

**Indonesia
Reproductive Health
Profile
2003**

Ministry of Health
Republic of Indonesia

The World Health
Organization

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List of abbreviations and acronyms

ANC	:	Antenatal Care
APBN/D	:	<i>Anggaran Pendapatan dan Belanja Nasional/Daerah</i> (National/ District/Provincial Budget)
ARH	:	Adolescent Reproductive Health
Balitbangkes	:	<i>Badan Penelitian dan Pengembangan Kesehatan</i> (Center of Health Development and Research)
BPS	:	<i>Badan Pusat Statistik</i> (Central Bureau of Statistic)
BEONC	:	Basic Emergency Obstetric and Neonatal Care
CBS	:	Central Bureau of Statistics
CBR	:	Crude Birth Rate
CEM	:	Chronic Energy Malnutrition
CEONC	:	Comprehensive Emergency Obstetric and Neonatal Care
CFR	:	Case Fatality Rate
CHC	:	Community Health Centers
CHR-UI:		Center for Health Research, University of Indonesia
CPR	:	Contraceptive Prevalence Rate
CRHC	:	Comprehensive Reproductive Health Care
CSW	:	Commercial Sex Worker
CU	:	Current User
Depkes	:	<i>Departemen Kesehatan</i> (= Ministry of Health/MOH)
EICo	:	Eligible Couple
ERHC	:	Essential Reproductive Health Care
FP	:	Family Planning
FC	:	Female Circumcision
GDP	:	Gross Domestic Product
GSI	:	<i>Gerakan Sayang Ibu</i> (Mother Friendly Movement)
Hb	:	Hemoglobin
HCPs	:	Health Care Providers
HIV/AIDS	:	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HP	:	Health Provider
HHS	:	Household Health Survey
IAKMI	:	<i>Ikatan Ahli Kesehatan Masyarakat Indonesia</i> (Indonesia Public Health Association)
IBI	:	<i>Ikatan Bidan Indonesia</i> (Indonesia Midwives Association)
ICPD	:	International Conference on Population and Development
IDAI	:	<i>Ikatan Dokter Anak Indonesia</i> (Indonesia Pediatrician Association)
IDD	:	Iodine Deficiency Disorder
IDHS	:	Indonesian Demographic and Health Survey
IDI	:	<i>Ikatan Dokter Indonesia</i> (Indonesia Medical Doctors Association)
IMR	:	Infant Mortality Rate
IPPA	:	Indonesian Planned Parenthood Association
KPA	:	<i>Komite Penanggulangan AIDs</i> (AIDs Management Committee)
LAM	:	Lactational Amenorrhic Method
LBW	:	Low Birth Weight
MCH	:	Maternal and Child Health
Menkes	:	<i>Menteri Kesehatan</i> (Minister of Health)
MMRatio	:	Maternal Mortality Ratio
MNH	:	Maternal and Neonatal Health
MOH	:	Ministry of Health
MR	:	Menstrual Regulation
MUAC	:	Maternal Upper Arm Circumference
NFPCB	:	National Family Planning Coordinating Board
NGOs	:	Non-Governmental Organizations
NRC	:	National Resource Center

PERDOSKI	:	<i>Persatuan Dokter Spesialis Kulit Indonesia</i> (Indonesian Dermatology Association)
PERINASIA	:	Indonesia Perinatology Association
PHC	:	Primary Health Care
PLKB	:	<i>Penyuluh Lapangan Keluarga Berencana</i> (FP Field Education Provider)
PMDF	:	The percentage of deaths from maternal causes among deaths from all causes for women 15-44 years or women 15-49 years
PNMR	:	Post Neonatal Mortality Rate
POGI	:	<i>Perkumpulan Obstetri Ginekologi Indonesia</i> (Indonesian Society for Obstetrics and Gynecology)
PONED :		<i>Pelayanan Obstetri Neonatal Dasar</i> (Essential Neonatal Obstetric Care)
POSYANDU	:	<i>Pos Pelayanan Terpadu</i> (Integrated Health Services Post)
PPKBD	:	<i>Pos Pelayanan KB Desa</i> (Village FP Post)
PPNI	:	Indonesia Nurses Association
P2MPLP	:	<i>Pemberantasan Penyakit Menular dan Penyehatan Lingkungan Pemukiman</i> (Communicable Diseases Control-Environment Health)
Pusdakes	:	<i>Pusat Data Kesehatan</i> (Health Data Center)
Puskesmas	:	Pusat Kesehatan Masyarakat (Community Health Centers)
RH	:	Reproductive Health
RTI	:	Reproductive Tract Infection
SDPs	:	Service delivery points
SEARO	:	South East Asia Regional Office
SKIA	:	<i>Survei Kesehatan Ibu dan Anak</i> (Mother and Children Health Survey)
SM	:	Safe Motherhood
STIs	:	Sexually Transmitted Infections
SUPAS	:	<i>Survei Penduduk Antar Sensus</i> (Inter-censal Population Survey)
SUSENAS	:	<i>Survei Sosial-Ekonomi Nasional</i> (National Socio-Economic Survey)
TBAs	:	Traditional Birth Attendants
TFR	:	Total Fertility Rate
TGR	:	Total Goiter Rate
TT	:	Tetanus Toxoid
TN	:	Tetanus Neonatorum
UAC	:	Upper Arm Circumference
VGR	:	Visible Goiter Rate
WHO	:	World Health Organization

Background

The profile

Reproductive Health is a priority program in all the Southeast Asia Regional countries, including Indonesia. In each of those countries some components of the reproductive health program have been implemented in differing degrees. In order to avoid duplication and to better focus for future support, the WHO has recommended that each country produce updated information on reproductive health. In line with this recommendation this profile was prepared. This profile is one of the steps towards addressing the challenges on reproductive health in Indonesia.

The main objective of generating this document is to present a general profile on Indonesia's reproductive health situation up to 2003. The presentation covers in general the reproductive health status, the state of access to the quality of relevant reproductive health services, the relevant programs that support them, as well as the policy and legal environments that legitimize them. The profile include updates on reproductive health status, existing programs in reproductive health, legal provision, financing schemes, and existing training programs in relation to reproductive health services.

Data sources

Where available, most recent major data sources were used. These originate from government reports and surveys generated by the Central Board of Statistics (CBS), including data from the Indonesia Demographic and Health Surveys 1997 and 2002/3 (or *IDHS* 1997 and 2002/3), the National Social and Economic Surveys (*Susenas* 1997 and 2002), Population Statistics of Indonesia 2000, Indonesia Health Statistics 2001, Indonesia Health Profile 2000, Peoples Welfare Statistics 1998, Child Welfare Statistics 1998, the Household Health Surveys (HHS) 1995, and the 100 Villages Survey (*Survei Seratus Desa*, 2000). Other data in the report arrive from the Situation analysis of women and children (BPS-UNICEF, 1995 and 2000), and the End Decade Statistical Report (GOI-UNICEF, 2000). Where national data are not available, information from specific surveys or studies are used to indicate the potential magnitude of a reproductive health problem.

Overview of reproductive health issues

Although there have been significant progress made in health and family planning programs in Indonesia in the past decade, the level of maternal mortality remain high, while coverage of births assisted by skilled providers is still low. The level of sexually transmitted infections is also relatively high. These issues impinge on related

reproductive health services, utility and accessibility of the clients. Other aggravating problems include the fact that:¹

- The level of active family planning users has not significantly increased, especially since the onslaught of the 1997 economic crisis
- Lack of knowledge and preparedness about reproductive health in the family, community, and health providers
- Inadequate number of reproductive health specialists
- Inadequate level of competency to manage complicated pregnancies and deliveries
- Inadequate quality and access to all levels of obstetric care and other reproductive health services

Although improving, available data indicate that the proportion of births assisted by trained providers are still inadequate. The 1998 Susenas data shows that deliveries in rural areas (53%) and in urban areas (19%) were performed by TBAs. Delivery by TBAs is significantly reduced from 54 per cent in the 1997 DHS to 32 per cent by the 2002/3 IDHS. However, the 1997 and 2002/3 IDHS indicate that the majority of women tend to deliver at home which often results in poor emergency obstetric management, especially for complicated deliveries.

