financial obstacles to education and improving efficiency and graduation rates at all levels. A key emphasis is placed on graduation rates at the primary school level, with a view to improving continuation rates to secondary school. Increasing the participation levels of the business community and the community in general in matters of education, and expanding the availability of education facilities (including improving access to senior secondary school in isolated areas) is also a key priority.
2. **Improving the quality, relevance and efficiency of education.** This is to be achieved through an emphasis on planning, with the aims of: improving teacher allocation; improving school decentralisation and institutional management (with the introduction of accountability mechanisms, audits and school-based management); reforming the school curriculum and related instruction manuals; decentralising planning for teacher development and management; and improving the monitoring of both school performance and student achievement.
3. **Improving the management, image and accountability of the education system.** The approach adopted seeks to improve, professionalise and standardize the management of schools both at provincial and district/municipal levels. The strengthening of planning and monitoring systems forms an important part of this process with a view to improving the governance and control systems within schools.
4. **Developing an education system rooted in Islamic values.** This is to be achieved through: the establishment of partnerships between the education authorities and key religious institutions; the provision of textbooks and materials with Islamic content; specific teacher training; and the setting up of a monitoring task force.

It is clear that the RPJMD seeks to address some of the key issues and weaknesses highlighted in earlier in this subsection. This in itself constitutes an important step, but whilst the intent is clear, the mechanisms and funding necessary to underpin these policy objectives are not always immediately clear. The shortfalls in budget and revenues due to declines in the oil and gas sector have consequences for the education budget, adding to the challenges of implementing the ambitious RPJMD. The Government of Aceh faces difficulty in financing education programmes:

> "[The] education funds from oil and gas revenues this year total IDR 160 billion, whereas we have budgeted IDR 154 billion rupiah for the public school teachers welfare fund, and at the same time we also have to fund the orphan scholarships programme which amounts to IDR 208 billion." (Interview with staff of the Provincial Office of Education, Banda Aceh, 22 June 2010)

Whilst the question of budgets and finances casts a long shadow over the future of education in the province, some important innovations in the management of education planning and monitoring have nonetheless taken place. At the end of 2009, the Government of Aceh established a Coordinating Task Force for the Development of Education in Aceh (TKP2A, Tim Koordinasi Pembangunan Pendidikan Aceh) to monitor the implementation of the Provincial RPJMD in the education sector, as well as to recommend revisions of education-related qanun.[454] Similar to the task forces established in other provinces to tackle problems in particular sectors, this Task Force is led by the Governor and is coordinated through the Aceh Education Assembly (MPA, Majelis Pendidikan Aceh), which was set up in 2006. The Task Force also incorporates a number of representatives from key local governmental institutions including the BAPPEDA and the Provincial Office of Religious Affairs, as well as NGOs, academics, and international development agencies.[455] The Task Force is co-financed through local budgets and by the Australian Government's Support Education in Aceh (SEDIA) programme. SEDIA's staff provide consultation for the Task Force and its working groups.[456] The working groups in the Task Force are divided into monitoring and evaluation, quality improvement, and financing.[457]

The work of the Task Force has important implications for local authorities who may face budget cuts if they fail to meet key targets, such as student/teacher ratios or reductions in early school leaving rates (as discussed above).[458] However, the working groups in the Task Force report that the lack of accurate data makes effective monitoring something of an arduous task.[459] The working groups have had to initiate their own data collection as well as institute checks on existing data from schools and local governments to circumvent these problems. The Task Force also works with consultants, research institutions, international NGOs and academics in order to overcome the resistance of local government and certain stakeholders to some of the initiatives it is trying to implement, especially in relation to data collection.[460] According to SEDIA staff, the Task Force is a positive innovation that contributes to better monitoring of the implementation of the educational components of Aceh's RPJMD.

4.4.7.2 Musrenbang and community influence over formal education policy

The decentralisation process has had a major impact on the planning, management and delivery of education services. As has been reiterated throughout this report, decentralisation provides opportunities to identify local priorities and to improve responsiveness within a participatory framework. However, the challenges of institution building and coordination also have the potential to weaken the positive contributions of decentralisation. Uneven capacities at the local level and the weaknesses of the supporting regulatory frameworks tend to be present throughout Indonesia, and Aceh is no exception. The evidence emerging from Aceh also suggests that

453 Ibid., pp39-41

454 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010) and with staff of SEDIA, Banda Aceh (1 July 2010)
455 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)
456 Interview with staff of SEDIA (1 July 2010)
457 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)
458 Interview with staff of the Provincial Office of Education, Banda Aceh (22 June 2010)
459 Interview with staff of SEDIA, Banda Aceh (1 July 2010)
460 Ibid.

while development planning is supposed to be both 'top-down' and 'bottom-up', there have been serious problems in setting up participatory institutions designed to reinforce the 'bottom-up' aspects of the procedures. The musrenbang (musyawarah perencanaan pembangunan, or consultative development planning forums) in particular is supposed to be institutionalised as a central mechanism of participatory consultation and deliberation, but the evidence from the fieldwork for this report suggests this is rarely the case. In general, community leaders in the FGD mentioned that lip service is paid to the musrenbang contribution to the formulation of district priorities, strategic plans and annual work-plans, but that effective incorporation of community voices in the policy planning process is lacking - as has been found to be sometimes the case in the other case studies presented in this report. FGD participants perceived that line agencies develop and set the plans to be proposed for inclusion in district budgets with little regard for community views:

> "There is no budget for musrenbang in villages. The musrenbang conducted in sub-districts should be attended by representatives from musrenbang at the village level, but in reality, those who attend in the sub-district musrenbang were only the village heads. This meant that a lot of programmes incorporated in the musrenbang are the result of line agency priorities, while programmes and priorities emerging from the sub-districts are rejected." (FGD participant, Aceh Timur, 14 September 2009)

At district level, similar mishandling of the musrenbang process was reported by FGD participants, indicating that education planning tends to be handed down based on provincial level priorities:

> "In the district musrenbang, we did not propose education programmes or activities because we were directed to concentrate on infrastructure, social and cultural affairs. Until now the programmes and activities related to education have always been handled by the Provincial Office of Education." (Interview with staff of the Peureulak sub-district office, Aceh Timur, 14 September 2009)

Further, the inclusion of women and children in discussions and decision-making has been weak. However, it is important to note that a number of alternative parallel or informal mechanisms of consultation and participation have also emerged in Aceh over the past few years. As mentioned earlier, international organisations and NGOs have been prominent actors in the wake of the tsunami and have played a positive role here in emphasising women's and children's participation. One example is the Child Forum initially set up by UNICEF and other NGOs in order to provide space and channels for children's voices and participation, which was later formalised though its adoption by the Ministry of Social Affairs. These distinct initiatives still fall short of a comprehensive policy, but they represent a step in the right direction.

4.4.7.3 School-based management and community/practitioner inputs into education practice

The political reforms provided for under Decentralisation Law No. 22/1999 have impacted on the decentralisation of public services, including on education. Law No. 20/2003 on the National Education System states that management of early education, basic education, and secondary school education is to be implemented based on minimum service standards with the principle of school-based management (Article 51). Under this model, schools are given broader autonomy in the management of school affairs with the participation of stakeholders (teachers, students, education staff, and community members). This led to the creation of a number of new approaches and institutional arrangements. These include the Education Council (Majelis Pendidikan Daerah), which serves as an independent board, comprising community members concerned with improving the quality, equity and efficiency of education management at the district/municipality level, and school committees[461].

The functions of the Education Council are:[462]

1. Promoting community concerns and commitment towards the implementation of quality education.
2. Promoting collaboration with civil society (individuals/organization), government, and parliament to implement quality education.
3. Taking stock and assessing community aspirations, ideas and needs related to education.
4. Giving advice and recommendations to local government/parliament regarding the formulation of education policies and programmes, and setting performance criteria for the local government, education staff (teachers/tutors and school principals), education facilities, and other related matters.
5. Promoting the participation of parents and communities in education management for increased education quality and more equitable distribution of resources.
6. Conducting evaluations and supervision of the implementation of policies, programmes, processes, and outcomes of education.

The school-based management system allows schools to manage their own funds and gives schools the ability to set up programmes that suit their needs and priorities, as identified with the involvement of local stakeholders (communities, teachers, principals). The participation of stakeholders is accommodated by the school committees - independent boards made up of elected parent representatives, businesses, and community leaders. Schools officials (principals and teachers) serve as the executive and work together with the school committee - as the legislative arm of the process - to design school programmes and budget allocation. School funds comprise the BOS fund (received from the central government) and other block grants (from local government), funds from donors and parents, and funds from other sources. Bottom-up planning in education begins with a proposal from the school administrator and school committee, and then proceeds up to the district and provincial government levels.

While innovative and improving community participation in education, the school-based management system is facing a series of challenges. First, there are overall budget limitations, which are set to become more problematic as oil and gas revenues, and ultimately Otsus funds, decrease. A number of operational issues have also emerged. On one hand, schools find it difficult to bid for funds from the district government in the time they have been allocated and there are notable problems of communication between schools and the government. Although school-based management is supposed to have been rolled out throughout Aceh, most schools have failed to have their budgets approved by district governments, as indicated by a primary school teacher in Banda Aceh:

461 Minister of Education Decree No. 044/U/2002 on Education Councils and School Committees; Pollitt, C., Birchall, J. and Putman, K. (1998) *Decentralising public service management,* Macmillan Press Ltd: London, p7 - There are two types of formal authority under decentralisation:
1. Administrative decentralisation, in which authority is given to a body that is appointed rather than elected, thus it is primarily managerial, administrative or expert rather than political.
2. Political decentralisation, in which the principal recipients of the decentralised authority include elected politicians and/or the directly elected representatives of some relevant public.
The formation of MPD represents the former, since the members are appointed by the governor, while enhancement of School Committee, which includes a substantial proportion of governors who are elected by parents, represents the latter.

462 Pollitt, C., Birchall, J. and Putman, K. (1998) *Decentralising public service management*

> "We have been trained by UNICEF to design programmes, but there is no response or follow-up from the [local] Office of Education. The money from the education cluster is largely absorbed by the Office. A large proportion of the education funds are still used by the Office, whereas the programmes developed by schools remain underfunded." (FGD, 7 September 2009)

Furthermore, difficult relations with local governments were a central preoccupation during the FGD with education practitioners. The participants concluded that overall local governments failed to act in the best interests of the schools, as described by one junior secondary school teacher:

> "School principal, teachers and school committees are working together to design programmes and school budgets which are then brought to the District Office of Education, then from the Office to the District Head, and then to the district government, but the problem is the local council members do not engage with us. They just keep deleting our proposals." (FGD, Banda Aceh, 17 September 2009)

These issues were already identified in a 2006 World Bank report, which established that most local governments in Aceh approve their budgets very late, often up to six months into the fiscal year, and the budgets rarely address the needs or priorities highlighted by the education sector.[463] This creates huge obstacles to advance planning:

> "The fund from district/municipal budget is not allocated at the beginning of the year, instead the provincial parliament holds a meeting in June and the routine budget arrives in August by which time the academic calendar has been going for six months. Some schools have to take up loans to keep the school running, but some other schools just wait. When the fund finally arrives, they just use it for new programmes that were not planned before." (interview with staff of the Regional Office of Religious Affairs, Banda Aceh, 7 September 2009)

Schools that resort to loans are then charged interest, which further reduces the funds available to schools. The issue of delay is well known and has been discussed in meetings between district governments and parliaments, but so far there has been no resolution, according to some interviewees.[464] This relates to the general weak capacity of districts to handle budget and financial flows, which was recounted by FGD participants and has been identified as a problem since 2006.[465]

4.4.7.4 Other challenges under Special Autonomy: Authority, coordination and budget allocations in Aceh

On the whole, the Special Autonomy status emphasises the duality of opportunities and challenges. As shown, the budgetary constraints and pressures are not as prominent in Aceh as they are elsewhere in Indonesia, such as in NTT. However, as in Papua, the construction of the institutional architecture underpinning Special Autonomy is a vast, complex and lengthy undertaking. Both provinces also deal with specific but acute challenges; ethnic diversity and cultural differences in Papua, and the post-conflict and post-tsunami context in Aceh. Further findings from the field in Aceh not discussed at length here include a number of similarities with findings from Papua, as follows:

463 World Bank (2006) *Aceh public expenditure*
464 Interview with a teacher and junior secondary school evaluator, Aceh Timur (17 June 2010)
465 World Bank (2006) *Aceh public expenditure*, p17

1. Difficulties in establishing clear divisions of power and authority between the varying levels of government as required for the implementation of decentralisation (which emphasised devolution of power to district levels), followed by the adoption of Special Autonomy status (which strengthens provincial authority).
2. Difficulties of coordination among the different layers of governments.
3. Difficulties in setting up effective budget allocation and disbursements.

According to staff from the Provincial BAPPEDA, the central, provincial, and district layers of government should complement each other in policymaking, budgeting and programming. One particular example they provided is that of the funding of the Nine Years Compulsory Education Programme. The provincial government allocates budget for increasing the quality and capacity of teachers as well as to rehabilitate schools, while the central government provides supporting funds from the Special Allocation Fund (DAK), and the district government funds teachers' salaries.[466]

In practice, however, far from complementing each other, there have been a number of issues when it comes to attributing the specific responsibilities, authority, functions and attributes of each distinct layer of government, and establishing the mechanisms through which they coordinate and function as a whole. There are still many areas of overlap between the central government's technical departments and provincial and district government line agencies. This is worsened by the fact that the devolution of public service management and service delivery to local governments was not complemented with an effective supporting regulatory framework. As a result, each government tier struggles to define their roles and responsibilities. Staff from the Provincial BAPPEDA describe these complexities in the context of planning budget allocations:

> "Sometimes overlapping does happen. It is because there is a lack of coordination. For instance, this happens when a programme funded by the national budget is implemented without our knowledge. Sometimes the programmes approved are different to what we proposed, but because we do not hear otherwise, but still put them in our budget. But then, it turns out that the programme is in fact being budgeted by the central government and we have to revise our budget again." (interview with staff of the Provincial BAPPEDA, Banda Aceh, 16 June 2010)

To synchronize some of the various budget planning processes, the Aceh Provincial BAPPEDA organises a forum on the Special Autonomy and Oil- and Gas-Derived Funds. The forum takes place once a year prior to the preparation and drafting of the local budget. This forum functions along similar lines to a musrenbang, in that it is a space for deliberation that aims to bring together the development aspirations of provincial and district governments, relevant line agencies and the Development Planning Agencies at each level. In this forum, local governments present their proposals, which have to be based on and refer to qanun regulations. One particular aspect of qanun that is emphasised in these forums is that Special Autonomy and oil- and gas-derived funds cannot be used to finance the government apparatus. The financing of local government apparatus is problematic for new districts created since 2001, as they lack revenue to set up and run new government institutions and they resort to tapping finances not designed for that purpose.[467] According to the staff of the Provincial BAPPEDA, the forum has functioned well and the qanun regulations are now clear enough to form the agreed base upon which conflicts or disagreements about budget proposals can be resolved.[468]

466 Interview staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)
467 World Bank (2006) *Aceh public expenditure*
468 Interview with staff of the Provincial BAPPEDA, Banda Aceh (16 June 2010)

The process of decentralisation and the granting of Special Autonomy status have led to a proliferation of new districts and local bureaucracies. The districts in Aceh are diverse geographically and economically, each with its own complex political system and its own priorities. In theory, decentralisation should facilitate appropriate responses to local contexts and issues. However, interviewees emphasised that this made the promotion of education policy and programmes that conform to the National and Provincial Medium-Term Development Plans (RPJMN and RPJMD) extremely difficult, requiring a key coordinating role for the Provincial Governor between different layers of government and across a multitude of districts:

> "Initially it was very difficult for the provincial government to monitor policy implementation or the development process at the local [district/municipality] level. After the law on local autonomy was issued in 2004, which instituted the governor as the representative of the central government, it became easier to control districts/municipalities. According to the 2004 Law, local budgets that are proposed by districts/municipalities have to be approved by the governor. It didn't happen before, the governor did not have this power and the local [district/municipality] governments submitted their budgets directly to central government, so that the provincial government did not know anything at all."[469] (Interview with staff from the Provincial BAPPEDA, Banda Aceh, 16 June 2010)

As in other provincial case studies in this report, effective evidence-based planning is greatly hampered by unreliable and inaccurate data. In Aceh, each office, institution, and agency has its own unit responsible for providing and managing data. Inevitably, some of the data are conflicting and this is particularly problematic for sensitive data on poverty, infrastructure and the numbers of teachers. Because there is no agreement on data and the actual state of affairs across the province, decision-making processes are not based on sound evidence and this weakens the likelihood of informed debates and consensus-building processes about particular aspects of policy. Instead, government actors or stakeholders tend to rely on data that suits their interests and arguments and ultimately the decisions on policy become hugely contested. The debates surrounding schools and the number of schools in the province illustrate these tensions. The position of the Provincial BAPPEDA is clearly that there are no issues with the number of schools in the province and that building school facilities is neither an appropriate nor a fiscally responsible one:

> "There is a case of a remote village that proposed to build a new school, and at the time we could not access the village…It turned out that there are only several households in the village and the school was a waste. A school was built and then not used. In another case two elementary schools stand next to each other, and in another case yet, a school only had four students. This is a waste. In Aceh the number of primary school buildings is 3,800, while the number of villages is 6,000, so the ratio is almost one school for two villages, schools are everywhere, as a result, the net enrolment rate at the village level is high." (Interview with staff from the Provincial BAPPEDA, Banda Aceh, 10 September 2009)

However the views from the FGDs are at odds with that of the staff from the Provincial BAPPEDA. The FGD participants agreed and complained about the lack of infrastructure and availability of schools especially in rural areas (FGD, 14 September 2009). As we have seen above, there are issues of distance and transport to schools in rural areas and, as with teachers, the problems relate not so much to overall numbers of schools (the data used by staff from the Provincial BAPPEDA staff to justify not building more schools) but concern the effective and appropriate distribution of facilities across districts.[470] The lack of appropriate and consistent data in this case results in conflicting views and understanding of the issue. A member of the Education Task Force in Aceh reported that disagreement on reference data is problematic in education policy and provokes tensions with stakeholders. To resolve this problem, the Education Task Force has undertaken consultancies, consultations, meetings and workshops with the concerned stakeholders and worked on establishing data that can be agreed on and that can be used as a basis and reference for policymaking.[471]

4.4.8 SUMMARY CONCLUSION

Aceh's record of in terms of education and education planning is mixed. On one hand, the impacts of the conflict and the tsunami make it one of the most challenging provinces for improving welfare in Indonesia. At the same time, however, Aceh also has a record of substantial achievements but on a narrow range of indicators. Enrolment figures are high in Aceh and were maintained despite accelerated and renewed violence in the early 2000s, which targeted schools in rural areas, and the tsunami in 2004, which devastated large tracts of Aceh's coastal areas. Yet as we have seen, this also led to unprecedented intervention from international and national organisations and the government. The proliferation of actors and programmes in Aceh makes it difficult - if not impossible - to effectively discern the causal mechanisms and processes between development outcomes. Certainly unpacking the specific workings of decentralisation and Special Autonomy is something of a challenge.

However, it is clear that Aceh has encountered a significant degree of success on some indicators, notably those relating to school access and enrolment for both boys and girls. However, the education record in Aceh concerning completion, early school leaving rates and transition rates, and further issues relating to the quality of education, are still problematic. District disparities and specifically rural/urban disparities are one major factor explaining Aceh's disappointing record with quality of education. Disaggregated data based on other socio-economic indicators, such wealth, were lacking at the district level.

It is evident from the discussion in this subsection that there is a lack of coordination, difficult communication between education staff and government, and general power struggles between different layers of government, particularly between the provincial and district levels of government. This is, to a large degree, a function of the Special Autonomy status since the devolution of power to district levels under decentralisation remains much weaker than in other provinces. As with Papua, the Special Autonomy status carries its own set of issues distinct from those present in provinces that have followed the general pattern of decentralisation. Three sets of issues are evident:

1. Difficulties in establishing clear divisions of power and authoritiy between the varying levels of government as required for the implementation of decentralisation (which emphasised devolution of power to district levels), followed by the adoption of Special Autonomy status (which strengthens provincial authority).
2. Difficulties of coordination among the different layers of government.
3. Difficulties in setting up effective budget allocation and disbursements.

469 Ibid.
470 Phone interview with staff of the Provincial BAPPEDA (16 June 2010)
471 Interview with staff of SEDIA, Banda Aceh (1 July 2010)

As seen in this case study, one of the central discussions regarding education and wider development planning in Aceh relates to budget and budget allocation issues. It is worth reiterating that Aceh had the highest provincial per capita spending on education of the whole of Indonesia in 2006, but there has been a notable failure to let this funding bonanza percolate to school budgets, and schools continue to struggle, particularly in rural areas. As seen, appropriate school budgets are essential to ensure that schools are free of fees and therefore accessible to the poorer sectors of society. Schools are struggling to get their programmes approved and funded by local governments and it is evident that many districts lack the capacity to handle financial flows appropriately. The system of decentralisation effectively provides important innovations but there are limitations. For instance, schools can prioritise how their budgets are allocated, but the limited budget means that in effect there is little flexibility and room for manoeuvre and they often face insurmountable delays in disbursement to get initiatives off the ground.

While Special Autonomy and decentralisation have rendered the institutional context uncertain and difficult to navigate on some levels, these are not insurmountable. For instance, the decentralisation process initially had a negative impact on welfare disparities among teachers, but the oil and gas revenues derived from Special Autonomy are now put to good use in order to regulate teacher welfare packages and reduce disparities.

On the whole, formal bottom-up development planning through the musrenbang, including on education, is weak and poorly institutionalised in Aceh, and the incorporation of children's and women's voices is barely incipient. However, it is important to note that on a number of occasions, the government of Aceh has successfully introduced or adopted mechanisms of consultation, such as in creating the Education Council (MPD) to ensure that views distinct from those of the Office of Education are considered and incorporated into the planning process.

The top-down aspect of education planning, however, appears to be functioning rather well. Education is a clear priority of the government of Aceh and the aims and objectives at the provincial level are in keeping with those at the national level. It is the communication and coordination between schools, districts and provincial governments that needs to be a continued focus in the future.

4.5
CHILDREN LIVING ON THE STREET IN CENTRAL JAVA PROVINCE: THE CHALLENGES OF CHILD (SPECIAL) PROTECTION

4.5.1 INTRODUCTION

The previous subsections of Section 4 have examined malnutrition, HIV and AIDS and education in three different contexts in Indonesia, each of which had a specific challenge for improving child welfare. In Aceh, devastation after the tsunami and conflict affected access to education; in Papua, the generalised epidemic of HIV must be understood in the context of high levels of poverty, low education levels, and growing development; and in Nusa Tenggara Timur (NTT), problems of poverty, drought, food shortages, low agricultural yields, poor access to health services, and problems of access to water and adequate sanitation have all contributed to malnutrition. Moreover, in some of these contexts, the field research revealed that, to some extent, local cultural practices and behaviours also add to the challenges of improving the situation of women and children.

This part of the 2010 SITAN report introduces Central Java Province as a case study of child protection through the lens of one particularly vulnerable group - children living on the streets - and the policy responses to the problem. The first part of this subsection describes in detail the circumstances in which children in Central Java are growing up - notably in terms of poverty levels, human development and wealth distribution, as well as in terms of health, education and population growth. It shows changes and trends over the past decade and highlights urban/rural disparities as potential factors contributing to the migration of children to urban areas. The second part of this chapter discusses the situation of children living on the streets and the innovative policy responses to the problem, as well as further challenges related to the creation of a 'Child-Friendly City' in Surakarta following decentralisation. Discussions in this subsection follow on from those pertaining to the national level legal and policy framework presented in Section 3.5 on child (special) protection in Indonesia.

Compared to other provinces, Central Java has a higher standard of living on average, but its large population and high levels of rural poverty mean there are large inter-district and inter-income group disparities in terms of child welfare. Rural poverty in the districts contributes to the migration of children to urban areas, some of whom end up living on the streets. Detailed data on Central Java are provided in annex 4.5.

The study of children living on the streets, their vulnerabilities, and the policy responses to the problem highlights a number of issues in child (special) protection. It is also notable that multi-sectoral responses seeking to improve the welfare of children living on the streets in Central Java (and Surakarta in particular) under decentralisation have required consistent commitment of the provincial and the municipal governments to prioritising children in policy formulation and budgeting and many other aspects. These responses have included the establishment of an Office of Community Empowerment, Women's Empowerment, Child Protection and Family Planning, the creation of a new set of services for children living on the streets, and a change in approach from one of punitive treatment for 'disturbing the social order' to special protection for some of the country's most vulnerable children.

For the fieldwork, Surakarta and Brebes were chosen to represent an urban and a rural area, respectively. Surakarta is also the pilot location for a Child-Friendly City, which has offered the opportunity to trial a wide range of policies aimed at preventing and assisting children living on the streets, as well as the opportunity to compare how children have fared in this environment versus other cities. This case study is not an exhaustive sectoral review of all aspects of child (special) protection in the province, but rather it is a case study of the basic aspects of the problems related to children living on the streets and some of the policy responses to these problems under decentralisation. It aims to illustrate both the innovations of local level governments and the challenges faced as the institutional environment strengthens.

4.5.2 GEOGRAPHY AND DEMOGRAPHY

Central Java Province has a large population of Muslims and is located on Java Island, covering some 25 per cent of the island's total area. It borders with the provinces of East and West Java, and surrounds the Special Region (Daerah Istimewa) of Yogyakarta. Currently, Central Java Province consists of 29 districts and 6 municipalities and has a population of 33,094,600 people.[472] With a total of approximately 140 million inhabitants, Java is currently not only the most densely populated island in Indonesia but also one of the most densely populated islands in the world.[473]

472 Badan Pusat Statistik (BPS) - Statistics Indonesia (August 2010) *Trends of the selected socio-economic indicators of Indonesia, August 2010*, BPS: Jakarta, available at: http://www.bps.go.id/65tahun/Boklet_Agustus_2010.pdf (Last accessed 17 March 2011).
473 Ibid.

Figure 4.5.1: Central Java map

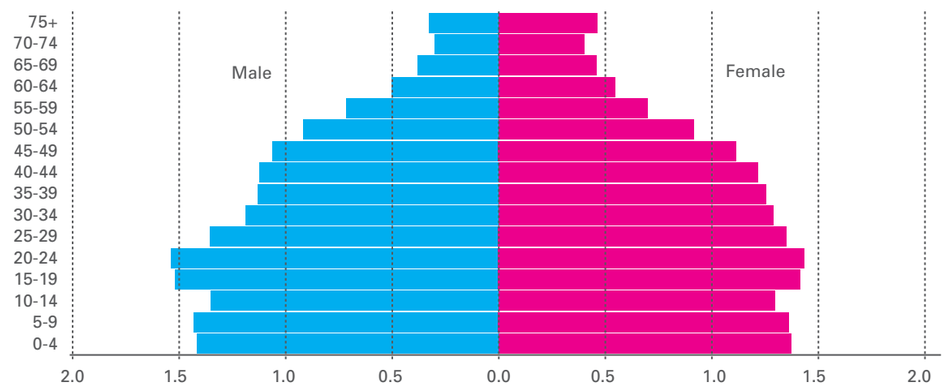
Source: Center for Population and Policy Studies, Gajah Mada University, 2010

Despite a relatively young population on average, Central Java's overall population growth has been decreasing over the past decade, especially over the last five years.[474] The decrease in population growth is likely linked to the decreasing fertility rate in Central Java since 1987. The total fertility rate (TFR) currently stands at 2.0, despite an increase from 2.1-2.3 during the period from 2002-2007 according to data from the Indonesian Demographic and Health Surveys (IDHS) 2002-2003 and 2007.[475] Central Java has a lower TFR than the national average, which is important given the current large population.[476]

However, Central Java's population is relatively young on average, with the largest segments of the population being those in the 20-24 years, 15-19 years, and 0-9 years age groups (see Figure 4.5.2). However, the number of children under age five has been decreasing in Central Java since 2005, likely due to recent decreases in fertility rates.[477] This may have some impact on the distribution of students, as a declining number of pupils will be attending primary schools in the next four years. Furthermore, there are more females compared to males, as discussed later in this subsection in relation to gender equity and development measures.

474 Projection based on BPS - Statistics Indonesia (2009) *Report based on the Intercensal Survey (SUPAS) 2005*, BPS: Jakarta
475 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2007* and *IDHS 2002-2003*, BPS and Macro International: Calverton, Maryland
476 Projection based on BPS - Statistics Indonesia (2009) *Report based on the Intercensal Survey (SUPAS) 2005*
477 Ibid.

Figure 4.5.2: Projected population pyramid, Central Java 2009



Source: BPS - Statistics Indonesia and UNFPA, based on projections from the 2005 Intercensal Survey (BAPPENAS)

Although Central Java is predominantly rural, more than 42 per cent of its population live in urban environments.[478] Continuously intensifying urbanisation poses certain challenges to urban infrastructure to keep pace with population growth.[479] Furthermore, persisting rural poverty can drive flight from rural to urban areas, including migration of children, who may face a range of problems such as inadequate access to basic health and education services, sanitation and housing, especially if they end up living on the streets.

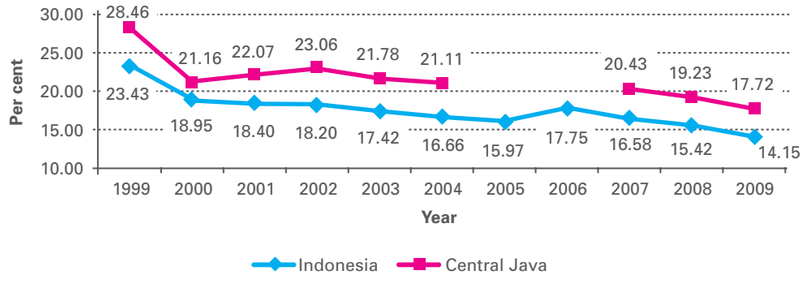
4.5.3 POVERTY, HUMAN DEVELOPMENT AND GENDER EQUITY

Overall poverty levels have declined in Central Java over the past decade. By 2002, poverty had fallen to 23 per cent of the total population from 28.5 per cent of the total population at the height of the financial crisis in 1999. The rate has continued to decrease in recent years, and by 2008 the population living below the poverty line in Central Java was 19.23 per cent of total population, according to data from the National Socio-Economic Survey 2009. However, poverty levels in the province have remained above the national average (see Figure 4.5.3).

Considerable disparities in poverty levels exist between urban and rural areas. Figure 4.5.4 illustrates that despite overall reduced poverty levels in recent years, a higher percentage of people in rural areas live below the poverty line compared with urban areas. While this gap has been decreasing recently, it is still larger than it was in 1999. In 1999, the difference between the proportion of the population below the poverty line differed by only 1 per cent between rural and urban areas. Soon after that, in 2001, the gap had widened to 18 per cent, but by 2009 the gap had narrowed to 4.5 per cent (see Figure 4.5.4).

478 Projection based on *Intercensal survey 2005*, processed by BPS - Statistics Indonesia, Jakarta, 2009
479 Zahnd, M. (2006) T*raditional urban quarters in Semarang and Yogyakarta Indonesia; Potential for innovative use of urban design for new quarters in Indonesian cities based on theoretical and traditional aspects*, available at: www.urban-is.com/deutch/unsere-publikationen/farchartikel/posterly.pdf (Last accessed 20 June 2010)

Figure 4.5.3: Percentage of households living below the national poverty line, Indonesia and Central Java 1999-2009



Source: National Socio-Economic Surveys 1999-2009

Figure 4.5.4: Percentage of population below the poverty line by area, Central Java 1999-2009

Source: National Socio-Economic Surveys 1999-2009

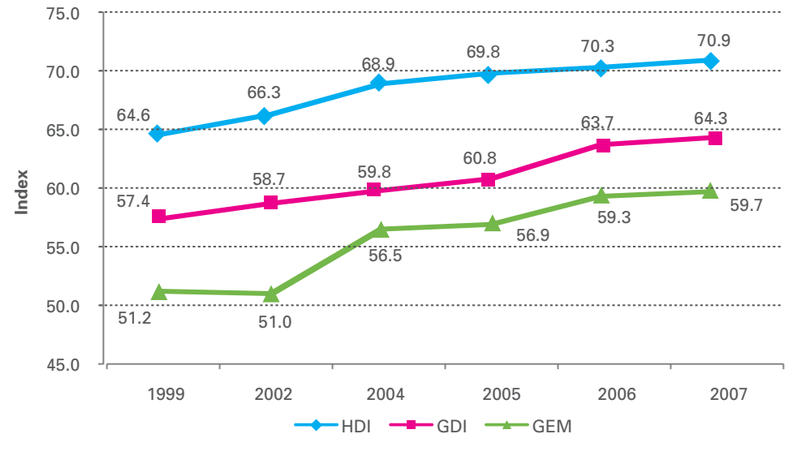
In line with the reduction in aggregate poverty levels in the province, Central Java's human development index (HDI) has been continuously improving since 2000. This is illustrated in Figure 4.5.5, which shows the improvements of Central Java's HDI, gender development index (GDI), and gender empowerment measure (GEM) from the year 1999 to 2007. As shown, by 2008, Central Java's HDI had increased to 70.92 from 68.9 in 2004.[480] According to the Central Java Provincial Medium-Term Development Plan (RPJMD), Central Java's HDI now ranks fourteenth among the nation's 31 provinces and 2 special regions.[481]

Although all districts of Central Java have improved their HDI, there is still wide inter-district variation (See annex 4.5). While some districts have improved even above the national average, others still rank below the national average. A comparison of urban and rural districts in Central Java shows disparities in the improvement of the HDI, similar to the uneven reduction in poverty in rural areas, such that some rural districts still sit well below the national and provincial averages. One example of above-average improvement has occurred in urban Surakarta, the district in which the Child-Friendly City is being piloted (as discussed in the second part of this subsection). In 2007, Surakarta's HDI ranked sixteenth among all 471 districts in Indonesia, and was the only district from Central Java to be ranked among the nation's 20 districts with the highest HDI.[482] An example of below-average improvement is Brebes district. While in 2007 the HDI of the district of Surakarta was 76, far above the provincial average, the HDI in Brebes was only 64.3, far below the provincial and national averages, ranking last among all districts in the province.

480 BPS - Statistics Indonesia and the Ministry of Women's Empowerment (2007) *Gender-based human development report*, BPS - Statistics Indonesia: Jakarta

481 Central Java Provincial Government (2009) *Central Java Medium-Term Development Plan (RPJMD) 2008-2013*, Central Java Provincial Government: Semarang, p13

Figure 4.5.5: Human development index (HDI), gender development index (GDI), and gender empowerment measure (GEM), Central Java 1999-2007



Source: BPS - BAPPENAS - UNDP, Indonesia Human Development Report, 2004 (data 1999 and 2002), BPS - The Ministry of Women's Empowerment, Gender Based Human Development Report

Overall, wealth distribution in Central Java has become more equal across population groups over the past years, as indicated by a small decrease in the Gini Index from 0.28 in 2005 to 0.25 in 2007.[483] However, the distribution of wealth within districts in Central Java is still highly unequal, especially in rural areas (see annex 4.5). Furthermore, the wide disparity across districts is also reflected in the Williamson Index,[484] which stood at 0.75 for Central Java in 2005 and 0.74 in 2007[485], indicating a wide disparity in the gross regional domestic product (GRDP) across districts/municipalities. Indeed, some cities, such as Semarang and Surakarta, have a relatively high GRDP, whereas some districts, such as Brebes and Wonosobo, show a lower GRDP.[486]

The combination of a large proportion of children and women in the population in Central Java (as discussed in section 4.5.2 on demographics) is important in terms of human, social and economic development measures and policy approaches. Despite overall improving poverty trends, gender-based inequality in human development persists in Central Java in terms of income, human rights and political freedom. Many women still face unequal income opportunities and employment conditions. This is evidenced by the 2007 GEM and GDI for Central Java, which stood at 64.3 and 59.7, respectively.[487] Furthermore, although the 2006 National Socio-Economic Survey data showed an almost equal number of men and women entering the employment market, on average women's wages were lower than men's despite overall increases

482 Ibid., p14; BPS - Statistics Indonesia and the Ministry of Women's Empowerment (2007) *Gender-based human development report*

483 BPS - Statistics Indonesia (relevant years) data from the *National Socio-Economic Survey*, BPS: Jakarta

484 The Williamson Index indicates inequality across regions, while the Gini Index indicates inequality across population groups

485 Central Java Provincial Government (2009) *Central Java Medium-Term Development Plan (RPJMD) 2008-2013*, p15

486 Ibid.

487 BPS - Statistics Indonesia and the Ministry of Women's Empowerment (2007) *Gender-based human development report*

in wages each year. For example, on average women freelance workers in the non-agricultural sector earned only 46 per cent of what men earned in February 2005, and this increased to 60 per cent in February 2007.[488]

4.5.4 HEALTH, NUTRITION, WATER AND SANITATION, AND EDUCATION

While indicators in health, nutrition, and access to clean water and adequate sanitation have improved province-wide in Central Java, they continue to be better in urban than in rural areas. Between 2000-2008, access to clean water among rural households improved from 45.9 per cent to 52.1 per cent, whereas this improved from 61.4 per cent to 64.4 per cent among urban households.[489] Likewise, access to adequate sanitation improved from 19.5 per cent to 38.2 per cent of rural households over the same period, whereas access improved from 54.5 per cent to 65.0 per cent of urban households.[490]

Compared to other provinces in Indonesia, such as NTT, Central Java has made relatively greater improvements in health and nutritional status. For instance, the infant mortality rate (IMR) has been decreasing since 2002-2003, from 36 per 1,000 to 26 per 1,000 in 2007, and the under-five mortality rate (U5MR) has been successfully reduced to and already reached the MDG target of 32 per 1,000 per live births in 2007.[491] One of the programmes introduced by the Central Java Office of Health, which has no doubt contributed to these improvements, has been the Planning for Deliveries and Preventing Complications during Birth programme (P4K, Perencanaan Persalinan dan Pencegahan Komplikasi). The importance of giving birth in health facilities attended by skilled professionals for reducing mortality rates has been highlighted previously both in the national overview of health (Section 3.1) and in the case study on health and nutrition in NTT (Section 4.2). In contrast to NTT where the IMR is far higher and births often take place at home without the assistance of skilled birth attendants, the geographic distances to travel to health facilities in Central Java are far smaller (the province is not formed of many islands) and there is greater uptake of skilled birth attendants.

> "The Central Java Provincial Office of Health has initiated the Planning for Deliveries and Preventing Complications during Birth programme (P4K)…The programme aims to have all expectant mothers registered with health facilities, allowing for easier identification of high-risk mothers. Successful implementation of the programme depends on the support of other village institutions as well as community participation. Village midwives, with the help of other health officials, identify expectant mothers and assist them in devising a safe birthing plan. The midwives also monitor the developing pregnancy, from conception to birth." (Staff at the Department of Family Health and Nutrition Unit, Central Java Provincial Office of Health, 9 September 2009)

Under this programme, the Office of Health actively monitors pregnant women by encouraging their participation in monitoring their own pregnancies.[492] However, the staff at the Office of Health stated that there is still low awareness about maternal health among women in rural areas, as well as a lack of health facilities for pregnant women. This has made reduction of the MMR and IMR more difficult in rural areas such as Brebes, Batang and Blora.[493]

Further indicators for child health and nutritional status include underweight, stunting, and wasting, which are indicators of malnutrition. Riskesdas 2007 data show that the prevalence of children under five years old suffering from stunting was still 36 per cent, wasting was 12 per cent and the rate of children who were underweight was 16 per cent.[494] While stunting rates in Central Java sit around the national average, wasting and underweight rates are below the national average. As stated in the RPJMD for Central Java:

> "The lower prevalence of severe malnutrition in Central Java compared to the national level is due to the Central Java government's intensive efforts to implement programmes aimed at reducing the number of cases of severe malnutrition. These intensive efforts have been made through the revitalisation of posyandu [integrated health service posts], hamlet head referrals, and providing guidance for families with members suffering from severe malnutrition. In line with these efforts, efforts have also been made to increase keluarga sadar gizi [families aware of the importance of nutrition]."[495]

Improvements in the health and nutritional status of a society are important for promoting human capabilities in other areas, such as education and employment productivity. In Central Java, however, despite the nine-year compulsory education programme, many children still leave school early, before the completion of junior secondary school, due to economic factors.[496] While enrolment rates at the primary school level are high in Central Java compared to other provinces (see annex 4.5), and early school leaving (dropout) rates are falling at the primary school level, the large population in Central Java means that a large number of children are still not receiving nine years of basic education. Transition rates to junior secondary school fell from 82 per cent in 2006/07 to 74 per cent in 2007/08, and there have only been marginal improvements (1-2 per cent) in net attendance rates at the junior secondary school level, with these rates roughly the same for boys and girls (see annex 4.5). Furthermore, early school leaving rates for secondary school have been rising in recent years (see annex 4.5). In urban areas, such as Surakarta and Semarang, many school-age children work on the street singing for money, begging, and so on. A lack of parental awareness about the importance of education often results in low support for their children's education and uncontrolled truancy.[497] Many parents remove their children from junior secondary school because they are considered mature enough to help their parents running small food shops and kiosks.[498] Often, children who live in rural villages must help their parents during the rice harvest times, or with fishing during high yield times in coastal areas. Some parents are hesitant to keep their children in school because they are uncertain about the future employment possibilities that result from schooling.[499]

In sum, despite overall improvements in poverty levels, human development, and other areas such as health and education in Central Java, urban/rural disparities persist. These factors likely contribute to the migration of children to urban areas, either with their families or alone. The

488 BAPPENAS (2007) *Laporan pencapaian Millennium Development Goals Indonesia 2007*, BAPPENAS: Jakarta
489 Based on the *National Socio-Economic Survey*, processed by BPS - Statistics Indonesia, Jakarta, 2009. For more detailed information refer to annex 4.5 on Central Java.
490 Ibid. The improvement is partly due to a programme called Community Based Drinking Water and Sanitation Provisions *(Pamsismas, Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat)*, which aims to improve clean water and sanitation, and to projects such as Water and Sanitation Support for Program for Low Income Communities (WSSLIC), Urban Poverty Reduction Programme (P2KP), which provide facilities to build suitable sanitation facilities in urban areas. These programs strive to improve the quality of basic infrastructure in relation to reaching MDGs such as clean drinking water and sanitation (BAPPENAS (2007) *Laporan Pencapaian Millennium Development Goals Indonesia 2007).*
491 BPS - Statistics Indonesia and Macro International (2008) *Indonesia Demographic and Health Survey (IDHS) 2002-2003 and 2007*
492 Interview with staff of the Central Java Office of Health (9 September 2009)
493 Ibid.
494 Ministry of Health (2008) *Riskesdas 2007*
495 Central Java Provincial Government (2009) *RPJMD 2010-2013*, p26
496 Ministry of National Education (2009), *Statistics of National Education*, available at: www.depdiknas.go.id/statistik (Last accessed 1 July 2009)
497 FGD staff with at BAPPEDA (District Development Planning Agency) in Brebes (16 September 2009)
498 Ibid.
499 Ibid.

focus group discussions (FGDs) conducted with policymakers and practitioners in Surakarta municipality (also known as Solo), which is one of Central Java's largest urban areas, emphasised that a large proportion of children living on the streets come from outside the city. For example, in one round-up of children living and working on the streets conducted by the Office of Social Affairs, 8 of the 20 children living on the streets came from rural areas outside Solo.[500] In the following section, the situation of children living on the streets and the policy responses to this are discussed in further detail.

4.5.5 CHILDREN LIVING ON THE STREETS IN CENTRAL JAVA

As stated in the first section of this SITAN report, the Indonesian government introduced the Indonesian Law on Child Protection (ILCP No. 23/2002), which identifies three main forms of child rights in relation to:

1. The provision of appropriate support and services for children's health and development
2. The protection from exploitation and abuse
3. Participation in decisions made about their upbringing and care

Within this framework, the GoI adopted A World Fit For Children (2002 UN Resolution[501]) into the National Program for Indonesian Children 2015 (PNBAI, Program Nasional Bagi Anak Indonesia) and introduced the Child-Friendly City programme in 2005 via the Ministry of Women's Empowerment and Child Protection. The aim of the Child-Friendly City programme is to create an environment in which child rights as specified above are fulfilled by bringing together parents, families, community and the state. In large-scale urban settings with high population density, the issue of children living in city streets is one of the contemporary intractable urban challenges that have put the implementation of the Child-Friendly City policy to the test.

In 2006, Central Java was awarded a Child-Friendly City pilot project.[502] The city of Surakarta, or Solo, was selected because it had comparatively widespread and stable institutions, and high levels of service delivery and participation compared to other provinces in Indonesia, in terms of women's and children's protection. Solo was also selected as a pilot city for this project on the basis of its comparatively low poverty, high HDI and good health and sanitation facilities.[503] The discussion in the remainder of this subsection examines the situation of children living in the streets of Solo. It will look at the children's vulnerabilities in this context and their reasons for migrating and living on the streets. It will also scrutinise the policy responses to their situation and identify some of the key issues in the way the institutional networks in child (special) protection integrate service delivery across sectors to address the needs of children living on the streets.

500 Conducted in Surakarta (8 September 2009)
501 United Nations (2002) *A world fit for children*, Resolution adopted by the General Assembly at the 27th special session, available at: http://www.unicef.org/specialsession/wffc/ (Last accessed 17 March 2011)
502 Kota Layak Anak (Child-Friendly City), available at: www.kotalayakanak.org (Last accessed 12 November 2010)
503 Interview with the Head of Child Protection Section of the Bureau of Community Empowerment, Women's Empowerment, Child Protection and Family Planning, Surakarta (30 June 2010)

Box 4.5.1: Definitions of children living on the streets

UNICEF defines a child living on the streets as "any boy or girl...for whom the street in the widest sense of the word...has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults."[504] The ILO makes a further and broadly accepted differentiation between children who live in the streets to undertake economic activities and those who live off the streets with little or no contact with family environment.[505]

According to the GoI's 2008 Manual for Updating Data on Populations with Social Welfare Problems (PMKS, Penyandang Masalah Kesejahteraan Sosial) and Potential Resources for Social Welfare (PSKS, Potensi Sumber Kesejahteraan Sosial)[506], a 'street child' is a child between the ages of 5-18 years who finds his or her means of living in the streets. Street children can be divided into two main categories:
- Children who live on the street engage in street economic activity but are still closely connected to the family and have a home to return to at the end of the day.
- Children who live off the street depend on street economic activity for their survival and have very little or no contact with family.

Although official and comprehensive data are scarce and definitions vary (see Box 4.5.1), the GoI has estimated that in 2000, about 40,000 children lived on the streets in the country's twelve largest cities.[507] These numbers have seen a marked increase in the late 2000s. Estimates gathered by the Ministry of Social Affairs put the number of 'street children' at around 50,000 in the late 1990s.[508] That estimate increased to 60,000-75,000 in 2004, and increased yet again to stand around 230,000 in 2008.[509] In Central Java, the number of children living on the streets in 2008 was approximately 9,770 or approximately 4 per cent of the total number of children living on the streets in Indonesia. In 2009, the estimate for Central Java was at least 8,027.[510] The number of children living on the streets in Central Java is higher than in Papua but slightly lower than in NTT, although data collection issues may affect the accuracy of these figures, given the large fluctuations found in all provinces from year to year (see annexes 4.2-4.5). Furthermore, according to Ministry of Social Affairs data, there are some 111,449 neglected children in Central Java.[511]

The majority of the children living on the streets in Central Java originate from the greater Surakarta area (outside of the city). They earn money from busking, collecting trash, begging, selling newspapers and shining shoes - although this last activity is becoming more rare.[512]

504 UNICEF (2009) *Child protection information management mapping: Towards a data surveillance system in Indonesia*, UNICEF: Jakarta, pp30-31
505 Ibid.
506 Central Java Provincial Office of Social Affairs (2008) The Manual for Updating Data on Populations with Social Welfare Problems (PMKS) and Potential Resources for Social Welfare (PSKS, *Potensi Sumber Kesejahteraan Sosial*)
507 Ministry of Social Affairs (2010) *Data on social welfare issues, available at:* www.depsos.go.id (Last accessed 1 October 2010)
508 UNICEF (2000) *Challenges for a new generation: The situation of children and women in Indonesia*, UNICEF: Jakarta, p144
509 UNICEF (2000) *The situation of children 2000*, pp144-146; and Government of Indonesia National Program for Children 2004-2015 and Ministry of Social Affairs (2008), cited in: UNICEF (2010) *Who are children without parental care?*, UNICEF: Jakarta, available at: www.unicef.org/indonesia/UNICEF_Indonesia_Children_Without_Parental_Care_Fact_Sheet_-_June_2010.pdf, (Last accessed 1 October 2010)
510 Ministry of Social Affairs (2010) *Data on social welfare issues, available at:* www.depsos.go.id (Last accessed 1 October 2010)
511 Ibid.
512 Interview with staff of Lembaga Studi Kemasyarakatan Bina Bakat Surakarta (8 June 2010)

The factors pushing children to live off the streets and in the streets are varied, often related to poverty, unemployment, rural-urban migration, failures to provide families with safety net programmes, violence in the home and/or the breakdown of families, notably through divorce and remarriage.[513] Increasing numbers of urban families relied on children's street-based work as their primary source of income after the economic crisis in 1997.[514]

Children living on the streets in Central Java face a potentially dangerous environment. They are vulnerable to economic exploitation, discrimination, violence and crimes, in the anonymity of the urban environment. At times, children, especially infants, are taken along by adults to beg on streets to rouse more empathy and hence more money. In Box 4.5.2, the story of Atin illustrates the discussion above from the perspective of a child who spends most of her time on the street (although Atin returns home most nights, unlike other children living on the streets).

Box 4.5.2: Stories from the street

Atin[515] is one of Surakarta's many children living on the streets. She is 16 years old. Her family comes from Jombor, in Klaten district. When the family was still in the village, Atin's mother was a batik worker (traditional waxing and dying of cloth). Pressing economic circumstances resulted in the family's move to Surakarta (Solo) when Atin was around four or five years old. Atin's father abandoned the family when Atin was still an infant, and his whereabouts remain unknown.

Atin was born in Klaten on 16 October 1993. Atin did not finish elementary school, but left school after Year 4. Atin's mother, Ngatinah, remarried, making Atin's stepfather, Yantoko, the head of the household. Yantoko drives a pedicab and also works as a night guard. Atin's only income comes from busking. Atin's stepfather completed six years of primary education, whereas her mother has no schooling at all. Atin now has three younger siblings who are still toddlers.

In Solo, Atin lives in the Gondang area with her family. The residential area, often referred to as boro, is essentially an illegal slum. Several members of Atin's extended family also reside there.

Every day Atin busks at the Sumber Solo traffic light. Along with a group of friends, she begins busking at 7 a.m. and ends her day at 10 p.m. It takes her 30 minutes to walk to the traffic light. Her homemade musical instrument, the kecrek/kecek, is made simply of bottle caps nailed to a small block of wood. Atin prefers busking at the traffic light rather than on buses. The latter would require her to constantly hop on and off buses, often fruitlessly. Busking at the traffic lights is much easier. When busking, Atin wears a jacket but forgoes footwear - she fears people will withhold money if they see that she can afford footwear. By remaining barefoot, she gains more sympathy, she says.

Atin still thinks of school and wants to go back to school, though it has been a long time since she was in school. She started street busking when she was only five years old and still managed to stay in school. Atin left school in Year 4 after being teased and bullied by her classmates. Atin's other desire is to have a Surakarta Resident Identity Card (KTP). She points to an older female busker, Wulan, who is married and holds a KTP.

Atin wants to help her parents take care of her younger siblings. She does so by taking her siblings with her when she busks. If they cry, she carries them and shows them the cars on the street. Sometimes she play-teases her siblings and they cry - making her mother very angry with Atin. To help her mother around the house, Atin does the dishes, the laundry and sweeps the house.

Atin hopes that the government will pay more attention to the fate of the 'little people', the poor. She hopes that the Civil Service Police Unit (Satpol PP) will stop making regular arrests and evictions. Atin's family are not beneficiaries of the National Health Insurance (Jamkesmas) programme. When one of her siblings fell ill, Atin's family was lucky to receive some help from Seroja, a local NGO (non-government organisation). Atin has participated in Seroja events in the past, the most recent being in 2005.

Busking does have its dangers. Atin was once picked up by a civil service police officer as she was counting the day's take. At the police station, she had feared she would be put in jail. Instead she was given advice and told not to busk. She was then told to clean the station's toilets before being given a meal and released.

Older buskers can also be a cause of problems. Some demand money for cigarettes. Others insist on territorial claims and force Atin to busk elsewhere - Atin has no choice but to comply.

Source: Interview with Atin (name changed) at her house in Gondang-Surakarta area, 27 September 2009

FGDs were conducted with children themselves about the experience and vulnerabilities of children living on the streets. Box 4.5.3 outlines in the results of these FGDs, highlighting a number of vulnerabilities that children living on the streets face, as well as children's suggestions for the government to provide support. These FGD results also highlight that children are aware of many of the challenges that vulnerable children face, and children themselves argued that they should have a greater role in child-friendly policymaking.

Box 4.5.3: Children's views on children living on the streets - FGD results

1. The number of children living on the streets in Solo (Surakarta) is high, you can see them hanging out at the traffic lights and in other public areas.
2. Some children living on the streets have homes but they prefer to stay on the street when their homes are places of domestic violence or when they are bored or ignored, or if their parents are absent for long periods for work. Children perceived that protection for these children should come from families.

513 UNICEF (2000) *The situation of children 2000*, pp144-146
514 Save the Children (2005) *Discipline and punishment of children: a rights-based review of laws, attitudes and practices in East Asia and the Pacific*, Save the Children Sweden, Southeast Asia and the Pacific, regional submission to the UN Secretary General's Global Study on Violence against Children, Save the Children Sweden
515 Name changed

3. Other children live on the streets because their families have been evicted from their homes, or their homes have been destroyed in floods (shacks are often built along the river). Many child workers and their families occupy homes on land with unclear status so that they are under risk of eviction by the government. Some of the FGD participants indicated that children living on the streets get more attention from civil society organisations than from the government.
4. Even though some children feel happy to live on the street, they still feel threatened and not protected by the government. Children living on the streets face problems of mass arrest (penangkapan massal) by the police, which happens frequently. Once they are arrested, they will be ordered to clean toilets in the police station and other such tasks to get food during their incarceration, and they are often released at night. Police operations are conducted frequently so children living on the streets feel intimidated.
5. Other threatening conditions faced by children living on the streets include: adults living on the street singing for money or begging (who often demand money from children living on the streets); no money to eat; being hit by cars while begging; alcohol, crimes and violence in the neighbourhoods where they live.
6. There are some children who live and work on the street but also go to school at the same time. However, sometimes they feel inferior since their 'friends' at school make fun of them, which discourages children living on the streets from continuing to go to school.
7. According to the children, Solo is not a child-friendly city yet since it lacks a playground.
8. The child participants see the Surakarta municipal government as active in issuing policies, but less so in effective implementation, such as in local regulations on Sexual and Commercial Exploitation of Children (ESKA) and on Child Protection.
9. There is a Surakarta Child Forum (FAS, Forum Anak Surakarta). Child members of this forum think it can be ineffective at times as they are perceived as 'inexperienced kids' and are expected to remain quiet by adults at meetings with government. But FGD participants argued that children are the ones who best understand their own problems.

Children recommended:

1. Schooling should be provided for free for all students, as in other districts.
2. The Surakarta government should send children living on the streets to school. Children living on the streets also need a future and employment so that they do not end up drinking alcohol or spending their life on the street.
3. The government should accommodate children living on the streets in proper houses.
4. Children, especially children living on the streets, should have identity cards (KTP, Kartu Tanda Penduduk) so that they are not perceived as illegal residents. But children living on the streets don't know how to get identity cards.
5. The government should help children living on the streets to find legal employment, and give them health insurance.

6. NGOs/CSOs should continue to assist more children to join and participate in Child Forums so they can voice their aspirations.
7. Participants expressed their hopes that the government will recognize children's voices and real aspirations. If there is no communication through forums such as these, children living on the streets, child workers and early school leavers sometimes do not benefit from their rights like other children. As a result, there will be inequality between members and non-members of the Surakarta Child Forum.
8. Participants expressed their hope that the Surakarta Child Forum will become more independent, especially in terms of funding, since funding is likely to end from UNICEF and other donors.
9. Participants expressed the hope that the government will listen more to children than it does at present.

Source: FGD participants were members of the Solo/Surakarta Child Forum and the 'Love the Earth' Child Forum in Surakarta. Multiple FGDs were held with participants (for the Solo Child Forum: on the 15 and 26 September 2009; for the Love the Earth Child Forum on 6, 13 and 16 September 2009). There were eight participants in the Solo Child Forum FGD, and five in the 'Love the Earth' Child Forum FGD. These views represent children who participate in these forums rather than those who may not know of or access such forums.

As FGDs participants and interview respondents (including children, policymakers and practitioners in child protection) have highlighted, many children living on the streets are fleeing (domestic) violence, with little or no protection, and are highly vulnerable to physical abuse, substance abuse and incarceration. A survey conducted by the provincial Child Protection Agency (LPA, Lembaga Perlindungan Anak) shows that 64.29 per cent of underage female children living on the streets have engaged in 'inappropriate' sexual relationships.[516] In many cities in Central Java, such as Semarang, Surakarta and Purwokerto, large numbers of girls are engaged in prostitution. Results of a survey conducted by Setara Foundation in 1999 showed that 46.4 per cent of female children living on the streets cited 'prostitution' as their profession.[517] Similarly, the only available later research, conducted by the Center for Population and Policy Studies (CPPS) at Gajah Mada University in 2002, found that in some Central Java cities, a significant number of children, particularly girls, are 'prostituted' on streets and in brothels, as well as in 'hidden prostitution' under the guise of beauty salons, discotheques, hotels, billiard halls, massage parlours, karaoke bars and steam baths.[518] These children were found to be mostly from poor economic backgrounds and from regions in rural Central Java.[519] The challenge for reducing the number of children living on the streets, and mitigating the risks they face, is that recent data are lacking and up-to-date reliable figures are scarce.

Furthermore, one of the challenges of responding to the problem of children living on the streets is defining who is classified as a 'street child'. According to FGDs held in Central Java, difficulties in developing criteria for identifying children living on the streets are still major barriers to policy development.[520] Opinions varied between those who felt one criterion should be that a child spends at least eight hours each day on the street while others thought that whether or not a child has a home to return to should be included among the criteria.[521] At present, there is no regional regulation in East Java that defines children living on the streets and appropriate responses to children living on the streets.[522] Participants stated that Central Java wants to learn from best practices in other provinces and regions, but as yet there are no provinces in Indonesia that have passed any regulations on children living on the streets.[523]

516 Putra Center (10 November 2008) *Anak jalanan perlu pengetahuan kesehatan reproduksi*, available at: http://putracenter.wordpress.com/tag/anak-jalanan (Last accessed 29 March 2010)
517 Ibid.
518 Center for Population and Policy Studies, Gajah Mada University (2002) *Rapid assessment of child prostitution* (Research Report), Center for Population and Policy Studies (CPPS), Gajah Mada University in collaboration with International Labour Organization - International Office, International Programme on the Elimination of Child Labour: Jakarta
519 Suyanto (2002) *Perdagangan anak perempuan: Kekerasan seksual dan gagasan kebijakan*, Center for Population and Policy Studies (CPPS), Gajah Mada University: Yogyakarta
520 FGD participants included staff from the provincial Bureau of Women's Empowerment, Child Protection and Family Planning, Office of Manpower and Transmigration, Bureau of Social Empowerment (Biro Bina Sosial), Community Empowerment Board, Bureau of Government Administration, Setara Foundation, Perisai organisation, Child Protection Agency (15 September 2009)
521 Ibid.
522 Ibid.
523 Ibid.

In spite of the severity of the problem of children living on the streets in the country, the response of the GoI nationally seems to have shifted over the recent years, from punitive approaches that criminalised children living on the streets and treated them as delinquents, to recognizing that they constitute a vulnerable group requiring special protection.[524] As was discussed in Section 3.3, there have been attempts to introduce more appropriate responses, which resulted partly in reducing punitive approaches. In the late 1990s, the UNDP, NGOs and the GoI (through the Ministry of Social Affairs) collaborated in setting up a number of shelters and 'safe houses' designed to host and rehabilitate children living on the streets.[525] In 2006, the Ministry of Social Affairs developed a network of social development centres for children.[526] Other initiatives have included setting up mobile schooling programmes to work towards fulfilling the educational needs and the provision of vocational training for children living on the streets who have dropped out of school.[527]

Despite this changing paradigm in policies relating to children living on the streets, round-ups are still frequent in many cities in Indonesia. Central Java is no exception, as mentioned by children themselves in the FGDs. Indeed, the provincial government of Central Java has passed regulations on social ordinance that allow social departments or the police to arrest and detain children living on the streets if they are perceived to be disturbing social order. However, it has been acknowledged that these punitive measures have had little success in reducing the numbers of children living on the streets. Furthermore, there are numerous reports that the enforcement of these regulations by public order officials frequently results in violence.[528] As one government official put it:

> "Actions taken so far include joint raid operations involving civil service police (Satpol PP), the police, hospital staff and the Office of Social Affairs. A regional regulation from the Office of Transportation is used as the legal basis for these raids. The regulation more or less states that no one is allowed to use public streets for economic activities without the consent of the Mayor. The Office of Social Affairs is tasked with empowering children living on the streets and ensuring their welfare, it should not primarily act to penalize children living on the streets. Therefore, their efforts should emphasise providing skills and training to children living on the streets. The Surakarta Office of Social Affairs conducts two assessments (raid operations) each month. From these assessments, it is estimated that there are 57 male children living on the streets and 6 female children living on the streets." (Department Head of Surakarta District Office of Social Affairs, 23 March 2010)

Results of FGDs with policymakers and practitioners working in child (special) protection also highlighted that children are being systematically mobilised into street work.[529] They also noted that children living on the streets endeavour to stay away during street raid operations but quickly return. Current efforts to alleviate the problem, aside from raid operations, include providing guidance and counselling to parents and the general community, emphasising the importance of children returning to school and to their homes (see further discussion of policy initiatives below).[530]

524 Save the Children (2010) *Review report: The implementation of the convention on the rights of the child, Indonesia 1997-2009*, Save the Children: Jakarta
525 UNICEF (2000) *The situation of children 2000*, pp144-146; Save the Children (2010) *Review report Indonesia*
526 UNICEF, Save the Children and Indonesian Ministry of Social Affairs/DEPSOS (2007) *Someone that matters: The quality of care in childcare institutions in Indonesia*, UNICEF: Jakarta, p29
527 Child Frontiers (2009) *Child and family welfare services in Indonesia: An assessment of the system for prevention and response to abuse, violence and exploitation against children*, Child Frontiers: Jakarta, p59
528 Child Frontiers (2009) *Child and family welfare services in Indonesia*, p136
529 FGD with Provincial Government staff in Central Java (15 September 2009)
530 Ibid.

4.5.6 SUPPORTING INSTITUTIONAL ENVIRONMENT FOR CHILD PROTECTION: PROVINCIAL LEVEL INITIATIVES

Following decentralisation, the administrative and operational functions of women's empowerment and child protection have been delegated to the provincial and district/municipal governments in Indonesia. Furthermore, in Central Java, child protection and women's empowerment have been incorporated into the Provincial Medium-Term Development Plan (RPJMD) 2008-2013[531] as one of the six priorities.

The Central Java Provincial Offices of Social Affairs, Education, Manpower and Health all have technical units set up specifically to tackle the protection of women and children in order to implement the programmes mandated by the RPJMD. For example, the Office of Health has a special technical unit to address issues related to children suffering from HIV and AIDS, while the Office of Manpower has a special technical unit to address child labour issues. Moreover, child protection is extended in Indonesia to include issues of health and education, and the issue is to be viewed holistically.

Government Regulation No. 41/2007 instructs provincial and district/municipal governments to form a bureau or institution that is specifically responsible for women's empowerment and child protection. As yet, these institutions have either not been set up or are not fully functioning in many of the sub-national administrative regions in Indonesia. In response to this regulation, however, the provincial government in Central Java formed special bodies and bureaus that address women's empowerment and child protection in different ways, such as the Governance Bureau, the Bureau of Social Empowerment (Bina Sosial), and the Community Empowerment Board (Bapermas).

4.5.6.1 The Bureau of Women's Empowerment, Child Protection and Family Planning

The provincial government also established the Bureau of Women's Empowerment, Child Protection and Family Planning (BP3AKB, Badan Pemberdayaan Perempuan dan Perlindungan Anak dan Keluarga Berencana) in 2008. The Bureau is charged with coordinating relevant programmes carried out by other line agencies, bureaus and bodies, although it does not have the budget or power to directly implement programmes itself if they are already covered by other line agencies. In other provinces, this Bureau tends to have a far smaller role. But the Bureau in Central Java is responsible for ensuring that each agency working with any aspect of child welfare has gender and child-sensitive budgets. It also has responsibility for policy development for children in conflict with the law, for the promotion of gender mainstreaming in local cultural values and customary systems, and for improving the participation of women in politics.[532] The approach employed by the Bureau is broad in relation to women's and children's welfare, with a view to improving: coordination and cooperation between agencies; the alleviation and prevention of insecurities; the rehabilitation of children and women who have suffered from particular vulnerabilities; the participation of women and children in policymaking; and social reintegration.[533]

531 Central Java Provincial Government (2009) *Central Java Medium-Term Development Plan (RPJMD) 2008-2013*
532 Interview with staff of the Central Java Women's Empowerment and Child Protection Bureau, Semarang (14 September 2009)
533 Ibid.

4.5.6.2 Innovations

The Bureau has established Integrated Service Units (PPT, Pusat Pelayanan Terpadu) to provide services for victims of trafficking and violence, and to provide legal assistance for children who are in conflict with the law. To do this, the Bureau has established partnerships with local NGOs and law enforcement institutions.[534] In its efforts towards rehabilitation of victims of sexual abuse, the Bureau collaborates with the Office of Education to provide support for such victims to continue their schooling. While the responsibility for formal development planning under decentralisation, as in other provinces, falls within the responsibility of the local Development Planning Agency (BAPPEDA), the Bureau takes the lead in coordinating inter-sectoral planning related to women's and children's protection.

However, the Central Java provincial government faces some challenges in implementing its initiatives, as do other provincial governments, for example, as discussed in the case of NTT (Section 4.2) which has a similar institutional environment under decentralisation to Central Java. Both provinces are subject to the standard national decentralisation laws as they do not have the Special Autonomy powers that have been granted to the provincial governments in Aceh and Papua, which provide for direct implementation powers for provincial governments. This means that the Central Java provincial government has limited direct implementation authority at the district level.

Similar to the case of NTT, in Central Java the provincial government's powers are generally limited to coordination. Therefore, achieving the provincial level goals and initiatives, such as those outlined above, requires gaining the support and commitment of district level governments and improving their capacity to implement initiatives at the district level. Some of these challenges have been discussed at length in the case study on NTT and will not be elaborated here. However, it is evident from the field interviews that more energy needs to be invested in working with district governments to ensure that child welfare and (special) protection remain high priority and that initiatives are implemented at the district level. As one respondent from a civil society organisation (CSO) working in child protection stated:

> "The Bureau of Women's Empowerment, Child Protection and Family Planning is a new institution and is still dependant on the Indonesian Planned Parenthood Association (PKBI) when they need a resource person for women-related activities. It seems that they're still chasing quantitative targets for their activities and largely ignoring the questionable quality of these activities. For example, in setting targets for the Centres for Information and Teenage Reproductive Health [PIKRR, Pusat Informasi Kesehatan Reproduksi Remaja], they've defined targets concerning the number of Centres to be established but they have no defined targets concerning the quality of these Centres.

The Bureau is doing well in its coordination tasks because they've involved several NGOs and related institutions. However, when it comes to coordinating with institutions at the district level their efforts are still subpar. Decentralisation has introduced a new barrier: at the district level there are now numerous women's empowerment institutions, each with interests are not automatically aligned to that of the provincial government." (Interview with staff of the Central Java Planned Parenthood Association, 15 June 2010)

534 Interview with the Head of the Central Java Women's Empowerment and Child Protection Bureau, Semarang (23 February 2010)

Recognising the challenges, in 2009 the Central Java provincial government felt there was an urgent need to form a new institution to specifically address the problem of women and children victims of violence. This was considered important because the Bureau of Women's Empowerment, Child Protection and Family Planning - as with other provincial initiatives throughout Indonesia under decentralisation - has limited authority over district governments. Hence, the Central Java provincial government established a task force called the Commission for Victims of Gender-Based Violence and Violence Against Children (KPK2BGA, Komisi Perlindungan Korban Kekerasan Berbasis Gender dan Anak), as described in Box 4.5.4. Another task force established to deal with issues of women and children in poverty was the Coordinating Team on Women's Empowerment and Child Protection (TKP2PA, Tim Koordinasi Pemberdayaan Perempuan dan Perlindungan Anak), as described in Box 4.5.5. In addition to these two task forces, the Provincial Office of Social Affairs has also formed the Child Protection Agency (LPA, Lembaga Perlindungan Anak), which has a role and function similar to that of the Coordinating Team on Women's Empowerment and Child Welfare Protection, except that it is limited to working with children.

These task forces have more power than the provincial Bureau of Women's Empowerment, Child Protection and Family Planning, since they are backed up by the relevant provincial regulations that provide the legal basis for working with district level agencies and district heads and they were instituted by the Deputy Governor, which to some extent gives them political influence. Furthermore, they have the flexibility to develop networks with other organisations, including NGOs, law enforcement institutions and hospitals. As is evident from the descriptions in Boxes 4.5.4 and 4.5.5, provincial level bodies are in practice performing more concrete tasks than coordination on an ad hoc basis.

Box 4.5.4: Commission for Protection of Victims of Gender-Based Violence and Violence Against Children (KPK2BGA, Komisi Perlindungan Korban Kekerasan Berbasis Gender dan Anak)

Function: Advocacy and mediation among institutions that deal with cases of violence at the provincial and district/municipal levels.

Implementing agencies: Technical implementation units handling women's and children's affairs include the Bureau of Women's Empowerment, Child Protection and Family Planning, the Office of Education, the Office of Health, the Office of Social Affairs, the Office of Manpower, Transmigration and Population, the Office of Community Empowerment, the Office of Agriculture, the Regional Development Planning Agency (BAPPEDA), the Community Empowerment Board (Bapermas), public hospital representatives, the police and NGOs (such as KJHAM, Setara, and Perisai).

A practitioner's view: "This commission is meant to have advocacy and mediating functions. In practice it functions like an NGO in that its staff often directly handle cases of violence. The task division has become blurred."

Source: Interview with NGO staff, Semarang, 18 June 2010

Box 4.5.5: Coordinating Team for Women's Empowerment and Child Protection (TKP2PA, Tim Koordinasi Pemberdayaan Perempuan dan Perlindungan Anak)

Function: Coordination of various provincial technical implementation units working with women and children, as stated in their core tasks and responsibilities.

Implementing Agencies: The Bureau of Women's Empowerment, Child Protection and Family Planning, the Office of Education, the Office of Health, the Office of Social Affairs, the Office of Manpower, Transmigration and Population, the Office of Community Empowerment, the Office of Agriculture, the Regional Development Planning Agency (BAPPEDA) and the Community Empowerment Board (Bapermas).

A practitioner's view: "The Coordination Team has yet to function optimally and is currently limited to an advisory role. Case handling is still carried out through Integrated Service Units (PPT). …Coordination between the provincial and the district/municipal level often stalls. Therefore, provincial PPT staff often end up directly handling cases of violence at the district/municipal level."

Source: Interview with NGO staff, Semarang, 18 June 2010

Despite the challenges, even setting up the Bureau and the task forces as described has required the commitment of the provincial level leadership. Both the Commission for Victims of Gender-Based Violence and Violence Against Children and the Coordinating Team on Women's Empowerment and Child Welfare Protection were instituted with the backing of the Deputy Governor (the Coordinating Team is actually chaired by the Deputy Governor). According to staff at the Bureau, the strong support of the Deputy Governor for child welfare is crucial for the success of the Bureau in advocating child-centred policies to agencies and to districts/municipal governments, such as the establishment of Integrated Service Units in each district/municipality.[535]

4.5.6.3 Challenges

Authority

The Bureau of Women's Empowerment, Child Protection and Family Planning conducts regular coordination and advocacy activities with sectoral agencies and NGOs with the backing of official letters and other relevant documents signed by the Deputy Governor[536], although some CSOs argue that not all local level government offices have responded.[537] For example, the Deputy Governor has instructed all government agencies to conduct at least two women's empowerment and gender mainstreaming activities each year, but as yet not all agencies have adopted this approach.[538] In another example, one child was facing prosecution and was prevented from sitting the national exams as a consequence. The Deputy Governor approved the request for the child to sit the exams and sent a letter to the Head of the Office of Education, but the Head didn't give permission for the child to sit the exam.[539]

535 Interview with staff of the Provincial Bureau of Women's Empowerment, Child Protection and Family Planning (22 February 2010)
536 Interview with the Head of the Provincial Bureau of Women's Empowerment, Child Protection and Family Planning (15 June 2010)
537 Interview with staff of an NGO in Semarang, (15 June 2010)
538 Ibid.
539 Ibid.

Inter-agency coordination and capacity

Coordination and capacity is a key issue at both the provincial and district/municipal level in Central Java given that child welfare has been made a key priority in the province, and new government agencies and CSOs are being created at both levels. However, each tend to focus on a particular aspect of child welfare, whereas often child protection issues (in particular, special protection) need to be viewed holistically across sectors. The creation of new agencies, or new tasks and functions of existing agencies, similar to the case of NTT, has been met with the problems of both field staff and office staff having insufficient capacity and training across sectors to manage service delivery for vulnerable children. They also have insufficient skills in some cases to manage problems with child welfare that are multidimensional and may simultaneously involve aspects of health, education, justice and legal awareness, family support, poverty, and so on. FGD respondents and interviewed agency staff stated that this is a problem in Central Java, not just for government but also for CSOs working with children.

A further problem cited in FGDs with policymakers and practitioners at both the provincial and district/municipal levels of government is the difficulty of dividing up different tasks and functions (tupoksi) related to child protection amongst all the relevant agencies. This was discussed in the case of tackling the pervasive problem of malnutrition in NTT and will not be further elaborated in detail here. Suffice to say that women's empowerment and child protection issues cut across several agencies including the coordinating Bureau at the provincial and district levels, and the Offices of Social Affairs, Manpower and Transmigration, Education, and Health, as well as the government administration and the Bureau of Social Empowerment. The delegation of tasks and functions is defined by the BAPPEDA and is approved by the regional secretary and by a Governor's Decree each year. Difficulties emerge when tasks and functions are transferred between agencies, and their perceptions vary on how to address problems for children living on the streets. There are also problems of agencies competing for authority to secure operational budgets, or replicating the tasks conducted by other offices.[540]

While there is commitment from the provincial government to improving child protection in Central Java, the process of building institutions and programmes is still underway in this province, as with many other provinces in Indonesia. CSOs are either working in partnership with government or supplementing government services while the system strengthens under decentralisation, due to the weaknesses in child (special) protection in practice in Indonesia, as was outlined in Section 3.5. As one respondent put it, despite the commitment at the provincial level to child protection, there is some way to go in achieving impact for women and children:

> "I haven't really seen the impact of child protection programmes in Central Java. Many of these programmes are full of holes, meaning that they have not been wholly implemented. For example, one of the programmes intended to handle children in conflict with the law is not running well. It seems like NGOs actually play more of a role in child protection than the government does. The NGO approach to children living on the streets is much more humane and our actions more direct. For example, NGOs clearly have more activities aimed at reducing sexual exploitation of children and improving the welfare of children with HIV. Even though the current deputy governor has prioritised child protection, NGOs have not really seen a significant change from the policies of the previous deputy governor. Just more of the same.

540 Provincial FGD (14 September 2009); confirmed by staff of the Surakarta Office of Social Affairs, Manpower and Transmigration (23 March 2010)

> "Actually, the number of child protection programmes went down after the passing of the regional law on child protection. The motivation of [the provincial government] to fight for child protection immediately subsided; as if they simply let the ball go after they got it to start rolling. Our NGO is a member of a working group handling children in conflict with the law. The Bureau of Women's Empowerment, Child Protection and Family Planning is meant to lead this working group, but these last few years there has been no coordination with the Bureau. Each institution does its own thing, and the Bureau just lets it happen." (Interview with staff of a local NGO in Semarang that focuses on child protection issues, 15 June 2010)

Coordination between different levels of government and scale of the problem

One of the greatest challenges for the provincial government in Central Java is evidently ensuring inter-agency coordination at the provincial and district levels, and ensuring that the relevant bodies of government give due attention to the ILCP, as discussed in Sections 1 and 3.5 of this report. Staff of the Provincial Office of Social Affairs argued that the provincial government has made some efforts to provide educational programmes for children living on the streets, but that the scale of the problem is beyond their capacity.[541] Geographical scale and population density in some districts have both added to the difficulties of working with some district governments.[542] For example, the provincial government argues that there have been better efforts in Sragen district in tackling the problem of children living on the streets compared to Semarang municipality, which has a much larger population and larger numbers of children living on the streets compared to Sragen. Even in Surakarta where the Child-Friendly City is being piloted, round-ups of children living on the streets are sometimes conducted by the civil service police (Satpol PP) in cooperation with the municipal police, hospitals, and the Office of Social Affairs.[543]

Yet the provincial government argues that district/municipal governments are better placed to deal with local issues and evidence-based policymaking. A staff member of the Provincial BAPPEDA stated:

> "If the policy comes from national and provincial level of government, the city government merely deals with administrative affairs. But if the policy is initiated by the city government, such as in the policy providing scholarships for poor students, the city government will conduct a survey before implementing the policy." (7 September 2009)

4.5.7 INNOVATIONS AT THE DISTRICT/MUNICIPAL LEVEL: THE CHILD-FRIENDLY CITY POLICY IN SURAKARTA

At the district level, efforts to improve child protection in Surakarta municipality demonstrate that with the political will to create a conducive regulatory and policy environment, backed by budget commitments and other initiatives, positive changes are occurring under decentralisation (albeit with the challenges of institutional strengthening and capacity for service provision which have been discussed in the previous case studies).

In beginning to establish the Child-Friendly City in Central Java, the Surakarta municipality hopes to establish best practices in terms of approaches towards children living on the streets in Indonesia. Such a policy indicates that efforts to work towards comprehensive child protection, incorporating appropriate responses and preventive measures, can and do take place in decentralised Indonesia. Surakarta (Solo) was selected as a pilot project for developing a Child-Friendly City in 2006. To implement this policy, Surakarta formed a team responsible for developing an action plan and achievement indicators of the Child-Friendly City in 2008, comprising around 50 institutions, including government agencies and NGOs. These stakeholders were integrated into a cross-institutional forum called the Commission for the Protection of Women and Children (KPPA, Komisi Perlindungan Perempuan dan Anak).[544] One particular responsibility of this team has been to provide an action plan on women's empowerment and child protection as a reference for the Surakarta government agencies, institutions, and NGOs in conducting their activities.[545]

The action plan to implement the Child-Friendly City has recently been established through Mayoral Decision No. 054/08-E/1/2009. As we have seen in previous case studies, the first step under decentralisation to improve child welfare is to establish an appropriate regulatory and policy environment, which requires the political will of local leaders and enactment in local regulations. These steps have been taken in Surakarta municipality. The action plan aims to improve both the regulatory environment and service provision holistically by considering many of the aspects of maternal and child welfare discussed in this report (including health, HIV awareness, education, vulnerability of children living on the streets, and special protection), and by increasing child participation in policy- and decision-making (see Box 4.5.6). In total, approximately IDR 19 billion has been allocated to different agencies for child protection programmes in Surakarta[546], and IDR 1.2 billion was allocated for child protection at the provincial level in 2010 in line with the prioritisation of child protection in the RPJMD.[547]

Box 4.5.6: Surakarta Municipal Action Plan for the Development of a Child-Friendly City

The Surakarta Municipal Action Plan for the Development of a Child-Friendly City (RAK-PKLA, Pengembangan Kota Layak Anak) 2009-2015 is stipulated in Surakarta Mayoral Decision No. 054/08-E/1/2009. The Action Plan covers the following four sectors:

Health:

- Providing health insurance for children
- Issuing regional regulations on building a healthy environment for children
- Specifying a children's health budget allocation in the Surakarta municipal budget
- Increasing quality and quantity of services provided through integrated health posts (posyandu), and of health post staff and health office staff
- Improving health services for expectant and new mothers
- Increasing the number of children under five years of age receiving health services at health posts, health clinics and hospitals
- Increasing the number of babies being exclusively breastfed
- Increasing the number of school-age children receiving health services
- Establishing children's health facilities in health clinics and hospitals
- Improving the provider-recipient ratio in the health sector

541 Interview with government representatives who participated in the provincial FGD (14 September 2009)
542 Ibid.
543 Ibid.
544 Information gathered from the Data and Analysis Section, Child Social Problems Policy, Child Protection Department, Surakarta municipal government (20 August 2009)
545 Ibid.
546 FGD with policymakers in Surakarta municipality (8 September 2009)
547 Interview with the Head of the Provincial Bureau for Women's Empowerment, Child Protection and Family Planning, Central Java (22 February 2010)

- Promoting prevention of HIV and AIDS and drug abuse, and improving access to information on adolescent reproductive health
- Developing a municipal contingency plan for handling health crises after a natural disaster
- Increasing the number of health workers trained in dealing with cases of child abuse in health clinics and hospitals
- Increasing the number of children health workers (PMR, Red Cross for Teenagers), paediatricians, and school health posts
- Issuing regulations on establishing breastfeeding stations in public buildings
- Increasing the number of breastfeeding stations in offices, public buildings and other public spaces
- Issuing regulations on day-care facilities
- Ensuring healthy dietary habits in children
- Conducting monitoring and evaluation of children's health programmes

Education:
- Developing a thorough database of school-age children and school attendance
- Issuing regulation on free compulsory education for children
- Allocating 20 per cent of the provincial budget for children's education
- Increasing access to early childhood education opportunities and facilities
- Providing a security guarantee for children travelling to and from school
- Developing sufficient play areas for children at the village level, and in public service buildings at the municipal level
- Establishing public libraries for children (including use of mobile libraries) at the village level
- Establishing a Museum of Children's Creativity
- Ensuring a learning process that adheres to the principles of PAKEM: Active, Creative, Effective and Enjoyable Learning (Pendidikan Aktif, Kreatif, Efektif dan Menyenangkan)
- Conducting monitoring and evaluation of education programmes

Protection:
- Upholding existing regulations on birth certificates
- Establishing clear mechanisms, guidelines and procedures for issuing birth certificates
- Disseminating information on the free birth certificate programme and increasing the percentage of children with birth certificates
- Improving the scope and quality of services provided through the Integrated Service Unit for Surakarta Women and Children (PTPAS, Pusat Terpadu Perempuan dan Anak Surakarta), training and building capacity of PTPAS staff, coordinating within the Subosukawonosraten region
- Issuing regulations on child protection
- Increasing municipal budget allocations for children's programmes
- Establishing database on children receiving special protection
- Establishing a pool of social workers to work exclusively with children
- Establishing a special service called Women's and Children's Services (PPA, Pelayanan Perempuan dan Anak)
- Establishing a 'Tesa 129' Child Help Line
- Implementing a restorative justice system for children in conflict with the law
- Decreasing the number of children in conflict with the law

- Fulfilling service standards and providing legal protection to children in conflict with the law
- Establishing a rehabilitation system for children in conflict with the law
- Establishing a database on children employed in industries included in the Worst Forms of Child Labour Convention
- Devising an action plan to eradicate violence against children
- Documenting the situation of violence against children, sexual exploitation of children, and child trafficking in Surakarta
- Planning and implementing programmes designed to eradicate sexual exploitation of children and child trafficking in Surakarta
- Establishing a coordination mechanism between technical implementation units, organisations and other institutions focusing on eradicating violence, sexual exploitation and trafficking of children
- Issuing regulations on protection of women and child victims of violence
- Establishing a mechanism for tackling and eradicating child trafficking
- Establishing a database mapping children living on the streets
- Establishing a mechanism for coordination among technical implementation units, organisations and other institutions focusing on children living on the streets
- Planning specific programmes targeting children living on the streets
- Establishing child-friendly and appropriate health and education facilities for children living on the streets
- Developing an integrated system of dealing with the issue of children living on the streets
- Building public facilities for disabled children
- Providing opportunities for disabled children to receive an education suited to their needs
- Providing adequate health services for disabled children
- Establishing a database of abandoned children
- Establishing a mechanism for handling abandoned children
- Building public facilities for abandoned children
- Supervising the management and operation of orphanages
- Developing a periodic report on orphanages and foster homes for abandoned children
- Monitoring the media
- Monitoring and evaluating child protection programmes

Participation:
- Devising a mechanism to include children's participation in the development planning consultation processes (musrenbang)
- Involving children in the musrenbang process at the village and municipal level meetings, especially on matters that directly concern children
- Increasing children's participation rates in Surakarta
- Developing a network of children's forums in Surakarta, involving groups of marginalised children, in all sectors
- Issuing regulations and allocating budget for a children's forum
- Expanding opportunities for children's participation in school, family, community and decision-making

Source: Surakarta Municipal Action Plan for the Development of a Child-Friendly City (RAK-PKLA, Pengembangan Kota Layak Anak) 2009-2015

In addition, the Surakarta Municipal Government, which has the authority under decentralisation to directly implement policies and programmes which cater to local needs, has launched several programmes in child protection to support the Child-Friendly City policy, including:

1. Rehabilitation houses for children and women victims of violence, sexual exploitation, abandonment and human trafficking
2. Child-friendly correctional facilities
3. Child-friendly orphanages
4. Provision of adequate health facilities for children with special needs (disabled children)
5. Support for halfway houses and foster homes

Furthermore, in order to develop Child-Friendly Villages, the local government has sought the commitment of the heads of sub-districts and villages. Starting in 2008, the municipal government included 51 villages in the Child-Friendly Village Programme and, in order to increase commitment, introduced the programme at sub-district and village level through training in participatory approaches to policymaking (i.e., public consultation to identify problems, opportunities and needs) and problem solving, and also appointed local facilitators for programme implementation, monitoring and evaluation.[548]

The discussion under the next subheadings elucidates some of the innovations in policy approaches, as well as the challenges for implementation (in some cases in conjunction with local CSOs) as the institutional environment and service provision capacity strengthens.

4.5.7.1 District/municipal government initiatives supporting the Child-Friendly City: Integrated Service Units for Surakarta Women and Children (PTPAS), and the Family Welfare Consultation Unit (LK3)

To coordinate child protection in Surakarta at the district level, in 2008 the Office of Community Empowerment, Women's Empowerment, Child Protection and Family Planning (BP3AKB, Badan Pemberdayaan Masyarakat Pemberdayaan Perempuan Perlindungan Anak dan Keluarga Berencana) was established. Within this Office sits the Integrated Service Unit for Surakarta Women and Children (PTPAS, Pelayanan Terpadu Perempuan dan Anak Surakarta), which was previously coordinated under the Community Welfare, Women's Empowerment and Family Planning Agency (Dinas Kesejahteraan Rakyat Pemberdayaan Perempuan dan Keluarga Berencana). The Integrated Service Unit is a consortium of several institutions/organisations that work closely on issues related to women and children and provides services for women and children who are victims of violence, in accordance with core functions and responsibilities. This Unit is similar to the Integrated Service Unit at the provincial level, and aims to coordinate law enforcement agencies, NGOs, hospitals, government offices, private sector and community based organisations (see Box 4.5.7).

548 Interview with a staff member of the Office of Community Empowerment, Women's Empowerment, Child Protection and Family Planning, Surakarta (30 June 2010)

Box 4.5.7: Integrated Service Unit for Surakarta Women and Children (PTPAS, Pelayanan Terpadu Perempuan dan Anak Surakarta)

Target: Women and children who are victims of violence

Mission: To empower and provide protection for children who are victims of violence and women who are victims of gender-based violence; to provide optimal medical, counselling, legal and rehabilitation services.

Aims: To strengthen the safety network for women and children who are victims of violence; to simplify administrative procedures for managing these cases; to lobby for a larger government role in protecting and providing services for women and children; and to motivate the public to adopt and support preventive measures against gender-based violence.

Main programmes: Victim care; organisational development; policy advocacy; public awareness campaigns; information management and documentation.

Members: Office of Community Empowerment, Women's Empowerment, Child Protection and Family Planning (Lead Coordinator), Women's Solidarity for Humanity and Human Rights (SPEK-HAM,) and staff of the Bhayangkara Polwil Surakarta Polyclinic, Dr. Moewardi Public Hospital, Surakarta Police, Surakarta Office of Health, Kakak Foundation, Advocacy for Community Transformation (ATMA), Central Java Talenta Lemhanas Aisyiyah Foundation, Social Analysis Research Institute (SARI), Krida Paramita Foundation (YKP), Surakarta Development Planning Agency (BAPPEDA), and Fatayat NU.

Services are provided to victims who come to the Unit directly and to those whose cases are reported to the Unit by community members.

Source: Interview with the Head of Child Protection Unit, in the Office of Community Empowerment, Women's Empowerment, Child Protection and Family Planning, 30 June 2010

To further support children living on the streets and reduce the vulnerabilities they face, the Surakarta Municipal Government is in the process of establishing the Family Welfare Consultation Unit (LK3, Lembaga Konsultasi Kesejahteraan Keluarga), which will sit within the Surakarta Office of Social Affairs, Manpower and Transmigration (Dinsosnakertrans, Dinas Sosial Tenaga Kerja dan Transmigrasi). The Unit will consist of doctors, psychologists, teachers and community leaders. The Office is currently developing this institution as one means of addressing the issue of children living on the streets. In handling children living on the streets, they aim to avoid punitive and abusive approaches (such as raid operations), and instead emphasise a more humane approach in collaboration with halfway houses and foster homes in Surakarta. The city has already established a foster home that houses abandoned and poor children as well as children living on the streets (see subsection 4.5.7.3). A city halfway house is currently being established as at present there is only an NGO that provides this facility (see next subsection 4.5.7.2). As the Head of the Office of Social Affairs, Manpower and Transmigration has explained,

> "Our department also hopes to establish a learning centre - as opposed to a formal school - that enables children living on the streets to remain comfortably within their community and their environment. Skills gathered from the foster home can then be practiced at these centres. Many children living on the streets would simply run away from foster homes because they feel distanced from their community.

"The Family Welfare and Consultation Unit will have a role in providing guidance and counselling to children in halfway houses. In addition, the Unit will make home visits to the parents of children living on the streets. This is important; several cases have demonstrated that children often turn to the street against their own wishes on the request of their parents. Hopefully consultation with the Unit will be able to get to the root of the problem and identify appropriate solutions. For example, if it is found that the primary problem is economic, then the solution will require steps to improve the family's economic conditions." (Interview with Head of the Office of Social Affairs, Surakarta, 23 March 2010)

However, as was stated in the provincial FGDs, the Office of Social Affairs still conducts raids or round-ups of children living on the streets. Some staff members argued that these round-ups are to provide children living on the streets with support.

"Actually, when we do round-ups, we try not to violate children's rights, so we try to strike a balance between maintaining public order and protecting children's rights. In that regard, the Office of Social Affairs has tried to establish the Family Welfare Consultation Unit which involves doctors, psychologists, counsellors, and community leaders who are based in or work with halfway houses to provide services to the children living on the streets [found during the round-ups]. So round-ups are a way of identifying children living on the streets and providing them with holistic support rather than just giving them economic assistance, which is not solving the problem." (Interview with staff of the Surakarta Office of Social Affairs, 25 March 2010)

4.5.7.2 The beginning of service delivery in the Child-Friendly City: Halfway houses in Surakarta

One of the alternative approaches taken by the Government of Indonesia is to provide halfway houses (rumah singgah) in major cities. Halfway houses are intended as places to cater for the needs of children living on the streets. Provisions include non-formal and vocational education for those who left school early, financial support for those who are still in school, supplemental feeding, and small grants for family businesses.[549] In Central Java at present there is one such facility that is specifically aimed at children living on the streets. The Putra Bangsa Child Social Protection House (RPSA Putra Bangsa, Rumah Perlindungan Sosial Anak Putra Bangsa) is run by a local NGO and receives some funding from the municipal government (see Box 4.5.7). The municipal government is also in the process of establishing a halfway house, but at present this is one example of where NGOs or CSOs can take a primary role in child protection in the region.

Box 4.5.7: Halfway house - Putra Bangsa Child Social Protection House

The NGO Lembaga Studi Kemasyarakatan Bina Bakat Surakarta (LSK Bina Bakat) has established a halfway house called the Putra Bangsa Child Social Protection House (RPSA Putra Bangsa, Rumah Perlindungan Sosial Anak Putra Bangsa) in Celolo, in the Kapidiro area of Surakarta. It currently houses 20 children from the streets. The NGO was able to get information on the halfway house to children on the streets by several means: dispatching staff to the streets to identify children living on the streets, disseminating information directly to children living on the streets, and by word of mouth (Getok tular, in Javanese).

At this halfway house, the children who have sought refuge are not given formal education. Instead they are provided life skills training and also psychological and spiritual guidance. The later consists of regular Quran readings at the mosque adjacent to the house. Life skills training sessions take into account both the children's interests and the RPSA's institutional capacity. Children are taught to sew, fix tires, or master basic auto repair. If a particular skill is beyond the NGO's capacity, then the NGO partners with other training providers – especially for auto repair skills. The halfway house also generates funds by operating a kiosk selling rice. This halfway house not only takes in children caught in raid operations but also houses abandoned and poor children. As children living on the streets tend to be more comfortable with a halfway house exclusively catering to children living on the streets, this often causes children living on the streets to feel out of place. Some even run away from the halfway house.

The RPSA Putra Bangsa was established in 2007 on donated property. The benefactor also built a mosque on location. However, the NGO LSK Bina Bakat has worked with children living on the streets since 1995. LSK Bina Bakat works closely with the Surakarta NGO network that includes other institutions such as Kakak, Sari and Spekham, while also working with NGO networks in Brebes, Yogyakarta, Purwokerto and Semarang.

Funding for RPSA Putra Bangsa's operations come from the Office of Social Affairs, donors and other philanthropists. In addition to routine fundraising, LSK Bina Bakat also funds part of its operations from selling rice to a relatively large distribution network. However, the project faces challenges. Currently no government-run halfway houses exist especially for children living on the streets, but LSK Bina Bakat cannot provide enough services for all the children in need.

