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Office of the United Nations High Commissioner for Human Rights
c/o Ms. Melinda Ching Simon
CH-1211, Geneva 10, Switzerland
Fax no. 022 917 9008
A Human Rights Based Approach to Eliminating Preventable Maternal Mortality and Morbidity in Indonesia

I. General

The Indonesian Government attaches great importance to the issue of healthcare and is committed to ensuring that the right to health is promoted and protected at all levels of society in Indonesia. This commitment is also reflected in the government's ongoing efforts to fulfill the economic, social and cultural rights of the Indonesian people and ensure their right to development.

Healthcare in Indonesia is founded on a basis of human rights, non-discrimination, empowerment, independence and equality. The government is working with various stakeholders to raise health awareness and improve the access and quality of healthcare for communities, in particular for vulnerable groups, such as mothers, infants, children, the elderly and poor families.

Maternal health is a key priority in a number of government health and development programmes. Mothers play a key role in nation-building and national development and efforts to improve maternal health are therefore a key priority for the Indonesian Government.


Increase in the Health Budget

In line with Indonesia's National Medium Term Development Plan 2010 - 2014, the Government's policy on health and development is aimed at improving community access to health care, increasing life expectancy and reducing both the maternal and infant mortality rate.

Efforts to steadily improve the standard of health care in Indonesia have been stepped up in recent years. In 2003, the budget allocation for health reached Rp. 6.63 trillion (approximately U.S. $ 0.74 billion), while in 2010 it has increased to Rp. 23.95 trillion (U.S. $ 2,662 billion). Most of the budget allocation has been used to develop health care services in local community health centers (Pusat Kesehatan masyarakat - Puskesmas and Pos Pelayanan Terpadu - Posyandu), funded by Community Health Insurance (Jaminan Kesehatan Masyarakat - Jamkesmas) which are aimed at the middle to lower income groups.

1 Submitted by the Government of Indonesia to the Office of UN High Commissioner for Human Rights in the framework of Formation of Analytical Compilation regarding best and effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity in Indonesia.
In 2008, this program provided health care service for up to 76.4 million people and significantly increased community access to medication by substantially lowering the price of generic drugs. Another portion of the increased health budget has been used to recruit doctors and nurses, assist local Governments in regenerating community health centers, and to build hospitals in several areas. In addition, the budget has also been used for the Family Planning Revitalization Program which was underdeveloped during the first period of Government reform in 1998.

Health Budget Allocation 2003-2010 (USD billion)

Strengthening Legislation and Policy

The Indonesian Government has enacted a number of legislations relating to the public health service, including maternal health matters. These include:


2. Law Number 30/1999 on Human Rights.


The Indonesian Government has also stipulated that the protection and improvement of the health of mothers, infants and children, is the first of the Ministry of Health's eight priorities. The measures include:

1. Improving facility-based outreach services by increasing the quality and number of community health centers, implementing Basic Neonatal Obstetrics Emergency Services (BNOES/Pelayanan Obstetri Neonatal Emergensi Dasar) at Community Health Centers and Comprehensive Neonatal Obstetrics Emergency Services (CNOES/Pelayanan Obstetri Neonatal Emergensi Komprehensif) at general hospitals, building maternal and infant hospital as well as revitalization of integrated local health service center (Posyandu).

2. Strengthening the functions of village midwives, including fostering partnerships with private health workers and traditional birth attendants as well as community-based health services such as integrated local and village health service centers.

3. Strengthening the referral system, to overcome the problem of 'three late' and saving the life of the mother in the occurrence of complications through timely and adequate treatment.

4. Reducing financial barriers through: the Family Hope Program (Program Keluarga Harapan), the Community Health Insurance (Jamkesmas), and Health Operational Assistance (Bantuan Operasional Kesehatan).

5. Increasing the number of care services which supply integrated services for mothers and babies from pregnancy through to childbirth, the postnatal period and early childhood.

6. Increasing the capability of health personnel (general practitioners, specialists, midwives, paramedics) both in quantity and quality, and improving their geographical distribution to meet the needs of health workers in remote areas, border regions and remote islands, through pre-service and in-services training for strategic health personnel and contract-based health personnel.

7. Improving public health education to increase awareness about health and safety for mothers in the community.

8. Improving the nutritional status of pregnant women by ensuring they have an adequate intake of nutrients.

9. Creating a conducive environment that supports management and stakeholder participation in policy development and the planning process. Encourage cross-
program and cross-sector partnerships as well as private and communities partnership to implement advocacy initiatives.

10. Strengthening information systems, by: (i) introducing analytic methods for measuring maternal mortality by utilizing various data sources in different quality, (ii) focus on groups and regions with greatest risk of maternal mortality, and (iii) construct different models to identify save and effective motherhood strategies.