The comparability of delivery data from IDHS 1997 and 2003/3 needs to be treated with caution due to categorical change. The 1997 IDHS indicates that only 21 per cent of birth in five years prior to the survey occurred at a health facility. However, in the 1997 DHS, health professionals who deliver birth at their home, such as the home of midwives and village midwives, are classified as birth delivered at home. In 2002/3 IDHS, these were reclassified into births at a medical facility. The 2002/3 IDHS results suggest that the majority of birth in the five years preceding the survey still occurs at home (60%). The rest were divided between public facility that includes government hospital and health centers (9%), and private facility including village midwives, private hospital/doctor/clinic (31%). Thus, the reported number of birth occurring in a health facility is substantially higher according to the 2002/2 IDHS (40%) relative to the 1997 IDHS (21%).

There is often a lack of preparedness on the part of family (e.g. in providing transportation and adequate funds). But the health system too is often unprepared: many birth attendants are unprepared to cope with delivery complications which in turn increase the risk of maternal death. Late referrals to appropriate health facility, or delays in patient handling at the health facility are also recognized factors that contribute to maternal deaths. A study has shown that from 12 hospitals, 92% of maternal death were emergency cases in which referral and case handling were delayed, and around 40% of the women died on the way.²

It has been estimated that around 15% of all pregnant women would experience obstetric complications that need medical attention.³ But the small number of obstetricians available in rural areas and in areas outside of the Java-Bali has made emergency obstetric complication service a major concern. In most cases these specialists tend to be concentrated in large provincial cities where Class-A and B hospitals are located. Class-C and D hospitals are located in district towns, while at the community level the services are provided through community health centers

(CHCs) and community midwives (*bidan di desa*) which provide mostly only basic midwifery and neonatal care.

The facilities at district hospitals to provide emergency obstetric care and as referral points are limited also by the competence of the providers. By 1995, there were only 30% of hospitals with the capacity to provide surgical interventions for obstetric complications.⁴ Of the total number of obstetricians (704), only 42% worked in district hospitals. The 2003 IDHS data indicate that efforts to improve the quality and access to obstetric care at all levels have not advanced since 1995, because by 2003 only 5% of all births were assisted by doctors, and 50% by midwives.

The midwives have been given greater role at the community level through a MOH 1996 Decree on the Role of Midwives. Now, midwives are able to legally perform life saving procedures. Despite this, there remain many problems facing the midwives: limited skills in basic and selected life saving clinical procedures, limited interpersonal skills while their supervisors have limited managerial and supervisory skills, and limited monitoring capacity for quality and coverage of service delivery. The midwives are also hampered by inadequate transportation and – in their early appointment - trust on the part of community members in regard to their skills, age, and social abilities.

Overview of reproductive health situation, Indonesia

<i>RH Issues</i>	Indicative RH Situation
<i>High risk of maternal death and obstetric complications among women and female adolescents</i>	<ul style="list-style-type: none"> • MMR = 307 per 100,000 live births (2002/3 IDHS) • IMR = 35 per 1000 live births (2002/3 IDHS) • High variation in rates between provinces in the Java-Bali and provinces in other islands
	Complications during delivery (2002/3 IDHS) <ul style="list-style-type: none"> • Prolonged labor = 30.5% • Excessive bleeding = 7.2% • Fever = 4.5% • Convulsions = 1.4 % • Other = 3.1 % • None = 64.3 %
<i>Unwanted and unintended births still high</i>	Births in the five years preceding the survey (2002/3IDHS) <ul style="list-style-type: none"> • Early pregnancy (at childbirth < 18 years) = 4.1% • 'Too old' at childbirth (> 34 years) = 3.8% • 'Too many births' (> 3 births) = 9.4% • 'Too close birth' intervals (< 2 years) = 5.2%
	<ul style="list-style-type: none"> • Incidence of unwanted pregnancies = 7% (2002/3 IDHS)
	<ul style="list-style-type: none"> • Abortion = 5-10% (1994 IPPA Survey) • Around 71% women seeking abortion are married • Around 58% of abortions are adolescents (15-24 years) (1994 IPPA survey)
<i>Child and early marriages still prevalent</i>	<ul style="list-style-type: none"> • Child marriages (<16 years) among ever married women aged 25-34 = 10% (1998 Susenas) • Provinces w/ child marriage higher than 10% = West Java (16%), South Kalimantan (15%), East Java (15%), Jambi (14%), Bengkulu (11%).
<i>Unmet needs</i>	<ul style="list-style-type: none"> • TFR = 2.78 (1997 IDHS); 2.60 (2002/3 IDHS) • Unmet need for FP services = 8.6% (2002/3 IDHS)
	<ul style="list-style-type: none"> • Contraceptive discontinuation rate = 20.7% (2002/3 IDHS) • Reason of discontinuation due to side effects = 14.4% (2002/3 IDHS)
<i>The level of malnutrition is still high among women and female adolescents</i>	<ul style="list-style-type: none"> • CEM women 15-49 years = 15% (1997 HKI) • CEM children (5-14 years) = 37% • CEM female adolescents (15-24 years) = 36% (1995 SKIA) • BMI < 18.5 kg/m² = 15% (1995 IDHS) • UAC < 23.5 cm = 29% (1995 HHS) • Anemia women 15-49 years = 40% (1995 HHS) • Anemia female adolescents = 52% (1995 IDHS)
<i>Many births are still not attended by trained providers</i>	Deliveries by: (2002/3 IDHS) <ul style="list-style-type: none"> • TBAs = 32% • Doctors = 5% • Trained midwives = 50%
<i>The exposure to STI and HIV/AIDS is growing</i>	Prevalence of STI among FP clients: (1999 Population Council) is high: <ul style="list-style-type: none"> • Chlamydia = 9% • Gonorrhea = 1% • Genital herpes = 3% (1995 RSCM STI clinic records)
	<ul style="list-style-type: none"> • Major areas in Papua, Jakarta, Riau, Bali, are at growing risk to HIV/AIDS. • Estimated 2-3% sex workers are HIV+ • Initial high risk sex as early as 13-14 years old (CHRUI 2000)

<i>ARH and life style impacts to young people</i>	<ul style="list-style-type: none"> • Smoking before 14 years old = 9% (1995 Susenas) • Smoking before 19 years old = 53% • Smoking among female adolescents = 1-8% (1999 LDFEUI) • Drinking alcohol among female adolescents = 6% • Drug use among female adolescents = 0.3-3% • Most drug users arrested were adolescent males (16-24 years) • Early marriages and early divorce in context of poverty often drive girls into prostitution • Around 70,000 girls < 18 years involved in prostitution/ sex industry (now found in 23 provinces)
	<ul style="list-style-type: none"> • Premarital sex = 0.4-5% (1999 LDFE-UI survey, 2000 CHR-UI survey)
	<ul style="list-style-type: none"> • Less than 70% female (15-24) have heard of HIV/AIDS • Almost 40% female (15-24) believes there is cure for AIDS (2000 IDHS)
<i>Many women have poor education level</i>	<ul style="list-style-type: none"> • Adolescents (13-19 years) out of school= 51% (1999 CBS) • Estimated 13% urban and 28% rural female adolescents (13-15 years) are out of school (1997 Susenas) • 35% rural and 63%urban female adolescents (16-18 years) are out of school (1997 Susenas)
<i>Poverty and impact of economic crisis</i>	<ul style="list-style-type: none"> • National economy contracted by 15% in 1998 • Food price index rose to 285% compared to March 1997 (pre-crisis) level • Consumer price index rose to 80% • Around 20% of population(40 million) live in poverty, More than 50% are poor/marginally poor families (1998 Susenas) • Female headed households are most affected by poverty during the protracted crisis period. • 93% of families allocate most of the expenditures (58%) for food

