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PERMANENT MISSION
OF THE REPUBLIC OF INDONESIA
TO THE UNITED NATIONS, THE WTO
AND OTHER INTERNATIONAL ORGANIZATIONS
IN GENEVA

No. 0115/Pol-II/VI/2010

The Permanent Mission of the Republic of Indonesia to the United Nations, WTO and Other International Organizations presents its compliments to the Office of the High Commissioner for Human Rights in Geneva and with reference to the latter's note verbal dated 12 April 2010 (*Reference: Poverty 2010 ER*), has the honor to enclosed herewith a written response to the questionnaire submitted by the Independent Expert on the Question of Human Rights and Extreme Poverty.

The Permanent Mission of the Republic of Indonesia to the United Nations, WTO and Other International Organizations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights in Geneva the assurances of its highest consideration.

Geneva, 21 June 2010

Office of the High Commissioner
for Human Rights/ UN IE on the
Question of Human Rights and
Extreme Poverty
in Geneva
Fax: 022 917 90 06/ 917 0123



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22 JUN 2010

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REFERENCE: POVERTY 2010 ER

The Office of the High Commissioner for Human Rights presents its compliments to the Permanent Missions to the United Nations Office in Geneva and has the honour to refer to Human Rights Council resolution 8/11 of 18 June 2008 entitled "Human rights and extreme poverty".

In paragraph 5 of resolution 8/11, the Human Rights Council has called upon "all Governments to cooperate with and assist the independent expert in his or her task, to supply all necessary information requested by him or her (...) to enable him or her to fulfill his or her mandate effectively".

The attached questionnaire has been developed in order to facilitate the submission of information by Governments for further analysis by the independent expert and inclusion into her next report to the General Assembly, which will be devoted to the achievement of Millennium Development Goals through social protection interventions.

In order to assist the independent expert in the preparation of her report to the sixty-fifth session of the General Assembly, the Office of the High Commissioner for Human Rights would be grateful if any information and materials in response to the questionnaire could be forwarded in an official UN language before Friday 4 June 2010 to the attention of:

UN Independent Expert on the question of human rights and extreme poverty
UNOG- OHCHR
CH - 1211 Geneva 10
Telefax: 41 22 917 90 06
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The Office of the High Commissioner for Human Rights avails itself of this opportunity to renew to the Permanent Missions to the United Nations Office in Geneva the assurances of its highest consideration.

12 April 2010

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IG. 15/04/10	N

GV: 0335

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Questionnaire on lessons learned, progress and challenges of the Government of Indonesia
to achieve the Millennium Development Goals for the most vulnerable
Addressed to Governments by the Independent Expert on the question of
human rights and extreme poverty

MDG 1 – Eradicate extreme poverty and hunger

1. Decent Work

1) *Who are those most likely to be working poor or those who are engaged in vulnerable work?*

- a. Low-educated people, with lack of training;
- b. People in low-productive jobs;
- c. Youth;
- d. Children.

2) *Please describe specific policies and programmes that are designed to benefit the most vulnerable?*

- a. We have implemented policies to create many formal employment opportunities, i.e. opportunities for any Indonesians to obtain highly-productive employment thus better welfare. We have been improving manpower regulations that pertain to such aspects as recruitment, outsourcing, wage settlement, layoffs, and by improving regulations that provide better protection. We are also improving policies to support labor market mechanism by encouraging the establishment of labor market information institution.
- b. We have been improving many government programs for the expansion of employment opportunities, such as programs on public works (labor-intensive programs, *PNPM Mandiri* or *Program Nasional Pemberdayaan Masyarakat Mandiri*, etc.), micro-credit, promotion of SMEs, and programs for reducing poverty.
- c. Since RPJMN 2004—2009 (Rencana Pembangunan Jangka Menengah Nasional 2004—2009) or midterm development plan, we have set broad policies to enhance the quality of human resources by, among others, improving educational services, trainings, and health services. Furthermore, one of the economic development priority focuses in RPJMN 2010—2014 is enhancing the competency and productivity of workers. This priority focus' objective is to set a basis for sound implementation of competency-based trainings in various sectors, including improvement of competency certification system. There are at least ten ministries who are involved in the development of competency-based training. All people, including the vulnerable, will have access to such trainings.
- d. Related to social protection dimension of decent work, we have made an effort to protect those who are the most vulnerable, e.g. child labors and migrant workers.
- i. To protect working children, especially child labor, since 2008 we have implemented a specific program called Child Labor Withdrawal Program. This program supports the implementation of *Program Keluarga Harapan*, i.e. conditional cash transfer program,

to make sure that child labors, especially those who work in worst forms of child labor, have the opportunity to leave their job and return to education.