11. Strengthening coordination by clarifying roles and responsibilities of central and local Government in order to strengthen supervision, monitoring, evaluation, and financing, with the emphasis on the target intensity of disadvantaged and poor areas. In addition, cross-program and cross-sector partnerships as well as support of Non-Governmental Organizations (NGOs) are necessary to ensure the synergy of the implementation of the program.

12. Enhancing efforts to achieve the indicators for Minimum Service Standards in health so as to guarantee the achievement of health development in central and regional level (district/city).

**Improvement of Programs**

In order to reduce maternal neonatal deaths rate and increase the access of maternal and infant to health services, particularly in cases of labour complications and premature birth, the Ministry of Health undertaken the following initiatives:

1. Increasing BNOES programs at Community Health Centers and CNOES programs at general hospitals.

The Indonesian Government has worked to improve the BNOES in Inpatient Community Health Centers (Puskesmas) an is hopeful that every district can now provide at least 4 Inpatient Community Health Center which already conducted BNOES.

Until 2010, the number of Inpatient Community Health Center stood at 1.580 units. Obstetrics cases which fall beyond the BEONC authority are referred to hospitals with the CNOES program. The number of District/City Hospitals with a CNOES programme increased from 317 in 2009 to 358 in 2010. Until now, there are 1.378 hospitals with a CNOES facility in Indonesia.

2. Increasing public access to quality health services through:

   a. Placement of health personnel (doctors and midwives) in 101 Community Health Centers in remote areas and islands with special incentives (2010-2014)
b. Establishment of 32,887 Village Health Posts with 1 midwife and 2 cadres in 52,000 villages (2010-2014). Until recently, there were only 32,887 villages which already had a midwifery program.

c. Establishment of 6,033 non-serviced Community Health Center, 2,704 serviced Community Health Centers, 56.8% among which are able to give BNOES program, and 22,273 assisted health centers.

3. Gender mainstreaming in health through disaggregated data in gender analysis by using Gender Analysis Pathaway (GAP) and the preparation of a gender responsive fund through the Gender Budget Statement (GBS), in line with the Regulation 104/PMK.02.2010 of the Ministry of Finance.


In 2010, there were 2,190 Community Health Centers across 33 provinces which were are able to conduct this program and it is intended that number will increase to 2,400 Community Health Centers in 2011. This program is extremely critical as 46% of Indonesia women marry at an early age, many under 20 years of age.

It is hoped that this program will increase the ability of young mothers/women to handle pregnancy and child birth and improve the prevention of maternal mortality and morbidity.


In order to achieve the MDG target to reduce the national Maternal and Infant Mortality Rates, the Indonesian Government is currently conducting the Jampersal program, a funding system for antenatal, labor assistance, and general childbirth services. This includes post-natal family planning services and assistance in pregnancy, labor, porturition, and with newborn babies. The Jampersal programme provides participants with 4 antenatal service visits, delivery assistance by health personnel, assistance dealing with complications referral, 3 sessions of childbirth related assistance, assistance with newborn babies, post-natal family planning services and private breast feeding counseling.

This program is targeted at all pregnant woman without health insurance and who only have access to very rudimentary health services (Basic village maternal health facilities such as Village Health Posts, Puskesmas, In-patient Puskesmas, BNOES Puskesmas, CNOES Hospitals, Private Maternal Hospitals, private doctors, and private midwives). The Jampersal initiative started gradually and is now estimated to cover 2.850.000 labours, and 4.6 million delivery’s every year-1.7 million among which are funded by Jampersal.

The Ministry of Health worked in collaboration with the Ministry of Law and Human Rights, the National Family Planning Coordinating Board (BKKBN/Badan Koordinasi Keluarga Berencana Nasional), and the Faculty of Community Health, University of Indonesia, to test-run this instrument in Indonesia. In 2008, it was applied in 2 provinces and plans to implement it nationwide are still under discussion.

7. Increasing access to quality family planning services through the improvement of integrated reproduction health services for adolescents and communities in poor and/or rural areas.

Efforts to improve the quality of family planning, and thus better control the population growth rate, are crucial if the goal of universal access to reproductive health is to be reached by 2015. The following strategy is in place for this to be achieved:

a. Creation and Improvement of Family Planning Independence through:

- increasing participation in family planning by providing clinics, methods of contraception and free family planning services for poor communities in 23,000 public/private health clinics

- increasing knowledge and changing the behaviour and attitudes and adolescents towards reproduction health, HIV/AIDS, the use of narcoticy, psychotropics, and other addictive essences (NAPZA), life and family for teenagers. Ensuring adolescent health is covered in school health programmes, establishing Health Information Centers for adolescents at the sub-district level and Adolescent Care Health Center in Puskesmas.