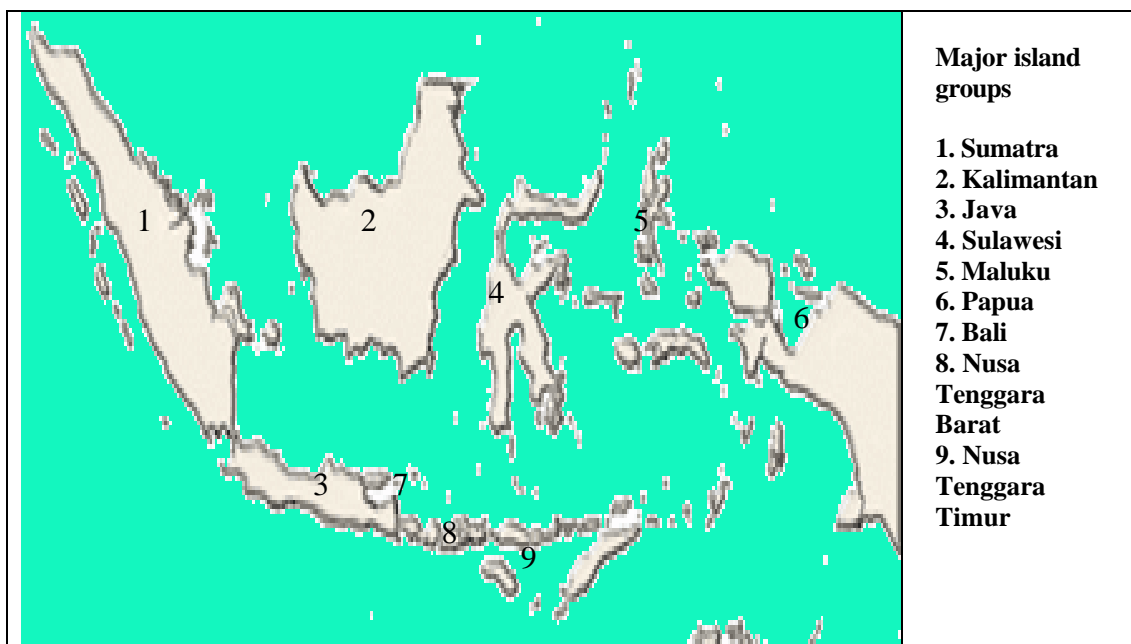
1. Indonesia

The country

Indonesia is a vast archipelagic country in terms of her physical and population size and social diversity, and therein lays the massive reproductive health challenges.

Located in the tropics, Indonesia is a fertile country supported by volcanic and alluvial soils which in turn sustains a very large population among her 6000 inhabited islands. The country consists of more than 17,500 islands, and covering more than 2 million square kilometers of land, spanning a bridge from the continent of Asia to Australia. As the fourth most populous country, with 206.3 million people in the year 2000, Indonesia is home to more than 300 different ethnic groups with twice as much in its language diversity. Although Islam is the dominant religion, there are other major co-existing religions (Christianity, Buddhism, Hinduism, and Confucianism) as well as other minor belief groups.

The country is now divided into 32 provinces due to the current trend of regionalism, each with a legislative council and headed by a Governor though the last IDHS covers only 30 provinces. At the time of IDHS 2002/3 publication, there are 302 regencies and 89 municipalities, that were further divided into 4,198 sub-districts with the total of 70,460 villages. Indonesia is thus a very heterogeneous country, and this is clearly manifested in the diversity of her varied geographical, economic, social, political, cultural, as well as health conditions of her population.



The people

The broader context of people's lives, including their economic circumstances, education, employment, living conditions and social structures within which they live, not only affect but is also affected by reproductive health.

The projection of Indonesia's population by the Central Bureau of Statistics for 1998 was 204 million. By year 2000 the population had reached around 206.3 million people. The rate of population growth has been declining from 2.1% in 1980s down to 1.5% in 1999.⁵ It has been estimated that Indonesia's population will grow by 3 million people per annum until 2005.⁶ In 1998, there were 21 million children aged 0-4 years old, or about 10% total population. Almost 22% of the population was in the ages of 10-19 years; 31% were in the ages 10-24 years; and about 7.5% were 60 years or older. For 2001 it was estimated that children under the age of five years will increase to 22 million, while school aged children will number 40 million. In 2001 it was projected that adolescents will make up 44% of the population. This means that the population is aging, as the number of children under the age 15 continues to decline from 36% in 1990 to about 29% in 2001.

Education

The level of education is a factor that links with other economical and social factors (income, life-style, reproduction pattern, contraception use/birth control, children's health status, and housing conditions). Education is also a factor influencing people's perception in order to make them amenable to accept new ideas. For girls/women, education is a powerful media to affect changes in social and economic status as well as control over own lives, health status, and fertility. Data indicate that in 1999, literacy rate among females (over 9 years old) is lower (86%) compared to males (94%), net primary school enrolment ratio in 1997 is lower for females (92%) compared to males (97%), and males tend to be in school longer (0.7 years longer) than females.⁷ The IDHS 2002/3 data indicate that around 62% among women had primary level education or less. Generally, the levels of education of populations in urban areas tend to be higher compared to those in rural areas. Contrary to popular notion, the level of education of people in Java-Bali was slightly lower than those people in provinces outside of Java-Bali area.

The government has invested substantially to improve the human resources in Indonesia. In 1995, the government affected the policy of compulsory 9 years of basic education. This policy forms the strategy to increase admission rates at higher education levels of junior and senior high school.

Household structure

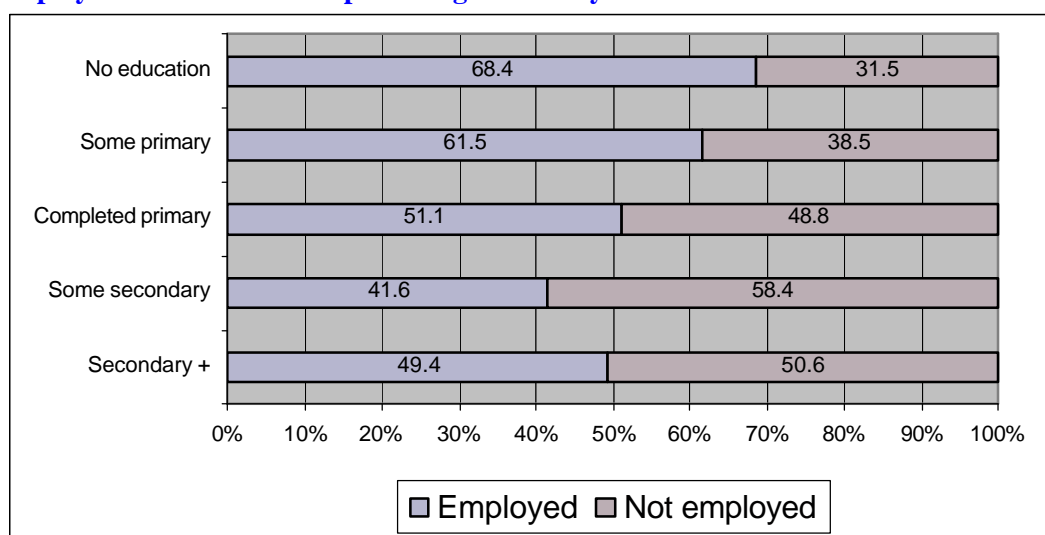
Household structure and composition affect the allocation of household resources, including incomes, between the members of household. In turn, pooling of resources will affect the level of prosperity of each member of the household. The larger the number of household members in a limited space and resources, the less sharing or allocation is affected and the members face a higher risk of morbidity. Similarly, in a

single parent household, especially when the single parent is a woman, where resource availability is limited, resource allocation or sharing is also impeded. The 2002/3 IDHS data show that on average, the total number of members per household was 4.3 persons. This means that the household tend to be nuclear families, with another person (often a non-nuclear family member or house maid). The pattern was almost similar for both urban and rural households. As much as 41% had 5 or more people in their household, and 12% had 7 people or more living together in their homes. Among all households, about 12% were households headed by a woman, and the pattern seems to be larger in the cities than in rural areas (12.3% as compared with 11.4%).