- ii. Furthermore, we have been improving our efforts to protect the most vulnerable migrant workers, especially those with limited education level and from poor families. Many of the poor find that working abroad is appealing in terms of earnings. Our efforts to protect the migrant workers include protection during their recruitment process in the country, during their time working abroad, and when they return to Indonesia. The efforts are comprehensively divided among related ministries according to their respective function, with good coordination acts as the main key.
 - e. To address the vulnerable youth, many ministries have set programs to encourage entrepreneurship, especially among youth. These programs offer business facilitation and training, and support them with access to micro-credits.
- 3) *What processes and mechanisms designed to ensure participation of civil society in decision-making as well as transparency and accountability have been most useful improving decent work for the most vulnerable, and which have been less useful?*
- a. Civil society involvement in decision-making process is most evident in *Program PNPM Mandiri*. This program, aside from its poverty reduction objective, also acts as a means to create employment opportunities in urban and rural areas. In this program, civil society determines what type of project they will execute, to ensure that the project matches their needs.
 - b. Our policies and programs are formulated by incorporating the process of social dialogue between different social and economic groups, such as employers, employees, and other social partners.

MDG 2 – Achieve universal primary education

- 1) *People from which population groups are most likely to drop out of primary school in your country and why?*
- a. Indonesia has achieved significant progress in meeting the MDGs targets for participation and access to education. Yet, Indonesia even sets higher target than set out in the MDGs for the basic education development by increasing the levels of mandatory education to Junior School (junior high school grade 7-9). During the period 1992-2008, Net Enrollment Rate (NER) Primary School/Islamic Elementary School (SD / MI) has increased significantly from 88.7% in 1992 and remained elevated despite the financial crisis in 1997 to 92.5%. In 2008, the NER SD / MI has reached 98% and Gross Enrollment Rate (GER) primary school has exceeded 100%.
 - b. Indonesia's expansion in enrollment rates is quite impressive, but still remain gaps in participation rates, especially for poor families. Not all children aged 7-15 years from poor families get a basic education services, some of them dropped out of school either due to geographical or cost constraints. Nationally, the dropout rate of SD / MI in the 2003/2004 academic year still amounted to 2.92%. It means that there are 1.63% or 486.426 students drop out in primary school level (National Education Data Summary

2007/2008). Approximately 57.2% of the reason is not / never attended school and not in school anymore is because there is no money (SUSENAS 2007). These occurrences of dropouts are usually caused by the inability of the parents. Many children had to work and leave school. Education is still seen as an expensive investment that has not benefit significantly compared to resources spent. Thus, the major challenge faced was to ensure that children who come from the marginalized can have the opportunity and access to schooling.

2) *Please describe specific social protection policies and programmes that have been put in place to prevent school drop-outs among the most vulnerable. Are there any social protection policies that have had an impact on the withdrawal rate of children from primary and secondary education?*

- a. In order to ease the burden of educational costs to poor families, the Indonesian government has conducted various educational subsidy programs such as the BOS (School Operational Funds), the BOS Buku (School Operational Funds for Books), and Scholarship for Poor Students. BOS program, one of the activities that has been carried out since July 2005 until 2010 is given to students of SD / MI / Salafiyah Ula, SMP / MTs / Salafiyah Wustha and non-Islamic education unit that organizes Compulsory Basic Education Program. BOS provision is intended to exempt tuition fees for poor students and to lighten education costs for non poor students so they gain a better quality education services until the completion of the Nine Years Compulsory Basic Education. BOS is constantly increased both in terms of coverage and unit costs.
- b. Besides being used to finance the operational needs of schools, BOS can also be used to help purchase cost of textbooks and transportation cost assistance to poor students who have difficulties with transport from home to school and vice versa. In 2010, BOS target has increased to 43.77 million students, each approximately 37.59 million public school students and 6.18 million madrasah students with a total allocation of funds BOS reach Rp 19,26 trillion. This amount is expected to increase by 2011 along with the increasing number of students in basic education. The increment of targets is hoped to contribute increase participation and quality of basic education schools.
- c. To improve the ability of poor people sending their children to schooling, the government also provided scholarships to poor students for all levels of education from primary school until the public and religious tertiary education. In 2010, the number of scholarship target in primary education reached 3.7 million students with an allocation of Rp. 1.7 trillion. The coverage of scholarships for poor students will be continued and improved even in the year 2011. This enhancement is expected to alleviate the cost of education to poor students as well as to draw in students who already dropped out of school.
- d. Independent survey conducted by Bureau of Statistics or BPS in 2006 (SUSENAS 2006) mentions that an increase in percentage of primary education students exempted from school tuition fees from 46.3 percent in 2004/2005 amounted to 61.5 percent in academic year 2005 / 2006. This finding is reinforced by data from the Ministry of National Education which states that in 2006 there were approximately 70.3% of basic education schools no longer charge tuition fees. Although its implementation still needs to be improved, providing the BOS also reduce parent's burden to meet the needs of

school operating costs. Thus, the quality of education can still be maintained even though the participation of parents in educational funding is getting smaller.