Source: Interview with staff of Lembaga Studi Kemasyarakatan Bina Bakat Surakarta, 8 June 2010

Halfway houses were first initiated as a pilot project in Indonesia between 1994-1998. Subsequently the programme was scaled up by the Government of Indonesia in 1999-2001 with a US$17 million loan from the ADB through the Social Protection Sector Development Program.[550] However, an evaluation of the national programme conducted in May 2002 revealed several problems in implementation:

1. The halfway house approach largely emphasised service delivery rather than strategies that promoted community participation and prevention.
2. The vocational training programmes had no connection to employment opportunities, while alternative education efforts were based on curricula that had not been field-tested with children living on the streets.
3. The programme had difficulty in promoting community mobilisation or advocacy efforts, and was confronted with issues related to scaling up.
4. In many cases the halfway house had become a 'pull factor' that separated children from their families and communities.
5. The programme had little recognition of the rapid changes in the political and social context brought about by the new decentralised governance system.[551]

549 Save the Children (2005) *Discipline and punishment of children.*

550 Save the Children (2005) *Discipline and punishment of children*
551 Ibid.

Some of these issues are being addressed through the Child-Friendly City policy in Surakarta. For example, the evaluation above points to the importance of providing life and employment skills for children living on the streets, as also highlighted by children themselves in the FGDs. Such a view is also advocated by practitioners working in child protection, as described by one interviewee from the NGO that runs the halfway house:

> "Children living on the streets can be given life skills training as well as psychological and spiritual guidance. Children armed with life skills training are given further support to enable them to become financially independent. Since 2005, there has been increasing emphasis on entrepreneurship training and guidance, with small capital grants made available to parents of children living on the streets since 2005. The LSK Bina Bakat monitors the use of the capital while also making sure that the grant recipient's children return to school. However, some parents simply disappear after receiving the grant. When this happens there is little effort to locate the parents or the children." (Interview with staff of Lembaga Studi Kemasyarakatan Bina Bakat Surakarta, 8 June 2010)

The halfway houses and foster homes aim to improve the employment opportunities and skills of children living on the streets.

4.5.7.3 Establishing holistic services in the Child-Friendly City: Foster homes in Surakarta

As mentioned earlier, children living on the streets have often migrated alone to cities, fleeing poverty, domestic violence or broken homes. Aside from the halfway house described above, the Surakarta Municipal Government has also sought to establish a foster home for poor and abandoned children, as described in Box 4.7.8.

Box 4.7.8: The Pamardi Yoga Surakarta Foster Home

The Pamardi Yoga Surakarta Foster Home houses abandoned and poor children of school age. This home is a Surakarta Municipal Government initiative and the six administrators of the home are government civil servants.

Numerous activities are available at this foster home. Religious activities are held every Thursday night. The home essentially acts as a family unit, providing food, shelter and discipline, as well as a daily allowance of IDR 5,000 per child to cover school transport costs. In ensuring the children's continued education, the foster home works closely with education providers to place the children in schools and skills training courses after graduation and to prepare them for the labour market. To encourage the development of skills in sports and music, the home holds regular band practice, weekly organ classes, and daily soccer and badminton practice. They also partner with local universities - Universitas Negeri Sebelas Maret and Universitas Slamet Riyadi Surakarta - to hold sessions on improving student motivation, English language classes, presenting skills, and tablecloth making.

There are several ways that children find their way into the foster home. Some children are admitted on the basis of information from the sub-district, village or hamlet apparatus. The home confirms this information and seeks parental consent before taking further action. Others are placed into the home after being caught in police-led street raid operations. Children abandoned at child-care centres upon reaching school age are also referred to the foster home.

Children eligible to live in the foster home must be of school age; between 7-18 years. After reaching 18, the home provides the child with capital and skills before returning the child to his or her parents. In the case of orphans, they will remain under the tutelage of the foster home until they are able to support themselves.

The home facilitates entry into the labour market by providing an introduction and reference letter to hiring companies. The department in charge of manpower within the Office of Social Affairs also provides routine and current information on employment opportunities.

Currently there are 28 male foster children, and 22 female foster children at the Pamardi Yoga Foster Home. Eight of the children are in primary school, 14 are in junior secondary school and 28 are in vocational senior secondary school.

The home receives funding from the Surakarta Municipal Government. The yearly budget allocation for 2010 is approximately IDR 622 million, provided in monthly tranches. The home must first submit a budget proposal to the Office of Social Affairs, which will then pass on the proposal to a Budgetary Committee at the Surakarta Parliament (DPRD).

Discipline is important in the foster home. Lights are out by 10 p.m., and 7-9 p.m. is strictly allocated for studies and homework. Children mostly adhere to the home's regulations because there is sufficient adult supervision. A 'foster mother' - in charge of feeding the foster children - lives on site, as does Hamzah, one of the home's managers.

Source: Interview with the manager of Pamardi Yoga, Surakarta, 8 June 2010

4.5.7.4 New approaches in Surakarta?: The Corrections Office

To assist children in conflict with the law, the Surakarta Office of Law and Human Rights established a rehabilitation institution called the Corrections Office (BAPAS, Balai Pemasyarakatan). This institution provides assistance to both adults and children in conflict with the law, with an emphasis on rehabilitation. While the Office has existed since 1974, under the Child-Friendly City initiative it aims to provide better services for children as previously few people knew about or used its services.[552] The Corrections Office is expected to provide representatives and other free legal assistance for children facing trial. However, its facilities are not being optimally used, as few people know about its existence.[553] Beginning in 2009, the Office has begun to advertise its services on the internet.[554] The Office provides community guidance and vocational, mental, social and religious guidance, in cooperation with other institutions such as vocational training centres and state prisons.[555] For children already incarcerated, the challenge is to assist them upon release in finding employment that utilises the skills they received from training schemes run within penitentiaries.[556]

The Corrections Office has also set up a task force for handling cases of children in conflict with the law, and to find alternatives to incarceration, in the form of a partnership with the police, the Office of the Prosecution and the courts (see Box 4.5.9).

552 Interview with the Section Head of Child Client Rehabilitation, BAPAS Surakarta (30 June 2010)
553 Ibid.
554 Ibid.
555 Interview with staff of the Surakarta Corrections Office (8 September 2009)
556 Ibid.

Box 4.5.9: The Corrections Office (BAPAS, Balai Pemasyarakatan)

The Corrections Office is tasked with providing assistance for adults and children tried in a court of law. The staff comprises salaried civil servants who function as advocates for their clients, free of charge.

In assisting children in conflict with the law, the Office partners with the police, the Office of the Prosecution and the court judges. Children are usually referred to the Office by the police. The Office's first task is to gather information on the background and chronology of the case. This involves interviewing the client, conducting research and interviewing community members in the client's neighbourhood, and establishing the client's family and social background.

The information gathered will help determine the severity of the case and the child's legal options. The three most common scenarios are: (1) If the child has committed a minor violation, the Office aims to facilitate the return of the child to his or her parents and solve the problem through negotiation processes outside the courtroom; (2) If a major violation has occurred but the child is still in school, the child will be given a suspended sentence and placed on probation; or (3) If the child is a repeat offender then the child will be given a jail sentence - in this case their guardianship will be transferred to the state if his or her parents are not willing to be responsible for their child, or if the community is not willing to accept the child's return to society.

Source: Interview with the Head of Child Clients Section, Surakarta Corrections Office, 30 June 2010

Aside from the services provided by the Corrections Office, the Surakarta municipal Police Department has also established a Service Unit for Women and Children (PPA, Pelayanan Perempuan dan Anak). The Unit provides special services to children in conflict with the law, limited to additional investigations, the results of which are submitted to the Office of the Prosecution. The police also monitor court rulings to make sure that the court makes the best interest of the child its first priority. However, this policy only applies to cases of theft and involves religious and community leaders in seeking alternatives to prosecution. It does not apply to cases of substance abuse, 'immoral behaviour', or cases of severe assault and battery.[557]

Many of the initiatives outlined earlier under the Child-Friendly City policy in Surakarta are in the process of either being established or strengthened, so it is likely too early to tell how effective these interventions are in terms of child welfare and protection. At a minimum, they are shifting the approach to children living on the streets towards one of protection, service, empowerment, and meeting their basic needs, rather than criminalisation. However, given all of the challenges and weaknesses in child (special) protection outlined in Section 3.5 (such as monitoring and the regulation of alternative care), it is important that the initiatives are monitored in the coming years, not only to ascertain whether they are having impact but also to ensure that the principles of the ILCP (outlined in Sections 1 and 3.5) are being upheld.

557 Interview with the Surakarta Metropolitan Police (8 September 2009)

4.5.8 OTHER ISSUES IN THE DEVELOPMENT PLANNING PROCESS FOR CHILD PROTECTION

4.5.8.1 Children's voices in the development planning process in Surakarta

The legislated development planning process explained in Section 4.1 involves: community consultation through deliberative musrenbang forums at the village, sub-district, district and provincial levels; priority-setting among sectoral agencies and other government offices and bodies at the district and provincial levels; the formulation of strategic plans and work-plans at the provincial and district levels overall and within district/provincial level government agencies; budgeting; and negotiation with, and securing approval from, district and provincial parliaments. The discussion in the case of health and malnutrition in NTT (Section 4.2) identified a number of challenges in development policymaking at the district/municipal level that required additional efforts to strengthen the capacity of district governments to deliver services and thereby improve the welfare of children. The challenges evident from the fieldwork on child protection and policies towards children living on the streets in Central Java were similar, and are therefore only briefly discussed here.

First, in particular at the district/municipal level, the fieldwork revealed that, similar to NTT, there was a tendency for district level government agencies to dominate the development planning process. One study highlighted that it was difficult for community members and practitioners to participate in the consultative development planning (musrenbang) processes in places such as Wonosobo district, as there is inadequate information about development programming at the district level.[558] The study found that lower levels of government had to conform to higher level government visions, missions and priorities. If village level proposals from village level musrenbang were not in line with existing priorities they were often ignored in higher level musrenbang.

Similarly, FGD participants in the study in Brebes district said that even though budget planning processes had begun at the village and sub-district level musrenbang, the finalisation of the budget by the budget committee in the District BAPPEDA, where the district work-plan is formulated, did not include many of the lower level priorities.

Furthermore, the study by Sutoro Eko (2007) on the musrenbang in Central Java identified other problems that impede the effectiveness of musrenbang, including poor understanding of sectoral issues at the village level and the lack of ability to articulate village needs in a way that highlights their importance in the view of higher level authorities.

Surakarta District BAPPEDA staff explained that the difficulties of achieving the objective of accommodating community inputs in budget formulation processes are partly due to their capacity to communicate budget processes to communities and CSOs.

> "Every proposal needs to be rationally explained in detail to the budget team. While all elements of the community should be involved in, say, dealing with health problems by providing suggestions, safeguards and supervision, and NGOs should provide input and data, the problem is that it is incredibly difficult to explain budget items and processes to people." (Interview with staff of BAPPEDA, 8 September 2009)

558 Eko, S. (2007) 'Desentralisasi dan demokrasi desa', cited in: BAPPENAS (2007) *Pro-poor planning and budgeting project (P3B): Mid-term progress report 2007*, BAPPENAS: Jakarta, available at: http://p3b.bappenas.go.id/docs/March%202007%20Report.pdf (Last accessed 23 February 2010)

At the same time, an FGD participant observed that in the sub-district level musrenbang,

> "[It is] more like a public speaking competition between District BAPPEDA staff, sectoral office staff, and representatives from the parliament, rather than an in-depth discussion about common programme priorities." (FGD participant, 8 September 2009)

Another challenge is late submission of proposals from sectoral agencies.[559] Even when child welfare programmes make it into the district level priorities, work-plans and budgets, at times these are not ratified by local parliaments, which also have their own list of priorities. For instance, the Surakarta Office of Social Affairs, Manpower and Transmigration, in the 2008 budget year, proposed a budget for tackling the problem of child workers, but it was not approved.[560]

As was stated previously, Surakarta has begun the process of creating child forums to better accommodate children's voices in policymaking, many members of these child forums participated in the FGDs for this research. This is an important first step in child-friendly policymaking. Child forums have been formed at the municipal, sub-district and village levels beginning in 2006 in Surakarta. Child forums have been established in 18 districts in Central Java, involving children aged 14-16 years old. Child forums also exist in seven wards and villages in Surakarta, and since 2009 they have participated in musrenbang at each level.[561]

However, partly because the process of involving children in such forums is still new, CSO members and children themselves in the FGDs argued that the public forums are still dominated by top-down priorities and government voices rather than those of children or practitioners working on child (special) protection issues on a daily basis. The evidence from the FGDs and interviews conducted and presented in this case study on Central Java (and in the previous case studies), suggests that children are acutely aware of the problems that they themselves and other children face and that in many cases they have useful ideas on priority-setting and suggestions for effective interventions. Hence, there is considerable scope for further commitment, creating initiatives, and improving facilitation at higher-level musrenbang and in government planning processes to ensure that children's voices are heard and prioritised. This is also supported by the ILCP and in other instruments as a basic child right. As one practitioner working in child protection stated:

> "In practice, the participation of children in the musrenbang is only a formality. Children's voices are listened to in the village musrenbang, but in the higher level musrenbang, most of the proposals containing children's aspirations are rejected in favour of sectoral agency interests." (8 September 2009)

4.5.8.2 Budgets for child protection

The budget for child (special) protection in Indonesia relates to a wider spectrum of activities than the way child protection is conceptualised internationally, and includes education, health and other aspects of child welfare. As stated previously, the commitment of both the Surakarta Municipal Government and the Central Java Provincial Government has increased with the prioritisation of child protection in regional development plans. For example, the budget at the provincial level increased from IDR 838 million in 2009 to IDR 1.2 million in 2010. However, interviews and FGDs with government staff working on the various aspects of child protection showed that many are of the opinion that even with such increases, the budgets are insufficient.

559 Interview with staff of BAPPEDA (8 September 2009)
560 Interview with staff of the Surakarta Office of Social Affairs, Manpower and Transmigration (8 September 2009)
561 Interview with staff of the Office of Data and Analysis of Child-Related Social Policy, and of the Child Protection Sector, Surakarta Municipality (31 August 2009)

The main reasons given were that budgets are shared across technical units, offices and agencies that have the primary tasks and functions for child protection (broadly defined). At the provincial level, the Bureau of Community Empowerment, Women's Empowerment, Child Protection and Family Planning gets 10 per cent, with the remaining 90 per cent being spread across different agencies. Staff from the Bureau stated that with the budget year beginning in January, by February 30 per cent of its budget had been spent and programmes were likely to be scaled back as a consequence.[562] Similar problems existed at the municipal level.

4.5.9 SUMMARY CONCLUSION: CHILD (SPECIAL) PROTECTION FOR CHILDREN LIVING ON THE STREETS IN CENTRAL JAVA

The case of Central Java illustrates both the innovations and challenges under decentralisation for addressing child (special) protection in relation to children living on the streets. Both provincial level initiatives and the Child-Friendly City pilot project in Surakarta demonstrate that important steps are being made to improve child welfare for some of Indonesia's most vulnerable children. Initiatives include providing alternative care, foster homes, housing, life skills, oversight, legal aid for children in conflict with the law, and a changing approach from one of punitive action against children living on the streets to one of assistance and protection. Decentralisation has allowed for district/municipal governments to adopt locally relevant policies to specific problems in each region. This has required the political will and budgetary commitments of both the provincial and local level governments and the creation of a supporting regulatory framework for the initiatives, in particular at the district/municipal level, to begin implementation of the initiatives.

However, similar to the findings from the other case studies in this section, CSOs continue to fill the void in government service provision and further efforts need to be made in relation to:

1) Coordination between agencies/bodies of government and between levels of government;
2) Coordination between government and CSOs, and greater involvement of CSOs in priority-setting and policy formulation;
3) Capacity building of technical and administrative government staff, particularly at the district/municipal level;
4) Increased budgets;
5) Involving women and children in policy formulation, particularly through the musrenbang; and
6) Support for families vulnerable to shocks, and other initiatives to prevent children living on the streets.

562 Interview with staff of the Surakarta Bureau (22 February 2010)

4.6
THE VOICES OF CHILDREN

4.6.1 INTRODUCTION

The previous sections have discussed the changing institutional environment in Indonesia, the trends over the past decade in poverty levels, education, and indicators of human development, maternal and child welfare, health, nutrition, water and sanitation, HIV and AIDS, adolescent health, and child (special) protection. They have highlighted aggregate improvements as well as persistent disparities - for the poor, for women, between urban and rural areas - and the national and local level policies introduced to try and address these challenges. The previous sections have underlined the importance of pro-poor growth and working towards achieving MDGs with equity. They have also explored the sub-national context and the innovations from policymakers and practitioners to improve child welfare and to overcome the challenges under decentralisation across the disparate provinces of the archipelago. Disparities also exist at the sub-national level between districts, regions and socio-economic groups. It is evident that there has been growing attention to child welfare over the past decade in Indonesia. At the sub-national level, under decentralisation, there are ongoing efforts to provide better local level services in the contexts where children live, and to strengthen the institutional environments within which children, families and communities function. However, while some mention has been made of the experience of children directly, as yet the holistic experience of children has not been explored to ascertain how they themselves respond to the challenges they face, and what they consider to be important aspects of their own welfare.

Much of the analysis so far has been conducted with a sectoral lens (such as from the perspective of education or health). Yet, the discussion in this subsection demonstrates that young people do not experience health problems, educational problems and others separately, nor do they seek out ways of linking these things together. They experience them in a single context, as a multidimensional series of life encounters. In most of the previous sections of this report, we have seen short life histories of children presented. These include the case of Budi the scavenger presented in Section 2 who was suffering from both poverty and low education (and a multitude of other problems) but was resisting returning to school for a variety of reasons and preferred to eke out a living sorting through rubbish. As described in Section 3.5, Pram was living on the streets in Papua, but for a range of reasons to do with childhood domestic abuse and residual anger at his father, he did not want to return home to where his mother lived even though his father was no longer present. Slamet, as explained in Section 3.4, had special needs, but wanted to participate in mainstream education and believed that this would be of benefit to children with special learning needs such as his. Mawar was poor and attended non-formal education in NTT while working long hours with her mother, and chose not to attend school on those days when teachers known for hitting children would be present (Section 4.2). In each case, the children's experience was presented as they described it, and in each case the children exercised a level of agency or choice in responding to the challenges they faced. They also had larger goals, aims and dreams that went beyond the vulnerabilities that were emphasised in the brief case histories.

4.6.2 POSITIVE APPROACHES TO ADOLESCENT AND CHILD DEVELOPMENT

Positive approaches to adolescent development espouse a positive youth development model based on what Edberg (2009) describes in a UNICEF report as:

> "[A]n understanding that adolescence is a diverse developmental period in which youth interact with biological change within a multi-layered, ecological web of self and self-definition, and family, peer, social, societal and institutional relationships - a person-context relationship."[563]

Children are resilient in challenging situations. Blum (1998) explores a positive view of children based on 'resilience theory' - i.e., what underpins the capacity for young people to survive the stresses and strains of that developmental period:

> "Social learning is central to self-efficacy. The social milieu is also central to the development of an internalized locus of control. Specifically, a person comes to see himself or herself as powerful (e.g., having an impact on the environment and/or those around) through behaviors that elicit or fail to elicit response from the environment. Without environmental response, there is no feedback, no acknowledgment of the individual, and no experience of having an impact. It is through interactions with the environment and the associated feedback that children receive that they come to realize that they can affect their environment."[564]

While the work of Edberg and Blum has applied to young people in relatively stable conditions, the cases explored in this and previous sections of this SITAN demonstrate that young people in Indonesia can be active agents in their own development, designing pathways through what are often unstable environments. Furthermore, using a positive approach to adolescent development, Guerra and Bradshaw (2008[565]) have identified five core competencies of young people:

1. Positive sense of self (or a sense of 'agency')
2. Self-control (or resistance to external influences)
3. Decision-making skills (capacity for situation analysis and independent judgement)
4. A moral system of belief (e.g., taking others into consideration)
5. Pro-social connectedness (capacity to build and retain positive relationships)

This set of competencies and capabilities[566] can be extended in many ways. For example, two attributes that are prominent in the life narratives discussed previously and below are personal courage and social responsibility. These can be operationalised in programmatic terms - in the form of school/informal curriculum, professional training courses, practitioner guidelines and standards, all focused on a 'well-being' agenda (again, favouring a 'capabilities' approach based on qualitative indicators). Drawing from the experiences of the children's cases described in this report, the analysis demonstrates that adolescence, even for the most vulnerable children, is a period of experimentation and reflection as a basis for constructing functional identities and life strategies (i.e., adults frequently misinterpret these experiments as 'risky' or 'pathogenic' behaviours).[567] Such analysis can also be extended to younger children. In the narratives in this SITAN, young people expose themselves to risk - for example, by leaving home, by striking an adult, or by smoking - in a way that may appear to the adult to be a 'problem', but which, to the young person may be a 'solution' to a problem. The operational question is not how to 'eliminate' poor solutions, but how to improve and optimise problem-solving capacity and ultimately how to protect children from having to cope with such challenges in the first place.

563 Edberg, M. (2009) *UNICEF Latin America/Caribbean (Adolescent) wellbeing indicators*, UNICEF/TACRO: Panama
564 Blum, R. W. (1998) 'Healthy youth development as a model for youth health promotion: A review', *Journal of Adolescent Health*, Vol.22(5): 368-375
565 Guerra, N. G. and Bradshaw, C. P. (2008) 'Linking the prevention of problem behaviors and positive youth development: Core competencies for positive youth development and risk prevention', *New Directions for Child and Adolescent Development*, Vol.8(2): 1-17
566 Nussbaum, M. C. and Sen, A. (Eds.) (1993) *The quality of life*, Clarendon Press: Oxford
567 Walker B. M. and Kushner S. (1999) 'The building site: An educational approach to masculine identity', *Journal of Youth Studies*, Vol.2(1): 45-58

4.6.3 CHILD NARRATIVES

The narratives presented in this SITAN are not necessarily 'exotic' or atypical. One young person discussed in the case of Papua was a child forced into sex work, another lives on the street, another is a tsunami-orphan, and another is a child labourer. However, these children are far more than that. Mawar, for example is more than a child-labourer - she is an ambitious young woman, a daughter, and someone who prioritises education and learning. Siska and Pram, who happen to live on the street, are no less complete individuals with ambitions, vulnerabilities, fears and accomplishments as are Joko and Siti discussed in the Boxes in this subsection (all names changed), who have family, homes and attend school.

Box 4.6.1: Siti

Siti is 17 years old. She lost her parents when the tsunami struck Aceh in December 2004. She came from a typical wealthy family, with a big house, housemaids and drivers. It was Sunday, she remembers, when a very high wave came in from the sea wiping out Lhokseumawe City. During the chaos her mother told her to run away from home to escape from the tsunami. She ran, following villagers to higher ground to safety, leaving her mother behind. When it was safe to return home, she found the body of her mother at the house. Her father and sister were missing and their bodies were never found. She was alone and miserable. This was a turning point in her life. She says she went from being a happy child in a wealthy family, to a lonely child struggling to find her destiny and trying unsuccessfully to return to her previous life which she says remains elusive.

Following the provision of humanitarian assistance, Siti found herself in the military barracks with other survivors. Her grandmother on her paternal side who also lived in Lhokseumawe found her in the barracks and took Siti to live with her. Siti says both her grandmothers are very mean to her; very different from her mother. She feels alone and misses her mother very much.

"I was not given an inheritance by my dad. Before the tsunami, my grandma was not as mean as she is now, she was good then. After the tsunami, she became so mean to

me, mad. Because I don't have any parents anymore, I don't feel respected. Both my grandmothers make trouble and want to look after me because they want my inheritance from my dad. After I finished junior secondary school, my dad's mum moved me to Banda Aceh [the capital of Aceh Province] to live with my other grandmother."

After the tsunami, Siti was very upset as her life was not as easy as it once was. She says she doesn't have pocket money or the love and care of her immediate family. She feels she can't rely on anyone to support her anymore. She gets a pension fund from the government because her father held an important position in the civil service, but she doesn't get the money herself; instead it is handled by her grandmother.

"My grandmother handles the inheritance. It makes me frustrated because she never gives me any money. When we moved to Banda Aceh, it turned out that my dad's pension would also be held by my other grandmother. In fact it makes me grumpy because my grandmother tries to have such tight control over me. She said to me, 'If there wasn't an inheritance, there would be no future for Siti here'. But I don't care when my grandmother is angry, I just go into my room and shut the door. Even though I don't feel at home there, I think its better to live at my grandmother's than at an orphanage."

Siti says she is stressed and has turned into what people usually call a 'naughty girl'. She has stolen from friends to get more money for herself.

"I often walk the streets, never go home. I hang out with my peers, and annoy people. If anyone does the wrong thing, we 'thump' them. I started smoking when I was in junior secondary school. One of my friends is a street kid who said to me, 'You should try smoking so you don't get depressed'. Now I am addicted. None of my family knows. Drinking, smoking: that's for when I leave the house."

Siti was traumatized after the tsunami and doesn't want to be teased at school for being a tsunami victim, so she never mentions it to her friends.

"Nobody at senior secondary school knows my father and mother passed away. When the school report comes out, I asked aunty to get it. When in Year 2 at this school, someone realised that I don't have parents. I was traumatized when I was in junior secondary school because my friends often teased me about not having parents."

On one occasion, in Year 3 of junior secondary school, because Siti was naughty she was slapped by her teacher. But she slapped her teacher back, saying, "Why do you enjoy slapping me? You have no right to do so!" She was put into counselling by the school for striking back at the teacher and was forced to pay a fine of IDR 150,000 to the teacher.

When she moved in with her grandmother who was mean to her, she started smoking to relieve the stress, like her friends told her. Then she moved to live with her other grandmother from her mother's side in the city of Banda Aceh, who was also mean to her, and she continued smoking, which she says helps relieve the stress. Many other adolescents in the adolescent survey conducted by the University of Indonesia discussed in Section 3.3 also have taken up smoking 'to relieve the stress'. Once Siti also tried cannabis with her friend.

Then she met Mary, her friend who was also a tsunami victim, who Siti perceives to be a 'naughty girl'. Mary sometimes gets paid for sex and has already slept with more than 10 men. Mary always tries to persuade Siti to be like her and has introduced her to some boys, but Siti is resolute: she says she doesn't want to be like Mary.

Siti also says that she is forced to wear the hijab in Aceh because of shariah law, which stipulates that women must wear it. Her grandma in Banda Aceh is very religious, so Siti always wears Muslim garb. But she wears her skirts at home, and once she is at her friends' houses she changes into trousers.

Source: Child interview conducted by PSKK, UGM in Aceh, 2009; Siti is not his real name

4.6.3.1 Understanding Siti's story

In Siti's journey of adolescence, she has not only faced extraordinary events, she has been influenced by adults in both positive and negative ways. The adult world has provided her with resources that shape her life and her values, but it has not defined or limited those values. From understanding Siti's story it is evident that young people - even when cast out of a stable world into chaos - find their own solutions and are capable of shaping their own moral learning. She actively shapes her own value system and often has to manage high levels of complexity - sometimes getting it right, sometimes not. For example:

- Siti learned rapidly to manage unpredictable relationships with family (both grandmothers sought to exploit her financially - but also cared for her). The relationship between herself as a rights-holder, and her grandparents as duty-bearers was confused. She was left to resolve the confusion - and did so by staying away from the home.
- At certain points in her life Siti conducted experiments - sometimes accepting the results (smoking cigarettes, robbing other kids), other times rejecting the results (payment for sex). What adults easily label as 'problems' (e.g., smoking, stealing, violence), the young person often sees as either solutions (e.g., cigarettes help to relieve stress) or learning encounters (e.g., experimenting with marijuana).
- Young people can sometimes show greater wisdom and understanding than the adults close to them. When her teacher slapped her Siti slapped her back - asserting her maturity and independence - but she also asked the teacher why she had done what she did. Similarly, she continues to live with her grandmothers even though they control her and her inheritance unfairly, recognising that this is still preferable to living in an orphanage.
- Siti learned through practical experience how material values and morality interact in complex ways. Her grandmothers wanted control of her inheritance in exchange for caring for her; her conflict with the teacher was resolved by paying a fine.
- Young people are known to construct their own informal decision-making communities - irrespective of what schools and family offer them. Here it is evident that Siti is doing just that. Her decision-making community includes Mary and other friends, her grandmothers, and even the memory of her mother, which gives her the moral strength to persevere.

What is evident in the case of Siti is more complex than behavioural changes of an average child over time; it is also the development of a value system that underpins these behaviours.

Box 4.6.2: Joko

Joko is eight years old and the only son of a couple who are traditional wedding-dress makers and farmers in Central Java. He is in Year 3 of primary school and enjoys going to school by bicycle, playing and helping his parents do domestic chores. In the mornings, he prepares for school, takes a bath, eats his breakfast and helps his mother with the housework. On returning from school, he eats and takes a nap if he is tired. After that, Joko said that he helps his mother to wash dishes and sometimes helps his father washing motorcycles and bicycles. He takes a rest while watching television in the afternoons, enjoying cartoon programmes like Tom and Jerry, Upin and Ipin, and Tarzan. At 4 p.m., he feeds the domestic chickens. Later, he takes another bath and studies for a while until finally he goes to sleep at 8 p.m. with his mother.

By the time he was in Year 3 of primary school, he says he was able to do his own laundry. When he was in Year 2 of primary school, he was already playing at the river with his friends, Yudi and Wahyu. He swims naked in the river so as not to get his clothes wet, as one time when they got wet his mum hit him with a wooden stick, and he then had to wash his clothes by himself. Sometimes he does the housework without being asked. Sometimes when he is asked, he says he is not available, and runs outside to play if his mum tries to smack him.

Joko sometimes tends the fire for cooking. Sometimes his mother does. Joko sleeps with his mother in the bedroom and asks her to massage him if he gets tired, which she does, Joko says because she loves him. His father, he says, also loves him because he gives him pocket money (IDR 5,000), and never hits him. According to Joko, his relationship with his parents is quite good. Joko feels closer to his father than his mother. Joko wants to be loved and never to be hit again. However, he feels that his mother gives him the most attention. Joko says he uses IDR 1,500 every day from his pocket money to buy ice. He saves the rest, and sometimes even asks for money from his grandparents.

Joko's hobby is football, and he plays with friends from 3-4 p.m. He loves rearing domestic chickens and attending cock fights with his friends. He has two chickens, and one that died. Sometimes he used to throw stones at them. Living in a village, Joko rarely goes to big cities like Solo, Semarang or Jakarta. "I love travelling by train, though, and looking at the scenery," he said.

When asked about school, Joko says he has to work harder to achieve first rank. The hardest lesson for him at school is Maths and Islam studies because he doesn't understand how to do them. Joko doesn't like to study at the Quran Education Centre. His mother sometimes threatens him that he won't get his pocket money if he doesn't go, but Joko has decided not to attend anymore. "I don't care if I don't have the pocket money as long as I don't have to go, I can't. The Arabic letters are so hard", he said, so he has dropped out and prefers to study the Quran at home with his father.

Joko is often annoyed by his friend, Zaenal, who hides Joko's books so he can cheat and copy Joko's homework. "I was really angry, I wanted to beat him. It's bad to hit people though, it's cruel. So I chose peace," he said.

Joko wants to buy a mobile phone, has saved IDR 350,000, but some of his money has been spent on buying an iron and helping his mum with costs to renovate their home, he explained.

He is very keen to give his mum money up to IDR 750,000 to help her do the renovations and has promised to mop the floor if they have two stories. He also wants to buy a car, a television and a mobile phone with a camera.

His father is not a smoker, but Joko often sees his friends smoke. Joko understands that smoking can cause heart disease and lung disease. He doesn't smoke because he doesn't want to get sick. Also, he has seen people drunk in the neighbourhood, and tells of how neighbours have stolen televisions and been caught and beaten by the neighbours who caught them.

Source: Child interview conducted by PSKK, UGM in Central Java, 2009; Joko is not his real name

4.6.3.2 Understanding Joko's story

Joko, like Siti has undergone a journey in his own development - but his is at home. He is only eight years old, an only son, living in a family in which adults give him full attention. His context is stable, and he has peers, neighbours and school nearby. Facilities are equally accessible: playground, river, domestic chickens and the yard. His life looks uncomplicated - in many ways it is. But no less than Siti, Joko has learned through observation to shape his personal agency. For example:

- As a small child, Joko learned to 'engineer' good relationships with family. Although his mother treated him 'bad' and punished him, he defined this as showing her love for him. The relationship between Joko as a rights-holder and his parents as duty-bearers was clear to him.
- The adult world has given him a resource in shaping his own moral journey - his capacity to choose what he deems to be bad or good. For example, his experience tells him that his father is a better person than his mother because he never hits him.
- Joko learned through practical experience how material values and morality interact in complex ways - his obsession with money mediates some of his family relationships.
- Joko's navigation through the confusion of physical violence and its links to affection lead him to sometimes conduct his own experiments with violence. He has copied corporal punishment as a recreation - throwing stones at his chickens. He was angry enough at his friend for hiding his books to want to hit him - but reflected that hitting is cruel, so he chose to maintain the peace with his friend.
- He is strong enough to assert himself in important and sensitive areas of life. He prefers to study Arabic and the Quran at home with his father rather than attending the Quran Education Centre. He is even willing to forego his top priority - pocket money - as the punishment for not attending.
- Joko shows a strong sense of social responsibility. Though he places a high value on the personal accumulation of money, he is happy to contribute to renovation of the house. One of his ambitions is to join the police force to work for social justice, an ambition fuelled by watching local drunks, and the beating of a thief by neighbours who caught him. As with Siti, the street is a classroom for moral education.
- Joko is an independent decision-maker, working from direct observation. He sees his friends and neighbours smoking but decides not to do so himself.

4.6.4 COMMONALITIES IN CHILDHOOD DEVELOPMENT

There are common threads running through these narratives and those presented in other sections. The five competencies of Guerra and Bradshaw (2008)[568] in varying stages of development are evident in the development of these children. Though the situations these young people face are often tragic or dangerous, there are consistent patterns of positive attributes and dispositions. There is evidence of personal commitment and courage, resilience, moral awareness, independent judgement, social responsibility and more. Prominent in the lives of these young people are:

- Home and family (these are not always the same thing)
- Street-level experience
- School as an element of the problem (not always the solution)
- Friendship and peer groups
- 'Intermediary infrastructure' (e.g., 'recovery' NGOs)
- Self as independent agent

One of the implications of this analysis is to avoid the tendency to portray adolescence as a problematic cycle, to see children only from the perspective of their vulnerabilities, as being easily attracted to antisocial behaviours, and to consider these a source of social failure. There is a growing commitment to a more positive view of young people and their capacities. Edberg (2009) in his review of adolescent research advocates a 'positive view' of young people and their agency, with

> "a focus more on protective rather than risk factors, with resulting programs concentrating more on enhancing protective factors and less on mitigating risk factors...using the terminology resilience for these protective qualities."[569]

The draft UNICEF global strategy for adolescents proposes that "Positive adolescent development must be approached as a growth of competencies and not only as an avoidance of problems and risks." The focus, that is, shifts to a view of young people that identifies both their vulnerabilities and their strengths or problem-solving capabilities, and collaborates with them in making these more effective, while providing supportive infrastructure.

What emerges from these children's and adolescents' stories, supported by indications from the adolescent survey results discussed in Section 3, is that:

- Young people, even as young as eight years old, or in the most stressful and unstable circumstances, have an overwhelming capacity to develop moral judgement and live by it - i.e., young people are not only taught morality, they learn it.
- Young people solve their own problems - mostly with peers - even though their solutions are not always optimal. Adults and institutions may be a resource in a young person's search for solutions, but they are not always the determinants of solutions.
- Young people may fail school, but school (perhaps more specifically, the curriculum or the teachers) often fails young people.
- Even where the family is a stable and disciplined social unit, the young person makes their own sense of it and envelopes it within their own system of autonomous values.
- Young people may find themselves in conflict with the law and authority, but the law and authority also find themselves in conflict with young people.

4.6.5 POLICY IMPLICATIONS

"Immaturity designates a positive force or ability, the power to grow...Growth is not something done to [children]. It is something they do." (John Dewey, Democracy and Education, 1916)[570]

1. The definition of 'duty-bearer' is unstable, and a duty-bearer's relationship to a rights-holder can be complex. It may be the young person who has to make sense of that relationship and even manage it on behalf of the duty-bearer. Interventions can be fashioned around supporting young people to accomplish this.

568 Guerra, N. G. and Bradshaw, C. P. (2008) 'Linking the prevention of problem behaviors and positive youth development'

569 Edberg, M. (2009) *UNICEF Latin America/Caribbean (Adolescent) wellbeing indicators*

2. What is a ‘problem’ for adults may be a ‘solution’ for young people - or a learning experience. We need not approve of ‘poor’ solutions (e.g., smoking) but can acknowledge them and support young people in discovering better solutions and learning well from their experimentation.
3. School curriculum should have a prominent element of critical reflection on young people’s experience, and should serve as an access point to a supportive infrastructure for young people.
4. At school we should see children as active agents of rights, not merely an audience to receive knowledge. They are active agents in shaping their own lives and making life choices. Young people in classrooms are not ‘preparing’ to become citizens; they are citizens in their own right.
5. Children need resources in order to grow. A range of resources, including family and community (moral, social, economic, etc.), should be available to support children’s healthy growth.

570 Dewey, J. (1916) *Democracy and education, Macmillan: NY*

SECTION 5:

POLICY RECOMMENDATIONS

INTRODUCTION

Based on the findings in this SITAN, the following recommendations are relevant for the Government of Indonesia (GoI), international and local donor agencies, and other key stakeholders concerned with improving child rights and welfare. In some, cases the recommendations are specific for particular stakeholders, and in others they are recommended for all parties.

In general this SITAN recommends that the national and local governments directly implement many of the proposals presented here. For donors and other key stakeholders, this SITAN recommends that support be provided for the GoI at the national and local levels to implement these recommendations, including through targeted direct implementation in cases where the GoI requires such assistance. This may be important in some sectors or regions facing particular challenges to improving child rights and welfare.

Given limited resources, the size of Indonesia, and the new decentralised framework, to improve child rights and welfare across the country ideally donors, in particular UNICEF, would assist the government in building the institutional framework and technical capacity to deliver policies, guidelines, services and programmes. This is in line with UNICEF's priority of scaling up its activities and supporting institution strengthening and capacity building. It is also in line with the GoI's priorities as stated in the National Programme for Indonesian Children (PNBAI) and the Government's National Medium-Term Development Plan (RPJMN) 2010-2014, which state the GoI's aim for a developed and inclusive Indonesia that ensures a sustainable and high quality of life for its entire population.

The recommendations presented here aim to support the Jakarta Commitment to strengthening government ownership of development programmes while ensuring a coordinated approach among its development partners. They also aim to contribute to the three United Nations Development Assistance Framework (UNDAF) focus areas that correspond to the main findings, namely: (a) addressing inequity; (b) enhancing participation; and (c) strengthening resilience.

There are 10 key recommendations presented in these SITAN policy recommendations. Recommendations 7, 8 and 9 are a series of sub-recommendations based on the findings in this SITAN.

5.1 SUMMARY OF THE 10 RECOMMENDATIONS FROM THIS SITAN

Recommendation 1: Harmonising the national and local level legal framework

Recommendation 2: Mainstreaming the Indonesian Law on Child Protection and other legislation related to child rights and welfare and promoting compliance in national and local regulations, guidelines and policies

Recommendation 3: Improving evidence-based policymaking - Reducing data deficiencies

Recommendation 4: Improving evidenced-based policymaking and monitoring - Strengthening knowledge management, data collection and analysis systems at the national and local levels

Recommendation 5: Improving evidenced-based policymaking - Producing biennial thematic SITAN of women and children and other key public documents

Recommendation 6: Establishing a comprehensive National Child (Special) Protection System to uphold and monitor child rights and welfare as mandated by the Indonesian Law on Child Protection

Recommendation 7: Promoting equitable development for women and children - Targeting interventions on worst performers to improve poverty reduction and pro-poor growth, and reach the MDGs with equity

Recommendation 8: Strengthening the decentralised system through local level capacity building and support in development planning processes - Improving consultative planning processes, regulations, policy formulation, programme design and service delivery to be pro-child and pro-women

Recommendation 9: Advocating the scale up of specific sectoral interventions to improve child rights and welfare and reduce inequity

Recommendation 10: Communications for development to assist with knowledge building and behavioural change to support other targeted interventions and improve the situation of women and children in Indonesia

5.1.1 RECOMMENDATION 1: HARMONISING THE NATIONAL AND LOCAL LEVEL LEGAL FRAMEWORK IN RELATION TO CHILD RIGHTS AND WELFARE

Recommended for: GoI with the support of UNICEF and international agencies

As a part of the GoI's current commitment to pro-child policymaking and continued efforts to improve the situation of women and children in Indonesia, this SITAN recommends:

- Ratifying the Optional Protocols in the UN Convention on the Elimination of Discrimination against Women (CEDAW) and the UN Convention of the Rights of the Child (CRC). This would further strengthen Indonesia's efforts over the past 10 years to institutionalise the human rights and child rights legal frameworks and policy platforms in the country.
- Together with the Indonesian Ministry of Home Affairs, reviewing provincial and district/ municipal regulations, decrees and other instruments to ensure that they are in line with national level laws (especially the Indonesian Law on Child Protection, ILCP), regulations, technical guidelines and the Indonesian constitution.
- Harmonizing the laws related to the age of children across the Marriage Law, the Health Law, the Citizenship Law, the ILCP, and other relevant laws, to ensure that the rights of all young people are protected and they have adequate access to special protection, health (including reproductive health) services, and other age-appropriate services. Ensure that these laws are also harmonised by gender (i.e., the Marriage Law has different legal ages for marriage).
- Monitoring the compliance of national and local level regulations and policies with key laws on child rights, in particular the ILCP.

5.2
RECOMMENDATION 2: MAINSTREAMING THE INDONESIAN LAW ON CHILD PROTECTION AND OTHER LEGISLATION RELATED TO CHILD RIGHTS AND WELFARE AND PROMOTING COMPLIANCE IN NATIONAL AND LOCAL REGULATIONS, GUIDELINES AND POLICIES

Recommended for: GoI together with UNICEF and other key stakeholders

The findings of this SITAN indicate that some of the violations of child rights are related to insufficient knowledge, in particular of the ILCP, Law No. 23/2002. The ILCP needs to be further mainstreamed and explained to all stakeholders, including the national and local governments (executive, legislative and judicial branches) to better feed into policy formulation, and to civil society (civil society organisations, academia, community and religious leaders, and political parties) to support policy implementation. As stated previously, child protection in Indonesia is understood more widely to include rights to education, health, legal aid, and other mechanisms, as compared with the UNICEF definition of child protection, which incorporates vulnerabilities to violence, trafficking, labour, prostitution, and other similar aspects, which are defined as 'special protection' in Indonesia.

Further efforts to mainstream the ILCP are required in order to strengthen capacity to administer the ILCP and resulting policies, directives, regulations, guidelines and services, which at present is uneven across Indonesia's provinces and districts. Mainstreaming should be undertaken through the initiatives outlined later in Recommendation 10 on Communications for development with government bodies, non-government organisations (NGOs) and civil society organisations (CSOs). This should further be expanded to include all levels of society, including families, schools and children in general. This could serve as a key role for both the Ministry of Women's Empowerment and Child Protection and the corresponding local Bureaus which are mandated to coordinate initiatives, conduct mainstreaming and knowledge dissemination, and to monitor activities. The Ministry and local Bureaus could also work with the Ministry of Home Affairs to monitor compliance with local level regulations and policies.

The successful interventions and establishment of child protection policies and services identified in the case studies in this SITAN involved, for example in the Child-Friendly City project in Surakarta, the political will of leaders in the executive and legislative branches of government to prioritise child protection in policies, budgets and regulations, and to establish inter-departmental initiatives and the steps towards establishing provincial and district level Bureaus of Women's Empowerment and Child Protection. Encouraging sharing between districts and provinces on these initiatives as a part of the mainstreaming process, and creating other incentives for compliance, are the necessary steps for creating the political will to improve child rights and welfare in the decentralised context.

Furthermore, creating such political will should be a dual process of providing the technical support for musrenbang processes (discussed in Recommendation 8) so that bottom-up demands for child-friendly policies and specific interventions reach the ears of local leadership, while top-down education on understanding and translating national policies on child protection, together with research and other information, would also be part of the mainstreaming process.

5.3
RECOMMENDATION 3: IMPROVING EVIDENCE-BASED POLICYMAKING - REDUCING DATA DEFICIENCIES

Recommended for: GoI with support of UNICEF and other stakeholders

It is clear from the process of formulating the SITAN that there are weaknesses in the systematic collection of data on child welfare and rights. Uniform data and clear definitions are essential for monitoring the gaps, performance and impact of programmes in each sector related to child welfare. It is also important for understanding the holistic situation of children and the multi-sectoral linkages; that is, how one vulnerability in the situation of a child may relate to other vulnerabilities. For example, how better nutrition may improve other outcomes in child welfare, such as reductions in mortality rates or better performance and attendance at school, and how better school attendance may lead to better knowledge of safe-sex practices and reduced rates of sexually transmitted infections (STIs), including HIV infection.

The discussion in Section 3 highlighted that data related to child protection - as defined by UNICEF and other international agencies concerned with child welfare - is particularly weak. In Indonesia, child protection is defined broadly in laws and regulations as well as the Medium- and Long-Term National Development Plans, and includes, for example, aspects of health and education. Other aspects of protecting child welfare, such as safeguarding children from domestic and other forms of violence, trafficking, forced migration, incarceration, etc., fall under the banner of 'special protection' in legal and policy instruments related to children. Hence, many of the data deficiencies in Indonesia exist in terms of 'special protection' for children.

There are data in some provinces and districts on certain aspects of special protection as well as in other sectors such as education, health and nutrition, water and sanitation, and the prevalence of HIV and AIDS. However, these data are not always systematically collected by the government or related agencies at both the national level and sub-national level, using the consistent definitions, or over time. For instance, the definitions and indicators used to define aspects of special protection in the small number of ad hoc studies conducted (mainly case studies) vary considerably. In some, 'violence' is limited to physical violence only, while in others it

includes aspects of psychological violence and neglect. As discussed in Section 3, when broader definitions are used they cannot always be disaggregated to in order to compare similar subsets of data with earlier studies, making it difficult to draw an accurate picture of the changes taking place over time.

In spite of this, this SITAN pieced together, from disparate data sources, a picture of the trends in key indicators of child welfare in Indonesia. It has shown that in many sectors there have been aggregate improvements, while identifying other sectors that require continued attention. This SITAN has also begun the process of trying to identify whether there are inequities between population groups in these improvements. Gaps in the available data have made it difficult to consistently identify both the sources of vulnerabilities and the populations most at risk. It has also been difficult to ascertain whether the interventions and policies introduced have improved the welfare of women and children over time, and how or under what circumstances international and local agencies can provide support for the GoI in its efforts to alleviate child suffering.

Nonetheless, this SITAN has demonstrated that despite improvements in those indicators for which data are available, inequalities still exist, particularly for the poor. It is therefore likely that equitable development will be one of the key issues in the future as Indonesia continues to makes progress towards achieving the Millennium Development Goals (MDGs), improving economic growth and reducing poverty. Therefore, data will be essential for future evidence-based policymaking that aims to understand the sources of inequality and inequity and the types of populations that may be lagging behind, to ensure the appropriate targeting of the poor, women and different populations of children. Comparisons need to be made between regions (urban/rural, provincial, district, sub-district and even villages) and groups within society (income, age, gender, religious, ethnic and other identities) by policymakers, government agencies and practitioners.

In line with the UNICEF Mid-Term Strategic Plan, this SITAN recommends that UNICEF and other agencies support the GoI at the local and national levels to conduct further research and data collection related to education and early childhood development (ECD); health, nutrition, water and sanitation; HIV and AIDS and the situation of adolescents; and, most importantly, child (special) protection and other aspects of child welfare more generally. The specific data gaps identified in the process of compiling this SITAN include data over time using standardised definitions on the following (this is not an exhaustive list):

Child (special) protection
- Child poverty (both income and non-income poverty)
- The hidden employment of children in informal sectors, which may result from forced migration such as trafficking, and domestic internment, etc.
- Numbers, handling, and past/current living conditions for:
  - children in pre-trial and post-trial detention and children in conflict with the law
  - children in contact with the law as victims and witnesses
  - orphaned children
  - children involved in pornography
  - children living on the streets
  - trafficked children
  - children forced into sex work
  - children and young people using drugs
  - children and young people living with HIV and AIDS
  - percentage of AIDS orphans (in high prevalence provinces)
  - displaced children
  - children of migrants
  - children migrating alone
  - children with special needs
  - children involved in the most hazardous forms of labour
  - children working illegally
  - child domestic workers
  - children experiencing violence at home
  - children experiencing violence at school
  - neglected children
- The provision and quality of care in alternative care institutions and the numbers of children in institutional care
- Unregistered births
- Child and women victims of domestic violence
  - types of violence
  - conditions in the home
  - likely causes
- Data deficiencies

Health, nutrition, water and sanitation
- Maternal mortality rates at the provincial level
- UN process indicators of emergency obstetric and neonatal care services
- Treatment coverage of diarrhoea with oral rehydration salts and zinc for children under five
- Treatment coverage of pneumonia with antibiotics for children under five
- Nationwide and provincial data of annual parasite incidence (malaria)
- Costing of health interventions at district level for financing and budgeting
- Exclusive breastfeeding practices and complementary feeding at the sub-national level
- Stunting, wasting and underweight rates over time
- Access to clean water and adequate sanitation using Joint Monitoring Programme (JMP) measurement methods

Education

Data issues for education are as much about accuracy of data as as about data gaps. Better quality data using standardised definitions[1], particularly at the sub-national level, are needed on:
- ECD education facilities (type, quality, access) and enrolment/attendance
- Gross and net primary school, junior and senior secondary school enrolment ratios (gender)
- Completion rates of primary school (Years 1-9)
- Early school leaving rates
- Last school year completed
- Transition rates from primary to junior secondary school
- Numbers of internet users, phone users

More research is needed on:
- 'Access to issues' among vulnerable and disadvantaged groups (i.e., applying the 'access to justice' approach to the education sector)

1 UNICEF (n.d.) Definitions - Education, available at: http://www.unicef.org/infobycountry/stats_popup5.html (Last accessed 17 March 2011)

HIV and AIDS

Need to expand and disaggregate existing indicators on HIV and AIDS by age cohort (10-14, 15-19, 20-24 years), especially for indicators on:

- Most-at-risk (MAR) adolescents, especially vulnerable adolescents
- Prevention of mother-to-child transmission (PMTCT)
- Protection

Examples of other kinds of data needed (not exhaustive)

- PMTCT and paediatric treatment:
  - o estimated number of HIV-positive pregnant women
  - o estimated percentage of HIV-positive pregnant women who received antiretroviral therapy (ART) for PMTCT
  - o estimated number of children (0-14 years) living with HIV
  - o number of children (0-14 years) receiving ART
  - o percentage of pregnant women who were tested for HIV and who know their results
  - o percentage of infants born to HIV-positive mothers who are infected
  - o percentage of infants born to HIV-positive mothers who received an HIV test within 12 months
  - Prevention:
  - o HIV prevalence among young people (15-24 years)
  - o percentage of young people (15-24 years) who have comprehensive knowledge of HIV
  - o percentage of sexually active young women and men aged 15-24 years who received an HIV test in the last 12 months and who know their results
  - o percentage of young people (15-24 years) who had sex with more than one partner in the last 12 months
  - o percentage of young people (15-24 years) with multiple partners and who used a condom at last sex
  - o percentage of young people (15-19 years) who had sex before age 15

Additional research is needed on:

- Youth vulnerability to HIV and AIDS (including sexual behaviours), MAR adolescents, especially vulnerable adolescents
- Socio-economic assessment of affected households and type of assistance received in terms of free basic external support
- Level of HIV sensitivity of social welfare schemes

Youth

- Onset of puberty and its consequences in terms of mobility, schooling and marriage
- Youth living arrangements
- Schooling experience
- Time use, mobility and social networks
- Transition to marriage, including the degree of choice in timing of marriage and selection of spouse
- Sexual activity and the context in which it occurs
- Economic status and livelihood opportunities
- Participation and membership in social and civic groups

Given that UNICEF and the GoI both place priority on working towards achieving the MDGs with equity, this requires the ability to monitor progress along regional and sub-population lines. Data should therefore be collected so that it can be disaggregated by:

- Province
- District
- Sub-district and village (at the local level)
- Urban/rural location
- Household income/expenditure
- Education
- Gender
- Age
- Religion
- Ethnicity (and customary groups)

There are some indications that discriminatory practices and inequalities exist in some districts in terms of access to services or resources along religious and ethnic lines, particularly in what were previously conflict areas, which also impacts on migration and displacement.[2] These inequalities may be differently experienced by women and children. Therefore, it is suggested that data be collected in a way that can be disaggregated by religious and ethnic group, as well as by age and gender.

5.4
RECOMMENDATION 4: IMPROVING EVIDENCE-BASED POLICYMAKING - PRODUCING BIENNIAL THEMATIC SITAN OF WOMEN AND CHILDREN AND OTHER KEY PUBLIC DOCUMENTS

Recommended for: UNICEF with the support of GoI

The rapid social, economic and political changes that Indonesia has experienced over the last 10 years indicate that the situation of women and children in Indonesia, particularly in the decentralised context, is rapidly changing. It has not been possible to examine all of these changes and their impact on the situation of women and children, every aspect of the progress made in terms of child rights, or every gap in welfare and access in detail in this SITAN. This is why, in addition to national trends, only four provinces were examined in one key sector each.

In order to maximise the utility of this information and explore new phenomena, gaps, behavioural and institutional changes, and so on, this SITAN recommends conducting biennial thematic SITAN and compiling other key public documents using data from smaller studies. Conducting SITAN every two years is recommended since data collection and analysis in a context as large as Indonesia is both time consuming and resource intensive. Particular thematic areas that would complement the findings of this SITAN are:

- Child (special) protection with a focus on juvenile justice, sexual exploitation, protecting women and children from violence and abuse, and the situation of migrant and displaced children, to form a holistic child protection and monitoring system.
- The well-being of young people given the emerging demographic window.
- Inequalities and safeguarding against discrimination along gender, religious, ethnic and income lines.

2 See for example: Diprose, R. (2009) 'Decentralisation, horizontal inequalities, and conflict management in Indonesia', in: Brown, G. and Diprose, R. *Ethnopolitics*. Vol.8(1): 107-134; Stewart, F. (Ed.) (2008) *Horizontal Inequalities and Conflict*, Palgrave Macmillan: Basingstoke

- Urban areas, and the situation in Indonesia's growing number of slums.
- The impact of climate change on child welfare.
- Access to education in general and for children with special needs in particular; incorporating perceptions of the barriers to and disincentives for continuing education and the problem of violence in schools.
- Issues related to young people, i.e., young people in urban and peri-urban environments[3], as well as youth-centreed research and knowledge generation, including cost analysis to highlight financial consequences of policy options.

5.5 RECOMMENDATION 5: STRENGTHENING KNOWLEDGE MANAGEMENT, DATA COLLECTION AND ANALYSIS SYSTEMS AT THE NATIONAL AND LOCAL LEVELS

Recommended for: National and local level GoI, with the support of UNICEF and other donors

In addition to Recommendations 3 and 4 above, this SITAN recommends creating an integrated (multi-sectoral) child welfare and rights information system at the national and local levels in the form of 'Knowledge Centres for Children' (KCC). Such KCCs are essential for evidenced-based advocacy and for the planning and formulation of targeted interventions based on particular vulnerabilities and in particular regions. The establishment of KCCs will result in new and ongoing data collection and analysis.

This would involve:

- Strengthening data collection at the local level and creating databases on key aspects of child welfare using standardised definitions and feeding these into a national knowledge management system.
- Establishing data collection and management systems where they are absent in districts/provinces, and training both government staff, practitioners and in some cases the community, in data collection, understanding definitions and monitoring changes over time.
- Improving collaboration and coordination between different levels of government.
- In some cases, new data collection and research through surveys and other methods where there is an absence of data.
- Establishing best practices in analysing data and producing timely reports.
- Strengthening coordination between the national and local levels on child (special) protection data collection (surveillance), storage and processing.
- Using the information system and other avenues to improve enforcement of the ILCP.
- Potentially establishing a think tank focussed on gender issues.

For some aspects of child welfare, this would include building or strengthening community based monitoring systems in:

- Education, i.e.:
  - (i) to identify accurately all eligible children (whether enrolled or not) in a school area;
  - (ii) to identify the concentration of children in a particular area and their enrolment distribution (to determine whether additional schools are needed, and whether there are barriers to accessing education, i.e., geographical remoteness), and to identify children with special needs; and
  - (iii) to use information generated to monitor irregular attendance and assign schools/teachers to follow-up enrolment and attendance issues.
- MDG achievement along quintiles of wealth, etc.
- Mortality rates, causes of deaths, practices in nutrition.

A KCC would require donor support on the request of the GoI, for sectoral offices at the district, provincial and national levels to promote skill building in website development, data analysis and report production, and knowledge dissemination practices, so that relevant information will be readily available to key stakeholders, and to ensure that the same sets of information are used in policy development, programming and monitoring.

There are some data collection and monitoring pilot projects, such as:

- The UNICEF-sponsored ASIA programme for monitoring MDG progress at the district and sub-district levels.
- The Community Based Education Information System (CBEIS), which has been adopted by the Minister of National Education as an integral part of the GoI's Education Monitoring System (EMIS); the Maternal and Child Health (MNCH) model on Local Area Monitoring and Tracking (LAMAT) system, which is now being scaled up in collaboration with the Ministry of Health.

These programmes could be scaled up from pilots to other districts/provinces or extended across sectors.

At the national and local levels, KCCs would require cross-sectoral coordination committees made up of focal point personnel from each sectoral ministry/agency/office as well as cross-cutting units like the Bureau of Women's Empowerment and Child Protection. Each focal point would be responsible for ensuring that new practices in data collection and analysis are implemented at the relevant sectoral agencies and units at the national and local levels. At the national level, the coordinating committee would also be responsible for formulating guidelines on data collection, analysis and reporting, and for ensuring that these are disseminated to sub-national governments. It would be essential that data and reports are produced in a timely fashion prior to compilation of annual, medium-term, and long-term work-plans, strategies, and policy frameworks at the national and local levels.

It would also be useful if such KCCs would work with local government offices/agencies to monitor the results of local strategic plans, action plans, policies and programmes, to improve monitoring of impact. Furthermore, involving local universities in this process would ensure that new ideas are shared between government and non-government stakeholders and that there is consistency in the definitions of indicators used.

Aside from UNICEF and other donors supporting the set-up, scale up and capacity building of such KCCs, they would also need to provide technical assistance in data collection and analysis as deemed necessary, in partnership with the national and local governments. They could also provide support to the national government in formulating national level guidelines for data

3 Close attention needs to be given to the differences between the social and economic circumstances of urban and rural areas. In cities and towns, key educational and health resources are more readily available than in rural villages. But it is far from obvious that young people - especially those who are poor - are in a position to take advantage of these urban resources and opportunities. For the urban poor, school enrolment rates are well below those of wealthier urban residents. In multiple dimensions of health, the urban poor hardly fare better than rural villagers. The social risks of city life may jeopardize both poor young people and those who are better off, as indicated by higher urban rates of HIV and AIDS.

collection and analysis, and to local governments in interpreting and enacting such guidelines. Furthermore, they could provide targeted assistance in particular districts for establishing or strengthening local level KCCs.

5.6 RECOMMENDATION 6: ESTABLISHING A COMPREHENSIVE NATIONAL CHILD (SPECIAL) PROTECTION SYSTEM TO UPHOLD AND MONITOR CHILD RIGHTS AND WELFARE AS MANDATED BY THE INDONESIAN LAW ON CHILD PROTECTION

Recommended for: National and local level GoI, with the support of UNICEF and other donors

Since signing of the CRC in 1990, Indonesia has acknowledged that all children are subject to their evolving capacities, and are therefore in need of special safeguards and care, and are entitled to certain fundamental rights. By ratifying the CRC through a Presidential Decree[4] and by ratifying the ILCP, which upholds many of the principles of the CRC, Indonesia has made a legally binding commitment to respect, promote and fulfil children's social, economic, cultural, civil and political rights. This requires the creation of an environment where all girls and boys are free from violence, exploitation, abuse, neglect, inappropriate judicial responses and unnecessary separation from their families.

While this SITAN has demonstrated that in general the situation for Indonesian children has considerably improved, particularly related to access to health and education, yet tangible gains for child protection are not keeping pace with progress in other areas.

The findings from Section 3, based on the limited data available on child (special) protection and data from the study on adolescents conducted by the University of Indonesia, highlight that children continue to face grave protection violations, such as sexual exploitation and abuse, neglect, detention as a first response, the worst forms of child labour, trafficking, corporal punishment, unnecessary institutionalisation, and violence in their homes, schools and communities. Such violations have persisted over time, despite ongoing efforts. The case study of children living on the streets in Central Java also indicates that despite the improvements and interventions, the mistreatment of children in public institutions (often based on insufficient knowledge of child rights and alternative non-violent methods of punishment or incarceration) continues to take place and may exist in other regions not covered in this study. Furthermore, information from Save the Children indicates that there is an absence of an accreditation system and monitoring of the treatment of children in alternative care institutions. There may also be synergies between treatment in the home, at school, and in the larger community, creating multiple-vulnerabilities for children, which may affect educational attainment, health and nutritional status, and longer-term development through adolescence and into adulthood. In addition, while the ILCP defines children as including babies in the womb through adolescents until they reach the age of 18 years, there are some contradictions in terms between this law and the marriage, citizenship and labour laws, in which the age range for childhood varies.

4 Although Recommendation 1 in this SITAN argues that it should also be ratified by the national parliament

Global analysis, clear evidence and systematic practices in many developed countries demonstrate that it is indeed possible to establish effective strategies to address child (special) protection violations. Many child (special) protection systems in other countries have proven to be more cost effective and of greater benefit to the diverse range of child (special) protection concerns, in contrast to development approaches that have focused on individual problems or specific child (special) protection issues. Thus, the global evolving strategic approach to child (special) protection concentrates on developing comprehensive national child (special) protection systems.
An effective national child (special) protection system would strengthen the protective environment to safeguard children against all forms of abuse, exploitation, neglect and violence, and should consist of three interlocking components:

1. A holistic social welfare system for children and families
2. The justice system
3. An integrated social behaviour change component

Such systems and components should be structured in a way that both prevents and responds to all child (special) protection concerns in an integrated manner. Thus, the national child (special) protection system should prevent violations from happening and protect children in all situations regardless of the nature of the violation or the context in which it occurs, including in emergencies, conflicts, and in periods of transition. The work of the national child (special) protection system should include the promotion of attitudes, beliefs, values and behaviours that support children's well-being and protection, and affirm children's human rights, as set forth in the ILCP, the CRC and its Optional Protocols, and other international instruments.

In order to promote a comprehensive systematic approach to child (special) protection, consideration of the following is encouraged, in addition to harmonising the legal and policy framework (see Recommendation 1), and mainstreaming the understanding and implementation of laws, policies and procedures relating to child rights (see Recommendation 2).

5.6.1 SERVICE DELIVERY

Social welfare and justice systems, structures and services are the 'who' and the 'what' of the national child (special) protection system. These structures refer to the organisation of institutions, including the different ministries, departments and agencies, as well as their mandates, lines of accountability, responsibilities, capacities (human, financial and infrastructure), and services provided, including for children, and the supporting, monitoring and coordinating bodies. Social welfare and justice structures support different strategies, including prevention of, response to and mitigation of child (special) protection violations.

Social welfare systems for children and families should be mandated in law to ensure that child rights to protection are fulfilled by those who have a role in their direct care, welfare, and protection and by those with a role in ensuring guidance and justice for children. Actors in the social welfare systems are accorded the authority and responsibility to undertake actions to prevent, respond to and mitigate the impact of any significant harm occurring to children, whether by their parents or relatives, other children, individuals, groups of individuals, or by officers of the state itself, such as teachers, police officers, and government institutional care providers. Social welfare systems within a national child (special) protection system should prevent and respond to such violations, in all situations regardless of the nature of the violation, or the context in which it occurs, including in emergencies, conflicts and periods of transition.

The social welfare system should provide a continuum of services from prevention to response through comprehensive primary, secondary and tertiary services. Studies have demonstrated that Indonesia has made good progress in developing tertiary services for children who have experienced various violations of child (special) protection, while secondary services are inadequate. Critical to child (special) protection in Indonesia is the continued development of the resilience of the family, through social work functions with vulnerable families and the strategic use of social cash transfers to decrease a family's vulnerability to various shocks.

This situation analysis is recommending a particular focus on the role of the Ministry of Social Affairs, which is responsible for many aspects of social welfare, and the local Offices of Social Affairs, as well as the Ministry of Women's Empowerment and Child Protection (and local level Bureaus), which are also responsible for monitoring and coordinating many aspects of child (special) protection policymaking. It also recommends a focus on the role of a professional and well-trained cadre of social workers. As such, the policy recommendations include:

- Set up comprehensive secondary services to ensure early identification and preventive services to children and families at risk.
- Develop a strategic vision and a long-term costed action plan to define the role of social workers in a broader, comprehensive child (special) protection system at national and sub-national levels, capable of providing a continuum of services from prevention to response. This plan should prioritize the following:
  - Ensure a cadre of professional holistic social workers, with numbers meeting an internationally accepted population ratio (the paid employment of para- professional social workers can be explored as a cost effective means to reach larger populations).
  - Ensure that recent graduates are well equipped with effective social work skills that promote family care and build family resilience to withstand various shocks through working with social work training colleges (Ministry of Social Affairs) and with state and private universities.
  - Develop appropriate in-service training agendas to upgrade the skills of existing social workers.
  - Review existing social welfare legislation and policies to ensure a solid legal framework of support for the emerging strategic role of social workers.
  - Work with the Ministry of Women's Empowerment and Child Protection and similar local level Bureaus in coordinating other cross-cutting initiatives and referrals of children to local Offices of Social Affairs and relevant service providers, as well as monitoring systems.
- Continue to undertake reforms related to justice for children to ensure adequate complementary efforts supportive of the social welfare role in preventing and responding to child (special) protection violations with appropriate coordination and linkages.

5.6.2 PREVENTION/BEHAVIOUR CHANGE

Changing negative attitudes, beliefs and behaviours that violate child rights is a central concern in the process of building a national child (special) protection system. Social, cultural and behaviour change is an inherent part of life, whereby knowledge, values and practices are continuously shifting, and have a direct impact on individuals, communities, organisations, institutions and society. The behaviour of individuals, groups and institutions is largely based on the views, attitudes, demands and practices that promote and permit, sanction and constrain what is acceptable and unacceptable behaviour. Therefore, where the legal framework and policies change, and social welfare and justice systems act to prevent, respond to and mitigate the impact of child (special) protection violations or deficits, a critical feature of a national child (special) protection systems approach must be to affect behavioural, institutional and societal change to promote and ensure child rights to protection, care, welfare and justice.

Strategies and approaches by social welfare systems would involve reinforcing those behaviours and actions that are in the best interests of children, as well as changing those behaviours and corresponding actions that people believe will benefit children, but which are actually damaging to both children and society, such as corporal punishment and the placement of children in inappropriate forms of care.

Poverty is often viewed as an underlying cause of violence against, and exploitation and abuse of children. While recognizing that violence, exploitation and abuse know no economic boundaries and that child (special) protection applies to children across all economic strata, nevertheless, reducing some of the unique vulnerabilities caused by poverty will reduce violence, exploitation and abuse for a large number of children. Therefore a critical cornerstone of child (special) protection includes building the resilience of families to cope with various shocks and stress. This would include case management as appropriate, good parenting skills, alternatives to physical discipline methods and access to social cash transfers, amongst other interventions. The following efforts are recommended:

- Develop comprehensive prevention campaigns using proven techniques to change behaviour at community and household levels, as well as a national level campaign with creative use of the mass media.
- Build resilience of vulnerable families to cope with stress and shocks through improved parenting programmes and access to social cash transfers, among other interventions and initiatives.
- Examine the role of social cash transfers to reduce some of the poverty-related causes of child abuse, exploitation and violence in order to more effectively target such programmes.
- Ensure effective linkages among professional social workers, para-professional social workers and prevention campaigns and interventions.
- Improve the enforcement Indonesia's various pieces of protective legislation.
- Improve monitoring and cross-agency collaboration to ensure the sharing of information on vulnerable children (both individuals and groups).

5.7 RECOMMENDATION 7: PROMOTING EQUITABLE DEVELOPMENT FOR WOMEN AND CHILDREN - TARGETING INTERVENTIONS ON WORST PERFORMERS TO IMPROVE POVERTY REDUCTION AND PRO-POOR GROWTH, AND REACH THE MDGS WITH EQUITY

Recommended for: National and local level GoI, UNICEF and other stakeholders

It is clear from Sections 2 and 3 of this report, on the national and provincial indicators of economic growth, poverty levels, human development, health and nutrition, water and sanitation, and child rights and welfare, that Indonesia has made extensive progress in improving the situation of households and individuals the past 10 years, and is on track to achieving some of the MDGs. Such achievements are notable given the extraordinary political, economic and fiscal

overhaul that the country has experienced since the end of the last century - a decade marked by multiple crises both political and economic. Such improvements in the last decade have no doubt contributed to Indonesia's recent achievement of 'lower-middle income' status in terms of the global rankings. The targeted interventions to protect children, particularly in terms of basic education and health (through social safety net programmes and conditional and other cash transfers to offset rising fuel and rice prices) no doubt lessened the impact of both the Asian financial crisis and the global financial crisis.

5.7.1 MDGs PROGRESS REQUIRING SPECIAL ATTENTION

However, at an aggregate level, several MDGs, particularly in terms of health and nutrition and water and sanitation, require special attention and extensive efforts to improve child welfare. Selected MDGs requiring the particular attention of agencies working in child welfare include:

- Maternal mortality rates (off track)
- Infant mortality rates per 1,000 births (when progress is compared to a 2000 baseline, it is clear this indicator needs special attention)
- Rates of children under five with severe malnutrition (needs special attention to reach MDG)
- Assisted births by trained health-care workers (needs special attention to reach MDG)
- Number of females (15-49 years) using birth control (needs special attention to reach MDG)
- HIV and AIDS infection rates (off track)
- Proportion of people with access to piped drinking water (needs special attention to reach MDG)

5.7.2 DISPARITIES

Despite improvements on an aggregate level, particularly in terms of education, some health and nutrition and water and sanitation outcomes, and the various initiatives outlined in this SITAN, yet the impacts have been uneven and wide disparities remain among provinces as well as among districts, and between urban and rural areas, income groups, men and women, girls and boys, and potentially other identity groupings such as ethnicity, which are difficult to analyse due to lack of disaggregated data.

In terms of provincial disparities, the indicators relating to women's and children's welfare in some areas are at similar levels to some of the poorest countries in the world and are particularly low in comparison to neighbouring Asian countries. For example, Indonesia's national maternal mortality rate, based on 2007 data, is worse than the rate in the Philippines, Sri Lanka, Bangladesh, Malaysia and Thailand, and the rates for certain eastern provinces like East Nusa Tenggara (NTT) and Papua are substantially worse than the national average.

Based on the findings in Section 3, several (but not all) disaster- and conflict-affected provinces still have significant gains to make on some indicators if they are to reach the MDGs, as do many of the newly formed provinces, especially those located in eastern Indonesia (in particular Papua, NTT and NTB). In Section 3, newly formed provinces such as West Sulawesi, Gorontalo and Jambi repeatedly featured as the worst performers on key indicators, as did the conflict-affected provinces of Maluku, Papua and Central Sulawesi. The problems associated with rural poverty, informal sector employment and poor access to water and sanitation were also problematic in more densely populated provinces, such as Central Java.

Given the geographic size and large populations of some of these provinces (in many cases larger than small countries in Asia and Africa), interventions on the part of national and local governments, as well as international and local non-government agencies concerned with child welfare, need to continue to strive to ensure that efforts to stimulate growth, alleviate poverty (both income and non-income poverty), and improve child welfare also include initiatives to reduce inequalities and improve equity between groups and regions Indonesia. This is also in line with the UNICEF's objective of achieving the MDGs with equity in its new policy directives. Using the Human Rights Based Approach to Development (HRBAD) that has been adopted by most UN agencies provides a useful approach with which to focus interventions and efforts on improving child welfare amongst the most vulnerable and disadvantaged groups and regions.

Regional and inter-group inequity in Indonesia is particularly prevalent in terms of:

- Health and nutrition (disease, maternal and infant mortality rates, nutrition status, food security, access to medical services and trained medical personnel, hygiene through access to clean water and adequate sanitation, and risk of HIV infection, amongst others).
- Education (particularly ECD, junior secondary school education, transition rates and early school leaving rates).
- Child protection (although the absence of data makes it difficult to ascertain where the greatest vulnerabilities exist, and what local factors may account for greater levels of violence in the home and other risks).
- Likelihood of disaster affectedness.
- Vulnerability to the spread of HIV and AIDS.

Disparities exist with regard to:

- Geographic location (provinces, districts, etc.)
- Population group - The focus of this report is on the following dimensions since large disparities are associated with each:
  - Economic status
  - Gender
  - Age
  - Rural/urban location

This SITAN has not explored disparities between ethnic, religious, and other identity groupings due to the absence of data. Socio-economic differences and marginalisation or discrimination may occur along such identity group lines. Other research (Stewart, 2008) has demonstrated that belonging to politically or economically marginalised groups (particularly politically sensitive identities) can affect access to public services and other resources that may have otherwise improved the welfare of group members. This includes the resources which may improve child welfare such as health, education, clean water and sanitation, legal aid, child welfare officers, and so on. It can also increase the likelihood of conflict. Religious, ethnic, customary and other identity groups may be concentrated in geographically isolated areas and this may affect access, or political tensions and power divides may also impact on how resources are allocated, in turn affecting child welfare. Therefore, this SITAN recommends the collection of data and further analysis of where such disparities may exist, followed by design of targeted interventions to address these.

As is evident from the more in-depth case studies of four provinces in Section 4, even in those provinces that are performing better overall in terms of the main province-level indicators (such

as Central Java), substantial inter-district disparities also exist. This SITAN therefore recommends that:

- If government or other agencies are working in provinces that are performing better overall in terms of national indicators of child welfare, then situation analyses should be undertaken to examine inter-district and group disparities in these areas, as well as the policy innovations and challenges which may enhance or constrain improvements. Efforts to improve child rights and welfare should then be focused on the worst performing regions and groups (see Section 3 for inter-provincial disparities on particular indicators, and Section 4 for inter-district disparities in education in Aceh, in health and nutrition in NTT, in HIV and AIDS prevalence in Papua, and the associated problems of rural poverty and resulting child migration in Central Java).
- If government or other agencies target the worst performing provinces overall, they should be aware that inter-district and inter-group disparities are still likely to be present within these provinces. Again, situation analysis of child welfare should be undertaken examining inter-district and group disparities in these areas, as well as the policy innovations and challenges which may enhance or constrain improvements. Efforts to improve child rights and welfare should then be focused on the worst performing regions and groups.

5.8 RECOMMENDATION 8: STRENGTHENING THE DECENTRALISED SYSTEM THROUGH LOCAL LEVEL CAPACITY BUILDING AND SUPPORT IN DEVELOPMENT PLANNING PROCESSES - IMPROVING CONSULTATIVE PLANNING PROCESSES, REGULATIONS, POLICY FORMULATION, PROGRAMME DESIGN, AND SERVICE DELIVERY TO BE PRO-CHILD AND PRO-WOMEN

Recommendation for: GoI, UNICEF and other donors to assist the national and local level governments

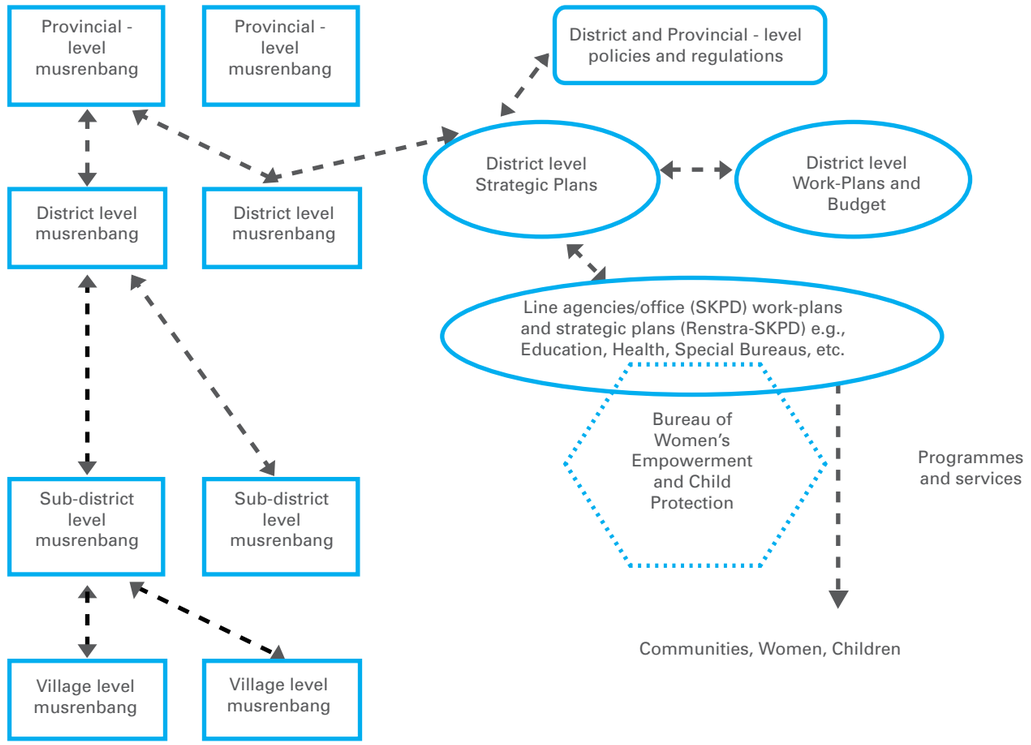
While the legal and coordination framework, national policy guidelines and strategic plans receive continued attention in the RPJMN and in policy instruments at the national level, and have either been established or are the process of being established in Indonesia, this SITAN finds in Section 4 that this does not always translate into strategies, policies, guidelines and practices at the local level. There is therefore adequate scope for systems strengthening, particularly at the district level, through technical assistance in the development planning processes.

The discussion throughout this SITAN, but particularly in Section 4, has demonstrated that programme and service delivery at the local level is both a part of the problem of inequity in child rights protection and child welfare, and part of the solution required to improve local conditions. Decentralisation allows for local governments to provide customised programming to address local problems and needs.

5.8.1 AREAS REQUIRING SYSTEMS STRENGTHENING

Section 4 outlined the development planning process. At the national, provincial and district/municipal levels, planning processes are undertaken for long-term, medium-term, and annual development plans. They include community consultation and deliberation processes on development (musrenbang) at the village, sub-district, district and provincial levels, the formulation of five-year strategic plans (Renstra) for each province and district overall as well as for local government Offices/Bureaus/Agencies, and finally annual work-plans, budgets and policies for each. BAPPEDA (the district and provincial planning agencies) has a key role in facilitating this process, and budgets and strategic plans must be ratified by the executive and legislative branches of government.
Figure 5.8.1 shows how the planning process works and the points at which the voices of children, families and practitioners (and their needs and priorities) should be incorporated into the social planning process. The evidence presented in Section 4 demonstrates that in some districts in the decentralised context this is uneven, weak or absent.

Figure 5.8.1: Weaknesses in the development planning process - Inadequate attention to the needs, priorities and voices of women and children



Furthermore, regardless of the resource base available for prioritising children's needs, a number of gaps and weaknesses were identified in the process of pro-child policymaking and service delivery, which are undermining the intended impact of local level initiatives on child rights and children's and women's welfare at the local level in the decentralised context. The key gaps and weaknesses are as follows:

Knowledge of:
- The latest development of national laws/regulations/guidelines.
- How to interpret national instruments/strategies/programmes and translate them locally, even when local coordination mechanisms and the political will exists.
- How to interpret national level regulations, principles and ideas into local dialects (mismatch between national language and local dialects).
- How to create a local enabling regulatory environment - e.g., draft local regulations/draft guidelines (or a complete absence of regulations based on lack of political will to create these).
- How to do child budgeting.
- How to socialise/mainstream guidelines/programmes/plans.
- How to create awareness in communities about key issues and stimulate behavioural change.

Insufficient capacity of:
- Local (mainly district/municipal) human resources in terms of technical capacity, knowledge and adequate numbers required to implement initiatives.
- Absent or weak (e.g., newly formed) Bureau of Women's Empowerment and Child Protection and thus absent or weak coordination of sectoral agencies providing services and programmes affecting children.

Data and monitoring:
- Absent or weak local level data collection and monitoring systems relating to child rights, protection and welfare, and programme/service impact and outreach.

An absence of political will and budget commitment:
- In some areas to prioritise children in policies and budgeting.
- To create an enabling regulatory environment (time delays were also a problem).
- To prioritise the outcomes of needs, priorities, ideas, and innovations from the consultative planning processes (musrenbang) at the village and sub-district levels (for district level development planning) and the district level (for provincial level development planning).

Coordination:
- Poor coordination between offices/agencies and between levels of government, sometimes replicating initiatives, sometimes complicating initiatives.
- Competition between offices/agencies for key tasks and functions and associated budgets (and year to year transfer between offices/agencies).

The voices of children, women and practitioners:
- An absence (or weak presence) of the voices of children, women and child-focused practitioners in the musrenbang; in many regions musrenbang processes continue to be dominated by elite views.
- Mismatch between children's and women's needs articulation processes (through musrenbang) and strategic plans and actual policies implemented, as these are often dominated by political priorities or elite views.

Partnership:
- Weak government-CSO partnerships and pro-child initiatives (in some cases); where government-CSO partnerships was stronger there were indications of improvements in service delivery.

Improving the system of development planning, policymaking and service delivery is particularly difficult when resource constraints are coupled with weak local capacity, as in the case of many of the provinces in eastern Indonesia, such as NTT. In these cases, the bulk of the local budgets (around three quarters) provided for by the national government in the general allocation fund (DAU) are required for operational costs (particularly civil service wages), and the special allocation fund (DAK) is in most cases reserved for infrastructure development, based on directives from the Ministry of Finance. This limits the extent to which the central government can earmark and distribute funds for special local level needs relating to children and ensure that they reach beneficiaries, as there are limited guarantees that funding distributed through the DAU to improve the situation of children will not be used for other priorities. Distributing such funds through line ministry projects is also made more difficult in the decentralised contexts as the process of increasing the absorption capacity is ongoing. In the poorer provinces and districts in Indonesia, children's needs are competing with infrastructure development and other priorities. Revising the national regulatory framework to allow for DAK funds to be distributed for non-infrastructure costs related to child needs may go some way to at least increasing the resource base for poorer areas and creating the political will for prioritizing children's needs.

There are also, however, the deconcentration funds, which the provincial governments can used to promote coordination and improve inter-district disparities, particularly in multi-sectoral approaches for knowledge management, training and capacity building at the district level, to improve child rights and welfare. However, the provinces have limited scope for direct programme implementation in most regions (with the exception of Special Autonomy provinces), and therefore greater attention needs to be given to gaining the commitment of district level governments and leadership to implement provincial goals and funded initiatives. Working with the provincial government in coordination and knowledge management is a key recommendation of this SITAN for donors and other stakeholders possessing the technical and programming knowledge to improve child welfare.

5.8.2 LEARNING FROM INNOVATIONS

In spite of the challenges, Section 4 demonstrated how attention to child welfare and rights could be improved through initiatives and innovations within districts. Some key findings that are relevant for the GoI include:

- For service delivery and programmes to have an impact they need to be enacted at the district level in most provinces and at both the provincial and district level in provinces with Special Autonomy.
- Effective interventions required:
  - A clear provincial and district regulatory framework that was aligned with strategic plans, annual work-plans, consultative planning forum priorities, budgets, technical guidelines and programmes.
  - The political will of the district and provincial leadership to create a pro-child policy and regulatory framework, as well as to earmark budgets for child needs (see, for example, the case of the Child-Friendly City in Surakarta, Section 4.5).
  - The creation of special working groups and task forces with a strong mandate (from the governor at the provincial level or the district head/mayor at the local level, together with the support of parliament and enacted through local regulations and decrees) and sufficient budget to act. Sectoral and multi-sectoral task forces that include both government and non-government initiatives, resources and expertise were key to

improving child welfare (see, for example, the marked educational improvements in Aceh, the improving approaches to protecting children on the streets in Central Java, and to some extent the interventions on health and nutrition in NTT).
    - Partnerships between CSOs and government can work to improve service delivery. CSO involvement in policymaking was key in terms of understanding child needs and vulnerabilities and how to address these (see, for example, HIV prevention and care initiatives in Papua). They were also filling the gaps provided in public service delivery as the system strengthens under-decentralisation. However, in many cases partnerships between district government and CSOs needed to be strengthened.
    - Coordination between provincial and district/municipal governments, and between offices/agencies/bureaus working in child welfare.
- The situation of women and children in the decentralised context improved when the relevant regulations were enacted with supporting technical guidelines and advocacy to government sectoral agencies and units, especially when these included ideas on how to protect child rights and manage cases (particularly in situations involving children in conflict with the law).
- Partnership between government and donors and other local and international organisations with specific knowledge sets was required for technical skills building, knowledge building, coordination, and programming to address some of the more dire situations in child welfare in each provincial case study.
- Children have important knowledge of how vulnerabilities develop, how to address these, and the kind of assistance they might need to complement their own coping strategies and development. They can also disseminate new knowledge and practices to other children.
- To reduce some inequities further material resources were required, but under decentralisation these could be targeted very specifically at district and sectoral needs, which may not have been the case previously (see, for example, the case of health and nutrition in NTT).

To strengthen the capacity of local governments to create pro-child policies and to work with local partners to deliver services to reduce vulnerabilities for children, improve child welfare, and protect child rights, this SITAN recommends the following strategies for donors and other agencies with technical skills and knowledge in sectors related to child welfare. Most supporting initiatives and interventions should be targeted at districts, but for cross-sectoral issues, knowledge management and data collection, interventions should be targeted at both the district and provincial levels. For particularly difficult situations where the province is in a far worse situation than other provinces in terms of child welfare (for example, maternal and child mortality rates in NTT), then both districts and provinces should be targeted sectorally in the initiatives to improve these situations. The recommendations include:

a) Providing technical assistance and capacity to provincial and district governments to establish KCCs (and to provide the relevant training). These KCCs should be coordinated by the province, which should also feed data upwards to the national level, as well as translate national guidelines/regulations and policies to the district level.
b) In collaboration with KCCs, support the establishment and the technical/knowledge capacity building of multi-stakeholder pro-child district task forces made up of government staff, practitioners, CSOs, and children, which focus on improving the relevant inequities in each district relating to child welfare. These task forces should be sectoral or multi-sectoral, as necessary, and should work to ensure that the district and sectoral office strategic plans and work-plans, budgets and programmes are pro-child and pro-women. They should also to ensure minimum service standards are upheld in line with national regulations.
c) Providing direct capacity building assistance, particularly to district governments, BAPPEDA and the multi-stakeholder task forces, to strengthen the bottom-up musrenbang processes to better include the voices of women, children and practitioners. Task force members can assist children/communities/families to identify and articulate their needs and attend musrenbang meetings with community representatives to ensure that these needs are voiced in musrenbang forums. They can also monitor resulting policies for impacts.
d) Providing capacity building and technical assistance to district and provincial governments (potentially through KCCs) in translating musrenbang and other pro-child priorities into development planning, particularly the formulation of district strategic plans (Renstra), regulations (Perda), policies, budgets, and sectoral and unit annual work-plans and guidelines on service delivery.
e) Work with local governments to plan the establishment of minimum service standards at the local level.
f) Providing technical assistance to district and provincial governments to establish or strengthen the Bureau of Women's Empowerment and Child Protection and improve monitoring systems, coordination and referrals of vulnerable children between agencies.
g) Promote partnerships among government agencies, the private sector and CSOs.

5.9 RECOMMENDATION 9: ADVOCATING THE SCALE UP OF SPECIFIC SECTORAL INTERVENTIONS TO IMPROVE CHILD RIGHTS AND WELFARE AND REDUCE INEQUITY

Recommended for: National and sub-national GoI, with the support of UNICEF and other stakeholders

Aside from the efforts mentioned above to reduce disparities between groups and regions overall, there are some specific issues which require further targeted interventions, either sectorally or multi-sectorally, based on the findings in this SITAN. These should be implemented together with Recommendation 7 on also targeting the worst performers and disadvantaged groups. These should be integrated into the approach outlined above for working in the decentralised context in Recommendation 8.

5.9.1 GENERAL FOR ALL STAKEHOLDERS

In order to effectively advocate for and implement the recommendations outlined below, this SITAN recommends that all sectors conduct the following in the regions where the interventions are targeted:

- Conduct district and provincial level SITAN to:
    - identify the cultural and family practices which:
        - discourage children/parents from prioritizing education
        - currently contribute to poor young child survival, growth and development
        - currently contribute to poor knowledge of children's and women's rights (including the use of violence in the home and community) and alternative non-violent practices of discipline

- identify weaknesses in community knowledge of available child support services and how to access these
- identify disadvantaged groups and regions, with a focus on children with special needs

- Use advocacy, communications for development strategies outlined in Recommendation 10 and working with customary leaders/elders/religious leaders to find innovative ways to reshape cultural, family and community care practices identified in the SITAN that are undermining child welfare.
- Provide continued support to relevant government agencies and partners in emergency and pandemic preparedness/response.
- Strengthen partnerships among government agencies, donors, CSOs and the private sector to improve access to education, standards of health and nutrition (and water and sanitation), HIV and AIDS prevention, treatment and protection services, and child (special) protection.
- Improve the planning, training and deployment of skilled health, education and social welfare professionals, particularly to remote and disadvantaged regions.
- Ensure that interventions promote outreach and quality of services and adhere to the minimum service standards outlined in the national regulations.
- Conduct deeper analysis into budgetary needs, cost-benefit analyses, and test costing strategies, especially for district/municipal initiatives.

5.9.2 HEALTH AND NUTRITION (AND WATER AND SANITATION)

For GoI:

- To improve health and nutrition standards among children, focus on the window of opportunity that is pregnancy and the first two years of life.
- To increase the number and quality of staff providing health services and reduce the gap in service provision, focus on improving pre-service training availability, coverage and outreach. This is particularly important for ensuring adequate numbers and quality of health workers that receive training who are from poorer provinces/districts, geographically large and disparate provinces/districts, and provinces/districts where particular health and nutrition problems are most acute. This involves working with district governments and health providers, as well as with provinces, to identify gaps.
- Aside from focussing on technical skills, pre-service training programmes and other government policies and programmes, attention should also be given to understanding the behavioural and cultural aspects of health and nutrition, and developing the communication skills of health workers so that they are sensitive to varied local environments, particularly if they do not originate from the areas where they work. This is because many of the case studies demonstrate that there are problems in service delivery that relate to the way health and nutrition (and reproductive health and HIV and AIDS) information is conveyed, which is not always sensitive to different local customs and practices. Miscommunication and communication problems may be preventing strategies from having full effect on behavioural change.
- Support planning mechanisms and strategies to improve nutrition overall, as well as micronutrient intake (vitamin A, iron folate, iodine) among vulnerable groups.
- Mainstream nutrition initiatives, such as exclusive breastfeeding, appropriate complementary feeding and continued breastfeeding from six months and upward, treatment of children with acute malnutrition, maternal nutrition hygiene best practices, and reproductive health.
- Strengthen access to clean water and sanitation in disadvantaged areas through water supply projects and improving sanitation.

- Prepare strategies to offset the impacts of growing urban poverty, climate change, growth in the number of slums and pressure on resources.

For GoI with the support of UNICEF and other agencies:

- Support the government to improve coordination as well as planning and budgeting for effective health, nutrition and water and sanitation interventions.
- Support CSOs working in educating families and communities in nutrition, hygiene best practice, breastfeeding and complementary feeding, maternal nutrition, reproductive health and other practices which have been identified as improving health and nutrition standards.
- Continue to design initiatives and public awareness campaigns focused on the importance of breastfeeding, complementary feeding, maternal nutrition, assisted deliveries, giving birth in healthcare facilities, nutrition, essential newborn care, care-seeking behaviour for diarrhoea and pneumonia treatment.
- Provide training and knowledge-building workshops through government (or through government-CSO partnerships) to develop capacity in health sector human resources and knowledge of epidemiological transition and the continuum of care.
- Identify unimmunised children, and groups/regions prone to maternal and neonatal tetanus in provinces/districts, and scale up routine immunisation.
- Scale up pilots in health information systems, monitoring and evaluation, while also documenting lessons learnt to improve governance, services and resource allocation.
- Use focus group discussions and other participatory learning mechanisms that can encourage the dissemination of information amongst children themselves on health and nutrition.
- Facilitate the development of training and the formulation/socialisation of community action plans on waste management, cleaning drains and water bodies.

For UNICEF and other agencies:

- Continue to design, and to work with the government to implement, innovative models that have high impact on maternal and child health and nutrition, including the formulation of health policies at the national and sub-national levels and the translation of these into service delivery and practice at the local level.
- Assist the government with providing continued interventions and education programmes to the poor to increase understanding and awareness of the causes of malnutrition.
- Promote and support the government to provide education in schools on nutrition, hygiene best practices, exclusive breastfeeding and complementary feeding, maternal nutrition, reproductive health, to improve health and nutrition standards among children.
- Support and assist with the development of thematic guidelines, training manuals and design standards, which replicate best practices in water and sanitation interventions.

5.9.3 EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

For GoI:

- Strengthened legislation and increased budget allocations aimed at achieving school readiness for children under age seven years.
- Improve access to play centres and pre-schools, particularly in rural areas.
- Provide targeted support for poor families to help them keep their children in school.
- Support the development of training programmes for early school leavers in practical skills and provide guidance counselling on options for employment and skills building.
- Remove structural/administrative barriers between primary and junior secondary schools to improve transition and retention of students and mitigate early leaving.

- Increased budget allocation for junior secondary with the adoption of catchment areas.
- Improve education service facilities for children with special needs.

For GoI with the support of UNICEF and other agencies:
- Identifying reliable predictors of early school leaving to develop effective responses to the problem. To that effect, knowledge, attitudes and perceptions surveys should be conducted among educational staff, parents and students in primary and junior secondary schools, as well as among young people who didn't transition and left schools early (to the extent that these young people can be identified) to identify the perceived and actual constraints and barriers hampering a smooth transition and participation in junior secondary education.
- Support peace studies in curriculum development, particularly in ethnically and religiously diverse areas or areas prone to conflict.
- Mainstreaming via pre-service training for teachers at the university level.
- Supporting the government to train volunteers in skills for home visits to improve parents' capacity to apply appropriate care practices in the family and community.
- Design initiatives to encourage teachers in urban areas where there are high teacher to student ratios (beyond national targets) to relocate to understaffed rural areas.
- Review of existing life skills and development/update of a comprehensive life skills programme for youth, encompassing different sectors (i.e., HIV and AIDS, WASH, nutrition, etc.).
- Considering the demographic situation of Indonesia, explore expanding the compulsory education period.
- Mass communication and social mobilisation activities in schools and in communities need to be used to increase awareness and demand for good quality basic education, with a strong focus on changing attitudes and behaviours from students and parents.
- Develop strategies to prevent violence in schools.
- Ensure that clean water and sanitation facilities at schools are accessible and meet girls' needs, and are not reserved in practice for use by teachers only.
- Review of BOS and other social welfare systems to assess their effectiveness in promoting higher transition and completion rates at the junior secondary level. These reviews could lead to capacity building interventions for the government to better target and develop strategies for financing children from poor families to tackle the economic factors that are often behind early school leaving.