Labor participation

For women, the challenges in social and economic domains are significant, especially in the current state of the economic crisis. The worsening economic situation has put greater demands on women to be not only as the care-taker and nurturer of the family, but also as the main income earner. This means that the multiple roles of women are unavoidable. About half of ever-married women surveyed in IDHS 2002/3 said that they worked in the past 12 months. The number was higher in the cities, where job opportunities are better than in rural areas. While 67 per cent of ever-married women in rural areas work in agriculture, about half of the women in urban areas work in sales and services. The 2002/3 IDHS data further show that there were more low educated women who had to work (70%) than women who had middle school or higher level of education (42-50%).

Labor participation of ever-married women by education: % employed and not employed in the 12 months preceding the survey



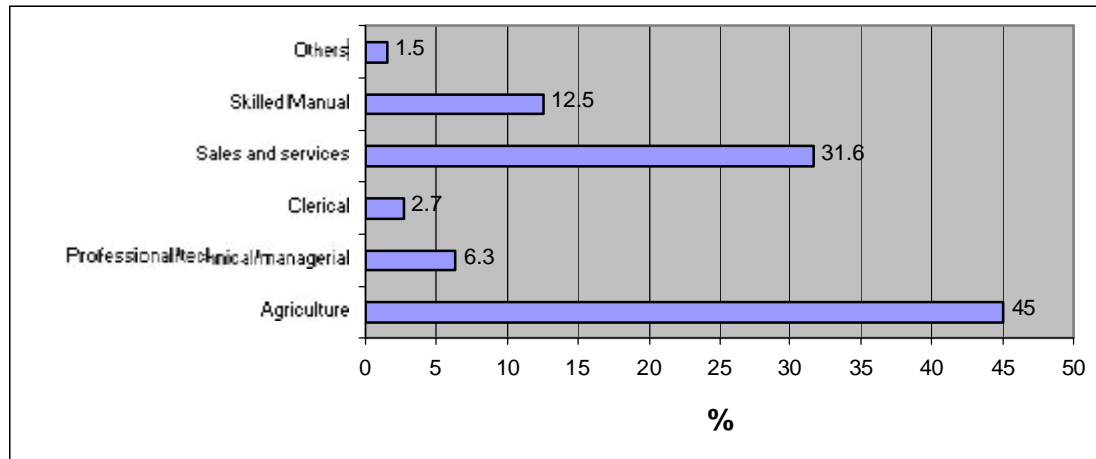
Source: 2002/3 IDHS.

Note that % employed in the last 12 months include those who are currently employed and not currently employed

For many women, especially the low educated population, work is often high risk hard labor which demand physical strength with very low levels of income. About 45 per cent of ever married of women worked in the in the agricultural sector, mostly as farmers where the work brings high risks reproductive health factors. Often, the women have to work in the field and at the same time take care of their small

children. The remainders of the women that live and work in urban areas also face similar problems. With the continued economic crisis, negative economic growth, high inflation, and ever increasing unemployment in urban areas, the level of poverty simply continued to increase. By 2000, there were almost 50 million people living below the official poverty line.

Occupational distribution of ever-married women by sector in Indonesia



Source: IDHS 2002/3

Note: others include unskilled manual and agricultural industries

There is a growing disparity in wealth and access to services along with rapid urbanization. This trend has been aggravated by the protracted economic crisis, which impacts mostly on the urban poor. The implications of such situation for all women are the increasingly difficult physical and emotional burdens they have to bear which ultimately affected their own health status as well as their children's, and the overall effect on the population has clearly been traumatic.

2. The concerns of reproductive health

Global concerns

Reproductive health issue is a growing global concern manifested in the International Conference on Population and Development (ICPD) in Cairo, 1994, which was attended by 180 countries, including Indonesia. The Conference proposed a definition of reproductive health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.'

In line with this perception on reproductive health, one of the outcomes of the ICPD was the call for a New Paradigm in Reproductive Health. This paradigm puts human rights, human development and individual well-being, rather than program-targets, as the center of program policies. The conference also emphasized the need for empowerment of women, involvement of women and young people, especially among the poor and the marginalized groups, in the development and implementation of

programs and services. Moreover, a greater responsibility on the part of men was also called for. The ICPD also proposed that the scope of reproductive health in the context of family life-cycle approach should cover maternal and newborn health, family planning, prevention and treatment of STD/HIV/AIDS, adolescent reproductive health, prevention and management of abortion, prevention and management of infertility, and cancers and problems of the elderly women such as osteoporosis, etc. The ICPD Program for Action implies a framework of 4 goals to better reproductive health status:

Goal 1. Every sex act should be free of coercion and based on informed and responsible choice

Indication of goal	Objective toward goal
<p>Every individual should be in control over their own body through informed and responsible choices in sexual relations. This leads to a state of healthy sexuality which is an important part of reproductive health</p>	<ul style="list-style-type: none"> • The elimination of commercial sex involving children • The reduction of female genital mutilation • The reduction of domestic violence against women • Improve the extent of appropriate RH education for grade level in all schools

Goal 2. That every sex act be free of infections

Indication of goal	Objective toward goal
<p>All sexual relations should be free of infections that affect reproductive health. Unchecked, sexually transmitted infections will facilitate the HIV/AIDS epidemic.</p>	<ul style="list-style-type: none"> • Increase the age of first sex • Reduction of high risk behaviors among sexually active people with more than one sex partners • Improve condom use behavior among sexually active people with more than one sex partners • Improved STI prevention, and proper treatment of STIs at FP and ANC services • Increase proportion of FP, prenatal, and PHC clients who are tested and treated for STI and RTI • Improve proportion of HCPs in gynecological services who can document adherence to infection control guidelines

Goal 3. Every pregnancy and birth is intended

Indication of goal	Objective toward goal
<p>By reducing the number of times a woman is exposed to the risk of pregnancy and childbearing, there will be less number of unintended pregnancies. Ultimately, these will promote better reproductive health status.</p>	<ul style="list-style-type: none"> • Ensure that all couples have access to more than one method of effective contraception • Better information for adolescents about contraceptive options, access to supplies, services, and information about health effects • All sexually active women have access to legal, proper and safe abortion services in the first trimester • Affordable services and access to contraceptives, safe abortion and post abortion services

Goal 4. Every pregnancy and birth is safe

Indication of goal	Objective toward goal
<p>In order to ensure that every pregnancy and birth is safe, awareness and understanding to quality of care and quality assurance must be ensured to complement community efforts to seek health care.</p>	<ul style="list-style-type: none"> • Prevent maternal death through increased proportion of skilled birth attendants and medical staff • Reduce maternal death due to correct case management • Reduce clinical and hospital case fatality rates for pregnant women and newborns • Reduce the prevalence of anemia among women ages 15-49 years

Indonesia's response

Following up the commitment from the ICPD, Indonesia responded by implementing a National Workshop on Reproductive Health in 1996, and reaffirming the ratified ICPD with Law (UU No. 23/1992 on Health) along with CEDAW with Law (UU No. 7/1984). Indonesia has also established her own vision of Healthy Indonesia 2010 and put into motion its new Healthy Paradigm, which among others include issues of reproductive health.

In-line with these ideals and Indonesia's commitments to CEDAW and ICPD, the National Committee on Reproductive Health was formed in 1998 with the mandate of defining better reproductive health issues and scope, developing appropriate Reproductive Health Package, planning for improved involvement of men on reproductive health, and identifying the needs for routine data collection on reproductive health.