- e. The other important achievement is the decrease of drop out percentage in level SD/MI from 2.92% (2003/2004) to 1.63% (2007/2008) and dropout SMP/MTs from 2.48% to 2.22% for the same academic year. Approximately 96.74 percent of the total numbers of primary school graduates continue to junior high school in the academic year 2007/2008. In other words, there are about 3.26% of students graduated from primary school who did not continue to the next level of education. The progress on educational performance as indicated by indicator of course not separated from the support of the BOS program and scholarships to poor students.
- 3) *What processes and mechanisms to ensure participation of users in decision making as well as transparency and accountability have been most useful in preventing school drop-out of the most vulnerable and which have been less useful?*
- a. After 2000, the Indonesian government began to implement decentralization. Responsibility for provision of education services was delegated to local governments at the district/municipality level while the central government level retained responsibility for national policy formulation and overall quality assurance. Funding for education is shared between three levels of government central, provincial, and local. Through the mechanism of decentralization, performance orientation on participatory, transparency, and accountability continue to be developed in order to strengthen the performance and evaluation and quality assurance systems in the basic education system. Through that system, financial reporting should be strengthened, together with efficient mechanisms to ensure accountability shared between central and local governments, schools and parents. Introducing a better performance orientation for information system of education and budget management; establish indicators of governance and accountability and information systems at district level, and improve the quality of information about the performance of the education sector to ensure implementation in accordance with existing standards.
 - b. At school level, School-Based Management (SBM) has been developed in which the schools make their own plans and take their own initiatives to improve education quality involving community participation in the process. In this approach, the responsibility of decision making regarding budget, staffing, and curriculum are placed at the school level and not at the local level, much less central government. Through the involvement of teachers, parents, and other community members in important decisions, the MBS is seen to create an effective learning environment for students, including preventing the occurrence of dropout rates, especially for poor students. Through the implementation of MBS allocation of funds to the schools become larger and these resources can be utilized according to the needs of the school itself. Decision making involving all stakeholders will support the creation of school culture that is democratic, transparent, and accountable. Including familiarize school to make a report of accountability to the public. For instance the model on a bulletin board display school budgets conducted by the Managing Basic Education (MBE) with International Organization support an early stage in a very positive and incidentally make a report in the form of booklets, leaflets or posters about the school action plan.

MDG 3 – Promote gender equality and empower women**1) From which population groups are girls and women least likely to attend secondary or tertiary education and to work in wage employment?**

- a. Strong effort has been made by the Government of Indonesia to improve access and quality of education at all levels (primary, secondary, and tertiary education), both for boys and girls, also men and women. Some indicators that can be used to measure the progress are the net enrollment ratio (NER) for junior secondary and the gross enrollment ratio (GER) for senior and tertiary education. The enrollment rates vary among level of education. Although there is a significant improvement in the enrollment rates, but the higher level of education is followed by the lower participation rate. Economic reason is one of the factors. The higher education means the higher opportunity cost. For the poor families (poorest quintile), it would be better if their children go to work as earlier as possible.
- b. Data from National Socio-Economic Survey (Susenas) 2008 shows that at all level of education, the poorest quintile has the lowest enrollment rate. In junior secondary level, NER of the poorest quintile was 60,29 for girls and 58,50 for boys, while the richest quintile was 70,25 and 72,99, respectively. At senior secondary level, NER of the poorest quintile was 31,95 for girls and 30,16 for boys, while the richest was 53,06 and 61,15, respectively. At the tertiary/higher education, GER of the poorest was 4,36 for women and 4,03 for men, while the richest was 30,86 and 34,13, respectively.
- c. Referring to the data, the hypothesis of the poorer the family, the lower the proportion of girls enrolling in school does not hold for Indonesia. The NER or GER of girls from the poorest quintile were about the same as, or higher than, those for boys at the junior secondary and senior secondary levels. This is probably due to cultural factors: when a family is poor, boys—rather than girls—are obliged to work. On the other hand, in the richest quintile, a bigger proportion of boys is enrolled at the secondary level than girls. Analysis of the GER's reveals the same pattern. But the gap between rich and poor in education enrolment is much greater than the gap between males and females. It means the main challenge in Indonesia is to increase the access to education among the poor. While at the tertiary/ higher education data shows that the GER both for man and women from the poorest and the richest quintile are low.
- d. Data from National Labor Force Survey (Sakernas) 2009 shows that women with academy and university background have the lowest number of women participation in wage employment, while women with no schooling was in second place. On the other hand, data shows that women with primary school background has the largest share in wage employment, and most of them worked as laborer/employee (2.88 million of workers) and casual employee in agricultural (2.65 million of workers). Women with

Junior and secondary school background were in the second and third place of the women largest share in wage employment.

2) Please describe social protection policies and programmes that facilitate access for the most vulnerable women to secondary or tertiary education and wage employment?