For UNICEF and other agencies:
- Provide technical assistance to local and provincial governments to further scale up good practice and schools-based management methods.
- Assisting with the production of training materials on good practices for quality education including school-based curriculum planning and sustainable school-based planning and management (potentially in collaboration with KCCs).
- Share materials and initiatives in the formulation of training materials on good practices for quality education including school-based curriculum planning and sustainable school-based planning and management with underperforming districts and provinces in the education sector.

5.9.4 HIV AND AIDS

For GoI:
- Overall, aim to mitigate the spread of HIV through providing universal access to treatment.
- Ensure that a comprehensive life skills education programme, including HIV and AIDS awareness and knowledge of reproductive health, is developed and mainstreamed.
- Provide assistance to local governments to synchronise government and civil society initiatives in HIV prevention and care.
- Include all relevant stakeholders in the design of HIV prevention policies and strategies that at present are not always well coordinated or inclusive of all relevant parties.
- Allocate more resources to state-based institutions to care for affected populations.
- In the interim, empower and support communities (families and CSOs) to provide home-based care to affected populations.
- Improve the provision of and use of services for Voluntary Counselling and Testing (VCT) and support and treatment for pregnant women with HIV and for youth.
- Promote provider-initiated testing and counselling (PITC) among pregnant women.
- Provide both pre- and postnatal and immediate treatment for HIV-infected mothers and children with antiretroviral (ARV) drugs and co-trimoxazole (GoI with the support of UNICEF and/or other donors).
- Increase the proportion of HIV-positive women and children receiving free antiretroviral therapy (ART).
- Provide full integration of PMTCT services into the antenatal care package, and develop 'PMTCT Plus' package focusing on ensuring continuum of care for mother/infant pairs (i.e., follow-up ART, nutrition components, etc.).

For GoI with the support of UNICEF and other agencies:
- Improve monitoring of the following:
  - HIV prevalence among the population aged 15-24 years
  - condom use at last high-risk sex
  - proportion of population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS
  - ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
  - proportion of population with advanced HIV infection with access to ARV drugs
- Promote community and school education programmes to reduce cultural barriers and increase a comprehensive understanding of HIV and AIDS to reduce the stigmatisation of infected populations. Also educate on the use of safe sex practices, needle sharing, etc., particularly in Papua, Aceh, and other high-risk areas.
- In the case of Papua, include tribal and religious leaders in culturally appropriate education initiatives to assist with improving understanding and reducing resistance to practices that reduce the risk of HIV infection.
- Continued support and education programmes for most-at-risk adolescents (MARA) - sex workers, men who have sex with men (MSM), transgenderists (waria), injecting drug users (IDU), and especially vulnerable adolescents (GoI with the support of UNICEF/other donors).
- Promote comprehensive behaviour change programmes for intimate partners of the above populations.
- Establish mechanisms/linkages with child (special) protection interventions to:
  - remove children from harmful environments and to provide them with support
  - to identify factors which lead to such situations to aid prevention

- Strengthen special initiatives to target and disseminate information on HIV and AIDS (prevention and trends), and support service availability to migrant and transient populations as well as partners and families of these vulnerable populations.
- Develop information dissemination campaigns in hard to reach areas and rural areas where the prevalence of HIV infection is higher. At present, in Papua, for example, many of the initiatives are in urban areas.
- Use focus group discussions and other innovative and participatory mechanisms, such as peer education or sport for development, that can encourage the dissemination of information on safe sex amongst children/adolescents themselves, in addition to other prevention mechanisms for HIV infection.
- Conduct rapid assessment of the socio-economic situation of affected households, at least in high prevalence areas. In addition, social schemes and safety nets should be reviewed to ensure that they are HIV sensitive.
- Assist local government AIDS Commissions to translate national policies into practice and to use locally relevant terms and dialects.
- Counselling on infant feeding should be provided to HIV-infected pregnant women, partners and families (GoI with the support of UNICEF/other donors).

For UNICEF and other agencies:
- Provide technical support and capacity building to provincial and districts AIDS Commissions to enable them to better coordinate and monitor the multi-sectoral response to HIV and AIDS in their respective provinces (especially in light of the '3 Ones').
- In certain regions, such as Papua, additional technical support needs to be provided in terms of planning and budgeting (e.g., to address situations where funds are available, but not used, or used for non-priority interventions).

5.9.5 YOUNG PEOPLE

For GoI with the support of UNICEF and other agencies:
- Support the capacity development of the Ministry of Youth and Sports to enable better coordination of policies related to youth, and increased advocacy for other sectors to pay special attention to young people.
- Develop a set of indicators or review the analysis (including disaggregation) of existing indicators[5] at national and provincial levels to assess progress with respect to domains related to adolescent/youth well-being, as well as relevant aspects of the MDGs, the CRC, and other statements and obligations to which Indonesia is a signatory. Significant efforts also need to be made to gather information about how children and young people perceive their lives, how far they feel their rights are respected and what are their priority concerns. These data could be compiled at provincial/district levels and will constitute a national baseline for an adolescent rights index. It will then be possible to use this for inter-district comparison and as a 'national thermometer' of youth status, and also be useful in updating national policy to incorporate emerging trends.
- Create strategies to redress employment issues for young people and the fact that in some cases the education system is not tailored to provide skills needed in the job market.

5 In the case of existing indicators, UNICEF will advocate for the greater disaggregation and updating of data. Data breakdown at provincial and district levels, as a means to assess and certify efforts in favour of children, will be also developed.

5.9.6 CHILD (SPECIAL) PROTECTION (TOGETHER WITH RECOMMENDATIONS 2 AND 6 ABOVE)

For GoI:
- Establish a comprehensive child protection system at national and sub-national levels. Priorities for a comprehensive child protection system include strengthened service delivery and prevention systems, promoting family-based care, developing a child-sensitive justice system, and promoting restorative justice for child offenders.
- Strengthen inter-departmental and inter-agency referral networks to ensure quality and decentralised services for women and child survivors of abuse, violence and exploitation.
- Ensure that there is adequate funding for state-based child and family welfare institutions and for the provision of social workers.
- Establish training institutions to turn out high quality professional social workers.
- Upgrade the status of social workers to that of a professional, well-respected cadre of social workers.
- Enforce the ILCP and establish strategies to prevent children from suffering from the many types of violence, abuse, exploitation and neglect discussed in this report.
- Link cash transfer systems (and other strategies to mitigate economic and other shocks for families) to child (special) protection, to increase resilience and decrease the vulnerability of children.

For GoI with the support of UNICEF and other agencies:
- Strengthen a national and sub-national child protection information management system in collaboration with KCCs and universities by scaling up current pilots to collect routine data on key child protection indicators in order to inform policy, planning and budget allocations.
- Support capacity building of service providers through government (or through government-CSO partnerships) to be able to provide family-based support and alternative care for vulnerable children (UNICEF and/or other donors).
- Strengthen the district Office of Social Affairs to provide child welfare officers (social workers) with the skills and training to provide multi-sectoral and holistic approaches to child and family welfare while ensuring child rights.
- Children in conflict with the law:
  - Institutionalise and disseminate more information and legal aid for children in conflict with the law, as well as child-friendly hearings, alternative sentencing (such as community service) and monitoring of these cases both during hearings and after alternative sentencing.
  - Separate children who are incarcerated from adults (support the provision of resources and services in correctional facilities to make this possible).
  - Work with national and local police and courts/bar association on guidelines for providing protection for child offenders and witnesses and the provision of legal aid (GoI with the support of UNICEF and/or other donors).
- Birth registrations:
  - Continue to advocate for universal birth registration and free birth registration and the adoption of these principles into district regulations and service provision.
  - Explore the use of alternative technologies to increase birth registration.
- Alternative care institutions:
  - Promote family care first - including family, kinship and foster care - use institutionalisation of children in need of care as a last response.
  - Create a registration, standards and accreditation system for alternative care institutions and enforce sanctions for non-compliance.

- Create guidelines for alternative care institutions to carry out assessments on whether children require alternative care or could in fact be supported by other services and remain in the home.
- Monitor childcare institutions to ensure that they meet quality assurance standards on child rights and welfare, that violence is not a sanctioned form of punishment in these institutions, that adequate food and nutrients, access to health care and education, as well as space for play are provided.
- Link government agencies providing welfare support for children and families (particularly in education) to childcare institutions so that following assessment, if it is ascertained that children do not need alternative care but rather require other support services, then these are accessible and available.
- Provide financial and spiritual support for families who have placed their children in orphanages to create space for the children to return home - monitor the transition and the welfare of the child following the return.
- Ensure that staff of alternative care institutions have the skills and training necessary to ensure child rights and welfare, and increase monitoring of this.
- Ensure that the chores children undertake in these alternative care institutions are not actually 'work', and that if children are engaged in work that they do not work longer than the legal maximum number of working hours by age and that the work is not hazardous.

- Working children:
  - Identify families with working children under the legal work age or who are working longer hours than the legal maximum - provide financial and other support services for these families and education in the detrimental effects of work for children.
  - Enforce penalties and sanctions for those who employ children and contravene national laws and regulations, particularly for those from outside the home who exploit child labour. In the case of poor families who encourage their children to work, education and alternative support should be the first avenue of intervention and only in the case that there are repeat violations of the law should sanctions be implemented.
- Children living on the streets:
  - Monitor the treatment of children living on the streets by the police, and encourage alternative care and other support service provision rather than incarceration.
  - Educate police in child rights and the appropriate treatment of children, and develop guidelines for cases involving children living on the streets.
- Trafficked children:
  - Develop strategies to prevent the hidden trafficking of children and the forced internment of children as domestic staff.
  - Provide child victims of trafficking with social rehabilitation, return assistance, social reintegration and monitoring of their progress.
  - Enforce penalties and sanctions for those who work with or facilitate child trafficking.
- Children forced into sex work:
  - Identify sex workers with children or who have influence over children forced into sex work. Provide education and support for these sex workers so that they discourage children from becoming/remaining sex workers in order to break intra-familial cycles of sex work and promote alternative options for children forced into sex work.
  - Provide support programmes for children formerly forced into sex work to find alternative forms of employment/subsistence.
  - Enforce penalties and sanctions for those who work with or facilitate child prostitution.
  - Support capacity building of service providers through government or CSOs to be able to provide alternative care for children forced into sex work.
  - Investigate the reasons for forcing children into sex work, i.e., trafficking or poverty.

For UNICEF and other agencies:
- Promote the enforcement of laws and regulations on protecting children from abuse, violence and exploitation, including exploitative child labour.
- Continue to advocate for the ratification of (1) the draft Bill on the Juvenile Justice System (RUU Sistim Peradilan Anak), and (2) the draft Law on Children in the Correctional System (RUU Sistim Pemasyarakatan), and for the translation of these bills together with the National Plan of Action on the Eradication of Trafficking in Persons and Sexual Exploitation of Children (Rencana Aksi Nasional Pemberantasan Tindak Pidana Perdagangan Orang (PTPPO) dan Eksploitasi Seksual Anak (ESA)) into local policies and practice (UNICEF and other donors).
- Monitor the provision of child and family welfare (GoI with the support of UNICEF/other donors).

5.10
RECOMMENDATION 10: COMMUNICATIONS FOR DEVELOPMENT AND TO ASSIST WITH KNOWLEDGE BUILDING AND BEHAVIOURAL CHANGE TO SUPPORT OTHER TARGETED INTERVENTIONS AND IMPROVE THE SITUATION OF WOMEN AND CHILDREN IN INDONESIA

Recommendation for: National and local level GoI in partnership with UNICEF and other stakeholders

For GoI with the support of UNICEF and other agencies:
- Make C4D an integral part of key government programmes to encourage active community participation and create sustained behavioural and social change. This can be achieved by establishing a consultative and oversight mechanism through which key government programmes, starting at the planning stage, are reviewed to ensure that the C4D approach is mainstreamed.
- Develop an umbrella C4D strategy for government programmes that includes prioritisation of behavioural and social change issues, so that limited government resources can be focused on attaining high-impact behavioural and social change results enhancing health, improving quality of education and the protection of children. Specific C4D strategies for particular programmes should be developed to identify enabling and disabling factors related to desired behavioural and social changes, and deliver technical inputs related to C4D activities.
- Increase investment in financial and human resources in C4D so that C4D programmes are adequately funded and staffed, in support of preventative approaches as well as curative. This approach should be backed by increased budgetary commitments from the government to support social mobilisation and community empowerment programmes such as PHBS (healthy and clean lifestyle), Desa Siaga (alert village) and UKS (school health initiative). This also means continuous capacity strengthening of concerned government staff and institutions that goes beyond traditional training to include institution strengthening and technical assistance.
- Build a better understanding on behavioural, social and cultural causes of poverty and inequity. Through an accumulation of knowledge of non-income causes of multiple vulnerabilities, a C4D intervention can be designed based on evidence not only to address behaviours, but also to tackle underlying and root causes. This can be implemented through

collaboration in behaviour, social and cultural research with academia, research institutes and think tanks to ensure research quality and to tap into their existing knowledge.

- Establish or strengthen coordination mechanisms under a clear lead ministry, to avoid duplication and redundancy, ensure concerted actions are taken, and limited resources and networks are pooled together to achieve behavioural and social changes on a larger scale. Ministries such as the Ministry of Communication and Information (Menkominfo) and the Ministry of Religious Affairs should be engaged in C4D programming in support of inter-sector collaboration and cross fertilisation between agencies working on common, multi-sector issues such as pandemic diseases, HIV/AIDS, adolescent reproductive health and hygiene practices.
- Strengthen partnerships in support of C4D to engage a broader range of actors including community groups, public and private sector. This includes civil society organisations, faith based organisations, women's organisations, youth organisations, and professional associations. Successful existing partnerships such as that between the Ministry of Health and faith based organisations should be developed in other sectors such as child protection and education. Serious efforts must be taken to involve the private sector in public-private partnerships that promote life saving behaviours such as hand washing, safe water treatment and diarrheal management.

Increase utilisation of affordable and accessible information and communication technologies such as cellular phones for behavioural and social change purposes, reaching audiences more effectively and efficiently. New technology enables both provision of information on various key practices, and mobile data collection for research purposes, as well as potential for developing customised messages to specific audiences in a particular geographic location.

ANNEX

ANNEX 1.
STATISTICAL TABLES FOR NATIONAL OVERVIEW

Economics, Demographic and Social Indicators at National and Provincial Levels with Particular reference on the Children and Women Wellbeing

Tables:
1. Economic Indicators
2. Demographic Indicators
3. Basic Indicators
4. Health and Nutrition Indicators
5. Water, Sanitation and Hygiene Indicators
6. HIV/AIDS Indicators
7. Child Protection Indicators
8. Women Indicators

General note on the data

The data presented in the following ststistical tables are derived from various sources; official publications and web-site from BPS (Badan Pusat Statistik)-Statistics Indonesia and related line ministries as well as special data processing conducted by BPS based on the National Socio-Economic Survey (SUSENAS) raw data and statistical record of Ministry of Health and the World Bank.

1. Economic Indicators
   a. Definition
   b. Sources
   c. Notes

2. Demographic Indicators
   a. Definition
   b. Sources
   c. Notes

3. Basic Indicators
   a. Definition
   b. Sources
   c. Notes

4. Health and Nutrition Indicators
   a. Definition
   b. Sources
   c. Notes

TABLE 1. ECONOMIC INDICATORS

Area	Gross Regional Domestic Product at Current Market Prices - million rupiahs (Statistical Year Book of Indonesia)									
Year	2000		2001		2002		2003		2004	
	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices
Indonesia	1,081,417,942	1,264,918,748	1,505,600,762	1,684,280,482	1,659,081,400	1,659,081,400	1,840,854,900	1,840,854,900	2,083,077,900	2,295,826,200
Aceh	14,929,817	28,923,265	20,409,899	34,733,404	24,488,663	24,488,663	27,011,582	27,011,582	30,149,761	50,357,262
North Sumatra	66,746,843	67,659,899	78,437,128	79,331,335	88,868,564	88,868,564	102,580,911	102,580,911	117,241,671	118,100,512
West Sumatra	22,462,448	22,462,448	26,154,135	26,154,135	29,899,130	29,899,130	33,130,683	33,130,683	37,358,646	37,358,646
Riau	23,135,725	55,260,499	55,698,977	107,293,094	67,653,078	67,653,078	51,799,212	51,799,212	64,527,875	114,246,374
Jambi	8,212,632	9,380,650	9,711,074	11,531,784	11,513,584	11,531,584	13,452,425	13,452,425	15,666,192	18,487,944
South Sumatra	28,571,314	39,252,009	31,960,107	47,100,349	35,773,989	35,773,989	40,113,615	40,133,615	45,470,766	64,319,375
Bengkulu	4,539,983	4,539,983	5,508,255	5,508,255	6,276,077	6,276,077	7,251,985	7,251,985	8,104,894	8,104,894
Lampung	22,869,761	23,200,302	25,332,315	25,693,710	28,190,005	28,190,005	31,285,579	31,285,579	34,872,457	36,015,536
Bangka Belitung	5,336,039	5,336,039	6,576,424	6,576,424	8,158,333	8,158,333	9,101,758	9,101,758	11,294,211	11,796,550
Riau Islands							30,483,328	30,483,328	33,614,230	36,736,621
D.K.I Jakarta	189,075,401	189,075,401	262,355,027	263,720,107	298,806,792	298,806,792	333,260,777	333,260,777	374,200,318	375,561,523
West Java	153,504,327	174,915,258	199,566,463	219,186,969	231,118,677	231,118,677	261,810,573	261,810,573	292,328,155	305,703,402
Central Java	112,208,774	117,782,925	124,388,761	133,227,558	139,053,208	139,053,208	156,155,729	156,155,729	175,584,779	193,435,263
D.I. Yogyakarta	13,093,980	13,093,980	15,229,910	15,229,910	17,521,778	17,521,778	19,613,418	19,613,418	22,023,880	22,023,880
East Java	168,911,396	169,680,628	233,573,262	234,192,715	266,557,637	266,557,637	299,951,720	299,951,720	340,326,617	341,065,251
Banten	43,184,332	43,184,332	51,970,381	51,970,381	60,612,554	60,612,554	66,575,297	66,575,297	73,713,784	73,713,784
Bali	16,509,986	16,509,986	20,190,206	20,190,206	23,856,438	23,856,438	26,167,942	26,167,942	28,986,596	28,986,596
West Nusa Tenggara	11,569,977	11,569,977	15,440,378	15,440,378	16,294,608	16,294,608	17,499,604	17,499,604	22,145,674	22,145,674
East Nusa Tenggara	6,357,557	6,357,557	9,138,301	9,138,301	10,274,236	10,274,236	11,382,810	11,382,810	13,004,160	13,004,160
West Kalimantan	17,968,167	17,968,167	21,359,187	21,359,187	23,914,131	23,914,131	26,062,747	26,062,747	29,750,226	29,750,226
Central Kalimantan	10,859,485	10,859,485	12,316,808	12,316,808	14,047,809	14,047,809	15,599,193	15,599,193	18,299,982	18,299,982
South Kalimantan	15,655,811	16,170,221	18,626,138	19,130,854	20,624,896	20,624,896	22,836,289	22,836,289	27,518,034	28,028,044
East Kalimantan	26,334,158	75,013,459	35,911,341	91,890,396	41,265,226	41,265,226	46,250,608	46,250,608	53,606,657	133,704,074
North Sulawesi	9,339,015	9,339,015	11,326,271	11,856,612	12,677,048	12,677,048	13,724,513	13,724,513	15,705,710	15,727,749
Central Sulawesi	8,240,293	8,240,293	10,380,275	10,380,275	11,793,833	11,793,833	13,013,148	13,013,148	14,659,017	14,659,017
South Sulawesi	27,646,426	27,772,137	34,634,238	34,770,983	38,434,147	38,434,147	42,763,941	42,763,941	48,495,663	48,580,245
Southeast Sulawesi	5,730,160	5,730,160	6,864,340	6,864,340	8,043,485	8,043,485	8,908,781	8,908,781	10,267,955	10,267,955
Gorontalo	1,622,000	1,622,000	1,821,856	1,821,856	2,148,436	2,148,436	2,479,720	2,479,720	2,801,544	2,801,544
West Sulawesi										
Maluku	2,717,040	2,729,582	2,991,579	3,006,472	3,448,437	3,448,437	3,670,950	3,670,950	4,030,011	4,048,283
North Maluku	1,865,627	1,865,627	1,952,867	1,952,867	2,035,156	2,035,156	2,175,010	2,175,010	2,368,865	2,368,865
West Papua					3,617,835	3,617,835	4,137,795	4,137,795	4,669,431	6,576,537
Papua	19,882,330	20,902,655	24,745,821	25,878,023	22,548,296	22,548,296	23,890,084	23,890,084	24,842,904	24,842,904

TABLE 1. ECONOMIC INDICATORS

Area	Gross Regional Domestic Product at Current Market Prices - million rupiahs (Statistical Year Book of Indonesia)							
Year	2005		2006		2007[1)]		2008[2)]	
	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices	At Current Market Prices (without oil and gas)	At Current Market Prices
Indonesia	2,458,234,300	2,774,281,100	2,967,040,300	3,339,216,800	3,532,807,700	3,949,321,400	4,426,384,700	4,954,028,900
Aceh	35,449,322	56,951,612	43,465,800	69,353,300	49,718,200	71,093,400	54,193,100	73,530,700
North Sumatra	138,556,297	139,618,314	159,187,900	160,376,800	180,375,400	181,819,700	212,145,500	213,931,700
West Sumatra	44,674,569	44,674,569	53,029,600	53,029,600	59,799,000	59,799,000	71,233,000	71,233,000
Riau	79,065,371	139,018,996	94,815,600	167,068,200	117,035,000	210,002,600	149,125,200	276,400,100
Jambi	18,403,956	22,487,011	22,080,200	26,061,800	26,193,600	32,076,700	30,680,100	39,665,300
South Sumatra	52,726,675	81,531,510	63,500,100	95,928,800	74,905,300	109,895,700	88,794,800	133,358,900
Bengkulu	10,134,451	10,134,451	11,397,000	11,397,000	12,820,300	12,820,300	14,447,000	144,477,000
Lampung	39,407,272	40,906,789	47,706,400	49,119,000	59,485,500	60,922,000	73,031,800	74,490,600
Bangka Belitung	13,535,454	14,171,630	15,299,600	15,920,500	17,369,400	17,895,000	21,221,200	21,720,600
Riau Islands	37,414,643	40,984,738	41,950,500	46,216,100	47,420,400	51,826,300	54,441,100	592,007,600
D.K.I Jakarta	431,900,924	433,860,253	499,354,100	501,771,700	563,813,300	566,449,400	674,189,800	677,411,100
West Java	370,693,823	389,244,654	448,250,500	473,187,300	501,445,200	526,608,800	572,282,600	602,420,600
Central Java	203,097,766	234,435,323	243,041,700	281,996,700	272,614,700	312,428,800	313,305,500	364,895,400
D.I. Yogyakarta	25,337,603	25,337,603	29,417,300	29,417,300	32,916,700	32,916,700	38,102,100	38,102,100
East Java	402,497,605	403,392,351	469,504,000	470,627,500	533,367,100	534,919,300	619,666,100	621,582,000
Banten	84,622,803	84,622,803	97,867,300	97,867,300	107,499,700	107,499,700	122,497,500	122,497,500
Bali	33,946,468	33,946,468	37,388,500	37,388,500	42,336,400	42,336,400	49,922,600	49,922,600
West Nusa Tenggara	25,682,675	25,682,675	28,596,900	28,596,900	33,522,200	33,522,200	35,261,700	35,261,700
East Nusa Tenggara	14,810,472	14,810,472	16,904,100	16,904,100	19,137,000	19,137,000	21,621,800	21,621,800
West Kalimantan	33,869,468	33,869,468	37,715,000	37,715,000	42,478,600	42,478,600	48,415,500	48,415,500
Central Kalimantan	20,983,170	20,983,170	24,480,000	24,480,000	27,920,100	27,920,100	32,350,800	32,350,800
South Kalimantan	31,282,872	31,794,069	34,142,300	34,670,500	38,852,800	39,438,800	44,889,800	45,515,600
East Kalimantan	68,106,493	180,289,090	82,234,400	199,588,100	93,810,300	212,096,600	128,097,000	315,220,400
North Sulawesi	18,744,519	18,763,479	21,190,000	21,216,500	24,052,100	24,081,100	27,810,500	27,843,000
Central Sulawesi	17,053,327	17,116,581	19,068,300	19,310,300	21,280,100	21,743,600	27,477,800	28,139,700
South Sulawesi	51,650,599	51,780,443	60,756,400	60,902,800	69,107,100	69,271,900	84,966,300	85,143,200
Southeast Sulawesi	12,981,046	12,981,046	15,270,400	15,270,400	17,953,100	17,953,100	22,173,900	22,173,900
Gorontalo	3,480,567	3,480,567	4,062,300	4,062,300	4,760,700	4,760,700	5,899,800	5,899,800
West Sulawesi	4,422,946	4,422,946	5,124,800	5,124,800	6,192,800	6,192,800	7,778,000	7,778,000
Maluku	4,551,496	4,570,664	5,059,600	5,079,800	5,682,700	5,698,800	6,251,900	6,269,700
North Maluku	2,583,101	2,583,101	2,818,400	2,818,400	3,160,000	3,160,000	3,856,400	3,856,400
West Papua	5,427,856	7,913,777	6,367,600	8,945,500	7,452,200	10,369,800	8,735,900	12,471,600
Papua	43,615,319	43,615,319	46,895,200	46,895,200	55,380,500	55,380,500	54,733,600	54,733,600

TABLE 1. ECONOMIC INDICATORS

Area	Gross Regional Domestic Product at Constant Market Prices - million rupiahs (Statistical Year Book of Indonesia)									
Year	2000		2001		2002		2003		2004	
	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices
Indonesia	363,758,675	398,016,853	1,280,638,841	1,442,984,554	1,344,906,300	1,505,216,400	1,421,474,800	1,577,171,300	1,506,296,600	1,656,516,800
Aceh	6,099,034	9,129,358	19,136,158	32,565,077	21,095,274	42,338,751	21,875,760	44,677,163	22,260,704	40,374,282
North Sumatra	23,843,539	24,016,595	71,036,930	71,908,359	74,326,325	75,189,141	77,995,379	78,805,609	82,675,239	83,328,949
West Sumatra	7,868,238	7,868,238	23,727,374	23,727,374	24,840,188	24,840,188	26,146,782	26,146,782	27,578,137	27,578,137
Riau	9,649,876	21,633,022	45,846,657	95,442,416	49,539,638	96,872,503	28,326,774	73,077,959	30,879,768	75,216,719
Jambi	3,059,777	3,354,146	8,724,131	10,205,592	9,264,356	10,803,423	9,778,185	11,343,280	10,411,851	11,953,885
South Sumatra	9,911,600	12,025,512	28,804,126	42,048,614	30,083,324	43,643,276	31,810,725	45,247,401	33,969,083	47,344,395
Bengkulu	1,744,250	1,744,250	5,070,102	5,070,102	5,310,017	5,310,017	5,595,029	5,595,029	5,896,255	5,896,255
Lampung	7,104,008	7,174,254	23,795,838	24,126,379	24,676,013	25,433,275	26,065,201	26,898,052	27,567,277	28,262,289
Bangka Belitung	1,872,602	1,872,602	6,103,270	6,103,270	6,904,687	6,904,687	7,253,850	7,719,713	8,014,748	8,414,980
Riau Islands							24,829,131	26,775,786	26,671,125	28,509,063
D.K.I Jakarta	59,694,419	59,694,419	237,399,209	238,673,940	249,097,905	250,331,157	262,564,636	263,624,242	277,537,331	278,524,822
West Java	51,402,291	55,660,205	184,304,149	203,369,000	201,421,740	211,391,703	211,747,822	221,628,174	220,295,697	230,003,496
Central Java	38,232,674	40,941,667	112,343,862	118,816,400	115,762,928	123,038,541	121,271,928	129,166,462	127,212,003	135,789,872
D.I. Yogyakarta	5,017,709	5,017,709	14,056,321	14,056,321	14,687,284	14,687,284	15,360,409	15,360,409	16,146,424	16,146,424
East Java	56,691,767	56,856,521	209,838,116	210,448,570	217,878,040	218,452,389	228,301,906	228,884,459	241,628,131	242,228,892
Banten	16,540,147	16,540,147	46,959,318	46,959,318	49,449,321	49,449,321	51,957,458	51,957,458	54,880,407	54,880,407
Bali	7,521,841	7,521,841	17,879,875	17,879,875	18,423,861	18,423,861	19,080,896	19,080,896	19,963,244	19,963,244
West Nusa Tenggara	4,377,225	4,377,225	13,074,109	13,074,109	13,544,496	13,544,496	14,073,340	14,073,340	14,928,175	14,928,175
East Nusa Tenggara	2,952,372	1,276,998	8,221,573	8,221,573	8,622,491	8,622,491	9,016,717	9,016,717	9,537,095	9,537,095
West Kalimantan	7,274,000	7,274,000	19,838,486	19,838,486	20,741,897	20,741,897	21,376,951	21,376,951	22,483,015	22,483,015
Central Kalimantan	4,092,515	4,092,515	11,304,872	11,304,872	11,904,502	11,904,502	12,488,475	12,488,475	13,253,081	13,253,081
South Kalimantan	6,335,173	6,424,665	17,356,719	17,861,435	18,085,604	18,606,512	18,976,956	19,483,169	21,692,484	22,171,332
East Kalimantan	11,966,186	22,384,086	32,420,025	86,348,106	34,764,412	87,850,398	36,586,682	89,483,542	39,307,435	91,050,429
North Sulawesi	3,220,688	3,220,688	10,543,193	10,996,587	11,273,402	11,291,463	11,631,389	11,652,793	12,127,463	12,149,501
Central Sulawesi	2,383,700	2,383,700	9,089,908	9,089,908	9,600,364	9,600,364	10,196,750	10,196,750	10,925,465	10,925,465
South Sulawesi	10,066,907	10,101,948	32,199,320	32,334,905	33,569,971	33,645,383	35,333,533	35,410,566	37,188,098	37,267,558
Southeast Sulawesi	1,672,193	1,672,193	6,063,986	6,063,986	6,468,062	6,468,062	6,957,662	6,957,662	7,480,180	7,480,180
Gorontalo	918,614	918,614	1,554,100	1,554,100	1,655,328	1,655,328	1,769,188	1,769,188	1,891,763	1,891,763
West Sulawesi										
Maluku	1,290,762	1,297,502	2,754,708	2,768,291	2,833,835	2,847,739	2,956,167	2,970,466	3,087,487	3,101,996
North Maluku	858,442	858,442	1,911,043	1,911,043	1,957,716	1,957,716	2,032,572	2,032,572	2,128,208	2,128,208
West Papua					3,221,266	4,276,966	3,448,700	4,613,164	3,665,643	4,969,210
Papua	8,139,284	8,338,145	22,913,215	23,988,662	21,078,934	21,078,934	21,019,420	21,019,420	16,282,968	16,282,968

TABLE 1. ECONOMIC INDICATORS

Area	Gross Regional Domestic Product at Current Market Prices - million rupiahs (Statistical Year Book of Indonesia)							
Year	2005		2006		2007[1]		2008[2]	
	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices	At Constant Market Prices (without oil and gas)	At Constant Market Prices
Indonesia	1,605,261,800	1,750,815,200	1,703,422,400	1,847,126,700	1,820,511,800	1,963,091,800	1,939,249,900	2,082,103,700
Aceh	22,531,792	36,287,915	24,267,800	36,853,900	26,022,200	35,983,100	26,510,600	34,085,500
North Sumatra	87,240,283	87,897,791	92,699,000	93,347,400	99,085,700	99,792,300	105,431,900	106,172,400
West Sumatra	29,159,481	29,159,481	30,949,900	30,949,900	32,913,000	32,913,000	35,007,000	35,007,000
Riau	33,516,542	79,287,587	36,417,600	83,370,900	39,420,800	86,213,300	42,596,900	91,085,400
Jambi	11,062,278	12,619,972	11,985,800	13,363,600	12,775,100	14,275,200	13,715,400	15,296,700
South Sumatra	36,317,674	49,633,536	38,971,000	52,214,800	42,106,100	55,262,100	44,777,700	58,080,000
Bengkulu	6,239,364	6,239,364	6,610,600	6,610,600	7,009,000	7,009,000	7,354,500	7,354,500
Lampung	28,837,138	29,397,248	30,367,200	30,861,400	32,231,900	32,694,900	33,951,000	34,414,700
Bangka Belitung	8,383,033	8,707,309	8,785,600	9,053,600	9,257,000	9,464,500	9,722,300	9,884,600
Riau Islands	28,559,848	30,381,500	30,625,300	32,441,000	32,937,700	34,713,800	35,314,300	37,021,400
D.K.I Jakarta	294,354,567	295,270,544	311,893,700	312,826,700	332,033,900	332,971,300	352,598,700	353,539,100
West Java	234,010,928	242,883,882	248,774,400	257,499,400	265,834,000	274,180,300	281,710,600	290,171,100
Central Java	133,578,036	143,051,214	140,681,400	150,682,700	149,083,100	159,100,300	157,023,600	167,790,400
D.I. Yogyakarta	16,910,877	16,910,877	17,535,700	17,535,700	18,291,500	18,291,500	19,208,900	19,208,900
East Java	255,744,993	256,374,727	270,564,900	271,249,300	286,912,100	287,814,200	303,714,500	30,479,900
Banten	58,106,948	58,106,948	61,341,700	61,341,700	65,046,800	65,046,800	68,830,600	68,830,600
Bali	21,072,445	21,072,445	22,184,700	22,184,700	23,497,000	23,497,000	24,900,600	24,900,600
West Nusa Tenggara	15,183,789	15,183,789	15,603,800	15,603,800	16,369,200	16,369,200	16,799,800	16,799,800
East Nusa Tenggara	9,867,309	9,867,309	10,368,500	10,368,500	10,902,400	10,902,400	11,426,400	11,426,400
West Kalimantan	23,538,350	23,538,350	24,768,400	24,768,400	26,260,600	26,260,600	27,683,600	27,683,600
Central Kalimantan	14,034,632	14,034,632	14,853,700	14,853,700	15,754,500	15,754,500	16,725,500	16,725,500
South Kalimantan	22,841,024	23,292,545	23,995,300	24,452,300	25,454,000	25,922,300	27,074,500	27,538,500
East Kalimantan	42,478,012	93,938,002	47,840,700	96,612,800	52,412,900	97,803,200	56,016,300	103,168,000
North Sulawesi	12,725,590	12,744,550	13,449,500	13,473,100	14,319,200	14,344,300	15,401,400	15,428,500
Central Sulawesi	11,710,851	11,752,236	12,556,500	12,671,500	13,467,200	13,683,900	14,490,100	14,770,100
South Sulawesi	36,337,250	36,421,787	38,781,500	38,867,700	41,242,700	41,332,400	44,456,800	44,549,800
Southeast Sulawesi	8,026,856	8,026,856	8,643,300	8,643,300	9,331,700	9,331,700	10,010,600	10,010,600
Gorontalo	2,027,723	2,027,723	2,175,800	2,175,800	2,339,200	2,339,200	2,520,700	2,520,700
West Sulawesi	3,106,723	3,106,723	3,321,100	3,321,100	3,567,800	3,567,800	3,872,500	3,872,500
Maluku	3,244,433	3,259,244	3,425,000	3,440,100	3,621,700	3,633,500	3,774,800	3,787,100
North Maluku	2,236,804	2,236,804	2,359,500	2,359,500	2,501,200	2,501,200	2,650,800	2,650,800
West Papua	3,915,926	5,307,329	4,204,000	5,548,900	4,566,100	5,934,300	4,962,300	6,369,400
Papua	22,209,193	22,209,193	18,402,200	18,402,200	19,200,300	19,200,300	18,914,900	18,914,900

TABLE 1. ECONOMIC INDICATORS

Area	Percentage of population below the poverty line (Statistical Year Book of Indonesia)																				
Year	1999			2000			2001			2002			2003			2004			2005		
At Constant Market Prices	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	19.41	26.03	23.43	14.58	22.14	18.95	9.76	24.95	18.40	14.46	21.10	18.20	13.57	20.23	17.42	12.13	20.11	16.66	11.68	19.98	15.97
Aceh	10.15	16.30	14.75							20.09	33.06	29.83	19.47	33.63	29.76	17.58	32.66	28.47			
North Sumatra	18.28	15.49	16.74	12.59	13.39	13.05	7.22	15.21	11.73	13.60	17.55	15.84	13.41	17.77	15.89	12.02	17.19	14.93			
West Sumatra	18.23	11.24	13.24	11.74	11.32	11.43	9.36	17.47	15.16	13.34	10.80	11.57	14.10	10.06	11.24	12.28	9.67	10.46			
Riau	9.06	16.95	14.00	5.84	13.71	10.38	4.19	14.30	10.06	7.40	18.79	13.61	7.47	18.08	13.52	6.44	18.36	13.12			
Jambi	22.35	28.59	26.64	22.14	20.77	21.15	14.89	21.65	19.71	19.04	10.76	13.18	18.53	10.46	12.74	17.34	10.46	12.45			
South Sumatra	23.99	23.32	23.53	19.20	16.38	17.37	7.42	20.71	16.07	22.62	22.16	22.32	21.05	21.79	21.54	20.13	21.33	20.92			
Bengkulu	22.01	18.88	19.79	12.53	19.90	17.83	10.44	26.23	21.65	25.60	21.41	22.70	26.11	21.36	22.69	25.43	21.16	22.39			
Lampung	24.03	30.24	29.11	27.71	31.14	30.43	16.69	27.20	24.91	22.42	24.53	24.05	21.36	22.98	22.63	20.17	22.81	22.22			
Bangka Belitung							20.23	8.27	13.28	9.98	12.84	11.62	8.94	10.89	10.06	7.73	10.06	9.07			
Riau Islands																					
D.K.I Jakarta	3.99		3.99	4.96		4.96	2.95		3.14	3.42		3.42	3.42		3.42	3.18		3.18			
West Java	21.15	18.53	19.78	14.54	16.26	15.40	8.92	22.17	15.34	13.62	13.10	13.38	12.71	13.09	12.90	11.21	13.08	12.10			
Central Java	27.80	28.82	28.46	20.23	21.77	21.16	11.41	29.38	22.07	20.50	24.96	23.06	19.66	23.19	21.78	17.52	23.64	21.11			
D.I. Yogyakarta	23.81	30.79	26.10	24.58	45.17	33.39	14.56	38.65	24.53	16.17	25.96	20.14	16.44	24.48	19.86	15.96	23.65	19.14			
East Java	24.69	32.10	29.47	16.29	27.17	22.77	12.56	28.20	21.64	18.90	24.18	21.91	16.84	23.74	20.93	14.62	24.02	20.08			
Banten							12.84	22.38	17.24	6.47	12.64	9.22	6.62	12.76	9.56	5.69	11.99	8.58			
Bali	9.42	7.94	8.53	5.49	5.85	5.68	4.30	11.35	7.87	5.72	8.25	6.89	6.14	8.48	7.34	5.05	8.71	6.85			
West Nusa Tenggara	31.93	33.21	32.96	26.01	29.24	28.13	21.94	35.38	30.43	34.10	23.84	27.76	34.64	21.86	26.34	32.66	21.09	25.38			28.19
East Nusa Tenggara	29.20	49.39	46.73	21.58	39.25	36.52	12.25	36.95	33.01	21.49	32.51	30.74	19.33	30.40	28.63	18.11	29.77	27.86			
West Kalimantan	10.79	30.72	26.17	11.60	35.85	29.42	10.83	22.36	19.23	17.47	14.77	15.46	15.81	14.42	14.79	13.29	14.15	13.91			
Central Kalimantan	5.64	28.54	15.06	5.11	14.59	11.97	3.99	14.86	11.72	7.45	13.71	11.88	8.10	12.64	11.37	6.13	12.20	10.44			
South Kalimantan	10.41	16.16	14.37	4.09	17.86	13.03	4.81	15.92	11.92	6.76	9.56	8.51	6.54	9.09	8.16	5.28	8.33	7.19			
East Kalimantan	9.96	30.74	20.16	6.72	28.94	16.30	8.66	21.11	14.04	5.17	21.58	12.20	6.40	19.11	12.15	5.63	18.68	11.57			
North Sulawesi	12.88	20.33	18.19	8.31	15.36	13.03	8.88	11.76	10.67	4.66	15.31	11.22	4.62	11.60	9.01	4.37	11.76	8.94			
Central Sulawesi	23.05	30.68	28.69	14.29	27.09	24.51	13.75	28.20	25.29	20.04	26.08	24.89	17.61	24.42	23.04	15.33	23.33	21.69			
South Sulawesi	18.26	18.35	18.32	15.09	15.59	15.44	7,65	20.21	16.50	7.16	19.61	15.88	7.15	19.49	15.85	6.11	18.65	14.90			
Southeast Sulawesi	15.73	34.23	29.51	10.60	27.40	23.88	8.70	29.68	25.20	10.69	27.87	24.22	9.86	26.36	22.84	9.21	25.39	21.90			
Gorontalo							19.82	33.16	29.74	22.94	35.52	32.12	19.98	32.39	29.25	18.63	32.70	29.01			
West Sulawesi																					
Maluku	27.20	53.47	46.14				12.76	42.83	34.79	12.76	42.83	34.78	12.53	40.56	32.85	11.99	39.86	32.13			
North Maluku							13.17	14.25	14.03	13.17	14.25	14.03	13.25	14.13	13.92	10.50	13.10	12.42			
West Papua			54.75									41.80									
Papua	9.03	70.95	54.75	9.01	59.78	46.35	9.23	53.14	41.80	9.76	51.21	41.80	8.32	49.75	39.03	7.71	49.28	38.69			

TABLE 1. ECONOMIC INDICATORS

Area	Percentage of population below the poverty line (Statistical Year Book of Indonesia)												Gini Coefficient (Income and Consumption Indicators)					
Year	2006			2007			2008			2009			1993	1996	1999	2002	2005	2007
At Constant Market Prices	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Total	Total	Total	Total	Total	Total
Indonesia	13.47	21.81	17.75	12.52	20.37	16.58	11.65	18.93	15.42	10.72	17.35	14.15	0.335	0.356	0.318	0.329	0.363	0.364
Aceh				18.68	29.87	26.65	16.67	26.30	23.53	15.44	24.37	21.80	0.293	0.259	0.251		0.299	0.268
North Sumatra				14.21	13.63	13.90	2.85	12.29	12.55	11.45	11.56	11.51	0.295	0.301	0.263	0.288	0.327	0.307
West Sumatra				9.78	13.01	11.90	8.30	11.91	10.67	7.50	10.60	9.54	0.305	0.278	0.275	0.268	0.303	0.305
Riau				9.53	12.90	11.20	9.12	12.16	10.63	8.04	10.93	9.48	0.266	0.300	0.241	0.292	0.283	0.323
Jambi				15.42	7.81	10.27	13.28	7.43	9.32	12.71	6.88	8.77	0.242	0.246	0.244	0.260	0.311	0.306
South Sumatra				20.30	18.43	19.15	18.87	17.01	17.73	16.93	15.87	16.28	0.297	0.300	0.269	0.291	0.311	0.316
Bengkulu				23.00	21.66	22.13	21.95	19.93	20.64	19.16	18.28	18.59	0.281	0.273	0.264	0.253	0.353	0.338
Lampung				18.11	23.70	22.19	17.85	22.14	20.98	16.78	21.49	20.22	0.264	0.276	0.292	0.254	0.375	0.390
Bangka Belitung				8.09	10.87	9.54	7.57	9.52	8.58	5.86	8.93	7.46				0.247	0.281	0.259
Riau Islands				10.08	10.54	10.30	8.81	9.60	9.18	7.63	8.98	8.27					0.274	0.302
D.K.I Jakarta				4.61		4.61	4.29		4.29	3.62		3.62	0.423	0.363	0.317	0.322	0.269	0.336
West Java				11.21	16.88	13.55	10.88	16.05	13.01	10.33	14.28	11.96	0.299	0.356	0.296	0.289	0.336	0.344
Central Java				17.23	23.45	20.43	16.34	21.96	19.23	15.41	19.89	17.72	0.295	0.291	0.273	0.284	0.306	0.326
D.I. Yogyakarta				15.63	25.03	18.99	14.99	24.32	18.32	14.25	22.60	17.23	0.331	0.378	0.366	0.367	0.415	0.366
East Java				14.71	25.02	19.98	13.15	23.64	18.51	12.17	21.00	16.68	0.325	0.311	0.303	0.311	0.356	0.337
Banten				6.79	12.52	9.07	6.15	11.18	8.15	5.62	10.70	7.64				0.330	0.356	0.365
Bali				6.01	7.47	6.63	5.70	6.81	6.17	4.50	5.98	5.13	0.315	0.309	0.281	0.298	0.330	0.333
West Nusa Tenggara			29.34	30.44	21.06	24.99	29.47	19.73	23.81	28.84	18.40	22.78	0.274	0.286	0.269	0.266	0.318	0.328
East Nusa Tenggara				16.41	29.95	27.51	15.50	27.88	25.65	14.01	25.35	23.31	0.254	0.296	0.280	0.292	0.351	0.353
West Kalimantan				11.45	13.47	12.91	9.98	11.49	11.07	7.23	10.09	9.30	0.302	0.300	0.284	0.301	0.310	0.309
Central Kalimantan				6.72	10.76	9.38	5.81	10.20	8.71	4.45	8.34	7.02	0.259	0.271	0.250	0.245	0.283	0.297
South Kalimantan				6.01	7.72	7.01	5.79	6.97	6.48	4.82	5.33	5.12	0.274	0.292	0.265	0.292	0.279	0.341
East Kalimantan				7.44	16.98	11.04	5.89	15.47	9.51	4.00	13.86	7.73	0.313	0.318	0.289	0.304	0.318	0.334
North Sulawesi				8.31	13.80	11.42	7.56	12.04	10.10	8.14	11.05	9.79	0.291	0.344	0.278	0.270	0.323	0.324
Central Sulawesi				12.86	24.97	22.42	11.47	23.22	20.75	10.09	21.35	18.98	0.287	0.302	0.295	0.283	0.301	0.318
South Sulawesi				6.18	17.87	14.11	6.05	16.79	13.34	4.94	15.81	12.31	0.273	0.323	0.297	0.301	0.353	0.370
Southeast Sulawesi				6.24	25.84	21.33	5.29	23.78	19.53	4.96	23.11	18.93	0.272	0.311	0.285	0.270	0.364	0.353
Gorontalo				11.08	34.76	27.35	9.87	31.72	24.88	7.89	32.82	25.01				0.241	0.355	0.388
West Sulawesi				16.53	20.29	19.03	14.14	18.03	16.73	12.59	16.65	15.29						0.314
Maluku				14.49	37.02	31.14	12.97	35.56	29.66	11.03	34.30	28.23	0.300	0.269	0.259		0.258	0.328
North Maluku				4.29	15.22	11.97	3.27	14.67	11.28	3.10	13.42	10.36					0.261	0.332
West Papua				7.14	48.82	39.31	5.93	43.74	35.12	5.22	44.71	35.71						0.299
Papua				7.97	50.47	40.78	7.02	45.69	37.08	6.10	46.81	37.53	0.363	0.386	0.378		0.389	0.412

DEFINITIONS OF THE INDICATORS

Gross Regional Domestic Product	The sum of value added by all provincial resident producers plus any product taxes (less subsidies) not included in the valuation of output
Percentage of population below the poverty line	The national poverty line is the rupiah value an individual needs to fulfil his or her daily minimum requirement for food of 2,100 kilocalories (kcal), plus non-food minimum needs, such as housing, clothing, health, education and transportation. The food poverty line is the cost of meeting the basic food needs of 2,100 kcal per day, while the non-food poverty line is how much a person has to spend to fulfil their basic, minimum non-food requirements. People whose expenditures are less than the Poverty Line are classified as living below the Poverty Line, or as poor population. The poverty standard used by the Central Statistical Office (BPS-Statistics Indonesia) is dynamic because it has to be realistic and adjust to shifts in consumption patterns and national aspirations. There are two different criteria: the 1996 standard and 1998 standard. The revision in 1998 was done not only because of the shift in consumption patterns but also because the definition of minimum basic requirements and commodities had to be broadened to take into account new policies affecting family expenditure, such as the introduction of nine years of compulsory basic education.
Gini Coefficient	A low Gini coefficient indicates a more equal distribution, with 0 corresponding to complete equality, while higher Gini Coefficients indicate more unequal distribution, with 1 corresponding to complete inequality.

MAIN DATA SOURCES

Gross Regional Domestic Product	BPS-Statistics Indonesia: Statistik Indonesia (Statistical Year-Book of Indonesia), Jakarta
Percentage of population below the poverty line	BPS-Statistics Indonesia: Based on National Socio-Economic Survey (SUSENAS), published in Statistical Year-Book of Indonesia
Gini Coefficient	BPS-Statistics Indonesia: Based on National Socio-Economic Survey (SUSENAS), published in Income and Consumption Indicators.

Notes - Data not available
1) Preliminary figures
2) Very preliminary figures
2000 at Constant 1993 Market Prices
2001-2008 at Constant 2000 Market Prices

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Population-millions (Census)	Population - thousand (Census projection)												
Year	2000[1]	2005[2]							2006[3]					
	Total	Aged 0-4 years old	Aged 5-9 years old	Aged 10-14 years old	Aged 15-19 years old	Male	Female	Total	Aged 0-4 years old	Aged 5-9 years old	Aged 10-14 years old	Aged 15-19 years old	Male	Female	Total
Indonesia	205.13	20,576.4	20,440.5	21,667.5	21,198.7	110,092.4	109,759.6	219,852.0	20,724.5	20,291.4	21,414.7	21,249.8	111,528.6	111,218.3	222,746.9
Aceh	3.92	423.4	432.2	466.6	470.6	2,031.7	2,051.8	4,083.5	433.6	430.0	459.1	469.3	2,066.2	2,087.4	4,153.6
North Sumatra	11.64	1,351.5	1,406.9	1,407.9	1,392.0	6,169.0	6,249.0	12,418.0	1,355.3	1,390.6	1,412.1	1,380.3	6,275.6	6,350.3	12,625.9
West Sumatra	4.24	468.5	504.6	501.2	497.7	2,241.4	2,325.8	4,567.2	466.1	496.5	496.8	485.8	2,276.1	2,356.4	4,632.5
Riau	3.90	550.3	533.4	450.9	435.2	2,562.0	2,273.9	4,835.9	563.7	536.6	467.8	440.4	2,619.6	2,333.4	4,953.0
Jambi	2.40	273.1	270.5	296.0	261.4	1,353.3	1,297.2	2,650.5	276.1	270.7	290.7	266.6	1,375.7	1,320.5	2,696.2
South Sumatra	6.21	705.2	725.0	715.1	781.7	3,447.0	3,368.9	6,815.9	711.2	720.3	715.9	765.2	3,498.0	3,419.9	6,917.9
Bengkulu	1.45	158.9	163.1	157.6	164.5	798.3	767.8	1,566.1	161.1	161.9	158.8	162.8	810.4	781.0	1,591.4
Lampung	6.73	705.9	696.4	789.8	726.7	3,620.8	3,466.6	7,087.4	711.7	691.9	768.2	738.3	3,670.4	3,518.0	7,188.4
Bangka Belitung	0.90	102.2	98.4	101.8	115.5	567.8	507.0	1,074.8	104.3	99.0	101.0	112.4	576.2	514.5	1,090.7
Riau Islands	1.04	145.5	141.1	119.3	115.1	631.7	647.2	1,278.9	153.6	142.4	125.3	121.3	657.0	677.9	1,334.9
D.K.I Jakarta	8.36	732.7	697.2	820.4	680.2	4,394.6	4,497.7	8,892.3	746.0	695.9	795.8	715.6	4,427.5	4,552.2	8,979.7
West Java	35.72	3,724.7	3,631.6	3,678.1	3,664.3	19,783.5	19,367.1	39,150.6	3,786.3	3,651.4	3,688.3	3,667.5	20,069.7	19,669.4	39,739.1
Central Java	31.22	2,901.6	2,678.2	2,960.1	3,133.6	15,800.4	16,073.1	31,873.5	2,853.4	2,672.2	2,914.9	3,066.6	15,933.7	16,194.9	32,128.6
D.I. Yogyakarta	3.12	203.5	196.4	241.5	275.4	1,684.3	1,681.2	3,365.5	206.9	198.5	234.7	274.0	1,703.6	1,696.6	3,400.2
East Java	34.76	-	-	-	-	18,079.7	18,402.1	36,481.8	-	-	-	-	18,185.8	18,504.8	36,690.6
Banten	8.09	-	-	-	-	4,585.1	4,486.0	9,071.1	-	-	-	-	4,672.3	4,573.8	9,246.1
Bali	3.15	-	-	-	-	1,718.9	1,686.5	3,405.4	-	-	-	-	1,737.7	1,705.1	3,442.8
West Nusa Tenggara	4.00	-	-	-	-	1,974.9	2,174.2	4,149.1	-	-	-	-	2,010.8	2,210.0	4,220.8
East Nusa Tenggara	3.82	463.1	476.0	537.1	448.4	2,128.1	2,151.4	4,279.5	484.2	473.5	524.5	465.2	2,170.3	2,193.5	4,363.8
West Kalimantan	4.01	-	-	-	-	2,045.3	1,991.9	4,037.2	-	-	-	-	2,079.1	2,028.7	4,107.8
Central Kalimantan	1.85	-	-	-	-	1,032.9	936.8	1,969.7	-	-	-	-	1,047.1	952.0	1,999.1
South Kalimantan	2.98	-	-	-	-	1,649.3	1,647.3	3,296.6	-	-	-	-	1,675.8	1,670.8	3,346.6
East Kalimantan	2.45	-	-	-	-	1,511.0	1,376.1	2,887.1	-	-	-	-	1,546.1	1,409.4	2,955.5
North Sulawesi	2.00	-	-	-	-	1,092.6	1,051.2	2,143.8	-	-	-	-	1,103.4	1,062.0	2,165.4
Central Sulawesi	2.17	-	-	-	-	1,179.9	1,132.1	2,312.0	-	-	-	-	1,200.4	1,153.6	2,354.0
South Sulawesi	7.15	-	-	-	-	3,600.9	3,888.8	7,489.7	-	-	-	-	3,654.6	3,940.4	7,595.0
Southeast Sulawesi	1.82	-	-	-	-	959.7	985.4	1,945.1	-	-	-	-	980.3	1,007.9	1,988.2
Gorontalo	0.83	-	-	-	-	472.8	463.5	936.3	-	-	-	-	479.2	469.1	948.3
West Sulawesi	0.89	-	-	-	-	498.9	486.8	985.7	-	-	-	-	506.7	494.5	1,001.2
Maluku	1.16	-	-	-	-	644.0	620.8	1,264.8	-	-	-	-	652.8	630.6	1,283.4
North Maluku	0.81	-	-	-	-	463.9	450.2	914.1	-	-	-	-	470.9	458.2	929.1
West Papua	0.53	-	-	-	-	361.2	327.0	688.2	-	-	-	-	368.6	333.5	702.1
Papua	1.68	225.6	183.1	236.4	198.7	1,007.5	927.2	1,934.7	228.4	191.0	224.9	206.3	1,027.0	948.0	1,975.0

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Population - thousand (Census projection)													
Year	2007[3]							2008[3]						
	Aged 0-4 years old	Aged 5-9 years old	Aged 10-14 years old	Aged 15-19 years old	Male	Female	Total	Aged 0-4 years old	Aged 5-9 years old	Aged 10-14 years old	Aged 15-19 years old	Male	Female	Total
Indonesia	20,952.2	20,060.2	21,041.5	21,373.6	112,966.9	112,675.1	225,642.0	21,167.5	20,227.2	20,833.8	21,287.4	114,399.2	114,124.1	228,523.3
Aceh	444.0	427.7	451.8	468.0	2,101.4	2,122.4	4,223.8	453.4	427.3	448.8	462.1	2,136.0	2,157.9	4,293.9
North Sumatra	1,374.3	1,344.9	1,409.1	1,389.2	6,381.9	6,452.5	12,834.4	1,399.4	1,340.9	1,406.7	1,387.0	6,488.9	6,553.4	13,042.3
West Sumatra	473.1	468.9	499.7	490.7	2,311.7	2,386.1	4,697.8	483.6	465.0	497.5	490.8	2,346.3	2,416.8	4,763.1
Riau	577.4	539.1	484.3	445.4	2,678.1	2,392.9	5,071.0	589.1	544.7	505.9	445.1	2,735.9	2,453.3	5,189.2
Jambi	279.3	270.5	285.5	274.4	1,398.7	1,343.5	2,742.2	281.7	272.5	281.9	276.4	1,422.3	1,366.0	2,788.3
South Sumatra	716.7	714.9	716.6	749.8	3,548.7	3,471.3	7,020.0	720.5	713.8	725.3	728.0	3,599.7	3,522.1	7,121.8
Bengkulu	163.1	160.7	159.6	161.7	823.1	793.6	1,616.7	164.9	160.3	161.1	158.0	835.2	806.7	1,641.9
Lampung	716.8	695.1	746.5	747.6	3,720.3	3,569.5	7,289.8	720.5	700.9	733.4	750.6	3,769.4	3,621.7	7,391.1
Bangka Belitung	106.6	100.1	100.1	109.4	584.2	522.5	1,106.7	107.0	101.2	100.7	105.8	592.6	529.9	1,122.5
Riau Islands	162.5	143.1	130.0	126.0	682.9	710.0	1,392.9	171.2	144.7	136.2	127.6	709.8	743.3	1,453.1
D.K.I Jakarta	758.0	696.0	766.8	747.8	4,460.3	4,604.3	9,064.6	769.3	699.4	740.1	769.3	4,491.4	4,654.8	9,146.2
West Java	3,845.2	3,668.8	3,658.0	3,669.4	20,355.4	19,973.7	40,329.1	3,895.3	3,701.9	3,685.2	3,632.5	20,642.1	20,276.2	40,918.3
Central Java	2828.3	2,634.5	2,806.8	3,045.4	16,064.1	16,316.2	32,380.3	2,806.5	2,718.4	2,722.2	2,989.9	16,192.3	16,434.1	32,626.4
D.I. Yogyakarta	209.1	200.5	227.6	272.0	1,722.8	1,711.7	3,434.5	211.9	203.5	221.7	265.2	1,740.8	1,727.7	3,468.5
East Java	-	-	-	-	18,290.4	18,605.2	36,895.6	-	-	-	-	18,393.1	18,701.7	37,094.8
Banten	-	-	-	-	4,760.1	4,663.3	9,423.4	-	-	-	-	4,848.7	4,753.7	9,602.4
Bali	-	-	-	-	1,756.2	1,723.6	3,479.8	-	-	-	-	1,773.8	1,742.2	3,516.0
West Nusa Tenggara	-	-	-	-	2,047.8	2,244.7	4,292.5	-	-	-	-	2,084.4	2,279.4	4,363.8
East Nusa Tenggara	505.1	470.6	511.6	481.5	2,213.0	2,235.9	4,448.9	524.4	469.6	504.3	493.3	2,256.6	2,277.7	4,534.3
West Kalimantan	-	-	-	-	2,113.1	2,065.4	4,178.5	-	-	-	-	2,147.0	2,102.1	4,249.1
Central Kalimantan	-	-	-	-	1,061.3	967.0	2,028.3	-	-	-	-	1,074.8	982.5	2,057.3
South Kalimantan	-	-	-	-	1,700.8	1,695.9	3,396.7	-	-	-	-	1,727.8	1,718.8	3,446.6
East Kalimantan	-	-	-	-	1,581.8	1,443.0	3,024.8	-	-	-	-	1,618.2	1,476.5	3,094.7
North Sulawesi	-	-	-	-	1,113.6	1,073.2	2,186.8	-	-	-	-	1,124.7	1,083.3	2,208.0
Central Sulawesi	-	-	-	-	1,222.1	1,174.1	2,396.2	-	-	-	-	1,242.2	1,196.2	2,438.4
South Sulawesi	-	-	-	-	3,707.9	3,992.4	7,700.3	-	-	-	-	3,761.8	4,043.2	7,805.0
Southeast Sulawesi	-	-	-	-	1,001.9	1,029.6	2,031.5	-	-	-	-	1,023.8	1,051.2	2,075.0
Gorontalo	-	-	-	-	485.2	475.1	960.3	-	-	-	-	491.7	480.5	972.2
West Sulawesi	-	-	-	-	514.5	502.2	1,016.7	-	-	-	-	522.3	510.0	1,032.3
Maluku	-	-	-	-	661.2	640.8	1,302.0	-	-	-	-	670.1	650.6	1,320.7
North Maluku	-	-	-	-	479.6	464.7	944.3	-	-	-	-	485.7	473.9	959.6
West Papua	-	-	-	-	375.5	340.5	716.0	-	-	-	-	383.1	346.9	730.0
Papua	231.3	198.7	214.1	214.1	1,047.3	968.3	2,015.6	233.9	207.6	204.6	218.9	1,066.7	989.8	2,056.5

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Population - thousand (Census projection)																		
Year	2009[3]							1990-2000	2000-2005	2000-2008	2000-2009	1990-2000	2005	2006	2007	2008	2009
	Aged 0-4 years old	Aged 5-9 years old	Aged 10-14 years old	Aged 15-19 years old	Male	Female	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	21,374.0	20,381.5	20,618.2	21,195.7	115,817.9	115,551.6	231,369.5	1.45	1.40	1.36	1.35	1.45 1.46	1.32	1.30	1.28	1.25	1.22
Aceh	461.8	425.9	446.1	456.2	2,171.4	2,192.1	4,363.5	1.46	0.77	1.12	1.17	1.32	1.72	1.69	1.66	1.62	1.58
North Sumatra	1,423.7	1,335.3	1,404.7	1,386.6	6,594.1	6,654.3	13,248.4	1.32	1.30	1.43	1.45	0.63	1.67	1.65	1.62	1.58	1.54
West Sumatra	493.1	462.0	496.7	492.9	2,380.8	2,447.2	4,828.0	0.63	1.46	1.44	1.43	4.35	1.43	1.41	1.39	1.36	1.33
Riau	601.4	548.6	527.9	442.6	2,794.6	2,511.9	5,306.5	4.35	4.14	3.47	3.46	1.84	2.42	2.38	2.33	2.26	2.20
Jambi	283.5	273.8	279.8	281.7	1,444.8	1,389.4	2,834.2	1.84	1.94	1.85	1.83	1.28	1.72	1.71	1.66	1.65	1.61
South Sumatra	724.2	711.2	733.2	707.3	3,650.6	3,572.0	7,222.6	1.28	1.88	1.73	1.69	2.20	1.50	1.48	1.45	1.42	1.38
Bengkulu	166.7	159.0	163.7	155.4	847.2	819.7	1,666.9	2.20	1.48	1.52	1.52	1.17	1.62	1.59	1.56	1.52	1.48
Lampung	724.7	706.7	720.6	753.7	3,819.4	3,672.5	7,491.9	1.17	1.04	1.18	1.20	0.97	1.43	1.41	1.39	1.36	1.34
Bangka Belitung	109.0	101.7	100.6	101.8	600.4	537.7	1,138.1	0.97	3.61	2.80	2.64		1.48	1.47	1.43	1.39	1.35
Riau Islands	179.1	146.3	141.8	127.4	737.8	777.5	1,515.3		5.05	4.79	4.27	0.17	4.38	4.34	4.32	4.28	4.24
D.K.I Jakarta	779.0	703.9	709.4	788.5	4,520.1	4,702.9	9,223.0	0.17	1.24	1.13	1.10	2.03	0.98	0.95	0.90	0.84	0.78
West Java	3,944.1	3,730.9	3,714.0	3,594.5	20,926.6	20,574.9	41,501.5	2.03	1.85	1.71	1.68	0.94	1.50	1.48	1.46	1.43	1.40
Central Java	2,783.7	2,800.7	2,639.5	2,940.7	16,317.0	16,547.6	32,864.6	0.94	0.41	0.55	0.57	0.72	0.80	0.78	0.60	0.73	0.70
D.I. Yogyakarta	213.5	206.2	214.7	256.5	1,759.9	1,742.0	3,501.9	0.72	1.52	1.33	1.29	0.70	1.03	1.01	0.99	0.96	0.93
East Java	-	-	-	-	18,491.9	18,794.3	37,286.2	0.70	0.97	0.81	0.78	2.21	0.57	0.56	0.54	0.52	0.49
Banten	-	-	-	-	4,939.1	4,843.7	9,782.8	2.21	2.30	2.15	2.12	1.31	1.93	1.92	1.90	1.88	1.86
Bali	-	-	-	-	1,792.3	1,758.7	3,551.0	1.31	1.57	1.38	1.34	1.82	1.10	1.07	1.04	1.00	0.95
West Nusa Tenggara	-	-	-	-	2,120.1	2,313.9	4,434.0	1.82	0.69	1.07	1.13	1.64	1.73	1.70	1.66	1.61	1.56
East Nusa Tenggara	543.0	467.5	497.2	505.3	2,299.0	2,320.7	4,619.7	1.64	2.28	2.16	2.13	2.29	1.97	1.95	1.92	1.88	1.64
West Kalimantan	-	-	-	-	2,181.5	2,137.6	4,319.1	2.29	0.10	0.71	0.81	2.99	1.75	1.72	1.69	1.65	1.61
Central Kalimantan	-	-	-	-	1,087.6	998.2	2,085.8	2.99	1.20	1.30	1.31	1.45	1.49	1.46	1.43	1.39	1.34
South Kalimantan	-	-	-	-	1,753.1	1,743.0	3,496.1	1.45	2.01	1.82	1.78	2.81	1.52	1.50	1.47	1.44	1.40
East Kalimantan	-	-	-	-	1,654.3	1,510.5	3,164.8	2.81	3.32	2.95	2.88	1.33	2.37	2.34	2.31	2.27	2.22
North Sulawesi	-	-	-	-	1,135.2	1,093.7	2,228.9	1.33	1.39	1.24	1.21	2.57	1.01	0.99	0.97	0.95	0.92
Central Sulawesi	-	-	-	-	1,262.7	1,217.6	2,480.3	2.57	1.22	1.43	1.46	1.49	1.82	1.79	1.76	1.72	1.67
South Sulawesi	-	-	-	-	3,814.2	4,094.3	7,908.5	1.49	1.03	1.16	1.11	3.15	1.41	1.39	1.36	1.33	1.29
Southeast Sulawesi	-	-	-	-	1,045.5	1,072.8	2,118.3	3.15	1.34	1.65	1.70	1.59	2.22	2.18	2.14	2.09	2.03
Gorontalo	-	-	-	-	497.6	486.4	984.0	1.59	2.35	1.94	1.86	-	1.28	1.27	1.24	1.21	1.17
West Sulawesi	-	-	-	-	530.0	517.7	1,047.7	-	-	-	-	0.11	1.57	1.55	1.53	1.49	1.47
Maluku	-	-	-	-	678.5	661.0	1,339.5	0.11	1.63	1.57	1.55	1.60	1.47	1.45	1.44	1.42	1.40
North Maluku	-	-	-	-	493.4	481.6	975.0	1.60	2.32	2.06	2.01	-	1.64	1.64	1.62	1.60	1.59
West Papua	-	-	-	-	390.0	353.9	743.9	-	3.45	2.90	3.43	3.22	2.02	1.98	1.96	1.90	1.86
Papua	236.5	215.7	196.0	223.6	1,087.2	1,010.3	2,097.5	3.22	3.45	2.93	2.60		2.08	2.06	2.03	1.99	1.95

TABLE 2. DEMOGRAPHIC INDICATORS

Area	"Percentage of population living in urban areas (Intercensal Survey)"																	
Year	2000						2001						2002					
	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total
Indonesia	40.70	42.50	44.90	41.95	42.35	42.14	41.90	43.70	46.00	42.90	43.30	43.10	43.30	44.50	47.10	44.30	44.60	44.40
Aceh						28.75												
North Sumatra	42.03	40.08	45.78	41.99	43.30	42.64	42.36	44.07	46.41	43.50	28.50	43.51	39.50	44.06	46.24	43.34	43.08	43.21
West Sumatra	27.93	27.81	30.18	27.75	27.50	28.93	28.53	28.40	30.68	28.36	42.10	28.43	30.18	30.40	33.05	30.06	30.60	30.34
Riau	41.99	39.18	45.47	41.79	42.81	34.59	45.47	36.59	43.94	41.66	28.60	41.87	52.21	39.57	50.14	43.98	47.03	45.50
Jambi	25.57	29.22	30.22	27.75	28.50	28.32	29.56	27.83	29.64	28.61	35.22	28.61	30.93	29.81	30.70	28.79	29.86	29.32
South Sumatra	34.25	35.98	37.25	34.56	35.88	33.78	36.37	35.35	37.35	34.64	28.82	34.93	37.57	36.42	37.22	34.56	36.15	35.35
Bengkulu	30.09	30.02	30.23	28.15	28.18	28.33	29.16	30.45	30.11	29.28	22.21	29.06	30.64	31.88	33.02	30.34	31.36	30.84
Lampung	20.29	21.53	23.02	20.14	21.38	21.24	21.56	22.39	22.74	21.40	42.87	21.79	24.71	22.12	23.90	21.99	22.90	22.43
Bangka Belitung	-	-	-	-	-	43.04	38.31	42.77	43.92	40.89		41.86	45.82	46.58	46.11	42.34	42.93	42.63
Riau Islands	-	-	-	-	-	76.01	-	-	-	-	-	-	-	-	-	-	-	-
D.K.I Jakarta	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
West Java	48.18	50.97	53.28	49.98	50.46	50.31	50.19	52.61	53.94	51.56	51.54	51.55	51.64	54.82	54.91	52.54	52.72	52.63
Central Java	38.34	40.67	41.15	39.12	39.40	40.19	39.58	42.24	42.95	40.43	40.90	40.67	41.35	43.38	44.19	42.43	42.62	42.53
D.I. Yogyakarta	53.17	59.47	61.75	57.39	57.11	57.64	53.83	61.80	63.15	58.85	58.32	58.58	59.74	59.57	63.31	60.37	58.64	59.50
East Java	41.40	41.85	42.35	40.38	40.54	40.88	41.59	43.74	44.29	41.68	42.28	41.98	44.62	43.43	44.68	43.09	42.97	43.03
Banten	49.07	46.80				52.17	54.02	52.56	59.73	53.04	54.65	53.83	54.67	51.84	59.61	54.55	56.26	55.39
Bali	34.48	35.75	50.52	46.80	46.94	49.74	52.27	49.65	51.84	49.60	49.24	49.42	53.75	52.93	56.51	53.92	53.51	53.72
West Nusa Tenggara	13.72	18.98	35.11	34.76	34.04	35.08	33.07	38.68	38.20	37.72	35.97	36.83	36.75	38.61	38.68	38.54	37.84	38.18
East Nusa Tenggara	27.22	28.39	17.46	15.57	15.34	15.46	14.33	19.26	18.04	15.83	16.04	15.93	14.16	19.38	18.11	16.15	15.93	16.04
West Kalimantan	28.79	28.32	28.54	25.95	27.05	26.40	24.74	28.64	29.27	27.03	27.35	27.18	26.75	25.40	26.60	24.91	26.08	25.48
Central Kalimantan	34.02	34.60	30.19	26.89	28.49	28.14	28.15	31.27	30.23	28.78	29.00	28.89	32.96	29.24	31.71	28.69	29.72	29.19
South Kalimantan	58.23	59.07	37.26	35.02	35.11	36.21	38.36	35.65	37.53	36.21	35.75	35.98	39.04	34.27	39.42	37.65	37.54	37.60
East Kalimantan	38.72	29.94	58.93	56.29	57.51	57.75	58.04	56.81	59.56	56.22	57.34	56.76	60.05	56.26	59.40	56.84	58.03	57.41
North Sulawesi	16.59	23.38	34.58	32.20	34.02	36.66	34.15	40.21	42.34	37.01	39.01	38.01	37.87	39.14	40.68	37.45	39.43	38.41
Central Sulawesi	28.09	29.56	22.58	20.03	20.32	19.82	17.73	22.70	22.33	19.93	20.40	20.17	18.94	20.62	22.15	19.02	20.24	19.62
South Sulawesi	19.87	23.69	31.61	29.43	28.93	31.07	30.24	30.88	32.51	29.27	29.74	29.51	30.17	30.74	32.08	30.12	29.85	29.99
Southeast Sulawesi	-	-	23.57	20.92	21.02	21.01	19.26	25.72	23.88	20.86	21.84	21.35	19.25	22.15	23.19	20.91	21.59	21.25
Gorontalo	-	-	-	-	-	25.54	26.07	24.80	27.31	24.43	26.88	25.65	25.02	29.97	28.35	25.89	28.14	26.99
West Sulawesi	-	-	-	-	-	17.97	-	-	-	-	-	-	-	-	-	-	-	-
Maluku	-	-	-	-	-	25.33	28.69	22.59	30.73	25.41	28.13	26.74	-	-	-	-	-	-
North Maluku	-	-	-	-	-	29.31	21.34	22.39	24.19	21.55	20.47	21.00	-	-	-	-	-	-
West Papua	-	-	-	-	-	33.13	-	-	-	-	-	-	-	-	-	-	-	-
Papua	29.33	29.79	27.84	26.06	26.90	21.14	27.36	26.06	26.69	26.16	25.47	25.83	-	-	-	-	-	-

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Percentage of population living in urban areas (Intercensal Survey)																	
Year	2003						2004						2005					
	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total
Indonesia	42.30	41.40	44.60	42.00	42.30	42.10	43.40	42.40	45.80	43.00	43.50	43.20	44.60	43.00	46.60	43.90	44.30	44.10
Aceh	25.86	24.72	26.87	25.65	26.41	26.03	31.25	27.32	29.10	28.14	27.60	27.87	-	-	-	-	-	
North Sumatra	42.63	40.45	46.16	43.33	42.99	43.17	42.02	43.06	46.99	43.40	44.06	43.73	43.93	42.32	47.09	43.97	44.65	44.31
West Sumatra	29.33	29.52	32.90	29.39	29.47	29.43	29.56	30.21	32.86	30.68	30.18	30.43	29.87	30.21	33.70	30.52	31.01	30.77
Riau	50.82	38.63	45.02	42.72	43.31	43.01	50.51	37.59	47.73	43.54	44.98	44.24	39.56	31.94	35.73	35.27	35.27	35.27
Jambi	31.10	27.75	30.43	27.75	28.82	28.28	32.10	28.96	30.12	28.23	29.67	28.94	34.55	26.60	30.37	28.97	29.22	29.09
South Sumatra	36.97	34.22	34.90	33.18	34.19	33.68	33.62	34.83	37.05	33.34	35.32	34.32	36.77	34.56	37.13	33.53	35.63	34.57
Bengkulu	31.66	29.25	30.06	27.61	28.26	27.93	31.41	31.08	31.40	28.11	29.68	28.88	31.79	29.49	30.21	28.42	28.54	28.48
Lampung	23.05	21.35	22.86	21.38	21.71	21.54	25.32	22.34	24.06	22.08	22.87	22.46	25.56	22.05	24.24	21.92	22.54	22.22
Bangka Belitung	38.30	43.84	42.37	42.56	42.31	42.44	41.93	41.82	41.71	42.08	42.73	42.40	37.32	40.23	43.23	42.60	42.87	42.73
Riau Islands	-	-	-	-	-	-	-	-	-	-	-	-	83.83	73.06	81.02	79.28	79.40	79.34
D.K.I Jakarta	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
West Java	50.51	51.93	53.11	50.46	50.83	50.64	54.63	52.09	54.70	51.93	52.25	52.09	52.26	52.90	55.78	53.00	52.94	52.97
Central Java	39.63	39.72	41.77	39.65	40.35	40.00	40.91	41.27	42.88	40.82	41.71	41.26	40.79	41.81	43.89	41.42	42.29	41.86
D.I. Yogyakarta	58.99	55.06	59.68	58.02	57.02	57.52	62.65	55.87	62.48	58.60	58.74	58.67	62.06	57.57	62.42	59.10	59.13	59.11
East Java	42.79	41.58	42.04	40.63	40.66	40.65	44.08	42.00	43.45	41.77	41.98	41.88	45.89	43.06	43.79	42.45	42.24	42.34
Banten	51.73	47.91	56.90	51.74	52.68	52.20	50.08	52.40	57.70	54.60	53.71	54.16	55.88	51.70	57.92	54.81	55.22	55.01
Bali	53.06	48.40	51.16	48.19	48.76	48.47	53.25	49.98	53.38	51.10	50.80	50.95	58.94	48.66	54.59	51.32	52.49	51.90
West Nusa Tenggara	38.04	34.64	35.84	34.32	35.70	35.03	35.95	37.56	37.56	37.06	37.21	37.14	37.89	38.76	39.78	37.91	37.93	37.92
East Nusa Tenggara	15.15	18.88	18.18	16.22	15.80	16.01	15.18	20.75	18.97	16.38	16.52	16.45	14.60	18.31	18.60	16.61	16.11	16.36
West Kalimantan	27.90	26.20	27.58	26.19	26.98	26.57	27.88	26.13	28.38	26.59	27.52	27.04	30.76	26.81	28.69	26.59	27.63	27.10
Central Kalimantan	32.94	26.34	29.70	27.64	28.23	27.92	30.48	30.53	31.21	28.72	29.54	29.11	37.04	28.00	30.67	29.10	29.57	29.33
South Kalimantan	35.01	36.23	38.18	36.56	36.65	36.61	38.04	36.69	39.75	37.41	38.23	37.82	41.87	34.34	38.83	37.00	37.43	37.22
East Kalimantan	58.98	53.40	57.35	54.90	55.27	55.07	54.89	56.41	57.03	54.21	54.99	54.58	58.24	52.94	55.71	53.84	54.52	54.17
North Sulawesi	40.24	36.51	40.02	36.43	37.89	37.13	41.53	38.35	40.22	38.01	38.57	38.28	40.30	38.84	40.84	37.56	39.35	38.43
Central Sulawesi	18.05	22.71	21.53	19.81	20.88	20.33	19.86	22.58	23.13	19.96	21.28	20.60	19.86	21.38	22.88	20.08	21.19	20.62
South Sulawesi	28.43	29.74	31.98	29.77	29.30	29.53	28.88	30.30	32.37	29.76	30.14	29.96	30.35	30.75	31.96	29.76	30.02	29.89
Southeast Sulawesi	20.09	22.76	23.60	21.05	21.59	21.31	20.18	22.94	24.70	21.47	22.07	21.77	20.92	21.67	23.86	20.78	21.25	21.02
Gorontalo	23.05	24.22	26.33	25.07	25.59	25.33	26.09	27.56	28.35	25.74	26.93	26.35	24.93	25.68	29.27	25.87	27.75	26.82
West Sulawesi	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Maluku	22.87	29.69	31.12	27.83	27.16	27.50	24.37	28.44	31.18	27.20	28.27	27.74	26.02	27.53	30.70	27.03	28.81	27.91
North Maluku	21.27	26.05	26.18	23.72	24.42	24.07	20.29	28.53	29.28	26.42	26.14	26.28	25.28	25.72	28.94	24.89	26.61	25.73
West Papua	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Papua	33.48	23.38	23.91	23.92	23.70	23.824	30.81	22.58	24.60	24.12	24.46	24.28	35.47	26.00	29.60	28.36	28.80	28.57

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Percentage of population living in urban areas (Intercensal Survey)																	
Year	2006						2007						2008					
	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total	Aged 0-2 years old	Aged 13-18 years old	Aged 15-49 years old	Male	Female	Total
Indonesia	44.70	41.90	45.70	43.40	43.70	43.60	42.80	42.80	46.40	43.60	43.90	43.70	47.70	47.90	50.90	48.10	48.60	48.30
Aceh	22.10	21.46	24.70	22.55	23.20	22.87	22.67	21.74	25.37	23.62	23.31	23.46	28.36	27.67	30.40	29.02	28.59	28.80
North Sumatra	43.55	41.84	46.58	43.87	44.72	44.30	41.68	42.76	46.80	44.48	44.16	44.32	43.35	44.50	48.62	46.16	46.04	46.10
West Sumatra	29.28	30.82	33.39	31.18	30.60	30.89	30.67	30.17	33.60	30.93	31.07	31.00	32.49	34.42	37.14	34.17	34.42	34.30
Riau	44.34	32.39	36.75	35.33	36.10	35.71	37.15	33.85	36.37	35.01	35.34	35.17	52.99	47.68	51.91	49.99	50.83	50.40
Jambi	32.50	26.77	28.92	27.97	28.93	28.44	30.22	28.36	30.14	28.48	28.82	28.65	34.28	31.94	33.52	31.86	32.95	32.40
South Sumatra	38.72	33.93	35.77	34.12	34.98	34.55	36.47	34.73	36.36	34.11	35.11	34.60	37.85	38.72	40.36	37.96	39.45	38.70
Bengkulu	27.61	27.96	29.81	27.26	28.55	27.90	29.63	27.85	30.40	27.30	28.44	27.86	33.67	38.30	37.93	34.00	36.44	35.20
Lampung	24.11	21.16	23.46	21.87	22.84	22.34	21.30	22.92	24.08	21.83	22.90	22.35	26.94	28.39	29.27	26.32	27.73	27.00
Bangka Belitung	44.43	36.60	40.81	41.82	42.37	42.08	41.86	37.44	42.00	40.83	41.39	41.10	44.64	42.77	47.92	47.52	48.09	47.80
Riau Islands	83.16	73.76	81.07	78.96	80.03	79.49	81.04	73.55	83.75	78.75	80.95	79.89	59.32	44.44	56.90	51.79	53.97	52.90
D.K.I Jakarta	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
West Java	54.03	52.16	55.43	52.85	53.18	53.01	52.63	52.03	55.77	52.91	53.24	53.07	58.84	58.99	61.38	58.51	59.09	58.80
Central Java	43.15	42.00	43.93	41.86	42.07	41.97	41.22	42.88	43.84	41.76	42.24	42.00	48.01	50.04	50.70	48.19	49.00	48.60
D.I. Yogyakarta	60.48	51.55	58.10	56.50	55.14	55.81	65.13	58.02	65.06	60.48	60.90	60.69	63.82	65.18	67.27	65.05	63.55	64.30
East Java	46.32	41.74	43.57	42.34	42.35	42.34	44.27	42.88	44.27	42.33	42.37	42.35	50.73	49.87	50.67	48.93	48.86	48.90
Banten	56.75	50.37	58.14	54.78	55.20	54.99	52.59	50.96	58.94	54.68	55.63	55.16	60.33	55.96	64.13	59.68	60.73	60.20
Bali	57.99	51.97	54.64	53.02	52.47	52.75	56.94	51.74	55.90	52.69	52.94	52.81	62.09	58.46	59.92	58.07	57.34	57.70
West Nusa Tenggara	38.60	38.26	38.44	38.46	37.30	37.86	36.20	37.39	37.84	38.58	37.16	37.83	38.91	44.35	43.50	42.54	41.32	41.90
East Nusa Tenggara	15.00	18.61	18.63	16.52	16.22	16.37	14.40	21.64	20.03	16.39	16.97	16.68	15.53	23.03	21.25	18.20	17.74	17.97
West Kalimantan	31.75	25.67	28.09	26.57	28.11	27.33	25.51	27.78	28.21	26.96	27.53	27.24	29.51	27.73	28.94	27.31	28.31	27.80
Central Kalimantan	40.68	28.92	31.20	29.01	29.82	29.40	31.92	28.72	30.90	29.32	29.46	29.39	37.45	35.28	35.75	33.70	34.31	34.00
South Kalimantan	39.35	35.97	38.79	37.49	37.97	37.73	41.17	36.08	39.25	38.19	37.89	38.04	42.16	39.47	43.59	40.66	42.33	41.50
East Kalimantan	59.73	52.08	56.43	54.07	54.96	54.50	56.32	53.30	56.66	53.45	55.42	54.39	64.00	62.00	64.15	61.92	62.51	62.20
North Sulawesi	39.01	36.12	40.63	37.22	39.37	38.28	36.62	36.38	38.82	36.14	37.31	36.72	44.07	44.86	45.80	42.68	44.13	43.40
Central Sulawesi	21.87	21.24	22.98	20.02	21.12	20.56	19.22	21.49	22.62	19.99	21.13	20.56	19.51	23.59	23.25	20.92	21.09	21.00
South Sulawesi	34.51	32.14	34.23	31.95	31.84	31.90	32.73	31.67	34.74	31.86	32.04	31.96	32.59	31.31	34.52	32.28	32.12	32.20
Southeast Sulawesi	19.86	22.59	24.00	21.23	21.81	21.52	21.25	21.98	24.85	21.70	22.41	22.06	22.01	24.27	26.19	22.84	23.16	23.00
Gorontalo	22.37	27.13	28.05	25.30	27.28	26.30	26.27	27.30	28.52	26.34	27.16	26.75	32.31	28.89	31.28	30.48	32.13	31.30
West Sulawesi	15.81	16.83	15.63	15.09	15.31	15.20	13.02	17.67	16.74	15.04	15.22	15.13	31.68	38.94	35.76	32.70	34.08	33.40
Maluku	26.18	28.55	31.04	27.90	28.83	28.37	24.79	35.31	32.91	28.36	29.39	28.87	27.02	27.83	30.37	25.80	26.41	26.10
North Maluku	23.79	25.26	27.42	25.22	25.46	25.33	24.29	27.53	29.07	24.40	26.44	25.40	25.68	29.64	34.02	29.04	30.39	29.70
West Papua	36.83	27.45	33.93	30.92	32.34	31.61	32.25	30.84	34.89	30.97	32.24	31.59	22.17	20.34	25.13	22.41	23.20	22.80
Papua	32.45	23.62	24.19	24.61	24.12	24.38	30.14	24.92	28.43	27.33	27.45	27.39	26.71	21.39	23.15	22.72	22.70	22.71

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Average annual growth rate of urban population (Census projection)	"Average annual growth rate of urban population (Intercensal Survey)"		Total fertility rate (IDHS)					Total fertility rate (Intercensal Survey)					Crude death rate (Intercensal Survey)				
Year	1990-1995	1995-1998	2005-2010	1991	1994	1997	2002-2003	2007	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	4.76	4.35	3.59	3.00	2.80	2.70	2.6	2.6	2.20	2.19	2.18	2.17	2.16	6.4	6.3	6.2	6.3	6.3
Aceh	7.92	6.85	5.03	3.70	3.30	3.00		3.1	2.46	2.44	2.42	2.40	2.38	5.0	5.0	5.1	5.2	5.4
North Sumatra	4.65	4.49	3.13	4.10	3.80	3.70	3.0	3.8	2.53	2.51	2.49	2.46	2.44	4.9	4.9	5.0	5.0	5.0
West Sumatra	6.02	5.59	4.35	3.60	3.20	3.40	3.2	3.4	2.52	2.50	2.47	2.45	2.42	5.9	5.9	5.9	6.0	6.0
Riau	5.07	3.68	4.33		3.10	3.40	3.2	2.7	2.40	2.39	2.37	2.35	2.33	3.9	3.5	3.2	3.3	3.3
Jambi	8.27	6.60	4.15		2.90	2.90	2.7	2.8	2.32	2.31	2.30	2.29	2.28	5.1	4.9	4.8	4.9	5.0
South Sumatra	3.36	2.30	3.59	3.40	2.80	2.60	2.3	2.7	2.24	2.23	2.21	2.20	2.19	4.9	5.0	5.0	5.0	5.1
Bengkulu	8.57	6.86	4.75		3.40	2.90	3.0	2.4	2.25	2.23	2.22	2.20	2.19	5.2	5.3	5.3	5.3	5.3
Lampung	6.93	6.06	5.78	3.20	3.40	2.90	2.7	2.5	2.31	2.29	2.28	2.27	2.26	5.4	5.4	5.4	5.5	5.5
Bangka Belitung	-	-	3.28				2.4	2.5	2.23	2.22	2.21	2.19	2.18	5.5	5.5	5.6	5.6	5.7
Riau Islands	-	-	4.66					3.1	2.40	2.39	2.37	2.35	2.33	3.6	3.6	3.6	3.6	3.7
D.K.I Jakarta	2.06	1.23	0.89	2.10	1.90	2.00	2.2	2.1	1.57	1.56	1.55	1.54	1.52	3.1	3.2	3.3	3.4	3.5
West Java	6.51	5.68	3.93	3.30	3.10	3.00	2.8	2.6	2.22	2.21	2.20	2.19	2.19	6.1	6.1	6.2	6.2	6.2
Central Java	4.22	4.32	3.70	2.80	2.70	2.60	2.1	2.3	2.05	2.04	2.03	2.02	2.00	7.1	7.0	6.9	7.0	7.0
D.I. Yogyakarta	5.52	5.31	2.76	2.00	1.80	1.80	1.9	1.8	1.39	1.39	1.39	1.39	1.39	7.2	7.2	7.2	7.2	7.2
East Java	4.00	3.90	3.44	2.10	2.20	2.30	2.1	2.1	1.68	1.68	1.67	1.67	1.66	7.6	7.7	7.7	7.8	7.8
Banten	-	-	4.24				2.6	2.6	2.30	2.30	2.29	2.29	2.28	5.3	5.3	5.3	5.4	5.4
Bali	6.24	6.09	3.41	2.20	2.10	2.10	2.1	2.1	1.71	1.70	1.69	1.68	1.67	5.8	5.9	6.0	6.1	6.2
West Nusa Tenggara	3.56	3.67	4.77	3.80	3.60	2.90	2.4	2.8	2.57	2.53	2.50	2.46	2.43	6.3	6.1	6.1	6.1	6.1
East Nusa Tenggara	5.94	5.70	4.74		3.80	3.50	4.1	4.2	2.99	2.94	2.89	2.84	2.80	6.5	6.4	6.4	6.3	6.3
West Kalimantan	4.09	3.53	3.77	3.90	3.30	3.30	2.9	2.8	2.53	2.50	2.48	2.45	2.43	5.0	5.0	5.1	5.1	5.2
Central Kalimantan	8.32	6.75	5.30		2.30	2.70	3.2	3.0	2.26	2.25	2.23	2.22	2.21	4.1	4.2	4.2	4.3	4.4
South Kalimantan	4.28	3.63	3.89	2.70	2.30	2.60	3.0	2.6	2.21	2.20	2.18	2.17	2.16	6.0	6.0	6.1	6.1	6.1
East Kalimantan	4.89	3.10	3.63		3.20	2.80	2.8	2.7	2.27	2.26	2.25	2.23	2.22	3.7	3.8	3.8	3.8	3.9
North Sulawesi	4.28	4.15	3.84	2.30	2.60	2.60	2.6	2.8	1.93	1.92	1.92	1.91	1.90	5.4	5.4	5.5	5.6	5.6
Central Sulawesi	8.56	7.70	3.34		3.10	3.00	3.2	3.3	2.39	2.37	2.35	2.33	2.31	5.4	5.3	5.2	5.3	5.4
South Sulawesi	4.53	4.39	4.01	3.00	2.90	2.80	2.6	2.8	2.33	2.32	2.30	2.28	2.27	6.0	6.0	6.0	6.0	6.1
Southeast Sulawesi	9.11	7.51	4.14		3.50	2.90	3.6	3.3	2.77	2.73	2.69	2.65	2.61	5.0	5.0	5.0	5.1	5.1
Gorontalo	-	-	4.67				2.8	2.6	2.31	2.29	2.28	2.27	2.25	5.8	5.8	5.9	5.9	5.9
West Sulawesi	-	-	5.96					3.5	2.33	2.31	2.30	2.28	2.26	6.1	6.0	5.9	5.9	5.9
Maluku	7.79	6.37	1.98		3.70	3.30		3.9	2.77	2.75	2.73	2.70	2.68	6.1	6.1	6.1	6.1	6.0
North Maluku	-	-	2.14					3.2	2.70	2.68	2.66	2.65	2.63	5.1	5.1	5.2	5.2	5.2
West Papua	-	-	2.51					2.9	2.78	2.76	2.73	2.71	2.69	4.3	4.3	4.3	4.3	4.4
Papua	-	-	2.58		3.10	3.40		3.4	2.73	2.71	2.70	2.68	2.67	4.0	4.0	4.1	4.1	4.2

TABLE 2. DEMOGRAPHIC INDICATORS

Area	Crude birth rate (Intercensal Survey)					Life expectancy at birth (Intercensal Survey)										Life expectancy at birth (Intercensal Survey)					
Year	2005	2006	2007	2008	2009	2000	2005			2006			2007			2008			2009		
	Total	Total	Total	Total	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	19.6	19.3	19.0	18.8	18.5		68.1	72.0		68.3	72.2	70.2	68.4	72.4	70.4	68.6	72.6	70.5	68.8	72.7	70.7
Aceh	22.2	21.9	21.7	21.4	21.2	67.13	66.9	70.8	68.8	67.0	71.0	68.9	67.1	71.1	69.0	67.2	71.2	69.1	67.3	71.3	69.2
North Sumatra	23.2	23.0	22.7	22.3	21.9	66.17	69.3	73.2	71.2	69.5	73.4	71.4	69.7	73.6	71.6	69.8	73.7	71.7	70.0	73.9	71.9
West Sumatra	21.2	21.0	20.7	20.5	20.2	64.02	68.1	72.1	70.0	68.3	72.3	70.2	68.5	72.5	70.5	68.8	72.7	70.7	69.0	72.9	70.9
Riau	23.1	22.4	21.7	21.1	20.4	65.21	69.7	73.6	71.6	69.8	73.7	71.7	70.0	73.8	71.9	70.1	74.0	72.0	70.2	74.1	72.1
Jambi	21.0	20.7	20.3	20.2	19.9	64.02	68.1	72.0	70.0	68.3	72.2	70.2	68.4	72.4	70.3	68.6	72.5	70.5	68.8	72.7	70.7
South Sumatra	21.1	21.0	20.7	20.4	20.1	64.02	68.6	72.6	70.6	68.8	72.7	70.7	69.0	72.9	70.9	69.1	73.1	71.1	69.3	73.2	71.2
Bengkulu	21.1	20.9	20.6	20.2	19.8	64.02	67.5	71.5	69.4	67.7	71.7	69.6	67.9	71.9	69.9	68.2	72.1	70.1	68.4	72.3	70.3
Lampung	20.2	20.0	19.8	19.6	19.4	65.21	68.4	72.4	70.4	68.7	72.6	70.6	68.9	72.9	70.9	69.2	73.1	71.1	69.4	73.3	71.3
Bangka Belitung	19.8	19.7	19.4	19.0	18.7	64.02	68.5	72.4	70.4	68.6	72.5	70.5	68.7	72.7	70.7	68.9	72.8	70.8	69.0	72.9	70.9
Riau Islands	25.3	25.8	26.5	26.9	27.4		70.3	74.2	72.2	70.4	74.2	72.3	70.5	74.3	72.3	70.5	74.4	72.4	70.6	74.5	72.5
D.K.I Jakarta	17.4	17.2	16.8	16.1	15.6	71.13	73.7	77.4	75.5	73.9	77.5	75.6	74.0	77.6	75.8	74.2	77.7	75.9	74.3	77.9	76.0
West Java	19.6	19.4	19.3	19.0	18.7	63.07	67.9	71.9	69.8	68.1	72.1	70.1	68.3	72.3	70.3	68.5	72.5	70.5	68.8	72.7	70.7
Central Java	17.2	16.9	16.6	16.4	16.1	66.17	69.9	73.8	71.8	70.1	73.9	72.0	70.2	74.1	72.1	70.4	74.3	72.3	70.6	74.4	72.5
D.I. Yogyakarta	12.1	12.0	11.8	11.6	11.3	71.13	73.5	77.1	75.2	73.6	77.2	75.4	73.8	77.4	75.5	73.9	77.5	75.7	74.1	77.7	75.8
East Java	13.8	13.8	13.6	13.5	13.2	65.21	68.6	72.5	70.5	68.8	72.8	70.7	69.1	73.0	71.0	69.3	73.2	71.2	69.5	73.4	71.4
Banten	21.0	20.9	20.7	20.6	20.5	61.03	66.9	70.9	68.9	67.1	71.1	69.0	67.3	71.2	69.2	67.4	71.4	69.3	67.6	71.5	69.5
Bali	14.6	14.5	14.3	14.0	13.6	68.08	72.1	75.8	73.9	72.2	75.9	74.0	72.2	76.0	74.1	72.3	76.0	74.1	72.4	76.1	74.2
West Nusa Tenggara	23.9	23.4	22.9	22.4	21.9	56.15	63.5	67.4	65.4	63.8	67.7	65.7	64.1	68.0	66.0	64.4	68.3	66.3	64.7	68.7	66.7
East Nusa Tenggara	26.1	25.8	25.5	25.0	24.6	63.07	66.7	70.6	68.6	66.9	70.9	68.9	67.2	71.1	69.1	67.5	71.4	69.4	67.7	71.7	69.6
West Kalimantan	23.3	23.0	22.8	22.4	22.1	63.07	68.0	72.0	69.9	68.2	72.1	70.1	68.3	72.3	70.2	68.5	72.4	70.4	68.6	72.5	70.5
Central Kalimantan	20.7	20.5	20.2	19.9	19.5	65.21	69.6	73.5	71.5	69.7	73.6	71.6	69.8	73.7	71.7	69.9	73.8	71.8	70.0	73.9	71.9
South Kalimantan	19.9	19.7	19.5	19.2	18.8	60.15	66.0	70.0	67.9	66.2	70.2	68.2	66.5	70.4	68.4	66.7	70.7	68.7	67.0	70.9	68.9
East Kalimantan	20.3	20.3	20.1	19.7	19.4	67.13	70.2	74.1	72.1	70.4	74.3	72.3	70.6	74.5	72.5	70.9	74.7	72.7	71.1	74.9	73.0
North Sulawesi	15.8	15.6	15.5	15.3	15.1	70.26	72.2	75.9	74.0	72.4	76.1	74.2	72.6	76.3	74.4	72.8	76.5	74.6	73.0	76.6	74.8
Central Sulawesi	21.4	21.0	20.6	20.3	20.1	61.03	65.7	69.7	67.7	66.0	69.9	67.9	66.2	70.2	68.2	66.5	70.4	68.4	66.7	70.7	68.6
South Sulawesi	21.3	21.1	20.8	20.5	20.2	63.07	67.8	71.8	69.7	68.0	72.0	70.0	68.2	72.2	70.2	68.5	72.4	70.4	68.7	72.6	70.6
Southeast Sulawesi	26.1	25.7	25.3	24.9	24.4	64.02	67.3	71.3	69.2	67.5	71.5	69.5	67.8	71.7	69.7	68.0	72.0	69.9	68.3	72.2	70.2
Gorontalo	19.6	19.5	19.3	19.0	18.7	63.07	66.7	70.6	68.6	67.0	70.9	68.9	67.3	71.2	69.2	67.5	71.5	69.5	67.8	71.8	69.8
West Sulawesi	20.4	20.1	19.8	19.5	19.2		67.8	71.8	69.7	68.0	72.0	70.0	68.2	72.2	70.2	68.5	72.4	70.4	68.7	72.6	70.6
Maluku	24.3	24.1	24.0	23.8	23.5	62.16	66.7	70.6	68.6	66.9	70.8	68.8	67.1	71.0	69.0	67.3	71.3	69.2	67.5	71.5	69.4
North Maluku	22.9	22.9	22.8	22.6	22.5	59.07	65.7	69.7	67.7	66.0	70.0	68.0	66.3	70.3	68.3	66.6	70.6	68.6	66.9	70.9	68.9
West Papua	23.2	22.8	22.5	22.0	21.8		66.5	70.5	68.5	66.8	70.8	68.7	67.1	71.0	69.0	67.3	71.3	69.3	67.6	71.6	69.5
Papua	23.2	22.9	22.7	22.4	22.1	63.07	66.8	70.8	68.8	67.1	71.0	69.0	67.3	71.3	69.3	67.6	71.5	69.5	67.8	71.8	69.8

DEFINITIONS OF THE INDICATORS

Population	Population are all residents of the entire territory of Republic of Indonesia who have stayed for six months or longer, and those who intended to stay more than six months even though their length of stay is less than six months.
Average annual growth rate of urban population (%)	"Average growth of urban population is the annual urban population growth rate over a certain period."
Total fertility rat	Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific
Crude death rate	Annual number of deaths per 1,000 population.
Life expectancy at birth	Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

MAIN DATA SOURCES

Population	"The main source of demographic data is Population Census, which is conducted every ten years. Population Census has been conducted six times since Indonesia's independence: 1961,1971, 1980, 1990, 2000 and 2010. In addition to the Census, BPS also conducted Intercensal Population Survey, called SUPAS which is designed to proceed demographic data between two censuses. SUPAS has been conducted four times: 1976, 1985, 1995 and 2005. Besides Population Census and SUPAS, this report also uses population projection."
Population by year, age groups and gender	Bappenas, BPS-Statistics Indonesia, UNFPA Indonesia. Proyeksi Penduduk Indonesia (Indonesia Population Projection) 2005-2025. Bappenas, Jakarta, 2008
Annual population growth rate (%)	BPS-Statistics Indonesia: Statistical Year-Book of Indonesia, Jakarta
Population growth rate	Bappenas, BPS-Statistics Indonesia, UNFPA Indonesia. Proyeksi Penduduk Indonesia (Indonesia Population Projection) 2005-2025. Bappenas, Jakarta, 2008
Percentage of population living in urban areas by year, age groups and gender	Projection based on Intercensal Population Survey 2005, Processed by BPS-Statistics Indonesia , Jakarta, 2009
Average annual growth rate of urban population (%)	BPS-Statistics Indonesia: Estimasi Parameter Demografi Indonesia + 27 Propinsi 1990-1998 (1990-1998 Estimate of Demographic Parameters for Indonesia + 27 Provinces), Internal BPS documentation, Jakarta; Population Projection Based on 2005 Intercensal Population Survey, 1995 and 2005
Total fertility rate	Indonesia Demographic and Health Survey 1994, 1997, 2002/2003, 2007; Population Projection Based on 2005 Intercensal Population Survey, 1995 and 2005.
Crude death rate	Population Projection Based on 2005 Intercensal Population Survey, 1995 and 2005.
Life expectancy at birth	Population Projection Based on 2005 Intercensal Population Survey, 1995 and 2005.