- Increasing the human rights capacity in the context of family planning and supporting the 23,000 clinics which need further support. Increasing participation in independent family planning.

b. Promoting community mobilization and awareness through:

- Increased levels of public information, communication and education about population control and family planning;

- Improvement in public knowledge and behavior with regard to population control, family planning, and reproduction health,
o Renewed commitment from local Government in implementing population growth and family planning programs.

o Strenghtening partnerships with non-Government organizations, the private sector and communities in implementing population growth and family planning programs.

IV. Achievements

National Development

Several efforts undertaken by the Indonesian Government have resulted in certain levels of improvement in the quality of maternal health services. This is reflected by an increase in the percentage of deliveries assisted by skilled health personnel and improvements in the initial neonatal and antenatal visits, as well as in health services for babies and infants.

The scope of labor assistance provided by health personnel increased from 40.7% in 1990 to 66.9% in 2000, 75.4% in 2007 and 82.3% in 2010. The driving factors behind this improvement, include amongst other things, are the “mother class” programs, improved labour planning, the implementation of the complication prevention program (P4K), and an increase in partnerships between midwives and trained childbirth healers, where 60.5% out of 106,983 childbirth healers are currently involved in this collaboration.

Health services for newborn infants (defined as aged 6-48 hours) has increased from 57.6% in 2007 to 71.4% in 2010. Midwives provide health visits and counseling for mothers and newborns.

The role of family and society in monitoring the growth of infants and children under the age of five has also improved significantly. This is reflected by an increase in the weighing of infants and children under the age of five from 45.7% of babies in 2007 to 49.4% in 2010, during which infants and children under the age of five were weighed 4 times or more in the period of 6 months. Improvements can also be seen by the increase of the ownership of Mother and Child Health Book (KIA/Kartu Ibu dan Anak) and Road to Health Card (KMS/Kartu Menuju Sehat).

MDGs Achievement Concerning the Improvement of Maternal Health

The Indonesian Government has been successful in reducing the Maternal Mortality Ratio (MMR) from 390 maternal deaths per 100 thousand live births in 1991 to 228 in 2007- according to the Indonesian Demographic and Health Survey (Survei Demografi dan Kesehatan Indonesia/ SDKI). The Indonesian Government is highly
committed to attaining the MDGs target for MMR in 2015, which is expected to amount to 102 per 100 thousand live births.

Realization and Projection of Maternal Mortality Rate in Indonesia

1991 - 2025

Realizing that the global success rate in reducing maternal mortality rate is still low, the Indonesian Government is actively participating in global efforts to meet the requirements of the MDGs. These efforts include contributing to the work of the Network of Global Leaders for Maternal and Children Health and the UNSG Initiative on Global Strategy for Women’s and Children Health, as well as through membership of the Commission on Information and Accountability for the Women and Children’s Health, formed by the World Health Organization (WHO).

III. Challenges

Despite the various achievements in improving maternal health in the country, the Indonesian Government is continuously striving to meet its national development and MDGs targets. Several challenges still undermine Government efforts to improve rates of maternal mortality, namely:

1. Insufficient public access to maternal health and pregnancy service centers as well as health care/midwives professional (in quantity and in quality) in remote, poor, disadvantaged and border areas, including remote islands. There is also a problem of insufficient medical instruments, medicines and blood supplies, which are needed when managing emergency deliveries. Indonesia is an archipelagic
nation consisting of approximately 17 thousand islands so access to remote areas can be challenging.

Percentage of Deliveries Assisted by Trained Medical Professionals

2009

![Bar Chart]

2. Inadequate knowledge and awareness on the part of local communities concerning the importance of maintaining maternal health and wellbeing.

3. Relatively poor health and nutritional status of pregnant mothers. The percentage of women of childbearing age (15-45 years) who suffer from chronic energy deficiencies is relatively high. According to the 2007 Indonesian Basic Health Research (Risksdas), this figure could reach 13.6 percent.

4. Relatively low rate of contraception use and high rate of unmet needs.

5. Inappropriate measurement of MMR. The current method for measuring MMR is through gathering data on the estimation of specific age directly related to maternal deaths, which are collected from immediate living siblings of the mother and then recorded as serial data in the SDKI Report since 1994. Hence, there is a need to immediately apply a complete "vital statistics" model, which can be done through the registration of deaths or through a population census, which would involve citing the cause of death so as to provide accurate mortality rates and their corresponding causes.
In the endeavor to improve the maternal health conditions for the future, the Indonesian Government continues to make the increase in health services and improvements in obstetric services matters of urgent priority. The improvement of national family planning services and the dissemination of education about maternal health is crucial not just for mother and baby, but for the Indonesian population as a whole.

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