- a. Referring to the answer on MDG2, social protection policies and programmes that facilitate access for the most vulnerable women are also provided to secondary or tertiary education.
- b. The Government of Indonesia has designed various educational subsidy programs for the vulnerable people, both women and men, such as the BOS (School Operational Funds), the BOMM (Quality Management Operational Funds), Scholarship for Poor Students, and Scholarship for Well-performing Students. BOS program, which has been carried out since July 2005 until 2010, is given to students of primary and junior secondary, also non-Islamic education unit that organizes Compulsory Basic Education Program. The BOS aims to exempt tuition fees for poor students and to lighten education costs for non poor students so they gain a better quality education services. The allocation of BOS in 2010 to basic education, (primary and junior secondary level) are describes in MDG2. Besides BOS and BOMM, government also provided scholarships for poor students at all levels of education from primary school to the public and religious tertiary education. Government also allocated scholarships for well-performing students at the university level. Those scholarships aim to alleviate the cost of education to poor students and giving access to them for the better education services. In 2010, the number of scholarship for poor students target in junior secondary education reached 1.29 million students, each approximately 0.75 million public school students and 0.54 million madrasah students. At the senior secondary level, the scholarship covers 0.76 million students, each approximately 0.24 million for public school, 0.20 million for vocational school, and 0.32 million for madrasah school. While allocation of BOMM in 2010, has been targeted around 5,7 million poor students in senior secondary education.
- c. At university level, it covers about 124.5 thousand students, which approximately 65 thousand for public university and 59 thousand for Islamic university. While scholarship for well-performing students covers 20.0 thousand students in public university and 2.03 thousand students in Muslim School.
- d. Gender equality is also a concern in regard to workforce participation as the female participation rate is lower than that of male. Law 13/2003 on Manpower and government ratified ILO convention have provided rooms for improvement for both employers and employee with regards to workforce participation, working opportunities, and wage determination.
- e. Law No. 13/2003 has been guaranteeing equal remuneration for the workforce. The law which is the main legislative umbrella on labor polices contains specific provisions

guaranteeing equal remuneration for the workforce as stated in article 5 and 6 which each individual working age community has a similar opportunity to get work and treatment without discrimination.

3) *What processes and mechanisms to ensure participation of women in decision-making as well as transparency and accountability have been most effective?*

- a. In recent years, the issue of the representation of women and their participation in the development, particularly in political participation, has become increasingly significant in Indonesia. In order not to lose valuable human resources consisting of women, a quota is essential. By involving women in the decision-making process, the process of democratization can begin. Democracy without the involvement of women is not democracy. The quota is a mechanism to ensure the recruitment of women into the political domain so that political, economic and ideological obstacles in the path of women's progress are minimized.
- b. There has been quantifiable improvement in women's participation in decision-making process, especially in legislative area. Endorsement of Laws No. 2/2008 on Political Parties and Law No. 10/2008 on General Elections, the Election of Members to the House of Representatives, the Regional Representative Council, and the Regional House of Representatives, provide opportunities for 30 percent women representation in management of political parties and as a legislative candidate. The data shows that in 2009, the total number of women legislative candidates was 3,910, representing 35 percent of the total elected. The quota for 30 percent women candidates as mandated by law has been met by 38 out of 44 registered political parties. Although the result of general election shows that there only 17.9 percent women representation in legislative for 2010-2014, but this number increasing from the previous period (2004-2005) of only 11.6 percent. The participation rates of women in the senior management positions of government institutions also shows the increase, especially for echelon II-IV. In 2006, percentage of women in echelon II to IV were 6.6 percent, 13.7 percent, and 22.4 percent, respectively. In 2008, those percentage increase to 7.1 percent, 14.5 percent, and 23.5 percent, respectively. Providing a qualified political and leadership education and training are one way to increase women representation. Besides that, a targeted advocacy campaigns also one factor for those achievement.

MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria and other diseases)

- 1) *Which population groups have the highest child and maternal mortality rates and the highest prevalence of major diseases?*
 - a. With tremendous geographic and socio-cultural diversity, Indonesian health authorities face particular challenges in providing quality health care to a population scattered among some 17,500 islands, often with difficult access and poor living conditions. This is reflected in coverage where the density of health providers to the population varies

from a low of 10 doctors per 100,000 population to a high of 43 per 100,000 population. Of particular concern are poor communities and outlying areas where some 25 percent of the population lives and health indicators are low and care is scarce. While the introduction of decentralization of health services provision to district levels has introduced particular challenges into the equation. On the other hands, some persistent conflict areas in Indonesia show that women and children, including youth are the most vulnerable groups who have poor or absent of access to basic social services, even including access to water and sanitation, the basic needs.