Notes - Data not available
1) Result of 2000 Indonesia Population Census
2) Result of 2005 Indonesia Intercensal Population Survey except NAD Province, Nias and Nias Selatan Regencies (Sumatera Utara Province), Boven Digul and Teluk Wandoma (Papua Province) were estimated.
3) Projection figures, based on the result of 2005 Intercensal Population Survey.

TABLE 3. BASIC INDICATORS

Area	Under-5 mortality rate (IDHS)[3]					Under-5 mortality rate (IDHS)[2]					Infant mortality rate (IDHS)[1]					Infant mortality rate (IDHS)[3]				
Year	1991	1994	1997	2002-2003	2007	1991	1994	1997	2002-2003	2007	1991	1994	1997	2002-2003	2007	1991	1994	1997	2002-2003	2007
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	107	93	70.6	79	69	97	81	58.2	46	44	74	66	52.2	43	39	68	57	45.7	35	34
Aceh		79	58.6		45							58	45.5		25					
North Sumatra		97	71.9	57	67							61	45.2	42	46					
West Sumatra		98	95.1	59	62							68	65.8	48	47					
Riau		94	82.4	60	47							72	60.4	43	37					
Jambi		88	82.4	51	47							60	68.3	41	39					
South Sumatra		92	70.4	49	52							60	53.0	30	42					
Bengkulu		124	115.2	68	65							74	72.3	53	46					
Lampung		58	64.0	64	55							38	48.2	55	43					
Bangka Belitung				47	46									43	39					
Riau Islands					58										43					
D.K.I Jakarta	60	50	41.7	41	36						45	30	26.1	35	28	43	26			
West Java	164	120	77.2	50	49						117	89	60.6	44	39	111	79			
Central Java	80	75	59.9	44	32						49	51	45.2	36	26	43	33			
D.I. Yogyakarta	49	35	30.3	23	22						38	30	23.4	20	19	35	26			
East Java	89	79	52.5	52	45						69	62	35.8	43	35	51	48			
Banten				56	58									38	46					
Bali	61	63	44.0	19	38						49	58	39.5	14	34	49	49			
West Nusa Tenggara		160	149.5	103	92							110	110.5	74	72					
East Nusa Tenggara		108	90.1	73	80							71	59.7	59	57					
West Kalimantan		135	88.2	63	59							97	70.3	47	46					
Central Kalimantan		38	68.9	47	34							16	55.3	40	30					
South Kalimantan		111	87.3	57	75							83	70.7	45	58					
East Kalimantan		76	66.2	50	38							61	50.7	42	26					
North Sulawesi		83	61.0	33	43							66	47.6	25	35					
Central Sulawesi		127	121.4	71	69							87	94.5	52	60					
South Sulawesi		86	79.0	72	53							64	63.0	47	41					
Southeast Sulawesi		105	94.2	92	62							79	78.1	67	41					
Gorontalo				97	69									77	52					
West Sulawesi					96										74					
Maluku		91	48.4		93							68	29.5		59					
North Maluku					74										51					
West Papua					62										36					
Papua		88	92.3	22.4	64							61	64.7		41					

TABLE 3. BASIC INDICATORS

Area	Infant mortality rate (Census)	Infant mortality rate (Intercensal Projection)						Maternal Mortality (IDHS)			Population - millions (Census)	Population - thousand (Intercensal Projection)						"Life Expectancy at Birth (Census)"
Year	2000	2005	2006	2007	2008	2009		1997	2002-2003	2007	2000	2005	2006	2007	2008	2009		2000
	Total	Total	Total	Total	Total	Total		Total	Total	Total	Total	Total	Total	Total	Total	Total		Total
Indonesia	47.00	28.9	28.2	27.5	26.8	26.2		334	307	228	205.13	219,852.0	222,746.9	225,642.0	228,523.3	231,369.5		
Aceh	39.71	33.4	33.0	32.6	32.1	31.7					3.92	4,083.5	4,153.6	4,223.8	4,293.9	4,363.5		67.13
North Sumatra	43.69	24.6	23.9	23.3	22.7	22.1					11.64	12,418.0	12,625.9	12,834.4	13,042.3	13,248.4		66.17
West Sumatra	52.66	28.9	28.0	27.1	26.3	25.5					4.24	4,567.2	4,632.5	4,697.8	4,763.1	4,828.0		64.02
Riau	47.68	23.3	22.8	22.3	21.8	21.3					3.90	4,835.9	4,953.0	5,071.0	5,189.2	5,306.5		65.21
Jambi	52.66	28.8	28.2	27.5	26.9	26.3					2.40	2,650.5	2,696.2	2,742.2	2,788.3	2,834.2		64.02
South Sumatra	52.66	26.9	26.3	25.6	25.0	24.4					6.21	6,815.9	6,917.9	7,020.0	7,121.8	7,222.6		64.02
Bengkulu	52.66	31.2	30.3	29.4	28.6	27.7					1.45	1,566.1	1,591.4	1,616.7	1,641.9	1,666.9		64.02
Lampung	47.68	27.7	26.7	25.8	24.8	23.9					6.73	7,087.4	7,188.4	7,289.8	7,391.1	7,491.9		65.21
Bangka Belitung	52.66	27.4	26.9	26.4	26.0	25.5					0.90	1,074.8	1,090.7	1,106.7	1,122.5	1,138.1		64.02
Riau Islands		21.1	20.8	20.6	20.3	20.1					1.04	1,278.9	1,334.9	1,392.9	1,453.1	1,515.3		
D.K.I Jakarta	24.79	8.8	8.6	8.4	8.2	8.1					8.36	8,892.3	8,979.7	9,064.6	9,146.2	9,223.0		71.13
West Java	56.65	29.5	28.7	27.9	27.1	26.3					35.72	39,150.6	39,739.1	40,329.1	40,918.3	41,501.5		63.07
Central Java	43.69	22.9	22.2	21.4	20.7	19.9					31.22	31,873.5	32,128.6	32,380.3	32,626.4	32,864.6		66.17
D.I. Yogyakarta	24.79	9.2	8.9	8.7	8.5	8.3					3.12	3,365.5	3,400.2	3,434.5	3,468.5	3,501.9		71.13
East Java	47.69	27.3	26.3	25.4	24.5	23.6					34.76	36,481.8	36,690.6	36,895.6	37,094.8	37,286.2		65.21
Banten	65.62	33.3	32.6	32.0	31.3	30.7					8.09	9,071.1	9,246.1	9,423.4	9,602.4	9,782.8		61.03
Bali	35.72	13.4	13.2	12.9	12.7	12.5					3.15	3,405.4	3,442.8	3,479.8	3,516.0	3,551.0		68.08
West Nusa Tenggara	88.55	47.6	46.1	44.6	43.2	41.9					4.00	4,149.1	4,220.8	4,292.5	4,363.8	4,434.0		56.15
East Nusa Tenggara	56.65	34.6	33.4	32.3	31.2	30.1					3.82	4,279.5	4,363.8	4,448.9	4,534.3	4,619.7		63.07
West Kalimantan	56.65	29.1	28.5	28.0	27.4	26.9					4.01	4,037.2	4,107.8	4,178.5	4,249.1	4,319.1		63.07
Central Kalimantan	47.68	23.7	23.2	22.8	22.4	22.0					1.85	1,969.7	1,999.1	2,028.3	2,057.3	2,085.8		65.21
South Kalimantan	69.6	37.1	36.0	34.9	33.9	32.9					2.98	3,296.6	3,346.6	3,396.7	3,446.6	3,496.1		60.15
East Kalimantan	39.71	22.9	21.5	20.2	19.0	17.8					2.45	2,887.1	2,955.5	3,024.8	3,094.7	3,164.8		67.13
North Sulawesi	27.77	13.3	12.7	12.1	11.5	10.9					2.00	2,143.8	2,165.4	2,186.8	2,208.0	2,228.9		70.26
Central Sulawesi	65.62	38.0	36.9	35.9	34.9	33.9					2.17	2,312.0	2,354.0	2,396.2	2,438.4	2,480.3		61.03
South Sulawesi	56.65	30.0	29.1	28.2	27.4	26.6					7.15	7,489.7	7,595.0	7,700.3	7,805.0	7,908.5		63.07
Southeast Sulawesi	52.66	32.0	31.0	30.0	29.1	28.2					1.82	1,945.1	1,988.2	2,031.5	2,075.0	2,118.3		64.02
Gorontalo	56.65	34.5	33.2	32.0	30.8	29.7					0.83	936.3	948.3	960.3	972.2	984.0		63.07
West Sulawesi		30.0	29.1	28.2	27.4	26.6					0.89	985.7	1,001.2	1,016.7	1,032.3	1,047.7		
Maluku	60.63	34.4	33.5	32.6	31.8	30.9					1.16	1,264.8	1,283.4	1,302.0	1,320.7	1,339.5		62.16
North Maluku	74.59	38.1	36.8	35.5	34.3	33.1					0.81	914.1	929.1	944.3	959.6	975.0		59.07
West Papua		35.0	33.9	32.7	31.6	30.5					0.53	688.2	702.1	716.0	730.0	743.9		
Papua	56.65	33.9	32.8	31.7	30.7	29.7					1.68	1,934.7	1,975.0	2,015.6	2,056.5	2,097.5		63.07

TABLE 3. BASIC INDICATORS

Area	Life Expectancy at Birth (Intercensal Projection)					Adult literacy rate of population aged 10 years old and above (Susenas)																
Year	2005	2006	2007	2008	2009	2000			2001			2002			2003			2004			2005		
	Total	Total	Total	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	70.0	70.2	70.4	70.5	70.7	93.74	86.15	89.92	93.13	85.46	89.27	94.15	87.31	90.71	94.16	87.72	90.93	94.66	88.29	91.47	94.91	88.93	91.91
Aceh	68.8	68.9	69.0	69.1	69.2										98.19	95.33	96.75	97.82	94.37	96.07			
North Sumatra	71.2	71.4	71.6	71.7	71.9	98.19	95.29	96.74	98.54	94.97	96.75	98.10	95.09	96.60	98.48	95.93	97.20	98.46	95.66	97.05	98.05	95.56	96.80
West Sumatra	70.0	70.2	70.5	70.7	70.9	97.45	93.84	95.58	96.54	93.00	94.71	96.99	94.31	95.60	97.61	94.68	96.10	97.94	94.59	96.21	97.59	95.18	96.34
Riau	71.6	71.7	71.9	72.0	72.1	97.85	94.74	96.29	96.48	93.25	94.91	97.70	96.13	96.92	97.77	95.24	96.53	97.61	95.97	96.80	98.75	97.30	98.04
Jambi	70.0	70.2	70.3	70.5	70.7	97.34	92.80	95.07	97.20	91.96	94.64	97.56	93.08	95.35	97.87	93.43	95.68	98.06	94.31	96.21	97.34	92.91	95.14
South Sumatra	70.6	70.7	70.9	71.1	71.2	97.12	92.36	94.76	96.13	91.50	93.83	97.02	92.54	94.78	97.54	93.95	95.75	97.60	94.75	96.19	97.65	94.68	96.16
Bengkulu	69.4	69.6	69.9	70.1	70.3	95.81	89.50	92.69	96.11	89.34	92.82	96.34	91.41	93.92	96.69	92.17	94.46	97.14	92.47	94.85	96.70	91.77	94.28
Lampung	70.4	70.6	70.9	71.1	71.3	95.00	89.13	92.17	95.36	89.35	92.46	96.47	91.28	93.95	95.23	90.09	92.75	96.25	91.41	93.93	96.07	91.27	93.72
Bangka Belitung	70.4	70.5	70.7	70.8	70.9				95.10	86.72	90.96	95.68	89.67	92.72	95.08	89.82	92.45	96.36	91.73	94.10	97.37	94.45	95.95
Riau Islands	72.2	72.3	72.3	72.4	72.5																97.76	94.64	96.23
D.K.I Jakarta	75.5	75.6	75.8	75.9	76.0	98.99	96.56	97.77	98.85	96.12	97.47	99.32	97.46	98.38	99.14	97.93	98.53	99.22	97.67	98.44	99.36	97.60	98.48
West Java	69.8	70.1	70.3	70.5	70.7	96.09	90.67	93.41	96.16	91.26	93.72	96.21	91.64	93.94	96.73	92.26	94.52	96.92	92.43	94.69	97.22	93.23	95.24
Central Java	71.8	72.0	72.1	72.3	72.5	92.53	82.39	87.38	90.89	79.95	85.33	92.59	82.28	87.38	92.32	82.73	87.47	93.04	83.58	88.28	93.23	84.59	88.87
D.I. Yogyakarta	75.2	75.4	75.5	75.7	75.8	89.15	75.63	82.25	91.49	76.85	83.96	91.13	79.29	85.13	92.09	82.03	86.99	92.57	81.55	86.94	93.20	82.79	87.89
East Java	70.5	70.7	71.0	71.2	71.4	90.00	77.56	83.61	89.14	76.87	82.85	90.51	79.47	84.84	90.41	79.71	84.97	91.43	80.90	86.06	92.29	82.35	87.21
Banten	68.9	69.0	69.2	69.3	69.5				95.70	89.15	92.46	96.91	92.21	94.59	96.85	92.29	94.60	96.90	92.49	94.72	97.82	94.53	96.19
Bali	73.9	74.0	74.1	74.1	74.2	92.02	79.31	85.66	89.71	75.84	82.78	91.68	79.55	85.64	91.14	80.57	85.86	92.39	81.20	86.83	93.15	81.73	87.48
West Nusa Tenggara	65.4	65.7	66.0	66.3	66.7	86.02	73.87	79.73	84.95	74.33	79.43	86.15	76.18	80.92	84.85	73.13	78.69	86.04	74.80	80.06	87.60	76.45	81.73
East Nusa Tenggara	68.6	68.9	69.1	69.4	69.6	87.06	82.46	84.72	86.26	82.17	84.17	88.26	83.52	85.83	88.71	84.30	86.48	89.33	84.55	86.88	88.79	84.61	86.68
West Kalimantan	69.9	70.1	70.2	70.4	70.5	92.31	81.88	87.16	91.18	80.12	85.80	92.66	83.69	88.26	93.25	84.65	89.09	93.90	85.16	89.67	93.14	84.88	89.11
Central Kalimantan	71.5	71.6	71.7	71.8	71.9	97.40	94.55	96.03	97.10	94.44	95.83	97.88	95.34	96.66	97.79	95.37	96.62	97.75	95.56	96.70	98.75	96.84	97.83
South Kalimantan	67.9	68.2	68.4	68.7	68.9	96.17	90.08	93.10	96.32	89.65	92.97	96.49	91.60	94.04	96.73	91.79	94.23	97.51	93.27	95.36	97.46	92.69	95.08
East Kalimantan	72.1	72.3	72.5	72.7	73.0	96.61	92.03	94.41	96.37	91.82	94.17	97.19	93.90	95.61	97.19	93.42	95.38	97.18	93.69	95.51	97.15	94.27	95.76
North Sulawesi	74.0	74.2	74.4	74.6	74.8	98.34	97.84	98.09	98.47	97.95	98.21	98.88	98.78	98.83	99.07	98.94	99.01	99.26	99.02	99.14	98.98	98.71	98.84
Central Sulawesi	67.7	67.9	68.2	68.4	68.6	95.37	91.68	93.54	95.09	92.00	93.55	95.31	92.60	93.98	95.90	92.45	94.22	96.16	93.69	94.95	95.95	93.07	94.54
South Sulawesi	69.7	70.0	70.2	70.4	70.6	88.45	82.75	85.48	86.56	80.80	83.55	87.67	82.73	85.12	87.48	82.77	85.05	88.63	83.74	86.10	88.67	84.09	86.29
Southeast Sulawesi	69.2	69.5	69.7	69.9	70.2	93.90	86.93	90.37	93.56	86.66	90.09	93.38	86.37	89.81	94.35	89.21	91.79	94.67	89.04	91.81	94.30	88.32	91.27
Gorontalo	68.6	68.9	69.2	69.5	69.8				93.74	93.51	93.63	95.45	95.19	95.32	94.74	94.86	94.80	94.12	95.85	95.01	94.75	95.47	95.12
West Sulawesi	69.7	70.0	70.2	70.4	70.6																		
Maluku	68.6	68.8	69.0	69.2	69.4	78.47	68.05	73.45	96.29	97.03	96.66				98.21	96.67	97.44	98.89	97.32	98.09	97.43	95.75	96.58
North Maluku	67.7	68.0	68.3	68.6	68.9				97.87	91.46	94.63				97.24	94.89	96.07	97.59	93.57	95.59	97.45	94.00	95.76
West Papua	68.5	68.7	69.0	69.3	69.5																		
Papua	68.8	69.0	69.3	69.5	69.8				76.17	67.04	71.80				81.21	71.70	76.61	81.25	71.16	76.44	78.15	68.60	73.57

TABLE 3. BASIC INDICATORS

Area	Adult literacy rate of population aged 10 years old and above (Susenas)						Adult literacy rate of population aged 15 years old and above (Susenas)															
Year	2006			2007			2000					2001					2002					
	Male	Female	Total	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	
Indonesia	95.12	89.88	92.39	95.66	89.88	92.74	94.00	84.40	92.96	84.30	88.58	93.30	83.60	92.33	83.53	87.89	94.06	85.72	93.46	85.66	89.51
Aceh	96.59	93.44	94.85	96.91	93.44	95.13															
North Sumatra	98.24	95.76	97.00	98.34	95.76	97.04			97.95	94.52	96.21			98.31	94.11	96.19			97.91	94.34	96.11
West Sumatra	97.52	95.48	96.35	97.56	95.48	96.49			97.17	92.98	94.99			96.37	92.00	94.09			96.85	93.58	95.15
Riau	98.39	96.51	97.54	98.50	96.51	97.53			97.64	93.97	95.80			96.13	92.30	94.26			97.49	95.65	96.56
Jambi	97.38	93.21	95.26	97.52	93.21	95.39			97.07	91.82	94.43			96.91	90.85	93.93			97.27	92.13	94.71
South Sumatra	98.18	95.63	96.91	98.27	95.63	96.97			96.82	91.10	93.98			95.71	90.05	92.90			96.79	91.42	94.11
Bengkulu	96.95	92.09	94.50	96.98	92.09	94.56			95.23	87.75	91.54			95.59	87.39	91.62			95.87	90.12	93.04
Lampung	96.31	91.10	93.70	96.52	91.10	93.90			94.22	87.37	90.91			94.74	87.68	91.34			96.01	89.80	93.00
Bangka Belitung	97.18	93.39	95.33	97.01	93.39	95.24								94.58	85.05	89.84			95.41	87.92	91.74
Riau Islands	97.14	95.10	95.77	97.08	95.10	96.03															
D.K.I Jakarta	99.07	97.89	98.34	99.79	97.89	98.83			98.93	96.21	97.56			98.79	95.72	97.24			99.27	97.23	98.23
West Java	97.31	93.92	95.52	97.76	93.92	95.85			95.56	89.36	92.49			95.50	89.26	92.40			95.74	90.48	93.11
Central Java	93.49	85.76	89.56	94.15	85.76	89.91			91.50	79.99	85.63			89.69	77.20	83.31			91.58	79.96	85.66
D.I. Yogyakarta	92.97	83.10	87.53	94.82	83.10	88.86			88.07	73.28	80.51			90.71	74.65	82.45			90.37	77.47	83.81
East Java	92.84	84.18	88.36	93.46	84.18	88.66			88.87	75.09	81.74			87.90	74.32	80.90			89.48	77.27	83.19
Banten	97.37	93.95	95.60	97.58	93.95	95.76								95.13	88.27	91.72			96.58	91.07	93.84
Bali	92.78	81.62	87.14	93.08	81.62	87.32			91.23	77.35	84.23			88.65	73.48	81.05			90.86	77.54	84.19
West Nusa Tenggara	86.99	76.94	81.65	88.65	76.94	82.44			83.55	69.75	76.32			82.42	70.36	76.07			84.05	72.36	77.87
East Nusa Tenggara	90.10	86.67	87.98	90.47	86.67	88.53			85.59	80.24	82.83			84.86	80.06	82.38			87.09	81.40	84.13
West Kalimantan	94.03	86.75	90.31	94.31	86.75	90.61			91.23	79.07	85.24			89.98	77.08	83.68			91.88	81.48	86.75
Central Kalimantan	97.80	95.75	96.80	98.12	95.75	96.98			97.36	93.92	95.68			96.66	93.53	95.17			97.70	94.84	96.32
South Kalimantan	96.73	92.53	94.60	96.88	92.53	94.67			95.74	88.78	92.21			96.00	88.21	92.09			96.16	90.48	93.29
East Kalimantan	97.49	94.39	95.96	97.72	94.39	96.13			96.31	91.00	93.73			95.94	90.73	93.41			97.07	93.14	95.19
North Sulawesi	99.02	98.73	99.00	99.15	98.73	98.94			98.39	97.82	98.10			98.49	97.79	98.14			98.90	98.67	98.79
Central Sulawesi	96.60	93.87	95.37	96.68	93.87	95.29			95.06	90.68	92.89			94.72	90.91	92.83			94.94	91.64	93.32
South Sulawesi	89.61	85.27	87.28	90.39	85.27	87.72			87.15	80.49	83.64			85.12	78.47	81.61			86.46	80.74	83.47
Southeast Sulawesi	94.42	88.83	91.24	94.53	88.83	91.64			93.09	84.63	88.76			92.86	84.56	88.64			92.38	84.31	88.24
Gorontalo	95.45	96.31	95.89	95.29	96.31	95.81								93.37	92.99	93.18			95.15	95.26	95.21
West Sulawesi	89.87	85.56	87.49	90.20	85.56	87.86															
Maluku	97.41	96.37	96.89	97.95	96.37	97.16			75.83	64.11	70.11			96.94	96.97	96.96					
North Maluku	96.76	93.36	95.04	97.01	93.36	95.22								97.49	89.93	93.63					
West Papua	91.62	88.53	89.23	92.64	88.53	90.62															
Papua	75.71	71.34	71.58	82.03	71.34	76.85								74.10	63.89	69.16					

TABLE 3. BASIC INDICATORS

Area	Adult literacy rate of population aged 15 years old and above (Susenas)																			
Year	2003					2004					2005					2006				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	94.51	86.20	93.48	86.16	89.79	94.64	87.00	94.04	86.80	90.38	95.10	87.48	94.34	87.54	90.91	95.28	88.40	94.56	88.39	91.45
Aceh	98.58	95.44	97.97	94.66	96.28			97.77	93.73	95.69								96.26	92.38	94.27
North Sumatra	98.30	95.55	98.32	95.32	96.80			98.30	95.03	96.64			97.87	94.95	96.39			98.05	95.19	96.61
West Sumatra	98.67	94.27	97.41	93.96	95.60			97.75	93.90	95.73			97.46	94.63	95.98			97.23	94.62	95.88
Riau	98.13	94.50	97.55	94.61	96.10			97.34	95.46	96.41			98.58	96.91	97.76			98.26	96.18	97.24
Jambi	96.74	94.51	97.69	92.62	95.17			97.88	93.58	95.76			97.05	92.03	94.54			97.15	92.25	94.71
South Sumatra	98.02	93.71	97.25	93.13	95.19			97.37	94.00	95.69			97.36	93.92	95.63			98.04	95.12	96.59
Bengkulu	98.63	91.56	96.18	90.93	93.59			96.96	91.33	94.21			96.26	90.61	93.47			96.55	90.79	93.69
Lampung	96.02	90.39	94.62	88.45	91.65			95.85	90.06	93.08			95.63	89.92	92.85			95.87	89.57	92.84
Bangka Belitung	94.47	89.06	94.54	88.46	91.48			96.15	90.74	93.51			97.12	93.66	95.44			96.87	92.71	94.86
Riau Islands													97.63	94.26	95.97			96.80	93.76	95.29
D.K.I Jakarta	98.41		99.10	97.73	98.41			99.18	97.45	98.31			99.31	97.35	98.32			99.07	97.41	98.23
West Java	96.49	91.04	96.34	91.27	93.83			96.50	91.39	93.96			96.93	92.33	94.65			96.97	92.84	94.91
Central Java	89.76	83.09	91.29	80.47	85.79			92.10	81.49	86.72			92.34	82.64	87.41			92.71	83.86	88.24
D.I. Yogyakarta	90.63	79.07	91.34	80.37	85.75			91.92	79.90	85.78			92.53	81.20	86.72			92.34	80.70	86.43
East Java	91.43	77.79	89.37	77.64	83.37			90.50	78.89	84.54			91.47	80.51	85.84			92.06	82.41	87.10
Banten	96.10	90.97	96.41	91.15	93.78			96.55	91.39	93.98			97.54	93.70	95.63			97.04	92.94	95.01
Bali	90.29	78.90	90.30	78.61	84.44			91.58	79.44	85.52			92.50	79.91	86.22			92.00	79.52	85.79
West Nusa Tenggara	80.26	72.23	82.44	68.59	75.11			83.73	70.99	76.85			85.62	72.74	78.79			84.82	73.55	78.78
East Nusa Tenggara	97.18	82.45	87.54	82.43	84.93			88.01	82.50	85.16			87.36	82.65	84.95			88.97	84.14	86.50
West Kalimantan	92.19	85.80	92.39	82.48	87.57			93.15	82.91	88.18			92.43	82.63	87.66			93.27	84.59	88.99
Central Kalimantan	97.85	95.48	97.54	94.67	96.16			97.49	94.88	96.23			98.60	96.35	97.50			97.52	95.11	96.35
South Kalimantan	97.44	91.20	96.47	90.71	93.53			97.20	92.40	94.76			97.19	91.76	94.47			96.31	91.55	93.90
East Kalimantan	97.80	91.16	96.96	92.56	94.86			96.89	92.86	94.97			96.93	93.55	95.31			97.25	93.55	95.48
North Sulawesi	99.37	98.70	99.00	98.90	98.95			99.28	99.01	99.15			99.08	98.65	98.87			99.08	98.89	98.99
Central Sulawesi	97.75	92.54	95.59	91.56	93.63			95.78	92.98	94.41			95.53	92.26	93.93			96.26	93.31	94.81
South Sulawesi	92.06	79.57	86.26	80.77	83.40			87.52	81.71	84.49			87.28	82.20	84.60			88.32	83.30	85.70
Southeast Sulawesi	97.26	88.51	93.59	87.44	90.47			94.19	87.46	90.73			93.55	86.61	89.99			93.56	86.32	89.84
Gorontalo	97.66	93.62	94.81	94.60	94.70			93.93	95.34	94.66			94.93	95.13	95.03			95.47	95.93	95.70
West Sulawesi																		88.73	83.21	85.90
Maluku	98.32	96.52	97.96	96.13	97.04			98.66	96.94	97.78			97.17	95.17	96.16			97.14	95.88	96.50
North Maluku	97.36	94.92	96.91	94.20	95.54			97.73	92.58	95.16			97.15	93.19	95.18			96.44	92.37	94.41
West Papua																		91.23	85.86	88.55
Papua	97.71	66.83	79.70	68.95	74.46			79.50	68.48	74.22			76.64	66.23	71.58			73.61	64.12	69.01

TABLE 3. BASIC INDICATORS

Area	Adult literacy rate of population aged 15 years old and above (Susenas)										Youth literacy rate of population aged 15-24 years old (Susenas)														
Year	2007					2008					2000			2001			2002			2003				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	95.69	88.77	95.22	88.62	91.87	95.44	89.03	95.38	89.10	92.16	98.73	98.16	98.44	98.47	98.06	98.27	98.76	98.57	98.67	99.44	97.80	98.68	98.42	98.55
Aceh			96.56	92.61	94.51			97.71	94.28	95.86										99.46	99.18	99.42	99.09	99.25
North Sumatra			98.30	95.21	96.73			98.68	95.46	97.01	99.51	99.32	99.41	99.53	99.42	99.47	99.26	99.04	99.15	99.52	99.17	99.36	99.30	99.33
West Sumatra			97.37	94.92	96.10			97.99	95.45	96.63	98.90	98.96	98.93	98.84	98.97	98.91	98.48	99.05	98.76	99.69	98.71	99.03	99.07	99.05
Riau			98.41	96.09	97.28			99.00	96.50	97.75	99.68	99.00	99.33	98.44	98.03	98.23	98.95	99.16	99.07	99.77	98.63	99.15	99.13	99.14
Jambi			97.27	92.37	94.83			97.89	92.69	95.30	99.65	99.14	99.38	98.93	98.92	98.93	98.92	99.00	98.96	99.23	99.14	99.07	99.26	99.17
South Sumatra			98.16	95.13	96.66			98.36	95.73	97.04	98.76	98.22	98.49	98.89	98.76	98.82	99.12	98.57	98.85	99.54	99.00	99.26	99.13	99.19
Bengkulu			96.75	91.03	93.91			96.98	92.18	94.52	99.01	98.55	98.79	99.15	99.05	99.11	98.89	98.28	98.59	99.29	98.17	99.22	97.86	98.53
Lampung			96.16	89.90	93.13			96.63	90.43	93.53	99.03	99.06	99.05	99.26	99.13	99.20	98.75	99.09	98.91	99.75	99.04	99.13	99.31	99.21
Bangka Belitung			96.89	92.76	94.87			97.32	93.24	95.26				98.88	97.60	98.23	97.18	97.91	97.52	98.42	97.87	98.35	97.88	98.11
Riau Islands			96.86	94.63	95.67			97.57	94.18	94.76														
D.K.I Jakarta			99.82	97.74	98.76			99.56	97.96	98.69	99.88	99.64	99.75	99.63	99.40	99.51	99.58	99.57	99.57	99.77		99.73	99.80	99.77
West Java			97.52	93.10	95.32			97.70	93.37	95.52	99.54	98.95	99.25	99.43	99.18	99.30	99.55	99.34	99.45	99.72	99.07	99.46	99.40	99.43
Central Java			93.42	84.01	88.62			93.82	84.89	89.12	99.01	99.06	99.04	98.94	98.87	98.91	99.26	99.09	99.17	99.40	98.59	98.92	98.95	98.94
D.I. Yogyakarta			94.32	81.52	87.78			94.46	84.64	89.50	98.04	99.01	98.50	99.24	99.26	99.25	99.06	99.67	99.36	99.79	98.63	99.51	99.28	99.40
East Java			92.76	82.47	87.42			92.35	82.64	87.55	98.49	97.44	97.97	98.48	97.61	98.04	98.77	98.15	98.46	99.27	97.53	98.69	97.89	98.29
Banten			97.42	93.09	95.24			97.54	92.88	95.15				99.32	99.08	99.20	99.28	98.36	98.81	99.19	98.76	99.43	98.61	99.00
Bali			92.43	79.68	85.98			92.80	81.20	87.07	99.11	97.84	98.49	98.43	95.96	97.24	98.30	96.99	97.65	98.94	97.13	98.80	97.39	98.10
West Nusa Tenggara			86.79	73.66	79.75			87.29	73.47	79.43	96.51	93.42	94.91	95.69	92.47	93.92	96.48	95.08	95.76	97.43	94.05	96.46	94.18	95.27
East Nusa Tenggara			89.71	84.96	87.25			89.78	85.68	87.31	95.09	95.40	95.25	93.59	95.89	94.78	95.71	96.00	95.86	99.67	94.06	94.49	95.95	95.22
West Kalimantan			93.69	84.95	89.40				83.55	88.34	97.61	96.63	97.12	97.65	95.81	96.73	97.45	96.79	97.13	98.86	96.93	98.06	96.90	97.49
Central Kalimantan			98.01	95.17	96.64				96.19	97.16	99.17	98.77	98.97	99.37	99.09	99.23	99.40	99.54	99.48	99.04	99.58	99.42	99.43	99.42
South Kalimantan			96.61	91.57	94.05				92.70	94.96	98.93	99.04	98.98	98.82	98.17	98.49	98.62	98.33	98.47	99.80	98.07	98.78	98.72	98.75
East Kalimantan			97.53	93.69	95.70				94.77	96.19	99.34	98.67	98.99	99.11	98.90	99.00	99.33	99.12	99.23	99.49	98.43	99.28	98.77	99.03
North Sulawesi			99.22	98.67	98.95				98.90	99.12	98.99	99.01	99.00	99.45	99.70	99.57	99.51	99.28	99.40	100.00	99.41	99.39	99.93	99.65
Central Sulawesi			96.42	93.28	94.86				93.96	95.29	98.47	98.28	98.37	97.71	98.71	98.21	98.54	98.61	98.57	99.09	97.26	97.97	97.39	97.69
South Sulawesi			89.41	83.42	86.24				84.15	85.96	95.79	96.39	96.10	94.52	95.61	95.10	94.29	96.24	95.38	98.44	94.54	94.69	97.06	95.90
Southeast Sulawesi			94.00	87.17	90.50				87.89	90.86	97.76	98.29	98.03	97.50	97.48	97.49	97.06	96.93	96.99	99.11	96.76	97.26	97.45	97.36
Gorontalo			95.47	96.02	95.75				95.17	95.15				95.51	97.17	96.34	95.19	98.44	96.82	99.30	95.20	94.80	97.74	96.32
West Sulawesi			89.41	83.51	86.40				84.55	86.97														
Maluku			97.78	95.94	96.85				96.28	97.28				97.12	97.94	97.53			99.30	99.34	98.97	98.88	99.33	99.09
North Maluku			96.83	92.42	94.65				93.24	95.52				98.67	98.73	98.70			100.00	98.96	99.68	99.52	99.43	99.47
West Papua			92.69	87.86	90.32				90.17	90.78														
Papua			81.01	68.78	75.06				66.61	72.95			80.13	81.37	72.64	76.93			99.80	98.67	79.26	88.97	79.75	84.22

TABLE 3. BASIC INDICATORS

Area	Youth literacy rate of population aged 15-24 years old (Susenas)												Net primary school enrolment ratio (Susenas)								
Year	2004			2005			2006			2007			2000	2001	2002	2003	2004	2005	2006	2007	2008
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	98.87	98.87	98.71	98.78	98.71	98.74	98.80	98.73	98.76	98.92	98.76	98.84	92.28	92.88	92.70	92.55	93.04	93.25	93.54	93.75	93.99
Aceh	99.38	99.38	99.44				98.68	98.84	98.76	99.04	98.95	99.00				95.36	95.88		95.48	95.73	96.05
North Sumatra	99.36	99.36	99.16	99.08	98.91	99.00	98.92	98.81	98.87	99.29	99.02	99.15	94.23	94.87	93.80	94.62	93.61	93.98	93.96	93.91	94.26
West Sumatra	99.30	99.30	99.19	99.00	99.23	99.12	98.93	99.25	99.09	99.00	99.35	99.18	92.66	93.81	92.30	92.59	93.64	93.65	94.17	94.45	94.63
Riau	99.11	99.11	99.33	99.58	99.56	99.57	98.85	99.48	99.17	99.56	99.11	99.34	93.95	94.44	94.23	94.13	94.64	94.95	94.72	94.80	95.04
Jambi	99.48	99.48	99.31	98.95	99.24	99.10	99.24	98.64	98.94	99.25	98.97	99.11	92.77	93.53	93.10	93.78	93.46	93.52	94.36	93.88	94.31
South Sumatra	98.85	98.85	98.86	99.34	99.01	99.17	99.29	99.19	99.24	99.40	99.19	99.30	92.28	92.23	91.52	92.36	93.13	94.14	93.01	92.69	92.97
Bengkulu	99.65	99.65	99.19	99.39	99.07	99.23	99.10	98.86	98.98	98.66	99.19	98.93	91.51	93.87	92.49	91.99	94.72	92.64	93.89	94.21	94.40
Lampung	99.29	99.29	99.42	98.73	99.41	99.06	98.92	99.33	99.11	99.54	99.43	99.49	93.20	94.05	93.08	92.06	92.73	93.54	93.94	94.04	94.28
Bangka Belitung	98.09	98.09	98.03	98.91	98.89	98.90	98.85	98.83	98.84	97.44	98.82	98.10		90.92	93.42	91.69	90.02	92.00	91.51	91.59	91.77
Riau Islands				99.09	98.51	98.79	98.85	99.39	99.13	98.41	99.35	99.00						91.65	93.66	93.50	93.79
D.K.I Jakarta	99.78	99.78	99.73	99.64	99.65	99.64	99.31	99.78	99.56	99.92	99.66	99.78	91.45	92.21	90.73	91.61	91.87	92.40	90.78	93.27	93.81
West Java	99.75	99.75	99.51	99.38	99.28	99.33	99.55	99.48	99.51	99.43	99.45	99.44	92.65	93.44	93.82	92.45	93.41	91.86	94.21	94.16	94.19
Central Java	99.38	99.38	99.30	99.15	99.38	99.26	99.35	99.36	99.35	99.35	99.28	99.31	93.86	94.47	94.10	93.70	93.32	94.47	94.05	94.78	95.14
D.I. Yogyakarta	99.52	99.52	99.63	99.53	99.62	99.57	99.88	99.75	99.82	99.77	99.72	99.75	94.33	95.48	93.23	91.98	92.55	95.46	94.38	93.53	94.32
East Java	98.91	98.91	98.61	99.00	98.73	98.86	99.11	99.10	99.11	99.04	98.84	98.94	92.33	94.07	93.20	93.48	93.71	94.91	94.20	94.45	94.57
Banten	99.32	99.32	99.32	99.62	99.55	99.58	99.41	99.31	99.36	99.61	99.09	99.35		90.50	93.08	93.77	94.12	93.24	94.83	92.97	93.39
Bali	98.80	98.80	98.33	99.49	98.22	98.88	98.91	98.40	98.66	98.89	98.03	98.47	93.36	92.74	92.19	91.58	93.48	93.26	93.33	94.43	94.93
West Nusa Tenggara	96.49	96.49	95.27	96.54	96.37	96.45	97.51	95.99	96.70	97.48	96.41	96.92	89.86	92.63	93.23	92.48	92.42	92.99	94.50	94.09	94.20
East Nusa Tenggara	95.93	95.93	96.08	94.54	95.98	95.25	94.79	95.31	95.05	95.43	96.55	95.99	88.94	87.92	87.07	88.27	90.79	92.00	91.58	91.59	91.72
West Kalimantan	97.76	97.76	97.87	98.26	97.22	97.76	97.94	97.68	97.81	98.23	97.76	98.01	89.53	91.14	89.46	88.89	93.11	92.49	93.82	93.48	93.95
Central Kalimantan	99.72	99.72	99.73	99.84	99.58	99.71	99.15	99.08	99.12	99.15	99.53	99.34	94.25	95.36	94.01	94.75	95.10	95.14	95.97	95.42	95.71
South Kalimantan	99.00	99.00	98.97	98.87	99.15	99.01	99.17	99.01	99.09	99.15	98.91	99.03	92.45	92.87	91.70	92.46	93.19	95.24	93.28	94.00	94.17
East Kalimantan	99.31	99.31	99.11	99.00	99.45	99.22	99.21	99.27	99.24	99.47	99.02	99.25	91.43	91.72	91.91	91.33	92.87	92.62	92.86	93.23	93.59
North Sulawesi	99.59	99.59	99.45	99.73	99.73	99.73	99.49	99.72	99.60	99.28	99.40	99.34	90.41	93.19	87.70	89.18	88.26	90.64	90.40	90.75	91.16
Central Sulawesi	98.14	98.14	98.56	98.57	97.98	98.29	98.30	98.60	98.45	98.07	98.98	98.53	91.08	90.92	90.13	90.85	91.44	92.10	92.87	92.04	92.82
South Sulawesi	95.28	95.28	96.15	95.33	97.06	96.24	96.39	97.68	97.04	95.81	97.24	96.54	88.58	88.76	88.97	89.21	90.64	92.04	91.08	92.06	92.15
Southeast Sulawesi	98.05	98.05	97.87	97.66	98.14	97.92	98.35	98.10	98.22	97.43	97.95	97.69	89.46	90.59	89.73	91.19	90.18	92.64	92.26	93.64	94.24
Gorontalo	95.87	95.87	97.39	96.24	97.57	96.92	96.24	98.35	97.32	97.02	97.46	97.25		86.43	80.71	87.33	88.85	88.22	90.48	90.18	90.40
West Sulawesi							94.05	95.36	94.72	96.11	95.71	95.90							91.67	92.17	92.75
Maluku	99.26	99.26	99.33	98.74	99.16	98.95	98.87	97.99	98.42	98.93	98.97	98.95		86.04		91.03	90.92	91.49	92.24	93.45	93.87
North Maluku	98.67	98.67	97.59	98.51	98.75	98.63	98.34	98.52	98.43	98.65	98.96	98.81		92.34		94.06	93.80	93.44	93.10	91.95	92.47
West Papua							95.75	92.93	94.28	93.15	91.78	92.44							88.16	90.67	90.76
Papua	87.87	87.87	82.98	86.17	75.63	80.84	84.35	74.59	79.52	90.99	81.50	86.21	81.85	79.20		83.86	85.21	81.05	78.11	80.92	81.76

TABLE 3. BASIC INDICATORS

Area	Net Junior secondary school enrolment ratio (Susenas)								
Year	2000	2001	2002	2003	2004	2005	2006	2007	2008
	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	60.27	60.47	61.64	63.49	65.24	65.37	66.52	66.64	66.98
Aceh				78.74	79.98		78.39	76.36	76.56
North Sumatra	67.20	72.32	69.02	72.95	73.02	72.79	73.08	73.61	73.97
West Sumatra	63.04	62.53	66.06	66.00	69.55	68.77	67.77	67.23	67.43
Riau	62.72	65.02	63.86	67.19	69.65	72.50	72.93	69.96	70.24
Jambi	56.50	60.43	61.03	61.30	65.69	64.44	65.32	65.77	66.05
South Sumatra	59.62	58.28	53.57	59.41	64.81	64.94	68.01	64.97	65.42
Bengkulu	57.34	59.93	59.13	60.44	67.02	61.87	66.73	68.73	68.98
Lampung	59.26	60.57	62.83	63.24	63.65	64.91	66.65	68.30	68.80
Bangka Belitung		44.90	45.15	50.61	56.38	61.61	55.30	52.24	52.71
Riau Islands						66.48	72.01	71.34	72.02
D.K.I Jakarta	77.01	71.65	77.49	77.58	76.08	74.95	71.41	71.26	71.35
West Java	57.69	56.30	60.79	61.02	61.74	59.99	62.13	66.90	67.43
Central Java	62.60	64.93	64.72	66.61	67.82	69.99	67.67	68.84	69.25
D.I. Yogyakarta	75.43	76.30	76.62	79.06	77.37	83.27	72.30	74.48	75.04
East Java	63.33	62.94	63.65	64.47	67.10	68.85	70.28	69.02	69.33
Banten		55.90	60.76	62.28	63.75	61.19	66.56	58.41	58.93
Bali	70.63	69.81	68.41	68.63	69.37	70.03	70.15	66.63	66.94
West Nusa Tenggara	58.19	56.62	57.57	57.19	61.70	67.53	69.62	70.65	71.02
East Nusa Tenggara	34.21	36.82	38.62	39.10	43.26	43.00	47.23	49.48	49.69
West Kalimantan	47.02	45.23	44.99	50.88	53.28	53.31	60.92	54.62	54.97
Central Kalimantan	60.72	54.12	52.82	58.64	65.15	71.49	67.69	60.07	60.23
South Kalimantan	51.78	54.35	55.89	56.33	59.27	56.89	62.12	59.27	59.67
East Kalimantan	60.38	63.08	62.61	67.98	70.20	69.80	64.00	71.14	71.30
North Sulawesi	63.14	71.44	66.69	68.33	67.87	65.86	66.03	65.95	66.32
Central Sulawesi	48.55	53.88	51.34	54.68	59.45	60.89	62.97	59.04	59.30
South Sulawesi	52.37	52.96	53.20	54.04	57.41	59.10	60.27	60.36	60.74
Southeast Sulawesi	60.59	59.64	58.42	63.39	64.02	66.04	72.42	65.77	66.14
Gorontalo		37.43	42.43	47.86	49.27	46.30	52.31	52.16	52.27
West Sulawesi							55.19	52.21	52.55
Maluku		60.35		62.59	68.06	70.43	76.86	70.08	70.58
North Maluku		57.25		62.15	64.17	61.00	65.31	64.67	65.13
West Papua							53.94	48.76	48.92
Papua		40.46		47.81	47.78	44.95	47.36	48.60	48.75

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Under-5 mortality rate	The probability of dying between birth and exact age five; expressed per 1,000 live births	**Under-5 mortality rate**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Infant mortality rate	The probability of dying between birth and exact age one year; expressed per 1,000 live births	**Infant mortality rate**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Projection based on Intercensal Population Survey 2005
Maternal Mortality Ratio	Ratio between maternal mortality rate and general fertility rate (0.078) for the same period; and expressed per 100,000 live births. Maternal mortality rate is any death that occurs during pregnancy, during childbirth, or within two months after the birth or the termination of the pregnancy; including all deaths that occurred during pregnancy and in the two months following the birth, even if the death was due to non-maternal causes	**Maternal Mortality Ratio**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
		Population (millions)	Population Census 2000
		Population (thousand)	Bappenas, BPS-Statistics Indonesia, UNFPA Indonesia. Proyeksi Penduduk Indonesia (Indonesia Population Projection) 2005-2025. Bappenas, Jakarta, 2008
Life Expectancy at Birth	Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.	**Life Expectancy at Birth**	Population Census 2000 , Population projection based on Intercensal Population Survey 2005, Processed by BPS-Statistics Indonesia , Jakarta, 2009
Adult literacy rate (10 years old and above)	Percentage of the population aged 10 years and older who were able to read and write Latin and or other common letter.	**Adult literacy rate (10 years old and above) by gender**	National Socio-Economic Survey
Adult literacy rate (15 years old and above)	Percentage of the population aged 15 years and older who were able to read and write Latin and or other common letter.	**Adult literacy rate (15 years old and above) by area and gender**	National Socio-Economic Survey
Youth literacy rate (15-24 years old)	Percentage of the population aged 15-24 years who were able to read and write Latin and or other common letter. Net enrollment ratio (NER) measures proportion of certain school age students to that age population and expressed percent.	**Youth literacy rate (15-24 years old) by area and gender**	National Socio-Economic Survey

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Net enrolment ratio NER of primary school	The number of children enrolled in junior secondary school who belong to the age group that officially corresponds to junior secondary schooling (aged 7-12 years old), divided by the total population of the same age group (aged 7-12 years old), and expressed as a percentage. It includes public and private schools (under the Ministry of National Education), and Islamic schools/Madrasah Ibtidaiyah (under the Ministry of Religious Affairs).	**Net primary school enrolment ratio**	National Socio-Economic Survey
NER of junior secondary school	The number of children enrolled in junior secondary school who belong to the age group that officially corresponds to junior secondary schooling (aged 13-15 years old), divided by the total population of the same age group (aged 13-15 years old), and expressed as a percentage. It includes public and private schools (under the Ministry of National Education), and Islamic schools/Madrasah Tsanawiyah (under the Ministry of Religious Affairs).	**Net Junior secondary school enrolment ratio**	National Socio-Economic Survey

Notes - Data not available
1) Data refer to 10 year period for preceding the survey
2) Data refer to 5 year period for preceding the survey

TABLE 4A. HEALTH INDICATORS

Area	Under-5 mortality rate (IDHS)																	
Year	1991						1994						1997					
	Male	Female	Urban	Rural	Total[1)]	Total[2)]	Male	Female	Urban	Rural	Total[1)]	Total[2)]	Male	Female	Urban	Rural	Total[1)]	Total[2)]
Indonesia	113	100	84	116	107	97	101	84	59	106	93	81	77	64	48	79	70.6	58.2
Aceh											79						58.6	
North Sumatra											97						71.9	
West Sumatra											98						95.1	
Riau											94						82.4	
Jambi											88						82.4	
South Sumatra											92						70.4	
Bengkulu											124						115.2	
Lampung											58						64.0	
Bangka Belitung																		
Riau Islands																		
D.K.I Jakarta					60						50						41.7	
West Java					164						120						77.2	
Central Java					80						75						59.9	
D.I. Yogyakarta					49						35						30.3	
East Java					89						79						52.5	
Banten																		
Bali					61						63						44.0	
West Nusa Tenggara											160						149.5	
East Nusa Tenggara											108						90.1	
West Kalimantan											135						88.2	
Central Kalimantan											38						68.9	
South Kalimantan											111						87.3	
East Kalimantan											76						66.2	
North Sulawesi											83						61.0	
Central Sulawesi											127						121.4	
South Sulawesi											86						79.0	
Southeast Sulawesi											105						94.2	
Gorontalo																		
West Sulawesi																		
Maluku											91						48.4	
North Maluku																		
West Papua																		
Papua											88						92.3	

TABLE 4A. HEALTH INDICATORS

Area	Under-5 mortality rate (IDHS)																							
Year	2002-2003												2007											
	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total[1)]	Total[2)]	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total[1)]	Total[2)]		
Indonesia	58	51	42	65	77	64	56	45	22	79	46	56	46	38	60	77	59	44	36	32	69	44		
Aceh																					45			
North Sumatra										57											67			
West Sumatra										59											62			
Riau										60											47			
Jambi										51											47			
South Sumatra										49											52			
Bengkulu										68											65			
Lampung										64											55			
Bangka Belitung										47											46			
Riau Islands																					58			
D.K.I Jakarta										41											36			
West Java										50											49			
Central Java										44											32			
D.I. Yogyakarta										23											22			
East Java										52											45			
Banten										56											58			
Bali										19											38			
West Nusa Tenggara										103											92			
East Nusa Tenggara										73											80			
West Kalimantan										63											59			
Central Kalimantan										47											34			
South Kalimantan										57											75			
East Kalimantan										50											38			
North Sulawesi										33											43			
Central Sulawesi										71											69			
South Sulawesi										72											53			
Southeast Sulawesi										92											62			
Gorontalo										97											69			
West Sulawesi																					96			
Maluku																					93			
North Maluku																					74			
West Papua																					62			
Papua																					64			

TABLE 4A. HEALTH INDICATORS

Area	Infant mortality rate (IDHS)																	
Year	1991						1994						1997					
	Male	Female	Urban	Rural	Total[1)]	Total[2)]	Male	Female	Urban	Rural	Total[1)]	Total[2)]	Male	Female	Urban	Rural	Total[1)]	Total[2)]
Indonesia	80	68	57	81	74	68	74	59	43	75	66	57	59	45	36	58	52.2	45.7
Aceh																	45.5	
North Sumatra											61						45.2	
West Sumatra											68						65.8	
Riau											72						60.4	
Jambi											60						68.3	
South Sumatra											60						53.0	
Bengkulu											74						72.3	
Lampung											38						48.2	
Bangka Belitung																		
Riau Islands																		
D.K.I Jakarta					45	43					30	26					26.1	
West Java					117	111					89	79					60.6	
Central Java					49	43					51	33					45.2	
D.I. Yogyakarta					38	35					30	26					23.4	
East Java					69	51					62	48					35.8	
Banten																		
Bali					49	49					58	49					39.5	
West Nusa Tenggara											110						110.5	
East Nusa Tenggara											71						59.7	
West Kalimantan											97						70.3	
Central Kalimantan											16						55.3	
South Kalimantan											83						70.7	
East Kalimantan											61						50.7	
North Sulawesi											66						47.6	
Central Sulawesi											87						94.5	
South Sulawesi											64						63.0	
Southeast Sulawesi											79						78.1	
Gorontalo																		
West Sulawesi																		
Maluku											68						29.5	
North Maluku																		
West Papua																		
Papua											61						64.7	

TABLE 4A. HEALTH INDICATORS

Area	Infant mortality rate (Census)	Under-5 mortality rate (IDHS)															Maternal Mortality Ratio (IDHS)				
Year	2000	2005			2006			2007			2008			2009			1991	1994	1997	2002-2003	2007
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Total	Total	Total	Total	Total
Indonesia	47.00	33.2	24.4	28.9	32.3	23.8	28.2	31.6	23.2	27.5	30.8	22.6	26.8	30.0	22.1	26.2	425	390	334	307	228
Aceh	39.71	38.0	28.5	33.4	37.6	28.1	33.0	37.1	27.8	32.6	36.7	27.4	32.1	36.2	27.0	31.7	-				
North Sumatra	43.69	28.2	20.8	24.6	27.5	20.2	23.9	26.8	19.7	23.3	26.1	19.2	22.7	25.4	18.7	22.1					
West Sumatra	52.66	33.2	24.4	28.9	32.2	23.6	28.0	31.1	22.9	27.1	30.2	22.2	26.3	29.2	21.5	25.5					
Riau	47.68	26.7	19.7	23.3	26.1	19.2	22.8	25.6	18.8	22.3	25.0	18.4	21.8	24.5	18.0	21.3					
Jambi	52.66	33.0	24.3	28.8	32.3	23.8	28.2	31.6	23.3	27.5	30.9	22.7	26.9	30.2	22.2	26.3					
South Sumatra	52.66	30.9	22.7	26.9	30.2	22.1	26.3	29.4	21.6	25.6	28.7	21.1	25.0	28.1	20.6	24.4					
Bengkulu	52.66	35.7	26.5	31.2	34.7	25.7	30.3	33.7	24.9	29.4	32.7	24.2	28.6	31.8	23.5	27.7					
Lampung	47.68	31.9	23.4	27.7	30.7	22.6	26.7	29.6	21.7	25.8	28.5	21.0	24.8	27.5	20.2	23.9					
Bangka Belitung	52.66	31.5	23.1	27.4	30.9	22.7	26.9	30.4	22.3	26.4	29.8	21.9	26.0	29.3	21.6	25.5					
Riau Islands		24.2	17.8	21.1	23.9	17.6	20.8	23.6	17.4	20.6	23.3	17.2	20.3	23.0	17.0	20.1					
D.K.I Jakarta	24.79	7.9	9.7	8.8	7.7	9.5	8.6	7.5	9.3	8.4	7.4	9.1	8.2	7.2	9.0	8.1					
West Java	56.65	33.9	25.0	29.5	32.9	24.3	28.7	32.0	23.6	27.9	31.1	22.9	27.1	30.2	22.3	26.3					
Central Java	43.69	26.6	19.1	22.9	25.6	18.6	22.2	24.6	18.0	21.4	23.7	17.5	20.7	22.8	17.0	19.9					
D.I. Yogyakarta	24.79	8.3	10.1	9.2	8.0	9.9	8.9	7.8	9.7	8.7	7.6	9.4	8.5	7.4	9.2	8.3					
East Java	47.69	31.3	23.0	27.3	30.2	22.2	26.3	29.1	21.4	25.4	28.1	20.6	24.5	27.1	19.9	23.6					
Banten	65.62	37.9	28.4	33.3	37.2	27.8	32.6	36.5	27.2	32.0	35.8	26.7	31.3	35.1	26.1	30.7					
Bali	35.72	13.3	13.4	13.4	13.1	13.3	13.2	12.8	13.1	12.9	12.5	12.9	12.7	12.3	12.7	12.5					
West Nusa Tenggara	88.55	53.3	41.6	47.6	51.7	40.2	46.1	50.2	38.8	44.6	48.7	37.5	43.2	47.2	36.3	41.9					
East Nusa Tenggara	56.65	39.3	29.6	34.6	38.0	28.5	33.4	36.8	27.5	32.3	35.6	26.5	31.2	34.4	25.6	30.1					
West Kalimantan	56.65	33.4	24.6	29.1	32.7	24.1	28.5	32.1	23.6	28.0	31.5	23.2	27.4	30.9	22.7	26.9					
Central Kalimantan	47.68	27.2	20.0	23.7	26.7	19.6	23.2	26.2	19.3	22.8	25.7	18.9	22.4	25.3	18.6	22.0					
South Kalimantan	69.6	42.1	31.8	37.1	40.9	30.8	36.0	39.7	29.9	34.9	38.6	29.0	33.9	37.5	28.1	32.9					
East Kalimantan	39.71	27.6	18.2	22.9	25.4	17.5	21.5	23.4	16.9	20.2	21.5	16.3	19.0	19.8	15.7	17.8					
North Sulawesi	27.77	13.4	13.3	13.3	12.6	12.8	12.7	11.8	12.3	12.1	11.1	11.9	11.5	10.4	11.4	10.9					
Central Sulawesi	65.62	43.1	32.7	38.0	41.9	31.7	36.9	40.8	30.8	35.9	39.7	29.9	34.9	38.6	29.0	33.9					
South Sulawesi	56.65	34.4	25.4	30.0	33.4	24.6	29.1	32.4	23.9	28.2	31.4	23.1	27.4	30.5	22.4	26.6					
Southeast Sulawesi	52.66	36.6	27.2	32.0	35.4	26.4	31.0	34.4	25.5	30.0	33.3	24.7	29.1	32.3	23.9	28.2					
Gorontalo	56.65	39.3	29.5	34.5	37.9	28.4	33.2	36.5	27.3	32.0	35.2	26.2	30.8	33.9	25.2	29.7					
West Sulawesi		34.4	25.4	30.0	33.4	24.6	29.1	32.4	23.9	28.2	31.4	23.1	27.4	30.5	22.4	26.6					
Maluku	60.63	39.1	29.4	34.4	38.1	28.6	33.5	37.2	27.8	32.6	36.3	27.1	31.8	35.3	26.3	30.9					
North Maluku	74.59	43.2	32.7	38.1	41.7	31.6	36.8	40.3	30.4	35.5	39.0	29.3	34.3	37.7	28.2	33.1					
West Papua		39.8	30.0	35.0	38.5	28.9	33.9	37.3	27.9	32.7	36.1	26.9	31.6	34.9	26.0	30.5					
Papua	56.65	38.6	28.9	33.9	37.4	28.0	32.8	36.2	27.0	31.7	35.1	26.1	30.7	34.0	25.2	29.7					

TABLE 4A. HEALTH INDICATORS

Area	Percentage of pregnant women fully immunized against tetanus - TT-2 (IDHS)														Percentage of receiving antenatal care from a skilled provider (IDHS)					
Year	1997			2002-2003			2007								1997			2002-2003		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	61.6	50.4	53.4	52.3	49.2	50.7	52.3	47.8	39.8	49.6	52.1	56.0	51.8	49.7	97.2	86.4	89.40	96.7	87.0	91.50
Aceh			47.1											42.7			85.20			
North Sumatra			31.8			21.0								19.3			82.00			85.70
West Sumatra			48.2			51.2								61.9			93.70			94.80
Riau			40.6			44.6								41.5			86.00			90.30
Jambi			42.6			41.3								46.7			69.30			82.20
South Sumatra			60.8			51.9								47.3			92.50			93.70
Bengkulu			57.1			61.7								59.5			86.70			91.90
Lampung			59.3			44.5								53.6			94.20			93.00
Bangka Belitung						44.5								58.8						88.80
Riau Islands														30.4						
D.K.I Jakarta			61.2			49.3								51.6			99.40			98.80
West Java			60.0			54.0								60.6			86.10			93.60
Central Java			57.3			61.5								53.1			93.80			96.10
D.I. Yogyakarta			57.2			66.9								56.1			98.30			99.30
East Java			51.2			52.2								39.0			94.40			90.90
Banten						46.0								45.1						85.80
Bali			55.2			55.6								58.6			97.50			97.70
West Nusa Tenggara			43.2			49.0								48.8			90.70			90.50
East Nusa Tenggara			67.5			63.7								54.8			85.40			87.70
West Kalimantan			52.1			55.8								49.5			81.30			82.80
Central Kalimantan			40.5			40.2								43.1			82.70			66.60
South Kalimantan			52.4			53.3								55.0			88.60			88.70
East Kalimantan			60.9			58.1								53.5			96.00			91.20
North Sulawesi			62.0			71.3								63.5			95.60			96.80
Central Sulawesi			53.7			55.6								59.3			82.50			82.40
South Sulawesi			51.4			47.1								59.2			88.10			94.30
Southeast Sulawesi			67.5			54.4								59.4			89.20			84.90
Gorontalo						44.6								33.0						87.90
West Sulawesi														56.6						
Maluku			43.5											42.6			67.40			
North Maluku														68.0						
West Papua														42.0						
Papua														31.6						

TABLE 4A. HEALTH INDICATORS

Area	Percentage of receiving antenatal care from a skilled provider (IDHS)								Percentage of pregnant women with 4 visits of antenatal care to skilled provider - ANC4 (IDHS)							Percentage of pregnant women with 4 visits of antenatal care to skilled provider following the recommended visit schedule - ANC4 (IDHS)					
Year	2007								1997	2002-2003			2007			2002-2003			2007	
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	97.7	90.1	82.2	92.1	95.5	98.3	99.3	93.30	82.00	87.5	75.2	81.0	89.9	75.5	81.5	71.7	56.7	63.7	76.5	57.5	65.5
Aceh								89.20													
North Sumatra								89.30													
West Sumatra								96.00													
Riau								93.20													
Jambi								84.60													
South Sumatra								91.30													
Bengkulu								93.70													
Lampung								95.40													
Bangka Belitung								94.00													
Riau Islands								93.80													
D.K.I Jakarta								99.50													
West Java								95.30													
Central Java								97.30													
D.I. Yogyakarta								99.30													
East Java								93.20													
Banten								86.30													
Bali								98.80													
West Nusa Tenggara								95.30													
East Nusa Tenggara								87.10													
West Kalimantan								90.60													
Central Kalimantan								91.00													
South Kalimantan								93.00													
East Kalimantan								93.90													
North Sulawesi								95.90													
Central Sulawesi								90.70													
South Sulawesi								92.20													
Southeast Sulawesi								91.30													
Gorontalo								88.50													
West Sulawesi								86.60													
Maluku								70.30													
North Maluku								88.00													
West Papua								80.40													
Papua								69.00													

TABLE 4A. HEALTH INDICATORS

Area	Percentage of pregnant women who receive iron tablets or syrup (IDHS)											Percentage of pregnant women who receive iron tablets - >90 tablets (IDHS)										
Year	2002-2003			2007								2002-2003			2007							
	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	82.8	74.5	78.4	84.0	72.5	61.9	72.9	81.7	85.8	86.1	77.3	34.7	24.2	29.1	35.4	24.7	15.4	25.8	30.6	32.8	43.0	29.20
Aceh											57.0											4.80
North Sumatra			59.1								62.7			3.2								13.40
West Sumatra			85.2								77.3			26.6								40.00
Riau			71.2								65.9			19.8								10.40
Jambi			59.4								70.9			14.1								19.20
South Sumatra			79.4								69.6			20.1								22.10
Bengkulu			84.6								78.8			32.0								31.70
Lampung			80.7								81.3			11.3								11.40
Bangka Belitung			66.0								78.5			19.8								34.50
Riau Islands											77.5											28.30
D.K.I Jakarta			91.3								80.3			60.5								28.80
West Java			76.4								82.1			22.9								28.00
Central Java			89.3								83.5			51.1								40.00
D.I. Yogyakarta			97.6								94.1			69.8								75.20
East Java			87.9								80.7			50.4								45.70
Banten			59.5								70.1			22.4								16.20
Bali			88.5								92.8			32.8								63.60
West Nusa Tenggara			86.6								87.4			25.7								45.50
East Nusa Tenggara			77.8								83.4			25.4								37.90
West Kalimantan			66.4								54.4			18.6								4.10
Central Kalimantan			58.3								72.8			7.8								19.30
South Kalimantan			83.5								75.7			29.6								30.20
East Kalimantan			81.9								81.3			41.5								37.00
North Sulawesi			91.6								88.5			11.2								13.40
Central Sulawesi			65.1								75.7			4.4								12.50
South Sulawesi			73.0								71.9			2.2								3.20
Southeast Sulawesi			72.2								58.9			7.8								6.00
Gorontalo			77.8								67.3			13.3								5.40
West Sulawesi											59.1											3.00
Maluku											57.0											15.00
North Maluku											84.1											23.20
West Papua											65.1											16.30
Papua											56.3											11.00

TABLE 4A. HEALTH INDICATORS

Area	Percentage of pregnant women protected by insecticide treated mosquito nets (IDHS)	Percentage of children under-fives with the last birth attendant were trained health worker (Susenas)						Percentage of children under-fives with the last birth attendant were trained health worker (Susenas)						Percentage of children under-fives with the last birth attendant were trained health worker (Susenas)					
Year	2007	2000			2001			2002			2003			2004			2005		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	2.30	81.54	49.82	62.84	83.51	50.71	64.24	83.77	53.70	66.64	85.73	55.44	67.91	85.79	61.03	71.52	84.77	59.26	70.46
Aceh	29.40										89.97	70.25	75.19	93.10	77.86	82.25	91.53	72.67	76.91
North Sumatra	0.70	94.62	72.61	81.82	96.02	73.39	82.57	97.45	76.50	84.57	97.74	76.89	85.54	96.55	74.80	83.71	96.38	77.93	85.89
West Sumatra	1.30	98.13	74.75	81.09	95.73	75.53	81.17	97.44	79.80	84.90	98.27	80.64	85.72	96.86	83.84	87.64	97.86	83.58	87.77
Riau	8.50	87.76	58.79	69.73	94.47	58.50	74.65	95.91	62.27	78.51	96.82	63.52	79.27	95.71	66.38	80.21	91.04	64.13	74.55
Jambi	8.90	90.68	35.25	50.18	85.81	53.80	63.28	87.90	50.48	61.66	85.52	54.26	63.35	88.90	64.50	72.03	81.55	54.31	63.20
South Sumatra	3.00	91.75	61.16	71.18	94.36	62.73	73.86	91.71	56.83	69.37	88.39	62.31	71.66	89.74	62.05	70.90	90.96	61.70	72.21
Bengkulu	18.70	92.62	57.79	68.45	95.10	62.48	72.06	93.44	66.27	74.81	91.67	55.79	66.43	93.69	69.80	77.01	85.40	69.17	74.48
Lampung	10.00	92.04	55.34	62.97	90.40	56.57	63.87	80.91	54.97	61.59	90.01	58.01	65.10	90.27	64.72	70.85	91.85	66.17	72.55
Bangka Belitung	18.40				83.59	57.23	67.31	92.83	59.50	72.45	92.17	65.47	75.16	92.38	74.27	81.31	89.83	64.93	74.34
Riau Islands	2.70																98.00	73.04	93.58
D.K.I Jakarta		92.90		92.90	95.88		95.88	97.09		97.09	95.99		95.99	97.59		97.59	95.59		95.59
West Java	0.60	73.77	33.76	53.60	69.84	34.77	52.39	70.06	38.39	54.61	74.20	40.14	56.94	73.27	46.04	60.51	72.43	44.34	58.92
Central Java		76.13	52.67	61.80	80.55	54.29	64.54	83.11	60.25	69.77	83.98	64.51	72.07	86.37	73.39	78.70	84.08	68.92	75.20
D.I. Yogyakarta	1.50	86.06	65.62	76.47	92.10	69.43	81.89	93.84	77.35	87.19	92.46	73.01	84.27	93.63	83.94	89.59	94.79	85.61	91.33
East Java		83.71	53.45	66.17	85.70	55.70	68.13	87.01	60.22	72.16	89.08	63.27	74.01	89.49	68.89	77.88	88.24	68.91	77.52
Banten					86.38	30.75	59.69	83.35	24.77	56.58	86.60	28.17	57.37	83.86	36.36	59.68	83.71	36.73	62.29
Bali		95.90	87.75	91.88	97.59	84.26	91.26	96.37	87.49	92.40	98.74	90.67	94.84	95.80	89.26	92.98	98.05	88.53	94.02
West Nusa Tenggara	0.90	57.30	43.28	48.21	59.55	38.07	45.31	61.90	43.46	50.32	62.63	44.67	50.84	67.44	53.98	58.73	69.81	53.24	59.26
East Nusa Tenggara	2.30	52.30	31.26	34.18	69.13	28.47	34.40	68.55	32.05	37.26	72.93	32.59	38.39	74.73	41.09	46.11	68.32	41.29	45.26
West Kalimantan	3.30	77.25	45.49	53.04	79.51	40.15	49.42	85.78	44.94	55.24	83.96	45.76	55.68	85.32	46.44	56.22	81.78	45.21	56.70
Central Kalimantan	3.20	74.38	53.48	60.04	84.84	59.87	66.16	87.89	48.15	60.73	86.06	52.35	63.15	81.36	62.58	68.09	87.92	55.48	66.28
South Kalimantan		77.61	47.44	57.62	87.84	49.68	63.67	82.01	53.41	64.06	87.64	57.83	68.47	86.61	62.69	71.49	86.48	61.93	71.79
East Kalimantan	0.70	82.66	57.59	71.23	89.53	67.25	79.81	89.32	65.07	79.19	90.65	61.35	77.82	91.91	71.49	82.69	87.44	66.00	77.85
North Sulawesi		84.46	56.26	64.61	94.17	79.17	83.90	91.62	81.39	85.19	90.96	84.11	86.69	92.08	81.29	85.54	93.73	80.60	85.69
Central Sulawesi	7.90	73.34	51.75	55.44	82.34	46.52	52.87	79.41	53.14	58.10	81.03	55.26	60.12	81.10	57.54	62.02	77.29	49.17	54.76
South Sulawesi		86.75	40.22	53.21	83.60	43.41	54.89	83.33	45.23	56.38	85.93	45.85	56.93	81.90	47.62	57.51	82.58	50.62	60.17
Southeast Sulawesi	1.80	62.30	25.38	33.70	65.11	29.87	36.62	55.43	29.35	34.00	63.79	29.77	36.68	63.61	37.96	43.15	67.14	40.27	45.69
Gorontalo					74.44	44.03	51.15	68.82	36.49	44.52	63.87	44.15	48.70	78.96	53.21	59.35	77.07	52.22	58.61
West Sulawesi	3.10																		
Maluku					84.77	48.75	58.81				80.69	43.43	52.32	69.25	36.74	44.70	76.39	48.55	55.19
North Maluku					79.97	41.76	49.32				63.86	18.33	27.87	78.19	28.92	39.10	68.60	32.83	40.96
West Papua	8.60																		
Papua					91.49	45.09	56.90				86.799	46.21	57.58	89.31	48.12	59.68	82.29	37.40	51.33

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children under-fives with the last birth attendant were trained health worker (Susenas)									Percentage of birth asissted by skilled provider - doctor, nurse, midwife[3] (IDHS)									
Year	2006			2007			2008			2002-2003			2007						
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	87.19	60.95	72.41	88.70	60.56	72.53	88.15	62.90	74.86	79.0	55.2	66.30	84.3	75.9	65.0	79.2	82.8	86.5	86.4	73.0
Aceh	95.03	71.49	76.40	97.23	75.59	80.40	97.00	77.44	83.08											72.5
North Sumatra	96.29	75.75	84.53	97.20	74.78	84.00	97.45	78.32	86.46			79.90								84.5
West Sumatra	97.65	82.77	87.05	97.73	80.54	85.77	97.98	83.55	88.15			79.80								80.5
Riau	92.64	64.72	76.26	96.29	64.94	76.25	92.83	65.51	79.76			74.00								84.9
Jambi	87.08	56.13	65.72	88.30	58.21	66.78	84.80	61.26	69.21			70.50								69.8
South Sumatra	92.73	67.02	76.62	94.46	62.58	73.49	93.69	65.91	76.43			76.40								67.5
Bengkulu	89.10	71.76	76.46	95.38	71.84	78.25	96.54	72.68	81.12			68.60								72.3
Lampung	91.21	60.96	68.22	91.42	65.13	70.93	91.07	68.17	74.18			62.40								69.8
Bangka Belitung	92.25	69.96	79.73	94.56	71.04	80.34	94.17	68.77	79.91			66.80								81.5
Riau Islands	95.96	55.82	89.12	96.09	63.11	89.87	99.15	81.48	91.52											91.6
D.K.I Jakarta	97.57		97.57	97.62		97.62	97.12		97.12			94.30								97.3
West Java	76.61	46.35	62.60	76.72	45.16	61.78	77.74	48.14	65.73			48.70								68.2
Central Java	88.41	72.80	79.31	88.67	73.68	79.88	91.25	78.95	84.88			67.20								83.0
D.I. Yogyakarta	98.46	89.81	94.78	97.85	91.12	95.49	98.52	94.11	96.99			85.20								95.8
East Java	90.66	73.31	81.13	91.37	74.37	81.87	91.94	76.07	84.03			80.70								77.5
Banten	88.83	36.25	64.90	91.41	33.74	64.06	85.77	30.41	63.54			62.90								52.1
Bali	97.80	92.72	95.64	99.03	87.29	93.73	97.82	93.72	96.22			87.80								92.6
West Nusa Tenggara	71.28	57.49	62.48	88.34	59.18	69.86	67.11	59.94	67.04			50.10								64.3
East Nusa Tenggara	66.19	39.54	43.39	82.23	35.84	42.47	76.56	40.62	46.05			36.40								46.2
West Kalimantan	80.56	52.75	61.19	94.23	47.20	59.21	88.56	50.34	61.14			63.70								62.2
Central Kalimantan	79.40	50.53	60.59	88.37	49.13	60.92	80.90	47.79	59.04			46.10								68.1
South Kalimantan	87.96	61.73	71.78	89.50	60.99	72.11	88.71	66.50	75.76			57.40								75.6
East Kalimantan	90.54	67.74	81.00	93.49	63.78	80.08	90.43	67.36	81.95			79.20								75.5
North Sulawesi	87.09	75.08	79.72	88.11	80.51	83.23	89.32	76.60	82.22			85.70								87.3
Central Sulawesi	80.86	52.78	58.41	81.23	52.73	58.24	79.32	53.52	58.37			54.00								59.6
South Sulawesi	81.42	53.59	62.93	88.62	50.69	62.77	83.66	53.78	63.49			62.20								58.8
Southeast Sulawesi	70.44	41.44	47.26	70.09	40.16	46.36	75.97	46.56	52.79			42.00								56.6
Gorontalo	62.96	49.69	52.57	73.36	52.35	57.56	71.11	53.81	59.31			48.80								53.6
West Sulawesi	56.41	32.35	35.93	69.32	39.80	43.50	62.22	31.17	39.71											43.8
Maluku	75.95	36.29	46.11	78.25	27.85	41.13	68.17	37.45	44.75											32.8
North Maluku	64.33	28.96	37.35	66.00	29.47	37.97	69.86	26.45	36.93											45.9
West Papua			56.35	77.01	46.71	55.99	83.30	54.38	60.77											57.7
Papua	92.60	44.97	58.73	87.13	37.71	52.27	90.53	32.83	46.87											46.3

TABLE 4A. HEALTH INDICATORS

Area	Percentage of birth assisted by traditional birth attendant [3] (IDHS)											Percentage of live births delivered in public health facilities (IDHS)									
Year	2002-2003			2007								2002-2003			2007						
	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	19.9	41.6	31.50	0.6	2.8	4.7	2.3	1.4	0.3	0.2	24.0	13.10	5.90	9.20	12.90	7.40	5.20	8.30	11.40	12.20	12.40	9.70
Aceh											25.9											7.70
North Sumatra			15.40								10.7			7.30								5.10
West Sumatra			18.00								18.7			14.20								18.50
Riau			22.80								13.1			8.30								4.90
Jambi			28.30								28.5			11.40								5.60
South Sumatra			22.50								28.6			7.90								7.60
Bengkulu			29.50								25.5			5.00								6.30
Lampung			37.10								28.9			6.80								2.50
Bangka Belitung			30.60								17.0			5.70								10.10
Riau Islands											5.3											11.00
D.K.I Jakarta			5.70								2.6			17.80								14.80
West Java			50.40								29.8			5.20								6.00
Central Java			32.20								16.7			8.00								7.60
D.I. Yogyakarta			14.80								4.0			18.70								16.90
East Java			17.00								21.6			10.10								8.50
Banten			35.70								46.8			4.60								3.70
Bali			9.60								5.3			23.80								24.60
West Nusa Tenggara			46.50								33.8			21.80								25.90
East Nusa Tenggara			54.90								42.9			9.40								16.10
West Kalimantan			33.30								34.9			7.40								8.80
Central Kalimantan			48.80								25.9			1.40								5.20
South Kalimantan			40.30								21.8			5.90								8.80
East Kalimantan			17.90								19.0			12.70								21.20
North Sulawesi			12.00								10.5			16.90								26.60
Central Sulawesi			41.40								36.6			12.10								11.70
South Sulawesi			31.20								32.4			20.30								16.00
Southeast Sulawesi			54.50								40.6			3.60								6.30
Gorontalo			50.60								45.0			11.70								13.70
West Sulawesi											44.8											8.90
Maluku											63.5											8.40
North Maluku											43.7											10.70
West Papua											27.1											32.50
Papua											7.4											18.90

TABLE 4A. HEALTH INDICATORS

Area	Percentage of live births delivered in private health facilities (IDHS)			Percentage of live births delivered in private health facilities (IDHS)								Percentage of live births delivered at home (IDHS)									
Year	2002-2003			2007								2002-2003			2007						
	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	46.50	16.60	30.50	57.40	21.50	8.40	23.40	36.50	49.50	71.00	36.40	39.50	76.10	59.00	28.60	69.60	84.80	66.80	51.10	37.10	15.50	52.70
Aceh											17.10											74.50
North Sumatra			25.70								29.90			65.30								64.40
West Sumatra			44.50								45.00			40.60								34.70
Riau			29.10								38.70			59.80								55.40
Jambi			25.40								20.50			62.30								72.90
South Sumatra			30.10								25.80			61.60								64.90
Bengkulu			8.00								5.80			85.00								87.90
Lampung			34.80								42.20			58.10								54.90
Bangka Belitung			27.30								33.10			64.90								54.40
Riau Islands											65.30											23.10
D.K.I Jakarta			71.30								73.70			10.90								11.20
West Java			23.40								38.60			70.60								54.50
Central Java			32.60								45.50			59.10								46.40
D.I. Yogyakarta			52.30								69.90			27.20								12.70
East Java			50.40								57.00			38.10								32.00
Banten			37.70								34.40			56.80								61.60
Bali			61.10								66.20			13.70								8.50
West Nusa Tenggara			5.60								6.30			64.20								58.40
East Nusa Tenggara			3.60								4.50			85.40								77.50
West Kalimantan			17.60								24.90			72.80								65.20
Central Kalimantan			1.60								8.90			94.20								84.90
South Kalimantan			3.10								10.50			90.20								79.80
East Kalimantan			32.30								24.60			53.30								53.50
North Sulawesi			31.70								28.40			48.70								43.00
Central Sulawesi			4.60								7.30			82.00								80.20
South Sulawesi			15.10								14.60			63.90								68.90
Southeast Sulawesi			2.50								2.00			93.00								90.50
Gorontalo			3.20								8.00			83.70								74.80
West Sulawesi											3.70											87.00
Maluku											4.00											87.10
North Maluku											7.30											80.50
West Papua											6.50											55.70
Papua											7.40											70.80

TABLE 4A. HEALTH INDICATORS

Area	Percentage of post partum women received postnatal care (IDHS)			Percentage of post partum women received postnatal care (IDHS)								Percentage of postpartum women received Vitamin A (IDHS)		Percentage of postpartum women received Vitamin A (Health Profile)		
Year	2002-2003			2007								2002-2003	2007	2005	2006	2007
	Urban	Rural	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Total	Total	Total	Total	Total
Indonesia	83.7	81.9	82.5	85.5	83.0	77.3	82.9	89.2	90.2	89.3	83.60	42.50	44.60	59.73	62.92	57.67
Aceh											78.20		43.80		53.17	71.23
North Sumatra			71.5								61.30	29.10	32.90		40.46	34.08
West Sumatra			80.4								76.70	40.70	47.30	65.10	62.15	61.71
Riau			78.7								72.30	44.70	34.60	67.80	61.14	37.22
Jambi			83.1								90.60	51.90	45.20	7.98	52.73	69.83
South Sumatra			68.5								81.80	38.50	31.20		74.48	90.03
Bengkulu			91.8								92.10	34.10	35.60	40.54	66.20	34.93
Lampung			96.4								94.60	25.90	41.90	49.86	26.65	37.36
Bangka Belitung			61.4								83.10	29.20	40.90	53.73	77.83	66.76
Riau Islands											81.70		61.30		66.11	62.41
D.K.I Jakarta			85.5								84.00	51.90	54.70		18.06	26.92
West Java			80.9								93.40	42.20	45.00		46.04	65.72
Central Java			89.0								93.10	38.20	47.60	84.01	88.18	74.39
D.I. Yogyakarta			95.5								98.00	49.00	54.80		70.34	74.97
East Java			91.7								91.50	59.10	43.70		74.90	59.52
Banten			79.2								73.40	33.80	40.00	48.39	63.20	26.37
Bali			76.8								71.20	35.30	64.50	80.01	80.20	67.77
West Nusa Tenggara			83.7								77.90	41.80	51.50		84.48	85.86
East Nusa Tenggara			71.0								76.10	45.10	58.30		53.36	83.81
West Kalimantan			83.5								79.80	38.10	40.40		47.45	35.33
Central Kalimantan			81.5								90.60	37.40	45.20		80.26	54.02
South Kalimantan			88.2								91.40	36.00	33.10		79.95	56.55
East Kalimantan			85.6								69.10	55.20	35.90	66.91	54.25	48.88
North Sulawesi			86.6								71.50	50.60	63.00	34.45	77.18	70.66
Central Sulawesi			85.1								93.60	31.80	46.60		72.31	77.10
South Sulawesi			80.7								76.90	41.70	41.70		74.92	47.36
Southeast Sulawesi			76.6								89.50	45.40	46.20	59.72	51.49	70.69
Gorontalo			82.6								83.30	54.90	51.30	69.87	66.52	66.61
West Sulawesi											78.30		43.00	41.78	34.68	65.61
Maluku											73.90		32.50	39.88	67.31	67.91
North Maluku											62.00		51.00	64.71	72.75	51.77
West Papua											44.50		33.20	47.38		21.58
Papua											34.00		42.20	13.32	4.97	21.96

TABLE 4A. HEALTH INDICATORS

	Prevalence of woman aged >= 15 years old suffered from anemia (Riskesdas)						Unmet need for family planning (IDHS)			Contraceptive prevalence rate (IDHS)		
Year	2007						1997	2002-2003	2007	1997		
	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Urban	Total	Total	Total	Urban	Rural	Total
Indonesia	11.00	10.00	9.00	7.90	7.40	19.70	9.20	8.60	9.10	59.8	56.5	57.40
Aceh						20.10	10.30		12.00			37.10
North Sumatra						25.00	12.90	13.00	12.30			46.00
West Sumatra						29.80	15.90	12.30	11.20			44.80
Riau						28.80	12.70	10.40	9.10			48.00
Jambi						9.00	6.60	6.10	7.00			61.80
South Sumatra						16.30	7.80	6.80	7.40			57.90
Bengkulu						16.20	7.40	8.00	6.10			66.60
Lampung						25.90	7.40	7.30	5.50			66.50
Bangka Belitung						21.10		5.60	3.20			
Riau Islands						12.50			12.30			
D.K.I Jakarta						27.60	8.90	6.90	6.90			58.90
West Java						13.40	9.80	9.90	10.00			57.60
Central Java						22.80	8.30	6.50	7.40			62.40
D.I. Yogyakarta						20.90	4.60	4.80	6.80			72.90
East Java						15.60	7.60	5.60	8.20			61.10
Banten						19.30		9.70	9.00			
Bali						10.80	5.80	6.90	5.80			68.10
West Nusa Tenggara						20.90	10.70	16.00	12.90			56.50
East Nusa Tenggara						28.80	13.50	16.70	17.40			39.30
West Kalimantan						23.40	7.40	10.10	7.70			58.10
Central Kalimantan						19.40	7.80	6.80	5.70			63.30
South Kalimantan						21.70	7.50	9.30	6.20			60.20
East Kalimantan						24.20	7.90	7.00	7.70			59.30
North Sulawesi						8.70	4.40	4.40	6.10			71.20
Central Sulawesi						13.40	9.40	10.20	8.30			51.70
South Sulawesi						19.70	11.70	11.80	13.90			41.50
Southeast Sulawesi						38.00	8.90	13.40	12.90			53.10
Gorontalo						31.40		11.00	6.60			
West Sulawesi						12.90			17.40			
Maluku						43.40	15.30		22.40			40.10
North Maluku						27.40			13.00			
West Papua						14.60			16.60			
Papua						17.90			15.80			

TABLE 4A. HEALTH INDICATORS

Area	Contraceptive prevalence rate (IDHS)																Percentage of Universal Child Immunization Villages (Health Profile)				
Year	2002-2003								2007								2004	2005	2006	2007	2008
	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Total	Total	Total	Total	Total
Indonesia	61.1	59.7	52.4	60.1	62.9	63.0	63.5	60.30	62.5	60.6	53.0	63.3	62.4	63.8	63.5	61.40	72.89	76.23	73.77	76.14	74.02
Aceh																47.40	28.02	50.00	85.76	85.76	
North Sumatra								52.50								54.20	78.59	79.01	83.09	72.60	70.67
West Sumatra								52.90								59.90	74.87	76.00	79.30	72.69	67.96
Riau								57.80								56.70	81.91	80.96	82.72	71.75	75.11
Jambi								59.00								65.20	83.14	88.95	92.98	85.06	
South Sumatra								61.40								64.80	81.35	84.07	84.09	89.28	81.87
Bengkulu								68.20								74.00	68.83	71.45	72.78	71.51	78.95
Lampung								61.40								71.10	92.42	90.00	79.71	87.38	65.41
Bangka Belitung								65.10								67.80	76.34	78.86	82.55	83.80	87.91
Riau Islands																57.60			88.00	60.48	70.03
D.K.I Jakarta								63.20								60.10	80.88	69.06	77.15	74.82	82.98
West Java								59.00								61.10	79.25	79.99	62.64	66.80	
Central Java								65.00								63.70	88.23	89.00	81.52	83.64	86.59
D.I. Yogyakarta								75.60								66.90	100.00	99.09	92.24	97.72	84.70
East Java								67.00								66.10	78.01	79.00	65.45	83.43	
Banten								58.60								57.40	74.72	79.00	60.79	59.49	58.18
Bali								61.20								69.40	99.42	100.00	99.28	100.00	
West Nusa Tenggara								53.50								54.80	90.36	87.53	89.91	87.17	89.60
East Nusa Tenggara								34.80								42.10	77.19	79.00	83.47	84.44	
West Kalimantan								57.80								62.70	60.95	65.01	73.12	76.29	69.54
Central Kalimantan								63.90								66.50	56.46	58.99	36.13	63.71	
South Kalimantan								57.60								64.40	66.34	66.45	71.69	64.68	
East Kalimantan								56.20								59.20	70.00	71.96	79.78	82.23	
North Sulawesi								70.10								69.30	80.03	80.97	76.86	66.27	
Central Sulawesi								54.60								63.60	67.21	68.97	73.87	67.88	72.63
South Sulawesi								49.10								53.40	73.56	78.00	79.13	82.66	81.78
Southeast Sulawesi								48.60								50.70	78.19	86.87	87.68	82.21	52.35
Gorontalo								52.00								60.10	41.91	50.11	50.20	50.71	61.73
West Sulawesi																45.40		76.05	76.05	14.92	36.10
Maluku																34.10	82.32	83.03	61.23	69.27	
North Maluku																48.80	36.92	52.92	38.89	54.53	49.22
West Papua																39.60				36.69	
Papua																38.30	35.00	36.97	14.83	54.42	