The Indonesia Reproductive Health Package is divided into two major programs: (1) the Essential Reproductive Health Package, which includes the following programs: a) Safe-motherhood, b) Family Planning, c) STD/HIV/AIDS, d) Adolescent reproductive health, and (2) the Comprehensive Reproductive Health Package which includes all the programs in the Essential Reproductive Health Package and adding Elderly Reproductive Health Programs.

The National Committee on Reproductive Health was divided into four task forces on: safe-motherhood, family planning, adolescent reproductive health, and elderly reproductive health. The role of the National Committee on Reproductive Health include directing policies and strategies for intervention, monitoring the task force activities, and facilitate collaborations with other sectors or organizations. This body is relatively new, and the challenges it will face are numerous. The National Committee on Reproductive Health, for example, is beginning to address the growing issues of infertility, genital mutilation, violence against women, or the increased awareness and role of men in reproductive health and family planning.

Despite these responses, there remain many problems facing women's reproductive health and services. One of the major problems is the fact that the Government of Indonesia is undergoing a rapid transition of decentralized and autonomous regional governments. With decentralization, the burden of responsibility to address reproductive health issues is borne on the local government. However, local governments have limited capacity to maintain and innovate programs while local resources is also very limited and have to be divided among competing development sectors. This means that many on going national initiatives on reproductive health may be under threat of being implemented as local governments are considering their limited resources to other non-health sectors.

There are now new efforts to readdress contemporary health and women's reproductive rights issues in the light of decentralization and discouraging indications that Indonesia's reproductive health status has not improved in the past years. A major move is to amend the Law (UU No. 23/ 1992 on health). The Government of Indonesia and members of the community has forwarded motions to the legislative council (DPR-RI) to consider: the effects of decentralized health institutions and services, that health is part of a basic human rights and that the government (central and regional) has the responsibility to fulfill those rights, that community participation is among the key in more effective preventive programs than merely focusing on curative services, that women's reproductive health issues need to be especially considered, and that the government is obliged to provide protection for women on unqualified pregnancy termination practices.

3. The current health system

During the New Order Regime of more than 30 years, the health system has improved in terms of facility, services and accessibility, and has expanded to all provinces, including remote areas. Indonesia health system is highly hierarchical and tiered.⁸ However, the recent changes in regional autonomy and decentralization have made the hierarchical structure less defined.

A tiered system

The tiered health system, which also provides reproductive health services, is covered at the lowest community level (the village) by at least one integrated village health post (*Posyandu*), village maternity hut (*Pondok bersalin*), and a village midwife (*bidan di desa*). At the higher sub-district level (*kecamatan*) there is at least one community health center (*Puskesmas*) served by one doctor. The *Posyandu* provide five basic services: MCH, nutrition, family planning, immunization and diarrheal disease control with technical assistance and guidance from health centers. The existing infrastructure includes 7,243 community health centers, and 21,115 sub-health centers, and 243,783 integrated village health posts. The *Posyandu* network run by Family Welfare Movement retains more than 1.2 million volunteers. These units make up Indonesia's primary health care services.

Health Professionals and Community Health Centres by Province per 100 000 People in 2000

Province	Per 100 000 People						
	GP	Specialists	Dentists	Midwives	Nurses	Puskesmas	Puskesmas Pembantu
Nangro Aceh Darussalam	9.1	1.9	3.1	7.1	47.1	5.4	19.0
North Sumatera	14.6	4.4	3.4	9.4	56.7	3.5	15.4
West Sumatera	3.4	2.1	1.2	14.4	31.1	4.8	19.5
Riau	6.1	2.8	2.4	8.5	42.1	3.1	13.7
Jambi	7.0	2.2	3.7	27.6	52.2	5.3	23.5
South Sumatera	6.9	2.4	2.1	3.8	37.1	3.5	12.9
Bengkulu	7.0	2.7	3.0	9.7	102.7	7.8	33.9
Lampung	2.3	1.4	1.1	9.5	23.1	3.0	10.3
DKI Jakarta	22.5	17.0	10.4	23.0	64.6	3.9	
West Java	4.3	1.6	1.7	4.2	21.4	2.6	3.8
Central Java	5.3	2.3	2.1	5.2	26.8	2.8	5.9
DI Yogyakarta	28.2	4.6	6.7	9.5	59.7	4.1	10.0
East Java	4.1	2.1	1.9	9.8	15.3	2.7	6.5
Bali	14.3	4.5	3.3	22.8	58.2	3.6	15.1
West Nusa Tenggara	8.0	0.7	2.2	6.0	37.1	3.0	11.4
East Nusa Tenggara	5.4	0.9	1.3	3.0	46.4	5.3	20.3
West Kalimantan	8.9	1.9	4.7	4.6	38.7	5.3	18.0
Central Kalimantan	13.2	2.3	2.9	8.6	87.5	6.3	36.8
South Kalimantan	9.0	2.9	4.9	7.4	65.4	6.0	19.6
East Kalimantan	4.0	4.5	1.3	6.0	66.9	5.0	23.1
North Sulawesi	9.9	0.4	1.6	4.5	59.4	6.3	25.3
Central Sulawesi	12.2	1.8	4.7	5.4	163.6	4.6	33.1
South Sulawesi	12.7	2.1	3.2	9.0	17.7	7.3	15.0
Southeast Sulawesi	11.8	1.5	3.6	6.2	92.4	12.3	26.4
Maluku	26.4	2.6	4.8	9.8	163.2	9.5	41.8
Papua	17.7	17.7	4.4	1.6	12.5	6.5	37.1
Indonesia	7.6	3.0	2.7	7.9	34.8	3.6	10.5

Source: BPS (2001), Profile of Mother and Children Health 2001, Table 2.15 p.104 quoting data from Staff Bureau Ministry of Health Republic of Indonesia, SIMKA, 2001

There are now 1,020 public and private hospitals. At the district level there is at least one district public hospital (so called Class C or Class D hospitals) served by at least four specialists. There were 284 of such hospitals in 1997. At the provincial level, there is at least one Class B public hospital, and by 1997 there were 54 such hospitals. At the national level (i.e. in the capital cities) there is at least one Class A top referral hospital served by at least 15 specialists. By 1997, there were 4 top referral hospitals serving the country. The health system, then, was already quite extensive in terms of numbers and types of services provided.

Although the tiered system is firmly established, there are still major issues relating to accessibility, especially in relation to obstetric and maternity services. Despite efforts to improve community-based health services (so that they are able to prevent some obstetric complications and manage less severe cases) onward referral system is still weak and requires to be improved in order to address more serious obstetric problems

such as eclampsia, obstructed labor, and severe hemorrhage. But because of the geographical variation and population make up of the country, in many cases, the PHC system that is able to identify women at risk often does not reach the social and geographic periphery (especially in Eastern Indonesia). In these cases the referral channels to life saving facilities are often found to be inadequate.

The *Posyandu* services, which are supposed to reach furthest part of the community, are regarded by the many health center staff more as a burden. Rather than being seen as community initiated and run activities that should be backed-up by health personnel, the staff often regard *Posyandu* activities as yet another burden they must supervise.⁹

A highly subsidized system

The provision of health care services in Indonesia is highly subsidized by the government. It is funded through various sources ranging from taxes to contributions and grants from the private sector. With the economic crisis the subsidies have been reduced precisely at the same time when people's reliance on these services has increased. Although government spending on health has increased somewhat, the proportion of increase was undermined by the inflation triggered by the devaluation of the *rupiah* currency. This, in turn means that MOH budget for its various programs and initiatives have actually been substantially reduced, and thus needing to stretch its limited resources even further.¹⁰ Under the new decentralized system, budgets for health services may be even more limited. With significantly reduced support from MOH, local governments would have to allocate and prioritize services based on their limited incomes. Already, less attention has been given by various district governments for health provisions, especially for the poor, compared to attention on infrastructure and physical developments, while districts in resource poor areas remain dependent on central government support.