- b. Most of health related MGDs achievements showed disparities between rural-urban, level of education and geographic, socio-economic status. Among provinces, even intra provinces the disparities are huge, especially in eastern part and islands area.
- c. Health status related with MDGs 4, 5 and 6 which has been already achieved shows disparities across rural-urban, level of education and geographic, socio-economic groups. There are significant disparities in achievement status of infant mortality rates, maternal mortality rate and prevalence of infectious diseases.
- d. The data shows that in 2007 the maternal mortality rate in Indonesia was 228 per 100,000 live births, which is the highest in Southeast Asia. Among women in the lowest quintile of household expenditure, only 40 per cent give birth assisted by medical personnel, while around 82 per cent of women in the highest quintile were assisted by medical personnel. Similarly, the mortality rate among young children from poor families is also very high, at 53 per 1000 live births. In contrast, the mortality rate of young children from better-off families is less than 24 per 1000 live births. In the education sector, chronic poverty is also closely related to low levels of education. In 2004 the primary school net enrolment rates (NER) for children from the poorest and richest quintiles did not differ greatly, at 91.95 per cent and 92.23 per cent respectively. However the difference at the junior and senior high school levels was quite substantial. At the junior high school level the NER for the poorest quintile was 49.97 per cent, compared to 76.60 per cent for the richest quintile; and at the senior high school level the NER for the poorest quintile was 21.9 per cent, compared to 65 per cent for the richest quintile.
- e. High mortality rates in early childhood (MDGs 4) reflect the poor health status of mothers and newborns of the poor, especially in rural areas, and also the low education of mother. This in turn is explained by issues related to maternal health, starting with family planning and including antenatal care and safe delivery. High mortality rate in mother (MDGs 5) is also related with level of education and socio-economic group. The important factor which cause mortality rate is percentage of births delivered by a skilled provider. It decreases with her level of education, and her income status. Only 14 percent of poor women deliver with a trained provider, compared with 83 percent of non-poor women (The lowest quintile compared to the highest quintile). Regional and residence area differences are important, place of delivery-home, health facility-also shows regional (provinces) and residence area (rural-urban) differences.
- f. The high maternal mortality ratio among others is caused by the high level of fertility rate and risk pregnancies (too many children, too young or and too old mother's age)

due to limited access to quality reproductive health services and reliable information on sexual and reproductive health.

- g. Unmet need for family planning is currently estimated at 9 percent, of which 4 percent is for spacing and 5 percent is for limiting, which has remained at about the same level since 1997. Unmet need also varies among social economic background characteristic, it is generally declines with increasing education; the more educated the women, the lower the percentage with unmet need. Unmet need for family planning tends to decrease with increasing wealth quintile; from 13 percent for women in the lowest quintile to 8 percent for women in the highest quintile.
 - h. Correspondingly, contraceptive use among currently married women is at 57 percent (modern method) and 61 percent (any method). There is no notable difference during the period between 2002 and 2007, and this contrasts with the steady increase in usage rates during the 1990s. The prevalence of contraceptive use among currently married women by background characteristics shows that use of family planning in urban areas is slightly higher than in the rural areas (63 and 61 percent, respectively). The contraceptive use in general increases with the respondent's level of education; the more educated the respondent, the higher the percentage of CPR. CPR also tends to increase with increasing wealth quintile; from 53 percent in the lowest quintile to 64 percent for the highest quintile.
 - i. In the regional/provinces disparities that shows geographic, socio-culture and economic disparities. Population who lives in eastern of Indonesia, which has low density of population, poor infrastructure, lack of social services delivery points, which usually also with low income, has low access to basic social (health) services.
 - j. In achievement status of MDGs 6, frequent illness is a major risk, especially among the poor population where prevalence of infectious diseases (whether it is air borne, water borne diseases) is highest. Specifically, HIV/AIDS in Indonesia is concentrated among injecting drug users and sex workers but is still rare among the general population. Malaria almost half the population lives in endemic areas and the highest prevalence rates of malaria are to be found in eastern Indonesia. Prevalence rate of TB is high in remote areas where the combination of poverty and TB can be especially devastating.
 - k. We may conclude that population group with the poorest outcomes, live in rural and low level in education displaying infant mortality rates, maternal mortality rate and prevalence of infectious diseases higher than population groups with high outcome, live in urban and have high level of education.
- 2) *Please describe specific policies and programs that ensure access to health care services for those most vulnerable. In particular provide information on how social protection mechanisms have directly impacted child mortality rates and maternal health, especially among vulnerable groups, and how social protection system have lessened incidence of preventable diseases trough improving access to health care ?*
- a. Government policy, as reflected in its strategic five-year plans for the health sector covering the period 2010-2014, is to improve access and quality of health services, especially for the poor. Key policy elements are improving the number and distribution

of health workers, ensure the functioning facility to be accessed, and providing social assistance that expected to improve access by removing financial barrier such as CCT program (Conditional Cash Transfer) and Jamkesmas (social assistance for health care for the poor).