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who received BCG vaccine (IDHS)																								
Year	1991	1994					1997					2002-2003					2007								
	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	69.7	77.5	78.0	90.6	72.8	77.8	85.3	85.5	92.6	81.7	84.9	84.4	80.4	88.4	77.2	82.5	86.1	84.7	92.0	80.8	70.7	83.6	84.8	94.3	94.0	85.4
Aceh						49.3					68.4															63.5
North Sumatra						68.9					67.9					74.2										66.2
West Sumatra						77.0					83.2					84.0										87.1
Riau						72.6					74.4					83.6										73.3
Jambi						81.6					65.2					84.7										71.7
South Sumatra						78.7					90.0					88.2										91.0
Bengkulu						79.8					88.4					93.6										89.6
Lampung						74.5					93.3					87.7										93.4
Bangka Belitung																77.9										76.7
Riau Islands																										82.8
D.K.I Jakarta						92.2					94.3					95.2										88.4
West Java						73.2					78.8					79.1										89.6
Central Java						88.5					92.3					87.1										95.7
D.I. Yogyakarta						92.0					98.9					100.0										100.0
East Java						77.7					89.2					84.6										87.1
Banten																69.3										80.4
Bali						93.7					94.5					88.1										94.3
West Nusa Tenggara						81.1					91.3					88.6										86.3
East Nusa Tenggara						78.1					95.4					92.7										86.5
West Kalimantan						68.2					81.1					70.2										81.2
Central Kalimantan						77.4					89.6					76.8										80.7
South Kalimantan						80.9					88.2					79.1										81.3
East Kalimantan						88.3					95.7					85.9										85.9
North Sulawesi						86.3					95.6					90.1										96.2
Central Sulawesi						69.2					85.6					86.7										80.5
South Sulawesi						76.5					78.5					80.3										79.8
Southeast Sulawesi						86.8					94.8					84.2										85.4
Gorontalo																87.7										83.2
West Sulawesi																										80.6
Maluku						66.9					83.5															67.7
North Maluku																										73.9
West Papua																										72.0
Papua																										61.0

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who received BCG vaccine (Riskesdas)										Percentage of children age 12-23 months who received DPT-3 vaccine (IDHS)										
Year	2007										1991	1994					1997				
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total
Indonesia	87.3	86.5	92.4	83.5	83.0	85.7	87.2	89.6	91.9	86.9	49.4	58.5	59.5	76.6	52.2	59.0	62.7	65.4	75.3	59.3	64.1
Aceh										77.4						31.0					55.3
North Sumatra										76.3						50.5					43.7
West Sumatra										83.1						42.0					52.0
Riau										88.9						59.0					59.0
Jambi										85.2						63.4					50.8
South Sumatra										88.8						59.7					71.8
Bengkulu										95.3						68.2					64.6
Lampung										93.3						58.8					77.8
Bangka Belitung										83.7											
Riau Islands										93.3											
D.K.I Jakarta										96.3						79.2					73.3
West Java										87.3						53.5					48.5
Central Java										95.7						70.0					68.1
D.I. Yogyakarta										100.0						80.4					89.9
East Java										88.6						56.3					74.1
Banten										76.5											
Bali										98.8						86.4					80.4
West Nusa Tenggara										96.4						53.7					79.1
East Nusa Tenggara										83.9						66.9					72.5
West Kalimantan										79.3						48.8					68.8
Central Kalimantan										82.1						52.7					55.9
South Kalimantan										90.4						51.8					67.5
East Kalimantan										93.1						81.3					84.6
North Sulawesi										94.4						70.2					80.7
Central Sulawesi										89.1						47.3					70.5
South Sulawesi										88.8						61.0					64.8
Southeast Sulawesi										93.6						63.9					83.8
Gorontalo										89.1											
West Sulawesi										73.2											
Maluku										73.5						57.5					64.4
North Maluku										85.5											
West Papua										84.3											
Papua										75.9						58.4					

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who received DPT-3 vaccine (IDHS)															Percentage of children age 12-23 months who received DPT-3 vaccine (Riskesdas)									
Year	2002-2003					2007										2007									
	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	57.7	58.9	64.5	52.8	58.3	65.6	67.9	74.8	61.0	44.9	62.6	66.7	78.2	81.4	66.7	67.7	67.6	74.9	63.1	62.9	64.7	69.1	71.0	74.7	67.7
Aceh															33.7										58.5
North Sumatra					41.9										39.2										54.7
West Sumatra					66.5										69.0										64.2
Riau					63.3										52.1										70.7
Jambi					51.6										55.2										79.3
South Sumatra					56.0										67.8										71.6
Bengkulu					76.3										61.6										81.0
Lampung					61.0										78.5										77.2
Bangka Belitung					67.5										69.3										67.7
Riau Islands															68.6										84.1
D.K.I Jakarta					76.0										77.4										68.6
West Java					48.3										70.0										61.8
Central Java					73.6										88.3										79.1
D.I. Yogyakarta					91.0										97.0										89.8
East Java					66.6										70.7										70.4
Banten					35.0										48.8										48.3
Bali					87.0										77.3										89.5
West Nusa Tenggara					44.6										62.0										66.3
East Nusa Tenggara					70.1										52.6										60.9
West Kalimantan					46.3										63.5										62.0
Central Kalimantan					56.2										50.1										64.6
South Kalimantan					59.4										55.0										71.8
East Kalimantan					71.0										75.0										79.8
North Sulawesi					77.9										81.8										79.6
Central Sulawesi					69.2										57.3										66.3
South Sulawesi					49.9										61.8										68.8
Southeast Sulawesi					68.1										65.9										67.4
Gorontalo					58.4										58.6										65.3
West Sulawesi															59.2										47.9
Maluku															44.2										55.3
North Maluku															41.5										72.8
West Papua															40.9										59.4
Papua															35.2										50.5

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who recevied Polio-3 vaccine (IDHS)																									
Year	1991	1994					1997					2002-2003					2007									
	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	49.3	60.2	59.6	77.9	52.9	59.9	72.2	74.8	84.9	68.8	73.6	46.5	46.0	49.1	43.7	46.2	72.2	74.8	82.2	67.3	54.9	67.2	75.4	83.6	86.4	73.5
Aceh						31.0					65.2															46.9
North Sumatra						53.3					57.7					31.4										60.7
West Sumatra						40.2					83.0					60.6										75.2
Riau						59.2					74.6					47.9										56.8
Jambi						64.4					82.3					34.8										64.3
South Sumatra						64.9					80.4					28.6										70.9
Bengkulu						66.4					80.0					71.9										79.0
Lampung						61.6					83.8					52.8										86.4
Bangka Belitung																67.6										70.3
Riau Islands																										75.3
D.K.I Jakarta						79.9					82.4					46.1										82.6
West Java						54.6					66.2					38.0										74.9
Central Java						69.3					68.1					61.5										91.5
D.I. Yogyakarta						80.4					92.0					80.9										100.0
East Java						58.7					81.8					56.4										74.7
Banten																22.9										63.1
Bali						86.7					80.8					76.0										86.7
West Nusa Tenggara						46.2					85.7					40.2										67.9
East Nusa Tenggara						67.8					84.4					54.7										58.1
West Kalimantan						46.6					80.0					40.2										63.6
Central Kalimantan						63.9					69.1					43.6										56.0
South Kalimantan						56.9					76.6					39.8										62.3
East Kalimantan						78.1					91.1					57.6										80.6
North Sulawesi						73.5					86.2					65.1										88.4
Central Sulawesi						45.8					73.2					60.2										72.1
South Sulawesi						60.3					64.8					38.5										67.8
Southeast Sulawesi						65.4					84.9					36.6										70.6
Gorontalo																49.9										70.3
West Sulawesi																										64.7
Maluku						52.7					69.7															45.2
North Maluku																										49.3
West Papua																										38.0
Papua						60.4																				55.8

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who recevied Polio-3 vaccine (Riskesdas)										Percentage of children age 12-23 months who received Measles vaccine (IDHS)															
Year	2007										1991	1994					1997					2002-2003				
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total
Indonesia	71.0	70.1	78.7	66.2	66.6	68.1	72.8	73.6	77.6	71.0	44.5	62.9	62.1	76.2	57.2	62.5	68.8	72.8	79.3	67.3	70.9	72.6	70.5	77.6	66.2	71.6
Aceh										63.7						33.1					61.1					
North Sumatra										64.0						49.4					53.0					56.3
West Sumatra										69.4						47.6					66.0					66.0
Riau										71.2						61.2					65.7					75.4
Jambi										74.6						60.3					53.1					73.2
South Sumatra										74.3						67.6					78.1					78.2
Bengkulu										77.7						70.0					73.9					82.3
Lampung										78.8						57.3					83.1					79.8
Bangka Belitung										66.7																71.4
Riau Islands										85.3																
D.K.I Jakarta										71.3						67.9					77.8					80.4
West Java										67.5						62.6					61.8					71.7
Central Java										83.6						73.7					70.6					75.9
D.I. Yogyakarta										96.1						83.5					96.3					91.1
East Java										73.9						59.2					79.4					76.5
Banten										59.0																44.0
Bali										89.1						83.7					81.5					82.7
West Nusa Tenggara										74.9						64.0					84.0					80.9
East Nusa Tenggara										64.8						68.0					85.5					88.6
West Kalimantan										65.5						50.7					66.1					61.0
Central Kalimantan										66.8						60.2					83.0					58.9
South Kalimantan										75.1						64.6					69.5					69.8
East Kalimantan										83.2						81.0					86.4					80.9
North Sulawesi										81.4						78.1					85.4					73.6
Central Sulawesi										65.9						53.1					72.7					84.1
South Sulawesi										72.3						56.2					65.3					71.0
Southeast Sulawesi										67.9						70.7					84.4					70.3
Gorontalo										68.9																75.5
West Sulawesi										47.9																
Maluku										57.3						56.2					76.6					
North Maluku										64.2																
West Papua										64.7																
Papua										56.1																

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who received Measles vaccine (IDHS)										Percentage of children age 12-23 months who received Measles vaccine (Riskesdas)										
Year	2007										2007										
	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	75.1	77.9	82.0	72.5	63.3	74.4	78.2	81.6	84.9	76.4	82.0	81.2	86.0	78.8	78.1	78.5	83.1	84.3	86.8	81.6
Aceh										50.1										69.5
North Sumatra										52.4										71.2
West Sumatra										72.7										75.4
Riau										68.9										84.1
Jambi										61.7										78.0
South Sumatra										73.0										83.5
Bengkulu										81.0										96.0
Lampung										83.5										90.3
Bangka Belitung										68.9										77.1
Riau Islands										82.4										88.9
D.K.I Jakarta										79.7										85.4
West Java										81.2										78.9
Central Java										87.1										89.1
D.I. Yogyakarta										95.2										99.2
East Java										80.3										83.3
Banten										76.6										62.5
Bali										85.5										95.7
West Nusa Tenggara										80.3										94.1
East Nusa Tenggara										77.2										81.6
West Kalimantan										68.2										77.0
Central Kalimantan										83.3										77.3
South Kalimantan										62.1										81.7
East Kalimantan										82.4										90.8
North Sulawesi										86.2										85.9
Central Sulawesi										72.3										84.3
South Sulawesi										69.0										83.5
Southeast Sulawesi										79.5										85.4
Gorontalo										69.3										87.1
West Sulawesi										74.9										78.5
Maluku										58.4										72.1
North Maluku										70.2										85.5
West Papua										63.0										80.8
Papua										55.3										68.7

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children age 12-23 months who received HB-3 vaccine (IDHS)															Percentage of children age 12-23 months who received HB-3 vaccine (Riskesdas)									
Year	2002-2003					2007										2007									
	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	42.9	47.9	51.5	39.9	45.3	59.4	61.2	70.0	53.5	41.1	51.0	58.7	74.2	76.8	60.3	63.2	62.3	71.0	57.3	58.7	59.7	63.2	65.5	70.9	62.8
Aceh															27.4										53.8
North Sumatra					31.7										38.1										51.4
West Sumatra					59.7										71.9										67.9
Riau					49.7										49.3										65.7
Jambi					42.5										41.5										64.0
South Sumatra					35.8										57.5										64.7
Bengkulu					39.9										61.6										74.4
Lampung					47.2										72.5										70.7
Bangka Belitung					60.6										64.3										67.7
Riau Islands															64.3										77.8
D.K.I Jakarta					49.5										67.3										62.3
West Java					34.9										66.0										59.8
Central Java					65.2										77.2										77.7
D.I. Yogyakarta					91.3										88.1										69.0
East Java					56.9										63.3										59.7
Banten					28.4										48.3										49.7
Bali					81.7										78.2										85.2
West Nusa Tenggara					21.2										59.4										52.5
East Nusa Tenggara					34.3										36.9										54.3
West Kalimantan					33.2										58.5										58.1
Central Kalimantan					48.0										47.6										60.3
South Kalimantan					46.9										52.9										67.1
East Kalimantan					65.2										67.3										77.7
North Sulawesi					50.7										58.6										73.2
Central Sulawesi					54.0										46.3										63.7
South Sulawesi					33.8										54.1										56.8
Southeast Sulawesi					49.6										60.5										62.8
Gorontalo					43.1										54.7										58.6
West Sulawesi															50.6										42.4
Maluku															39.2										51.0
North Maluku															35.2										68.6
West Papua															35.4										51.0
Papua															31.4										46.5

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children aged 12-23 months fully immunized against all basic antigen (IDHS)																										
Year	1991	1994					1997					2002-2003					2007										
	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	36.9	50.5	50.3	67.0	43.9	50.4	53.4	56.0	65.9	50.0	54.8	50.8	52.2	56.4	47.1	51.5	56.4	61.0	67.5	52.3	39.4	53.0	58.1	68.0	74.9	58.6
Aceh																										
North Sumatra						25.1					46.1															26.8
West Sumatra						40.8					35.9					36.5										32.8
Riau						28.4					44.3					58.6										60.2
Jambi						52.1					52.1					57.2										41.4
South Sumatra						53.8					41.3					50.6										44.8
Bengkulu						56.2					62.3					50.7										54.6
Lampung						58.7					55.3					69.2										54.9
Bangka Belitung						48.1					69.3					46.3										67.0
Riau Islands																64.9										59.3
D.K.I Jakarta																										62.5
West Java						62.1					60.7					67.0										71.5
Central Java						43.6					42.4					41.4										63.9
D.I. Yogyakarta						63.3					51.1					63.5										74.7
East Java						76.2					87.2					84.2										93.8
Banten						49.7					67.3					64.2										64.8
Bali																25.4										37.4
West Nusa Tenggara						76.7					71.0					80.3										72.2
East Nusa Tenggara						38.0					69.5					42.5										55.7
West Kalimantan						57.0					59.3					62.7										45.7
Central Kalimantan						41.5					52.9					38.3										50.1
South Kalimantan						43.0					49.0					49.0										42.2
East Kalimantan						48.2					56.3					52.2										50.8
North Sulawesi						74.7					78.5					66.6										69.2
Central Sulawesi						64.6					73.1					68.6										76.1
South Sulawesi						41.9					60.9					66.5										50.3
Southeast Sulawesi						50.9					56.2					43.7										55.1
Gorontalo						59.9					78.9					52.8										64.6
West Sulawesi																56.6										55.2
Maluku																										53.0
North Maluku						45.8					60.3															39.7
West Papua																										37.1
Papua																										32.6

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children aged 12-23 months fully immunized against all basic antigen (Riskesdas)										Prevalence of Acute Respiratory Infection (IDHS)									
Year	2007										1991					1994				
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total
Indonesia	46.6	45.7	54.0	41.3	41.6	43.4	47.3	49.4	53.5	46.2	9.9	9.6	8.9	10.1	9.8	10.7	9.3	9.3	10.3	10.0
Aceh										35.1					11.0					10.2
North Sumatra										31.0					10.6					10.6
West Sumatra										45.9					14.1					15.5
Riau										47.4										11.2
Jambi										46.0										10.8
South Sumatra										47.1					5.6					6.8
Bengkulu										48.0										10.1
Lampung										51.9					8.0					4.1
Bangka Belitung										52.7										
Riau Islands										60.3										
D.K.I Jakarta										45.7					9.1					5.2
West Java										41.4					10.7					14.5
Central Java										64.3					7.6					7.8
D.I. Yogyakarta										64.6					7.6					5.1
East Java										46.7					8.4					7.2
Banten										30.6										
Bali										73.9					14.0					8.1
West Nusa Tenggara										38.0					12.3					16.6
East Nusa Tenggara										41.6										15.8
West Kalimantan										43.9					24.9					10.4
Central Kalimantan										47.9										5.9
South Kalimantan										57.0					5.2					8.2
East Kalimantan										62.0										7.5
North Sulawesi										58.2					18.2					16.6
Central Sulawesi										48.0										11.8
South Sulawesi										43.4					7.9					9.2
Southeast Sulawesi										44.6										7.1
Gorontalo										39.2										
West Sulawesi										17.3										
Maluku										40.4										10.7
North Maluku										55.9										
West Papua										37.3										
Papua										32.4										

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Acute Respiratory Infection (IDHS)																				
Year	1997					2002-2003					2007										
	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	9.4	8.5	7.7	9.4	9.0	7.7	7.4	7.6	7.6	7.6	11.8	10.6	10.3	11.9	13.9	12.5	10.8	9.9	8.5	11.2
Aceh					9.9															16.4
North Sumatra					10.7					10.2										13.5
West Sumatra					12.3					11.7										15.5
Riau					14.7					7.1										13.5
Jambi					9.5					6.1										9.9
South Sumatra					11.0					3.5										8.9
Bengkulu					9.5					9.7										18.9
Lampung					8.6					3.7										5.3
Bangka Belitung										20.3										10.3
Riau Islands																				16.9
D.K.I Jakarta					8.4					6.8										8.1
West Java					8.9					9.0										11.3
Central Java					8.4					5.2										8.3
D.I. Yogyakarta					4.7					3.2										5.3
East Java					7.5					2.8										12.0
Banten										16.5										9.2
Bali					12.9					6.2										10.0
West Nusa Tenggara					14.0					8.4										12.6
East Nusa Tenggara					10.1					8.1										16.5
West Kalimantan					9.1					12.3										17.2
Central Kalimantan					13.7					4.2										9.2
South Kalimantan					4.2					8.1										13.5
East Kalimantan					6.3					8.0										12.2
North Sulawesi					11.1					6.5										14.6
Central Sulawesi					10.8					9.7										14.7
South Sulawesi					5.2					6.1										6.7
Southeast Sulawesi					9.2					8.9										16.2
Gorontalo										13.8										20.9
West Sulawesi																				23.5
Maluku					4.3															8.2
North Maluku																				13.7
West Papua																				7.6
Papua					10.5															4.5

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children with symptom of ARI (IDHS)																			
Year	1997										2002-2003									
	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months
Indonesia	27.6	26.1	29.0	26.1	17.7	36.9	31.8	28.7	24.5	22.0	7.7	7.4	7.6	7.6	6.3	9.0	9.2	8.3	6.5	6.2
Aceh																				
North Sumatra																				
West Sumatra																				
Riau																				
Jambi																				
South Sumatra																				
Bengkulu																				
Lampung																				
Bangka Belitung																				
Riau Islands																				
D.K.I Jakarta																				
West Java																				
Central Java																				
D.I. Yogyakarta																				
East Java																				
Banten																				
Bali																				
West Nusa Tenggara																				
East Nusa Tenggara																				
West Kalimantan																				
Central Kalimantan																				
South Kalimantan																				
East Kalimantan																				
North Sulawesi																				
Central Sulawesi																				
South Sulawesi																				
Southeast Sulawesi																				
Gorontalo																				
West Sulawesi																				
Maluku																				
North Maluku																				
West Papua																				
Papua																				

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children with symptom of ARI (IDHS)															Percentage of children who had ARI taken for treatment to a health facility or provider (IDHS)									
Year	2007															1991					1994				
	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Lowest	Second	Middle	Fourth	Highest	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total
Indonesia	11.8	10.6	10.3	11.9	6.4	12.2	13.0	14.0	9.9	10.1	13.9	12.5	10.8	9.9	8.5	66.4	62.3	75.6	60.4	64.5	65.0	60.1	77.9	57.4	62.8
Aceh																				66.4					57.6
North Sumatra																				68.8					67.2
West Sumatra																				64.4					56.6
Riau																									52.8
Jambi																									59.1
South Sumatra																				74.5					67.9
Bengkulu																									45.9
Lampung																				63.4					59.9
Bangka Belitung																									
Riau Islands																									
D.K.I Jakarta																				79.3					79.4
West Java																				63.4					61.9
Central Java																				69.2					75.7
D.I. Yogyakarta																				81.0					56.1
East Java																				61.3					58.5
Banten																									
Bali																				84.3					74.7
West Nusa Tenggara																				65.2					59.4
East Nusa Tenggara																									62.1
West Kalimantan																				42.7					52.7
Central Kalimantan																									75.4
South Kalimantan																									53.4
East Kalimantan																									58.4
North Sulawesi																				61.4					68.7
Central Sulawesi																									46.8
South Sulawesi																				59.1					51.6
Southeast Sulawesi																									49.5
Gorontalo																									
West Sulawesi																									
Maluku																									61.2
North Maluku																									
West Papua																									
Papua																									72.1

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had ARI taken for treatment to a health facility or provider (IDHS)															Prevalence of Diarrhea (IDHS)									
Year	1997					2002-2003					2007					1991					1994				
	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total
Indonesia	69.1	68.4	78.2	65.9	68.8	56.9	56.6	63.6	50.9	56.8	64.6	67.4	70.5	63.0	65.9	11.5	10.7	12.0	10.7	11.1	13.1	11.0	12.4	12.0	12.1
Aceh					70.1										74.5					9.0					7.9
North Sumatra					72.1					46.9					64.8					11.9					13.1
West Sumatra					79.6					56.6					69.1					10.8					12.3
Riau					59.8					66.6					75.1					10.6					11.1
Jambi					61.0					60.8					69.8					7.5					10.9
South Sumatra					81.1					68.8					70.0					6.3					7.0
Bengkulu					68.4					60.1					73.0					14.0					21.6
Lampung					60.7					55.2					68.3					7.3					8.1
Bangka Belitung										63.3					76.6										
Riau Islands										0.0					78.7										
D.K.I Jakarta					92.0					75.4					81.2					8.1					6.9
West Java					59.3					50.3					58.1					17.9					20.5
Central Java					73.4					66.2					72.4					10.2					7.8
D.I. Yogyakarta					83.9					82.3					73.2					8.0					4.6
East Java					62.8					64.5					71.4					9.4					10.5
Banten										67.7					63.6										
Bali					82.3					77.4					83.2					11.3					7.5
West Nusa Tenggara					14.0					46.4					61.7					10.7					15.3
East Nusa Tenggara					78.4					53.7					62.0					5.6					11.0
West Kalimantan					72.4					41.9					55.0					15.6					14.4
Central Kalimantan					68.6										61.6					6.5					5.8
South Kalimantan					60.1					46.9					48.6					6.4					12.9
East Kalimantan					69.9					57.1					63.0					9.0					7.6
North Sulawesi					73.3					60.2					77.3					10.5					13.2
Central Sulawesi					52.0					48.2					56.0					12.0					9.3
South Sulawesi					51.2					58.7					64.9					7.9					10.6
Southeast Sulawesi					63.8					35.1					45.3					10.0					9.0
Gorontalo										41.0					55.7										
West Sulawesi															52.5										
Maluku					87.7										42.6					6.0					3.7
North Maluku															66.9										
West Papua															74.7										
Papua					73.8										78.8					7.3					9.4

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Diarrhea (IDHS)																			
Year	1997					2002-2003					2007									
	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	11.4	9.4	9.1	10.9	10.4	10.8	11.2	11.2	10.8	11.0	14.8	12.5	12.0	14.9	17.7	14.7	12.5	13.1	9.7	13.7
Aceh					6.0															19.1
North Sumatra					8.9					12.3										15.8
West Sumatra					13.5					14.3										14.5
Riau					13.9					6.1										16.7
Jambi					8.2					8.1										15.3
South Sumatra					11.0					3.3										14.7
Bengkulu					16.5					8.2										20.5
Lampung					8.4					9.2										10.6
Bangka Belitung										9.4										6.4
Riau Islands																				14.3
D.K.I Jakarta					8.3					7.8										6.9
West Java					12.7					15.1										18.2
Central Java					8.4					7.9										9.3
D.I. Yogyakarta					6.7					5.2										5.4
East Java					9.4					9.8										13.3
Banten										12.5										10.1
Bali					8.5					11.9										9.1
West Nusa Tenggara					12.5					13.5										18.5
East Nusa Tenggara					13.5					12.9										15.2
West Kalimantan					15.0					8.3										15.2
Central Kalimantan					19.5					2.4										20.8
South Kalimantan					11.4					9.9										15.7
East Kalimantan					12.2					11.1										13.7
North Sulawesi					15.6					9.5										14.1
Central Sulawesi					6.5					6.4										15.8
South Sulawesi					9.0					15.5										11.7
Southeast Sulawesi					11.4					9.0										14.2
Gorontalo										12.2										16.7
West Sulawesi																				22.2
Maluku																				9.7
North Maluku																				14.1
West Papua																				15.3
Papua					13.3															13.0

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children with diarrhea (IDHS)																			
Year	1997										2002-2003									
	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months
Indonesia	11.4	9.4	9.1	10.9	7.5	17.0	14.6	12.5	6.7	5.7	10.8	11.2	11.2	10.8	8.7	19.4	14.8	12.0	7.9	6.4
Aceh																				
North Sumatra																				
West Sumatra																				
Riau																				
Jambi																				
South Sumatra																				
Bengkulu																				
Lampung																				
Bangka Belitung																				
Riau Islands																				
D.K.I Jakarta																				
West Java																				
Central Java																				
D.I. Yogyakarta																				
East Java																				
Banten																				
Bali																				
West Nusa Tenggara																				
East Nusa Tenggara																				
West Kalimantan																				
Central Kalimantan																				
South Kalimantan																				
East Kalimantan																				
North Sulawesi																				
Central Sulawesi																				
South Sulawesi																				
Southeast Sulawesi																				
Gorontalo																				
West Sulawesi																				
Maluku																				
North Maluku																				
West Papua																				
Papua																				

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children with diarrhea (IDHS)															Percentage of children who had diarrhea received Oral Rehydration Salts packets (IDHS)				
Year	2007															1997				
	Male	Female	Urban	Rural	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Lowest	Second	Middle	Fourth	Highest	Urban	Rural	Male	Female	Total
Indonesia	14.8	12.5	12.0	14.9	11.1	17.6	20.7	15.3	9.9	8.3	17.7	14.7	12.5	13.1	9.7	44.2	48.8	46.7	48.9	47.7
Aceh																				47.9
North Sumatra																				42.6
West Sumatra																				40.8
Riau																				50.6
Jambi																				64.7
South Sumatra																				59.7
Bengkulu																				47.9
Lampung																				56.2
Bangka Belitung																				
Riau Islands																				
D.K.I Jakarta																				39.8
West Java																				38.2
Central Java																				49.5
D.I. Yogyakarta																				45.8
East Java																				46.7
Banten																				
Bali																				48.4
West Nusa Tenggara																				70.6
East Nusa Tenggara																				68.3
West Kalimantan																				52.7
Central Kalimantan																				57.7
South Kalimantan																				47.8
East Kalimantan																				41.0
North Sulawesi																				59.0
Central Sulawesi																				42.8
South Sulawesi																				51.4
Southeast Sulawesi																				42.2
Gorontalo																				
West Sulawesi																				
Maluku																				
North Maluku																				
West Papua																				
Papua																				

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea received Oral Rehydration Salts packets (IDHS)																			
Year	2003											2007								
	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Total	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months
Indonesia	35.0	35.9	33.0	36.0	15.3	35.5	35.4	34.7	40.4	46.6	35.5	33.4	35.4	35.4	33.7	6.6	28.0	40.2	37.7	35.1	42.7
Aceh																					
North Sumatra																					
West Sumatra																					
Riau																					
Jambi																					
South Sumatra																					
Bengkulu																					
Lampung																					
Bangka Belitung																					
Riau Islands																					
D.K.I Jakarta																					
West Java																					
Central Java																					
D.I. Yogyakarta																					
East Java																					
Banten																					
Bali																					
West Nusa Tenggara																					
East Nusa Tenggara																					
West Kalimantan																					
Central Kalimantan																					
South Kalimantan																					
East Kalimantan																					
North Sulawesi																					
Central Sulawesi																					
South Sulawesi																					
Southeast Sulawesi																					
Gorontalo																					
West Sulawesi																					
Maluku																					
North Maluku																					
West Papua																					
Papua																					

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea received Oral Rehydration Salts packets (IDHS)						Percentage of children who had diarrhea received Oral Rehydration Therapy (ORT) and Increase Fluid (IDHS)																					
Year	2007						1991					1994					1997					2002-2003					
	Lowest	Second	Middle	Fourth	Highest	Total	Male	Female	Urban	Rural	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	31.6	36.1	38.4	39.6	27.4	34.7	78.9	77.4	78.2	78.3	78.2	82.4	85.2	87.7	82.0	83.6	85.1	84.7	84.1	85.2	84.9	56.3	65.0	62.5	58.9	60.6
Aceh						36.2										85.7					84.8					
North Sumatra						25.0										76.9					78.4					
West Sumatra						37.1										85.2					92.5					
Riau						45.9										89.9					87.7					
Jambi						55.3										81.4					96.3					
South Sumatra						49.9										90.6					97.0					
Bengkulu						33.8										82.8					83.5					
Lampung						34.0										86.5					80.1					
Bangka Belitung						53.9																				
Riau Islands						45.7																				
D.K.I Jakarta						48.2					72.6					88.0					82.9					
West Java						30.1					79.4					87.6					76.5					
Central Java						23.2					89.7					92.1					94.0					
D.I. Yogyakarta						49.6					84.6					95.1					90.0					
East Java						32.0					76.2					68.1					83.7					
Banten						27.3					96.4															
Bali						54.3										71.1					85.4					
West Nusa Tenggara						43.2										79.6					93.9					
East Nusa Tenggara						57.5										84.5					90.5					
West Kalimantan						41.4										79.4					90.6					
Central Kalimantan						48.5										92.2					88.1					
South Kalimantan						34.4										78.5					83.2					
East Kalimantan						39.6										77.5					81.8					
North Sulawesi						33.0										96.8					92.9					
Central Sulawesi						34.2										73.4					83.4					
South Sulawesi						32.8										82.6					89.2					
Southeast Sulawesi						33.9										87.1					76.5					
Gorontalo						38.7																				
West Sulawesi						35.2																				
Maluku						20.9										90.5										
North Maluku						35.5																				
West Papua						56.7																				
Papua						57.7										82.9					91.7					

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea received Oral Rehydration Therapy (ORT) and Increase Fluid (IDHS)										Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)										
Year	2007										1991										
	Urban	Rural	Male	Female	Lowest	Second	Middle	Fourth	Highest	Total	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Total
Indonesia	63.7	57.5	58.7	62.2	60.1	63.4	64.8	58.5	56.9	60.9	50.9	44.2	46.7	46.0	28.8	48.1	50.3	47.2	45.0	43.0	46.3
Aceh										67.8											
North Sumatra										46.8											
West Sumatra										81.0											
Riau										56.8											
Jambi										80.4											
South Sumatra										66.5											
Bengkulu										67.3											
Lampung										59.5											
Bangka Belitung										71.2											
Riau Islands										58.9											
D.K.I Jakarta										71.0											54.8
West Java										56.8											42.5
Central Java										52.2											55.2
D.I. Yogyakarta										89.7											74.4
East Java										62.5											48.7
Banten										46.0											
Bali										67.8											66.0
West Nusa Tenggara										68.8											
East Nusa Tenggara										83.0											
West Kalimantan										62.3											
Central Kalimantan										66.5											
South Kalimantan										58.9											
East Kalimantan										61.4											
North Sulawesi										67.2											
Central Sulawesi										68.4											
South Sulawesi										60.0											
Southeast Sulawesi										64.1											
Gorontalo										75.6											
West Sulawesi										64.3											
Maluku										65.1											
North Maluku										64.4											
West Papua										69.6											
Papua										73.6											

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)										Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)										
Year	1994										1997										
	Urban	Rural	Male	Female	< 6 months	6-11 months	12-17 months	18-23 months	24-29 months	30-35 months	Total	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Total
Indonesia	52.6	54.1	59.7	50.6	46.0	60.3	55.3	49.2	51.1	53.5	53.2	51.5	55.0	54.8	53.5	28.0	58.5	60.7	50.6	51.5	59.4	54.1
Aceh											42.8											64.3
North Sumatra											44.9											49.8
West Sumatra											54.5											49.9
Riau											45.1											48.2
Jambi											42.0											51.5
South Sumatra											66.1											65.5
Bengkulu											54.5											45.6
Lampung											41.8											63.3
Bangka Belitung																						
Riau Islands																						
D.K.I Jakarta											62.0											49.9
West Java											53.0											46.2
Central Java											58.7											50.4
D.I. Yogyakarta											86.4											65.5
East Java											54.6											62.9
Banten																						
Bali											47.8											63.4
West Nusa Tenggara											52.6											67.0
East Nusa Tenggara											66.6											75.9
West Kalimantan											44.8											60.2
Central Kalimantan											72.1											68.4
South Kalimantan											45.8											47.1
East Kalimantan											47.5											39.4
North Sulawesi											63.0											51.7
Central Sulawesi											42,1											48.7
South Sulawesi											56,7											53.8
Southeast Sulawesi											41.5											51.7
Gorontalo																						
West Sulawesi																						
Maluku											48.7											
North Maluku																						
West Papua																						
Papua											64.9											

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)											Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)									
Year	2002-2003											2007									
	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Total	Urban	Rural	Male	Female	< 6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months
Indonesia	54.6	47.3	49.0	52.7	24.0	60.0	59.7	55.2	39.1	43.7	50.8	54.4	49.1	52.1	49.7	31.3	59.1	57.1	52.0	39.7	52.3
Aceh																					
North Sumatra																					
West Sumatra																					
Riau																					
Jambi																					
South Sumatra																					
Bengkulu																					
Lampung																					
Bangka Belitung																					
Riau Islands																					
D.K.I Jakarta																					
West Java																					
Central Java																					
D.I. Yogyakarta																					
East Java																					
Banten																					
Bali																					
West Nusa Tenggara																					
East Nusa Tenggara																					
West Kalimantan																					
Central Kalimantan																					
South Kalimantan																					
East Kalimantan																					
North Sulawesi																					
Central Sulawesi																					
South Sulawesi																					
Southeast Sulawesi																					
Gorontalo																					
West Sulawesi																					
Maluku																					
North Maluku																					
West Papua																					
Papua																					

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children who had diarrhea taken for treatment to a health facility or provider (IDHS)						Number of Malaria Cases (Health Profile)					Annual Malaria Incidence / Annual Parasite Incidence - per 1,000 population (Health Profile)				
Year	2007						2004	2005	2006	2007	2008[a]	2004	2005	2006	2007	2008
	Lowest	Second	Middle	Fourth	Highest	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	37.7	46.2	61.3	58.3	64.3	51.0	2,331,567	183,012	2,116,066	1,774,845	1,891,207	21.35	19.61	19.60	16.44	17.77
Aceh						68.9	8,990	3,312	25,220	50,616	9,690	2.17	7.11	6.32	12.57	2.03
North Sumatra						45.5	48,341	11	149,815	33,179	75,549	5.43	7.24	16.93	3.75	8.15
West Sumatra						51.3	4,971	145	2,150	2,446	7,340	1.10	0.71	0.90	0.54	2.58
Riau						49.7	20,183	1,707	17,099	18,449	13,601	3.68	3.96	5.22	4.00	3.06
Jambi						67.2	60,127	4,305	56,026	19,122	57,429	24.40	13.55	20.96	6.86	18.08
South Sumatra						53.6	56,762	2,246	58,875	2,132	31,601	8.04	5.95	11.00	0.40	5.46
Bengkulu						47.8	119,068		8,064	16,148	37,419	56.91	0.00	6.29	9.21	22.96
Lampung						60.6	275,654	3,025	32,356	24,406	19,674	38.52	5.70	5.14	3.34	2.79
Bangka Belitung						73.7	17,335	5,378	44,734	31,080	50,714	18.68	11.18	43.05	29.30	40.58
Riau Islands						59.4		6,140	6,140	15,424	18,238			4.93	11.54	13.32
D.K.I Jakarta						59.5										
West Java						47.9	8,105	1,124	29,901	22,240	43,560	1.11	0.96	0.52	0.37	0.58
Central Java						51.7	327,706	1,966	206,566	171,924	120,989	0.15	0.06	0.13	0.12	0.07
D.I. Yogyakarta						69.6	23,206	175	38,125	2,458	3,107	0.13	0.06	0.10	0.05	0.03
East Java						50.2	118,195	1,822	105,281	9,167	41,571	0.28	0.47	0.18	0.18	0.71
Banten						57.5	2,836	21	658	2,692	2,795	0.01	0.00	0.02	0.05	0.03
Bali						84.3		76	32,053	17,925	18,764		0.02	0.55	0.42	0.17
West Nusa Tenggara						42.2	83,310	10,535	79,958	51,963	118,185	20.51	20.51	19.25	12.51	21.85
East Nusa Tenggara						51.6	626,278	70,390	453,306	332,114	508,244	172.77	100.49	105.66	81.32	104.10
West Kalimantan						47.3	3,915		3,096	40,857	13,027	0.99	0.00	0.90	11.89	3.23
Central Kalimantan						63.3	22,090	4,559	25,679	31,297	24,254	12.16	11.90	14.84	18.08	11.21
South Kalimantan						42.5	8,598	2,304	8,766	8,297	13,211	2.78	2.14	3.51	2.50	4.20
East Kalimantan						35.4	19,428	62	8,059	5,919	18,141	8.83	1.12	5.01	8.44	8.59
North Sulawesi						58.4	31,827	2,613	33,321	20,129	32,593	14.93	11.53	20.29	9.30	16.48
Central Sulawesi						42.9	58,770	5,919	58,224	34,686	51,650	27.28	23.05	25.71	19.87	17.81
South Sulawesi						48.3	18,315	601	9,504	2,132	11,319	2.40	0.52	1.53	0.34	1.51
Southeast Sulawesi						41.4	38,480	346	29,942	20,356	23,221	21.11	6.92	14.95	9.21	10.26
Gorontalo						52.2	12,633	817	11,793	10,674	13,834	14.85	11.85	15.40	11.53	13.94
West Sulawesi						51.7			1,001	1,552	8,604			0.87	13.59	11.98
Maluku						21.8	62,856	10,824	21,258	39,488	67,283	46.43	66.16	15.35	28.51	39.65
North Maluku						49.5	65,379	4,140	56,606	88,937	58,289	72.44	67.24	58.58	92.04	51.42
West Papua						75.9			138,901	242,722	149,803			198.02	346.04	167.47
Papua						70.6	188,209	38,449	363,589	390,264	227,508	73.69	208.82	164.75	176.84	84.74

TABLE 4A. HEALTH INDICATORS

Area	Annual Parasite Incidence - per 1,000 population (Health Profile)									Annual Malaria Incidence - per 1,000 population (Health Profile)									Morbidity of Malaria - per 1,000 population (Health Profile)			
Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2000	2001	2002	2003	2004	2005	2006	2007	2008	2000		2001	
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Target	Realization	Target	Realization
Indonesia	0.81	0.62	0.47	0.22	0.15	0.15	0.19	0.16	0.16	31.09	26.20	22.27	21.80	21.20	24.75	23.98	19.67	18.82	50.00	51.60	45.00	44.70
Aceh																						
North Sumatra																						
West Sumatra																						
Riau																						
Jambi																						
South Sumatra																						
Bengkulu																						
Lampung																						
Bangka Belitung																						
Riau Islands																						
D.K.I Jakarta																						
West Java																						
Central Java																						
D.I. Yogyakarta																						
East Java																						
Banten																						
Bali																						
West Nusa Tenggara																						
East Nusa Tenggara																						
West Kalimantan																						
Central Kalimantan																						
South Kalimantan																						
East Kalimantan																						
North Sulawesi																						
Central Sulawesi																						
South Sulawesi																						
Southeast Sulawesi																						
Gorontalo																						
West Sulawesi																						
Maluku																						
North Maluku																						
West Papua																						
Papua																						

TABLE 4A. HEALTH INDICATORS

Area	Morbidity of Malaria - per 1,000 population (Health Profile)												Mortality Rate of Malaria (Health Profile)					
Year	2002		2003		2004		2005		2006		2007		2000		2001		2002	
	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization
Indonesia	40.00	35.80	30.00	30.66	25.00	21.74	22.50	19.61	20.00	19.60	17.50	16.44	1.03	2.69	0.90	1.40	0.75	2.70
Aceh																		
North Sumatra																		
West Sumatra																		
Riau																		
Jambi																		
South Sumatra																		
Bengkulu																		
Lampung																		
Bangka Belitung																		
Riau Islands																		
D.K.I Jakarta																		
West Java																		
Central Java																		
D.I. Yogyakarta																		
East Java																		
Banten																		
Bali																		
West Nusa Tenggara																		
East Nusa Tenggara																		
West Kalimantan																		
Central Kalimantan																		
South Kalimantan																		
East Kalimantan																		
North Sulawesi																		
Central Sulawesi																		
South Sulawesi																		
Southeast Sulawesi																		
Gorontalo																		
West Sulawesi																		
Maluku																		
North Maluku																		
West Papua																		
Papua																		

TABLE 4A. HEALTH INDICATORS

Area	Mortality Rate of Malaria (Health Profile)										Prevalence of Malaria Diagnosis (Riskesdas)							
Year	2003		2004		2005		2006		2007		2007							
	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Target	Realization	Urban	Rural	Male	Female	<1 year	1-4 years	5-14 years	15-24 years
Indonesia	0.60	4.90	0.55	1.68	0.51	0.92	0.45	0.42	0.40	0.56	0.83	1.75	1.55	1.26	0.50	1.43	1.37	1.31
Aceh																		
North Sumatra																		
West Sumatra																		
Riau																		
Jambi																		
South Sumatra																		
Bengkulu																		
Lampung																		
Bangka Belitung																		
Riau Islands																		
D.K.I Jakarta																		
West Java																		
Central Java																		
D.I. Yogyakarta																		
East Java																		
Banten																		
Bali																		
West Nusa Tenggara																		
East Nusa Tenggara																		
West Kalimantan																		
Central Kalimantan																		
South Kalimantan																		
East Kalimantan																		
North Sulawesi																		
Central Sulawesi																		
South Sulawesi																		
Southeast Sulawesi																		
Gorontalo																		
West Sulawesi																		
Maluku																		
North Maluku																		
West Papua																		
Papua																		

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Malaria Diagnosis (Riskesdas)						Prevalence of Malaria Diagnosis and Symptom (Riskesdas)											
Year	2007						2007											
	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Male	Female	<1 year	1-4 years	5-14 years	15-24 years	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	1.42	1.38	1.38	1.35	1.35	1.39	1.46	3.69	3.05	2.66	1.02	2.64	2.69	2.62	3.05	2.90	2.83	2.72	2.52	2.85
Aceh						1.89														3.66
North Sumatra						1.32														2.86
West Sumatra						0.55														1.65
Riau						0.85														2.03
Jambi						1.73														3.23
South Sumatra						1.01														1.63
Bengkulu						4.81														7.14
Lampung						0.27														1.42
Bangka Belitung						5.07														7.09
Riau Islands						0.79														1.41
D.K.I Jakarta						0.10														0.51
West Java						0.07														0.42
Central Java						0.08														0.41
D.I. Yogyakarta						0.07														0.30
East Java						0.05														0.18
Banten						0.09														0.32
Bali						0.10														0.31
West Nusa Tenggara						2.22														3.75
East Nusa Tenggara						5.73														12.04
West Kalimantan						1.82														3.26
Central Kalimantan						1.51														3.37
South Kalimantan						0.31														1.41
East Kalimantan						1.06														1.67
North Sulawesi						0.45														2.12
Central Sulawesi						2.58														7.36
South Sulawesi						0.32														1.37
Southeast Sulawesi						0.88														2.16
Gorontalo						0.88														2.87
West Sulawesi						0.86														2.02
Maluku						2.97														6.06
North Maluku						3.31														7.23
West Papua						15.65														26.14
Papua						12.09														18.41

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Malaria - Program Drug (Riskesdas)														Percentage of children protected by insecticide treated nets (IDHS)			
Year	2007														2007			
	Urban	Rural	Male	Female	<1 year	1-4 years	5-14 years	15-24 years	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Male	Female
Indonesia	53.72	46.25	48.85	46.40	57.23	57.80	50.19	46.03	44.44	48.47	47.73	47.84	49.78	47.68	1.6	4.5	3.4	3.2
Aceh														36.41				
North Sumatra														42.57				
West Sumatra														46.33				
Riau														43.55				
Jambi														42.34				
South Sumatra														44.69				
Bengkulu														60.99				
Lampung														30.67				
Bangka Belitung														58.32				
Riau Islands														64.77				
D.K.I Jakarta														26.44				
West Java														24.46				
Central Java														23.03				
D.I. Yogyakarta														20.00				
East Java														34.83				
Banten														28.57				
Bali														43.08				
West Nusa Tenggara														48.37				
East Nusa Tenggara														47.78				
West Kalimantan														53.66				
Central Kalimantan														49.41				
South Kalimantan														27.35				
East Kalimantan														51.28				
North Sulawesi														43.10				
Central Sulawesi														41.78				
South Sulawesi														23.62				
Southeast Sulawesi														36.36				
Gorontalo														39.53				
West Sulawesi														36.10				
Maluku														39.90				
North Maluku														49.27				
West Papua														59.33				
Papua														65.52				

TABLE 4A. HEALTH INDICATORS

Area	Percentage of children protected by insecticide treated nets (IDHS)											Number of children protected by insecticide treated nets (IDHS)	Prevalence of Worm Disease (Health Profile)					
Year	2007											2007	2002	2003	2004	2005	2006	2008
	<1 month	1 month	2 months	3 months	4 months	Lowest	Second	Middle	Fourth	Highest	Total	Total	Primary Student	Primary Student	Primary Student	Primary Student	Primary Student	Primary Student
Indonesia	3.6	3.7	3.1	2.9	3.1	5.9	4.3	2.9	1.5	1.3	3.3	16,566	33.3	33.0	46.8	28.4	32.6	24.1
Aceh											32.4	323						
North Sumatra											5.1	1,178						
West Sumatra											2.3	368						
Riau											4.5	292						
Jambi											13.4	184						
South Sumatra											8.6	493						
Bengkulu											33.9	109						
Lampung											15.0	470						
Bangka Belitung											37.1	102						
Riau Islands											8.9	88						
D.K.I Jakarta											0.6	729						
West Java											0.7	2,617						
Central Java											0.3	2,385						
D.I. Yogyakarta											1.2	206						
East Java											0.0	2,234						
Banten											0.2	692						
Bali											0.3	248						
West Nusa Tenggara											0.7	405						
East Nusa Tenggara											6.7	503						
West Kalimantan											4.6	363						
Central Kalimantan											8.1	158						
South Kalimantan											1.4	276						
East Kalimantan											1.3	265						
North Sulawesi											0.0	197						
Central Sulawesi											2.1	241						
South Sulawesi											1.0	620						
Southeast Sulawesi											0.5	194						
Gorontalo											1.1	81						
West Sulawesi											0.6	101						
Maluku											0.8	142						
North Maluku											2.5	92						
West Papua											6.9	151						
Papua											4.9	62						

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Worm Disease (Health Profile)														
Year	2002			2003			2004			2005			2006		
	Roundworm	Cacing Cambuk	Hookworm	Roundworm	Cacing Cambuk	Hookworm	Roundworm	Cacing Cambuk	Hookworm	Roundworm	Cacing Cambuk	Hookworm	Roundworm	Cacing Cambuk	Hookworm
Indonesia	22.0	19.9	2.4	21.7	21.0	0.6	16.1	17.2	5.1	12.5	20.2	1.6	17.8	24.2	1.0
Aceh															
North Sumatra															
West Sumatra															
Riau															
Jambi															
South Sumatra															
Bengkulu															
Lampung															
Bangka Belitung															
Riau Islands															
D.K.I Jakarta															
West Java															
Central Java															
D.I. Yogyakarta															
East Java															
Banten															
Bali															
West Nusa Tenggara															
East Nusa Tenggara															
West Kalimantan															
Central Kalimantan															
South Kalimantan															
East Kalimantan															
North Sulawesi															
Central Sulawesi															
South Sulawesi															
Southeast Sulawesi															
Gorontalo															
West Sulawesi															
Maluku															
North Maluku															
West Papua															
Papua															

TABLE 4A. HEALTH INDICATORS

Area	Prevalence of Worm Disease (Health Profile)			Percentage of Under-5 Children who weighed at Posyandu (Riskesdas)								Percentage of Household using Posyandu (Riskesdas)							
Year	2008			2007								2007							
	Roundworm	Cacing Cambuk	Hookworm	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	13.9	14.5	3.6	71.3	83.1	83.2	80.5	78.4	76.7	70.3	78.3	24.3	29.1	35.4	31.0	27.3	23.9	18.5	27.3
Aceh											76.9								30.4
North Sumatra											61.6								24.1
West Sumatra											83.0								28.5
Riau											67.3								28.8
Jambi											65.9								25.9
South Sumatra											66.2								27.8
Bengkulu											74.6								30.7
Lampung											85.0								23.4
Bangka Belitung											65.3								19.8
Riau Islands											47.9								22.4
D.K.I Jakarta											67.2								25.4
West Java											87.0								28.4
Central Java											86.9								27.0
D.I. Yogyakarta											85.0								23.8
East Java											84.7								23.8
Banten											72.1								26.6
Bali											77.8								22.8
West Nusa Tenggara											91.3								31.3
East Nusa Tenggara											89.9								42.9
West Kalimantan											75.3								30.5
Central Kalimantan											60.9								22.4
South Kalimantan											68.6								25.2
East Kalimantan											74.1								26.6
North Sulawesi											78.9								20.9
Central Sulawesi											81.1								33.0
South Sulawesi											73.6								26.2
Southeast Sulawesi											92.6								31.3
Gorontalo											82.8								25.0
West Sulawesi											78.1								27.9
Maluku											86.6								27.7
North Maluku											95.2								36.8
West Papua											81.1								33.7
Papua											59.8								27.6

TABLE 4A. HEALTH INDICATORS

Area	Percentage of Household using Bidan/Polindes for Children under-5 (Riskesdas)								Percentage of population with access to health services (Susenas)													
Year	2007								2000			2001			2002			2003				
	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total		
Indonesia	33.2	27.7	32.9	30.2	28.9	26.5	25.2	29.2	96.50	95.64	96.04	97.81	97.66	97.74	97.73	97.20	97.44	93.03	91.23	92.04		
Aceh								42.8										96.57	87.77	89.28		
North Sumatra								23.1	95.32	91.91	93.41	96.98	97.78	97.36	94.69	93.20	93.87	91.03	87.84	89.37		
West Sumatra								28.4	91.65	89.15	89.76	96.12	91.17	92.71	95.94	90.56	91.94	88.42	83.56	84.78		
Riau								30.7	93.37	94.95	94.25	98.64	98.58	98.62	96.98	92.68	94.60	92.39	87.29	89.91		
Jambi								39.4	98.29	96.12	96.78	93.36	97.35	96.23	96.06	98.37	97.78	92.91	91.76	92.14		
South Sumatra								25.4	98.72	95.53	96.66	95.82	98.45	97.15	99.40	95.94	97.52	95.52	86.16	90.21		
Bengkulu								17.7	99.99	96.96	88.18	95.94	93.87	94.56	97.92	94.55	95.71	95.92	89.31	92.19		
Lampung								24.8	97.92	97.29	97.45	98.35	97.55	97.70	95.03	98.01	97.42	96.69	89.24	91.12		
Bangka Belitung								23.9				93.79	93.88	93.82	97.61	97.97	97.78	96.86	86.18	90.93		
Riau Islands								33.1														
D.K.I Jakarta								34.7	95.84		95.84	96.46		96.46	97.43	43.51	97.43	88.98		88.98		
West Java								29.4	95.71	97.19	96.39	98.33	97.98	98.16	98.29	99.91	98.26	93.10	93.44	93.25		
Central Java								20.5	97.43	97.32	97.37	98.05	97.58	97.78	98.54	89.50	98.14	96.22	94.02	94.87		
D.I. Yogyakarta								36.2	98.52	97.86	98.24	97.67	98.17	97.90	98.84	116.64	98.48	93.88	93.99	93.94		
East Java								34.4	97.49	95.73	96.54	99.29	98.14	98.65	98.39	94.34	98.06	94.10	91.99	92.88		
Banten								30.8		0.00		94.20	96.09	94.81	97.01	92.86	97.35	91.99	88.42	90.72		
Bali								47.2	96.38	96.90	96.67	98.18	97.65	97.90	97.98	103.01	97.27	94.98	93.54	94.19		
West Nusa Tenggara								49.8	93.38	91.18	91.82	96.41	96.36	96.38	89.64	104.50	93.42	90.62	91.73	91.36		
East Nusa Tenggara								30.9	96.98	97.54	97.45	99.47	99.31	99.32	99.47	96.67	99.46	91.51	85.36	86.34		
West Kalimantan								30.2	91.31	95.70	94.54	95.13	96.58	96.07	96.18	86.24	96.52	92.29	90.90	91.37		
Central Kalimantan								20.7	94.72	96.79	96.06	96.44	99.37	98.17	97.18	102.58	97.28	89.18	89.82	89.55		
South Kalimantan								20.6	95.27	94.06	94.46	95.65	97.85	97.00	96.00	94.25	96.50	83.40	88.76	86.77		
East Kalimantan								22.7	98.71	98.62	98.69	99.83	99.82	99.82	99.18	94.34	98.89	95.26	94.61	94.94		
North Sulawesi								44.1	97.54	97.16	97.30	99.76	99.75	99.74	99.64	110.33	99.50	93.74	95.62	94.80		
Central Sulawesi								32.8	98.04	92.32	93.44	97.41	96.95	97.04	97.91	79.33	97.11	84.02	96.22	92.86		
South Sulawesi								23.8	96.21	94.80	95.23	99.26	98.74	98.95	99.03	99.59	98.37	94.32	90.96	91.93		
Southeast Sulawesi								39.0	93.97	84.61	87.42	99.18	97.40	97.76	96.08	96.59	95.18	94.20	86.42	87.87		
Gorontalo								48.3				99.18	98.37	98.55	98.93	50.59	96.25	96.52	81.68	86.05		
West Sulawesi								30.4														
Maluku								24.1				96.49	98.99	98.34				92.93	84.06	87.29		
North Maluku								69.1				100.00	100.00	99.99				82.49	90.55	87.54		
West Papua								45.1														
Papua								34.3				98.79	99.71	99.58				85.61	93.42	91.33		

TABLE 4A. HEALTH INDICATORS

Area	Percentage of population with access to health services (Susenas)											
Year	2004			2005			2006			2007		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	94.62	92.34	93.35	94.56	94.00	94.23	97.82	94.60	96.01	93.74	93.63	93.67
Aceh	92.36	94.36	93.88	93.64	92.99	93.12	92.81	89.44	90.16	90.28	92.44	91.98
North Sumatra	88.49	90.54	89.56	92.46	89.00	90.68	90.53	88.32	89.40	85.50	89.98	88.24
West Sumatra	94.44	86.00	87.95	93.43	89.12	90.10	90.97	85.21	86.75	91.09	87.12	88.24
Riau	95.94	93.56	94.71	98.07	94.90	96.14	100.53	90.63	94.87	95.84	93.45	94.43
Jambi	90.04	84.52	86.08	93.22	92.53	92.74	94.03	94.33	94.22	93.67	93.18	93.31
South Sumatra	88.17	87.44	87.72	95.00	91.67	92.84	96.43	91.35	93.39	95.74	91.39	92.94
Bengkulu	96.45	86.48	89.35	88.87	91.49	90.66	92.55	90.15	90.89	90.16	91.40	90.97
Lampung	93.71	92.43	92.79	95.81	94.66	94.98	93.63	91.62	92.10	96.34	94.99	95.35
Bangka Belitung	90.97	90.39	90.66	95.10	92.30	93.42	94.40	92.36	93.32	92.99	92.59	92.75
Riau Islands				93.81	89.42	92.83	93.72	91.96	93.31	94.94	93.96	94.65
D.K.I Jakarta	94.70		94.70	95.45		95.45	94.02		94.02	93.98		93.98
West Java	95.44	93.09	94.32	93.62	95.44	94.52	114.72	108.38	111.54	93.37	95.96	94.63
Central Java	96.84	95.75	96.20	95.66	94.50	94.99	96.18	95.03	95.50	94.47	94.48	94.48
D.I. Yogyakarta	97.06	98.59	97.67	95.69	97.17	96.31	95.44	97.23	96.32	96.57	96.67	96.62
East Java	93.83	91.98	92.82	93.91	94.54	94.28	94.88	93.32	94.00	95.90	93.51	94.48
Banten	97.28	89.36	93.79	95.97	96.67	96.25	93.16	90.98	92.24	89.18	95.73	91.83
Bali	96.32	91.92	94.00	94.24	93.71	93.98	96.55	94.99	95.72	96.54	92.99	94.52
West Nusa Tenggara	91.58	89.58	90.39	95.21	94.71	94.91	93.49	86.76	89.05	90.43	89.71	89.95
East Nusa Tenggara	96.34	88.10	89.26	97.25	93.92	94.42	97.46	93.64	94.27	95.63	92.64	93.05
West Kalimantan	94.24	90.59	92.01	91.30	91.40	91.35	93.46	92.53	92.86	93.85	92.71	93.11
Central Kalimantan	97.55	95.26	95.99	97.35	96.87	97.01	95.82	96.21	96.05	94.84	96.78	96.16
South Kalimantan	92.25	89.10	90.36	93.49	89.59	91.34	95.98	92.80	94.01	93.69	92.42	92.97
East Kalimantan	92.70	96.80	94.84	95.26	95.87	95.50	95.73	111.13	101.90	95.62	95.33	95.49
North Sulawesi	97.60	98.71	98.34	97.16	96.65	96.81	97.32	95.19	95.92	94.92	97.50	96.87
Central Sulawesi	95.92	91.59	92.51	97.06	93.15	94.04	96.88	86.04	88.05	95.86	93.77	94.11
South Sulawesi	92.25	94.19	93.56	95.64	94.31	94.79	93.31	92.16	92.53	96.60	94.43	95.17
Southeast Sulawesi	95.29	83.59	85.98	92.07	92.63	92.53	92.71	92.44	92.49	95.44	92.23	92.98
Gorontalo	92.29	97.40	95.30	97.04	93.33	94.65	89.25	91.08	90.40	95.88	93.30	93.81
West Sulawesi							93.82	94.11	94.06	94.83	92.20	92.45
Maluku	96.65	78.28	85.77	95.15	96.68	96.01	99.16	96.05	96.87	94.45	96.65	95.86
North Maluku	93.66	88.97	90.40	99.53	89.81	91.97	90.97	90.30	90.49	97.85	94.19	95.12
West Papua							70.96	98.89	79.55	98.46	97.72	97.96
Papua	96.27	95.77	95.89	97.87	92.62	94.03	95.75	94.42	94.70	97.38	96.19	96.45

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Under-5 mortality rate	The probability of dying between birth and exact age five; expressed per 1,000 live births	**Under-5 mortality rate by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Infant mortality rate	The probability of dying between birth and exact age one year; expressed per 1,000 live births	**Infant mortality rate by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Census 2000; Projection based on Intercensal Population Survey 2005
Maternal Mortality Ratio	The proportion of deaaths of women of reproductive age (15-49 years old) due to maternal causes per 100,000 live births. A maternal death is defined as any death that occures during pregnancy, during childbirth, or within two months after the birth or the termination of the pregnancy.; including all deaths that occurred during pregnancy and in the two months following the birth, even if the death was due to non-maternal causes	**Maternal Mortality Ratio**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Percentage of pregnant women fully immunized against tetanus (TT2)	Percentage of mother age 15-49 who had a live birth in the five years preceding the survey and received two or more tetanus toxoid injections during pregnancies to total mother age 15-49 who had a live birth in the five years preceding the survey.	**Percentage of pregnant women fully immunized against tetanus (TT2)**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Percentage of receiving antenatal care from a skilled provide	Percentage of women who have antenatal care visit to a medical professional during pregnancy for the most recent birth in the past five years. Medical professional includes general practitioner, obstetrician, gynecologist, nurse, midwife, or village midwife.	**Percentage of receiving antenatal care from a skilled provide**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Percentage of pregnant women with 4 visits of antenatal care to skilled provider following the recommended visit schedule	Percentage of women have at least 4 times antenatal care visits to a medical professional during pregnancy for the most recent birth in the past five years, according to the following schedule: at least one visit in the first trimester, at least one visit in the second trismester, and at least two visits in the third trimester.	**Percentage of pregnant women with 4 visits of antenatal care to skilled provider following the recommended visit schedule**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Percentage of pregnant women who receive iron tablets - >90 tablets	Percentage of women who gave birth during the five years prior to the survey who received at least 90 iron tablets or equal iron syrup during their last pregnancy.	**Percentage of pregnant women who receive iron tablets - >90 tablets**	Indonesia Demographic and Health Survey 2002/2003, 2007
Percentage of children under-fives with the last birth attendant were trained health worker	Percentage of children under-fives whose birth were assisted by doctor, midwife, or other paramedics	**Percentage of children under-fives with the last birth attendant were trained health worker**	National Socio-Economic Survey 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Percentage of birth asissted by skilled provider	Percentage of children under-fives whose birth were assisted by doctor, midwife, or nurse	**Percentage of birth asissted by skilled provider**	Indonesia Demographic and Health Survey 2002/2003, 2007
Percentage of live births delivered in public health facilities	Percentage of live births in the five years preceding the survey were delivered in a government hospital or health center	**Percentage of live births delivered in public health facilities**	Indonesia Demographic and Health Survey 2002/2003, 2007
Percentage of live births delivered in private health facilities	Percentage of live births in the five years preceding the survey were delivered in a private hospital, clinic, private doctor/midwife	**Percentage of live births delivered in private health facilities**	Indonesia Demographic and Health Survey 2002/2003, 2007
Unmet need for family planning	Percentage of currently married women who either do not want any more children or want to wait before having their next birth, but are not using any method of family planning.	**Unmet need for family planning**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Percentage of postpartum women received Vitamin A	Percentage of postpartum women received Vitamin A in the first two months after delivery	**Percentage of postpartum women received Vitamin A**	Indonesia Demographic and Health Survey 2002/2003, 2007; Ministry of Health: Indonesia Health Profile 2005, 2006, 2007
Contraceptive prevalence rate	proportion of currently married women age 15-49 that were using any method of family planning at the time of the survey.	**Contraceptive prevalence rate**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Universal Child Immunization (UCI) Villages	Villages with the achievements of > 80% of infants in the village are fully immunized.	**Percentage of Universal Child Immunization (UCI) Villages**	Ministry of Health: Indonesia Health Profile 2007, 2008
Percentage of children age 12-23 months who received BCG vaccine	Percentage of children age 12-23 months who received BCG vaccines at any time before the survey, based on any source of information (health card or mother's report)	**Percentage of children age 12-23 months who received BCG vaccine by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007
Percentage of children age 12-23 months who received DPT-3 vaccine	Percentage of children age 12-23 months who received three times DPT vaccines at any time before the survey, based on any source of information (health card or mother's report)	**Percentage of children age 12-23 months who received DPT-3 vaccine by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Percentage of children age 12-23 months who recevied Polio-3 vaccine	Percentage of children age 12-23 months who received three times Polio vaccines at any time before the survey, based on any source of information (health card or mother's report)	**Percentage of children age 12-23 months who recevied Polio-3 vaccine by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007
Percentage of children age 12-23 months who received Measles vaccine	Percentage of children age 12-23 months who received Measles vaccines at any time before the survey, based on any source of information (health card or mother's report)	**Percentage of children age 12-23 months who received Measles vaccine by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007
Percentage of children age 12-23 months who received HB-3 vaccine	Percentage of children age 12-23 months who received three times HB vaccines at any time before the survey, based on any source of information (health card or mother's report)	**Percentage of children age 12-23 months who received HB-3 vaccine by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007
Percentage of children aged 12-23 months fully immunized against all basic antigen	Percentage of children age 12-23 months who received one dose of the vaccine against tuberculosis (BCG), three doses each of the DPT and polio vaccines, and one dose of measles vaccine.	**Percentage of children aged 12-23 months fully immunized against all basic antigen by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007
Prevalence of Acute Respiratory Infection (ARI)	The percentage of children under five having Acute Respiratory Infection (ARI) in the two weeks preceding the survey. The prevalence of ARI was estimated by asking mothers whether their children under five years had been ill with a cough accompanied by short, rapid breathing and difficulty breathing as a result of a problem in the chest.	**Prevalence of Acute Respiratory Infection (ARI) by area and gender**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Percentage of children with symptom of ARI	Percentage of children had symptoms of ARI in the two weeks preceding the survey. A cough accompanied by short, rapid breathing and difficulty breathing as a result of a problem in the chest, are compatible symptoms with ARI.	**Percentage of children with symptom of ARI by area, gender, age groups, and wealth quintile**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Percentage of children who had ARI taken for treatment to a health facility or provider	Percentage of children with symptoms of ARI who took advice or treatment was sought from a health facility or provider, excudes pharmacy, shop, traditional practitioner, delivery post, health post, and health cadre	**Percentage of children who had ARI taken for treatment to a health facility or provider by area and gender**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Prevalence of Diarrhea	Percentage of children under five years with diarrhea in the two weeks preceding the survey	**Prevalence of Diarrhea by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Annual Parasite Incidence (per 1,000 population)	Malaria morbidity rate (based on laboratory test results) per 1000 population in 1 year expressed in permil (‰)	**Percentage of children with diarrhea by area, gender, age groups, and wealth quintile**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Annual Malaria Incidence (per 1,000 population)	Malaria morbidity rate (based on clinical symptoms) per 1000 population in 1 year expressed in permil (‰)	**Percentage of children who had diarrhea received Oral Rehydration Salts (ORS) packets by area, gender, age groups, and wealth quintile**	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007
Mortality of Malaria (Case Fatality Rate/ CFR) (%)	The ratio of the number of deaths caused by a specified disease to the number of diagnosed cases of that disease	**Percentage of children who had diarrhea received Oral Rehydration Therapy (ORT) and Increase Fluid by area, gender, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Prevalence of malaria	Percentage of malaria patients (diagnosis, diagnosis and symptoms, and who received drug program)	**Percentage of children who had diarrhea taken for treatment to a health facility or provider by area, gender, age groups, and wealth quintile**	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Prevalence of worm disease	The percentage of patients with intestinal worms in children in local primary schools survey	**Number of Malaria Cases**	Ministry of Health: Indonesia Health Profile 2004, 2005, 2006, 2007, 2008
		Annual Malaria Incidence / Annual Parasite Incidence (per 1,000 population)	Ministry of Health: Indonesia Health Profile 2004, 2005, 2006, 2007, 2008
		Annual Parasite Incidence (per 1,000 population)	Ministry of Health: Indonesia Health Profile 2008

MAIN DATA SOURCES

Annual Malaria Incidence (per 1,000 population)	Ministry of Health: Indonesia Health Profile 2008
Morbidity of Malaria (per 1,000 population)	Ministry of Health: Indonesia Health Profile 2007
Mortality of Malaria (Case Fatality Rate/ CFR) (%)	Ministry of Health: Indonesia Health Profile 2007
Prevalence of Malaria (Diagnosis) by area, gender, age groups and wealth quintile	Basic Health Research (Riskesdas) 2007
Prevalence of Malaria (Diagnosis and Symptom) by area, gender, age groups and wealth quintile	Basic Health Research (Riskesdas) 2007
Prevalence of Malaria (Program Drug) by area, gender, age groups and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of children protected by insecticide treated nets by area, gender, age groups and wealth quintile	Indonesia Demographic and Health Survey 2007
Number of children protected by insecticide treated nets	Indonesia Demographic and Health Survey 2007
Prevalence of Worm Disease (primary student)	Ministry of Health: Indonesia Health Profile 2008
Prevalence of Worm Disease by type of worm	Ministry of Health: Indonesia Health Profile 2008

Notes - Data not available
1) Under-fives Mortality Ratio for the 10 year period for preceding the survey
2) Under-fives Mortality Ratio for the 5 year period for preceding the survey
3) Most qualified person (the person to whom the woman may have been referred if she had any problem in her pregnancy)
4) Data 2008 merupakan penjumlahan penderita malaria klinis dan malaria positif.

MAIN DATA SOURCES

Percentage of Under-5 Children who weighed at Posyandu by area and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of Household using Posyandu by area and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of Household using Bidan/Polindes for Children under-5 by area and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of population with access to health services by area	National Socio-Economic Survey

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of incidence of low birth weight (IDHS)											Percentage of infants with low birth weight (Riskesdas)									
Year	2002-2003			2007								2007									
	Urban	Rural	Total	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	6.1	5.0	7.6	5.4	5.6	6.1	5.6	4.2	5.8	5.8	11.5	10.0	13.0	10.8	12.2	13.1	10.7	11.9	11.3	10.5	11.5
Aceh											3.5										11.5
North Sumatra			3.1								3.8										8.5
West Sumatra			6.2								5.7										8.3
Riau			3.5								3.9										7.6
Jambi			2.4								3.9										7.5
South Sumatra			5.6								5.2										19.5
Bengkulu			4.0								4.4										8.9
Lampung			3.9								3.4										10.3
Bangka Belitung			7.2								4.8										13.5
Riau Islands											3.3										8.0
D.K.I Jakarta			7.7								6.0										10.6
West Java			6.4								5.7										11.8
Central Java			6.6								5.7										9.8
D.I. Yogyakarta			6.7								7.0										14.9
East Java			5.9								5.2										10.2
Banten			6.3								3.0										17.5
Bali			2.9								6.5										5.8
West Nusa Tenggara			5.2								10.0										12.8
East Nusa Tenggara			4.0								8.3										20.3
West Kalimantan			5.8								7.6										16.6
Central Kalimantan			4.5								3.2										16.2
South Kalimantan			4.6								7.9										12.4
East Kalimantan			5.1								9.4										11.5
North Sulawesi			3.1								6.7										7.9
Central Sulawesi			6.1								6.0										15.7
South Sulawesi			7.3								6.2										14.5
Southeast Sulawesi			2.7								3.5										11.1
Gorontalo			5.6								4.9										8.6
West Sulawesi											5.0										7.2
Maluku											1.7										15.7
North Maluku											7.8										10.3
West Papua											3.8										23.8
Papua											5.1										27.0

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of under-fives suffering from severe underweight (Riskesdas)										Percentage of under-fives suffering from moderate underweight (Riskesdas)									
Year	2007										2007									
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	5.8	5.0	4.2	6.4	6.7	5.7	5.2	4.7	4.1	5.4	13.3	12.7	11.7	14.0	15.4	13.8	12.9	11.8	9.6	13.0
Aceh										10.7										15.8
North Sumatra										8.4										14.3
West Sumatra										5.9										14.3
Riau										7.5										13.9
Jambi										6.3										12.6
South Sumatra										6.5										11.7
Bengkulu										4.8										11.9
Lampung										5.7										11.8
Bangka Belitung										4.6										13.7
Riau Islands										3.0										9.4
D.K.I Jakarta										2.9										10.0
West Java										3.7										11.3
Central Java										4.0										12.0
D.I. Yogyakarta										2.4										8.5
East Java										4.8										12.6
Banten										4.4										12.2
Bali										3.2										8.2
West Nusa Tenggara										8.1										16.7
East Nusa Tenggara										9.4										24.2
West Kalimantan										8.5										14.0
Central Kalimantan										8.1										16.1
South Kalimantan										8.4										18.2
East Kalimantan										6.2										13.1
North Sulawesi										4.3										11.5
Central Sulawesi										8.9										18.7
South Sulawesi										5.1										12.5
Southeast Sulawesi										6.8										15.9
Gorontalo										8.2										17.2
West Sulawesi										10.0										15.4
Maluku										9.3										18.5
North Maluku										6.7										16.1
West Papua										6.8										16.4
Papua										6.6										14.6

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of under-fives suffering from severe stunting (Riskesdas)										Percentage of under-fives suffering from moderate stunting (Riskesdas)									
Year	2007										2007									
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	19.6	17.9	16.0	20.9	21.3	19.9	18.8	17.0	15.2	18.8	18.1	17.9	16.7	19.0	19.2	19.0	18.5	17.1	15.1	18.0
Aceh										26.9										17.7
North Sumatra										25.2										17.9
West Sumatra										17.1										19.4
Riau										18.0										15.0
Jambi										20.1										16.3
South Sumatra										28.1										16.6
Bengkulu										20.0										16.0
Lampung										22.6										16.1
Bangka Belitung										18.1										17.5
Riau Islands										13.4										12.7
D.K.I Jakarta										13.7										13.0
West Java										15.7										19.7
Central Java										17.8										18.6
D.I. Yogyakarta										11.5										16.1
East Java										17.4										17.4
Banten										20.6										18.3
Bali										16.0										15.0
West Nusa Tenggara										23.8										19.9
East Nusa Tenggara										24.2										22.5
West Kalimantan										20.9										18.3
Central Kalimantan										23.5										19.3
South Kalimantan										20.9										20.9
East Kalimantan										17.9										17.3
North Sulawesi										14.6										16.6
Central Sulawesi										19.8										20.5
South Sulawesi										13.9										15.2
Southeast Sulawesi										21.6										18.9
Gorontalo										19.7										20.2
West Sulawesi										27.1										17.4
Maluku										25.9										19.9
North Maluku										25.4										14.8
West Papua										19.7										19.7
Papua										20.2										17.4

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of under-fives suffering from severe wasting (Riskesdas)										Percentage of under-fives suffering from moderate wasting (Riskesdas)									
Year	2007										2007									
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	6.6	5.8	5.6	6.7	6.8	6.2	6.1	5.9	6.0	6.2	7.6	7.3	7.5	7.4	7.9	7.7	7.3	7.1	7.0	7.4
Aceh										9.2										9.1
North Sumatra										9.1										7.9
West Sumatra										7.6										7.7
Riau										12.2										9.9
Jambi										10.6										8.6
South Sumatra										7.9										7.9
Bengkulu										7.3										6.9
Lampung										7.3										6.4
Bangka Belitung										4.8										6.0
Riau Islands										5.4										8.1
D.K.I Jakarta										8.6										8.4
West Java										3.6										5.4
Central Java										4.7										7.1
D.I. Yogyakarta										3.8										5.2
East Java										5.8										7.9
Banten										6.6										7.5
Bali										4.4										5.6
West Nusa Tenggara										7.9										7.6
East Nusa Tenggara										9.5										10.5
West Kalimantan										8.1										9.3
Central Kalimantan										8.2										8.7
South Kalimantan										7.8										8.5
East Kalimantan										7.2										8.7
North Sulawesi										3.9										6.3
Central Sulawesi										6.5										9.0
South Sulawesi										5.7										8.0
Southeast Sulawesi										5.4										9.2
Gorontalo										8.3										8.4
West Sulawesi										8.7										8.1
Maluku										7.5										9.7
North Maluku										3.8										11.1
West Papua										6.5										9.9
Papua										5.4										7.0

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of Nutritional status of children under-fives years old (Susenas)								Percentage of Nutritional status of children under-fives years old (Riskesdas)		Percentage of children aged 6-59 months who given vitamin A suplement (IDHS)													
Year	2001	2002	2003	2005	2001[1]	2002[1]	2003[1]	2005[1]	2007[2]	2007[2]	2002-2003					2007								
	severe nourished				moderate & severe nourished				severe nourished	moderate & severe nourished	Male	Female	Urban	Rural	Total	Male	Female	Urban	Rural	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	1.8	6.13	6.03	5.84	24.5	25.59	18.1		4.0	16.0					79.4										73.0
Aceh	1.5	2.09	4.07	4.08	17.1	17.43	11.0		2.4	10.9					87.6										84.1
North Sumatra	5.0	6.83	5.95	5.67	25.8	23.36	18.1		4.8	17.4					83.4										72.8
West Sumatra		4.74	8.25	6.98	19.9	27.09	19.2		4.4	16.6					69.9										62.6
Riau	7.5	4.46	3.59	5.10	17.9	16.39	15.4		3.2	11.4					79.9										78.6
Jambi		13.07	10.45	8.44	38.0	34.13	24.9		8.1	24.8					88.9										77.9
South Sumatra	5.0	12.26	12.65	13.04	38.6	38.80	28.0		9.4	33.6					79.5										76.3
Bengkulu	12.8	11.78	13.81	11.56	33.6	39.14	21.2		8.5	22.5					76.2										67.2
Lampung	2.7	13.59	9.49	10.19	30.8	29.00	17.2		8.1	24.2					57.4										71.4
Bangka Belitung	26.8	8.12	9.62	11.29	30.8	32.78	24.5		8.4	26.6					78.4										70.1
Riau Islands	68.4	6.34	9.16	7.59	23.8	26.97	18.3		6.2	19.3					73.7										75.9
D.K.I Jakarta	9.4	6.93	9.90	8.44	23.2	25.62	14.7		4.3	15.8					80.4										77.0
West Java	3.2	9.07	9.55	10.36	31.3	31.57	21.0		8.9	27.6					58.2										77.6
Central Java	3.5	8.60	9.96	8.65	29.5	30.95	21.5		5.1	17.6					77.3										65.1
D.I. Yogyakarta	67.7	8.82	5.74	10.04	27.9	22.54	19.3		6.8	22.7					73.1										68.0
East Java		15.28	12.66	15.41	42.3	46.22	26.1		8.2	25.4					83.6										60.0
Banten									10.0	25.4															60.7
Bali			8.55	15.19		29.92	18.5		9.3	27.8															45.7
West Nusa Tenggara			9.23	10.24		26.53	17.1		6.7	22.8															54.1
East Nusa Tenggara	17.2								6.8	23.2															57.8
West Kalimantan			15.24	13.75		32.09	17.5		6.6	21.2															57.2
Central Kalimantan																									
South Kalimantan																									
East Kalimantan																									
North Sulawesi																									
Central Sulawesi																									
South Sulawesi																									
Southeast Sulawesi																									
Gorontalo																									
West Sulawesi																									
Maluku																									
North Maluku																									
West Papua																									
Papua																									

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of children aged 6-59 months who given vitamin A suplement (Riskesdas)										Percentage of children aged 1-4 years with Vitamin A by August (Health Profile)				Percentage of households consuming adequately iodized salt (Susenas)		
Year	2007										2004	2005	2006	2007	2002	2003	2003
	Male	Female	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	71.3	71.7	74.4	69.7	69.3	70.5	71.7	73.5	74.1	71.5	82.93	75.66	81.29	87.08	68.53	73.24	72.81
Aceh										74.9		89.21	93.3	94.44			
North Sumatra										51.0	76.28	81.78	81.78	84.21	85.60	90.62	91.22
West Sumatra										73.5	87.11	90.26	83.61	92.98	92.88	93.02	88.34
Riau										66.9	77.14	85.11	83.26	86.31	91.59	90.10	89.24
Jambi										73.1	84.38	73.15	91.95	87.82	95.57	96.47	91.82
South Sumatra										62.9	83.1		86.59	85.84	89.04	92.19	86.89
Bengkulu										62.4	67.77	79.98	68.41	84.71	95.39	94.53	86.17
Lampung										65.5	67.97	58.46	81.23	80.75	85.68	85.48	75.61
Bangka Belitung										69.7	75.11		82.79	80.36	87.08	95.00	93.53
Riau Islands										67.6	83.38	19.7	83.96	81.93			87.90
D.K.I Jakarta										79.7	74.55	61.87	80.45	67.47	59.93	55.91	61.37
West Java										79.8	86.91	84.5	63.7	91.73	67.83	69.71	66.39
Central Java										82.3	96.22	98.29	98.56	98.85	54.62	59.43	62.77
D.I. Yogyakarta										84.7	87.87	93.31	93.48	108.74	65.86	67.16	74.33
East Java										73.8	80.85	47.33	85.21	84.84	67.82	74.75	72.32
Banten										72.3	70.05	84.91	84.73	85.37	61.92	61.33	51.66
Bali										81.2	94.62	87.08	94.28	97.45	45.21	43.56	45.48
West Nusa Tenggara										82.1	70.22	97.5	97.27	94.83	18.02	21.45	23.97
East Nusa Tenggara										74.2	70.79		87.35	85.53	32.55	34.07	36.77
West Kalimantan										73.0	86.17	67.9	64.73	85.57	86.36	88.29	83.73
Central Kalimantan										67.5	58.15		74.22	78.97	92.51	93.23	88.94
South Kalimantan										81.9	96.61	84.97	63.99	85.22	90.53	90.25	84.37
East Kalimantan										79.1	80.61	76.53	78.28	84.33	93.42	96.26	82.63
North Sulawesi										78.4	88.16	94.87	89.23	97	96.97	94.33	92.09
Central Sulawesi										69.2	85.42		98.13	90.05	84.57	89.85	84.40
South Sulawesi										74.2	82.64	90.26	84.43	92.24	59.94	59.69	59.54
Southeast Sulawesi										69.9	66.3	60.77	77.43	85.74	58.71	66.84	64.36
Gorontalo										77.3	66.7	20.37	75.74	86.07	98.45	88.58	85.38
West Sulawesi										65.6	76.6	79.61	81.58	91.55			
Maluku										57.8	72.82	32.62	62.68	59.9		39.09	43.93
North Maluku										71.2	68.05	62.25	51.87	56.31		69.53	72.15
West Papua										61.6	34.66	57.41	30.82	46.61			
Papua										59.9	24.62	28.73	88.16	21.11		91.67	93.57

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of households consuming adequately iodized salt (Riskesdas)								Percentage of share of total household consumption on all food (Susenas)					
Year	2007								2002			2005		
	Urban	Rural	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	70.4	56.3	56.7	59.3	61.8	64.1	70.0	62.30	52.82	66.56	58.47	45.11	61.13	51.37
Aceh								47.30				71.66	81.91	76.32
North Sumatra								89.90	59.27	73.29	65.52	47.88	66.97	55.61
West Sumatra								90.30	58.46	68.48	64.63	51.67	64.97	59.15
Riau								82.80	57.38	68.26	61.99	47.03	29.14	55.81
Jambi								94.00	61.24	69.21	66.22	47.07	64.59	57.41
South Sumatra								93.00	55.81	71.64	63.75	50.03	68.32	59.62
Bengkulu								69.70	62.46	71.88	68.08	44.87	66.38	56.58
Lampung								76.80	58.94	68.02	65.22	38.96	61.55	52.37
Bangka Belitung								98.70	59.97	71.59	65.50	53.76	61.07	57.47
Riau Islands								89.10				44.92	61.80	47.19
D.K.I Jakarta								68.70	40.53		40.53	37.72		37.72
West Java								58.30	55.08	66.25	59.16	45.66	60.12	50.42
Central Java								58.60	55.54	63.42	59.31	48.71	56.88	52.61
D.I. Yogyakarta								82.70	46.67	60.51	50.41	36.62	51.65	40.13
East Java								45.10	54.36	61.99	57.87	45.91	57.37	50.75
Banten								46.40	52.45	67.78	56.62	44.22	62.30	48.98
Bali								45.10	47.32	57.96	50.96	39.82	51.03	43.81
West Nusa Tenggara								27.90	63.63	71.34	67.89	54.75	63.72	59.31
East Nusa Tenggara								31.00	56.62	71.20	67.28	52.91	66.78	62.34
West Kalimantan								84.40	52.72	73.67	65.18	53.75	68.88	62.74
Central Kalimantan								88.70	59.14	76.07	69.93	54.53	71.59	64.53
South Kalimantan								76.20	60.41	69.49	65.14	54.60	64.54	59.96
East Kalimantan								83.80	52.64	65.00	56.59	44.47	61.34	49.57
North Sulawesi								89.20	55.20	64.97	60.19	53.20	57.47	55.43
Central Sulawesi								62.30	55.25	66.40	63.30	48.35	61.83	57.75
South Sulawesi								61.00	56.03	67.12	62.32	46.46	63.72	55.51
Southeast Sulawesi								43.50	54.55	68.39	64.18	46.57	60.01	55.20
Gorontalo								90.10	66.70	71.78	70.01	47.49	59.54	54.39
West Sulawesi								34.20						
Maluku								45.10				53.79	67.59	62.38
North Maluku								83.00				57.91	64.88	62.34
West Papua								90.90						
Papua								86.20				48.20	66.96	58.81

TABLE 4B. NUTRITION INDICATORS

Area	Percentage of share of total household consumption on all food (Susenas)						Percentage of share of total household consumption on cereals (Susenas)								
Year	2007			2008			2002			2005			2007		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	43.85	58.32	49.24	44.96	58.67	50.17	8.64	17.95	12.47	5.61	13.10	8.54	7.09	15.30	10.15
Aceh			60.62	50.87	66.04	60.24									
North Sumatra			53.48	47.63	62.30	54.06									
West Sumatra			56.22	51.28	61.80	57.19									
Riau			49.19	46.46	55.93	50.30									
Jambi			52.83	47.12	57.18	53.38									
South Sumatra			53.83	50.20	58.76	54.80									
Bengkulu			53.50	46.38	56.70	52.39									
Lampung			49.66	42.09	58.49	51.89									
Bangka Belitung			54.13	51.77	55.91	53.82									
Riau Islands			47.08	44.13	57.70	48.96									
D.K.I Jakarta			35.28	36.34		36.34									
West Java			49.15	46.64	58.97	50.23									
Central Java			49.97	48.09	56.49	51.55									
D.I. Yogyakarta			41.80	40.40	50.67	42.86									
East Java			48.59	45.99	55.33	49.61									
Banten			45.68	41.99	61.13	46.95									
Bali			43.82	43.60	49.60	45.60									
West Nusa Tenggara			55.09	51.98	59.56	55.77									
East Nusa Tenggara			59.70	47.85	65.30	59.66									
West Kalimantan			58.14	48.64	62.71	57.68									
Central Kalimantan			57.79	54.23	64.64	60.21									
South Kalimantan			53.70	46.28	61.33	53.13									
East Kalimantan			44.06	40.06	53.18	43.38									
North Sulawesi			52.63	48.81	58.23	53.66									
Central Sulawesi			54.55	47.77	57.45	54.55									
South Sulawesi			52.03	44.86	59.47	52.35									
Southeast Sulawesi			54.45	46.05	58.71	54.02									
Gorontalo			51.80	47.85	59.53	54.37									
West Sulawesi			58.00	56.29	57.99	57.34									
Maluku			57.02	49.81	62.55	57.47									
North Maluku			55.62	45.43	58.59	52.80									
West Papua			57.76	52.96	62.52	59.19									
Papua			59.44	47.79	61.55	55.97									

DEFINITIONS OF THE INDICATORS	
Exclusively breastfed	Giving breastmilk without any additional food or drink, not even water for infants aged 0-6 months
Percentage of children aged <6 months who are exclusively breastfed	Comparison between the number of infants less than six months who received only breast milk compared with all children under five
Low birth weight	Percentage of children underfives whose irth weight less than 2500 grams
Underweight	Percentage of children underfives who are underweight. Underweight is indicator of body weight according to age (Weight/Age). The weight are converted into standardized values (Z-score) using the 2006 WHO standard anthropometric There are moderate underweight represent poor nuttition (Z-score >=-3,0 s/d Z-score <-2,0) and malnutrition (Z-score < -3,0), while severe underweight represent malnutrition.
Stunting	Percentage of children underfives who are stunted. Stunting is indicator of body height according to age (Height/Age). The height are converted into standardized values (Z-score) using the 2006 WHO standard anthropometric. Status of short and very short are combined into one category and called a short or moderate stunting, while very short is called severe stunting.
	Indicators height per age illustrates that chronic nutritional status, meaning that arise as a result of circumstances that lasted a long time, such as poverty, often suffer from recurrent disease because of hygiene and poor sanitation.
Wasting	Percentage of children underfives who are wasted. Wasting is indicator of body weight according to height (weight/height). The weight and height are converted into standardized values (Z-score) using the 2006 WHO standard anthropometric. Status of skinny and very thin are combined into one category and called thin or moderate stunting, while very thin is called severe stunting.