Still inadequate quality of services

Low fiscal support directly impinges in the quality of services. Poor quality of services from the health centers has been noted by many surveys and studies. A study of ten health centers in Lombok, West Nusa Tenggara, showed that doctors were not satisfied with the health centers' conditions, and complained about inadequate water supply, equipment and furniture.¹¹ Yet the most salient issues were various deficiencies in the process of providing care to health center visitors, such as not washing hands before or after a delivery; frequent reuse of non-sterilized needles; per-functionary physical examination and inconsistency between diagnosis and prescription, especially by nurses and paramedics; overuse of drugs and injections; limited attention of staff in instructing patients about appropriate use of medication, possible side effects and so forth.

Another study in several health centers in Central Java showed that the effectiveness of health center staff was disrupted and undermined by several operational factors:¹² 'Flexible' personal interpretation of working hours; inappropriate deployment of personnel resources; haphazard and personally determined ways of conducting

activities; conflicts between staff factions; inadequate biomedical knowledge among nurses; over emphasis on injections and less emphasis on examinations and communications; unwillingness to become involved in various community-based health delivery activities and failure to view villagers as partners in a health development process; arbitrary increases of fees; heavy requirements for duplicative and inconsistent reporting and recording activities; emphasis of quantitative target on service provision; supervision which was more ceremonial than functional.

In a different light, a study conducted in samples of health centers and *Posyandu* in West Java, South Sulawesi, and East Java provinces also discovered deficiencies in service provision and supervision of services.¹³ However clients generally expressed satisfaction, though they really had no way of knowing if the service was adequate or not. They merely trusted the health center personnel.

Limited access and human resources

International experiences indicate that obstetric problems can only be effectively managed by continuous, community-based medical interventions. The health services must be able to use potent drugs (such as oxytocin and antibiotics), provide blood transfusions, perform obstetric surgery, and handle life-threatening complications.¹⁴

Because of life-threatening obstetric complications are often unpredictable, qualified maternal health services must be widely and rapidly accessible. The important principles to be applied here are: to bring life saving obstetric functions as close to people's homes, and to carry out these functions at the most peripheral level at which they can be undertaken safely and effectively. In fact, many hospitals in Indonesia with life-saving obstetric functions are often located at the district capital or cities, and are usually far from homes of the majority of women. Thus, a woman with obstructed labor who cannot get appropriate medical care, i.e., cesarean section, will probably die whether she is malnourished or not.¹⁵

Hospitals where emergency cases are referred often have chronic shortages of trained staff and essential supplies. District hospitals will be unable to function effectively as referral sites for complicated pregnancies until their facilities and levels of professional competence are upgraded. The distribution of obstetrician-gynecologists is concentrated at Class A and B hospitals at the central and provincial levels as opposed to Class C and D hospitals at the district level.¹⁶ One study in five districts of West Java showed that not all the district hospitals have one obstetrician-gynecologist at 24 hours around the clock as planned.¹⁷ As of 1995, it was estimated that only 30% of hospitals had the capacity to provide surgical interventions for obstetric emergencies.¹⁸

Training of providers

In Indonesia, training in reproductive health services is divided into two types: Pre-service Training and In-service Training. The Pre-service training is provided for all health providers, including midwives, doctors and nurses, prior to their professional work service. The pre-service training for doctors is typically conducted by the

faculties of medicine in universities, while the training for midwives and nurses is conducted by institutions under the Ministry of Health as well as private schools or academy. In-service training is developed for particular needs of training and it is mostly targeted for those with previous working experience. In-service training can be conducted either independently by MOH or collaboratively with other parties.

Various in-service training in reproductive health has been conducted, either by the government sectors (MOH, NFPCB, Ministry of National Education, and Ministry of Religious Affairs) independently, or in collaboration, or with participation of donor organizations. Areas of training include: Maternal and Neonatal Health, Family Planning, and STI for midwives, nurses and doctors.¹⁹ However, there are several areas in reproductive health services that can still be added or improved, due to the application of new practices, as a response to current issues, and as efforts toward better quality of care.

The current model for formal training program for a nurse/midwife is basically directed towards a three year Diploma level (the D-3 program). This diploma program takes 3 years of midwifery training after senior high school. Another is an add-on program for those *bidan* who already has working experience but want to upgrade their education level. The length of this add-on *bidan* program is between 2 to 2.5 years in midwifery. This program has produced its first graduates in 1999.

The curriculum for midwifery is quite comprehensive and basically includes 5 semester-credits on obstetrics and gynecology,²⁰ 6 credits on obstetric care,²¹ 2 credits on Family Planning Care; 2 credits on Obstetric Care with RTIs,²² 3 credits on Child's health; 3 credits on Child care, 2 credits on Maternal and Child Nutrition and 2 credits on Population and Family Planning.

Despite these extensive topics, it is obvious that there are not yet specific topics on adolescent reproductive health, elderly reproductive health, STIs and HIV/AIDS, and communication/ counseling knowledge and skills. The curriculums for graduate level medical doctors have currently been adapted to cover more topics that include reproductive health, and especially safe-motherhood.

Training of community midwives

The government is trying to accelerate the reduction of maternal death through increased numbers, distribution, and role of midwives at the village level. Now, most of midwives (currently 54,000 for an allocation of about 65,000 villages), has been trained to provide services on normal deliveries, but to managing some complicated cases. These midwives were trained under 'Type-A' program which is given for a period of a year. This program has been operational for about 6 years (1990-1996). However, the outcome this type of training, in terms of the quality of the trainees, has been questioned. This is so because:

- The opportunities for the trainees to experience enough deliveries are limited.
- Many trained midwives are still young, mostly in ages of about 18-19 years. This factor adds to the pressures faced by the midwives who were posted straight to their assigned village once they finished school.
- Hasty posting often cause mistrust and lack of support from the community.

- Many midwives tend not to stay in their post due to lack of economic opportunities or incentives.

Given the situation, several types of in-service training activities for community midwives were subsequently implemented. Such in-service training includes: training on Essential Obstetric and Neonatal Clinical Care; Life Saving Skills; Clinical Post-partum Care; Post-partum Hemorrhage; and Inter-personal Communications and Counseling Skills (IPC/C). The investments for many of these training activities have been donor driven. As such, the government needs to consider the sustainability of the village midwife concept as well as ensuring the monitoring and evaluation aspects to ensure quality of care.

In terms of qualifications, the village midwife is a paramedic school graduate with one additional year midwifery training. To adequately perform their jobs, the village midwives are equipped with various manuals of MCH-Family Planning programs,²³ a midwifery kit, and an IUD kit. In addition to financial support for accommodation, transport, and field activities, the village midwives should also receive technical supervision from the Ministry of Health, and administrative supervision from the local government.²⁴ Ideally, village midwives should have the following midwifery skills: treating anemia cases, managing pre-eclampsia and eclampsia cases, suturing birth canal laceration, managing hemorrhage cases by performing bimanual placental extraction, stabilizing cases before referral, resuscitating shock cases, managing infection cases, performing intravenous infusion, performing vacuum extraction, preventing hypothermia of newborns, basic care of newborn babies, and resuscitating the low APGAR babies.²⁵ The real impact of the village midwife program, however, is not yet known. In fact, there is an indication that maternal mortality level during the last five-years has been stagnant.²⁶

Training Materials

The government has adopted and prepared many training modules toward improved reproductive health services. A few examples topics are:

- *Basic Clinical Obstetrics and Neonatal Skills Modules*
- *Standard Midwifery Practice for Safe-motherhood.*
- *Healthy Mother and Healthy Newborn Care Manual*
- *Life Saving Skills Module*
- *Postpartum Hemorrhage Material for Trainers of Bidans*
- *Refresher Training for IUD and Implant Insertion,*
- *Guidelines on Infection Prevention for IUD and Implant Insertion*
- *Guidelines on STD Management using Syndromic Approach in the Facilities with Simple and Specific Laboratory Availability.*
- *Comprehensive Periodic STD Services among Women of High Risk Behavior*
- *Post-abortion Clinical Care Training*
- *Standard Operating Procedure of STD Management using Syndromic Approach and Laboratory*
- *Interactive Guidelines on the Management of STD using Syndromic Approach (8 volumes)*
- *Training on Training Skills*
- *Training in Inter-personal Communication and Counseling (IPC/C)*
- *Basic Clinical Obstetrics and Neonatal Skills Modules*

4. Major issues impinging RH programs

In Indonesia, around 400 women die in childbirth for every 100,000 live births. On average, a woman dies every hour from complications during delivery, late referral to hospital services or poor emergency obstetric care.