- b. Current policies does focus on ensuring access to health care services for those most vulnerable group which emphasis might be placed on four policy areas:
 - i. Raising awareness about safe motherhood at the community and household level through IEC programs that are designed to respond to local circumstances in order to encourage preventive and curative care-seeking;
 - ii. Facilitating access to care through:
 - o Facility-based and outreach services that are anchored in community needs, are evidence-based, and have the community health center/"puskesmas" as primary provider of services;
 - o Expanding the village midwife function, including partnering with TBAs, especially in places where these have an important role in maternal health in the community;
 - o Increasing the number of health workers (general practitioners, specialists, village midwives, paramedical staff) and their distribution;
 - o Building effective partnerships across programs and sectors to make use of synergies in service provision and advocacy; and increasingly leveraging care; and
 - o Increasing primary health care and referral health services, with specific strategies: promotion of basic health services and the revitalization of integrated service post/"posyandu", repair facilities to become Basic and Comprehensive Emergency Obstetrics and Neonatal Care; focus on operating costs for hospitals and health centers for basic health services, or called Operational Cost of Health and has started in the year 2010.
 - iii. Introducing better program oversight and management through surveillance, monitoring, evaluation and financing; and defining modalities for sharing roles and responsibilities between central, provincial and district authorities.
 - iv. Scaling-up preventive interventions and case management of infectious diseases
 - v. strengthening governance, improving service provision, and mobilizing communities
 - vi. Strengthening social services and social protection. Government support for strengthening the procurement of health services will be developed. Several key strategies will be developed that (1) seek the benefits of efficiency in the use of resources currently available, based on performance management mechanism, (2) simplification of health care assurance/"Jamkesmas" program, focusing on the poor and MDG-related essential services, and (3) mobilize additional resources to encourage increased financing of the MDGs by the district service, and (4) streamline and focus the distribution of donor funds; (5) provide operational cost of health assistance.

3) *What processes and mechanisms designed to ensure participation of beneficiaries in decision-making as well as transparency and accountability have been most useful in improving the coverage and quality of health services to the most vulnerable and which have been less useful.*

- a. Government has Some of programs which designed to achieve the target of MDGs 4, 5 and 6 in central, provincial and district authorities, have already involved of participation of beneficiaries in decision-making to decide in using health service. One of these is PKH.

PKH (Program Keluarga Harapan)

- b. In 2007 the government began to trial a conditional cash transfer (CCT) programme known as Program Keluarga Harapan, PKH in seven provinces: West Sumatra, DKI Jakarta, West Java, East Java, North Sulawesi, Gorontalo and East Nusa Tenggara (Figure 1). This programme is hoped to be more aimed at helping to increase the education and health of poor communities in an ongoing manner. The idea of implementing the CCT programme emerged initially in early 2005, as an alternative poverty reduction strategy for the major reduction in fuel subsidy.
- c. PKH funds are given to targeted poor families. The programme guidelines state that the main goal of the programme is to improve the quality of human development especially for children from poor families. Families are provided with an allowance conditional on their attention to their children's education and health (Tim Penyusun Pedoman Umum PKH, 2008: 1).
- d. Under PKH it is expected that children from poor families could escape from inter-generational poverty trap they might inherit from the poor condition of their parents. However, PKH is only one of the Gol's poverty reduction programmes, and serves to strengthen its efforts in poverty alleviation. The Gol manages many other programmes to help the poor cope with their livelihood difficulties and keep those vulnerable from falling into poverty. In addition to the programmes mentioned above, the CCT scheme that defines the design of PKH is also adopted in a community CCT named PNPM Generasi. PNPM Generasi was launched simultaneously with PKH, but implemented in different regions. Thus, a village that receives PKH will not be included in PNPM Generasi.
- e. Unlike PKH, in the PNPM Generasi block grants will be allocated to communities rather than to individual targeted households. A condition for participation in the programme is that communities must commit to improving health and education conditions. PNPM Generasi places a strong focus on education and health activities, emphasizing investment in certain lagging health and education outcomes. Applying the principles of community-driven development, communities decide how best to use the block grants to reach several education and health targets. Communities manage and decide the use of the grants through a facilitated participatory planning process. In PNPM Generasi conditionality will take the form of performance-based financial incentives for villages. Communities will submit proposals to fund certain activities or investments. The PNPM Generasi approach builds extensively upon the work of the Kecamatan (subdistrict) Development Project (KDP).

f. Sector Indicators in PKH, are as follows:

- (1) Four prenatal care visits for pregnant women at health institutions
- (2) Taking iron tablets during pregnancy
- (3) Delivery assisted by a trained health professional
- (4) Two postnatal care visits
- (5) Complete immunisations (BCG (Tuberculosis), DPT (Diphtheria, Pertussis, Tetanus), polio, measles, and Hepatitis B) and additional immunizations for children aged 0-11 and 12-59 months
- (6) Ensuring of monthly weight increases for infants
- (7) Monthly weighing of children under three and bi-annually for under-fives
- (8) Vitamin A twice a year for under-fives

MDG 7 – Ensure environmental sustainability

1) *Which population groups are most affected by biodiversity loss, have least access to safe drinking water and basic sanitation, and are most likely to live in slums?*