MAIN DATA SOURCES	
Percentage of children under-five years who were ever breastfed by area and gender	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Percentage of children aged <6 months who are exclusively breastfed	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Percentage of ever breastfed children aged 2-4 years who were breastfed for 18-23 months by area	National Socio Economic Survey
Percentage of children who started breastfeeding within 1 hour of birth by area, gender and wealth quintile	Indonesia Demographic and Health Survey 1994, 1997, 2002/2003, 2007
Percentage of children aged 6-9 months who are breastfed and consuming complementary food	Indonesia Demographic and Health Survey 1994, 1997, 2002/2003, 2007
Percentage of children aged 20-23 months who are still breastfeeding	Indonesia Demographic and Health Survey 1994, 1997, 2002/2003, 2007
Percentage of children who are exclusively breastfed by age groups	Indonesia Demographic and Health Survey 1997, 2002/2003, 2007

DEFINITIONS OF THE INDICATORS	
	The indicator weight / height describe the nature of acute nutritional status as a result of circumstances that took place within a short time, such as decreased appetite due to illness or because of suffering from diarrhea. In such circumstances the child's weight will quickly come down so that no longer proportional to her height and the child becomes thin.
Nutritional status	The physical condition of children or infants as measured by weight per age. WHO-NCHS standards are used as measurement references.
Percentage of children aged 6-59 months who given vitamin A suplement	Percentage of children aged 6-59 months who were given vitamin A suplement in the six months preceding the survey
Percentage of children aged 1-4 years received Vitamin A (Agustus)	Percentage of children aged 0-4 years who were given vitamin A suplement in the last August. High-dose vitamin A capsules to infants and toddlers are given twice a year, in February and August.
Adequately iodized salt	Households have enough iodine salt, if ioudium levels in consumed salt was ≥ 30 ppm KIO3. In Riskesdas, households declared to have "adequate iodine salt (≥ 30 ppm KIO3)" if the salt rapid test results shows blue / purple colour; and have "not enough iodine salt (≤ 30 ppm KIO3)" if the salt test results shows light blue, and declared to have "no iodized salt" if the rapid salt test results at the household is colorless.
Consumption on all food	The pattern of household consumption is one indicator of household welfare/family. Usually, the proportion of expenditure on food consumption to all household expenditures can provide a snapshot of the household welfare.
	The more proportion of expenditures on food consumption indicate that low-income households. The higher the household income level, the smaller the proportion of expenditure on food for all household expenses. In other words we can say that households / families will be more prosperous if the percentage of expenditure on food is much smaller than the percentage for non-food expenditure

MAIN DATA SOURCES	
Percentage of incidence of low birth weight by area and wealth quintile	Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002/2003, 2007
Percentage of infants with low birth weight by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of under-fives suffering from underweight (severe and moderate) by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of under-fives suffering from stunting (severe and moderate) by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of under-fives suffering from wasting (severe and moderate) by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of nutritional status of children under-fives years old	National Socio-Economic Survey 2001; Iodized Salt Survey 2002, 2003 and 2005 ; Basic Health Research (Riskesdas) 2007 ; NCHS population reference ; WHO reference population
Percentage of children aged 6-59 months who given vitamin A suplement by area, gender, and wealth quintile	Indonesia Demographic and Health Survey 2002/2003, 2007 ; Basic Health Research (Riskesdas) 2007

MAIN DATA SOURCES

Percentage of children aged 1-4 years with Vitamin A (Agustus)	Ministry of Health: Indonesia Health Profile, 2004, 2005, 2006, 2007
Percentage of households consuming adequately iodized salt	Survey Garam Yodium 2002-2005 ; Basic Health Research (Riskesdas) 2007
Percentage of share of total household consumption on all food by area	National Socio-Economic Survey: expenditure for consumption of Indonesia
Percentage of share of total household consumption on cereals by area	National Socio-Economic Survey: expenditure for consumption of Indonesia

Notes - Data not available
1) Data base on NCHS population reference
2) Data based on WHO reference population

TABLE 5. WATER AND SANITATION INDICATORS

Area	Percentage of households with sustainable access to adequate sanitation - ventilated pit latrine and septic tank (Susenas)																							
Year	2000			2001			2002			2003			2004			2006			2007			2008		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	54.91	17.79	33.44	57.67	17.91	35.05	58.23	18.50	36.32	57.84	21.21	36.39	60.31	23.16	38.96	55.08	21.15	35.73	66.03	29.40	45.22	67.82	32.24	49.54
Aceh							94.18		94.18	63.37	22.77	32.68	68.76	27.85	38.85	53.25	19.04	26.45	63.92	24.76	33.42	74.49	31.23	43.69
North Sumatra	66.35	15.20	37.13	67.23	19.55	40.39	68.54	18.69	40.33	66.22	17.89	38.16	66.39	21.75	40.62	65.36	24.29	42.17	74.44	30.34	49.54	77.21	33.20	53.49
West Sumatra	57.20	13.79	25.71	59.21	15.95	28.18	56.34	16.15	28.23	63.62	16.12	29.68	56.74	17.02	28.77	58.98	17.38	30.28	66.22	23.41	36.73	65.78	23.78	38.20
Riau	71.52	13.99	38.74	62.55	14.68	35.33	64.41	17.92	39.82	62.67	17.97	37.30	64.76	17.80	38.47	65.58	15.55	32.91	68.67	30.45	43.51	78.13	31.16	54.84
Jambi	62.02	13.15	26.26	63.28	12.47	26.40	63.73	15.66	29.15	56.04	16.65	27.13	61.07	19.38	30.71	59.10	18.27	29.33	67.99	23.46	35.57	63.01	28.13	39.43
South Sumatra	45.46	16.83	26.38	51.93	10.43	23.83	58.46	9.82	26.40	50.77	11.94	24.45	50.37	15.59	26.91	51.09	13.32	25.53	73.52	21.28	38.19	70.64	19.28	39.13
Bengkulu	61.41	13.74	27.06	67.35	13.08	28.71	61.31	8.15	23.66	54.13	10.08	21.63	55.51	17.71	28.44	51.33	14.59	24.51	65.49	18.99	31.56	54.36	19.88	31.97
Lampung	49.09	11.60	19.08	54.86	13.25	22.01	49.14	15.85	23.11	48.01	15.71	22.06	57.05	18.19	26.55	49.15	18.43	24.84	65.83	23.85	32.60	65.51	29.84	38.22
Bangka Belitung				53.91	26.28	38.38	53.88	26.91	38.67	62.59	29.00	40.05	59.97	27.48	41.62	55.93	29.37	40.14	70.73	34.35	48.76	72.23	44.40	57.70
Riau Islands																41.29	10.91	35.34	55.79	21.73	49.27	74.22	16.33	46.95
D.K.I Jakarta	68.63		68.63	75.20		75.20	78.09		78.09	71.12		71.12	73.73		73.73	68.09		68.09	78.29		78.29	78.10		78.10
West Java	47.08	22.49	34.57	47.08	22.22	34.42	47.19	23.14	35.43	49.56	27.04	37.95	50.34	29.04	39.56	49.17	23.44	36.53	56.71	34.46	45.80	59.06	36.42	49.70
Central Java	54.53	19.46	33.05	55.30	19.37	33.81	56.01	21.18	35.85	56.33	24.96	37.26	58.79	26.58	39.66	58.55	27.96	40.42	65.00	35.08	47.29	65.04	38.23	51.26
D.I. Yogyakarta	57.55	31.89	47.48	73.18	32.72	57.90	67.43	28.35	53.07	72.40	32.44	56.69	75.71	41.10	62.39	72.23	30.87	55.51	78.78	52.00	68.90	83.45	56.74	73.91
East Java	52.42	13.31	28.82	51.91	14.57	29.99	53.73	14.49	31.13	55.04	17.47	32.20	59.84	20.11	36.33	51.91	19.74	33.04	65.84	27.37	43.29	65.96	31.38	48.29
Banten				72.04	19.97	49.53	68.97	16.57	46.43	67.02	26.65	48.99	73.06	27.14	52.45	58.81	18.89	41.15	72.21	24.67	51.24	80.11	26.43	58.75
Bali	82.58	49.07	64.94	77.36	42.25	59.80	74.28	46.26	61.48	78.46	45.13	61.40	75.34	50.56	63.22	74.44	46.22	61.33	87.37	59.14	74.29	88.27	62.89	77.53
West Nusa Tenggara	31.29	24.30	26.69	47.74	19.00	29.36	36.42	19.86	25.98	36.92	17.21	23.93	39.90	20.83	27.72	20.52	14.65	16.77	44.22	29.59	34.89	54.15	35.94	43.57
East Nusa Tenggara	34.53	5.26	9.55	34.83	6.15	10.50	32.50	6.50	10.64	35.98	6.17	10.77	31.92	6.79	10.79	29.51	5.57	9.31	37.95	11.76	15.91	47.58	11.47	17.91
West Kalimantan	65.13	10.15	24.39	65.68	10.84	25.48	61.33	11.28	24.10	62.60	11.87	25.15	61.62	12.91	25.32	60.75	13.00	25.60	68.42	19.50	32.36	73.76	22.68	36.88
Central Kalimantan	36.05	5.73	14.22	55.83	6.04	20.59	48.81	5.08	17.99	50.82	8.57	20.41	53.28	9.82	22.44	38.98	7.54	16.77	53.90	9.59	22.64	49.59	12.29	24.97
South Kalimantan	33.85	10.37	18.56	38.29	12.76	21.94	38.57	10.60	21.19	33.75	16.22	22.49	45.79	15.40	26.58	35.55	14.05	22.05	48.50	16.58	28.52	61.09	21.97	38.21
East Kalimantan	56.29	9.12	35.63	64.37	18.58	44.28	64.91	19.54	45.39	64.60	21.61	45.82	57.78	23.50	41.83	48.43	20.82	35.85	64.27	32.86	49.96	68.45	29.18	53.60
North Sulawesi	72.81	34.75	47.57	69.31	40.35	51.60	71.62	36.20	50.27	61.27	44.54	50.59	73.85	34.12	49.46	50.54	38.09	42.83	71.83	47.78	56.55	67.86	45.95	55.46
Central Sulawesi	50.06	19.11	25.06	63.03	16.04	24.96	59.06	19.52	27.03	54.11	25.62	31.22	62.68	23.04	30.87	62.94	20.60	29.10	66.64	28.56	36.18	80.87	37.68	46.75
South Sulawesi	70.79	24.01	37.61	67.23	20.44	34.31	77.04	24.00	39.96	72.85	25.75	39.29	72.34	26.12	39.80	63.46	25.34	37.46	78.34	34.39	48.40	80.66	38.37	51.99
Southeast Sulawesi	59.98	18.66	27.25	71.81	18.54	29.83	54.93	16.49	24.64	62.98	19.68	28.58	57.42	22.12	29.75	54.30	20.53	27.94	76.22	26.85	37.82	78.81	34.26	44.46
Gorontalo				66.61	17.60	30.11	48.26	19.87	27.47	55.56	20.02	29.98	59.80	19.99	30.50	40.61	15.08	21.96	71.77	26.08	38.60	73.90	31.54	44.80
West Sulawesi																26.38	12.80	14.80	61.23	24.63	29.93	65.30	27.25	39.96
Maluku				43.56	19.32	26.30	48.92	4.68	42.14	38.71	21.33	26.38	53.47	17.89	28.24	41.91	13.04	21.34	68.58	19.99	34.16	72.74	33.51	43.75
North Maluku				83.55	37.22	47.28	80.40	15.62	72.83	68.79	36.11	43.63	89.77	34.23	48.84	65.78	26.46	36.16	83.21	40.24	50.84	81.10	43.44	54.63
West Papua	48.11	4.62	16.37	63.42	6.24	21.85	33.59	21.88	32.93				61.76	12.62	24.05	45.63	11.58	23.39	52.82	16.59	29.18	41.93	27.62	30.88
Papua										52.18	8.66	19.29				35.18	7.48	13.92	54.43	12.35	23.47	46.96	11.51	19.51

TABLE 5. WATER AND SANITATION INDICATORS

Area	Percentage of households with sustainable access to clean water (Susenas)																											
Year	2000			2001			2002			2003			2004			2005			2006			2007			2008		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	71.09	47.61	57.51	60.91	36.44	47.05	59.75	36.59	46.98	59.81	37.77	46.90	60.31	39.93	48.60	62.02	39.01	48.98	62.18	40.28	49.69	67.25	42.04	52.92	68.66	42.20	55.07
Aceh							83.35			61.03	30.52	37.97	67.85	33.80	42.95				62.14	26.41	34.15	66.78	30.39	38.44	65.33	31.49	41.23
North Sumatra	69.10	44.96	55.31	68.66	36.45	50.53	68.04	34.24	83.35	68.53	33.67	48.29	66.59	36.83	49.41	66.59	33.25	47.80	71.53	34.39	50.57	70.26	35.96	50.89	71.56	35.78	52.27
West Sumatra	74.58	40.31	49.72	72.13	33.74	44.59	67.46	35.49	48.91	66.10	37.24	45.48	63.17	40.77	47.40	62.30	37.47	44.83	68.54	35.29	45.60	71.14	39.64	49.44	71.53	38.00	49.51
Riau	39.13	13.83	24.72	39.62	17.59	27.10	44.32	15.14	45.10	45.25	15.09	28.13	47.25	15.64	29.56	35.03	17.96	23.82	37.24	16.79	23.89	53.34	25.58	35.06	55.45	26.35	41.02
Jambi	53.50	24.39	32.19	58.22	31.34	38.71	58.12	27.39	28.89	52.57	28.74	35.08	61.06	34.11	41.44	57.29	31.09	38.21	54.71	28.45	35.57	65.00	34.81	43.02	64.09	38.64	46.89
South Sumatra	57.79	28.67	38.38	64.17	27.68	39.46	58.15	25.55	36.01	63.08	30.41	40.94	60.38	27.03	37.88	65.47	30.54	41.85	62.30	30.36	40.69	77.13	32.52	46.97	72.61	32.88	48.23
Bengkulu	44.33	28.90	33.21	49.40	24.55	31.71	51.20	29.24	36.66	54.47	22.69	31.02	44.56	27.12	32.07	56.40	26.99	35.11	58.76	30.37	38.03	48.75	22.80	29.82	51.95	20.16	31.31
Lampung	34.78	24.82	26.81	49.12	29.18	33.38	48.92	33.56	35.65	45.03	38.72	39.96	50.11	37.51	40.22	56.63	39.92	43.57	51.09	40.63	42.82	58.35	37.04	41.48	57.65	41.13	45.01
Bangka Belitung				56.37	29.40	41.22	47.97	32.55	36.91	50.92	23.01	32.20	40.06	25.93	32.08	44.56	30.24	36.38	45.12	28.91	35.48	62.70	40.03	49.01	66.49	42.63	54.03
Riau Islands									39.27							66.79	32.87	59.76	68.83	24.32	60.11	80.03	34.29	71.27	77.61	33.47	56.82
D.K.I Jakarta	94.98		94.98	69.89		69.89	69.73		69.73	70.30		70.30	71.82		71.82	75.30		75.30	77.49		77.49	80.36		80.36	87.77		87.77
West Java	69.67	50.58	59.96	50.89	31.27	41.10	49.15	31.23	69.73	47.12	32.39	39.52	46.79	37.64	42.16	51.95	33.96	42.88	50.19	35.87	43.15	56.11	36.10	46.30	58.84	38.46	50.41
Central Java	68.04	57.03	61.30	61.43	45.70	52.02	59.59	46.36	40.39	58.03	45.92	50.67	62.90	50.55	55.56	62.86	48.09	54.11	62.13	51.63	55.91	65.26	51.55	57.14	64.42	52.10	58.09
D.I. Yogyakarta	51.07	43.48	48.09	59.22	47.90	54.95	51.58	54.37	51.93	56.70	48.39	53.43	56.34	49.33	53.64	58.58	58.15	58.42	64.38	51.11	59.01	72.55	61.01	68.30	76.27	57.62	69.61
East Java	74.05	59.51	65.28	67.39	48.43	56.26	67.78	47.11	52.61	68.35	51.64	58.19	68.22	50.57	57.78	67.38	51.28	57.94	66.05	51.69	57.63	72.74	56.87	63.44	73.39	57.28	65.16
Banten				49.05	22.54	37.39	47.15	27.50	55.87	51.67	26.19	40.29	48.76	31.91	41.20	54.36	28.13	42.49	54.30	25.55	41.58	58.67	30.26	46.14	69.14	30.84	53.89
Bali	75.09	68.40	71.57	77.76	61.78	69.77	71.68	65.78	38.69	77.99	63.53	70.59	76.29	63.15	69.86	82.52	60.36	71.92	79.82	63.24	72.12	83.92	61.54	73.54	83.32	62.65	74.57
West Nusa Tenggara	64.85	58.29	60.53	51.72	35.15	41.12	48.58	39.25	68.99	44.28	32.24	36.35	43.51	37.35	39.58	49.86	36.94	41.59	49.83	39.95	43.53	60.44	45.81	51.11	56.60	45.24	50.00
East Nusa Tenggara	85.00	51.32	56.25	74.85	36.54	42.34	70.54	33.26	42.70	75.29	30.99	37.82	76.35	34.43	41.11	75.26	35.18	41.46	75.22	37.40	43.30	69.37	38.42	43.33	79.68	37.63	45.13
West Kalimantan	43.81	9.52	18.41	32.87	6.50	13.54	32.32	8.79	39.19	29.17	11.43	16.07	28.95	11.53	15.97	31.65	11.78	16.82	30.89	15.25	19.37	29.35	14.08	18.09	33.32	14.10	19.44
Central Kalimantan	73.53	14.65	31.13	64.37	12.32	27.53	56.21	12.86	14.81	59.80	23.03	33.33	66.42	20.34	33.72	62.05	21.39	33.19	59.16	22.49	33.26	60.45	20.63	32.36	61.90	21.84	35.46
South Kalimantan	77.76	35.14	49.99	77.55	27.69	45.62	78.13	24.97	25.65	78.35	24.64	43.85	78.72	33.82	50.34	79.86	32.17	49.12	83.44	36.84	54.17	84.20	36.57	54.39	83.64	32.97	54.00
East Kalimantan	84.05	18.20	55.20	73.70	22.32	51.16	79.31	24.45	45.09	78.21	30.45	57.34	80.60	33.79	58.81	80.46	32.63	57.69	82.38	38.61	62.43	85.69	41.41	65.51	85.43	38.03	67.51
North Sulawesi	62.17	52.64	55.85	68.32	52.30	58.52	69.72	47.17	55.71	69.75	43.65	53.09	69.50	51.38	58.38	58.84	43.33	49.59	64.11	54.95	58.44	70.91	48.02	56.36	75.92	45.08	58.47
Central Sulawesi	84.74	48.95	55.83	59.36	35.27	39.84	50.11	34.39	56.13	56.43	35.25	39.41	58.45	31.97	37.20	65.76	40.30	45.37	68.94	34.05	41.05	62.08	35.90	41.14	77.34	37.34	45.74
South Sulawesi	79.68	51.20	59.48	72.98	29.16	42.15	76.49	29.51	37.38	77.76	32.92	45.82	75.91	33.87	46.31	73.08	35.68	46.60	76.51	39.32	51.15	80.82	37.69	51.44	81.40	40.95	53.97
Southeast Sulawesi	86.57	51.34	58.66	74.27	40.10	47.34	76.28	38.49	43.65	72.50	45.95	51.41	77.08	44.73	51.72	78.49	44.58	52.05	77.02	46.24	52.99	79.42	45.83	53.29	81.58	48.46	56.04
Gorontalo				59.57	23.91	33.01	52.58	22.43	46.51	56.67	21.15	31.10	49.41	36.09	39.61	50.46	29.99	35.65	57.37	33.86	40.20	65.97	35.65	43.96	53.65	35.66	41.29
West Sulawesi									30.50										54.28	28.81	32.55	80.42	35.15	41.70	73.71	30.46	44.91
Maluku				70.14	54.83	59.24	75.87	17.26		72.04	37.64	47.65	73.36	41.08	50.47	68.91	56.77	60.41	66.40	50.60	55.14	73.74	46.06	54.13	71.53	38.23	46.92
North Maluku				73.65	15.76	28.32	80.97	46.85	66.88	77.90	26.07	38.00	75.64	26.22	39.22	69.55	28.76	40.27	74.97	31.91	42.53	67.12	31.02	39.93	73.53	28.42	41.82
West Papua									76.99										66.70	22.06	37.55	81.47	27.13	46.02	78.36	28.66	40.00
Papua	62.28	16.33	28.74	64.57	13.03	27.10	90.32	78.12		71.98	14.22	28.33	65.43	14.06	26.01	68.06	13.49	28.89	62.59	18.14	28.47	70.09	18.61	32.21	69.81	15.58	27.83

TABLE 5. WATER AND SANITATION INDICATORS

Area	Percentage of child uses toilet/latrine (IDHS)															
Year	2002-2003			2007												
	Urban	Rural	Total	Urban	Rural	<6 months	6-11 months	12-23 months	24-35 months	36-47 months	48-59 months	Lowest	Second	Middle	Fourth	Highest	Total
Indonesia	29.8	13.9	21.3	35.1	17.4	4.7	8.5	17.5	29.1	36.6	44.0	7.8	16.1	23.4	35.5	43.6	24.8
Aceh																	7.5
North Sumatra			7.4														17.8
West Sumatra			19.3														11.2
Riau			18.0														17.5
Jambi			18.9														21.1
South Sumatra			15.7														19.8
Bengkulu			27.8														27.9
Lampung			28.8														25.6
Bangka Belitung			14.2														22.1
Riau Islands																	8.2
D.K.I Jakarta			44.6														42.5
West Java			26.4														37.5
Central Java			20.4														31.7
D.I. Yogyakarta			27.7														35.2
East Java			27.1														19.7
Banten			22.1														19.0
Bali			30.0														29.8
West Nusa Tenggara			6.2														17.0
East Nusa Tenggara			6.3														6.6
West Kalimantan			19.7														19.1
Central Kalimantan			6.9														29.8
South Kalimantan			11.0														24.4
East Kalimantan			21.9														25.4
North Sulawesi			30.1														19.3
Central Sulawesi			16.3														12.1
South Sulawesi			10.1														18.4
Southeast Sulawesi			9.1														7.2
Gorontalo			11.5														11.4
West Sulawesi																	10.3
Maluku																	18.5
North Maluku																	16.5
West Papua																	13.1
Papua																	12.1

TABLE 5. WATER AND SANITATION INDICATORS

Area	Percentage of population aged 10 years and above with correct practices on hygiene behavior: who defecate in the toilet or whose stools are disposed of safely (Riskesdas)										Percentage of population aged 10 years and above with correct practices on hygiene behavior: wash the hands with soap before eating, before preparing food, after defecation, after cleaning the baby poo, and after handling poultr/animal (Riskesdas)									
Year	2007										2007									
	Urban	Rural	Male	Female	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total	Urban	Rural	Male	Female	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Indonesia	89.4	59.7	70.9	71.2	58.0	64.3	70.6	75.8	84.5	71.1	28.7	19.8	18.4	27.8	19.6	21.4	22.4	24.4	27.7	23.2
Aceh										61.6										16.0
North Sumatra										76.2										14.5
West Sumatra										59.3										8.4
Riau										80.0										14.6
Jambi										68.1										18.5
South Sumatra										59.7										35.9
Bengkulu										71.8										15.4
Lampung										72.9										15.4
Bangka Belitung										73.3										20.6
Riau Islands										84.0										29.3
D.K.I Jakarta										98.6										44.7
West Java										79.3										27.2
Central Java										68.2										25.1
D.I. Yogyakarta										89.3										32.8
East Java										68.7										26.3
Banten										67.4										24.0
Bali										82.6										30.6
West Nusa Tenggara										60.0										14.2
East Nusa Tenggara										81.1										20.0
West Kalimantan										72.7										23.3
Central Kalimantan										60.1										25.9
South Kalimantan										69.9										17.9
East Kalimantan										83.2										29.0
North Sulawesi										86.2										36.5
Central Sulawesi										59.5										19.9
South Sulawesi										73.0										20.8
Southeast Sulawesi										65.7										24.9
Gorontalo										59.2										22.9
West Sulawesi										57.4										18.4
Maluku										63.2										43.1
North Maluku										72.9										32.8
West Papua										68.3										38.5
Papua										59.9										30.6

DEFINITIONS OF THE INDICATORS

Adequate sanitation	Ventilated pit latrine and septic tank
Percentage of households with sustainable access to adequate sanitation (ventilated pit latrine and septic tank)	Proportion of the number of households which use ventilated pit latrine and septic tank to the number of households, which are expressed in percentage.
Clean water	Water is sourced from the tap, bottled water, and pump, protected well and protected spring that the distance to the final disposal site (septic tank) => 10 m
Percentage of households with sustainable access to clean water	Proportion of the number of households using clean water to the number of households, which are expressed in percentage.
Hygiene behavior	Hygienic behaviors include washing hands with soap, bowel habits, use of tobacco/smoking behavior, drinking alcohol, physical activity, fruit and vegetable consumption behavior, and patterns of risky food consumption

MAIN DATA SOURCES

Percentage of households with sustainable access to adequate sanitation (ventilated pit latrine and septic tank) by area	National Socio-Economic Survey
Percentage of households with sustainable access to clean water by area	National Socio-Economic Survey
Percentage of child uses toilet/latrine by area, age groups, and wealth quintile	Indonesia Demographic and Health Survey 2002/2003, 2007
Percentage of population aged 10 years and above with correct practices on hygiene behavior: who defecate in the toilet or whose stools are disposed of safely by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007
Percentage of population aged 10 years and above with correct practices on hygiene behavior: wash the hands with soap before eating, before preparing food, after defecation, after cleaning the baby poo, and after handling poultr/ animal by area, gender, and wealth quintile	Basic Health Research (Riskesdas) 2007

Notes - Data not available

TABLE 6. HIV AIDS INDICATORS

Year	Cumulative AIDS cases in Indonesia (MoH)							Cumulative AIDS/IDU cases in Indonesia (MoH)					Cumulative AIDS cases from perinatal transmission in Indonesia (MoH)	Cumulative HIV and AIDS cases from perinatal transmission in Indonesia (MoH)	Cumulative HIV cases by mode of transmission in Indonesia (MoH)	
	Aged <1 year old	Aged 1-4 year old	Aged 5-14 year old	Aged 15-19 year old	Male	Female	Total	Aged 5-14 year old	Aged 15-19 year old	Male	Female	Total	Total	Total	IDU	Perinatal Transmission
1995	0	0	1	2	80	7	87						0	0		
1996	0	0	1	3	105	14	119						0	1		
1997	1	0	1	3	128	25	153						1	4		
1998	2	0	1	8	184	43	227						3	13		
1999	2	0	2	9	222	52	274						4	7	174	**4**
2000	1	4	3	26	364	88	452					80	6	10	373	**4**
2001	1	7	3	42	531	140	671	0	20	131	9	140	9	13	543	**5**
2002	2	10	4	67	782	224	1016	0	27	219	14	237	14	19	543	**5**
2003	4	17	4	78	1,071	285	1,371	0	33	333	23	360	23	28	816	**14**
2004	17	14	5	119	2,193	443	2,682	0	61	1,084	73	1,183	48	62	1,117	**28**
2005	29	31	12	193	4,305	957	5,321	0	84	2,394	171	2,601	66	94		
2006	37	70	22	222	6,604	1,529	8,194	1	97	3,807	274	4,118	123			
2007	51	110	39	279	8,864	2,215	11,141			5,170	347	5,555	189			
2008	116	166	84	495	12,061	3,970	16,110	6	122	6,258	509	6,810	351			
2009	184	228	116	609	14,720	5,163	19,973			7,312	605	7,966	519			

TABLE 6. HIV AIDS INDICATORS

Area	Prevalence of AIDS cases - per 100,000 population (MoH)										Cumulative AIDS cases (MoH)												Cumulative AIDS cases (MoH)		
Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	0.21	0.32	0.48	1.33	1.33	2.65	3.61	4.91	7.12	8.66	87	119	153	227	274	452	671	1,016	1,371	2,682	5,321	8,194	11,141	16,110	19,973
Aceh					0.17	0.17	0.15	0.41	0.67	1.05			0	0	0	0	0	0	0	1	3	6	16	26	43
North Sumatra	0	0	0	0	1	1	2	3	4	4	1	1	2	3	3	5	9	21	46	75	125	242	420	487	485
West Sumatra	0	0	0	0	0	0	1	3	4	7	0	0	0	0	0	1	1	2	2	2	19	64	155	204	330
Riau	0	0	1	2	1	5	2	4	8	8	0	0	0	5	8	14	15	45	75	37	91	97	166	364	475
Jambi				0	0	1	3	4	4	6					0	0	0	5	5	9	30	83	112	106	165
South Sumatra	0	0	0	0	0	1	1	2	2	3	1	1	1	1	1	2	4	4	8	25	59	91	124	153	219
Bengkulu				0	0	1	1	2	3	5							0	0	1	5	23	23	28	46	91
Lampung				0	0	1	1	2	2	2				0	0	0	0	0	1	6	67	102	123	143	144
Bangka Belitung				0	2	4	5	7	9	11								1	3	18	33	50	69	95	117
Riau Islands							17	20	23	22										48	146	203	238	277	333
D.K.I Jakarta	2	3	3	4	15	23	28	33	31	32	50	61	70	93	108	191	264	315	346	1,272	1,927	2,565	3,048	2,781	2,828
West Java	0	0	0	0	0	1	2	4	7	9	8	10	11	11	16	33	38	41	67	107	332	940	1,675	2,888	3,598
Central Java	0	0	0	0	0	0	1	1	1	2	0	2	2	3	3	6	6	12	22	40	99	290	389	530	717
D.I. Yogyakarta	0	0	0	1	1	1	3	3	8	9	2	2	2	3	3	3	6	7	18	18	19	89	103	246	290
East Java	0	0	0	1	1	2	2	3	7	9	5	6	8	8	14	21	63	157	213	220	724	863	1,091	2,591	3,227
Banten				0	1	1	0	1	1	3									1	6	42	42	51	74	318
Bali	1	1	1	2	4	7	11	21	34	45	11	12	14	14	19	26	30	38	76	128	226	399	735	1,177	1,615
West Nusa Tenggara	0	0		0	0	1	1	2	2	3	1	2	2	2	2	2	3	3	3	16	43	62	82	80	119
East Nusa Tenggara		0	0	0	1	1	1	2	3	3		0	0	0	0	0	1	7	14	20	29	29	92	110	138
West Kalimantan	0	0	1	1	2	3	14	14	18	17	0	0	0	0	1	1	1	13	43	79	107	553	553	730	794
Central Kalimantan						0	0	0	0	1			0	0	0	0	0	0	0	0	1	1	3	9	21
South Kalimantan				0	0	0	0	0	1	1		0	0	0	0	0	0	0	3	3	6	12	15	22	27
East Kalimantan		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	4	5	7	10	12	11	11
North Sulawesi	0	0	1	1	3	5	5	6	7	8		1	2	2	2	7	7	14	20	54	93	101	124	161	173
Central Sulawesi				0	0	0	0	0	0	0								0	2	2	2	2	2	8	12
South Sulawesi	0	0	0	0	0	2	2	2	2	7		0	0	1	1	1	1	1	2	14	143	143	143	143	591
Southeast Sulawesi							0	0	1	1										0	0	2	8	11	21
Gorontalo						0	0	0	0	0										0	2	3	3	3	3
West Sulawesi							0	0	0	0												0	0	0	0
Maluku	0	0	0	1	3	6	9	12	14	14	0	0	2	3	3	3	3	3	8	33	66	119	157	187	192
North Maluku					0	0	0	1	1	1										1	1	3	7	7	10
West Papua							10	10	10	9										0	51	58	58	58	58
Papua	6	10	14	23	24	49	51	73	129	133	8	21	37	78	90	136	218	325	388	399	772	947	1,339	2,382	2,808

TABLE 6. HIV AIDS INDICATORS

Area	Cumulative AIDS cases (MoH)			Cumulative HIV+ cases (MoH)						Cumulative Deaths cases due to HIV/AIDS (MoH)									
Year	2007	2008	2009	2000	2001	2002	2003	2004	2005	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	11,141	16,110	19,973	1,172	1,904	2,552	2,720	3,368	4,244	232	280	379	479	740	1,332	1,871	2,369	3,362	3,846
Aceh	16	26	43	1	1	1	1	1	1	0	0	0	0	1	2	2	3	7	11
North Sumatra	420	487	485	27	27	28	30	64	80	0	3	7	15	25	37	48	77	95	93
West Sumatra	155	204	330	4	8	8	9	9	9	1	1	1	1	1	13	32	54	65	81
Riau	166	364	475	103	183	202	202	204	206	6	7	23	34	43	39	40	61	116	131
Jambi	112	106	165	3	6	17	17	17	17	0	0	3	3	4	10	29	31	30	50
South Sumatra	124	153	219	49	72	72	72	74	88	2	3	3	6	12	15	22	29	31	38
Bengkulu	28	46	91		3	10	10	10	10		0	0	1	1	6	6	9	13	21
Lampung	123	143	144	3	3	19	19	19	20	0	0	0	1	2	19	32	37	42	42
Bangka Belitung	69	95	117				0					0	1	2	3	3	4	13	18
Riau Islands	238	277	333											0	81	91	102	115	130
D.K.I Jakarta	3,048	2,781	2,828	432	742	861	861	1,233	1,500	79	87	97	100	278	338	420	429	419	426
West Java	1,675	2,888	3,598	46	62	66	66	168	226	13	16	16	23	28	49	138	330	544	634
Central Java	389	530	717	24	24	75	76	77	79	5	5	8	13	27	52	138	167	221	246
D.I. Yogyakarta	103	246	290	3	7	7	30	30	30	0	3	4	7	7	8	11	15	70	81
East Java	1,091	2,591	3,227	94	172	282	282	282	283	12	23	48	66	69	225	258	311	584	691
Banten	51	74	318				0						0	1	11	11	11	12	54
Bali	735	1,177	1,615	44	100	174	206	307	513	9	9	10	22	33	47	74	120	228	371
West Nusa Tenggara	82	80	119	0	1	1	5	8	15	0	0	0	0	7	11	16	24	47	63
East Nusa Tenggara	92	110	138	1	4	8	8	8	13	0	0	3	3	4	4	4	16	23	25
West Kalimantan	553	730	794	45	49	75	75	82	84	0	1	6	12	17	27	106	106	103	107
Central Kalimantan	3	9	21	27	27	27	27	27	27	0	0	0	0	0	1	1	2	2	2
South Kalimantan	15	22	27	4	4	4	4	4	4	0	0	0	2	2	4	5	6	5	5
East Kalimantan	12	11	11	13	13	35	35	35	35	0	1	2	3	3	5	8	10	10	10
North Sulawesi	124	161	173	1	1	1	1	1	6	4	4	5	9	27	32	37	45	53	62
Central Sulawesi	2	8	12			3	3	3	4				1	1	1	1	1	1	6
South Sulawesi	143	143	591	15	32	32	32	32	32	1	1	1	1	12	62	62	62	62	62
Southeast Sulawesi	8	11	21					7	7					0	0	0	1	1	5
Gorontalo	3	3	3											0	1	1	1	1	1
West Sulawesi	0	0	0													0	0	0	0
Maluku	157	187	192	16	16	16	16	34	34	2	2	2	6	24	36	53	62	69	70
North Maluku	7	7	10					0	0					1	1	1	5	7	8
West Papua	58	58	58											0		0	0	19	19
Papua	1,339	2,382	2,808	217	338	527	632	632	920	95	112	140	149	107	192	221	238	351	426

DEFINITIONS OF THE INDICATORS

Prevalence of AIDS cases	Percentage of people suffered from AIDS, expressed in per 100,000 population
Cumulative AIDS cases	Cummulative number of people suffered from AIDS
Cumulative HIV+ cases	Cummulative number of people suffered from HIV+
Cumulative Deaths cases due to HIV/AIDS	Cummulative number of people people death due to HIV/AIDS

Notes - Data not available

MAIN DATA SOURCES

Cumulative AIDS cases by age groups and gender	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 1996-2010
Cumulative AIDS/IDU cases by age groups and gender	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 2001-2010
Cumulative AIDS cases from perinatal transmission	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 1996-2010
Cumulative HIV cases by mode of transmission (IDU, perinatal transmission)	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 2001-2006
Cumulative HIV and AIDS cases from perinatal transmission	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 1996-2006
Prevalence of AIDS cases (per 100,000 population)	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 2001-2010
Cumulative HIV+ cases	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 2001-2006
Cumulative Deaths cases (HIV/AIDS)	Ministry of Health: Directorate General Communicable Diseases Control & Environmental Health, 2001-2010

TABLE 7. EDUCATION INDICATORS

Area	Adult literacy rate - aged 10 years old and above (Susenas)																	
Year	2000			2001			2002			2003			2004			2005		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	93.74	86.15	89.92	93.13	85.46	89.27	94.15	87.31	90.71	94.16	87.72	90.93	94.66	88.29	91.47	94.91	88.93	91.91
Aceh										98.19	95.33	96.75	97.82	94.37	96.07			
North Sumatera	98.19	95.29	96.74	98.54	94.97	96.75	98.10	95.09	96.60	98.48	95.93	97.20	98.46	95.66	97.05	98.05	95.56	96.80
West Sumatera	97.45	93.84	95.58	96.54	93.00	94.71	96.99	94.31	95.60	97.61	94.68	96.10	97.94	94.59	96.21	97.59	95.18	96.34
Riau	97.85	94.74	96.29	96.48	93.25	94.91	97.70	96.13	96.92	97.77	95.24	96.53	97.61	95.97	96.80	98.75	97.30	98.04
Jambi	97.34	92.80	95.07	97.20	91.96	94.64	97.56	93.08	95.35	97.87	93.43	95.68	98.06	94.31	96.21	97.34	92.91	95.14
South Sumatera	97.12	92.36	94.76	96.13	91.50	93.83	97.02	92.54	94.78	97.54	93.95	95.75	97.60	94.75	96.19	97.65	94.68	96.16
Bengkulu	95.81	89.50	92.69	96.11	89.34	92.82	96.34	91.41	93.92	96.69	92.17	94.46	97.14	92.47	94.85	96.70	91.77	94.28
Lampung	95.00	89.13	92.17	95.36	89.35	92.46	96.47	91.28	93.95	95.23	90.09	92.75	96.25	91.41	93.93	96.07	91.27	93.72
Bangka Belitung				95.10	86.72	90.96	95.68	89.67	92.72	95.08	89.82	92.45	96.36	91.73	94.10	97.37	94.45	95.95
Riau Islands																97.76	94.64	96.23
Jakarta	98.99	96.56	97.77	98.85	96.12	97.47	99.32	97.46	98.38	99.14	97.93	98.53	99.22	97.67	98.44	99.36	97.60	98.48
West Java	96.09	90.67	93.41	96.16	91.26	93.72	96.21	91.64	93.94	96.73	92.26	94.52	96.92	92.43	94.69	97.22	93.23	95.24
Central Java	92.53	82.39	87.38	90.89	79.95	85.33	92.59	82.28	87.38	92.32	82.73	87.47	93.04	83.58	88.28	93.23	84.59	88.87
Yogyakarta	89.15	75.63	82.25	91.49	76.85	83.96	91.13	79.29	85.13	92.09	82.03	86.99	92.57	81.55	86.94	93.20	82.79	87.89
East Java	90.00	77.56	83.61	89.14	76.87	82.85	90.51	79.47	84.84	90.41	79.71	84.97	91.43	80.90	86.06	92.29	82.35	87.21
Banten				95.70	89.15	92.46	96.91	92.21	94.59	96.85	92.29	94.60	96.90	92.49	94.72	97.82	94.53	96.19
Bali	92.02	79.31	85.66	89.71	75.84	82.78	91.68	79.55	85.64	91.14	80.57	85.86	92.39	81.20	86.83	93.15	81.73	87.48
West Nusa Tenggara	86.02	73.87	79.73	84.95	74.33	79.43	86.15	76.18	80.92	84.85	73.13	78.69	86.04	74.80	80.06	87.60	76.45	81.73
East Nusa Tenggara	87.06	82.46	84.72	86.26	82.17	84.17	88.26	83.52	85.83	88.71	84.30	86.48	89.33	84.55	86.88	88.79	84.61	86.68
West Kalimantan	92.31	81.88	87.16	91.18	80.12	85.80	92.66	83.69	88.26	93.25	84.65	89.09	93.90	85.16	89.67	93.14	84.88	89.11
Central Kalimantan	97.40	94.55	96.03	97.10	94.44	95.83	97.88	95.34	96.66	97.79	95.37	96.62	97.75	95.56	96.70	98.75	96.84	97.83
South Kalimantan	96.17	90.08	93.10	96.32	89.65	92.97	96.49	91.60	94.04	96.73	91.79	94.23	97.51	93.27	95.36	97.46	92.69	95.08
East Kalimantan	96.61	92.03	94.41	96.37	91.82	94.17	97.19	93.90	95.61	97.19	93.42	95.38	97.18	93.69	95.51	97.15	94.27	95.76
North Sulawesi	98.34	97.84	98.09	98.47	97.95	98.21	98.88	98.78	98.83	99.07	98.94	99.01	99.26	99.02	99.14	98.98	98.71	98.84
Central Sulawesi	95.37	91.68	93.54	95.09	92.00	93.55	95.31	92.60	93.98	95.90	92.45	94.22	96.16	93.69	94.95	95.95	93.07	94.54
South Sulawesi	88.45	82.75	85.48	86.56	80.80	83.55	87.67	82.73	85.12	87.48	82.77	85.05	88.63	83.74	86.10	88.67	84.09	86.29
Southeast Sulawesi	93.90	86.93	90.37	93.56	86.66	90.09	93.38	86.37	89.81	94.35	89.21	91.79	94.67	89.04	91.81	94.30	88.32	91.27
Gorontalo				93.74	93.51	93.63	95.45	95.19	95.32	94.74	94.86	94.80	94.12	95.85	95.01	94.75	95.47	95.12
West Sulawesi																		
Maluku	78.47	68.05	73.45	96.29	97.03	96.66				98.21	96.67	97.44	98.89	97.32	98.09	97.43	95.75	96.58
North Maluku				97.87	91.46	94.63				97.24	94.89	96.07	97.59	93.57	95.59	97.45	94.00	95.76
West Papua																		
Papua				76.17	67.04	71.80				81.21	71.70	**76.61**	81.25	71.16	76.44	**78.15**	68.60	73.57

TABLE 7. EDUCATION INDICATORS

Area	Adult literacy rate - aged 10 years old and above (Susenas)							Adult literacy rate - aged 15 years old and above (Susenas)										
Year	2006			2007			2008	2000					2001					
	Male	Female	Total	Male	Female	Total	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	95.12	89.88	92.39	95.66	89.88	92.74	92.98	94.00	84.40	92.96	84.30	88.58	93.30	83.60	92.33	83.53	87.89
Aceh	96.59	93.44	94.85	96.91	93.44	95.13	96.30										
North Sumatera	98.24	95.76	97.00	98.34	95.76	97.04	97.31			97.95	94.52	96.21			98.31	94.11	96.19
West Sumatera	97.52	95.48	96.35	97.56	95.48	96.49	96.95			97.17	92.98	94.99			96.37	92.00	94.09
Riau	98.39	96.51	97.54	98.50	96.51	97.53	97.93			97.64	93.97	95.80			96.13	92.30	94.26
Jambi	97.38	93.21	95.26	97.52	93.21	95.39	95.79			97.07	91.82	94.43			96.91	90.85	93.93
South Sumatera	98.18	95.63	96.91	98.27	95.63	96.97	97.34			96.82	91.10	93.98			95.71	90.05	92.90
Bengkulu	96.95	92.09	94.50	96.98	92.09	94.56	95.17			95.23	87.75	91.54			95.59	87.39	91.62
Lampung	96.31	91.10	93.70	96.52	91.10	93.90	94.29			94.22	87.37	90.91			94.74	87.68	91.34
Bangka Belitung	97.18	93.39	95.33	97.01	93.39	95.24	95.64								94.58	85.05	89.84
Riau Islands	97.14	95.10	95.77	97.08	95.10	96.03	95.33										
Jakarta	99.07	97.89	98.34	99.79	97.89	98.83	98.77			98.93	96.21	97.56			98.79	95.72	97.24
West Java	97.31	93.92	95.52	97.76	93.92	95.85	96.04			95.56	89.36	92.49			95.50	89.26	92.40
Central Java	93.49	85.76	89.56	94.15	85.76	89.91	90.32			91.50	79.99	85.63			89.69	77.20	83.31
Yogyakarta	92.97	83.10	87.53	94.82	83.10	88.86	90.27			88.07	73.28	80.51			90.71	74.65	82.45
East Java	92.84	84.18	88.36	93.46	84.18	88.66	88.79			88.87	75.09	81.74			87.90	74.32	80.90
Banten	97.37	93.95	95.60	97.58	93.95	95.76	95.72								95.13	88.27	91.72
Bali	92.78	81.62	87.14	93.08	81.62	87.32	88.30			91.23	77.35	84.23			88.65	73.48	81.05
West Nusa Tenggara	86.99	76.94	81.65	88.65	76.94	82.44	82.10			83.55	69.75	76.32			82.42	70.36	76.07
East Nusa Tenggara	90.10	86.67	87.98	90.47	86.67	88.53	88.63			85.59	80.24	82.83			84.86	80.06	82.38
West Kalimantan	94.03	86.75	90.31	94.31	86.75	90.61	89.66			91.23	79.07	85.24			89.98	77.08	83.68
Central Kalimantan	97.80	95.75	96.80	98.12	95.75	96.98	97.39			97.36	93.92	95.68			96.66	93.53	95.17
South Kalimantan	96.73	92.53	94.60	96.88	92.53	94.67	95.46			95.74	88.78	92.21			96.00	88.21	92.09
East Kalimantan	97.49	94.39	95.96	97.72	94.39	96.13	96.55			96.31	91.00	93.73			95.94	90.73	93.41
North Sulawesi	99.02	98.73	99.00	99.15	98.73	98.94	99.13			98.39	97.82	98.10			98.49	97.79	98.14
Central Sulawesi	96.60	93.87	95.37	96.68	93.87	95.29	95.64			95.06	90.68	92.89			94.72	90.91	92.83
South Sulawesi	89.61	85.27	87.28	90.39	85.27	87.72	87.54			87.15	80.49	83.64			85.12	78.47	81.61
Southeast Sulawesi	94.42	88.83	91.24	94.53	88.83	91.64	91.91			93.09	84.63	88.76			92.86	84.56	88.64
Gorontalo	95.45	96.31	95.89	95.29	96.31	95.81	95.37								93.37	92.99	93.18
West Sulawesi	89.87	85.56	87.49	90.20	85.56	87.86	88.45										
Maluku	97.41	96.37	96.89	97.95	96.37	97.16	97.44			75.83	64.11	70.11			96.94	96.97	96.96
North Maluku	96.76	93.36	95.04	97.01	93.36	95.22	95.98								97.49	89.93	93.63
West Papua	91.62	88.53	89.23	92.64	88.53	90.62	90.73										
Papua	75.71	71.34	71.58	82.03	71.34	76.85	74.47								74.10	63.89	69.16

TABLE 7. EDUCATION INDICATORS

Area	Adult literacy rate - aged 15 years old and above (Susenas)																			
Year	2002					2003					2004					2005				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	94.00	85.72	93.46	85.66	89.51	94.51	86.20	93.48	86.16	89.79	94.64	87.00	94.04	86.80	90.38	95.10	87.48	94.34	87.54	90.91
Aceh						98.58	95.44	97.97	94.66	96.28			97.77	93.73	95.69					
North Sumatera			97.91	94.34	96.11	98.30	95.55	98.32	95.32	96.80			98.30	95.03	96.64			97.87	94.95	96.39
West Sumatera			96.85	93.58	95.15	98.67	94.27	97.41	93.96	95.60			97.75	93.90	95.73			97.46	94.63	95.98
Riau			97.49	95.65	96.56	98.13	94.50	97.55	94.61	96.10			97.34	95.46	96.41			98.58	96.91	97.76
Jambi			97.27	92.13	94.71	96.74	94.51	97.69	92.62	95.17			97.88	93.58	95.76			97.05	92.03	94.54
South Sumatera			96.79	91.42	94.11	98.02	93.71	97.25	93.13	95.19			97.37	94.00	95.69			97.36	93.92	95.63
Bengkulu			95.87	90.12	93.04	98.63	91.56	96.18	90.93	93.59			96.96	91.33	94.21			96.26	90.61	93.47
Lampung			96.01	89.80	93.00	96.02	90.39	94.62	88.45	91.65			95.85	90.06	93.08			95.63	89.92	92.85
Bangka Belitung			95.41	87.92	91.74	94.47	89.06	94.54	88.46	91.48			96.15	90.74	93.51			97.12	93.66	95.44
Riau Islands																		97.63	94.26	95.97
Jakarta			99.27	97.23	98.23	98.41		99.10	97.73	98.41			99.18	97.45	98.31			99.31	97.35	98.32
West Java			95.74	90.48	93.11	96.49	91.04	96.34	91.27	93.83			96.50	91.39	93.96			96.93	92.33	94.65
Central Java			91.58	79.96	85.66	89.76	83.09	91.29	80.47	85.79			92.10	81.49	86.72			92.34	82.64	87.41
Yogyakarta			90.37	77.47	83.81	90.63	79.07	91.34	80.37	85.75			91.92	79.90	85.78			92.53	81.20	86.72
East Java			89.48	77.27	83.19	91.43	77.79	89.37	77.64	83.37			90.50	78.89	84.54			91.47	80.51	85.84
Banten			96.58	91.07	93.84	96.10	90.97	96.41	91.15	93.78			96.55	91.39	93.98			97.54	93.70	95.63
Bali			90.86	77.54	84.19	90.29	78.90	90.30	78.61	84.44			91.58	79.44	85.52			92.50	79.91	86.22
West Nusa Tenggara			84.05	72.36	77.87	80.26	72.23	82.44	68.59	75.11			83.73	70.99	76.85			85.62	72.74	78.79
East Nusa Tenggara			87.09	81.40	84.13	97.18	82.45	87.54	82.43	84.93			88.01	82.50	85.16			87.36	82.65	84.95
West Kalimantan			91.88	81.48	86.75	92.19	85.80	92.39	82.48	87.57			93.15	82.91	88.18			92.43	82.63	87.66
Central Kalimantan			97.70	94.84	96.32	97.85	95.48	97.54	94.67	96.16			97.49	94.88	96.23			98.60	96.35	97.50
South Kalimantan			96.16	90.48	93.29	97.44	91.20	96.47	90.71	93.53			97.20	92.40	94.76			97.19	91.76	94.47
East Kalimantan			97.07	93.14	95.19	97.80	91.16	96.96	92.56	94.86			96.89	92.86	94.97			96.93	93.55	95.31
North Sulawesi			98.90	98.67	98.79	99.37	98.70	99.00	98.90	98.95			99.28	99.01	99.15			99.08	98.65	98.87
Central Sulawesi			94.94	91.64	93.32	97.75	92.54	95.59	91.56	93.63			95.78	92.98	94.41			95.53	92.26	93.93
South Sulawesi			86.46	80.74	83.47	92.06	79.57	86.26	80.77	83.40			87.52	81.71	84.49			87.28	82.20	84.60
Southeast Sulawesi			92.38	84.31	88.24	97.26	88.51	93.59	87.44	90.47			94.19	87.46	90.73			93.55	86.61	89.99
Gorontalo			95.15	95.26	95.21	97.66	93.62	94.81	94.60	94.70			93.93	95.34	94.66			94.93	95.13	95.03
West Sulawesi																				
Maluku						98.32	96.52	97.96	96.13	97.04			98.66	96.94	97.78			97.17	95.17	96.16
North Maluku						97.36	94.92	96.91	94.20	95.54			97.73	92.58	95.16			97.15	93.19	95.18
West Papua																				
Papua						97.71	66.83	79.70	68.95	74.46			79.50	68.48	74.22			76.64	66.23	71.58

TABLE 7. EDUCATION INDICATORS

Area	Adult literacy rate - aged 15 years old and above (Susenas)															Youth literacy rate - aged 15-24 years old (Susenas)					
Year	2006					2007					2008					2005			2001		
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	95.28	88.40	94.56	88.39	91.45	95.69	88.77	95.22	88.62	91.87	95.44	89.03	95.38	89.10	92.16	98.73	98.16	98.44	98.47	98.06	98.27
Aceh			96.26	92.38	94.27			96.56	92.61	94.51	98.47	94.89	97.71	94.28	95.86						
North Sumatera			98.05	95.19	96.61			98.30	95.21	96.73	98.63	95.57	98.68	95.46	97.01	99.51	99.32	99.41	99.53	99.42	99.47
West Sumatera			97.23	94.62	95.88			97.37	94.92	96.10	98.57	95.62	97.99	95.45	96.63	98.90	98.96	98.93	98.84	98.97	98.91
Riau			98.26	96.18	97.24			98.41	96.09	97.28	98.44	97.07	99.00	96.50	97.75	99.68	99.00	99.33	98.44	98.03	98.23
Jambi			97.15	92.25	94.71			97.27	92.37	94.83	97.14	94.41	97.89	92.69	95.30	99.65	99.14	99.38	98.93	98.92	98.93
South Sumatera			98.04	95.12	96.59			98.16	95.13	96.66	98.24	96.28	98.36	95.73	97.04	98.76	98.22	98.49	98.89	98.76	98.82
Bengkulu			96.55	90.79	93.69			96.75	91.03	93.91	97.76	92.88	96.98	92.18	94.52	99.01	98.55	98.79	99.15	99.05	99.11
Lampung			95.87	89.57	92.84			96.16	89.90	93.13	96.71	92.47	96.63	90.43	93.53	99.03	99.06	99.05	99.26	99.13	99.20
Bangka Belitung			96.87	92.71	94.86			96.89	92.76	94.87	96..67	94.04	97.32	93.24	95.26				98.88	97.60	98.23
Riau Islands			96.80	93.76	95.29			96.86	94.63	95.67	97.48	93.86	97.57	94.18	94.76						
Jakarta			99.07	97.41	98.23			99.82	97.74	98.76	98.74		99.56	97.96	98.69	99.88	99.64	99.75	99.63	99.40	99.51
West Java			96.97	92.84	94.91			97.52	93.10	95.32	97.07	93.31	97.70	93.37	95.52	99.54	98.95	99.25	99.43	99.18	99.30
Central Java			92.71	83.86	88.24			93.42	84.01	88.62	92.21	86.34	93.82	84.89	89.12	99.01	99.06	99.04	98.94	98.87	98.91
Yogyakarta			92.34	80.70	86.43			94.32	81.52	87.78	92.41	84.10	94.46	84.64	89.50	98.04	99.01	98.50	99.24	99.26	99.25
East Java			92.06	82.41	87.10			92.76	82.47	87.42	92.44	82.38	92.35	82.64	87.55	98.49	97.44	97.97	98.48	97.61	98.04
Banten			97.04	92.94	95.01			97.42	93.09	95.24	96.80	92.59	97.54	92.88	95.15				99.32	99.08	99.20
Bali			92.00	79.52	85.79			92.43	79.68	85.98	91.16	81.24	92.80	81.20	87.07	99.11	97.84	98.49	98.43	95.96	97.24
West Nusa Tenggara			84.82	73.55	78.78			86.79	73.66	79.75	85.11	75.95	87.29	73.47	79.43	96.51	93.42	94.91	95.69	92.47	93.92
East Nusa Tenggara			88.97	84.14	86.50			89.71	84.96	87.25	97.51	85.23	89.78	85.68	87.31	95.09	95.40	95.25	93.59	95.89	94.78
West Kalimantan			93.27	84.59	88.99			93.69	84.95	89.40	92.75	86.84	93.32	83.55	88.34	97.61	96.63	97.12	97.65	95.81	96.73
Central Kalimantan			97.52	95.11	96.35			98.01	95.17	96.64	98.45	96.65	98.30	96.19	97.16	99.17	98.77	98.97	99.37	99.09	99.23
South Kalimantan			96.31	91.55	93.90			96.61	91.57	94.05	97.17	93.54	97.54	92.70	94.96	98.93	99.04	98.98	98.82	98.17	98.49
East Kalimantan			97.25	93.55	95.48			97.53	93.69	95.70	97.86	93.80	97.82	94.77	96.19	99.34	98.67	98.99	99.11	98.90	99.00
North Sulawesi			99.08	98.89	98.99			99.22	98.67	98.95	99.36	98.98	99.39	98.90	99.12	98.99	99.01	99.00	99.45	99.70	99.57
Central Sulawesi			96.26	93.31	94.81			96.42	93.28	94.86	98.94	94.75	97.34	93.96	95.29	98.47	98.28	98.37	97.71	98.71	98.21
South Sulawesi			88.32	83.30	85.70			89.41	83.42	86.24	94.64	82.57	89.23	84.15	85.96	95.79	96.39	96.10	94.52	95.61	95.10
Southeast Sulawesi			93.56	86.32	89.84			94.00	87.17	90.50	97.19	89.16	94.69	87.89	90.86	97.76	98.29	98.03	97.50	97.48	97.49
Gorontalo			95.47	95.93	95.70			95.47	96.02	95.75	98.06	94.32	95.86	95.17	95.15				95.51	97.17	96.34
West Sulawesi			88.73	83.21	85.90			89.41	83.51	86.40	92.33	84.54	90.28	84.55	86.97						
Maluku			97.14	95.88	96.50			97.78	95.94	96.85	98.82	96.72	98.37	96.28	97.28				97.12	97.94	97.53
North Maluku			96.44	92.37	94.41			96.83	92.42	94.65	98.34	94.05	97.61	93.24	95.52				98.67	98.73	98.70
West Papua			91.23	85.86	88.55			92.69	87.86	90.32	98.45	90.07	93.97	90.17	90.78						
Papua			73.61	64.12	69.01			81.01	68.78	75.06	98.38	64.12	77.97	66.61	72.95			80.13	81.37	72.64	76.93

TABLE 7. EDUCATION INDICATORS

Area	Youth literacy rate - aged 15-24 years old (Susenas)																				
Year	2002			2003					2004			2005			2006			2007			
	Male	Female	Total	Urban	Rural	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Indonesia	98.76	98.57	98.67	99.44	97.80	98.68	98.42	98.55	98.87	98.54	98.71	98.78	98.71	98.74	98.80	98.73	98.76	98.92	98.76	98.84	
Aceh				99.46	99.18	99.42	99.09	99.25	99.38	99.49	99.44				98.68	98.84	98.76	99.04	98.95	99.00	
North Sumatera	99.26	99.04	99.15	99.52	99.17	99.36	99.30	99.33	99.36	98.96	99.16	99.08	98.91	99.00	98.92	98.81	98.87	99.29	99.02	99.15	
West Sumatera	98.48	99.05	98.76	99.69	98.71	99.03	99.07	99.05	99.30	99.07	99.19	99.00	99.23	99.12	98.93	99.25	99.09	99.00	99.35	99.18	
Riau	98.95	99.16	99.07	99.77	98.63	99.15	99.13	99.14	99.11	99.53	99.33	99.58	99.56	99.57	98.85	99.48	99.17	99.56	99.11	99.34	
Jambi	98.92	99.00	98.96	99.23	99.14	99.07	99.26	99.17	99.48	99.14	99.31	98.95	99.24	99.10	99.24	98.64	98.94	99.25	98.97	99.11	
South Sumatera	99.12	98.57	98.85	99.54	99.00	99.26	99.13	99.19	98.85	98.88	98.86	99.34	99.01	99.17	99.29	99.19	99.24	99.40	99.19	99.30	
Bengkulu	98.89	98.28	98.59	99.29	98.17	99.22	97.86	98.53	99.65	98.73	99.19	99.39	99.07	99.23	99.10	98.86	98.98	98.66	99.19	98.93	
Lampung	98.75	99.09	98.91	99.75	99.04	99.13	99.31	99.21	99.29	99.58	99.42	98.73	99.41	99.06	98.92	99.33	99.11	99.54	99.43	99.49	
Bangka Belitung	97.18	97.91	97.52	98.42	97.87	98.35	97.88	98.11	98.09	97.97	98.03	98.91	98.89	98.90	98.85	98.83	98.84	97.44	98.82	98.10	
Riau Islands												99.09	98.51	98.79	98.85	99.39	99.13	98.41	99.35	99.00	
Jakarta	99.58	99.57	99.57	99.77		99.73	99.80	99.77	99.78	99.69	99.73	99.64	99.65	99.64	99.31	99.78	99.56	99.92	99.66	99.78	
West Java	99.55	99.34	99.45	99.72	99.07	99.46	99.40	99.43	99.75	99.27	99.51	99.38	99.28	99.33	99.55	99.48	99.51	99.43	99.45	99.44	
Central Java	99.26	99.09	99.17	99.40	98.59	98.92	98.95	98.94	99.38	99.22	99.30	99.15	99.38	99.26	99.35	99.36	99.35	99.35	99.28	99.31	
Yogyakarta	99.06	99.67	99.36	99.79	98.63	99.51	99.28	99.40	99.52	99.74	99.63	99.53	99.62	99.57	99.88	99.75	99.82	99.77	99.72	99.75	
East Java	98.77	98.15	98.46	99.27	97.53	98.69	97.89	98.29	98.91	98.30	98.61	99.00	98.73	98.86	99.11	99.10	99.11	99.04	98.84	98.94	
Banten	99.28	98.36	98.81	99.19	98.76	99.43	98.61	99.00	99.32	99.33	99.32	99.62	99.55	99.58	99.41	99.31	99.36	99.61	99.09	99.35	
Bali	98.30	96.99	97.65	98.94	97.13	98.80	97.39	98.10	98.80	97.83	98.33	99.49	98.22	98.88	98.91	98.40	98.66	98.89	98.03	98.47	
West Nusa Tenggara	96.48	95.08	95.76	97.43	94.05	96.46	94.18	95.27	96.49	94.28	95.27	96.54	96.37	96.45	97.51	95.99	96.70	97.48	96.41	96.92	
East Nusa Tenggara	95.71	96.00	95.86	99.67	94.06	94.49	95.95	95.22	95.93	96.23	96.08	94.54	95.98	95.25	94.79	95.31	95.05	95.43	96.55	95.99	
West Kalimantan	97.45	96.79	97.13	98.86	96.93	98.06	96.90	97.49	97.76	97.99	97.87	98.26	97.22	97.76	97.94	97.68	97.81	98.23	97.76	98.01	
Central Kalimantan	99.40	99.54	99.48	99.04	99.58	99.42	99.43	99.42	99.72	99.74	99.73	99.84	99.58	99.71	99.15	99.08	99.12	99.15	99.53	99.34	
South Kalimantan	98.62	98.33	98.47	99.80	98.07	98.78	98.72	98.75	99.00	98.95	98.97	98.87	99.15	99.01	99.17	99.01	99.09	99.15	98.91	99.03	
East Kalimantan	99.33	99.12	99.23	99.49	98.43	99.28	98.77	99.03	99.31	98.91	99.11	99.00	99.45	99.22	99.21	99.27	99.24	99.47	99.02	99.25	
North Sulawesi	99.51	99.28	99.40	100.00	99.41	99.39	99.93	99.65	99.59	99.30	99.45	99.73	99.73	99.73	99.49	99.72	99.60	99.28	99.40	99.34	
Central Sulawesi	98.54	98.61	98.57	99.09	97.26	97.97	97.39	97.69	98.14	99.00	98.56	98.57	97.98	98.29	98.30	98.60	98.45	98.07	98.98	98.53	
South Sulawesi	94.29	96.24	95.38	98.44	94.54	94.69	97.06	95.90	95.28	97.01	96.15	95.33	97.06	96.24	96.39	97.68	97.04	95.81	97.24	96.54	
Southeast Sulawesi	97.06	96.93	96.99	99.11	96.76	97.26	97.45	97.36	98.05	97.70	97.87	97.66	98.14	97.92	98.35	98.10	98.22	97.43	97.95	97.69	
Gorontalo	95.19	98.44	96.82	99.30	95.20	94.80	97.74	96.32	95.87	98.76	97.39	96.24	97.57	96.92	96.24	98.35	97.32	97.02	97.46	97.25	
West Sulawesi															94.05	95.36	94.72	96.11	95.71	95.90	
Maluku			99.30	99.34	98.97	98.88	99.33	99.09	99.26	99.40	99.33	98.74	99.16	98.95	98.87	97.99	98.42	98.93	98.97	98.95	
North Maluku			100.00	98.96	99.68	99.52	99.43	99.47	98.67	96.55	97.59	98.51	98.75	98.63	98.34	98.52	98.43	98.65	98.96	98.81	
West Papua															95.75	92.93	94.28	93.15	91.78	92.44	
Papua			99.80	98.67	79.26	88.97	79.75	84.22	87.87	77.68	82.98	86.17	75.63	80.84	84.35	74.59	79.52	90.99	81.50	86.21	

TABLE 7. EDUCATION INDICATORS

Area	Pre-school participation rate - aged 4-6 years old (Susenas)							Percentage of qualified kindergarten teachers (World Bank)					Gross primary school enrolment ratio (Susenas)								
Year	2001	2002	2003	2004	2005	2006	2007	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2000			2001			2002		
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	21.08	19.24	16.86	18.36	20.64	17.09	12.44	9.70	9.80	9.40	9.40	29.90	108.03	107.30	107.67	107.27	107.15	107.20	105.99	105.99	105.99
Aceh			8.08	10.27		13.23	8.78														
North Sumatera	11.99	11.30	9.28	11.41	15.90	9.98	6.74						110.32	108.99	109.69	107.96	108.75	108.34	107.71	106.89	107.31
West Sumatera	16.16	14.42	14.33	12.53	15.07	15.21	9.32						110.40	107.59	109.04	109.34	108.64	109.00	104.11	103.91	104.01
Riau	19.23	10.21	11.05	14.32	12.86	11.54	7.72						108.46	107.40	107.94	108.25	109.88	109.03	107.88	106.88	107.40
Jambi	17.17	11.15	8.53	10.93	14.03	9.76	8.54						108.67	109.74	109.17	110.53	110.41	110.47	108.79	106.87	107.88
South Sumatera	14.22	14.28	6.92	7.59	12.48	10.42	6.90						108.28	105.42	106.86	107.71	107.52	107.61	108.45	107.49	107.97
Bengkulu	12.85	12.84	8.81	9.76	12.77	11.66	8.74						109.14	105.24	107.17	112.37	111.08	111.76	107.37	107.50	107.43
Lampung	16.14	11.31	11.86	13.16	11.78	12.05	8.52						113.45	110.15	111.89	109.55	109.90	109.71	106.54	105.42	105.98
Bangka Belitung	12.54	8.47	8.93	11.92	13.10	9.91	8.28									110.46	108.68	109.61	108.56	107.60	108.08
Riau Islands					15.41	15.55	9.86														
Jakarta	27.79	20.65	18.62	22.54	28.04	25.43	17.41						105.72	108.59	107.12	109.73	105.19	107.49	102.85	105.99	104.30
West Java	16.24	18.58	14.19	16.46	17.18	13.92	10.77						105.09	104.39	104.74	104.45	104.95	104.69	104.34	104.58	104.45
Central Java	28.83	25.26	25.55	24.11	28.55	22.97	16.40						111.80	110.22	111.02	110.78	108.89	109.86	108.54	107.79	108.18
Yogyakarta	50.67	41.12	47.07	36.58	35.91	37.12	26.55						109.93	110.69	110.29	107.98	101.83	104.66	106.36	103.06	104.77
East Java	37.87	33.63	35.20	33.80	36.81	30.60	22.91						108.32	107.03	107.69	109.29	108.51	108.90	107.15	107.30	107.22
Banten	18.65	12.39	10.09	12.59	15.19	13.19	8.86									99.83	104.54	101.99	103.27	105.26	104.21
Bali	17.15	19.47	19.95	19.00	18.13	15.54	10.67						108.55	109.50	108.99	107.42	104.44	105.96	106.48	103.31	104.97
West Nusa Tenggara	9.80	10.89	9.94	15.50	15.98	17.42	11.43						102.10	102.32	102.20	103.99	104.20	104.09	102.20	104.72	103.44
East Nusa Tenggara	8.70	10.40	7.55	10.21	9.12	8.61	6.60						110.88	110.50	110.69	105.90	108.01	106.91	106.45	107.02	106.71
West Kalimantan	11.67	13.05	8.26	10.88	6.83	7.62	4.56						107.73	111.54	109.64	112.11	111.75	111.94	110.53	107.18	108.92
Central Kalimantan	17.77	9.28	7.98	10.01	10.84	11.11	8.56						111.17	113.65	112.30	115.33	113.52	114.50	110.39	112.54	111.42
South Kalimantan	20.30	21.47	19.38	17.81	21.42	19.52	14.51						108.43	107.73	108.08	107.82	107.52	107.67	103.58	104.55	104.05
East Kalimantan	23.07	19.70	11.89	17.74	19.12	15.74	12.19						108.50	114.51	111.27	110.94	108.71	109.91	108.29	107.90	108.10
North Sulawesi	17.36	17.58	12.74	20.67	17.13	13.78	9.04						109.05	107.66	108.37	109.87	108.32	109.11	101.64	105.85	103.50
Central Sulawesi	15.02	9.31	9.31	13.36	15.77	13.46	8.79						106.80	110.96	108.81	105.92	109.90	107.83	104.88	106.94	105.85
South Sulawesi	12.26	10.83	11.09	12.12	15.53	14.03	10.20						102.65	103.90	103.24	100.05	103.04	101.47	100.60	100.40	100.50
Southeast Sulawesi	17.78	12.67	8.86	9.84	16.78	12.35	8.63						103.90	103.00	103.47	105.86	105.52	105.69	104.20	102.83	103.54
Gorontalo	18.06	17.40	15.57	13.20	15.38	18.96	14.85									98.02	101.32	99.56	88.13	98.17	92.64
West Sulawesi						14.83	9.79														
Maluku	14.06		6.75	5.01	6.11	5.60	4.73						104.30	101.41	102.94	99.52	108.64	103.53			
North Maluku	3.13		4.30	6.08	7.76	4.89	6.66									109.61	99.70	104.80			
West Papua						6.09	4.41														
Papua	14.99		5.59	14.63	11.45	10.22	4.97									99.64	96.85	98.32			

TABLE 7. EDUCATION INDICATORS

Area	Gross primary school enrolment ratio (Susenas)																		Net primary school enrolment ratio (Susenas)				
Year	2003			2004			2005			2006			2007			2008			2000				
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	106.04	105.59	105.82	107.53	106.71	107.13	107.21	106.03	106.63	110.32	109.56	109.96	110.28	110.44	110.35	109.42	109.41	109.37	93.30	92.40	92.13	92.45	92.28
Aceh	107.44	107.88	107.64	109.11	108.51	108.84				113.46	113.35	113.40	114.56	114.14	114.36	113.63	114.60	114.38					
North Sumatera	108.24	106.94	107.62	106.69	106.55	106.62	107.47	106.05	106.79	112.54	110.56	111.57	111.74	110.22	111.01	112.03	111.98	112.26			94.47	93.97	94.23
West Sumatera	105.79	104.63	105.23	106.38	106.97	106.66	105.89	105.27	105.60	108.57	109.18	108.85	112.18	108.58	110.42	109.65	109.15	109.86			92.86	92.44	92.66
Riau	108.14	106.19	107.19	109.43	107.52	108.52	106.60	107.69	107.11	109.97	110.03	110.00	111.04	110.90	110.97	111.78	110.45	112.34			94.11	93.77	93.95
Jambi	108.30	108.52	108.41	108.46	110.19	109.29	109.04	107.62	108.36	114.56	112.03	113.35	112.32	111.65	112.01	111.09	109.69	110.51			92.52	93.05	92.77
South Sumatera	105.48	108.14	106.77	108.86	106.57	107.75	112.17	107.70	109.92	113.71	112.10	112.92	112.59	111.90	112.26	111.71	111.43	111.88			92.48	92.07	92.28
Bengkulu	103.34	104.70	103.98	112.04	109.38	110.73	106.31	104.87	105.63	110.73	110.06	110.40	107.82	110.72	109.23	107.69	112.59	110.43			91.82	91.20	91.51
Lampung	108.33	106.14	107.26	109.50	109.16	109.33	110.78	106.76	108.78	111.73	111.36	111.55	108.18	110.87	109.48	106.66	110.77	106.66			93.56	92.80	93.20
Bangka Belitung	114.67	114.07	114.38	110.86	109.02	109.94	110.24	106.88	108.59	112.13	117.90	114.87	111.34	115.10	113.10	111.72	113.19	111.67					
Riau Islands							107.55	108.57	108.03	109.92	112.90	111.33	115.21	115.15	115.18	113.45	113.12	115.15					
Jakarta	106.96	106.20	106.57	108.50	107.51	108.02	105.44	105.37	105.40	110.46	108.72	109.63	110.83	112.02	111.42	110.24	109.45	109.80			91.28	91.62	91.45
West Java	103.00	102.70	102.85	105.29	104.02	104.67	103.03	102.40	102.72	106.63	108.48	107.52	106.19	108.42	107.26	105.69	106.17	105.97			92.35	92.97	92.65
Central Java	108.21	107.18	107.70	108.49	107.76	108.14	109.18	106.63	107.92	113.16	108.78	111.00	112.13	112.47	112.29	109.56	109.53	109.76			93.98	93.74	93.86
Yogyakarta	102.96	102.71	102.83	109.18	105.52	107.36	106.61	106.59	106.60	106.24	109.99	107.97	113.41	105.48	109.36	113.56	110.55	112.78			93.49	95.25	94.33
East Java	107.25	106.18	106.74	108.09	107.48	107.79	109.45	107.86	108.68	110.71	107.76	109.26	110.24	109.75	110.00	108.95	109.85	109.70			92.24	92.43	92.33
Banten	105.02	104.99	105.01	106.33	106.22	106.28	106.48	107.70	107.06	107.24	109.39	108.28	107.63	109.10	108.34	107.49	106.76	107.28					
Bali	105.92	106.65	106.26	108.95	109.72	109.31	104.45	104.67	104.56	111.47	109.35	110.45	112.22	110.23	111.26	111.50	109.19	110.29			93.68	93.01	93.36
West Nusa Tenggara	104.82	101.23	103.03	103.50	101.86	102.69	102.12	103.94	103.00	105.75	108.74	107.19	109.77	106.67	108.20	109.66	106.71	105.75			88.19	91.65	89.86
East Nusa Tenggara	106.20	106.36	106.28	112.79	110.45	111.64	113.28	109.29	111.35	114.39	113.82	114.12	111.04	110.17	110.63	109.35	107.23	108.42			87.96	90.00	88.94
West Kalimantan	110.13	109.89	110.02	115.24	111.70	113.52	111.04	112.44	111.71	114.31	114.82	114.56	118.43	116.74	117.63	115.55	115.52	115.71			90.02	89.04	89.53
Central Kalimantan	107.82	111.73	109.58	111.90	110.39	111.20	111.56	107.92	109.81	112.94	113.30	113.11	116.33	119.41	117.82	115.82	117.47	115.98			93.77	94.83	94.25
South Kalimantan	106.90	105.43	106.21	107.66	106.46	107.07	109.54	111.86	110.66	112.11	112.32	112.21	116.63	114.18	115.46	116.62	111.61	111.34			92.15	92.77	92.45
East Kalimantan	109.45	105.05	107.29	109.10	109.49	109.29	108.22	104.89	106.62	112.06	110.77	111.45	110.96	111.94	111.43	110.90	111.13	110.95			90.83	92.15	91.43
North Sulawesi	105.98	105.57	105.80	105.23	106.58	105.87	108.23	105.44	106.93	112.30	113.12	112.70	114.85	111.32	113.11	114.80	111.39	111.69			90.04	90.79	90.41
Central Sulawesi	106.99	105.72	106.39	107.86	107.19	107.54	106.34	105.65	106.01	112.77	114.24	113.45	108.43	109.48	108.93	109.01	109.37	109.34			90.60	91.59	91.08
South Sulawesi	100.00	103.48	101.67	102.53	104.08	103.28	104.29	104.57	104.42	108.15	107.23	107.70	108.51	108.61	108.56	109.56	108.37	109.25			88.13	89.08	88.58
Southeast Sulawesi	106.54	103.70	105.17	105.31	106.56	105.90	108.62	106.77	107.73	109.95	108.50	109.25	110.23	109.04	109.66	112.02	111.13	113.34			88.57	90.43	89.46
Gorontalo	96.16	99.15	97.59	102.77	102.06	102.41	102.39	105.07	103.69	111.52	110.88	111.20	105.48	115.69	110.35	107.05	115.68	108.89					
West Sulawesi										105.92	106.23	106.06	107.90	112.07	109.93	105.18	111.77	106.83					
Maluku	107.01	108.99	107.93	111.17	109.16	110.22	108.17	109.44	108.75	109.89	114.72	112.24	113.29	117.55	115.34	111.29	117.02	112.96					
North Maluku	108.31	117.75	112.48	111.16	109.83	110.49	110.37	113.13	111.64	114.46	118.00	116.06	113.86	111.13	112.55	113.84	111.73	110.78					
West Papua										116.89	111.66	114.44	120.44	118.74	119.62	119.36	117.45	111.41					
Papua	99.78	100.00	99.88	105.48	103.63	104.64	100.56	98.24	99.51	99.67	97.79	98.83	103.00	98.80	101.01	102.98	97.36	99.42					81.85

TABLE 7. EDUCATION INDICATORS

Area	Net primary school enrolment ratio (Susenas)																														
Year	2001					2002					2003					2004					2005				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	93.10	92.70	92.75	93.02	92.88	92.56	92.80	92.65	92.76	92.70	92.17	92.79	92.49	92.61	92.55	92.73	93.25	93.11	92.97	93.04	92.76	93.58	93.31	93.18	93.25
Aceh											93.50	95.93	94.89	95.91	95.36			96.11	95.62	95.88					
North Sumatera			94.86	94.89	94.87			93.99	93.59	93.80	93.43	95.32	94.65	94.58	94.62			93.96	93.23	93.61			94.11	93.83	93.98
West Sumatera			93.56	94.08	93.81			92.38	92.22	92.30	90.77	93.27	92.22	92.98	92.59			93.68	93.60	93.64			94.04	93.22	93.65
Riau			94.10	94.80	94.44			94.16	94.29	94.23	93.47	94.54	93.61	94.69	94.13			95.13	94.11	94.64			94.91	94.99	94.95
Jambi			92.88	94.26	93.53			93.70	92.43	93.10	92.30	94.23	93.82	93.73	93.78			93.22	93.73	93.46			93.82	93.20	93.52
South Sumatera			91.89	92.60	92.23			91.84	91.19	91.52	89.05	93.83	92.22	92.51	92.36			93.32	92.93	93.13			94.77	93.52	94.14
Bengkulu			94.06	93.67	93.87			92.44	92.54	92.49	89.88	92.64	90.98	93.10	91.99			94.34	95.11	94.72			93.35	91.85	92.64
Lampung			94.16	93.93	94.05			92.91	93.26	93.08	91.15	92.27	92.72	91.37	92.06			92.36	93.10	92.73			94.14	92.92	93.54
Bangka Belitung			91.22	90.58	90.92			92.49	94.39	93.42	89.63	92.97	91.34	92.08	91.69			88.66	91.40	90.02			92.81	91.16	92.00
Riau Islands																							91.36	91.98	91.65
Jakarta			93.72	90.66	92.21			89.96	91.62	90.73	91.61		92.13	91.12	91.61			92.42	91.28	91.87			91.73	93.06	92.40
West Java			93.20	93.69	93.44			93.59	94.07	93.82	92.04	92.84	92.22	92.69	92.45			93.68	93.13	93.41			92.05	91.67	91.86
Central Java			94.55	94.39	94.47			94.46	93.70	94.10	93.66	93.72	93.79	93.60	93.70			93.55	93.08	93.32			94.48	94.47	94.47
Yogyakarta			96.12	94.94	95.48			93.41	93.03	93.23	90.63	93.68	92.46	91.50	91.98			91.71	93.38	92.55			95.21	95.73	95.46
East Java			94.37	93.77	94.07			93.15	93.24	93.20	93.12	93.71	93.50	93.47	93.48			93.69	93.72	93.71			95.28	94.51	94.91
Banten			90.00	91.08	90.50			92.49	93.74	93.08	93.24	94.23	93.61	93.95	93.77			93.86	94.39	94.12			92.27	94.32	93.24
Bali			93.36	92.10	92.74			93.28	90.98	92.19	91.26	91.85	91.81	91.33	91.58			93.89	93.02	93.48			92.77	93.79	93.26
West Nusa Tenggara			92.63	92.62	92.63			92.70	93.77	93.23	93.46	91.99	93.24	91.72	92.48			93.12	91.69	92.42			92.81	93.18	92.99
East Nusa Tenggara			87.00	88.92	87.92			86.59	87.59	87.07	90.01	87.97	87.89	88.70	88.27			90.50	91.09	90.79			91.99	92.00	92.00
West Kalimantan			90.03	92.36	91.14			89.95	88.94	89.46	88.10	89.13	89.24	88.49	88.89			93.37	92.84	93.11			92.25	92.75	92.49
Central Kalimantan			95.23	95.52	95.36			94.23	93.78	94.01	92.71	95.44	94.05	95.59	94.75			95.61	94.50	95.10			95.43	94.83	95.14
South Kalimantan			93.02	92.71	92.87			90.92	92.53	91.70	90.14	93.65	93.11	91.73	92.46			92.89	93.50	93.19			95.38	95.09	95.24
East Kalimantan			91.83	91.60	91.72			92.21	91.57	91.91	90.79	91.92	92.70	89.91	91.33			92.93	92.80	92.87			93.39	91.80	92.62
North Sulawesi			93.40	92.96	93.19			87.67	87.74	87.70	90.42	88.50	89.95	88.26	89.18			88.21	88.33	88.26			90.26	91.07	90.64
Central Sulawesi			90.32	91.57	90.92			89.81	90.49	90.13	84.34	92.40	91.22	90.43	90.85			92.00	90.82	91.44			92.32	91.86	92.10
South Sulawesi			87.45	90.19	88.76			88.84	89.11	88.97	88.71	89.39	87.97	90.55	89.21			89.48	91.87	90.64			91.62	92.50	92.04
Southeast Sulawesi			90.28	90.92	90.59			90.60	88.77	89.73	88.15	91.90	91.55	90.80	91.19			89.97	90.41	90.18			92.97	92.30	92.64
Gorontalo			86.06	86.85	86.43			78.15	83.84	80.71	90.23	86.52	86.37	88.39	87.33			86.86	90.82	88.85			86.95	89.57	88.22
West Sulawesi																									
Maluku			82.18	90.95	86.04						91.39	90.92	90.23	91.95	91.03			91.08	90.74	90.92			91.90	91.00	91.49
North Maluku			94.27	90.30	92.34						87.39	95.91	93.23	95.12	94.06			93.08	94.50	93.80			93.90	92.90	93.44
West Papua																									
Papua			79.37	79.00	79.20						92.38	81.83	83.58	84.20	83.86			85.68	84.65	85.21			80.99	81.11	81.05

TABLE 7. EDUCATION INDICATORS

Area	Net primary school enrolment ratio (Susenas)																Primary school completion rate (Ministry of National Education)				
Year	2006					2007					2008						1998-1999	1999-2000	2000-2001	2001-2002	2003-2004
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total		Total	Total	Total	Total	Total
Indonesia	93.07	93.66	93.80	93.26	93.54	93.59	93.89	93.88	93.62	93.75	93.33	94.51	94.06	93.91	93.99		96.48	96.75	97.81	97.41	95.05
Aceh			95.69	95.25	95.48			95.59	95.88	95.73			95.78	96.33	96.05		94.19	90.98	93.18	92.35	89.72
North Sumatera			94.64	93.23	93.96			94.19	93.62	93.91			94.57	93.94	94.26		96.37	96.82	99.22	98.42	96.16
West Sumatera			94.53	93.76	94.17			94.64	94.26	94.45			94.67	94.58	94.63		96.42	96.55	99.31	98.37	87.55
Riau			94.52	94.94	94.72			95.36	94.16	94.80			95.50	94.52	95.04		94.68	97.14	96.50	98.26	98.52
Jambi			94.89	93.79	94.36			94.17	93.55	93.88			94.58	94.02	94.31		94.39	95.45	95.07	94.78	93.52
South Sumatera			93.22	92.80	93.01			92.66	92.72	92.69			93.02	92.92	92.97		95.82	95.93	99.27	98.62	84.13
Bengkulu			94.01	93.76	93.89			93.65	94.81	94.21			93.74	95.13	94.40		95.26	98.00	95.08	99.06	99.71
Lampung			94.47	93.42	93.94			93.81	94.28	94.04			94.20	94.36	94.28		99.28	99.30	98.39	98.88	98.39
Bangka Belitung			91.94	91.03	91.51			91.31	91.92	91.59			91.39	92.13	91.77					97.93	97.51
Riau Islands			93.75	93.56	93.66			94.32	92.58	93.50			94.46	93.05	93.79						
Jakarta			92.33	89.06	90.78			94.08	92.45	93.27			94.64	92.98	93.81		99.43	98.74	99.03	98.22	99.53
West Java			93.85	94.60	94.21			94.02	94.31	94.16			94.03	94.36	94.19		97.17	98.34	99.12	96.35	92.30
Central Java			94.91	93.16	94.05			95.06	94.46	94.78			95.37	94.89	95.14		98.59	98.07	98.29	98.48	98.60
Yogyakarta			95.31	93.31	94.38			93.88	93.21	93.53			94.88	93.77	94.32		99.13	101.63	97.00	96.02	98.77
East Java			94.67	93.70	94.20			94.79	94.11	94.45			94.80	94.32	94.57		98.06	97.74	99.02	98.24	99.62
Banten			95.08	94.56	94.83			92.19	93.82	92.97			92.43	94.41	93.39					96.45	96.41
Bali			93.80	92.83	93.33			95.10	93.71	94.43			95.45	94.39	94.93		99.50	101.27	97.08	98.60	98.56
West Nusa Tenggara			93.91	95.13	94.50			94.27	93.92	94.09			94.34	94.06	94.20		94.21	98.08	96.23	98.48	95.19
East Nusa Tenggara			91.74	91.39	91.58			91.80	91.35	91.59			91.82	91.61	91.72		90.33	90.57	95.89	92.10	94.42
West Kalimantan			93.53	94.12	93.82			93.55	93.41	93.48			93.65	94.27	93.95		96.27	97.46	97.97	97.55	90.30
Central Kalimantan			96.03	95.90	95.97			95.07	95.79	95.42			95.40	96.03	95.71		90.96	98.33	98.10	98.00	83.23
South Kalimantan			93.18	93.39	93.28			94.24	93.74	94.00			94.42	93.92	94.17		94.77	95.04	95.97	95.58	93.34
East Kalimantan			93.59	92.05	92.86			93.64	92.79	93.23			94.04	93.06	93.59		99.09	99.14	98.52	98.12	85.96
North Sulawesi			90.64	90.15	90.40			91.47	90.01	90.75			91.79	90.42	91.16		87.30	87.76	95.85	99.08	99.33
Central Sulawesi			92.68	93.10	92.87			92.54	91.50	92.04			93.40	92.20	92.82		91.65	91.70	96.89	93.67	88.73
South Sulawesi			90.92	91.24	91.08			92.27	91.83	92.06			92.35	91.95	92.15		91.92	96.64	94.77	98.07	91.92
Southeast Sulawesi			92.72	91.77	92.26			93.57	93.70	93.64			94.00	94.48	94.24		94.85	99.31	95.33	99.05	95.90
Gorontalo			89.87	91.11	90.48			89.17	91.29	90.18			89.35	91.52	90.40					99.00	93.00
West Sulawesi			91.39	91.98	91.67			91.04	93.37	92.17			91.42	94.17	92.75						
Maluku			92.10	92.38	92.24			93.15	93.77	93.45			93.50	94.28	93.87		81.35	81.38	82.66	91.12	92.06
North Maluku			94.17	91.80	93.10			92.27	91.60	91.95			92.63	92.29	92.47					94.36	95.46
West Papua			88.46	87.83	88.16			92.22	88.98	90.67			92.39	89.17	90.76						
Papua			78.69	77.41	78.11			82.02	79.70	80.92			82.78	80.60	81.76		91.27	95.43	90.25	97.22	96.34

TABLE 7. EDUCATION INDICATORS

Area	Primary school completion rate (Ministry of National Education)					Primary school drop out rate (Ministry of National Education)								Primary school repetition rate (Ministry of National Education)							
Year	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	1997-1998	1998-1999	1999-2000	2000-2001	2003-2004	2004-2005	2005-2006	2006-2007	1998-1999	1999-2000	2000-2001	2001-2002	2004-2005	2005-2006	2006-2007	2007-2008
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	97.41	95.05	96.81	96.86	97.02	2.90	2.40	2.62	2.66	2.97	3.17	2.41	1.81	5.99	5.90	5.90	5.40	5.40	3.95	3.81	2.98
Aceh	96.12	98.50	96.60	96.46	96.68	4.10	6.33	6.23	4.21	6.22	5.59	4.01	2.88	8.00	6.48	6.55	6.28	3.37	2.34	3.79	3.69
North Sumatera	96.48	96.72	97.47	95.99	96.54	3.37	2.98	2.98	1.37	3.76	3.33	1.80	1.27	5.11	5.05	5.11	4.95	3.61	3.56	3.67	1.30
West Sumatera	99.00	99.70	94.31	94.73	95.67	4.23	4.93	4.69	3.64	2.57	7.58	4.65	2.59	8.84	8.68	8.95	7.92	8.34	7.81	8.87	6.83
Riau	99.38	98.83	95.20	96.36	96.75	3.03	1.52	1.81	3.56	3.84	2.10	2.42	2.65	7.47	7.12	6.71	6.12	3.95	4.71	5.14	3.92
Jambi	92.45	98.66	93.06	93.65	93.85	3.86	3.39	4.06	2.57	3.84	2.15	3.99	1.41	7.42	7.42	7.08	6.62	6.34	5.01	5.70	3.03
South Sumatera	80.19	95.52	95.77	95.08	95.14	4.54	4.22	4.20	2.81	2.50	5.41	3.00	2.00	7.29	7.33	7.37	6.08	6.57	5.86	4.36	3.46
Bengkulu	85.27	92.15	92.50	92.69	92.98	4.93	3.96	3.64	2.90	2.28	1.92	5.86	2.75	7.71	8.18	7.72	6.35	5.45	4.42	6.20	5.39
Lampung	90.73	93.44	97.77	97.09	97.55	2.98	3.90	4.96	4.65	2.88	1.56	2.29	2.06	5.61	4.93	5.04	4.79	5.53	3.01	1.64	1.44
Bangka Belitung	89.10	90.88	94.01	95.36	95.83				6.80	3.28	1.83	3.18	2.35				5.97	8.17	8.49	9.58	7.03
Riau Islands		94.18	95.40	95.40	96.54						2.81	2.65	1.41						3.00	5.00	2.37
Jakarta	95.31	97.80	99.12	99.08	99.15	3.35	2.80	2.75	1.57	2.79	5.59	1.78	2.43	2.56	2.71	2.81	2.51	2.03	2.04	1.83	1.72
West Java	97.77	99.45	98.41	98.17	98.15	2.59	0.53	0.58	2.17	3.58	2.55	2.52	1.26	2.71	2.75	2.67	1.93	1.84	1.84	1.34	1.27
Central Java	99.72	97.65	97.29	97.84	98.06	1.52	1.50	1.81	1.38	1.59	2.49	1.35	1.06	6.16	6.56	6.77	6.77	5.63	5.17	4.98	4.36
Yogyakarta	96.58	98.64	97.44	97.47	97.47	0.47	-1.87	3.08	2.22	2.46	1.13	1.21	1.00	4.57	4.79	2.79	2.29	4.50	3.86	3.28	3.61
East Java	98.44	98.39	96.04	96.99	96.91	1.50	2.00	1.81	1.34	2.20	2.84	1.43	1.73	5.17	4.89	5.11	4.95	4.04	3.81	3.62	2.84
Banten	96.21	97.88	97.60	96.92	97.28				0.91	2.09	1.47	1.84	1.35				2.85	3.12	2.74	2.99	1.97
Bali	99.15	97.81	97.32	97.58	98.06	1.62	1.27	1.76	2.14	1.66	1.51	2.20	2.37	3.41	3.42	3.39	3.42	3.64	3.13	3.45	2.25
West Nusa Tenggara	86.53	90.47	95.70	95.74	96.11	3.19	1.97	2.14	3.21	2.87	0.62	2.61	2.68	7.22	6.96	6.91	6.80	5.64	4.89	4.17	4.09
East Nusa Tenggara	93.10	97.87	92.47	94.25	94.23	5.97	5.72	5.59	5.42	4.45	1.50	2.01	3.53	13.27	13.24	13.31	10.38	13.70	4.85	6.09	4.93
West Kalimantan	89.78	96.87	96.35	96.21	95.91	4.27	4.78	4.86	6.78	3.14	4.76	3.10	2.90	11.34	11.15	11.02	10.57	9.77	7.31	8.16	5.30
Central Kalimantan	91.09	90.36	96.43	96.42	96.83	5.03	5.07	6.13	3.11	3.42	4.61	2.63	1.85	9.26	8.45	8.21	8.25	5.47	4.82	4.82	3.84
South Kalimantan	92.22	96.72	94.01	94.37	94.38	4.67	3.68	2.92	3.32	3.08	2.87	4.00	2.63	10.16	9.87	9.77	10.13	8.81	5.69	5.80	4.87
East Kalimantan	92.55	95.03	97.52	97.56	98.04	1.13	1.24	1.76	2.73	3.37	3.37	4.85	3.21	7.00	6.14	6.00	5.62	5.45	3.14	2.82	2.74
North Sulawesi	86.71	97.21	96.10	97.06	96.67	3.44	8.33	8.53	3.79	2.61	0.91	3.43	2.09	7.83	7.60	7.30	7.96	4.26	4.54	3.58	3.43
Central Sulawesi	97.40	94.69	95.49	95.63	95.95	3.86	4.46	3.76	5.00	4.24	10.04	2.76	2.22	11.32	9.00	9.07	8.52	4.38	4.90	4.07	3.66
South Sulawesi	95.69	98.60	96.16	95.46	95.64	3.62	1.62	2.03	4.46	4.17	1.54	3.83	1.61	7.91	7.75	6.80	6.61	4.03	4.32	4.43	2.84
Southeast Sulawesi	98.09	96.92	98.17	98.07	98.45	2.91	1.46	5.88	3.28	1.29	8.18	1.57	1.35	8.04	7.31	7.51	7.36	1.25	2.01	3.03	2.21
Gorontalo	88.62	88.53	95.41	95.45	95.45				3.09	1.15	3.67	3.34	2.42				5.63	9.05	14.46	4.36	4.63
West Sulawesi		96.58	95.66	96.50	96.76						6.51	3.36	2.60						5.00	7.00	4.71
Maluku	96.87	96.23	98.91	97.53	97.38	4.00	4.26	5.78	6.20	3.76	7.12	1.45	1.30	8.81	9.99	11.29	10.73	1.03	3.45	4.38	2.57
North Maluku	91.26	97.77	96.17	96.53	96.71				5.74	3.15	8.27	4.86	2.66				4.54	2.13	1.73	3.47	2.35
West Papua		97.41	94.77	95.31	95.45						5.39	5.28	3.69						7.00	4.12	4.24
Papua	85.78	96.12	96.07	95.28	96.08	8.62	3.68	3.97	8.23	7.18	7.23	4.04	3.35	11.65	14.26	13.48	10.04	5.79	6.01	5.20	4.59

TABLE 7. EDUCATION INDICATORS

Area	Primary school student per class ratio (Ministry of National Education)											Primary school student - teacher ratio (Ministry of National Education)									
Year	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	1997-1998	1998-1999	1999-2000	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	25	25	25	26	26	26	26	26	26	30	27	22	22	22	23	22	21	19	19	19	18
Aceh	27	27	27	27	27	27	28	24	24	26	22	23	23	23	23	23	19	17	18	15	14
North Sumatera	27	27	27	27	27	27	27	26	24	28	28	23	24	24	24	22	21	20	20	20	19
West Sumatera	24	24	24	22	22	23	23	22	20	32	24	21	21	21	20	21	19	17	17	16	16
Riau	27	26	26	26	26	27	26	25	26	29	29	24	24	24	25	23	20	19	19	20	18
Jambi	24	24	22	23	26	23	23	24	23	27	26	20	20	20	20	20	18	18	19	18	19
South Sumatera	26	27	27	26	26	26	27	27	24	30	25	24	23	23	22	21	21	21	18	18	19
Bengkulu	25	25	24	23	23	26	26	25	28	30	28	20	19	19	20	21	18	17	19	19	18
Lampung	29	30	30	30	30	30	31	29	29	30	29	25	23	23	23	22	23	22	23	23	21
Bangka Belitung						23	24	25	26	26	24					20	19	17	17	16	15
Riau Islands								27	29	28	23							19	17	17	17
Jakarta	31	32	32	32	32	33	33	31	32	33	35	24	23	23	24	24	24	22	29	21	23
West Java	28	28	28	30	30	30	29	29	30	33	35	29	30	30	33	29	26	25	25	24	24
Central Java	27	27	27	27	27	27	27	27	27	28	28	22	22	22	22	22	22	19	18	18	18
Yogyakarta	20	20	21	21	21	21	22	22	22	23	22	15	16	16	16	16	15	14	13	13	12
East Java	23	23	22	23	23	24	22	24	24	26	26	19	19	19	19	20	19	17	17	16	16
Banten			21			32	31	31	32	31	31					33	31	26	26	25	27
Bali	21	20	31	20	20	21	23	24	24	30	26	15	15	15	16	17	15	16	16	16	16
West Nusa Tenggara	30	30	25	31	31	29	29	30	29	32	30	25	26	26	26	26	23	23	23	21	19
East Nusa Tenggara	25	24		24	24	25	25	25	25	29	26	23	23	23	22	20	20	19	19	20	18
West Kalimantan	24	24	24	24	25	26	25	23	23	31	21	21	22	22	23	23	22	18	20	20	20
Central Kalimantan	18	18	18	17	17	19	20	20	20	33	21	15	15	15	13	15	15	14	16	15	14
South Kalimantan	20	20	20	21	21	21	21	21	21	30	20	16	17	17	18	17	15	14	14	14	14
East Kalimantan	23	22	23	24	25	25	26	24	24	32	26	20	20	20	21	20	20	16	16	17	17
North Sulawesi	19	17	19	18	18	17	17	16	17	30	21	15	15	15	15	12	12	12	16	15	14
Central Sulawesi	21	21	21	21	21	23	22	18	16	31	21	19	19	19	19	21	18	17	10	15	14
South Sulawesi	21	21	22	22	22	24	25	24	24	30	25	19	20	20	22	21	20	20	19	18	17
Southeast Sulawesi	24	23	24	23	23	24	25	25	25	31	26	21	22	22	22	23	20	26	17	18	16
Gorontalo						27	25	22	26	30	25					21	19	18	24	21	19
West Sulawesi								25	23	32	26							19	20	19	17
Maluku	20	21	21	21	21	18	18	18	17	32	22	21	21	21	16	22	18	18	18	19	14
North Maluku					22	21	21	24	27	34	23				32	23	19	19	18	20	21
West Papua								23	23	33	29							22	20	21	20
Papua	21	21	20	21	21	22	23	23	19	31	26	20	20	20	21	20	22	19	18	19	22

TABLE 7. EDUCATION INDICATORS

Area	Transition rate to junior secondary school (Ministry of National Education)										Percentage of qualified primary school teachers (World Bank)				Gross junior secondary school enrolment ratio (Susenas)					
Year	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2001-2002	2002-2003	2003-2004	2004-2005	2000			2001		
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Male	Female	Total	Male	Female	Total
Indonesia	70.47	71.83	72.12	70.44	69.15	70.02	71.40	79.73	81.97	75.58	7.92	8.35	9.01	15.24	77.24	78.02	77.62	77.58	86.06	82.85
Aceh	81.28	79.92	72.39	75.28	75.63	72.20	92.72	99.44	111.20	84.45									84.35	84.81
North Sumatera	75.26	78.08	74.79	76.44	77.03	74.30	74.60	89.66	88.59	85.06					82.78	85.02	83.83	88.43	80.88	78.95
West Sumatera	72.23	73.65	71.58	69.39	76.10	75.39	67.50	77.61	89.98	79.66					81.02	87.11	84.08	79.77	79.06	77.55
Riau	62.94	65.90	61.89	61.40	66.57	61.95	65.13	77.27	78.15	70.71					80.35	85.94	83.04	85.23	79.92	77.78
Jambi	62.67	66.09	67.91	64.11	68.01	67.70	65.92	71.27	74.14	73.73					80.23	77.08	78.58	77.44	82.97	80.44
South Sumatera	73.78	70.14	67.95	66.73	70.58	75.38	75.41	82.35	88.46	81.31					76.70	75.44	76.06	76.09	59.23	57.31
Bengkulu	82.77	84.84	80.25	71.54	71.06	56.90	81.85	98.37	93.79	100.11					74.78	77.15	75.93	75.74		
Lampung	71.17	67.39	69.79	68.62	74.46	65.89	67.30	70.61	64.01	61.14					73.67	82.11	77.54	78.05	97.08	99.71
Bangka Belitung				72.41	73.49	86.80	75.16	91.01	96.25	84.37								55.47	69.43	70.40
Riau Islands								99.71	83.71	107.28									82.96	82.81
Jakarta	103.66	102.11	103.65	106.63	95.99	104.58	100.08	102.15	102.37	96.00					102.93	93.11	97.78	102.38	96.13	94.83
West Java	57.15	61.17	62.53	61.31	58.61	59.89	61.37	69.50	68.32	62.82					71.83	72.36	72.08	71.40	83.34	81.92
Central Java	69.33	71.73	68.62	72.28	69.97	70.84	72.42	77.38	82.05	73.90					79.70	81.30	80.49	82.67	69.92	71.59
Yogyakarta	101.45	106.12	112.67	95.97	95.57	92.88	99.89	102.96	107.75	98.01					90.30	93.25	91.73	93.71	80.28	85.81
East Java	73.45	77.14	80.17	75.07	71.59	73.87	75.77	77.31	84.79	74.23					83.58	83.21	83.40	80.61	72.71	69.07
Banten				52.17	54.67	50.15	53.28	72.28	67.76	62.97						78.18		73.44	60.10	56.00
Bali	85.92	83.99	84.85	89.18	76.81	90.28	92.34	98.75	109.58	99.43					91.58	69.39	85.51	90.82	64.20	65.16
West Nusa Tenggara	55.36	54.16	59.84	59.51	53.90	59.94	60.73	70.98	72.51	63.14					77.81	54.63	73.51	65.52	71.70	70.25
East Nusa Tenggara	64.20	75.03	66.71	76.17	68.74	64.60	81.29	99.35	97.78	89.61					48.55	64.16	51.48	52.12	71.59	70.15
West Kalimantan	67.82	63.53	67.24	63.80	73.63	72.50	68.44	85.52	81.21	81.46					68.10	79.23	66.13	66.01	88.69	85.67
Central Kalimantan	67.49	63.36	69.01	63.86	48.40	63.44	60.10	65.30	72.90	58.04					78.48	67.16	78.82	69.12	93.11	89.09
South Kalimantan	59.52	59.82	57.80	53.76	52.86	56.45	57.59	68.24	74.68	73.96					63.61	78.30	65.30	68.68	67.41	69.09
East Kalimantan	77.15	74.49	83.43	74.28	71.87	78.24	85.68	96.88	96.07	93.06					85.42	80.36	81.93	82.95	68.92	66.82
North Sulawesi	86.81	85.37	90.10	93.06	95.36	104.43	107.45	96.65	106.32	104.66					78.88	60.78	79.60	84.73	80.05	76.73
Central Sulawesi	57.53	62.26	63.03	64.00	69.18	59.57	59.91	78.60	79.49	77.68					66.38	69.07	63.60	70.89	59.23	52.98
South Sulawesi	76.09	67.04	71.89	71.16	79.82	71.07	68.78	77.81	80.10	80.57					66.12	81.59	67.54	64.82		
Southeast Sulawesi	73.87	73.79	82.29	76.64	79.34	87.86	66.44	81.31	83.49	75.14					76.12		78.73	73.50	88.22	83.82
Gorontalo				63.00	60.39	49.59	57.42	95.63	86.07	84.90								46.71	66.89	68.93
West Sulawesi								89.37	87.40	79.86										
Maluku	77.34	82.30	81.29	69.08	89.64	76.80	77.64	98.95	103.21	93.30					50.53	59.35	54.43	80.45	59.37	60.39
North Maluku				61.08	51.67	49.07	51.69	75.75	81.93	71.83								70.53		
West Papua								64.51	80.24	89.58										
Papua	89.80	82.88	93.20	87.68	93.58	94.19	98.39	92.81	105.06	114.11								61.22		