The causes of this problem are complex. They include poorly trained health staff and midwives, a lack of local transport and late referral, and a lack of emergency obstetric care. Trained personnel attend only 66 per cent of deliveries (IDHS 2002/3). The nutritional status of women and children remains a most pressing concern, and one further aggravated by the economic crisis that began in 1997. The basic causes of these problems are chronic and continue to hamper action to improve maternal health.

The basic strategy of the Indonesian program seems to fit with the findings of international policy argumentation – work on a variety of fronts at once, improving the status of women (through education), improving the biological condition of mothers (through nutrition and ante-natal care), improving the quality of delivery assistance (through training TBAs and community midwives) and improving the availability of emergency obstetric care (through the establishment of local hospitals with specialist doctors).

This review also suggests the need to give a priority on improvements in the speed and quality of case referral. The question, however, remains on how to translate the strategy and the priority into operations at ground levels, at service delivery and community levels. At the policy levels, there should be a comprehensive, pragmatic, yet proactive perspective on the medical service needs of pregnant women in poor economic and social environments. All related programs should be strategically planned and managed on the basis of relevant and accurate data. Resources should be mobilized to improve the speed and quality of case referral and emergency obstetric services.

Based on the profiles in this report, Indonesia clearly continues to face several immediate reproductive health issues:

- Maternal deaths and complications continue to be high
- Services and care during pregnancy and delivery continue to be inadequate
- Referrals and emergency obstetric care are still delayed by various factors
- Reproductive health status and access to family planning services remain inadequate and inaccessible for many women
- Women and men are increasingly at risk to STIs and HIV/AIDS

The analysis indicates that in order to address these issues at the more immediate levels, the focus of resources and investments for improved reproductive health need to include:

- Intensifying and expanding coverage to address maternal deaths and complications, especially in rural and in poor areas
- Improve and expand the availability of services and quality of care for pregnant and delivering women

- Improve the existing referral system to reduce delays from the community to the appropriate health services
- Improve emergency obstetric care at all levels through training and skills development
- Monitor and sustain the level of reproductive health status and access to family planning services and ensure that the various services are adequate and accessible for all women and adolescents
- Intensify efforts to monitor and address the risk of women and adolescent to the risk to STIs and HIV/AIDS

5. Policy and fiscal environment

Based on the analysis and responses from various national and government reports,²⁷ the data indicate that the priority issues that need to be continually dealt with, especially those focusing attention for women and girls, at the most basic level include:

- Clear legal support and protection
- Improved access to education
- Sexual reproductive rights for all women and adolescents
- Improved role and status of women
- Poverty alleviation

Legal support and protection of women

In support to the national family planning movement, the Government has set the legal age of marriage at 21 years, based on the Law (UU No.1/1974) on Marriage. Unfortunately, the law is still gender biased and oblivious to those who will be marrying at younger age with parental consent. It is stipulated that a man must be 19 years old, and the woman must at least be 16 years to marry and they both must have consent from their parents. If a girl is to be married before she reaches 16 years old, the family has to obtain the consent from civil court officer. Furthermore, based on the another Law (UU No.10/1992) on Population Development and the Development of Prosperous Family, the government has stipulated that family planning services is restricted to those married adolescent women. This means only legally married couples may have legal access to family planning services and contraception.

Although the Law (UU No.1/1974) on Marriages mandates that marriages should be agreed by both partners, and that the legal minimum age of marriage should be 16 for women and 19 for men, it also states that those persons under the age of 21 can be married with consent of the parents. This loophole allows for the community to marry children under the age of 16. In areas where people are faced with difficult social and economic situations, the consequences include high divorce rates, increasing violence against women spouses, child prostitution, and increasing child labor and exploitation.

Legal support and protection of mid-wives

To reduce maternal deaths, it is important that midwives are trained to be able to manage obstetric complications or at least provide first aid for emergency cases before they are referred. To bring the obstetric services closer to the community, the government has trained more than 54,000 midwives (*bidan di desa*), in the period 1990-1996, to be placed in all the villages throughout Indonesia. Previously, the closest service delivery point for midwives was the CHC, or *Puskesmas*, located at sub-district level, which was usually headed by a doctor as the midwife's supervisor. The legal operations of the midwives need to be supported by government regulations in order that they have flexibility in providing health services. Accordingly, the government initiated a regulation, Minister's of Health Decree (SK MenKes No.572/1996) on Midwife Registration and Practices. Under the regulation the midwife's authority include: a) providing basic midwifery services (for mothers and children); b) providing family planning services; and c) providing public health education. Included in the midwifery services for mothers are education, antenatal care, deliveries of normal and complicated cases and post-partum care. Midwives may also provide certain medical services, including local anesthetic injection, perform episiotomy, extraction of multiple births, and vacuum extraction.

Need for improved access to education

The GOI has begun to address the issue of access to education since 1995 with a national policy for 9 years compulsory primary education. However, despite the decreases in gender gaps in primary school participation, the opportunities for young girls to enter secondary education seems to be limited when compared to boys.

Despite the increase of school-age children's participation at primary schools in the past 15 years, neither junior nor high school participation has shown an increasing trend. The 1997 Susenas data show a declining trend in school participation among older age-groups, from 95% at elementary school (7-12 years age-group) to 77% at junior high school (13-15 years), and even lower (49%) at senior high-school level (16-18 years).²⁸

Among those who register for secondary school, the sex ratio is about 81 females to 100 males, and falls drastically to 48 to 100 at the university level. If girls are given equal opportunity, their capability is not significantly lower than that of boys, since, out of children who were able to attend primary schools, 32.5% of girls graduated, compared with 33.5% of boys. At the level of lower secondary school, about 13% of female adolescents graduated compared to 15.1% of males, and among those who went to high school, 11.4% of females graduated compared to 15.7% of males. As for higher education, 2.1% of women have graduated compared with 3.2% of men. Overall, the percentage of the female population aged 10 and over who may not be able to read and write, having never attended school, is 14.9%, compared with only 6.8% of men.²⁹

Post-economic crisis findings from a survey of 600 primary and junior high schools in five provinces in December 1998 show that overall enrollments at the primary level fell by 1.6% in 1998 but they do not appear to be deviating from their past trend.³⁰

Grade 1 enrollment for boys in the poorer areas in Jakarta fell by 8.3%, which could indicate that parents are either delaying enrollment for boys or that boys will never go to school.

Enrollments for girls entering grade 1 of junior secondary school in Jakarta saw even larger declines (1.9%), as did poorer rural areas. Overall enrollments at the junior secondary level fell by 1.6% in 1998/1999, but a much larger decline (which had puzzlingly started the year before) of 6.3% is noticed in urban areas. Regional variations are evident: Jakarta, urban Central Java, and urban Maluku experienced large enrollment declines (8.6%, 5.6%, and 5.8%, respectively); while rural South Sulawesi showed an 8.1% increase (a fact which may be associated with the cash crop nature of its economy). Jakarta also saw a higher increase in student absenteeism than rural areas.

Addressing inadequate reproductive rights for all women and adolescents

The Law (UU No. 10/1992) on Population Development and Family Welfare recognized only married women as having rights to family planning services. As a result, the reproductive rights of sexually active adolescents and unmarried women of reproductive ages who are at risk of pregnancy and unsafe abortions are not being met by existing services. This situation may be contributing to continued high levels of maternal mortality rates.