- a. Vulnerable groups particularly women and children and poor communities especially in rural areas and urban slums are more likely affected by unsafe and unreliable water and basic sanitation. Lack of access to safe drinking water and basic sanitation has a significant contribution on the transmission of communicable diseases and one of important causes of children mortality and morbidity. Although access to safe drinking water has been increased from 20.6% in 1993 to 47.6% in 2009, there is wide disparity among provinces and between urban and rural areas. The proportion of household with access to safe drinking water in rural areas in 2009 was 45.7%, while in urban areas the proportion was 49.8%. This situation is similar with access to basic sanitation. Coverage of basic sanitation has been improved, from 24.7% in 1993 to 51.0 % in 2009. However, the proportion of household with access to basic sanitation in rural areas (34.0%) tends to be lower than urban areas (69.6%).
- b. By using the current definition of indicators, less than half the population has access to an improved water source, and about half population have sanitation coverage.
- c. There was some increase in urban coverage levels, but there was no change for rural coverage levels with only 34% of its rural population having access to improved sanitation. Urban coverage rates are headed toward the same conclusion, with only 76% of Indonesia's urban dwellers having access to improved sanitation in 2015. While a significant number of people have gained access to basic sanitation since 1990, some 94 million Indonesians still do not have sanitary toilets.
- d. In fact, the percentage of people practicing open defecation has not significantly changed over the last two decades, with about 18% in urban and over 40% in rural areas still defecating in the open. Taking into account population growth, this translates into more people practicing open defecation every day.
- e. In terms of gaps between rural and urban access to improved sanitation by province, shows that 17 provinces have a higher gap than the national average, with highest gap is found in Riau Islands, North Maluku and followed by West Kalimantan.

- f. In 2009, some 47.6 % of households had access to improved sources of drinking water : of these 15.2% had access to piped drinking water and remaining 32.4 percent had access to non-piped protected water (excluding bottled drinking water). There are still 24 provinces out of 33 with unimproved drinking water access equal to or higher than the national average – 39% (Figure 7.7). Of these 24, Banten, West Java and Bangka Belitung provide their populations with no access to improved water with bottled water, mainly in urban areas.
 - g. There are 12 Provinces with a higher proportion of households with access to bottled water than the national average (13%), - Aceh, Riau, Riau Islands and Bangka Belitung in Sumatera; DKI Jakarta, West Java and Banten in Java; Bali, East Kalimantan; North and Central Sulawesi; and Papua and West Papua.
 - h. The use of bottled water is mainly in urban areas. The trend tends to increase from time to time due to high population growth with insufficient growth of piped drinking water.
 - i. DKI Jakarta is an interesting case, where more than half of households are using bottled water. The tendency to reduce unimproved water coverage by resorting to packaged drinking water also is found in Riau, Riau Islands, Bali, East Kalimantan, North Sulawesi and even West Papua (province where unimproved drinking water coverage is lower than the national average – 39%). The trend towards bottled drinking water in urban areas needs to be watched, because of the socio-economic disparities it may generate with increased urban poverty and urbanization, especially the growth of slum dwelling.
- 2) *Please describe specific policies and programs for the benefit of the most vulnerable to: reduce biodiversity loss; increase access to safe drinking water and sanitation and ensure safe shelters. Please detail how social protection mechanism have directly improve the vulnerability of slum dwellers and helped provide secure access to adequate housing.*
- a. To improve sustainable access to safe drinking water and basic sanitation, several policies and strategies have been implemented. Ministry of Public Works and Drinking Water Local Company (PDAM) have implemented community based water supply and expansion of household network for piped drinking water. In improving access to basic sanitation, Ministry of Health has developed a community based national sanitation strategy (CLTS). This emphasizes behavioral change and broad community participation in creating a clean environment-improving access and behavior, while at the same time building up the necessary infrastructure.
 - b. Beside strategies has been mentioned above, there are some action need to be taken in the future in improving access to safe drinking water and basic sanitation:
 - i. investment spending needs to increase, and it needs to be focused on serving growing urban populations, most of whom are poor, and more generally areas that are lagging in access to safe, adequate and reliable water and sanitation;
 - ii. the role and responsibilities of local governments—formally responsible for water and sanitation—will need to be better delineated: (i) in planning, budgeting and infrastructure provision; (ii) in managing water and sanitation systems; (iii) in

financing; and (iv) in supporting the community in creating a safe water and clean sanitary environment; and