TABLE 7. EDUCATION INDICATORS

Area	Gross junior secondary school enrolment ratio (Susenas)																				
Year	2002			2003			2004			2005			2006			2007			2008		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	79.31	80.33	79.81	79.92	82.37	81.09	81.34	83.20	82.24	80.75	83.53	82.09	81.25	82.53	81.87	81.17	82.93	82.03	80.89	81.89	81.08
Aceh				94.21	94.10	94.16	96.81	94.89	95.87			92.00	97.03	95.93	96.50	90.01	92.40	91.12	90.00	87.88	87.41
North Sumatera	87.19	88.97	88.03	89.15	90.15	89.63	89.83	90.01	89.92	90.44	93.64	89.03	87.82	91.13	89.48	90.41	92.36	91.36	90.33	88.55	87.54
West Sumatera	85.01	93.84	89.54	85.82	90.09	87.86	85.75	91.83	88.80	85.41	92.66	91.39	79.34	87.83	83.53	77.60	87.19	82.27	76.83	83.57	78.88
Riau	85.02	81.67	83.40	82.37	87.85	84.93	85.89	89.24	87.54	90.32	92.56	86.01	92.29	87.43	89.88	88.30	87.07	87.70	88.22	84.93	83.57
Jambi	80.36	79.10	79.73	80.83	82.44	81.58	85.46	84.64	85.04	82.59	89.56	80.35	78.76	84.59	81.47	77.70	82.30	79.94	77.56	80.88	77.76
South Sumatera	72.25	72.27	72.26	76.09	76.07	76.08	81.82	86.26	83.95	79.35	81.43	83.52	80.55	88.37	84.24	80.55	85.63	83.05	80.53	84.94	82.60
Bengkulu	76.59	78.01	77.27	81.20	78.57	79.86	84.58	82.50	83.59	81.15	86.16	81.87	88.17	83.01	85.60	86.52	85.22	85.88	86.48	82.66	84.24
Lampung	79.88	84.20	82.03	78.38	88.18	83.03	82.27	85.67	83.82	77.45	86.79	80.87	77.18	84.88	80.83	79.82	86.47	82.99	79.79	85.09	82.21
Bangka Belitung	58.33	61.07	59.64	61.06	76.70	68.47	75.81	79.55	77.43	76.22	85.64	87.55	72.23	75.48	73.74	69.60	69.66	69.63	69.39	69.47	70.09
Riau Islands										91.02	83.37		90.71	93.02	91.79	89.57	88.33	88.93	87.33	88.29	85.54
Jakarta	104.39	96.76	100.55	94.76	101.88	98.14	99.03	94.65	96.88	99.88	90.76	95.35	94.02	91.33	92.66	90.10	87.73	88.89	89.09	87.45	89.35
West Java	75.87	76.09	75.97	76.39	77.47	76.91	73.85	76.64	75.19	74.69	76.35	75.50	77.60	72.43	75.13	80.23	80.34	80.29	80.21	80.05	80.60
Central Java	81.68	83.74	82.70	82.05	86.93	84.37	84.56	85.92	85.21	83.01	87.43	85.08	78.73	85.71	82.11	81.56	85.06	83.23	80.99	84.61	82.29
Yogyakarta	100.80	100.10	100.45	101.35	99.64	100.57	97.03	97.55	97.29	97.67	98.79	98.21	92.96	89.83	91.30	92.20	99.01	95.34	91.88	98.71	93.22
East Java	83.38	83.77	83.57	82.29	83.53	82.87	82.61	87.11	84.77	81.69	88.84	85.07	85.20	87.28	86.19	83.94	85.07	84.49	83.93	85.06	84.56
Banten	75.26	73.53	74.41	75.81	78.70	77.19	79.80	80.01	79.90	77.84	72.95	75.35	78.48	76.41	77.47	79.69	73.76	76.67	79.64	73.73	78.56
Bali	90.28	88.36	89.34	94.45	82.21	88.27	91.91	83.94	88.01	87.53	84.62	86.08	87.38	82.08	85.01	77.93	77.90	77.92	77.92	77.89	78.10
West Nusa Tenggara	74.33	69.03	71.55	73.20	65.65	69.54	70.86	76.16	73.51	78.58	83.00	80.85	86.13	80.79	83.58	82.95	84.33	83.60	82.94	82.36	82.32
East Nusa Tenggara	57.04	61.68	59.27	55.39	58.32	56.82	63.32	63.55	63.43	58.35	65.79	61.78	62.66	68.59	65.39	63.37	67.62	65.42	61.84	64.44	62.50
West Kalimantan	62.82	64.01	63.39	69.57	74.46	71.93	70.69	69.80	70.27	73.57	73.65	73.61	78.50	77.35	77.93	72.07	69.84	70.96	71.98	68.19	70.46
Central Kalimantan	66.85	70.27	68.46	72.85	81.16	76.91	86.40	81.00	83.78	88.50	90.32	89.36	79.40	81.68	80.46	74.34	76.26	75.31	74.23	74.95	74.45
South Kalimantan	75.15	75.32	75.23	71.21	78.44	74.76	78.61	79.93	79.30	74.47	71.64	73.08	78.99	76.92	78.02	74.26	76.28	75.27	74.16	76.27	75.49
East Kalimantan	85.65	89.16	87.43	85.72	93.71	89.61	90.04	90.96	90.49	92.10	90.92	91.50	83.22	83.61	83.41	91.36	91.17	91.27	91.30	89.82	87.53
North Sulawesi	87.34	87.84	87.59	91.54	96.07	93.75	92.08	89.32	90.79	88.29	84.08	86.16	78.51	88.99	83.71	78.65	88.87	83.45	78.51	88.08	83.98
Central Sulawesi	69.85	72.11	70.97	76.03	76.70	76.35	77.24	81.42	79.28	73.47	83.06	78.20	75.19	79.86	77.48	75.83	79.27	77.53	75.75	78.94	75.23
South Sulawesi	65.58	71.95	68.76	66.88	68.71	67.75	69.69	70.56	70.10	71.96	73.70	72.81	74.62	73.91	74.28	67.57	75.93	71.70	67.53	75.72	72.43
Southeast Sulawesi	74.37	83.47	78.92	76.83	87.99	81.77	80.60	86.40	83.40	84.01	87.96	85.92	89.13	93.94	91.40	78.54	86.74	82.53	78.45	86.06	77.16
Gorontalo	59.99	56.59	58.36	60.39	70.04	65.12	61.73	66.83	64.43	59.38	67.52	63.81	52.85	78.82	65.68	65.58	62.64	64.05	65.47	62.61	63.93
West Sulawesi													66.35	71.85	68.90	62.45	65.17	63.79	60.05	60.71	59.46
Maluku				85.13	84.30	84.72	86.54	92.89	89.62	97.76	94.39	96.04	99.06	94.77	96.96	89.18	85.95	87.56	88.91	83.16	82.80
North Maluku				84.71	74.85	79.72	77.24	78.07	77.65	80.84	78.99	79.95	86.21	82.09	84.28	87.16	85.37	86.30	85.05	82.13	83.56
West Papua													79.06	76.23	77.68	64.35	65.39	64.89	64.34	60.43	70.63
Papua				68.76	66.80	67.90	73.07	68.75	71.07	72.50	65.93	69.50	75.56	66.92	71.87	71.23	71.33	71.28	71.10	67.75	63.72

TABLE 7. EDUCATION INDICATORS

Area	Net Junior secondary school enrolment ratio (Susenas)																									
Year	2000					2001					2002					2003										
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total						
Indonesia	71.50	51.90	59.06	61.56	60.27	71.50	52.80	59.07	61.94	60.47	71.85	54.12	60.88	62.44	61.64	72.72	57.47	62.60	64.46	63.49						
Aceh																85.67	76.51	77.74	79.87	78.74						
North Sumatera			66.47	68.02	67.20			70.93	73.90	72.32			67.94	70.21	69.02	78.59	69.55	72.58	73.35	72.95						
West Sumatera			59.47	66.59	63.04			59.92	65.26	62.53			62.15	69.77	66.06	72.57	63.53	64.21	67.96	66.00						
Riau			61.03	64.54	62.72			64.99	65.06	65.02			63.67	64.07	63.86	79.10	59.98	64.97	69.73	67.19						
Jambi			56.04	56.92	56.50			59.68	61.38	60.43			61.88	60.18	61.03	70.89	58.13	60.88	61.79	61.30						
South Sumatera			58.34	60.85	59.62			55.74	60.93	58.28			53.81	53.33	53.57	69.50	54.43	59.51	59.30	59.41						
Bengkulu			55.89	58.87	57.34			56.76	63.24	59.93			58.72	59.57	59.13	74.34	55.55	58.14	62.65	60.44						
Lampung			57.04	61.89	59.26			59.09	62.14	60.57			60.74	64.93	62.83	71.51	61.25	60.43	66.36	63.24						
Bangka Belitung								37.95	52.17	44.90			42.33	48.24	45.15	64.37	40.80	44.05	57.89	50.61						
Riau Islands																										
Jakarta			79.34	74.90	77.01			73.66	69.66	71.65			79.46	75.54	77.49	77.58		77.54	77.62	77.58						
West Java			56.73	58.78	57.69			55.05	57.53	56.30			60.98	60.57	60.79	70.28	51.62	60.16	61.95	61.02						
Central Java			60.60	64.62	62.60			63.54	66.40	64.93			62.99	66.50	64.72	71.95	63.25	64.67	68.75	66.61						
Yogyakarta			72.31	78.74	75.43			75.73	76.97	76.30			75.53	77.71	76.62	77.97	80.22	80.44	77.40	79.06						
East Java			62.07	64.68	63.33			61.84	64.13	62.94			62.49	64.87	63.65	75.52	57.05	64.11	64.88	64.47						
Banten								54.17	57.45	55.90			61.20	60.30	60.76	73.13	52.78	61.33	63.33	62.28						
Bali			74.85	65.52	70.63			73.75	65.47	69.81			69.24	67.53	68.41	73.90	64.29	71.23	66.09	68.63						
West Nusa Tenggara			58.63	57.77	58.19			53.48	59.86	56.62			59.51	55.81	57.57	62.21	54.65	60.02	54.18	57.19						
East Nusa Tenggara			32.02	36.59	34.21			34.13	39.67	36.82			37.12	40.23	38.62	69.99	32.62	37.94	40.32	39.10						
West Kalimantan			49.09	44.95	47.02			44.62	45.92	45.23			43.33	46.79	44.99	61.50	47.50	50.00	51.82	50.88						
Central Kalimantan			59.58	62.07	60.72			51.42	57.60	54.12			54.07	51.41	52.82	63.33	57.23	56.12	61.28	58.64						
South Kalimantan			50.02	53.73	51.78			52.03	56.60	54.35			56.33	55.39	55.89	65.99	51.25	54.51	58.21	56.33						
East Kalimantan			62.11	58.56	60.38			60.10	66.38	63.08			59.26	65.84	62.61	75.80	59.99	65.10	71.02	67.98						
North Sulawesi			61.68	64.69	63.14			67.19	75.36	71.44			66.27	67.13	66.69	69.25	67.86	63.81	73.09	68.33						
Central Sulawesi			48.70	48.40	48.55			53.48	54.26	53.88			49.21	53.51	51.34	66.13	51.89	54.80	54.54	54.68						
South Sulawesi			50.62	54.26	52.37			51.10	54.91	52.96			51.44	54.97	53.20	62.66	50.75	53.82	54.29	54.04						
Southeast Sulawesi			56.91	64.63	60.59			55.22	64.18	59.64			55.21	61.64	58.42	75.57	60.43	62.81	64.11	63.39						
Gorontalo								33.44	41.40	37.43			42.97	41.85	42.43	64.51	42.74	43.64	52.25	47.86						
West Sulawesi																										
Maluku								52.29	70.86	60.35						73.77	58.10	61.88	63.33	62.59						
North Maluku								58.44	55.74	57.25						69.54	59.62	65.31	59.07	62.15						
West Papua																										
Papua								37.72	43.81	40.46						73.59	40.71	48.17	47.36	47.81						

TABLE 7. EDUCATION INDICATORS

Area	Net Junior secondary school enrolment ratio (Susenas)																			
Year	2004					2005					2006					2007				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	72.67	60.11	64.17	66.37	65.24	72.74	65.24	64.34	66.47	65.37	73.56	61.76	66.53	66.51	66.52	71.99	62.93	66.01	67.30	66.64
Aceh			80.30	79.65	79.98								78.65	78.10	78.39			75.63	77.21	76.36
North Sumatera			72.89	73.15	73.02			71.68	73.97	72.79			72.63	73.54	73.08			73.30	73.93	73.61
West Sumatera			66.77	72.30	69.55			67.00	70.54	68.77			64.99	70.63	67.77			64.15	70.46	67.23
Riau			69.12	70.20	69.65			72.45	72.55	72.50			73.17	72.69	72.93			68.89	71.08	69.96
Jambi			66.26	65.13	65.69			63.17	65.75	64.44			64.50	66.25	65.32			64.61	67.00	65.77
South Sumatera			62.57	67.23	64.81			65.16	64.71	64.94			65.24	71.10	68.01			63.45	66.54	64.97
Bengkulu			68.15	65.76	67.02			61.65	62.12	61.87			67.65	65.81	66.73			67.40	70.09	68.73
Lampung			63.09	64.31	63.65			61.69	68.49	64.91			64.74	68.78	66.65			65.73	71.13	68.30
Bangka Belitung			51.29	63.04	56.38			58.01	65.30	61.61			55.92	54.59	55.30			51.36	53.08	52.24
Riau Islands								68.13	64.50	66.48			71.55	72.53	72.01			71.16	71.50	71.34
Jakarta			78.51	73.58	76.08			78.72	71.13	74.95			74.91	67.96	71.41			74.65	68.02	71.26
West Java			60.83	62.71	61.74			59.54	60.45	59.99			64.04	60.04	62.13			67.19	66.60	66.90
Central Java			66.11	69.66	67.82			67.96	72.30	69.99			66.66	68.74	67.67			67.83	69.95	68.84
Yogyakarta			74.52	80.22	77.37			82.01	84.58	83.27			70.94	73.51	72.30			72.89	76.34	74.48
East Java			65.40	68.94	67.10			66.61	71.35	68.85			69.83	70.78	70.28			68.38	69.69	69.02
Banten			63.14	64.41	63.75			61.75	60.65	61.19			68.31	64.69	66.56			57.99	58.82	58.41
Bali			70.66	68.03	69.37			70.54	69.53	70.03			73.75	65.71	70.15			67.79	65.23	66.63
West Nusa Tenggara			60.11	63.28	61.70			65.12	69.83	67.53			70.83	68.30	69.62			70.43	70.91	70.65
East Nusa Tenggara			42.49	44.11	43.26			40.51	45.91	43.00			45.01	49.81	47.23			47.45	51.65	49.48
West Kalimantan			52.25	54.43	53.28			54.44	52.17	53.31			61.19	60.64	60.92			54.99	54.24	54.62
Central Kalimantan			66.90	63.30	65.15			69.56	73.65	71.49			66.94	68.56	67.69			58.72	61.39	60.07
South Kalimantan			57.31	61.05	59.27			56.36	57.43	56.89			62.83	61.33	62.12			57.13	61.43	59.27
East Kalimantan			69.77	70.66	70.20			70.30	69.32	69.80			63.95	64.05	64.00			71.74	70.47	71.14
North Sulawesi			69.75	65.73	67.87			65.40	66.31	65.86			63.05	69.05	66.03			64.92	67.12	65.95
Central Sulawesi			57.52	61.47	59.45			57.54	64.32	60.89			61.54	64.46	62.97			56.81	61.32	59.04
South Sulawesi			56.51	58.40	57.41			58.81	59.42	59.10			60.89	59.62	60.27			57.53	63.26	60.36
Southeast Sulawesi			61.89	66.29	64.02			65.43	66.68	66.04			71.72	73.20	72.42			63.05	68.63	65.77
Gorontalo			46.89	51.39	49.27			40.99	50.75	46.30			42.24	62.63	52.31			50.30	53.88	52.16
West Sulawesi													52.51	58.31	55.19			50.16	54.32	52.21
Maluku			65.42	70.86	68.06			70.14	70.70	70.43			78.70	74.94	76.86			70.72	69.45	70.08
North Maluku			61.71	66.62	64.17			62.44	59.45	61.00			69.11	60.99	65.31			64.21	65.16	64.67
West Papua													53.39	54.52	53.94			46.69	50.65	48.76
Papua			46.17	49.64	47.78			43.46	46.71	44.95			49.93	43.91	47.36			47.53	49.77	48.60

TABLE 7. EDUCATION INDICATORS

Area	Net Junior secondary school enrolment ratio (Susenas)					Junior secondary school completion rate (Ministry of National Education)								Junior secondary school drop out rate (Ministry of National Education)							
Year	2008					1998-1999	1999-2000	2000-2001	2001-2002	2003-2004	2004-2005	2005-2006	2006-2007	1998-1999	1999-2000	2000-2001	2001-2002	2003-2004	2004-2005	2005-2006	2006-2007
	Urban	Rural	Male	Female	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	69.34	64.95	66.36	67.62	66.98	96.09	90.92	92.43	95.00	94.24	93.79	97.56	98.17	3.64	4.14	4.39	3.50	2.83	1.97	2.88	3.94
Aceh			75.81	77.38	76.56	95.13	95.48	94.50	97.00	93.90	92.91	95.46	98.12	3.88	10.75	5.53	4.95	2.17	2.25	3.46	6.44
North Sumatera			73.65	74.32	73.97	95.60	96.67	98.70	95.00	92.63	90.73	98.84	99.35	2.42	3.93	3.85	4.60	3.04	2.94	3.23	4.85
West Sumatera			64.43	70.53	67.43	96.73	97.75	97.22	97.00	97.55	98.03	98.77	96.18	4.47	5.52	4.43	4.73	1.55	0.28	2.91	3.48
Riau			69.24	71.32	70.24	96.06	93.99	91.35	96.00	81.80	90.48	97.91	99.26	4.39	5.35	9.04	3.49	1.51	2.45	2.37	5.54
Jambi			64.82	67.33	66.05	96.91	93.81	89.82	95.00	97.57	97.02	98.06	95.35	4.77	5.72	6.73	5.97	1.15	0.84	3.46	2.53
South Sumatera			64.10	66.83	65.42	95.03	91.23	89.07	93.00	95.42	94.53	97.34	97.83	5.39	4.05	5.65	3.95	2.01	1.65	3.23	2.90
Bengkulu			67.73	70.25	68.98	96.95	97.09	84.91	92.00	88.22	89.80	94.55	97.55	6.10	4.60	9.58	7.79	6.09	3.17	6.78	7.50
Lampung			66.23	71.52	68.80	96.69	98.84	86.26	96.00	90.88	91.10	98.27	94.92	5.11	7.46	5.27	2.49	3.30	3.00	2.48	2.91
Bangka Belitung			51.91	53.56	52.71				93.00	92.39	92.84	98.37	96.89				4.95	7.03	2.10	4.36	9.95
Riau Islands			72.10	71.96	72.02						90.55	95.57	96.56						2.35	7.50	2.02
Jakarta			74.93	68.17	71.35	98.60	96.58	99.88	96.00	98.98	98.98	97.21	98.07	2.47	5.99	1.53	1.45	3.70	0.37	1.87	0.77
West Java			67.84	67.02	67.43	94.88	91.56	97.55	97.00	93.53	93.53	97.55	98.62	3.91	2.12	3.01	2.79	2.83	2.77	2.11	2.63
Central Java			68.29	70.27	69.25	96.71	90.37	90.23	96.00	97.69	96.23	97.66	98.31	3.04	2.30	4.63	1.99	2.42	1.00	2.58	2.51
Yogyakarta			73.35	76.93	75.04	98.92	89.27	91.16	96.00	98.02	98.02	97.99	98.24	2.17	3.01	4.82	3.43	2.23	0.62	2.14	1.84
East Java			68.80	69.90	69.33	96.67	87.57	91.06	96.00	95.20	95.20	98.86	98.56	3.13	2.47	3.46	3.33	1.98	1.49	2.01	2.28
Banten			58.82	59.04	58.93				96.00	97.13	97.13	99.47	98.60				3.66	1.08	0.91	3.35	3.73
Bali			68.24	65.50	66.94	97.21	99.23	94.12	93.00	92.55	99.37	96.89	98.86	5.16	2.91	6.98	1.88	4.71	0.18	2.64	5.98
West Nusa Tenggara			70.73	71.30	71.02	96.62	80.57	80.89	96.00	87.10	92.50	88.59	99.52	4.34	5.64	6.92	2.92	4.90	1.91	4.47	8.48
East Nusa Tenggara			47.50	52.04	49.69	94.03	85.16	95.77	95.00	94.73	91.99	98.42	99.41	4.58	4.20	3.58	3.43	1.65	2.38	5.24	8.24
West Kalimantan			55.22	54.69	54.97	96.43	96.00	84.65	92.00	91.04	91.49	97.97	98.90	5.15	2.41	5.00	5.66	4.21	2.61	4.64	7.47
Central Kalimantan			59.02	61.59	60.23	94.38	72.95	80.21	90.00	83.36	92.76	98.14	96.99	5.24	6.48	7.48	7.22	8.07	1.20	2.70	10.70
South Kalimantan			57.54	61.86	59.67	96.47	97.47	97.71	95.00	93.31	93.14	97.00	95.17	3.83	6.26	1.31	5.08	4.54	1.70	3.73	5.21
East Kalimantan			71.84	70.77	71.30	95.94	96.37	90.65	93.00	87.67	99.11	97.94	98.26	4.02	4.66	4.92	5.68	5.46	0.20	3.10	4.43
North Sulawesi			65.19	67.50	66.32	95.43	85.02	89.46	95.00	89.61	90.80	93.56	98.41	2.58	5.62	6.58	5.12	5.31	2.80	3.54	6.41
Central Sulawesi			56.94	61.89	59.30	95.57	82.58	90.27	95.00	83.24	87.40	93.58	96.99	4.34	5.37	7.93	7.48	6.61	4.20	4.67	6.32
South Sulawesi			57.68	63.76	60.74	95.29	79.77	85.32	96.00	85.22	85.98	98.39	98.63	3.11	4.56	5.89	3.49	12.15	4.49	3.44	4.87
Southeast Sulawesi			63.33	69.09	66.14	95.93	96.27	84.49	93.00	85.92	87.89	92.19	97.24	3.27	3.11	6.50	6.25	8.46	3.71	4.35	3.46
Gorontalo			50.39	54.07	52.27	95.78			95.00	88.22	93.61	88.81	97.78				6.35	7.50	1.74	7.28	18.28
West Sulawesi			50.50	54.63	52.55						87.59	99.26	94.10						4.06	6.02	14.47
Maluku			71.19	69.94	70.58		99.94	93.60	98.00	92.27	91.32	98.02	94.74	7.20	6.31	4.37	9.02	3.32	3.03	4.16	9.38
North Maluku			64.68	65.58	65.13			98.88	83.00	98.01	97.29	96.64	95.97			7.57	8.79	2.62	0.76	2.07	18.24
West Papua			46.85	50.85	48.92							79.60	96.81						0.36	4.01	1.91
Papua			47.54	50.07	48.75	90.94	82.08	85.63	94.00	71.86	93.79	97.41	97.27	3.62	6.16	5.70	5.58	24.34	6.05	3.55	3.53

TABLE 7. EDUCATION INDICATORS

Area	Junior secondary school repition rate (Ministry of National Education)								Junior secondary school student per class ratio (Ministry of National Education)								
Year	1998-1999	1998-2000	2000-2001	2001-2002	2003/04-2004/05	2004/05-2005/06	2005/06-2006/07	2006/07-2007/08	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia		0.30	0.31	0.30	0.50	0.47	0.53	0.42	40	40	40	40	39	38	37	36	37	37
Aceh	0.52	0.25	0.52	0.51	0.86	0.83	0.97	0.62	37	37	37	35	36	30	33	38	37	41
North Sumatera	0.34	0.20	0.36	0.36	0.37	0.41	0.44	0.36	40	40	40	41	41	41	40	39	38	37
West Sumatera	1.01	1.18	1.05	1.02	1.19	1.29	1.01	1.08	37	37	37	37	38	35	36	34	34	32
Riau	0.79	0.72	0.44	0.46	0.79	0.83	0.84	0.74	37	38	39	37	38	37	39	40	35	31
Jambi	0.57	0.55	0.67	0.65	0.87	0.79	0.72	0.44	36	38	38	34	35	36	37	35	34	32
South Sumatera	0.50	0.40	0.46	0.34	0.78	0.56	0.58	0.34	39	36	37	39	39	39	34	36	35	37
Bengkulu	0.69	0.48	0.58	0.55	1.08	0.72	1.54	0.32	36	43	43	35	35	32	30	35	36	43
Lampung	0.13	0.14	0.07	0.07	0.26	0.28	0.24	0.42	38	37	38	38	40	38	38	37	40	40
Bangka Belitung				0.25	1.07		0.70	0.73					39	33	38	38	35	34
Riau Islands							3.28	0.65							32	29	32	35
Jakarta	0.52	0.66	0.87	0.88	0.84	0.69	0.63	0.57	43	43	40	39	38	39	39	38	38	37
West Java	0.14	0.16	0.06	0.04	0.20	0.20	0.17	0.16	41	44	44	42	43	41	38	35	37	37
Central Java	0.18	0.20	0.20	0.21	0.42	0.45	0.37	0.32	42	43	44	42	41	40	39	39	38	39
Yogyakarta	0.23	0.34	0.19	0.14	0.36	0.13	0.35	0.32	37	32	33	34	33	36	35	37	36	36
East Java	0.19	0.19	0.23	0.21	0.35	0.24	0.31	0.25	42	41	41	41	41	41	39	33	37	37
Banten				0.01	0.28	0.20	0.25	0.26					42	38	36	37	39	38
Bali	0.10	0.13	0.21	0.78	0.17	0.09	0.11	0.07	38	37	38	38	39	30	37	40	37	37
West Nusa Tenggara	0.43	0.44	0.35	0.35	0.58	0.63	0.47	0.44	39	38	38	38	40	41	37	42	38	36
East Nusa Tenggara	0.47	0.35	0.42	0.49	1.05	1.04	1.09	1.55	38	38	39	37	38	35	34	37	34	35
West Kalimantan	0.72	0.67	0.91	0.88	1.26	1.02	1.91	1.18	39	39	39	39	38	36	34	38	37	41
Central Kalimantan	0.16	0.15	0.19	0.19	0.88	1.00	0.59	0.78	36	37	38	37	35	36	27	35	33	28
South Kalimantan	0.41	0.37	0.48	0.46	0.55	0.60	0.92	0.58	34	34	34	34	33	32	30	37	33	37
East Kalimantan	0.35	0.27	0.55	0.52	0.72	0.47	0.50	0.57	38	40	40	39	37	34	32	36	33	37
North Sulawesi	0.35	0.41	0.47	0.24	0.32	0.30	0.34	0.31	31	31	32	31	30	31	30	30	32	34
Central Sulawesi	0.35	0.15	0.03	0.03	0.40	0.54	0.36	0.26	35	34	36	38	37	38	33	31	35	30
South Sulawesi	0.40	0.31	0.33	0.33	0.41	0.45	0.77	0.77	37	36	36	37	37	36	37	34	34	33
Southeast Sulawesi	0.40	0.34	0.32	0.33	0.41	0.38	0.74	0.67	35	36	39	36	34	32	36	35	34	33
Gorontalo				0.17	0.48	0.68	0.45	0.13					35	28	28	32	34	32
West Sulawesi							0.63	0.32							33	36	34	36
Maluku	0.17	0.02	0.03	0.03	0.81	0.70	2.10	0.86	35	34	32	26	30	31	32	31	31	30
North Maluku			0.02	0.01	2.58	2.00	3.02	0.03				39	36	28	29	29	31	36
West Papua							0.97	0.35							36	22	36	27
Papua	1.29	0.80	0.45	0.27	0.80	0.78	1.15	0.72	38	37	38	37	35	40	37	35	36	35

TABLE 7. EDUCATION INDICATORS

Area	Junior secondary school teacher - student ratio (Ministry of National Education)										Transition rate to senior secondary school (Ministry of National Education)								Percentage of qualified junior secondary school teachers (World Bank)			
Year	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	1998-1999	1999-2000	2000-2001	2001-2002	2003-2004	2004-2005	2005-2006	2006-2007	2001-2002	2002-2003	2003-2004	2004-2005
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	18	17	17	17	16	15	14	13	14	14	69.48	73.95	74.66	77.45	82.59	89.77	89.18	95.42	42.22	42.35	54.87	60.59
Aceh	16	14	14	14	14	13	11	12	12	12	69.19	60.46	82.19	71.44	81.28	85.21	100.85	92.87				
North Sumatera	17	17	17	16	16	17	15	14	15	15	74.2	80.17	80.03	90.87	93.47	97.34	96.45	106.46				
West Sumatera	15	14	14	14	14	12	13	12	11	12	83.98	89.8	93.78	88.22	92.04	99.95	97.08	117.67				
Riau	18	17	17	16	15	14	14	12	12	12	75.13	78.24	81.93	87.59	80.86	88.28	81.6	100.21				
Jambi	17	15	15	15	14	16	14	12	11	11	72.26	83.67	81.51	75.54	72.79	79.75	79.69	98.69				
South Sumatera	16	16	17	18	17	14	12	11	12	14	70.33	73.23	74.57	68.23	82.94	92.74	88.5	96.26				
Bengkulu	17	17	17	18	16	16	14	14	15	14	76.35	81.89	87.19	81.47	87.71	87.65	109.36	96.68				
Lampung	16	16	16	16	14	16	14	12	12	13	59.55	65.26	60.8	65.89	67.33	69.27	72.17	79.95				
Bangka Belitung					17	17	17	14	15	14				87.54	88.06	97.83	77.74	107.01				
Riau Islands							14	12	12	14					97.3	99.73	112.29	142.21				
Jakarta	16	16	15	15	15	15	16	15	17	17	97.47	108.76	16.45	111.17	112.36	119.87	113.5	124.63				
West Java	23	21	21	19	19	19	15	15	16	16	61.25	58.93	61.3	66.84	73.42	81.51	87.58	88.35				
Central Java	20	19	20	18	18	17	16	14	15	16	62.94	64.07	67.39	69.08	71.32	80.24	79.05	79.82				
Yogyakarta	14	13	13	11	11	11	11	10	11	12	95.79	99	92.79	96.55	99.97	104.28	99.55	105.85				
East Java	17	16	17	16	15	14	13	12	12	13	67.81	72.37	71.9	79.66	85.71	93.31	90.16	99.15				
Banten					18	24	18	19	18	17				73.01	85.61	90.98	91.86	100.89				
Bali	15	14	13	13	14	13	12	11	14	11	81.44	78.01	76.73	76.75	88.52	102.53	88.91	94.56				
West Nusa Tenggara	18	16	17	17	17	16	14	14	14	12	68.43	92.14	83.16	77.51	80.65	96.89	88.6	88.88				
East Nusa Tenggara	17	16	16	16	15	14	14	14	15	15	46.77	74.95	66.44	66.97	82.02	82.54	89.77	93.82				
West Kalimantan	17	16	18	17	15	13	14	12	14	16	58.47	68.5	70.6	62.97	68.92	69.77	74.53	83.2				
Central Kalimantan	16	16	15	14	12	20	10	11	11	10	66.02	96.36	66.81	68.73	78.99	114.87	89.68	98.45				
South Kalimantan	16	14	14	13	12	11	10	10	10	11	67.04	72.31	91.32	90.62	93.41	92.59	88.77	92.1				
East Kalimantan	15	15	17	15	15	13	12	12	12	12	74	85.6	85.09	87.97	96.13	112.16	100.06	102.43				
North Sulawesi	13	12	13	12	12	11	12	11	11	11	76.38	87.02	80.71	82.22	96.62	98.51	94.65	90.37				
Central Sulawesi	13	12	13	13	13	15	13	12	12	12	70.49	83.46	74.78	74.31	82.2	82.19	92.09	103.41				
South Sulawesi	15	15	16	16	14	15	13	13	12	12	71.69	92.27	75.91	75.85	83.19	88.28	80.46	90.57				
Southeast Sulawesi	17	18	19	17	15	15	15	14	14	13	60.17	69.63	72.44	82.34	81.63	92.78	87.41	94.79				
Gorontalo					13	6	9	10	12	11				74.74	94.46	100.34	125.9	105.49				
West Sulawesi							17	16	15	15					71.44	74.43	68.23	99.03				
Maluku	15	15	17	12	13	10	9	8	8	8	63.05	70.2	84.6	95.52	95.84	97.46	117.27	133.82				
North Maluku				21	14	15	12	10	10	9			62.84	45.14	89.85	99.85	104.88	124.39				
West Papua							15	9	10	9					115.95	121.3	10.379	143.12				
Papua	17	14	15	16	14	18	15	13	13	14	72.03	86.63	86.72	84.47	73.81	92.95	75.05	87.32				

TABLE 7. EDUCATION INDICATORS

Area	Gross senior secondary school enrolment ratio (Susenas)		Net senior secondary school enrolment ratio (Susenas)															
Year	2008		2000					2001					2002					
	Male	Female	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	57.87	56.95	55.40	26.80	39.00	40.60	39.80	51.80	24.40	37.10	37.20	37.10	52.76	25.40	38.65	37.54	38.11
Aceh	76.16	76.29															
North Sumatera	66.85	71.13					51.50					50.80					49.10
West Sumatera	65.52	73.49					49.20					46.70					48.60
Riau	66.59	68.11					39.90					35.60					40.70
Jambi	58.23	57.82					36.20					34.70					35.70
South Sumatera	53.27	54.17					37.90					35.50					34.30
Bengkulu	60.41	64.06					39.90					40.20					36.30
Lampung	51.80	52.59					31.50					34.20					31.00
Bangka Belitung	46.27	56.34										32.80					35.40
Riau Islands	65.62	66.81															
Jakarta	69.81	59.59					58.80					52.90					57.40
West Java	47.83	46.44					36.10					31.70					33.00
Central Java	57.29	57.33					38.60					37.60					38.20
Yogyakarta	79.32	71.10					62.00					64.60					58.60
East Java	66.05	58.33					41.10					36.80					38.90
Banten	53.88	50.38										31.10					37.80
Bali	74.37	68.01					54.40					49.80					51.00
West Nusa Tenggara	53.59	57.98					36.30					34.20					35.90
East Nusa Tenggara	49.67	51.02					21.20					20.00					21.80
West Kalimantan	49.67	54.36					24.20					24.40					24.70
Central Kalimantan	49.57	53.79					34.30					25.30					30.30
South Kalimantan	40.48	43.97					31.30					30.60					28.00
East Kalimantan	71.25	66.78					42.60					41.80					44.90
North Sulawesi	61.63	74.97					40.20					45.40					43.60
Central Sulawesi	56.34	53.79					30.90					22.60					26.80
South Sulawesi	52.82	54.02					36.00					35.00					34.60
Southeast Sulawesi	60.70	61.14					38.80					37.20					36.30
Gorontalo	46.85	50.49										19.60					23.00
West Sulawesi	44.29	35.80															
Maluku	81.39	69.39										53.60					
North Maluku	60.30	72.01										38.30					
West Papua	59.34	47.66															
Papua	49.62	47.65															

TABLE 7. EDUCATION INDICATORS

Area	Net senior secondary school enrolment ratio (Susenas)																					
Year	2003					2004					2005					2006				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	56.06	28.72	40.48	40.64	40.56	56.75	32.11	43.23	42.66	42.96	56.81	32.75	43.57	43.43	43.50	57.17	33.47	43.77	43.78	43.77
Aceh					61.60					62.00										57.07
North Sumatera					53.00					56.60					53.50					54.14
West Sumatera					49.90					53.10					53.36					51.05
Riau					47.20					47.70					50.51					49.43
Jambi					40.70					42.20					39.54					40.95
South Sumatera					35.70					39.50					42.54					43.15
Bengkulu					42.50					49.00					45.41					47.10
Lampung					35.80					35.70					39.64					39.87
Bangka Belitung					33.80					38.20					39.57					34.84
Riau Islands															51.06					52.13
Jakarta					63.30					61.20					58.62					52.82
West Java					34.60					37.20					36.89					37.84
Central Java					38.30					41.70					43.30					42.36
Yogyakarta					59.80					61.50					62.45					55.85
East Java					40.80					41.90					44.86					46.35
Banten					36.40					39.70					44.37					41.44
Bali					53.40					54.10					53.04					53.54
West Nusa Tenggara					33.40					38.60					41.25					43.58
East Nusa Tenggara					23.60					28.30					27.77					30.97
West Kalimantan					29.10					31.50					32.25					34.77
Central Kalimantan					37.20					38.80					39.49					42.66
South Kalimantan					30.50					35.60					33.54					37.23
East Kalimantan					49.80					52.40					49.08					50.41
North Sulawesi					44.40					50.70					50.02					48.78
Central Sulawesi					33.20					36.30					35.45					39.51
South Sulawesi					37.20					38.40					39.95					40.86
Southeast Sulawesi					36.60					40.20					44.04					47.28
Gorontalo					24.60					28.10					32.44					34.47
West Sulawesi																				32.35
Maluku					43.50					56.40					54.37					55.66
North Maluku					38.70					44.10					52.65					48.66
West Papua																				35.31
Papua					30.10					30.40					40.49					33.36

TABLE 7. EDUCATION INDICATORS

Area	Net senior secondary school enrolment ratio (Susenas)									
Year	2007					2008				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	55.66	35.58	44.82	44.29	44.56	50.92	38.66	44.98	44.51	44.75
Aceh					61.80			60.80	63.21	62.02
North Sumatera					54.80			52.64	57.55	55.10
West Sumatera					54.20			50.96	57.76	54.38
Riau					51.40			49.60	53.91	51.66
Jambi					44.20			44.34	44.70	44.51
South Sumatera					42.60			43.50	42.30	42.91
Bengkulu					48.50			46.07	51.62	48.59
Lampung					40.60			39.46	42.76	40.95
Bangka Belitung					37.10			34.00	40.73	37.38
Riau Islands					52.50			53.84	51.89	52.87
Jakarta					49.60			57.05	43.55	49.82
West Java					37.90			39.22	36.80	38.06
Central Java					43.80			43.58	44.71	44.11
Yogyakarta					57.90			60.32	56.29	58.26
East Java					47.60			49.77	45.81	47.85
Banten					38.40			39.40	37.92	38.66
Bali					55.60			59.19	51.80	55.65
West Nusa Tenggara					48.00			49.72	46.70	48.08
East Nusa Tenggara					33.60			33.04	34.94	33.95
West Kalimantan					36.10			34.80	38.08	36.36
Central Kalimantan					39.00			37.74	40.73	39.13
South Kalimantan					35.20			35.48	35.31	35.40
East Kalimantan					52.70			54.37	51.36	52.96
North Sulawesi					50.20			47.88	53.21	50.35
Central Sulawesi					39.00			38.61	39.89	39.24
South Sulawesi					41.60			41.26	42.36	41.80
Southeast Sulawesi					47.30			46.43	48.73	47.62
Gorontalo					37.70			34.03	42.18	37.83
West Sulawesi					33.00			31.69	34.68	33.17
Maluku					59.20			62.15	55.99	59.38
North Maluku					51.30			49.19	53.82	51.50
West Papua					43.20			45.13	41.72	43.57
Papua					35.70			37.59	33.61	35.72

DEFINITIONS OF THE INDICATORS

Adult literacy rate (10 years old and above)	Percentage of the population ages 10 years-old and above who can both read and write with understanding a short simple statement in Latin or other letters on everyday life.
Adult literacy rate (15 years old and above)	Percentage of the population ages 15 years-old and above who can both read and write with understanding a short simple statement in Latin or other letters on everyday life.
Youth literacy rate (15-24 years old)	Percentage of the population ages 15-24 years-old who can both read and write with understanding a short simple statement in Latin or other letters on everyday life.
Pre-school (4-6 years old) participation rate	The number of children aged 4-6 years old enrolled in a pre-school programme/kindergarten, divided by the number of children aged 4-6 years old, and expressed as a percentage.
Gross enrolment ratio	the number of children enrolled in a specified level of school regardless of age, divided by the population of the age group that officially corresponds to the level of school, and expressed as a percentage.
- GER of primary school	the number of children enrolled in primary school, included Islamic Madrasah Ibtidaiyah (MI), regardless of age, divided by the population of children aged 7-12 years old. It is expressed as a percentage.
- GER of junior secondary school	the number of children enrolled in junior secondary school, included Islamic Madrasah Tsanawiyah (MTs), regardless of age, divided by the population of children aged 13-15 years old. It is expressed as a percentage.
- GER of senior secondary school	the number of children enrolled in senior secondary school, included Islamic Madrasah Aliyah (MA), regardless of age, divided by the population of children aged 16-18 years old. It is expressed as a percentage.
Net enrolment ratio	the number of children enrolled in a specified level of school who belong to the age group that officially corresponds to the school level, divided by the total population of the same age group, and expressed as a percentage

MAIN DATA SOURCES

Adult literacy rate (10 years old and above)	National Socio-Economic Survey
Adult literacy rate (15 years old and above)	National Socio-Economic Survey
Youth literacy rate (15-24 years old)	National Socio-Economic Survey
Pre-school (4-6 years old) participation rate	National Socio-Economic Survey
Gross primary school enrolment ratio	National Socio-Economic Survey
Net primary school enrolment ratio	National Socio-Economic Survey
Primary school completion rate	Ministry of Education: Educational Statistics
Primary school drop out rate	Ministry of Education: Educational Statistics
Primary school repition rate	Ministry of Education: Educational Statistics

- NER of primary school	The number of children enrolled in primary school, including Islamic Madrasah Ibtidaiyah (MI) who are at 7-12 years old, divided by the total population of the same age group, and expressed as a percentage
- NER of junior secondary school	The number of children enrolled in junior secondary school, including Islamic Madrasah Tsanawiyah (MTs) who are at 13-15 years old, divided by the total population of the same age group, and expressed as a percentage
- NER of senior secondary school	The number of children enrolled in senior secondary school, including Islamic Madrasah Aliyah (MA) who are at 16-18 years old, divided by the total population of the same age group, and expressed as a percentage
Completion rate	the ratio of the total number of students successfully completing (or graduating from) the last year of a specified school level in a given year to the total number of children of official graduation age in the population. It is expressed as a percentage.
Drop out rate	The proportion of pupils who leave the system without completing a given grade in a given school year. It is expressed as a percentage and obtained by subtracting promotion rate and repetition rate from 100.
Repetition rate	The proportion of pupils who repeat a grade. It is expressed as a percentage and obtained by dividing number of repeaters of a specified grade in a specified year by number of pulils enrolled last year in the grade.
Student per class ratio	Total number of pupils in a specified level of education, divided by total number of class in the level of education
Student - teacher ratio	Total number of pupils in a specified level of education, divided by total number of teachers in the level of education
Transition rate	The number of new entrants in the first grade of the specified higher cycle or level of education, divided by the number of students enrolled in the final grade of the preceding cycle or level of education in the previous school year. It is expressed as a percentage.
Percentage of qualified teachers	The number of teachers with at least the minimum academic qualifications required (at least having Bachelor/Diplomma 4 degree) by the public authorities for teaching in a specified level of education, expressed as a percentage of the total number of school teachers in the specified level of education.

Primary school student per class ratio	Ministry of Education: Educational Statistics
Primary school student - teacher ratio	Ministry of Education: Educational Statistics
Transition rate to junior secondary school	Ministry of Education: Educational Statistics
Percentage of qualified primary school teachers	WorldBank_MoNE 2004/2005 teacher data
Gross junior secondary school enrolment ratio	National Socio-Economic Survey
Net junior secondary school enrolment ratio	National Socio-Economic Survey
Junior secondary school completion rate	Ministry of Education: Educational Statistics
Junior secondary school drop out rate	Ministry of Education: Educational Statistics
Junior secondary school repition rate	Ministry of Education: Educational Statistics
Junior secondary school student per class ratio	Ministry of Education: Educational Statistics
Junior secondary school student - teacher ratio	Ministry of Education: Educational Statistics
Transition rate to senior secondary school	Ministry of Education: Educational Statistics
Percentage of qualified junior secondary school teachers	WorldBank_MoNE 2004/2005 teacher data
Gross senior secondary school enrolment ratio	National Socio-Economic Survey
Net senior secondary school enrolment ratio	National Socio-Economic Survey
Percentage of qualified kindergarten teachers	WorldBank_MoNE 2004/2005 teacher data

Notes - Data not available

TABLE 8. CHILD PROTECTION INDICATORS

Area	Number of child worker aged 10-14 years old, in agriculture, manufacturing, and service sectors - in thousands (Sakernas)															Percentage of child worker aged 10-14 years old (Susenas)									
Year	2001			2002			2003			2004			2005			2001					2002				
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	573.1	375.6	948.7	510.3	332.0	842.2	286.0	192.6	478.6	3967.0	276.8	673.5	319.0	197.1	516.1	2.12	6.16	5.2	3.8	4.55	1.71	5.55	4.6	3.2	3.96
Aceh																									
North Sumatra																									
West Sumatra																									
Riau																									
Jambi																									
South Sumatra																									
Bengkulu																									
Lampung																									
Bangka Belitung																									
Riau Islands																									
D.K.I Jakarta																									
West Java																									
Central Java																									
D.I. Yogyakarta																									
East Java																									
Banten																									
Bali																									
West Nusa Tenggara																									
East Nusa Tenggara																									
West Kalimantan																									
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Central Sulawesi																									
South Sulawesi																									
Southeast Sulawesi																									
Gorontalo																									
West Sulawesi																									
Maluku																									
North Maluku																									
West Papua																									
Papua																									

TABLE 8. CHILD PROTECTION INDICATORS

Area	Percentage of child worker aged 10-14 years old (Susenas)															Percentage of child worker aged 10-14 years old (Susenas)									
Year	2003					2004					2005					2006					2007				
	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total	Urban	Rural	Male	Female	Total
Indonesia	1.31	3.26	3.1	2.3	2.46	1.28	4.49	3.7	2.7	3.21	0.91	3.35	2.8	1.9	2.38	1.2	3.2	2.8	2.0	2.4	2.4	6.6	5.7	4.0	4.9
Aceh																									
North Sumatra																									
West Sumatra																									
Riau																									
Jambi																									
South Sumatra																									
Bengkulu																									
Lampung																									
Bangka Belitung																									
Riau Islands																									
D.K.I Jakarta																									
West Java																									
Central Java																									
D.I. Yogyakarta																									
East Java																									
Banten																									
Bali																									
West Nusa Tenggara																									
East Nusa Tenggara																									
West Kalimantan																									
Central Kalimantan																									
South Kalimantan																									
East Kalimantan																									
North Sulawesi																									
Central Sulawesi																									
South Sulawesi																									
Southeast Sulawesi																									
Gorontalo																									
West Sulawesi																									
Maluku																									
North Maluku																									
West Papua																									
Papua																									

TABLE 8. CHILD PROTECTION INDICATORS

Area	"Percentage of child worker aged 10-14 years old (Susenas)"					Number of child labor aged 10-14 years old - in thousands (Susenas)					Number of child labor aged 10-14 years old - in thousands (Susenas)											
Year	2008					2001	2002	2003	2004	2005	2001			2002			2003			2004		
	Urban	Rural	Male	Female	Total	Total	Total	Total	Total	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	2.2	5.7	5.1	3.5	4.3	1,322.7	1,414.1	898.6	1,224.2	960.7	3.70	8.09	6.34	3.66	8.76	6.65	2.84	5.85	4.62	2.87	7.80	5.83
Aceh																						
North Sumatra																						
West Sumatra																						
Riau																						
Jambi																						
South Sumatra																						
Bengkulu																						
Lampung																						
Bangka Belitung																						
Riau Islands																						
D.K.I Jakarta																						
West Java																						
Central Java																						
D.I. Yogyakarta																						
East Java																						
Banten																						
Bali																						
West Nusa Tenggara																						
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South Sulawesi																						
Southeast Sulawesi																						
Gorontalo																						
West Sulawesi																						
Maluku																						
North Maluku																						
West Papua																						
Papua																						

TABLE 8. CHILD PROTECTION INDICATORS

Area	"Percentage of child worker aged 10-14 years old (Susenas)"					Number of child labor aged 10-14 years old - in thousands (Susenas)					Number of child labor aged 10-14 years old - in thousands (Susenas)											
Year	2008					2001	2002	2003	2004	2005	2001			2002			2003			2004		
	Urban	Rural	Male	Female	Total	Total	Total	Total	Total	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	2.2	5.7	5.1	3.5	4.3	1,322.7	1,414.1	898.6	1,224.2	960.7	3.70	8.09	6.34	3.66	8.76	6.65	2.84	5.85	4.62	2.87	7.80	5.83
Aceh																						
North Sumatra																						
West Sumatra																						
Riau																						
Jambi																						
South Sumatra																						
Bengkulu																						
Lampung																						
Bangka Belitung																						
Riau Islands																						
D.K.I Jakarta																						
West Java																						
Central Java																						
D.I. Yogyakarta																						
East Java																						
Banten																						
Bali																						
West Nusa Tenggara																						
East Nusa Tenggara																						
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North Sulawesi																						
Central Sulawesi																						
South Sulawesi																						
Southeast Sulawesi																						
Gorontalo																						
West Sulawesi																						
Maluku																						
North Maluku																						
West Papua																						
Papua																						

TABLE 8. CHILD PROTECTION INDICATORS

Area	Child labor participation rate - children aged 10-14 years old (Susenas)			Estimated number of child worker aged 10-17 years (Susenas)					Estimated number of child worker aged 10-17 years (Susenas)					
Year	2005			2004	2005	2006	2007	2008	2009					
	Urban	Rural	Total	Total	Total	Total	Total	Total	Working Children aged 10-12 years	Working Children aged 13-14 with working hours >15 hours per week	Working Children aged 15-17 with working hours >40 hours per week	Male	Female	Total
Indonesia	2.33	5.82	4.43	1,390.0	1,147.9	1,284.1	1,808.4	1,713.2	320.1	341.9	1017.2	949.5	729.7	1,679.1
Aceh			1.19											
North Sumatra			6.47											
West Sumatra			3.15											
Riau			2.58											
Jambi			9.29											
South Sumatra			5.08											
Bengkulu			3.82											
Lampung			4.98											
Bangka Belitung			6.83											
Riau Islands			1.25											
D.K.I Jakarta			2.72											
West Java			3.12											
Central Java			3.31											
D.I. Yogyakarta			3.34											
East Java			3.94											
Banten			9.90											
Bali			9.67											
West Nusa Tenggara			7.14											
East Nusa Tenggara			6.08											
West Kalimantan			1.88											
Central Kalimantan			7.54											
South Kalimantan			3.88											
East Kalimantan			3.19											
North Sulawesi			4.64											
Central Sulawesi			9.66											
South Sulawesi			6.97											
Southeast Sulawesi			5.57											
Gorontalo			1.55											
West Sulawesi			3.85											
Maluku														
North Maluku														
West Papua														
Papua			15.94											

TABLE 8. CHILD PROTECTION INDICATORS

Area		Labour force participation rates children aged 10-17 years (Susenas)										Labour force participation rates children aged 10-17 years (Susenas)									
Year		2004									2005	2006	2007	2008	2009						
	Total	10yr	11yr	12yr	13yr	14yr	15yr	16yr	17yr	Total	Total	Total	Total	Total	10yr	11yr	12yr	13yr	14yr	15yr	16yr	17yr	Total
Indonesia	1,679.1	2	3	4	8	12	20	30	38	10.93	9.27	9.84	13.18	11.87	2	3	4	7	10	16	23	33	12/.10
Aceh																							
North Sumatra																							
West Sumatra																							
Riau																							
Jambi																							
South Sumatra																							
Bengkulu																							
Lampung																							
Bangka Belitung																							
Riau Islands																							
D.K.I Jakarta																							
West Java																							
Central Java																							
D.I. Yogyakarta																							
East Java																							
Banten																							
Bali																							
West Nusa Tenggara																							
East Nusa Tenggara																							
West Kalimantan																							
Central Kalimantan																							
South Kalimantan																							
East Kalimantan																							
North Sulawesi																							
Central Sulawesi																							
South Sulawesi																							
Southeast Sulawesi																							
Gorontalo																							
West Sulawesi																							
Maluku																							
North Maluku																							
West Papua																							
Papua																							

TABLE 8. CHILD PROTECTION INDICATORS

Area	Percentage married at an early age (Susenas)																	
Year	2000			2001			2002			2003			2004			2005		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Indonesia	23.64	38.74	33.49	22.89	37.32	31.99	23.13	36.58	31.56	22.06	36.12	31.12	22.26	35.71	30.67	22.65	36.15	30.97
Aceh							23.76		23.76	16.41	21.34	20.27	20.51	29.73	27.45			
North Sumatra	13.94	18.54	16.75	14.11	19.65	17.56	11.47	15.87	14.40	13.99	16.82	15.82	12.79	20.48	17.55	14.21	15.87	15.21
West Sumatra	15.81	22.73	21.30	13.04	22.98	20.92	16.38	24.24	22.52	15.22	24.95	22.74	12.81	21.44	19.25	16.19	21.49	20.19
Riau	11.78	35.36	27.41	13.74	26.87	22.31	11.38	27.47	21.10	8.61	25.87	19.77	8.46	29.13	19.93	18.41	30.87	27.02
Jambi	14.78	45.11	38.91	25.73	46.11	42.43	15.59	38.31	34.03	23.16	36.10	33.38	22.39	36.81	33.66	28.03	34.92	33.49
South Sumatra	15.89	28.01	24.99	31.42	28.39	29.15	23.48	35.22	32.45	23.76	36.60	33.29	19.06	37.00	32.18	14.85	34.82	29.43
Bengkulu	20.67	33.43	30.50	19.73	32.81	29.65	18.61	31.18	28.79	17.79	35.54	31.46	10.94	33.54	28.40	22.63	31.40	29.36
Lampung	18.54	34.37	32.09	12.58	31.81	28.26	17.32	30.08	27.53	21.27	26.62	25.60	14.48	29.69	27.09	13.58	29.71	26.59
Bangka Belitung				18.85	35.28	29.65	12.52	33.55	26.59	20.72	27.73	25.65	21.36	46.00	38.34	22.16	31.04	28.10
Riau Islands																11.40	20.35	13.50
D.K.I Jakarta	19.15	0.00	19.15	12.34	0.00	12.34	18.03	0.00	18.03	13.63	0.00	13.63	18.03	0.00	18.03	17.54	0.00	17.54
West Java	29.90	49.28	40.96	31.21	48.07	40.73	30.84	46.02	39.20	29.10	45.21	38.41	27.26	45.58	36.83	26.41	45.51	36.61
Central Java	23.32	36.10	32.14	20.61	35.76	30.54	24.28	33.95	30.58	18.85	34.95	29.55	20.10	33.48	28.87	21.35	32.39	28.33
D.I. Yogyakarta	9.01	38.49	25.93	8.45	12.84	10.73	7.07	19.28	13.02	8.70	18.86	14.00	14.62	15.54	15.15	12.62	14.52	13.52
East Java	24.40	45.10	38.55	26.23	44.38	37.92	23.06	44.19	36.39	22.50	41.79	35.40	23.89	40.61	35.04	24.79	39.18	34.11
Banten				17.63	48.62	33.43	21.62	51.68	38.67	29.08	46.99	38.40	25.81	43.63	35.60	22.05	43.93	34.39
Bali	10.50	17.12	14.32	14.37	20.87	17.57	12.72	18.44	15.49	13.26	22.37	17.58	14.35	18.93	16.65	13.05	30.50	21.00
West Nusa Tenggara	25.21	28.04	27.32	25.59	27.50	26.91	24.43	22.84	23.35	22.10	28.35	26.53	31.35	27.56	28.75	34.50	33.24	33.65
East Nusa Tenggara	10.15	19.15	18.13	5.04	21.80	19.22	16.69	17.83	17.71	15.87	15.99	15.98	14.29	22.72	21.73	17.54	20.58	20.14
West Kalimantan	14.34	36.24	31.32	18.57	28.58	26.20	19.88	29.90	28.20	20.40	35.47	32.54	20.93	34.75	31.23	30.54	36.16	34.81
Central Kalimantan	32.36	26.00	27.71	20.56	32.19	29.80	26.38	28.73	28.10	35.28	33.23	33.73	27.35	34.92	32.95	27.83	41.91	37.64
South Kalimantan	27.67	42.59	37.74	33.75	46.31	42.10	29.04	47.37	41.48	25.39	41.81	37.27	33.54	40.16	37.86	36.42	42.71	40.68
East Kalimantan	20.60	37.93	29.45	19.05	36.21	27.38	19.75	25.13	22.26	20.06	38.38	29.51	21.29	35.62	28.37	20.35	39.14	30.33
North Sulawesi	18.65	31.35	26.93	18.65	20.62	19.90	19.70	22.59	21.60	20.04	27.88	25.40	17.38	23.07	21.00	16.75	36.35	30.34
Central Sulawesi	33.01	38.17	37.34	19.78	42.31	38.69	20.31	35.95	33.20	24.26	39.00	36.59	28.67	31.98	31.45	19.22	39.32	35.59
South Sulawesi	25.75	34.79	32.54	25.04	33.55	31.17	24.01	33.07	30.55	26.80	34.23	32.15	26.17	36.12	33.47	30.74	38.10	36.20
Southeast Sulawesi	17.51	35.95	32.53	21.07	30.44	28.87	21.87	35.74	32.87	21.24	37.76	34.73	22.24	34.53	32.24	21.64	39.86	36.18
Gorontalo				15.62	30.59	27.80	14.41	36.84	31.36	20.75	31.54	29.10	19.47	27.63	25.86	29.10	33.22	32.23
West Sulawesi																		
Maluku				8.25	19.47	15.99	15.98	0.00	12.29	8.82	24.77	20.47	16.63	17.61	17.36	23.04	27.92	26.64
North Maluku				19.73	33.40	31.02	20.53	28.63	21.64	16.28	34.48	29.57	14.74	28.33	25.04	23.53	33.72	31.50
West Papua																		
Papua	17.10	37.34	32.99	19.19	25.90	24.39	9.21	75.22	14.54	21.00	31.22	29.18	19.78	26.74	25.23	16.97	30.56	27.57

TABLE 8. CHILD PROTECTION INDICATORS

Area	Percentage married at an early age (Susenas)									Percentage of children aged 0-59 months who have a birth certificate (Susenas)								
Year	2006			2007			2008			2001			2006			2007		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Indonesia	23.89	37.75	32.58	17.12	31.13	25.92	18.82	33.46	27.36	40.15	39.89	40.03	44.58	44.66	44.62	42.61	42.12	42.37
Aceh	13.94	28.14	25.92	9.93	24.34	21.57	14.06	21.07	19.50				23.96	24.88	24.40	28.83	28.06	28.45
North Sumatra	13.35	13.48	13.43	12.04	19.26	16.45	7.85	18.05	13.96	22.37	23.57	22.95	22.88	22.94	22.1	15.89	15.36	15.63
West Sumatra	10.59	22.25	19.62	15.50	22.22	20.68	13.10	20.69	18.97	27.06	28.82	27.92	27.10	25.58	26.36	28.68	29.83	29.22
Riau	20.02	34.91	30.88	10.37	28.46	23.59	12.44	28.67	22.44	37.46	37.48	37.47	32.94	31.35	32.16	30.20	28.98	29.62
Jambi	18.70	32.92	29.84	15.80	34.54	30.56	25.06	34.81	32.19	47.88	45.39	46.64	49.69	50.07	49.87	52.31	50.34	51.35
South Sumatra	21.50	28.22	26.38	18.81	30.74	27.44	22.35	30.73	28.27	27.58	25.32	26.45	37.28	36.35	36.82	36.05	35.78	35.92
Bengkulu	12.79	32.65	28.07	11.78	33.27	28.56	15.31	33.92	29.58	37.30	38.10	37.69	52.55	51.26	51.92	52.16	52.45	52.30
Lampung	25.05	27.72	27.27	12.80	24.39	22.78	13.08	25.17	22.63	29.49	30.81	30.16	39.44	39.85	39.64	38.66	39.55	39.11
Bangka Belitung	20.06	34.27	29.06	22.57	26.86	25.47	28.45	29.85	29.30	35.86	39.20	37.37	54.52	54.01	54.27	54.08	56.63	55.33
Riau Islands	10.94	25.89	14.40	8.01	33.32	14.27	11.37	51.42	36.91				60.79	66.88	63.97	67.11	65.10	66.16
D.K.I Jakarta	14.15	0.00	14.15	11.59	0.00	11.59	12.79	0.00	12.79	81.64	77.99	79.83	85.25	84.22	84.75	80.54	81.45	80.96
West Java	39.47	58.15	49.94	19.50	39.13	29.84	23.28	43.88	33.09	40.62	39.27	39.96	46.43	47.93	47.16	43.72	43.36	43.54
Central Java	16.97	33.32	27.63	14.42	28.30	23.58	13.66	29.37	22.98	44.01	45.78	44.86	54.45	55.57	54.99	55.19	55.53	55.35
D.I. Yogyakarta	3.49	24.99	13.39	7.65	11.60	9.68	12.80	15.10	13.84	79.60	75.40	77.53	85.01	83.91	84.48	78.13	82.28	80.06
East Java	21.82	39.88	33.61	19.67	32.18	27.69	19.34	36.74	29.47	49.21	48.74	48.98	57.48	56.59	57.04	54.81	54.00	54.42
Banten	27.67	42.05	34.10	14.67	29.83	23.24	21.45	39.06	29.41	46.81	45.74	46.34	48.61	48.61	48.61	43.38	42.77	43.08
Bali	18.86	18.57	18.73	14.58	19.70	17.13	12.28	20.45	15.87	37.40	35.01	36.23	45.09	45.09	45.09	44.48	41.24	42.86
West Nusa Tenggara	24.38	28.14	27.00	26.05	36.07	32.68	24.88	29.16	27.50	21.08	22.60	21.85	25.20	23.81	24.51	21.20	19.38	20.30
East Nusa Tenggara	19.98	21.00	20.82	11.99	22.10	20.55	16.44	20.36	19.80	17.15	19.29	18.20	15.07	14.30	14.70	14.99	13.73	14.38
West Kalimantan	25.56	33.45	31.86	21.71	27.58	26.25	20.14	30.49	28.24	31.39	30.77	31.08	37.08	34.09	35.58	34.74	33.61	34.20
Central Kalimantan	24.70	41.39	36.55	25.62	40.00	35.93	29.15	41.94	37.48	33.45	34.98	34.18	31.96	28.68	30.39	28.88	26.85	27.90
South Kalimantan	28.53	44.30	39.33	25.01	33.49	30.33	22.81	40.63	33.87	39.79	34.84	37.41	40.43	40.82	40.61	42.80	41.02	41.94
East Kalimantan	21.12	46.10	33.69	16.79	32.22	24.40	24.42	34.96	29.00	50.40	48.74	49.61	57.68	57.45	57.57	57.00	58.94	57.93
North Sulawesi	23.81	32.70	29.52	27.38	27.58	27.51	22.83	26.91	25.03	46.88	51.81	49.41	47.20	44.03	45.60	33.21	35.47	34.32
Central Sulawesi	16.50	39.10	34.57	19.53	34.98	32.38	28.72	39.67	37.98	27.34	23.80	25.54	24.29	27.73	26.00	20.58	21.05	20.82
South Sulawesi	25.19	38.46	34.08	21.24	35.58	31.42	25.39	38.74	34.83	27.86	29.79	28.78	37.84	35.44	36.71	34.39	33.00	33.71
Southeast Sulawesi	19.72	36.82	33.63	20.09	38.90	35.88	29.10	36.62	35.14	31.20	31.33	31.26	26.40	25.53	25.97	20.96	21.61	21.28
Gorontalo	11.17	35.99	31.13	14.47	32.97	29.15	15.64	37.96	32.06	27.18	22.15	24.77	23.12	22.11	22.63	22.05	23.22	22.62
West Sulawesi	21.46	37.97	35.82	44.10	46.91	46.61	24.26	46.06	40.62				23.76	24.05	23.89	26.34	28.64	27.41
Maluku	20.45	25.28	23.89	14.62	26.29	22.73	14.95	26.68	23.59	38.83	37.48	38.26	21.21	19.79	20.52	21.31	22.78	22.02
North Maluku	25.75	34.56	32.58	16.13	34.36	30.36	23.68	25.64	25.07	34.72	33.37	33.99	25.17	23.78	24.49	19.89	20.80	20.33
West Papua	20.41	31.93	28.06	23.69	24.59	24.36	9.28	25.85	22.20				38.23	41.58	39.74	31.93	30.37	31.17
Papua	12.89	42.04	35.99	20.16	33.22	30.51	19.74	42.35	38.25	37.80	37.56	37.69	36.66	36.82	36.73	32.38	31.72	32.07

TABLE 8. CHILD PROTECTION INDICATORS

Area	Percentage of children aged 0-4 years who have a birth certificate (Intercensal survey)			Percentage of births registered (IDHS)									Number of neglected under-five children (Ministry of Social Affair)		Number of neglected children aged 5 - <18 years (Ministry of Social Affair)		Number of naughty children (Ministry of Social Affair)		Number of street children (Ministry of Social Affair)	
Year	2005			2002-2003			2007						2008	2009	2008	2009	2008	2009	2008	2009
	Urban	Rural	Total	Urban	Rural	Total	Lowest	Second	Middle	Fourth	Highest	Total	Total	Total	Total	Total	Total	Total	Total	Total
Indonesia	2.33	5.82	4.43	2.33	5.82	4.43						4.43	1,147.9	1,284.1	1,808.4	1,713.2	1,808.4	1,713.2	1,808.4	1,713.2
Aceh			1.19			1.19						1.19								
North Sumatra			6.47			6.47						6.47								
West Sumatra			3.15			3.15						3.15								
Riau			2.58			2.58						2.58								
Jambi			9.29			9.29						9.29								
South Sumatra			5.08			5.08						5.08								
Bengkulu			3.82			3.82						3.82								
Lampung			4.98			4.98						4.98								
Bangka Belitung			6.83			6.83						6.83								
Riau Islands			1.25			1.25						1.25								
D.K.I Jakarta			2.72			2.72						2.72								
West Java			3.12			3.12						3.12								
Central Java			3.31			3.31						3.31								
D.I. Yogyakarta			3.34			3.34						3.34								
East Java			3.94			3.94						3.94								
Banten			9.90			9.90						9.90								
Bali			9.67			9.67						9.67								
West Nusa Tenggara			7.14			7.14						7.14								
East Nusa Tenggara			6.08			6.08						6.08								
West Kalimantan			1.88			1.88						1.88								
Central Kalimantan			7.54			7.54						7.54								
South Kalimantan			3.88			3.88						3.88								
East Kalimantan			3.19			3.19						3.19								
North Sulawesi			4.64			4.64						4.64								
Central Sulawesi			9.66			9.66						9.66								
South Sulawesi			6.97			6.97						6.97								
Southeast Sulawesi			5.57			5.57						5.57								
Gorontalo			1.55			1.55						1.55								
West Sulawesi			3.85			3.85						3.85								
Maluku																				
North Maluku																				
West Papua																				
Papua			15.94			15.94						15.94								

DEFINITIONS OF THE INDICATORS

Child worker (10-14 years old)	Children aged 10-14 years engaged in activities / work with the intent to obtain or assist in obtaining income or profit and with duration of work at least one whole hour in the past week (including unpaid family workers who assist in a business / economic activity)
Child labourer (aged 10-14 years old)	Children aged 10-14 years who work or have a job but are temporarily not working, and those who are looking for a job
Percentage of children aged 0-59 months who have a birth certificate	Percentage of infants aged 0-59 months who have a birth certificate issued by the Civil Registration Office
Percentage of births registered	Percentage of all births in the five years preceding the survey that were officially registered
Percentage married at an early age	Percentage of women 20-24 years old who were married or in union before they were 18 years old
Neglected children	Children whose parents, for certain reasons, cannot perform their duties (e.g., due to poverty, illness, death, disruption of family harmony, lack of child carer) such that the children's basic needs (physical, spiritual and social) are not met.
Naughty children	Children aged over 5 (but not yet 18) years whose behaviour deviates from prevailing norms and customs in society, and is detrimental to himself, his family and others, and disrupts the public order, but who, because of their age, cannot be prosecuted.
Street children	Children aged over 5 (but not yet 18) years who spend most of their time making a living from and roaming the streets and public places.

Notes - Data not available

MAIN DATA SOURCES

Child worker (10-14 years old)	National Labour Force Surveys 2001-2005
Child labourer (aged 10-14 years old)	National Labour Force Surveys 2001-2005
Percentage of children aged 0-59 months who have a birth certificate	National Socio-Economic Survey, processed by BPS - Statistics Indonesia, based on projection from the Intercensal Population Survey 2005
Percentage of births registered	Indonesia Demographic and Health Surveys 2002/2003 and 2007
Percentage married at an early age	National Socio-Economic Survey
Neglected children	Ministry of Social Affairs: Data Penyandang Masalah Kesejahteraan Sosial - PMKS Tahun 2008, 2009
Naughty children	Ministry of Social Affairs: Data Penyandang Masalah Kesejahteraan Sosial - PMKS Tahun 2008, 2009
Street children	Ministry of Social Affairs: Data Penyandang Masalah Kesejahteraan Sosial - PMKS Tahun 2008, 2009

TABLE 9. WOMEN INDICATORS

Area	Life expectancy at birth, among females as a % of males (Intercensal Survey)					Adult literacy rate among females as % of males (Susenas)											
Year	2005	2006	2007	2008	2009	2000			2001			2002			2003		
	Total	Total	Total	Total	Total	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above
Indonesia	105.7	105.7	105.8	105.8	105.7	91.9	90.7	99.4	91.8	90.5	99.6	92.7	91.7	99.8	93.2	92.2	99.7
Aceh	105.8	106.0	106.0	106.0	105.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.1	96.6	99.7
North Sumatra	105.6	105.6	105.6	105.6	105.6	97.0	96.5	99.8	96.4	95.7	99.9	96.9	96.4	99.8	97.4	96.9	99.9
West Sumatra	105.9	105.9	105.8	105.7	105.7	96.3	95.7	100.1	96.3	95.5	100.1	97.2	96.6	100.6	97.0	96.5	100.0
Riau	105.6	105.6	105.4	105.6	105.6	96.8	96.2	99.3	96.7	96.0	99.6	98.4	98.1	100.2	97.4	97.0	100.0
Jambi	105.7	105.7	105.8	105.7	105.7	95.3	94.6	99.5	94.6	93.7	100.0	95.4	94.7	100.1	95.5	94.8	100.2
South Sumatra	105.8	105.7	105.7	105.8	105.6	95.1	94.1	99.5	95.2	94.1	99.9	95.4	94.5	99.4	96.3	95.8	99.9
Bengkulu	105.9	105.9	105.9	105.7	105.7	93.4	92.1	99.5	93.0	91.4	99.9	94.9	94.0	99.4	95.3	94.5	98.6
Lampung	105.8	105.7	105.8	105.6	105.6	93.8	92.7	100.0	93.7	92.5	99.9	94.6	93.5	100.3	94.6	93.5	100.2
Bangka Belitung	105.7	105.7	105.8	105.7	105.7	0.0	0.0	0.0	91.2	89.9	98.7	93.7	92.1	100.8	94.5	93.6	99.5
Riau Islands	105.5	105.4	105.4	105.5	105.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
D.K.I Jakarta	105.0	104.9	104.9	104.7	104.8	97.5	97.3	99.8	97.2	96.9	99.8	98.1	97.9	100.0	98.8	98.6	100.1
West Java	105.9	105.9	105.9	105.8	105.7	94.4	93.5	99.4	94.9	93.5	99.7	95.2	94.5	99.8	95.4	94.7	99.9
Central Java	105.6	105.4	105.6	105.5	105.4	89.0	87.4	100.1	88.0	86.1	99.9	88.9	87.3	99.8	89.6	88.1	100.0
D.I. Yogyakarta	104.9	104.9	104.9	104.9	104.9	84.8	83.2	101.0	84.0	82.3	100.0	87.0	85.7	100.6	89.1	88.0	99.8
East Java	105.7	105.8	105.6	105.6	105.6	86.2	84.5	98.9	86.2	84.6	99.1	87.8	86.4	99.4	88.2	86.9	99.2
Banten	106.0	106.0	105.8	105.9	105.8	0.0	0.0	0.0	93.2	92.8	99.8	95.2	94.3	99.1	95.3	94.5	99.2
Bali	105.1	105.1	105.3	105.1	105.1	86.2	84.8	98.7	84.5	82.9	97.5	86.8	85.3	98.7	88.4	87.1	98.6
West Nusa Tenggara	106.1	106.1	106.1	106.1	106.2	85.9	83.5	96.8	87.5	85.4	96.6	88.4	86.1	98.5	86.2	83.2	97.6
East Nusa Tenggara	105.8	106.0	105.8	105.8	105.9	94.7	93.7	100.3	95.3	94.3	102.5	94.6	93.5	100.3	95.0	94.2	101.6
West Kalimantan	105.9	105.7	105.9	105.7	105.7	88.7	86.7	99.0	87.9	85.7	98.1	90.3	88.7	99.3	90.8	89.3	98.8
Central Kalimantan	105.6	105.6	105.6	105.6	105.6	97.1	96.5	99.6	97.3	96.8	99.7	97.4	97.1	100.1	97.5	97.1	100.0
South Kalimantan	106.1	106.0	105.9	106.0	105.8	93.7	92.7	100.1	93.1	91.9	99.3	94.9	94.1	99.7	94.9	94.0	99.9
East Kalimantan	105.6	105.5	105.5	105.4	105.3	95.3	94.5	99.3	95.3	94.6	99.8	96.6	96.0	99.8	96.1	95.5	99.5
North Sulawesi	105.1	105.1	105.1	105.1	104.9	99.5	99.4	100.0	99.5	99.3	100.3	99.9	99.8	99.8	99.9	99.9	100.5
Central Sulawesi	106.1	105.9	106.0	105.9	106.0	96.1	95.4	99.8	96.7	96.0	101.0	97.2	96.5	100.1	96.4	95.8	99.4
South Sulawesi	105.9	105.9	105.9	105.7	105.7	93.6	92.4	100.6	93.4	92.2	101.2	94.4	93.4	102.1	94.6	93.6	102.5
Southeast Sulawesi	105.9	105.9	105.8	105.9	105.7	92.6	90.9	100.5	92.6	91.1	100.0	92.5	91.3	99.9	94.6	93.4	100.2
Gorontalo	105.8	105.8	105.8	105.9	105.9	0.0	0.0	0.0	99.8	99.6	101.7	99.7	100.1	103.4	100.1	99.8	103.1
West Sulawesi	105.9	105.9	105.9	105.7	105.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Maluku	105.8	105.8	105.8	105.9	105.9	86.7	84.5	0.0	100.8	100.0	100.8	0.0	0.0	0.0	98.4	98.1	100.5
North Maluku	106.1	106.1	106.0	106.0	106.0	0.0	0.0	0.0	93.5	92.2	100.1	0.0	0.0	0.0	97.6	97.2	99.9
West Papua	106.0	106.0	105.8	105.9	105.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Papua	106.0	105.8	105.9	105.8	105.9	0.0	0.0	0.0	88.0	86.2	89.3	0.0	0.0	0.0	88.3	86.5	89.6

TABLE 9. WOMEN INDICATORS

Area	Adult literacy rate among females as % of males (Susenas)												Primary school enrolment rate among females as % to males (Susenas)							
Year	2004			2005			2006			2007			2000		2001		2002		2003	
	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	10 yrs old and above	15 yrs old and above	15-24 yrs old and above	Gross	Net	Gross	Net	Gross	Net	Gross	Net
Indonesia	93.3	92.3	99.7	93.7	92.8	99.9	94.3	93.5	99.9	94.0	93.1	99.8	99.3	100.3	99.	100.3	100.0	100.1	99.6	100.1
Aceh	96.5	95.9	100.1	0.0	0.0	0.0	96.5	96.0	100.2	96.4	95.9	99.9	.0	0.0	0.0	0.0	0.0	0.0	100.4	101.1
North Sumatra	97.2	96.7	99.6	97.5	97.0	99.8	97.5	97.1	99.9	97.4	96.9	99.7	98.8	99.5	100.7	100.0	99.2	99.6	98.8	99.9
West Sumatra	96.6	96.1	99.8	97.5	97.1	100.2	97.7	97.3	100.3	97.9	97.5	100.4	97.5	99.6	99.4	100.6	99.8	99.8	98.9	100.8
Riau	98.3	98.1	100.4	98.5	98.3	100.0	98.2	97.9	100.6	98.0	97.6	99.6	99.0	99.6	101.5	100.7	99.1	100.1	98.2	101.2
Jambi	96.2	95.6	99.7	95.5	94.8	100.3	95.6	95.0	99.4	95.6	95.0	99.7	101.0	100.6	99.9	101.5	98.2	98.6	100.2	99.9
South Sumatra	97.1	96.5	100.0	97.0	96.5	99.7	97.4	97.0	99.9	97.3	96.9	99.8	97.4	99.6	99.8	100.8	99.1	99.3	102.5	100.3
Bengkulu	95.2	94.2	99.1	94.9	94.1	99.7	94.9	94.0	99.8	95.0	94.1	100.5	96.4	99.3	98.9	99.6	100.1	100.1	101.3	102.3
Lampung	95.0	94.0	100.3	95.0	94.0	100.7	94.4	93.4	100.4	94.4	93.5	99.9	97.1	99.2	100.3	99.8	98.9	100.4	98.0	98.5
Bangka Belitung	95.2	94.4	99.9	97.0	96.4	100.0	96.0	95.7	100.0	96.3	95.7	101.4	0.0	0.0	98.4	99.3	99.1	102.0	99.5	100.8
Riau Islands	0.0	0.0	0.0	96.8	96.5	99.4	97.1	96.9	100.5	98.0	97.7	101.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
D.K.I Jakarta	98.4	98.3	99.9	98.2	98.0	100.0	98.5	98.3	100.5	98.1	97.9	99.7	102.7	100.4	95.9	96.7	103.1	101.8	99.3	98.9
West Java	95.4	94.7	99.5	95.9	95.3	99.9	96.3	95.7	99.9	96.1	95.5	100.0	99.3	100.7	100.5	100.5	100.2	100.5	99.7	100.5
Central Java	89.8	88.5	99.8	90.7	89.5	100.2	91.7	90.5	100.0	91.1	89.9	99.9	98.6	99.8	98.3	99.8	99.3	99.2	99.0	99.8
D.I. Yogyakarta	88.1	86.9	100.2	88.8	87.8	100.1	88.4	87.4	99.9	87.6	86.4	100.0	100.7	101.9	94.3	98.8	96.9	99.6	99.8	99.0
East Java	88.5	87.2	99.4	89.2	88.0	99.7	90.5	89.5	100.0	90.1	88.9	99.8	98.8	100.2	99.3	99.4	100.1	100.1	99.0	100.0
Banten	95.5	94.7	100.0	96.6	96.1	99.9	96.3	95.8	99.9	96.3	95.6	99.5	0.0	0.0	104.7	101.2	101.9	101.3	100.0	100.4
Bali	87.9	86.7	99.0	87.7	86.4	98.7	87.7	86.4	99.5	87.7	86.2	99.1	100.9	99.3	97.2	98.7	97.0	97.5	100.7	99.5
West Nusa Tenggara	86.9	84.8	97.7	87.3	85.0	99.8	88.4	86.7	98.4	86.8	84.9	98.9	100.2	103.9	100.2	100.0	102.5	101.2	96.6	98.4
East Nusa Tenggara	94.6	93.7	100.3	95.3	94.6	101.5	95.3	94.6	100.6	95.8	94.7	101.2	99.7	102.3	102.0	102.2	100.5	101.2	100.2	100.9
West Kalimantan	90.7	89.0	100.2	91.1	89.4	98.9	92.0	90.7	99.7	92.0	90.7	99.5	103.5	98.9	99.7	102.6	97.0	98.9	99.8	99.2
Central Kalimantan	97.8	97.3	100.0	98.1	97.7	99.7	97.9	97.5	99.9	97.6	97.1	100.4	102.2	101.1	98.4	100.3	101.9	99.5	103.6	101.6
South Kalimantan	95.7	95.1	99.9	95.1	94.4	100.3	95.6	95.1	99.8	95.5	94.8	99.8	99.4	100.7	99.7	99.7	100.9	101.8	98.6	98.5
East Kalimantan	96.4	95.8	99.6	97.0	96.5	100.5	96.7	96.2	100.1	96.6	96.1	99.6	105.5	101.5	98.0	99.7	99.6	99.3	96.0	97.0
North Sulawesi	99.8	99.7	99.7	99.7	99.6	100.0	100.0	99.8	100.2	99.6	99.4	100.1	98.7	100.8	98.6	99.5	104.1	100.1	99.6	98.1
Central Sulawesi	97.4	97.1	100.9	97.0	96.6	99.4	97.4	96.9	100.3	97.1	96.7	100.9	103.9	101.1	103.8	101.4	102.0	100.8	98.8	99.1
South Sulawesi	94.5	93.4	101.8	94.8	94.2	101.8	95.0	94.3	101.3	94.3	93.3	101.5	101.2	101.1	103.0	103.1	99.8	100.3	103.5	102.9
Southeast Sulawesi	94.0	92.9	99.6	93.7	92.6	100.5	93.4	92.3	99.7	94.0	92.7	100.5	99.1	102.1	99.7	100.7	98.7	98.0	97.3	99.2
Gorontalo	101.8	101.5	103.0	100.8	100.2	101.4	100.9	100.5	102.2	101.1	100.6	100.5	0.0	0.0	103.4	100.9	111.4	107.3	103.1	102.3
West Sulawesi	0.0	0.0	0.0	0.0	0.0	0.0	94.8	93.8	101.4	94.8	93.4	99.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Maluku	98.4	98.3	100.1	98.3	97.9	100.4	99.0	98.7	99.1	98.4	98.1	100.0	97.2	0.0	109.2	110.7	0.0	0.0	101.9	101.9
North Maluku	95.9	94.7	97.9	96.5	95.9	100.2	96.4	95.8	100.2	96.2	95.4	100.3	0.0	0.0	91.0	95.8	0.0	0.0	108.7	102.0
West Papua	0.0	0.0	0.0	0.0	0.0	0.0	94.7	94.1	97.1	95.6	94.8	98.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Papua	87.6	86.1	88.4	87.8	86.4	87.8	88.6	87.1	88.4	87.0	84.9	89.6	0.0	0.0	97.2	99.5	0.0	0.0	100.2	100.7

TABLE 9. WOMEN INDICATORS

Area	Primary school enrolment rate among females as % to males (Susenas)								Junior secondary school enrolment rate among females as % to males (Susenas)													
Year	2004		2005		2006		2007		2000		2001		2002		2003		2004		2005		2006		2007	
	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net	Gross	Net
Indonesia	99.2	99.8	98.9	99.9	99.3	99.4	100.1	99.7	101.0	104.2	101.4	104.8	101.3	102.6	103.1	103.0	102.3	103.4	103.4	103.3	101.6	100.0	102.2	102.0
Aceh	99.5	99.5	0.0	0.0	99.9	99.5	99.6	100.3	0.0	0.0	0.0	0.0	0.0	0.0	99.9	102.7	98.0	99.2	0.0	0.0	98.9	99.3	102.7	102.1
North Sumatra	99.9	99.2	98.7	99.7	98.2	98.5	98.6	99.4	102.7	102.3	104.7	104.2	102.0	103.3	101.1	101.1	100.2	100.4	103.5	103.2	103.8	101.3	102.2	100.9
West Sumatra	100.6	99.9	99.4	99.1	100.6	99.2	96.8	99.6	107.5	112.0	107.9	108.9	110.4	112.3	105.0	105.8	107.1	108.3	108.5	105.3	110.7	108.7	112.4	109.8
Riau	98.3	98.9	101.0	100.1	100.1	100.4	99.9	98.7	107.0	105.8	99.0	100.1	96.1	100.6	106.7	107.3	103.9	101.6	102.5	100.1	94.7	99.3	98.6	103.2
Jambi	101.6	100.5	98.7	99.3	97.8	98.8	99.4	99.3	96.1	101.6	104.4	102.9	98.4	97.3	102.0	101.5	99.0	98.3	108.4	104.1	107.4	102.7	105.9	103.7
South Sumatra	97.9	99.6	96.0	98.7	98.6	99.5	99.4	100.1	98.4	104.3	103.9	109.3	100.0	99.1	100.0	99.6	105.4	107.4	102.6	99.3	109.7	109.0	106.3	104.9
Bengkulu	97.6	100.8	98.6	98.4	99.4	99.7	102.7	101.2	103.2	105.3	105.5	111.4	101.9	101.4	96.8	107.8	97.5	96.5	106.2	100.8	94.1	97.3	98.5	104.0
Lampung	99.7	100.8	96.4	98.7	99.7	98.9	102.5	100.5	111.5	108.5	106.3	105.2	105.4	106.9	112.5	109.8	104.1	101.9	112.1	111.0	110.0	106.2	108.3	108.2
Bangka Belitung	98.3	103.1	97.0	98.2	105.1	99.0	103.4	100.7	0.0	0.0	106.8	137.4	104.7	114.0	125.6	131.4	104.9	122.9	112.4	112.6	104.5	97.6	100.1	103.3
Riau Islands	0.0	0.0	100.9	100.7	102.7	99.8	99.9	98.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	91.6	94.7	102.5	101.4	98.6	100.5
D.K.I Jakarta	99.1	98.8	99.9	101.4	98.4	96.5	101.1	98.3	90.5	94.4	94.8	94.6	92.7	95.1	107.5	100.1	95.6	93.7	90.9	90.4	97.1	90.7	97.4	91.1
West Java	98.8	99.4	99.4	99.6	101.7	100.8	102.1	100.3	100.7	103.6	97.2	104.5	100.3	99.3	101.4	103.0	103.8	103.1	102.2	101.5	93.3	93.8	100.1	99.1
Central Java	99.3	99.5	97.7	100.0	96.1	98.2	100.3	99.4	102.0	106.6	100.3	104.5	102.5	105.6	105.9	106.3	101.6	105.4	105.3	106.4	108.9	103.1	104.3	103.1
D.I. Yogyakarta	96.6	101.8	100.0	100.5	103.5	97.9	93.0	99.3	103.3	108.9	102.6	101.6	99.3	102.9	98.3	96.2	100.5	107.6	101.1	103.1	96.6	103.6	107.4	104.7
East Java	99.4	100.0	98.5	99.2	97.3	99.0	99.6	99.3	99.6	104.2	103.4	103.7	100.5	103.8	101.5	101.2	105.4	105.4	108.8	107.1	102.4	101.4	101.3	101.9
Banten	99.9	100.6	101.1	102.2	102.0	99.5	101.4	101.8	0.0	0.0	95.2	106.1	97.7	98.5	103.8	103.3	100.3	102.0	93.7	98.2	97.4	94.7	92.6	101.4
Bali	100.7	99.1	100.2	101.1	98.1	99.0	98.2	98.5	75.8	87.5	88.4	88.8	97.9	97.5	87.0	92.8	91.3	96.3	96.7	98.6	93.9	89.1	100.0	96.2
West Nusa Tenggara	98.4	98.5	101.8	100.4	102.8	101.3	97.2	99.6	70.2	98.5	111.0	111.9	92.9	93.8	89.7	90.3	107.5	105.3	105.6	107.2	93.8	96.4	101.7	100.7
East Nusa Tenggara	97.9	100.7	96.5	100.0	99.5	99.6	99.2	99.5	132.1	114.3	115.3	116.2	108.1	108.4	105.3	106.3	100.4	103.8	112.8	113.3	109.5	110.7	106.7	108.9
West Kalimantan	96.9	99.4	101.3	100.5	100.4	100.6	98.6	99.9	116.3	91.6	97.2	102.9	101.9	108.0	107.0	103.6	98.7	104.2	100.1	95.8	98.5	99.1	96.9	98.6
Central Kalimantan	98.7	98.8	96.7	99.4	100.3	99.9	102.6	100.8	85.6	104.2	103.7	112.0	105.1	95.1	111.4	109.2	93.8	94.6	102.1	105.9	102.9	102.4	102.6	104.5
South Kalimantan	98.9	100.7	102.1	99.7	100.2	100.2	97.9	99.5	123.1	107.4	104.2	108.8	100.2	98.3	110.2	106.8	101.7	106.5	96.2	101.9	97.4	97.6	102.7	107.5
East Kalimantan	100.4	99.9	96.9	98.3	98.8	98.4	100.9	99.1	94.1	94.3	106.9	110.5	104.1	111.1	109.3	109.1	101.0	101.3	98.7	98.6	100.5	100.2	99.8	98.2
North Sulawesi	101.3	100.1	97.4	100.9	100.7	99.5	96.9	98.4	77.0	104.9	109.9	112.2	100.6	101.3	104.9	114.5	97.0	94.2	95.2	101.4	113.3	109.5	113.0	103.4
Central Sulawesi	99.4	98.7	99.4	99.5	101.3	100.5	101.0	98.9	104.1	99.4	95.1	101.5	103.2	108.8	100.9	99.5	105.4	106.9	113.1	111.8	106.2	104.7	104.5	107.9
South Sulawesi	101.5	102.7	100.3	101.0	99.1	100.4	100.1	99.5	123.4	107.2	106.3	107.4	109.7	106.9	102.7	100.9	101.2	103.3	102.4	101.0	99.0	97.9	112.4	110.0
Southeast Sulawesi	101.2	100.5	98.3	99.3	98.7	99.0	98.9	100.1	0.0	113.6	108.9	116.2	112.2	111.6	114.5	102.1	107.2	107.1	104.7	101.9	105.4	102.1	110.4	108.9
Gorontalo	99.3	104.6	102.6	103.0	99.4	101.4	109.7	102.4	0.0	0.0	126.8	123.8	94.3	97.4	116.0	119.7	108.3	109.6	113.7	123.8	149.1	148.3	95.5	107.1
West Sulawesi	0.0	0.0	0.0	0.0	100.3	100.6	103.9	102.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	108.3	111.0	104.4	108.3
Maluku	98.2	99.6	101.2	99.0	104.4	100.3	103.8	100.7	117.4	0.0	109.7	135.5	0.0	0.0	99.0	102.3	107.3	101.8	96.6	84.8	95.7	95.2	96.4	98.2
North Maluku	98.8	101.5	102.5	98.9	103.1	97.5	97.6	99.3	0.0	0.0	94.8	95.4	0.0	0.0	88.4	90.4	101.1	80.4	97.7	74.8	95.2	88.3	97.9	101.5
West Papua	0.0	0.0	0.0	0.0	95.5	99.3	98.6	96.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	96.4	102.1	101.6	108.5
Papua	98.2	98.8	97.7	100.1	98.1	98.4	95.9	97.2	0.0	0.0	97.0	116.1	0.0	0.0	97.1	98.3	94.1	0.0	90.9	0.0	88.6	87.9	100.1	104.7

DEFINITIONS OF THE INDICATORS

Life expectancy at birth	Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.
Adult literacy rate among females as % of males	Ratio of the female literacy rate to the male literacy rate for the age group 15–24 years old. The indicator is derived by dividing the literacy rate of women ages 15–24 years old by the literacy rate of men ages 15–24 years old.
Primary school enrolment rate among females as % to males	the ratio of the net /gross enrolment rate of female students enrolled at primary levels in public and private schools to the net/gross enrolment rate of male students. It is expressed in percent.
Junior secondary school enrolment rate among females as % to males	the ratio of the net /gross enrolment rate of female students enrolled at junior secondary levels in public and private schools to the net/ gross enrolment rate of male students. It is expressed in percent.

Notes - Data not available

MAIN DATA SOURCES

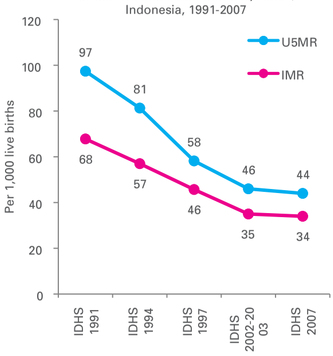
Life expectancy at birth, among females as a % of males	Population Projection based on Intercensal Population Survey 2005
Adult literacy rate among females as % of males (10 years and above, 15 years and above, 15-24 years old)	National Socio-Economic Survey
Primary school enrolment rate among females as % to males (GER and NER)	National Socio-Economic Survey
Junior secondary school enrolment rate among females as % to males (GER and NER)	National Socio-Economic Survey

1
UNDER-FIVE AND INFANT MORTALITY RATE

PROGRESS

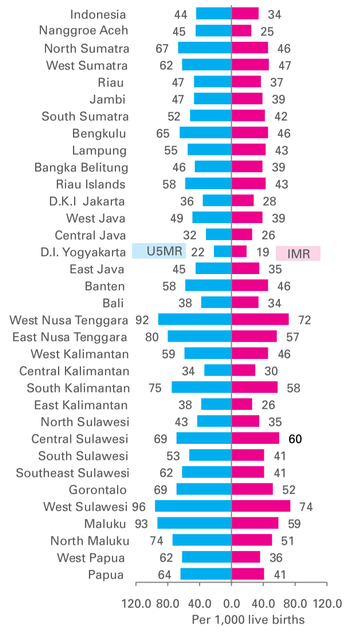
After two decades of significant improvements in IMR and U5MR, the progress since 2002/2003 to 2007 is still ongoing but at a much slower rate: a two point reduction in the U5MR and a one point reduction in the IMR.