- iii. while the provision of BCC and IEC messages about clean water use, sanitary practices and hygienic behavior need to continue, they will need to be adapted to local/community circumstances and aim at changing public perceptions about water as a free good to increase a sense of responsibility for water use in the household and the community.
- c. In addition, the policies that should be adopted and applied in the programs, are (i) respond to community need; (ii) community contribute to part or whole development stages; (iii) community actively manage the project; (iv) community decided the technology option; (v) behavior changes as the main prerequisite; (vi) planning is done by community and local government, and facilitated by experts.
- d. In National Mid-Term Development Plan 2010-2014, policy direction of provision adequate shelter is increasing the accessibility of low-income community to a decent and affordable housing, through:
 - i. Improvement of decent and affordable housing provision for low-income communities through the construction of multi-storey rental housing and construction of subsidized health simple house;
 - ii. Increase of access for low-middle-income community to a decent and affordable housing through provision housing subsidies;
 - iii. Improvement of the settlements neighborhood quality through the provision of adequate and integrated basic means and infrastructure and general utilities, with the development of housing areas in order to develop a city without slums; and
 - iv. Enhancement of legal assurance in living (secure tenure) through the facilitation of pre-certification and post-land certification assistance for low-income communities.
- e. Programs related to slum-upgrading are Development and Management of Settlement Infrastructure Program, and Housing and Settlement Development Program. In specific, activities related are construction of multi-storey housing and supporting facilities, management of urban slum areas, and facilitation and stimulation of slum areas structuring.
- f. Social protection in Indonesia consists of social assistance and social insurance. Social assistance is type of social protection that has direct contribution to improve housing and settlement in urban slum areas. There are two kind of social assistance, house construction material assistance and Urban Poverty Program (UPP). House construction material assistance is given to low-income household in form of cash or good that aim to improve their housing condition. While UPP is a national program that aim to reduce poverty through empowering community and local stakeholders. UPP provide fund to urban communities to help the communities in making plan and manage investments for poverty reduction such as improving the basic infrastructure (water supply, sanitation, drainage, etc).

3) *What processes and mechanisms to ensure the participation of those most vulnerable in decision making as well as transparency and accountability have been most effective?*

- a. Several interventions in improving access to safe drinking water and basic sanitation, such as PNPM and CLTS, used community based approach, where the community can play a potentially greater role, starting from planning process to operation and maintenance phase. Those approaches will empower the community to identify their water and sanitation problems, decide the appropriate technology, and implement mechanism to operate and maintain the facilities.
- b. In rural areas, where the community can play a potentially greater role, advocate broad community participation in the water and sanitation management process; including managing related infrastructure with some responsibility for meeting capital charges and/or operating and maintenance costs; and with public authorities serving an advisory and supportive role.
- c. With supports from donors, the GOI has initiated to improve the community participations and contribution as well as their awareness in investing the adequate basic water and sanitation, incorporating by the improvement in community healthy behavior and practice (PHBS). While other efforts such as public private partnership, PDAM policy and management strengthening and improving infrastructure. Those are expected to increase percentage of population with access to improved water and sanitation.
- d. The involvement of community and local government since the first implementation phase can ensure the transparency and accountability process. The principles of, by, and for community in water supply and sanitation development have the ultimate goal to create community that can operate, manage, maintain, and develop water supply and sanitation infrastructure. This policy has also aim to increase the sense of belonging and to introduce from the beginning about the management system.

MDG 8 – Global partnership for development

- 1) *Please describe how ODA is impacting the MDG results in your country. Are the quantity and quality, transparency and predictability of aid appropriate?*
- a. As Indonesia status changed to become Lower Middle Income Countries (LMIC), the Government of Indonesia will no longer be eligible for receiving low interest rates loans from the multilateral development partners. However, over the past, even though the amount of received ODA has been reduced, the Government of Indonesia has been utilizing the ODA in the infrastructure for basic services and public facilities and other development sectors that support the MDGs achievement. Due to the change of Indonesia status and its high ratio debt stock to GDP, it is preferable that MDGs achievement is supported through the Debt Swap to MDGs. The issue of Debt Swap to MDGs has to be one of the agenda to accelerate progress towards the achievement of MDGs in Indonesia.

- b. The Government of Indonesia commitment on the utilization of ODA to achieve the MDGs is reflected in the government policy on efficiency improvement of foreign loans and grants as written in National Medium Term Development Planning 2010-2014 (RPJM Nasional 2010-2014), as follows;
- i. International loans and grants will be used to support achievement of the national priorities, goals and objectives in accordance with the National Medium Term Development Plan (RPJM Nasional) and in harmony with Indonesia's commitment to achieve the Millenium Development Goals (MDGs)
 - ii. To Improve efficiency and effectiveness in utilization of international loans and grants, the government also commits to improve the national planning, budgeting, procurement, monitoring and evaluation and to strengthen the institutions and the human resources required to implement these systems.
 - iii. To increase national ownership for programs funded by international loans and grants.
- c. In accordance with the national development strategy, the Government of Indonesia signed Jakarta Commitment with other 26 countries/international in January 2009 to achieve greater benefits of foreign aids, including the benefits to achieve the MDGs. Jakarta commitment represents a shared recognition between the government and development partners to enhance the effectiveness of foreign aid. Through Jakarta Commitment, it is desired that the foreign aids will be more transparent, predictable, and accountable. The main component of Jakarta Commitment are as follows;
- i. Strengthening country ownerships over development
 - Strengthening capacities and using stronger government system
 - Improving the international governance of aid and strengthening south-south cooperation
 - ii. Building more effective and inclusive partnerships for development
 - Developing a new partnership paradigm
 - Strengthening existing aid Instruments and shaping new ones
 - Expanding dialogue to include new actors
 - iii. Delivering and accounting for development results
 - Strengthening a focus on, and capacity to manage by, development results
 - Working together to review progress across development partnerships