Under-five and Infant Mortality Rate*, Indonesia, 1991-2007



Source: Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1993, 1995, 1998, 2003, 2008
*: U5MR and IMR for the five years period for preceding the survey

Disparity of Child Mortality Rate in Indonesia
Under-five and Infant Mortality Rate by Province, 2007



Source: Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2008

BUT

... at a provincial level the IMR is as low as 19 (IMR) and 22 (U5MR) for DI Yogyakarta and as high as 74(IMR) and 96 (U5MR) for the newly formed province of West Sulawesi. The disparity is also occurs between areas (urban-rural), gender, and wealth quantile.

ANNEX 2.
PROGRESS SINCE SITAN 2000

A Statistical Review of Selected Indicators

This Annex provides a statistical overview of key aspects of the situation of children and women in Indonesia, related to health and nutrition, water and sanitation, HIV/AIDS, education (focusing on basic education, early child education, and literacy rate), child protection (focusing on birth registration, child married, and child labour) and lastly fertility and poverty.

Considerable progress has been made in almost all indicators towards improving the situation of children and women over the past decade at national aggregate figures in health, nutrition, water and sanitation, and education, although much work remains to be undertaken in the area of HIV and AIDS prevention and Child (Special) Protection. However, across these indicators, there are consistent inequalities and inequity between the provinces, where in many cases a few drag up the aggregates for the majority. Furthermore, the poorest quintiles and people in rural areas tend to be left behind in the achievements which have been made for women and children in recent years. Moreover, on some indicators gender inequities remain.

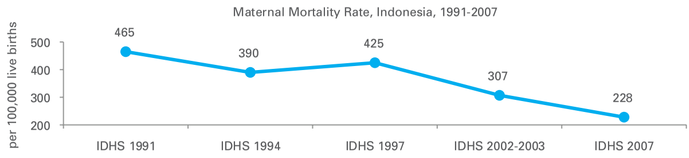
These results indicate the importance of policy initiatives which aim to achieve the MDGs with equity and ensure growth in Indonesia is pro-poor and seeks to remedy regional, socio-economic and gender inequities.

Key indicators:
1. Infant and Under-five Mortality Rate
2. Maternal Mortality
3. Child Malnutrition
4. Safe drinking water and sanitation
5. HIV/AIDS
6. Breastfeeding
7. Basic Education(Primary and secondary education)
8. Early Child Education
9. Literacy Rate
10. Birth registration
11. Child Marriage
12. Child Labour
13. Total fertility Rate
14. Poverty

2. MATERNAL MORTALITY

PROGRESS

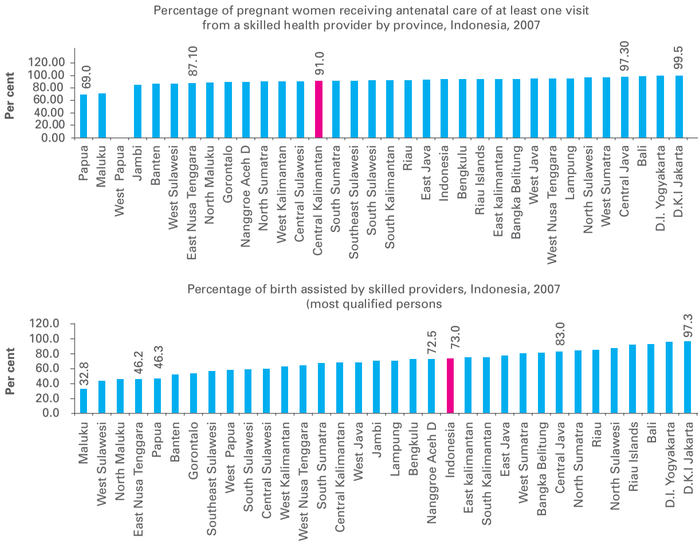
While the MMR has decreased to 228, the rate is still far above that of neighbouring countries in Southeast Asia (in 2007 the rate for Viet Nam was 160; Thailand was 12; Malaysia was 28; and 160 for the Philippines).

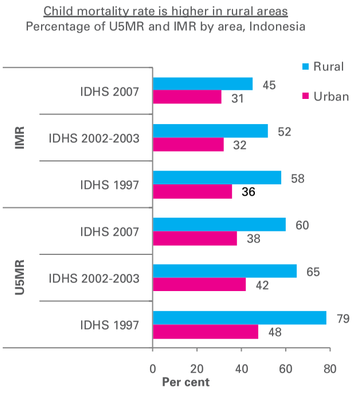


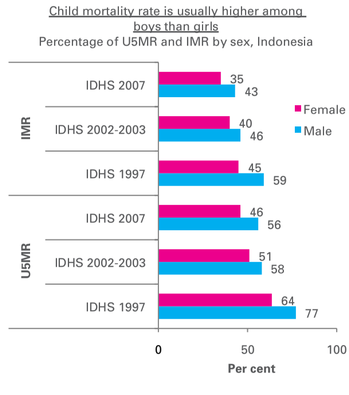
Source: Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1993, 1995, 1998, 2003, 2008

BUT

... although the provincial MMR is not available but the disparity across provinces can be observed by comparing the critical services related to mortality incidence, such as ante natal care and birth/delivery assistance. There are some notable differences across provinces in the use and availability of these services.







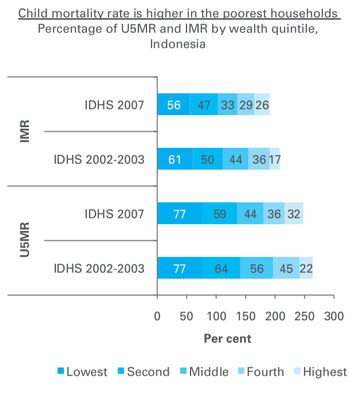
Source: Indonesia Demographic and Health Survey 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1998, 2003, 2008

ISSUE

Most childhood mortality in Indonesia takes place in infancy due to neonatal problems (such as respiratory failures, low-birth weight, premature births, neonatal infections, etc.), as well as in early childhood due to diarrhoea and pneumonia.

The contribution of neonatal deaths (i.e. the death of child born alive before 28 days) and post neonatal deaths (deaths of child born alive after 28 days but before a year old) to the overall mortality rates requires further attention. Data from the 2007 IDHS indicates a similar pattern in Indonesia with over two-thirds of under-five deaths taking place within the first month after birth (77 percent) and 80 percent of these deaths taking place within the first week of life.

The introduction of safety net programmes in health with the onset of the financial crisis, may have had some impact on the decline of disparities in the IMR between 1997 and 2003. However, the increasing gap between provinces indicates that current health interventions related to the IMR are not effectively reducing provincial disparities.



Source: Indonesia Demographic and Health Survey 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2003, 2008

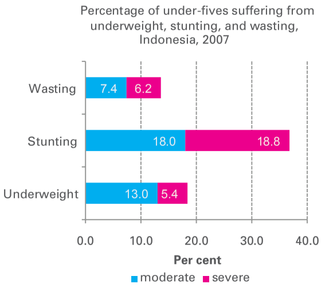
3. CHILD MALNUTRITION

PROGRESS

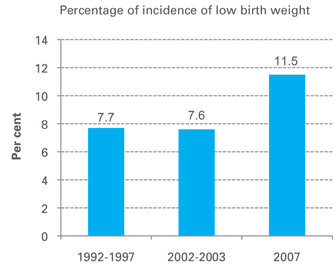
Child malnutrition remains a key issue in Indonesia. Although over the last decades, the number of underweight children has been reduced, 18 percent of Indonesian children remain affected based on 2007 data (Figure 3.1.33). Yet, stunting and wasting are of great concern as 37 percent of Indonesian children are stunted while 14 percent are wasted.

Child stunting is widely accepted as one of the best predictors of the quality of human capital, influencing potential academic performance and future earning capability of a nation. But the fact is Indonesia currently ranks fifth in the world in terms of number of stunted children. Indonesia is currently ranked amongst the 10 worst countries in the world for the prevalence of stunting

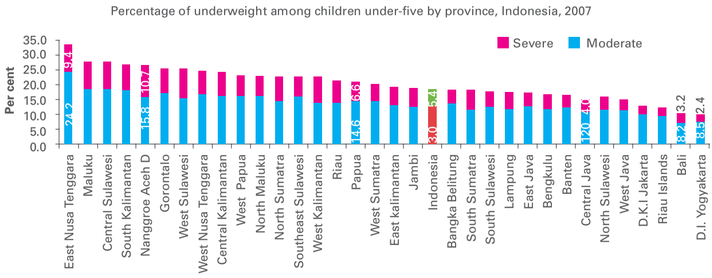
Low birth weight in Indonesia is still high and more worrying still that is has increased between 2002-3 and 2007 from 7.6 percent to 11.5 percent (IDHS 2007).



Source: Riskesdas (Riset Kesehatan Dasar) 2007, Laporan Nasional, Ministry of Health, 2008, Jakarta



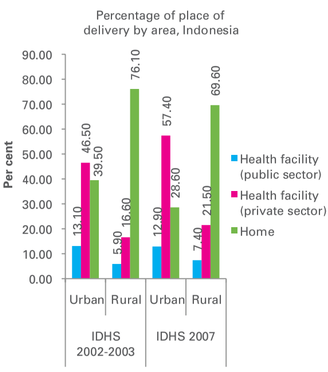
Source: Indonesia Demographic and Health Survey

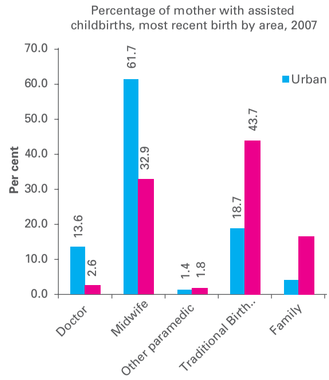


ISSUES

The leading immediate causes of maternal mortality in Indonesia are haemorrhage (28 percent), eclampsia (24 percent) and infections (11 percent). Haemorrhage, often due to retained placenta, is an indication of poor medical support during labour. Eclampsia reflects inadequate care and management during pregnancy and delivery. Death by infection is due to poor prevention and management of infections, unsafe abortions (the majority among married women) and lack of clean delivery. Indirect contributing factors relating to maternal mortality are discussed later in this sub-section and are likely to be related to prenatal care, birth assistance by skilled health professionals, giving birth in health facilities to reduce the likelihood that death results in complicated births, and level of maternal nutrition among others.

In Indonesia, most of births are still taking place at home. This shows the challenges in the provision of service and readiness of population to use health facilities; a manifestation of structural, social as well as behavioural problems. Although the attendance of skilled health personnel is increasing from 40.7 per cent in 1992 to 66.3 per cent in 2002 and 73 per cent in 2007, but it is still far from the target of 90 per cent.





Source: Indonesia Demographic and Health Survey 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2003, 2008

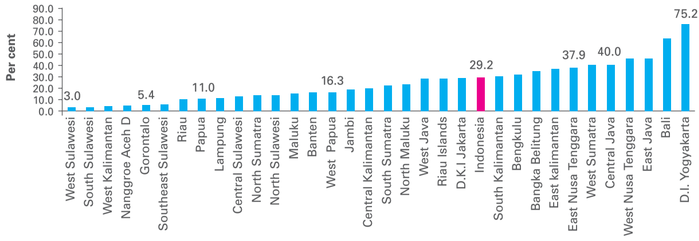
Maternal nutrition is also of concern. Riskesdas 2007 data indicates that 14 percent of women have chronic energy deficiency (mid-upper arm circumference <23.5 cm). According to WHO, a prevalence rate between 10-19 percent is considered as a medium prevalence, indicating a poor nutrition situation. Riskesdas 2007 data shows that in general urban areas 20 percent of reproductive age women are anaemic, and 25 percent are anaemic in pregnancy. Maternal undernutrition increases the risk of low birth weight.

ISSUES

Under-nutrition is associated with a number of infectious and non infection diseases (i.e. anaemia) and under-nutrition is estimated to contribute to a third of the U5MR at global level (WHO/UNICEF 2010). In addition, nutritional deficiencies during early childhood (often measured through stunting) have a long-term negative impact on children growth and development, not least on the work capacity and intellectual performance of adults.

There is a wide disparities in the percentage of women who receive over 90 tablets by province where the difference between best and worst performer (D.I Yogyakarta and West Sulawesi respectively) is over 72 percent. In addition, a majority of provinces (22) perform less well than the national average).

Percentage of pregnant women who receive iron tablets (>90 tablets) by province, Indonesia, 2007

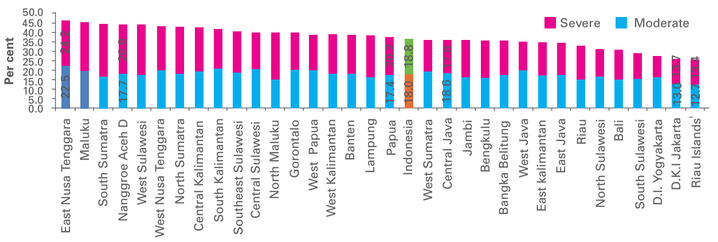


Source: Indonesia Demographic and Health Survey (IDHS) 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2008

The most effective interventions in reducing mortality for children under five is exclusive breastfeeding up to six months old, and timely appropriate complementary feeding from six months onwards with continued breastfeeding up to 2 years of age. However, the 2007 IDHS data indicates that only 32.4 percent of Indonesian children less than six months of age are exclusively breastfed. This represents a net decrease from the 40 percent rate in 2002 and is likely attributed to the sharp increase of bottle-feeding practices from 17 percent to 28 percent among children.

Although the commitment to act for nutrition is reasonably strong, the capacity to act for nutrition still needs to be strengthened. The existing strong commitment to act for nutrition is misdirected at trying to resolve acute nutrition problems rather than putting into place systems and interventions to prevent children and women becoming malnourished, largely because the latter is not generally recognised as a problem. Commitment to resolving the problem of stunting is growing at the national level, but at the provincial and district levels where all the action is decided and implemented, the nutrition problem is still largely equated with severe undernutrition (Gizi Buruk) and/or to a lack of food.

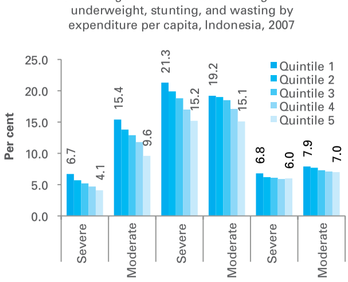
Percentage of stunting among children under-five by province, Indonesia, 2007



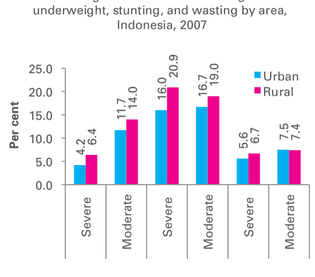
Percentage of wasting among children under-five by province, Indonesia, 2007

Rural children and children born in the poorest quintiles of the population are most affected by all aspects of malnutrition. The incidence of low birth weight is more prominent in rural area, affects female infants more than male infants and as would be expected is more concentrated amongst the first and poorest quintile of the population.

Percentage of under-fives suffering from underweight, stunting, and wasting by expenditure per capita, Indonesia, 2007



Percentage of under-fives suffering from underweight, stunting, and wasting by area, Indonesia, 2007



Source: Riskesdas (Riset Kesehatan Dasar) 2007, Laporan Nasional, Ministry of Health, 2008, Jakarta

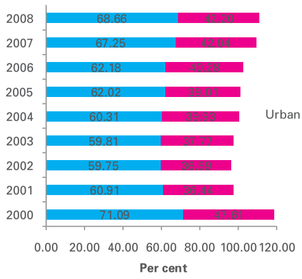
BUT

Provincial level data however indicates that a majority of provinces are underperforming compared to the national average. The pattern of rural/urban disparities is once again very strong with less than half of the number of rural households have access to clean water; even worse for the case of accessing adequate sanitation

Within a context of ongoing high inequalities and disparities

Clean water coverage in urban areas is higher than in rural areas

Percentage of households with sustainable access to clean water by area, Indonesia



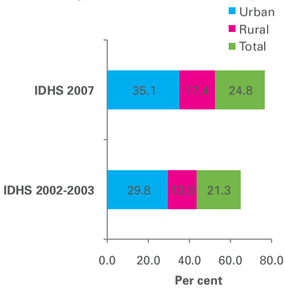
Clean water coverage in urban areas is higher than in rural areas

Percentage of households with sustainable access to clean water by area, Indonesia

Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

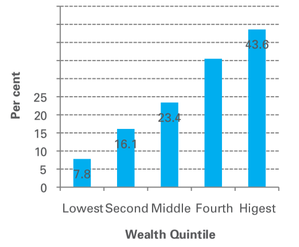
Sanitation coverage in urban areas is higher than rural areas

Percentage of child uses toilet/latrine by area, Indonesia



Sanitation coverage is higher in the rich households

Percentage of child uses toilet/latrine by wealth quintile, Indonesia, 2007



Source: Indonesia Demographic and Health Survey 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2003, 2008

ISSUES

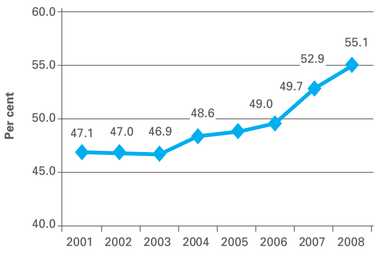
The provision of facilities and services is only one of the key constituent parts for improving water and sanitation. Knowledge, information, and the promotion of good hygiene practices are needed to be consolidated in order to generate sustainable behavioral change.

4. WATER AND SANITATION

PROGRESS

Access to clean water in Indonesia has since increased steadily since 2001 according to National Socio-Economic Survey Data.

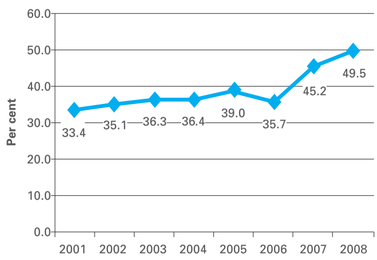
Percentage of households with sustainable access to clean water, Indonesia, 2001-2008



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

The pattern with regards to basic sanitation facilities** is one of ongoing and steady increases at national level, but still failing to reach a majority of the population in 2008

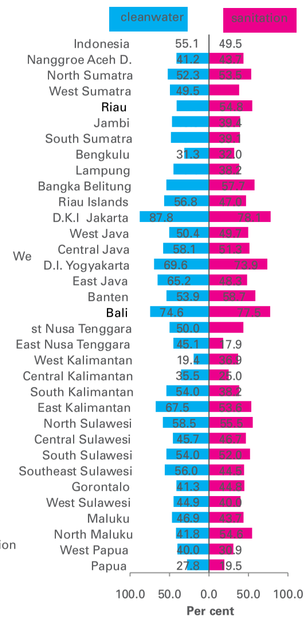
Percentage of households with sustainable access to adequate sanitation (pit latrine and septic tanks), 2000-2008, Indonesia



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

Disparity of Access to Clean Water and Sanitation in Inonesia

Access to clean water and sanitation by province, 2008



ISSUES

Since the year 2000, HIV prevalence has been consistently over 5 percent in several key populations such as Injecting Drug Users (IDUs), sex workers, transgenders (waria), and Men having Sex with Men (MSM) leading to classification of the epidemic in Indonesia as a concentrated one.

Injecting drug use and sexual transmission remain the main modes of HIV transmission in Indonesia.
The data gaps and indications of poor knowledge of adolescents on HIV infection, and weak outreach services providing HIV testing and protection for young people aged 15-25 highlight that there is a need to pay more attention to most at risk adolescents, as at present there is an absence of policy and programming tools specifically designed for this group.

The National AIDS Commission has introduced a new HIV and AIDS strategy and action plan 2010-2014, however, the specific areas which need additional attention including:

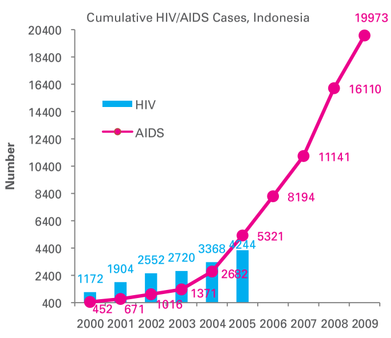
1. Weak leadership in several government departments and regions has led, thus far, to inadequate support policies as well as severely limited programme implementation.
2. Improvement is needed in management, including, budget design more sharply focused to facilitate achievement of targets as well budget management which is more transparent.
3. Strengthening of logistics management, particularly for ARV and methadone, to ensure sufficient ARV and methadone stock is reliably available in treatment service sites when needed.
4. Improvement of coordination and partnership at provincial and district level to overcome difficulties experienced by some local AIDS Commissions in their effort to coordinate with government departments, implementing agencies, local NGOs and other stake holders in the response to HIV and AIDS.
5. Increased involvement of key populations, particularly for prevention programmes.
6. Improvement of monitoring and evaluation, particularly at local level (province and district) and related to the work of government departments.

5. HIV/AIDS

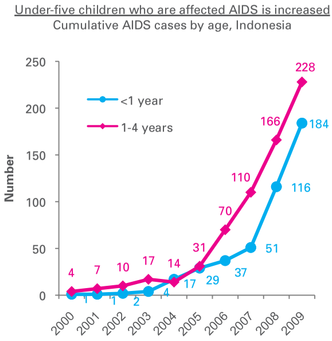
PROGRESS

Indonesia has been one of the fastest growing HIV epidemics in the region. It is important to note that these are only reported cases and the data may be equally showing improved reporting tendencies and methods as it is increased infection rates.

There is an indication of feminization of the AIDS epidemic in Indonesia. In 2009, 25 percent of people living with HIV (PLHIV) were women, an increase from 21 percent in 2006, particularly the partners of IDUs and men who are the clients of sex workers - being increasingly exposed to HIV infection



Source: Directorate General of Communicable Diseases Control & Environmental Health, Ministry of Health



Source: Directorate General of Communicable Diseases Control & Environmental Health, Ministry of Health

ISSUES

The net decrease of breasfeeding rate from 40 per cent in 2002/3 to 32.4 per cent in 2007 is likely attributed to the sharp increase of bottle-feeding practices from 17 percent to 28 percent among children under-six months of age during the same period. The median duration of exclusive breastfeeding has dropped from 3.2 months in 2002 to 2.7 in 2007. The median duration of any breastfeeding in Indonesia has been steadily decreasing from about 23.9 months in 1997 to around 22 months in 2002-2003 to about 20.7 months in 2007.

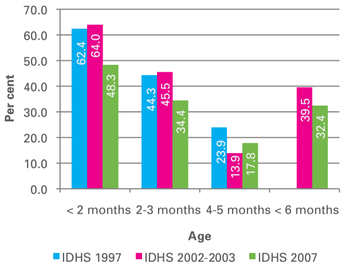
The poor level of exclusive early breastfeeding among the poor and the general declining trend in breastfeeding overall is a key source of concern in Indonesia and plays significant part in Indonesia's ongoing child malnutrition problems.

6. BREASTFEEDING

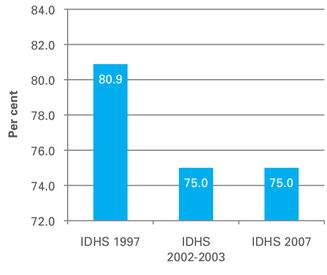
PROGRESS

Exclusive breastfeeding rates decreased over the decade. The decrease was also noted in breastfeeding with complementary feeding for infant aged 6-9 months.

Percentage children who are exclusively breastfed by age, Indonesia



Percentage of children who are breastfed with complementary food (6-9 months), Indonesia

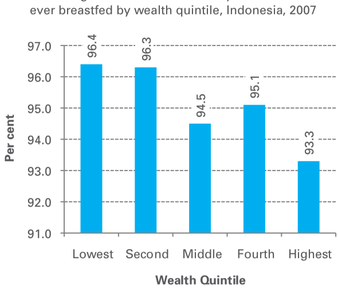


Source: Indonesia Demographic and Health Survey 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1998, 2003, 2008

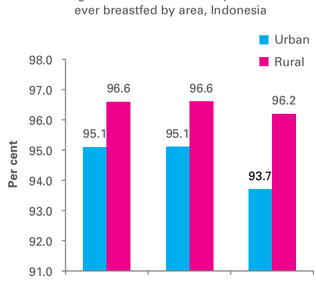
BUT

Children from poorer household or from rural areas are more likely to be breastfed than their wealthier or urban counterparts. Children born to mothers with secondary or higher education, children of mothers who were assisted by a health professional during delivery and born in a health facility, and children from more prosperous family are those more likely to receive a pre-lacteal feeding.

Percentage of children under-five years who were ever breastfed by wealth quintile, Indonesia, 2007



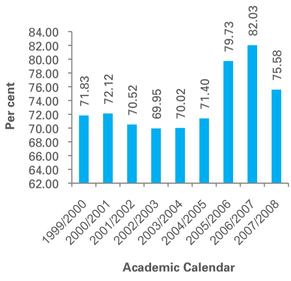
Percentage of children under-five years who were ever breastfed by area, Indonesia



Source: Indonesia Demographic and Health Survey 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1998, 2003, 2008

A substantial number of provinces are performing better than the national average (15) suggesting some success in improving access to secondary schools nationwide. However, these advances are more limited than those for primary schools with eighteen provinces underperforming compared to the national average and fourteen of the provinces have an attendance rate more than 10 percent below that of the best performer.

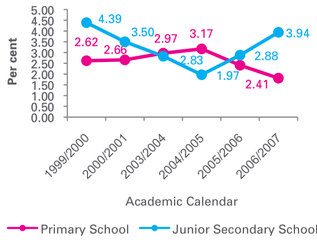
Transition rate to junior secondary school, Indonesia, 1998/1999 - 2007/2008



Source: Indonesia Ministry of Education, website, www. depdiknas.go.id/statistik, accessed July 1st, 2009

Drop out rate of primary school is low and has decreased, but drop out of junior secondary school is increased

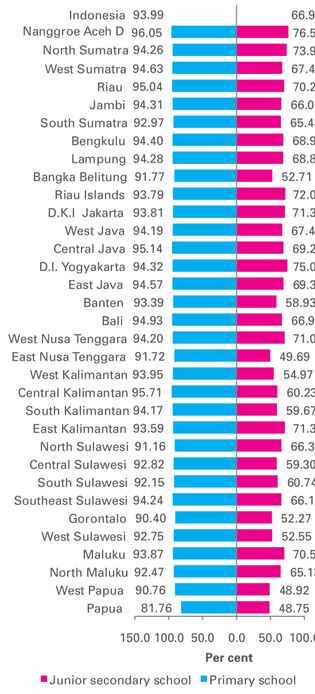
Junior secondary school drop out rate, Indonesia



Source: Indonesia Ministry of Education, website, www.depdiknas.go.id/statistik, accessed July 1st, 2009

Disparity between provinces

NER primary and junior secondary school, Indonesia, 2008



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

ISSUES

Increasing access and number of pupils is of limited if the education is of poor dubious quality. There are several broad areas relating to the quality of education that have been identified by the GoI (RPJPM 2010-2014), including learning achievement; the quality of teachers; and, the need to improve the structure, responsiveness and the coherence of the educational system.

7. BASIC EDUCATION (PRIMARY AND JUNIOR SECONDARY SCHOOL)

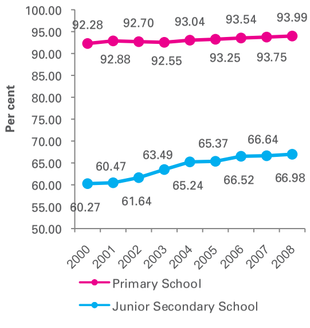
PROGRESS

Working towards universal basic education (six years of primary education and three years of junior secondary education) has been a major goal and undertaking by the Government of Indonesia and the expansion of access to basic education over the past two decades has been impressive. The Net Attendance Rate of primary school over the period of 2000-2008 is not only very high, but have also been steadily increasing. Whilst the attendance rate for junior secondary schools are substantially lower than for primary education, the trend nonetheless shows a continuous and substantial increase between 2000 and 2008, from 60.27 percent to 66.98 percent.

The completion rate is also increasing especially since 2005, it is attributable to the introduction of BOS assistance program by the government in 2005 which gives financial assistance to poor students at schools, both in rural and urban areas.

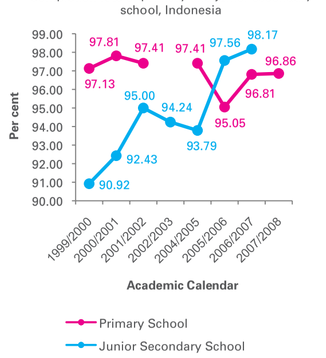
Achieving universal access to basic education in Indonesia

Net enrollment rate of primary and junior secondary school, Indonesia, 2000-2008



The completion rate of primary and junior secondary school are increased

Completion rate of primary and junior secondary school, Indonesia



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

Source: Indonesia Ministry of Education, website, www.depdiknas.go.id/statistik, accessed July 1st, 2009

But There are alarming situations on the indicators. There are 24 percent of children who graduated from primary schools failed to enrol into secondary school. Besides the drop-out rate at junior secondary school increased from 1.97 percent in 2004-2005 to 3.94 percent in 2006-2007. The disparity across province was also still remain although the rate is diminishing due to the implementation of universal primary education policy.

There was almost even distribution between provinces that perform better than the national average (16) and those that underperform (17), however while 32 of the 33 provinces achieve attendance rates above 90 percent, Papua was still lags far behind with a primary school attendance rate of 81.8 percent.

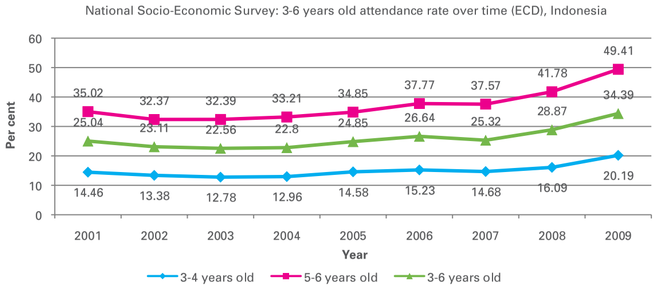
Mothers level of education and household socio-economic status both correlate strongly with accessing early childhood education.

There are also significant provincial and district variations in ECE access, which appear to correlate significantly with a number of child health indicators such as levels of child malnutrition, infant mortality and immunization rates

8. EARLY CHILDHOOD EDUCATION (ECE)

PROGRESS

Early childhood education in Indonesia is dispensed by a variety of institutions including kindergarten, religion based kindergarten, playgroup, day care, holistic integrated ECD service, ECE post (pos PAUD), religion based ECD post. The GoI considers early childhood education within the wider framework of early childhood services that also comprises child and maternal health services (i.e. Integrated Service Post and Mother's programmes). However, the ECD service gross attendance rate for children from aged 3-6 years over the period of 2001-2009 has been slowly increased.



Source: National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009. Note: the National Socio-Economic Survey report provides data on pre-school attendance (ages 3-6)

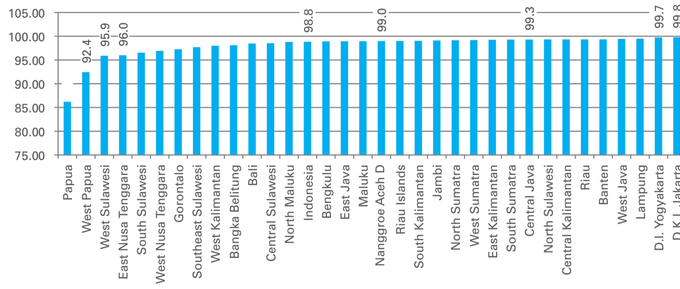
Data published in the mid –term report of Education For All (EFA) also points towards significant urban /rural disparities for the enrolment of 3 to 6 years old, standing at 25.4 percent and 15.4 percent respectively. Furthermore, data from a study of ECD financing demonstrates that around 30 percent of children of Indonesia are excluded from a set of services that are critically important for early childhood development, which is strongly related to poverty. Access disparities between the richest and poorest quintiles are also significant at 24.8% and 15.8% respectively.

ISSUES

The very substantial improvement of ECE is mainly due to expansion and better reporting of non-formal community based educational institutions.A report by UNESCO conducted in 2005 underlined that there was an almost complete absence of government investment in early childhood education and that kindergarten education was supported almost entirely by 'private' sources, with parents making the greatest contribution. As a result, under these circumstances children benefiting from early education services have tended to be from higher income groups, thus fuelling inequity and disparity in relation to equitable access to services.

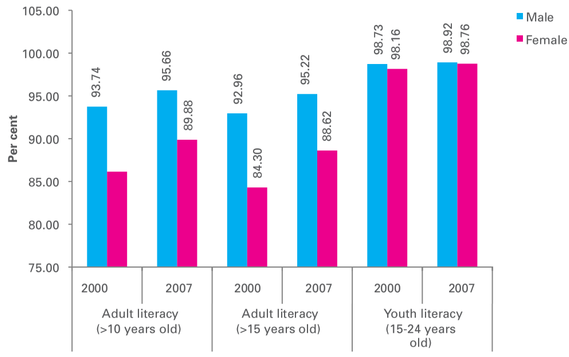
Particular challenges that have been identified as improving access to and the quality of ECD services include: urban-rural divides, income group disparities, the low quality of facilities, restricted hours of service, as well as low qualifications of early childhood teachers.

Youth literacy rate (15 – 24 years) by province, 2007



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia , Jakarta, 2009

Female to be at a distinctive disadvantage in adult literacy
Literacy rate by sex, Indonesia, 2000 and 2007



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

9. LITERACY RATE (YOUTH AND ADULT LITERACY RATE)

PROGRESS

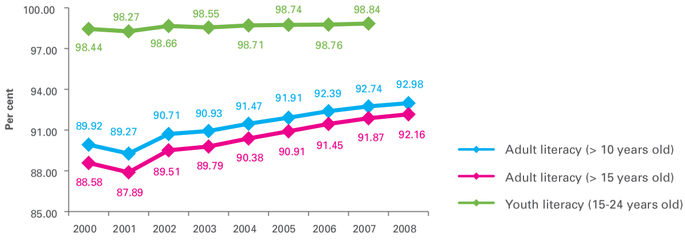
The youth literacy rate (15-24 years) is high and has ranged between 98-99 percent over the period 0f 2000-2008. Improving trend is also profound in adult literacy rate (aged 10 or 15 and above).

BUT

The breakdown of the data at provincial level provides a slightly contrasted picture. On the one hand, a large number of provinces are performing well and 20 of the 33 Indonesian provinces have youth literacy rates above 98 percent. Amongst the disadvantaged provinces, 13 provinces have youth literacy rates below the national average, although most have rates above 90 percent. Once again Papua stands out with a youth literacy rate of 86.21 percent.

Urban areas have much better adult literacy rates (15-24) than rural areas but whereas the urban adult literacy rates has remain stable between 2000 and 2008 around the 95 percent mark, the adult literacy rates in rural areas has improved from just over 84 percent to 89 percent in 2008, decreasing the difference between urban and rural areas from 9.66 percent to 6.4 percent by 2008.

The youth literacy rate is high and adult literacy rate is improving
Literacy Rate, Indonesia



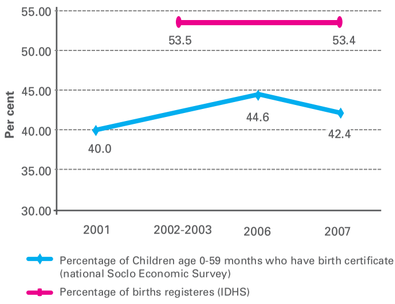
Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

10. BIRTH REGISTRATIN

PROGRESS

Birth registration in Indonesia in 2007 wast just above 42 per cent, a marginal improvement from 40 percent in 2001, a clear evidence that a majority of children in Indonesia have no legal identity.

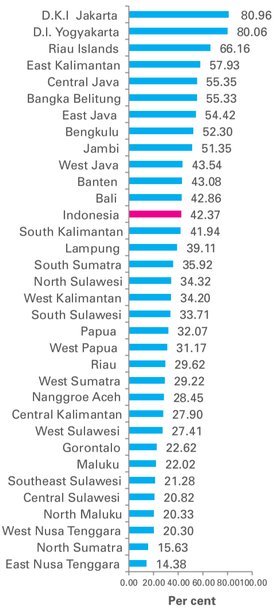
Percentage of birth registrations, Indonesia, 2001-2007



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009 and Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta

There was also significant disparities across provinces in birth registration, with a range of 14.4 percent of children less than 60 months old being in possession of birth certificate up to 81 percent in the capital city Jakarta. Although there were already 12 of Indonesia's 33 provinces achieved a better record than the national average but the majority of the provinces underperformed.

High disparity between provinces
Percentage of children aged 0-59 months who have a birth certificate, Indonesia, 2007



ISSUES

There was a significant disparities, according to wealth, and between rural and urban areas in the possesion of birth certificate.

- A very strong association between wealth and the majority of children the two poorest quintiles remain without legal identity.
- The cost remains overwhelmingly the most commonly cited reason for failing to register birth, both in rural and urban areas and regardless of economic status (including among the wealthiest quintile of the population).
- There was also lack of information about birth registration; meaning that the parents were not knowing they had to register birth or not knowing where the registration could be effected. Information about birth registration clearly reached urban population better than it did rural ones.

Urban areas have much better adult literacy than rural areas
Adult literacy rate (15 years old) by area, Indonesia

Source: Indikator Kesejahteraan Rakyat (Welfare Indicator) 2000-2008, BPS-Statistics Indonesia, Jakarta, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 (Based on National Socio-Economic Survey)

ISSUES

The economic factor is the main reason for someone to not attending or drop out from school to be more focus on economic activities.

11. EARLY MARRIAGE

PROGRESS

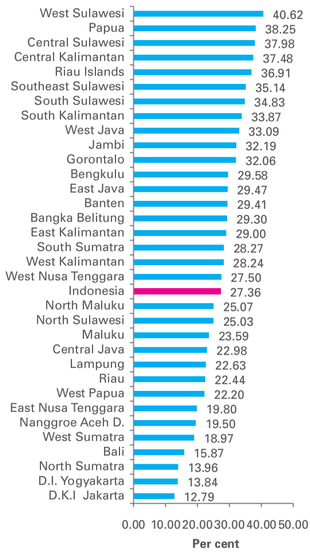
In Indonesia, the Marital Act No 1/1974 states that youth less than 21 years old need their parents' permission to get married (article 6). Further, the law sets the minimum legal age at 19 years old for men and 16 years old for women (article 7). Indeed, getting married before 16 is possible and legal with an official dispensation from the Religious Court for Muslim and District Court for non Muslim or any appointed government officer (article 6). However, none of the articles in the law mention about the children's consent.

In Indonesia, child marriage has been on a downward trend only to increase somewhere in the middle of 2006 and fluctuated between then and 2008; it decrease from 33.5 percent in 2000 to 27.36 percent in 2008.

Prevalence of child marriage is declining
Percentage of women 20-24 years old who were married or in union before they were 18 years old, Indonesia

Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

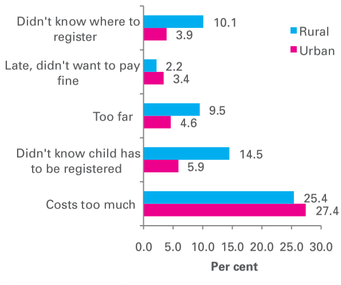
Percentage of women 20-24 years old who were married or in union before they were 18 years old by province, Indonesia, 2008



Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

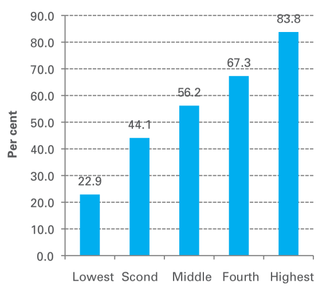
- There was also poor awareness of the importance of birth registration, as well as cumbersome bureaucratic procedures, reducing the willingness of the parents to register the birth of their child in government office in order to obtain birth certificate.

The primary reason of not having the birth certificate is an expensive cost of getting the service
Reason for not registering birth by area, Indonesia, 2007



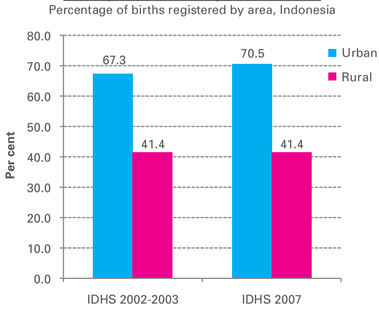
Source: Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta

High disparity in birth registration rates between poorest and wealtheir household
Percentage of births registered by wealth quintile, Indonesia, 2007



Source: Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta

Birth registration rate is higher in urban area
Percentage of births registered by area, Indonesia



Source: Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta

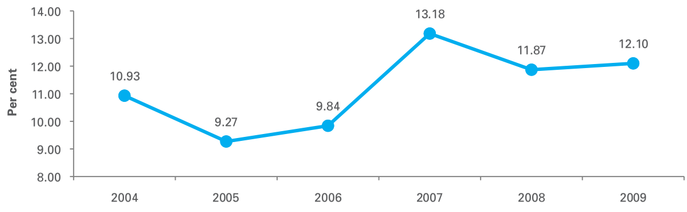
12. CHILD LABOUR

PROGRESS

The overall trend of Labour Force Participation Rates (LPFRs) children aged 10-17 years is increasing; from 10 percent in 2004 to 12 percent in 2009.

Working children, measured by labour force participation rate of children aged 10-17 years was fluctuated but the trend is increasing over time. It increased from 10 percent in 2004 to 12 percent in 2009. This an is indication that there are growing number of children in Indonesia who are leaving school and entering labour market too early. In contrast to the increase of LFPR, school participation rate is decreasing by age.

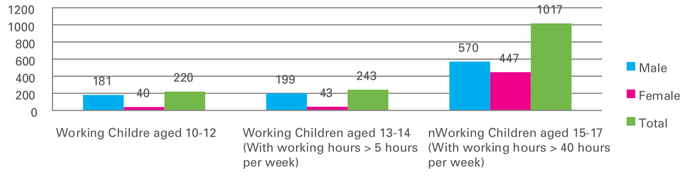
Labour force participation rates children aged 10-17 years, Indonesia



Source: Working Children in Indonesia 2009, BPS-Statistis Indonesia and ILO, Jakarta, 2010 (Based on Survei Angkatan Kerja Nasional)

Based on definition from ILO, not all working children are categorized by child labour, i.e if they are aged 13-14 and work less than 15 hours and if they are aged 15-17 and work less than 40 hours. By this definition there are there are more boys than girls.

Estimated Number of Child Labour Aged 10-17 (In thousand), Indonesia, 2009



Source: Working Children in Indonesia 2009, BPS-Statistis Indonesia and ILO, Jakarta, 2010 (Based on Survei Angkatan Kerja Nasion

BUT

The figures remain high at a national level, while there was a very clear disparities, from a lowly rate of 12.8 percent in DKI Jakarta to above 40 percent in the newly formed West Sulawesi; with a majority of provinces have a percentage of child marriage above the national average.

Child marriage is more prevalent in rural than urban areas. Although the percentage of women experiencing child marriage has diminished by approximately 5 percent between 2000 and 2008 both in rural and urban areas but girls from rural areas remain at a profound disadvantaged compared to their urban counterparts. The rural urban gap in terms of age of marriage is attributable to the greater availability of choices and better education facilities in urban areas. In urban setting parents encourage their daughters to complete secondary education or beyond and in turn educated people tend to marry later.

Prevalence of child marriage is higher in rural areas than urban areas
Percentage of of women 20-24 years old who were married or in union before they were 18 years old by area, Indonesia, 2008

Source: Based on the National Socio-Economic Survey, Processed by BPS-Statistics Indonesia, Jakarta, 2009

ISSUES

Factors that influence child marriage rates include: the state of the country's civil registration system, which provides proof of age for children; the existence of an adequate legislative framework with an accompanying enforcement mechanism to address cases of child marriage; and the existence of customary or religious laws that condone the practice.

Early marriage which is referred to as child marriage is common all over the globe and has inflicted dangerous and devastating effects on young children who are compelled to tie the knot in most cases.

Child marriage is also indicative of the levels of development of a region or country and is generally conducted between very young girls and older men. In many parts of the world child marriage is a gratification for overcoming the family's financial and social needs.

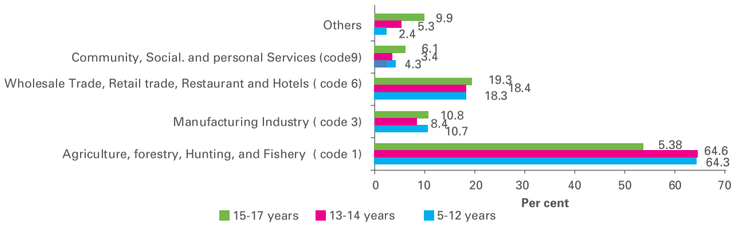
A specific dimension of child work that deserves special consideration is that of domestic workers. According to 2008 Center Bureau of Statistics (BPS) and 2009 International Labor Organization (ILO) estimates, there are over 3 million domestic workers, and there are nearly 700,000 child domestic workers in Indonesia.There is no data and little information about the prevalence of abuse amongst domestic workers but many [domestic workers] are subjected to physical, psychological and sexual violence". As with other forms of 'domestic' violence, abuse which takes place behind the closed door of the private sphere often go unreported and mostly unpunished. The lack of regulation and effective protection combined with societal attitudes that child domestic workers are vulnerable to harm and with little prospect of accessing redress through formal or legal mechanisms.

BUT

Indonesia's working children work very long hours indeed. Children under thirteen years old are not supposed to work at all but 4.2 percent of those who do work more than 40 hours a week. Additional data indicates that children in this group attend school as well as work over 40 hours a week.

Majority of working children are unpaid family workers (65.5 percent). They work primarily on plantations and farm rather than at family dwellings, but substantial numbers of children work in environments that are often associated with hazardous work: 7.7 percent work in mines, construction sites and quarries whilst 8.2 percent work in mobile places, streets or traffic lights.

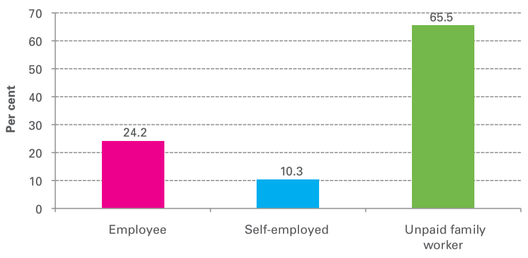
Percentage of working children by industry and age group, Indonesia, 2009



Source: Working Children in Indonesia 2009, BPS-Statistis Indonesia and ILO, Jakarta, 2010 (Based on Survei Angkatan Kerja Nasional)

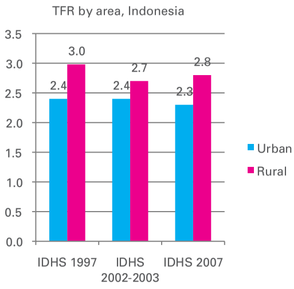
Most do family work

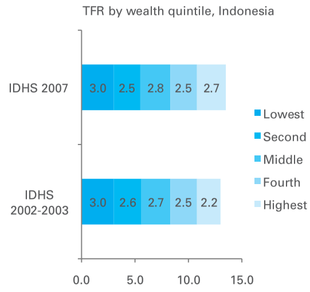
Percentage of working children aged 5-17 years by employment status, Indonesia, 2009



ISSUES

The information on child labour and working children in Indonesia paints a troublesome picture where large numbers of children are working, often combining work with other chores or activities and that these numbers have been increasing since 2004. Other troublesome factors include the fact that Indonesia's child labour laws are hardly stringent but in addition, they are clearly poorly enforced. Under these conditions, the potential for exploitation and abuse under the guise of unpaid family work is clear.





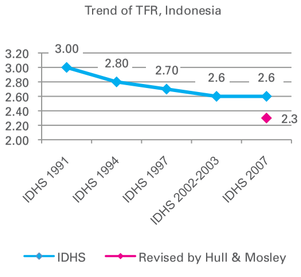
ISSUES

With this population growth, however, Indonesia has an opportunity to take opportunity of what is known as the demographic bonus, when the proportion of the younger age groups will increase during the period of 2020-2040. As more of them enter the labor market, the dependency ratio will decrease and the opportunity of Indonesia to take advantage of their both economic capacities and number will promote Indonesia's development and wellbeing. If social services and development is not maximized during this period, not only will this be a loss for Indonesia, it could result in a demographic crisis in the following years, especially if a large percentage of the aging population after 2040 is reliant on social welfare.

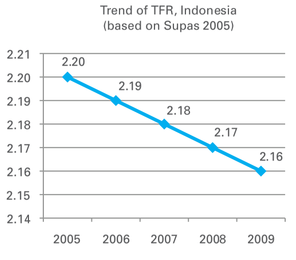
13. TOTAL FERTILITY RATE

PROGRES

The reduction of Total Fertility Rate during the period of 1991-2007 is slowing, even during 2002/3 – 2007, the TFR was flat. The total population based on 2010 Population Census was 237.6 million, higher than the estimation based on Indonesia population projection calculated by BPS and national demographers. This can be two folds; the estimation is too low or the population growth is faster than its estimation.



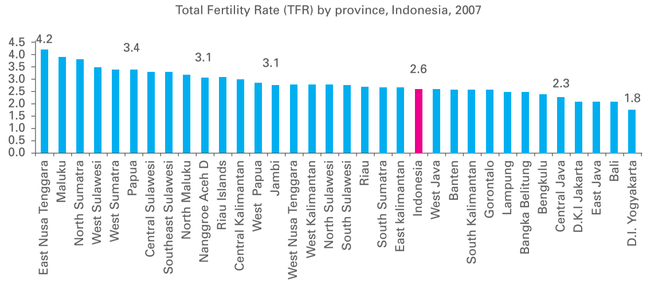
Source: Projection based on Supas 2005, Processed by BPS-Statistics Indonesia, Jakarta, 2009



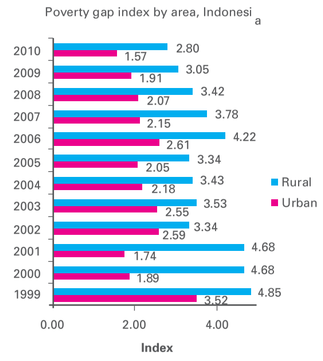
Source: Indonesia Demographic and Health Survey 1991, 1994, 1997, 2002-2003, 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 1993, 1995, 1998, 2003, 2008

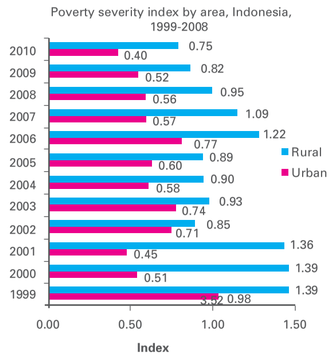
BUT

There are significant variation in TFR across provinces and usually the rate are also higher in rural areas and amongst the poor.

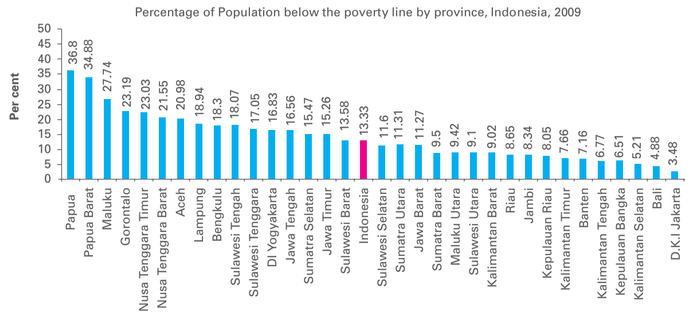


Source: Indonesia Demographic and Health Survey 2007, BPS-Statistics Indonesia and Macro International, Jakarta, 2008





Source: Trend of the Selected Socio-Economic Indicators of Indonesia, November 2010, BPS-Statistics, Jakarta, 2010.



Source: Trend of the Selected Socio-Economic Indicators of Indonesia, November 2010, BPS-Statistics, Jakarta, 2010.

ISSUES

Poor households tend to be concentrated in the agricultural sector and poverty is highly associated with working in the informal sector.

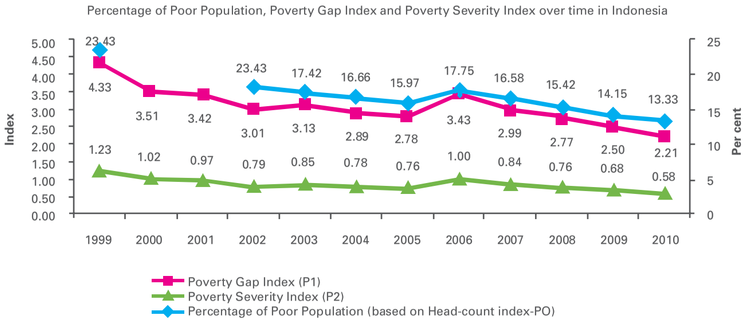
Poor people tend to have less education and poor households are larger in terms of household members. Poor people in rural areas are less likely to have access to health services in which more poor pregnant women are less likely to be helped by skilled health professionals and after birth many babies in poor households are not breastfed.

Poverty is very much devastating for children and often results in lower performance at school, early leaving (drop-outs) and lower standards of living.

14. POVERTY

PROGRESS

Based on the poverty headcount index, the percentage of the poor population has decreased from 23 percent in 1999 to 13.3 percent in 2010. Despite the efforts to reduce poverty, of the 31 million Indonesian people living under the poverty line it is estimated that at least 14 million of them are children. However, there is currently insufficient information on child poverty, which is a composite index of material and non-material indicators of poverty for children.



Source: Trend of the Selected Socio-Economic Indicators of Indonesia, November 2010, BPS-Statistics, Jakarta, 2010.

BUT

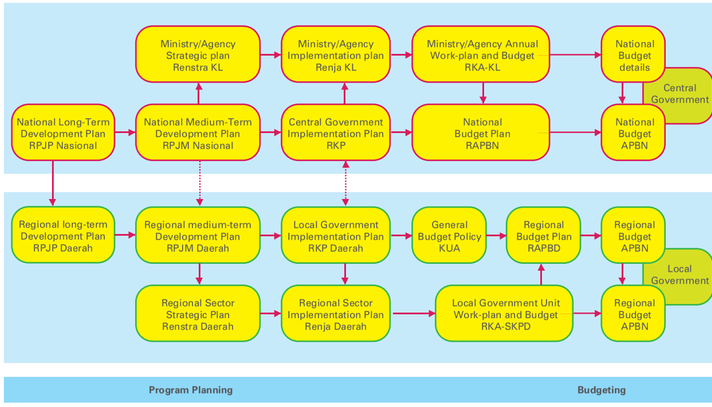
It is also evident that the poverty gaps and severity of poverty is higher in rural areas, and that rural areas were more likely to be affected by both the impacts of the financial crisis (in which interventions seem to have reduced poverty levels in urban areas but not rural areas). Disparities are also evident in poverty levels when provinces are compared. Many of the provinces in Eastern Indonesia such as Papua, Maluku, East and West Nusa Tenggara have the highest poverty levels in the country, some ten times higher than in Jakarta, the capital.

Each Local Government Unit/Office (SKPD) designs a **Local Office Strategic Plan (Rencana Pembangunan Jangka Menengah SKPD or Renstra-SKPD)** for the 5-year period, in addition to the annual **Local Office Work Plan (Rencana Kerja Satuan Kerja Perangkat Daerah or Renja-SKPD)** for a given year. The head of the SKPD is the Local Development Planning Agency (Badan Perencanaan Pembangunan Daerah or BAPPEDA).

Renstra-SKPD outlines the vision, mission, aim, strategy as well as development policies, programs and activities in line with the duties and functions of SKPD, in accordance with RPJM Daerah and is indicative in nature (Article 7(1)).

Renja-SKPD outlines development policies, programs, and activities to be undertaken either directly by the local government or indirectly though community participation (Article 7(2)).

Figure A.1 The planning process



Source: Law No. 25/2004

Linkages between local and national planning

National level planning

Ministers write the National Long-Term Development Plan outlining the vision, mission and direction of national development for a 20-year period (Article 10).

The draft is deliberated in an **Annual Consultative Development Planning Meeting (*Musyawarah Perencanaan Pembangungan* or musrenbang)** involving ministers, government apparatus and civil society (Article 11). This Musrenbang must be held within one year of the end of the current RPJPN period. The musrenbang finalizes the RPJPN (Article 12(1)) and passes the plan into law (Article 13(1)).

ANNEX 3.
THE DEVELOPMENT PLANNING SYSTEM

Key aspects:
The National Development Planning System (Sistem Perencanaan Pembangunan Nasional or SPPN) is outlined in Law No 25/2004. This law states that both central and local governments must design development plans for the long term (20 years), medium term (5 years) in addition to an annual development plan (Article 1).

The National Long-Term Development Plan (RPJP N) outlines the vision, mission, and direction of national development for a 20-year period (Article 4 (1)).

The National Medium-Term Development Plan (RPJM N) outlines the President of Indonesia's development plan during a given 5-year period, based on the RPJPN. This plan outlines the president's vision for national development strategy, public policy, Ministerial/Institutional programming and coordination, regional and inter-regional policy, as well as macroeconomic and fiscal policy (Article 4 (2)).

The Medium-Term Development Plan is translated into an annual work plan in a **Government Work Plan (Rencana Kerja Pemerinah or RKP)** document. The RKP further stipulates development priorities, Ministerial/Institutional programming and coordination, regional and inter-regional policy, as well as macroeconomic framework and directions for fiscal policy for a given year (article 4 (3)).

The Medium-Term Ministry/Agency Strategic Plan (Rencana Strategis Kementerian/Lembaga or Renstra-KL) outlines the vision, mission, aim, strategy as well as development policies, programs, and activities to be undertaken in accordance with the duties and fuctions of the Ministry/Agency. This plan must reference the RPJMN and is indicative in nature (Article 6(1)).

The Ministry/Agency Annual WorkPlan (Rencana Kerja Kementerian/Lembaga or Renja-KL) references the Renstra-KL and outlines development policies, programs and activities to be undertaken directly by the government as well indirectly through community participation (Article 6(2)).

The local government designs a Local Long-Term Development Plan (RPJPD) that references the RPJPN and outlines the vision, mission and direction of local development (Article 5(1)).

The Local Medium-Term Development Plan (RPJMD) outlines the vision, mission and work plan of the Governor concerning regional development strategy and priority, regional fiscal policy, public policy, as well as programming and coordination policies for Local Government Units/Offices (Satuan Kerja Perangkat Daerah). This plan must be in accordance with the RPJP Daerah and RPJM Nasional (Article 5(2)).

RPJM Daerah is translated into a Local Government Implementation Plan (Rencana Kerja Pemerintah Daerah or RKPD) in full agreement with the National Government Work Plan. RKPD outlines plans for the local economic framework, regional development priorities, work plan and budgeting of programs to be undertaken directly by the regional government as well as indirectly through community participation (Article 5(3)).

1) Long- Term Development Plan (20 years)
2) Medium-Term Development Plan (5 years)

ANNEX 4.
STATISTICAL TABLES FOR SELECTED PROVINCES

Indicators:
1. Human Development Index (HDI)
2. Gender Development Index (GDI)
3. Gender Empowerment Index (GEM)
4. Poor Population
5. Poverty Gap Index
6. Poverty Severity Index
7. Percentage Of Households Using Clean Water
8. Percentage Of Households Using Latrines

General note on the data

The data presented in the following statistical tables are derived from various sources; official publications and web-site from BPS (Badan Pusat Statistik)-Statistics Indonesia and related line ministries as well as special data processing conducted by BPS based on the National Socio-Economic Survey (SUSENAS) raw data and statistical record of Ministry of Health and the World Bank.

The Draft National Long-Term Development Plan provides general guidelines for the preparation of the Medium-Term Ministry/Agency Strategic Plans according to each ministry's core tasks and functions (Article 15(1)). Thereafter, ministers should reference the strategic plans to draft and finalize the National Medium-Term Development Plans(Article 15(2)).This is deliberated in a Medim-Term musrenbang involving the ministers, government apparatus, and civil society (Article 16(2)), no later than 2 months after the Presidential Inauguration (Article 19).

Ministers prepare a Draft Government Work Plan ((Article 20(1)). Ministerial/Institutional heads use the Draft Work Plan and Strategic Plans to prepare a Ministry/Agency Annual Work Plan in accordance with the duties and functions of the Ministry/Agency (Article 21(1)). Subsequently, Ministerial heads reference the Medium Term Strategic Plans to finalize the draft Work Plans (Article 21(2)). Ministerial heads must then hold musrenbang to discuss the draft Work Plans with other state apparatus and civil society (Article 22) by the month of April (Article 23(1)). The finalized Work Plans will guide the preparation of the Draft National Budget Plan (RAPBN) (Article 25(1)) which is then instituted through a Presidential decree (Article 26(1)).

Local Level Planning

The head of the Local Development Planning Agency (BAPPEDA) prepares a Draft Local Long-Term Development Plan that references the National Long-Term Development Plan and outlines the vision, mission and direction of local development for a 20-year period (Article 10). This draft is deliberated in a musrenbang held by the head of BAPPEDA and involving various government apparatus and civil society. This musrenbang must be held within one year of the end of the current Long-Term Development Plan period (Article 11). The results of this consultation process will inform the finalized Local Long-Term Development and is passed into law through Local Regulations (Article 13(1)).

The Local Long-Term Development Plan informs the Draft Local Medium-Term Development Plan(Article 14), which in turn informs the drafting of Regional Sector Strategic Plan (Rencana Pembangunan Jangka Menengah SKPD or Renstra-SKPD) in every Local Government Unit/Sector (SKPD) (Article 15(1)). The head of BAPPEDA holds Medium-Term musrenbang to deliberate the Draft RPJM Daerah (Article 16(1)) no later than 2 months after the inauguration of the District/ Municipal Heads (Article 19).

The head of BAPPEDA elaborates the RPJMD into a Draft Local Government Work Plan (RKPD) in full agreement with the RKP Nasional (Article 20(1)). This draft, along with the Draft Renstra-SKPD will inform the Draft Annual Regional Sector Work Plans (Renja-SKPD) (Article 21(1). A Musrenbang is held no later than March to deliberate and finalize the RKPD (Article 23(1). The resulting RKPD will guide the preparation of the Regional Budget Plan (RAPBD) (Article 25(1)) and is passed into law through a Governor's Regulation (Article (1)).

ACEH

District	Human development index (HDI)						Gender development index (GDI)						Gender empowerment measure (GEM)					
Data Source	BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation					
Year	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007
Aceh Province	65.3	66.0	68.7	69.0	69.4	70.4	59.0	62.1	59.3	59.6	62.8	63.9	52.4	55.5	42.1	46.5	49.7	50.3
Simeulue		61.8	64.5	65.2	66.4	68.0		60.1	51.0	52.1	54.8	55.1		37.0	40.1	49.0	51.6	51.8
Aceh Singkil		62.2	65.8	66.5	67.2	68.0		61.8	52.0	53.2	56.5	57.9		42.8	46.3	51.9	54.9	55.4
Aceh Selatan	62.1	63.8	66.9	67.7	68.4	68.9	51.7	60.3	51.5	51.8	54.2	56.5	38.5	44.4	44.4	44.8	46.8	49.1
Aceh Tenggara	63.9	66.8	69.4	70.2	70.6	71.0	63.0	65.4	58.0	58.5	60.4	62.1	50.6	43.7	29.3	42.7	44.9	46.4
Aceh Timur	65.4	66.7	67.7	68.4	68.8	69.4	56.7	62.5	51.7	52.2	56.5	59.2	42.5	44.0	31.0	41.1	45.4	47.8
Aceh Tengah	66.0	66.7	69.9	70.8	71.2	72.1	58.0	64.6	65.3	66.3	66.9	67.9	40.6	48.3	45.5	46.5	47.2	47.8
Aceh Barat	64.3	65.6	66.7	67.4	68.1	69.3	56.2	60.2	56.0	56.7	58.4	59.7	42.2	44.6	41.2	43.0	44.5	44.8
Aceh Besar	66.8	67.2	70.6	71.4	71.9	72.7	62.6	65.0	55.3	56.7	58.5	59.9	43.4	46.5	32.2	36.6	38.6	39.6
Piddie	64.1	67.8	68.8	69.5	70.0	70.8	57.2	66.3	54.5	55.4	56.8	59.7	42.4	54.1	36.3	43.9	45.1	47.6
Bireuen		70.5	71.3	71.5	72.2	72.5		68.3	65.5	66.3	68.4	68.8		59.6	48.3	52.9	54.4	54.8
Aceh Utara	63.1	65.9	68.6	69.7	70.4	71.4	58.8	53.8	60.2	61.7	64.6	65.1	50.3	40.0	46.0	55.0	57.9	57.9
Aceh Barat Daya			65.9	66.9	67.5	68.4			52.1	53.7	57.1	58.1			32.7	37.8	40.6	41.2
Gayo Lues			64.8	66.1	66.6	67.1			55.8	56.3	58.2	61.6			37.9	40.9	41.6	44.9
Aceh Tamiang			67.3	68.3	68.7	69.2			55.7	55.8	57.4	58.7			39.2	45.8	47.5	48.4
Nagan Raya			65.5	66.3	66.9	67.6			53.1	53.8	57.6	58.4			36.4	42.7	46.4	46.6
Aceh Jaya			66.2	66.8	67.8	68.2			59.6	60.8	64.8	65.5			43.0	43.6	46.7	46.9
Bener Meriah			66.3	67.4	68.1	68.9			57.1	57.6	58.0	60.0			42.0	40.0	40.0	41.4
Pidie Jaya					69.4	70.0					63.4	63.9					45.7	46.0
Kota Banda Aceh	70.5	71.9	74.0	74.7	75.4	76.3	57.5	69.7	60.8	61.0	61.2	63.8	37.4	49.7	48.0	49.2	48.2	49.9
Kota Sabang	63.7	69.5	72.5	73.3	73.7	74.5	56.0	60.5	63.1	63.3	66.4	67.3	43.3	45.0	42.6	43.1	46.2	46.2
Kota Langsa			69.5	70.4	71.5	72.2			56.1	56.7	59.7	61.1			35.4	36.8	39.2	40.1
Kota Lhokseumawe			72.8	73.1	73.8	74.7			48.3	49.7	57.2	58.6			19.7	39.4	46.5	47.2
Subulussalam					67.8	68.3					62.5	63.9					45.6	47.6

ACEH

District	Number of poor population - thousands	Percentage of poor population	Poverty gap index	Poverty severity index	Percentage of households using clean water	Percentage of households using latrines
Data Source	National Socio-Economic Survey (SUSENAS)					
Year	2008	2008	2008	2008	2008	2008
Aceh Province	962.3	23.55	5.18	1.55	41.24	63.72
Simeulue	20.6	26.45	4.51	1.19	11.90	56.88
Aceh Singkil	22.2	23.27	4.82	1.38	42.33	81.72
Aceh Selatan	38.8	19.40	3.62	1.01	27.70	51.10
Aceh Tenggara	30.9	18.51	2.83	0.66	24.88	43.40
Aceh Timur	76.2	24.05	5.29	1.72	30.42	69.56
Aceh Tengah	40.6	23.36	4.39	1.03	40.69	66.77
Aceh Barat	43.7	29.96	11.06	4.83	29.30	48.37
Aceh Besar	63.5	21.52	5.56	1.70	53.32	75.64
Piddie	101.8	28.11	6.33	1.62	28.35	29.25
Bireuen	79.1	23.27	5.21	1.66	37.13	77.61
Aceh Utara	135.7	27.56	5.61	1.68	29.30	57.88
Aceh Barat Daya	27.4	23.42	3.72	0.82	31.03	33.79
Gayo Lues	18.9	26.57	4.85	1.09	35.75	26.21
Aceh Tamiang	50.8	22.29	3.58	0.88	51.71	90.98
Nagan Raya	33.2	28.11	7.62	2.26	23.50	52.11
Aceh Jaya	17.2	23.86	5.79	1.94	42.84	64.55
Bener Meriah	31.3	29.21	5.13	1.11	39.53	73.01
Pidie Jaya	37.7	30.26	8.33	2.57	38.84	34.38
Kota Banda Aceh	19.9	9.56	3.44	1.31	94.31	98.53
Kota Sabang	7.1	25.72	6.16	1.82	89.93	77.48
Kota Langsa	24.0	17.97	3.88	1.31	65.70	91.08
Kota Lhokseumawe	23.9	15.87	2.77	0.72	78.51	81.27
Subulussalam	17.7	28.99	5.11	1.28	24.28	81.76

CENTRAL JAVA

District	Human development index (HDI)						Gender development index (GDI)						Gender empowerment measure (GEM)					
Data Source	BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation					
Year	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007
Central Java Province	64.6	66.3	68.9	69.8	70.3	70.9	57.4	58.7	59.8	60.8	63.7	64.3	51.2	51.0	56.5	56.9	59.3	59.7
Cilacap	63.1	65.3	68.8	69.5	69.8	70.3	50.3	55.4	53.8	54.2	56.1	56.8	50.2	52.6	55.4	56.3	57.7	58.2
Banyumas	66.0	66.7	70.3	70.7	70.8	71.2	57.4	50.9	58.1	58.7	62.1	62.6	52.4	46.2	58.3	59.3	62.4	62.5
Purbalingga	63.0	65.0	68.7	69.3	69.9	70.4	46.7	64.7	58.2	58.6	58.5	60.6	44.2	63.5	62.5	62.3	62.1	63.1
Banjarnegara	63.6	63.7	66.9	67.3	68.3	68.5	59.4	52.6	53.3	54.4	55.2	57.5	51.6	39.2	47.8	48.6	48.5	50.1
Kebumen	64.9	65.6	68.0	68.9	69.5	70.0	55.2	52.0	50.4	51.8	53.9	55.3	49.5	46.4	53.4	55.6	56.6	58.4
Purworejo	65.3	68.4	68.7	69.1	70.2	70.7	58.2	58.5	59.7	60.2	61.0	63.8	49.5	48.8	54.7	54.8	55.4	57.9
Wonosobo	63.9	64.7	66.9	67.6	68.8	69.2	57.9	54.0	48.6	49.4	52.3	53.8	53.6	51.2	43.3	43.0	45.5	46.9
Magelang	65.1	67.2	69.1	69.9	70.6	71.0	60.5	60.1	63.0	64.1	64.7	67.3	49.1	54.2	57.1	57.8	57.7	60.0
Boyolali	64.4	65.7	68.5	69.0	69.4	69.6	61.9	60.1	62.3	62.7	63.3	65.8	47.1	46.9	52.7	52.3	52.4	53.6
Klaten	65.1	67.8	71.0	71.4	71.8	72.5	61.4	62.7	62.6	64.0	64.9	67.2	58.0	64.7	52.3	53.2	54.2	55.0
Sukoharjo	66.5	67.7	70.7	71.2	71.7	72.5	61.8	62.4	65.0	66.6	68.7	69.6	54.4	53.9	58.9	59.8	61.5	62.4
Wonogiri	64.0	66.5	68.4	69.0	69.9	70.1	58.5	61.6	58.9	60.3	63.2	64.5	54.9	56.3	52.5	50.4	53.4	54.6
Karanganyar	64.5	68.5	70.5	70.7	71.1	71.6	58.3	61.0	65.2	65.3	67.5	68.1	54.7	61.2	60.1	59.6	62.0	62.4
Sragen	62.3	64.9	66.1	66.6	67.8	69.0	55.2	58.6	59.1	59.6	63.2	64.9	50.9	53.6	58.6	59.2	61.7	62.2
Grobogan	64.2	65.5	67.3	67.6	69.2	69.8	58.1	55.3	47.9	48.7	52.4	54.0	48.0	43.5	51.3	49.5	52.5	54.7
Blora	61.6	64.7	66.5	67.9	68.4	69.1	55.3	57.5	60.8	61.3	62.9	63.4	46.7	43.6	60.0	60.6	62.2	62.4
Rembang	64.7	65.5	67.5	69.0	69.7	70.5	55.9	49.0	59.1	60.7	62.6	63.0	46.8	40.0	62.9	64.8	66.3	66.3
Pati	65.2	68.6	70.6	70.9	71.8	71.9	56.8	59.9	57.7	58.4	59.6	62.1	49.9	51.0	47.4	48.7	49.5	50.5
Kudus	66.0	66.9	69.4	70.0	71.3	71.7	60.3	58.3	62.3	64.5	65.9	68.7	57.7	53.1	59.1	62.5	63.4	65.9
Jepara	65.3	66.9	69.1	69.6	70.0	71.5	53.4	54.4	51.8	53.3	54.9	55.8	36.9	38.0	45.8	47.1	48.5	48.9
Demak	65.9	66.4	69.0	69.4	70.3	71.1	60.4	56.7	62.8	63.5	66.6	67.1	43.6	40.7	57.7	58.3	61.2	61.5
Semarang	67.9	69.5	71.4	71.9	72.2	72.9	61.1	66.3	69.1	70.6	71.5	72.2	52.6	53.2	56.4	56.6	56.9	58.0
Temanggung	67.1	69.6	71.4	71.8	72.7	73.1	65.5	59.4	67.7	67.7	69.3	70.4	49.4	44.7	52.3	50.8	51.8	53.7
Kendal	62.1	65.5	67.3	67.9	68.3	68.9	57.3	58.4	60.1	60.2	62.7	63.3	53.6	52.0	54.6	54.0	55.5	56.2
Batang	63.6	65.5	67.0	67.6	68.4	68.6	52.1	50.4	56.5	56.8	57.6	58.1	43.1	41.1	53.6	52.7	53.1	54.1
Pekalongan	61.8	63.9	67.6	68.2	69.4	69.7	52.3	59.8	50.3	51.8	52.6	55.4	52.8	58.1	51.1	53.0	52.6	53.6
Pemalang	60.7	62.2	65.6	66.3	67.4	67.9	53.7	50.8	56.8	58.3	60.5	61.4	43.1	37.1	57.5	57.9	59.9	60.4
Tegal	62.2	63.3	66.8	67.5	67.8	68.8	50.2	54.6	52.8	53.7	56.8	57.9	44.3	47.7	51.1	51.2	54.3	54.4
Brebes	60.2	61.3	63.4	64.3	65.9	66.6	49.7	57.2	46.9	48.0	50.2	52.8	49.6	55.9	46.9	45.3	47.0	47.2
Kota Magelang	70.2	73.0	74.5	74.7	75.5	75.7	64.2	65.3	68.6	70.3	70.7	71.7	59.4	55.1	72.8	74.4	74.4	75.0
Kota Surakarta	70.5	73.0	75.8	76.0	76.4	76.6	66.5	66.5	71.4	71.9	74.1	74.8	49.9	48.3	55.7	56.4	59.2	59.4
Kota Salatiga	71.5	72.8	74.4	74.8	75.1	75.4	69.8	72.5	68.8	69.1	71.1	72.5	54.8	57.5	65.3	65.3	67.3	67.7
Kota Semarang	70.2	73.6	74.9	75.3	75.9	76.1	64.6	67.2	66.8	67.5	68.5	70.4	61.1	59.7	61.2	60.9	61.8	61.8
Kota Pekalongan	65.9	68.2	71.4	71.9	72.5	73.1	57.4	57.3	57.4	57.9	59.6	61.5	49.7	48.3	48.0	49.4	52.1	53.6
Kota Tegal	65.3	68.5	71.2	71.4	72.4	72.7	54.3	59.2	56.9	58.2	59.3	61.1	43.5	47.1	55.9	59.9	61.2	61.8

CENTRAL JAVA

District	Number of poor population - thousands	Percentage of poor population	Poverty gap index	Poverty severity index	Percentage of households using clean water	Percentage of households using latrines
Data Source	National Socio-Economic Survey (SUSENAS)					
Year	2008	2008	2008	2008	2008	2008
Central Java Province	6122.6	18.99	4.25	1.24	57.29	72.97
Cilacap	343.9	21.40	4.67	1.35	37.01	79.07
Banyumas	340.7	22.93	3.95	0.93	41.88	62.78
Purbalingga	221.9	27.12	5.40	1.49	47.11	59.72
Banjarnegara	200.6	23.34	5.75	1.72	41.21	52.86
Kebumen	334.9	27.87	7.05	2.05	41.95	70.55
Purworejo	130.0	18.22	4.17	1.21	59.58	69.12
Wonosobo	207.5	27.72	8.07	2.86	69.65	56.83
Magelang	190.8	16.49	5.01	1.69	54.47	72.47
Boyolali	158.4	17.08	3.64	1.01	47.38	85.61
Klaten	243.1	21.72	7.09	2.50	54.39	75.54
Sukoharjo	99.1	12.13	2.63	0.74	57.45	85.28
Wonogiri	201.1	20.71	6.03	2.06	52.56	93.59
Karanganyar	125.9	15.68	3.02	0.78	80.01	84.33
Sragen	177.1	20.83	3.50	0.85	73.04	87.06
Grobogan	262.0	19.84	4.49	1.23	50.34	68.10
Blora	155.1	18.79	5.12	1.61	68.23	77.63
Rembang	154.7	27.21	5.48	1.43	59.23	60.48
Pati	207.2	17.90	6.01	2.08	72.79	86.71
Kudus	97.8	12.58	2.76	0.71	65.20	83.17
Jepara	119.2	11.05	1.99	0.46	59.29	90.69
Demak	217.2	21.24	3.86	0.88	57.65	63.11
Semarang	102.5	11.37	2.33	0.65	70.80	89.62
Temanggung	114.7	16.39	4.66	1.50	61.38	70.18
Kendal	168.2	17.87	4.02	1.23	73.30	61.31
Batang	122.0	18.08	5.41	1.93	43.85	50.39
Pekalongan	164.3	19.52	4.23	1.02	41.81	59.15
Pemalang	325.2	23.92	3.59	0.85	45.71	55.70
Tegal	26.8	15.78	2.70	0.68	47.69	63.13
Brebes	459.3	25.98	5.06	1.36	51.02	50.20
Kota Magelang	14.9	11.16	1.68	0.44	82.16	89.91
Kota Surakarta	83.4	16.13	2.71	0.75	76.87	88.91
Kota Salatiga	14.9	8.47	1.28	0.34	86.04	95.34
Kota Semarang	89.6	6.00	0.99	0.29	84.72	93.09
Kota Pekalongan	28.0	10.29	1.03	0.18	60.23	84.32
Kota Tegal	220.7	11.28	1.42	0.21	93.73	94.72

EAST NUSA TENGGARA

District	Human development index (HDI)						Gender development index (GDI)						Gender empowerment measure (GEM)					
Data Source	BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation					
Year	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007
East Nusa Tenggara Province	60.4	60.3	62.7	63.6	64.8	65.4	56.8	56.3	58.6	59.6	61.3	63.1	46.4	46.2	56.3	57.3	59.0	61.0
West Sumba	45.4	53.4	58.7	59.8	60.1	60.8	42.4	51.6	51.3	51.8	58.0	58.5	34.4	42.2	44.2	46.5	52.8	52.9
East Sumba	55.7	56.9	58.7	59.6	60.0	60.3	50.5	56.8	50.8	52.6	59.8	59.9	40.7	48.5	57.7	57.9	67.1	68.5
Kupang	57.0	56.9	61.2	62.0	63.1	64.6	53.9	45.6	56.8	57.0	60.2	60.4	47.1	36.9	48.9	47.9	52.3	52.3
Timor Tengah Selatan	49.2	57.7	61.8	62.7	63.6	64.4	39.6	38.1	45.5	47.0	52.3	53.3	34.8	19.3	43.2	39.2	46.1	48.2
Timor Tengah Utara	53.7	59.5	62.4	63.1	64.0	65.8	46.4	52.4	59.1	59.6	60.1	61.8	35.3	27.0	58.0	58.9	60.5	60.7
Belu	51.8	58.3	60.5	61.2	61.7	62.8	45.9	53.6	52.5	54.0	58.3	58.9	35.6	44.0	59.3	64.3	68.4	68.6
Alor	55.3	57.1	64.5	65.4	66.9	67.3	51.9	47.3	63.2	63.9	64.4	64.8	33.5	33.5	57.9	60.8	61.0	61.0
Lembata		61.6	64.4	65.1	65.6	66.1		61.3	63.0	63.1	63.2	64.9		43.6	50.6	49.3	50.1	52.0
East Flores	58.1	62.6	63.8	64.7	66.4	66.7	56.2	62.1	56.7	58.1	63.9	64.3	40.8	44.3	46.3	51.8	57.9	58.0
Sikka	51.5	58.4	63.9	64.6	65.9	66.0	48.5	54.4	57.2	57.3	57.9	59.5	43.8	48.0	52.6	55.0	54.5	54.7
Ende	55.8	61.3	63.9	64.6	65.0	65.4	55.8	59.9	59.8	61.3	64.0	64.7	46.5	50.9	53.8	54.7	56.6	57.8
Ngada	63.2	64.0	65.5	66.0	67.3	68.0	62.3	61.0	57.9	58.5	66.0	66.4	47.4	48.4	46.7	45.3	52.1	52.6
Manggarai	60.9	60.3	64.5	65.2	65.7	65.8	59.4	59.9	61.1	61.8	63.5	64.9	41.1	33.3	50.3	52.4	54.8	56.1
Rote Nda			61.4	62.1	64.3	64.6			55.9	56.1	60.4	60.5			45.4	44.0	48.0	48.2
West Manggarai			62.4	63.2	63.5	64.0			59.3	59.5	60.0	61.2			48.0	45.5	45.6	46.8
Sumbar Barat Daya					58.9	59.3					57.4	58.2					46.4	46.9
Central Sumba					58.4	58.6					57.9	58.4					47.5	47.9
Nageko					64.6	65.3					62.3	64.2					48.8	50.1
Kota Kupang	66.6	70.9	73.9	74.5	74.7	75.9	58.2	60.3	67.6	67.7	71.0	72.4	52.6	44.1	48.6	46.8	52.1	52.4

EAST NUSA TENGGARA

District	Number of poor population - thousands	Percentage of poor population	Poverty gap index	Poverty severity index	Percentage of households using clean water	Percentage of households using latrines
Data Source	National Socio-Economic Survey (SUSENAS)					
Year	2008	2008	2008	2008	2008	2008
East Nusa Tenggara Province	1105.8	25.68	8.27	3.08	44.39	73.59
West Sumba	38.4	37.85	13.19	5.40	26.96	44.04
East Sumba	81.1	37.14	12.74	4.91	36.46	50.21
Kupang	95.6	26.95	6.46	1.76	40.16	77.16
Timor Tengah Selatan	130.8	33.55	11.07	4.05	35.62	93.43
Timor Tengah Utara	55.2	27.74	9.02	3.35	56.94	87.13
Belu	82.7	19.69	7.50	3.04	47.18	70.99
Alor	43.2	25.14	7.75	2.77	39.88	78.34
Lembata	28.8	29.24	8.50	2.66	53.87	78.71
East Flores	29.3	13.21	4.11	1.49	29.12	77.75
Sikka	45.9	17.34	7.38	3.45	44.67	64.30
Ende	57.5	24.87	7.16	2.39	67.66	75.11
Ngada	19.4	15.49	4.61	1.54	74.00	90.10
Manggarai	137.8	28.57	7.66	2.28	51.38	75.18
Rote Nda	38.8	36.58	10.70	4.25	27.06	44.06
West Manggarai	48.3	25.05	7.84	2.73	31.90	50.09
Sumbar Barat Daya	88.6	36.45	16.22	7.64	4.91	47.99
Central Sumba	21.5	38.65	7.88	2.21	9.39	50.05
Nageko	16.8	14.53	3.32	0.88	48.82	69.66
Kota Kupang	46.1	14.66	4.98	1.91	78.03	98.48

PAPUA

District	Human development index (HDI)						Gender development index (GDI)						Gender empowerment measure (GEM)					
Data Source	BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation						BPS - Statistic Indonesia calculation					
Year	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007	1999	2002	2004	2005	2006	2007
Papua Province	58.8	60.1	60.9	62.1	62.8	63.4	55.7	54.3	57.4	58.6	59.3	61.1		49.0	57.1	61.9	63.5	63.8
Merauke	57.0	58.1	60.7	61.5	62.5	64.0	52.6	55.4	56.6	58.1	60.5	61.7	47.7	43.7	46.2	49.5	52.0	52.0
Jayawijaya	48.7	47.0	47.1	47.6	52.4	53.0	47.7	46.7	44.5	45.1	49.9	51.6	53.7	29.9	40.9	37.8	45.8	47.6
Jayapura	65.6	65.0	67.2	67.5	68.8	70.0	56.2	59.6	60.1	60.3	63.2	64.9	42.1	38.9	54.5	61.5	64.8	64.9
Nabire		54.1	63.0	65.1	65.2	65.6		38.5	55.6	56.4	60.1	61.3	53.3	27.5	43.7	39.0	44.2	46.2
Yapen Waropen	60.8	56.9	65.1	66.4	67.0	68.1	54.6	40.6	59.9	60.1	65.1	66.5	43.8	18.4	43.0	49.6	57.7	57.9
Biak Namfor	66.0	64.8	66.6	66.9	67.3	68.6	58.8	50.7	59.2	59.3	59.5	60.7	36.5	41.5	45.4	55.5	56.3	57.3
Paniai	43.6	58.0	58.3	58.3	58.5	58.7	43.4	57.6	53.9	54.1	54.8	57.0		30.1	35.6	46.1	48.2	48.6
Puncak Jaya		66.3	66.7	66.7	67.0	67.2		65.9	63.6	64.2	64.4	64.8	50.0	32.8	45.0	57.1	58.4	58.3
Mimika		64.8	65.7	66.2	67.1	67.8		58.3	52.4	52.7	54.5	57.3	28.2	24.8	27.1	29.7	34.6	36.9
Boven Digoel			46.8	47.6	48.3	48.7			41.8	42.7	45.1	46.0			37.0	40.7	43.1	43.8
Mappi			46.6	47.0	48.0	49.0			43.2	44.6	47.5	47.5			39.1	44.7	48.1	48.2
Asmat			45.7	47.2	48.3	49.5			42.1	43.3	46.2	46.9			38.8	45.2	47.5	47.7
Yahukimo			46.9	47.4	48.0	48.3			42.8	43.0	46.9	48.6			47.3	50.9	58.0	59.3
Pegunungan			46.5	46.9	47.2	47.4			37.0	38.3	46.7	46.8			49.8	53.9	60.0	60.2
Bintang			47.0	49.2	49.6	50.4			45.8	46.8	49.9	51.5			42.7	45.6	51.0	51.7
Tolikara			63.8	64.8	65.2	65.9			63.2	63.4	65.9	66.4			62.3	64.1	68.6	68.7
Sarmi			66.1	66.5	66.9	68.0			61.4	61.6	61.8	63.9			45.8	48.7	49.6	51.0
Keerom			61.0	61.3	61.6	62.0			55.7	56.5	58.3	58.9			39.6	43.7	48.2	48.3
Waropen			65.6	65.9	66.2	66.9			59.5	60.3	61.7	62.0			60.5	63.7	66.1	66.8
Supiori						57.3						55.0						42.6
Membramo Raya	69.7	71.4	71.9	72.1	73.1	73.8	58.4	64.6	60.9	61.3	65.1	65.5	43.6	48.2	45.7	48.5	53.1	53.5
Kota Jayapura																		

PAPUA

District	Number of poor population - thousands	Percentage of poor population	Poverty gap index	Poverty severity index	Percentage of households using clean water	Percentage of households using latrines
Data Source	National Socio-Economic Survey (SUSENAS)					
Year	2008	2008	2008	2008	2008	2008
Papua Province	709.3	35.53	11.16	4.50	29.46	61.12
Merauke	26.7	15.69	3.54	1.18	36.49	95.37
Jayawijaya	105.4	48.15	10.16	3.04	15.69	25.26
Jayapura	21.3	21.80	6.31	2.19	51.58	73.15
Nabire	63.2	37.56	11.89	4.36	34.91	85.11
Yapen Waropen	28.5	37.31	14.23	5.62	32.61	61.05
Biak Namfor	39.4	37.06	11.97	4.43	40.08	81.97
Paniai	56.3	48.29	12.58	4.53	9.40	77.64
Puncak Jaya	57.7	49.42	8.91	2.08	7.08	51.87
Mimika	37.8	26.63	9.75	4.06	55.69	74.31
Boven Digoel	9.1	27.49	10.68	4.56	11.23	42.09
Mappi	24.4	36.23	8.12	2.45	8.40	29.62
Asmat	25.7	39.77	15.95	7.38	0.00	12.00
Yahukimo	72.7	50.63	22.68	10.32	0.00	13.62
Pegunungan	42.0	45.81	18.06	8.09	7.04	48.77
Bintang	21.1	45.08	6.89	1.50	0.00	0.64
Tolikara	8.3	24.52	4.77	1.31	9.77	53.27
Sarmi	11.5	27.19	10.39	5.23	31.63	85.04
Keerom	9.9	44.50	17.57	7.28	14.37	66.67
Waropen	6.1	50.92	7.72	1.64	19.20	88.82
Supiori						
Membramo Raya	42.1	18.67	10.34	6.13	77.27	94.31
Kota Jayapura						

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
Human development index (HDI)	The HDI is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development: (1) A long and healthy life, as measured by life expectancy at birth, (2) Knowledge, as measured by the adult literacy rate (with two thirds weight) and the combined primary, secondary and tertiary gross enrolment ratio (with one third weight), and (3) A decent standard of living, as measured by GDP per capita (PPP US$). Before the HDI itself is calculated, an index needs to be created for each of these dimensions. To calculate these dimension indices - the life expectancy, knowledge and GDP indices - minimum and maximum values ('goalposts') are chosen for each underlying indicator. Performance in each dimension is expressed as a value between 0 and 1 by applying the following general formula: (actual value – minimum value) / (maximum value – minimum value). The HDI is then calculated as a simple average of the dimension indices.	**HDI**	BPS - Statistics Indonesia/BAPPENAS/UNDP, Indonesia Human Development Report, 2004
Gender development index (GDI)	While the HDI measures average achievement, the GDI adjusts the average achievement to reflect the inequalities between men and women in the following dimensions: (1) A long and healthy life, as measured by life expectancy at birth, (2) Knowledge, as measured by the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio, and (3) A decent standard of living, as measured by estimated earned income (PPP US$). The calculation of the GDI involves three steps. First, female and male indices in each dimension are calculated. Second, the female and male indices in each dimension are combined in a way that penalizes differences in achievement between men and women. The resulting index is referred to as the equally distributed index. Third, the GDI is calculated by combining the three equally distributed indices in an unweighted average. Calculating the GDI is straightforward. It is simply the unweighted average of the three component indices - the equally distributed life expectancy index, the equally distributed knowledge index and the equally distributed income index: 1/3 (life expectancy index) + 1/3 (education index) + 1/3 (income index).	**GDI**	BPS - Statistics Indonesia/The Ministry of Women Empowerment, Gender Based Human Development 2005 and 2006
Gender empowerment measure (GEM)	Focusing on women's opportunities rather than their capabilities, the GEM captures gender inequality in three key areas: (1) Political participation and decision-making power, as measured by women's and men's percentage shares of parliamentary seats, (2) Economic participation and decision-making power, as measured by two indicators - women's and men's percentage shares of positions as	**GEM**	BPS - Statistics Indonesia/The Ministry of Women Empowerment, Gender Based Human Development 2005 and 2006

DEFINITIONS OF THE INDICATORS		MAIN DATA SOURCES	
	legislators, senior officials and managers, and women's and men's percentage shares of professional and technical positions, and (3) Power over economic resources, as measured by women's and men's estimated earned income (PPP US$). For each of these three dimensions, an equally distributed equivalent percentage (EDEP) is calculated, as a population-weighted average. Finally, the GEM is calculated as a simple average of the three indexed EDEPs.		
Poor population	Population below the provincial poverty line. The provincial poverty line is the local currency (IDR) value an individual needs to fulfil his or her daily minimum requirement for food of 2,100 kilocalories (kcal), plus non-food minimum needs, such as housing, clothing, health, education and transportation. The provincial food poverty line is the cost of meeting the basic food needs of 2,100 kcal per day in the province, while the non-food provincial poverty line is how much a person has to spend to fulfil their basic, minimum non-food requirements in the province. People whose expenditures are less than the level of the poverty line are classified as living below the poverty line, or as poor population. The poverty standard used by the Badan Pusat Statistik (BPS) -Statistics Indonesia is dynamic because it has to be realistic and to adjust to shifts in consumption patterns and provincial aspirations. There are two different criteria: the 1996 standard and 1998 standard. The revision in 1998 was done not only because of the shift in consumption patterns but also because the definition of minimum basic requirements and commodities had to be broadened to take into account new policies affecting family expenditure, such as the introduction of nine years of compulsory basic education.	**Poor population**	BPS - Statistics Indonesia: Based on National Socio-Economic Survey (SUSENAS), published in the Statistical Year-Book of Indonesia
Poverty gap index	The average size of the expenditure gap among the poor as compared with the poverty line. The higher the index value, the farther the average expenditure of the population is from the poverty line. The poverty gap is defined as: (incidence of povery) x (depth of poverty). The poverty gap index measures the depth or intensity of poverty; how far the poor are below the poverty line.	**Poverty severity index**	BPS - Statistics Indonesia, Data and Information Poverty 2008 (Book 2: District / Municipality), Jakarta (based on the National Socio-Economic Survey 2008), 2009
Poverty severity index	The poverty severity index gives an overview of the patterns of expenditure among the poor. The higher the index value, the higher the expenditure inequality among the poor.	**Poverty severity index**	BPS - Statistics Indonesia, Data and Information Poverty 2008 (Book 2: District / Municipality), Jakarta (based on the National Socio-Economic Survey 2008), 2009

DEFINITIONS OF THE INDICATORS

Percentage of households using clean water	Proportion of the number of households using clean water among the total number of households, expressed as a percentage. Clean water is water is sourced from taps, bottled water, water from protected wells and protected springs with distance from any final disposal site (septic tank) of at least 10 metres.
Percentage of households using latrines	Proportion of the number of households that use latrines among the total number of households, expressed as a percentage.

MAIN DATA SOURCES

Percentage of households using clean water	BPS - Statistics Indonesia, Data and Information Poverty 2008 (Book 2: District / Municipality), Jakarta (based on the National Socio-Economic Survey 2008), 2009
Percentage of households using latrines	BPS - Statistics Indonesia, Data and Information Poverty 2008 (Book 2: District / Municipality), Jakarta (based on the National Socio-Economic Survey 2008), 2009

Notes - Data not available