In relation to abortion, there is the Law (UU No.23/1992) on Health which prohibits abortion. Induced abortion is considered a crime, except for medical reasons, including the reason for the survival of the mothers. This law is also supported by the Criminal Code Act (KUHP) under Article 229. The law stipulate that in an emergency situation where mother's and baby's life are in danger, only certain medical procedures can be conducted, but which is determined only by government's consent. It is further stated that the procedure is to be carried out when the medical reason is clear, and that it is to be conducted by competent health provider with proper authority. The procedure must be done professional responsibility, and based on guidance and assistance by a team of experts and only in a accredited facility. Moreover abortions must be done with the consent of the pregnant woman and/or the husband and/or the family. Based on the Criminal Code Act, there are various sanctions already predetermined for mothers who terminate pregnancy, for those who encouraged the abortion, and for those who carry out the induced abortion. The sanctions are particularly stronger for those who carry out the process of abortion, such as the doctor, midwife, or nurse.

In regards to the issue on violence against women, it is only covered in the Criminal Code, (KUHP 14), on Crimes against Decency (morality). This code operates besides the various laws above. The Code predetermined various sanctions against pornography, sex with minors, incest and trafficking. However, there is yet to be developed a legal provision for statutory rapes.

There are also supporting regulations on education of STI and HIV/AIDS issues. In the efforts to better socialize STI and HIV/AIDS issues through education, the government issued several regulations related to education and training on

reproductive health, including STIs and HIV/AIDS, in schools. The Ministry of National Education has issued a Decree (SK MenDikNas No.303/U/1997) on the guidelines on school based HIV/AIDS prevention. The ministry also issued an instruction of the Minister of National Education, (No.9/U/1997), on HIV/AIDS, on extra-curricular activities on reproductive health and STI and HIV/AIDS, which were to be affected for all levels of school.

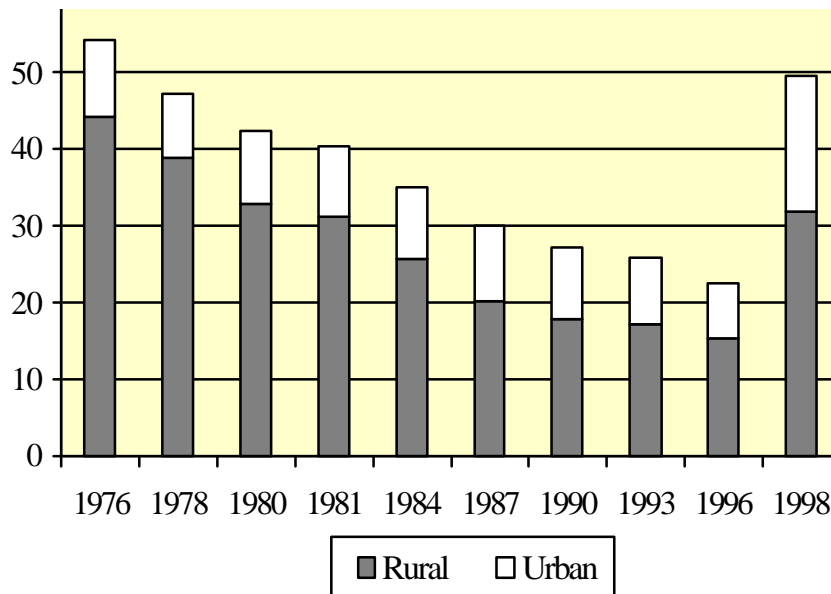
It is clear that to date, there have been established many laws and government regulations related to reproductive health in Indonesia. These laws have been issued as part of the efforts to protect the people, in particular, women and children, and to ensure their safety and development. Despite these laws and regulations, there remain many constraints in their enforcement as well as implementations. These laws also operate alongside social conventions, religious values and norms, as well as traditional rules that relate to sexual relationships and reproductive health. Sometimes, they contradict each other and are ambiguous. These problems are not so much related to lack of effective legal material or structure, rather they are more related to the social structure or culture context related to the laws.

The GOI has recognized the need to have clearer definition of the status of women. However, translating and operating these as effective policies and gender sensitive programs will face a strong barrier of paternalism in a paternalistic culture as well as traditional attitudes about the role of women in society. Yet, the recognition that reproductive health issues are gender issues is still limited. There should be more effort to increase male participation in family planning, pregnancy care, and health delivery services, and protection of women (in labor domestic, workplace contexts).

Poverty alleviation

With the protracted economic crisis that began in late 1997, the level of poverty in Indonesia has increased from 11% in 1996 to almost 50% in 1998. The nation was regarded as being 'in a state of deep crisis. A country that achieved decades of rapid growth, stability and poverty reduction is now near economic collapse. No country in recent history, let alone one the size of Indonesia, have ever suffered such dramatic reversal of fortune.'³¹ In 1998, 9% of all poor households were headed by women. Most of these women have 2-3 children in their care. They earn only around \$50 USD a month. Poverty effect women's reproductive health status due to low nutrition and higher exposure to diseases puts these women in a state of dependency, shame, and suffering.

Official estimates of the percent of population living below the poverty line (by residence)



Source: BPS, 1999f, p.4

Fiscal support for reproductive health programs

The sources of funding for reproductive health programs are varied. In general, there are two sources of funding for health program in Indonesia: government funding (which include loans and grants), and community funding (including from the private sectors). The sources of government funding arrive from the national development (*APBN*) and regional development (*APBD*) budgets.

At the national level, the main source is from central government's budget (the *APBN*, or the State Income and Expenditure Budget) while at the regional level, the sources arrive from the local budget allocations at the provincial level (the *APBD-I*, or the Provincial Income and Expenditure Budget) and from the district level (the *APBD-II*). Both the *APBN* and *APBD* are divided into two budget plans, one is budget for development and the other one is for routine expenditures.

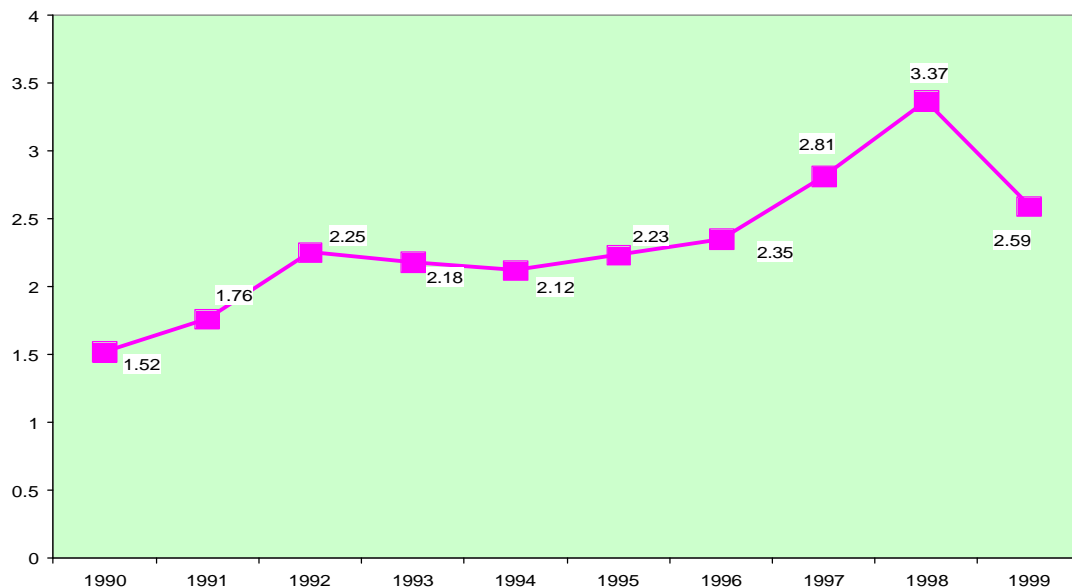
The state's *APBN* budget for development includes: Sectoral Project List (*DIP*), International Grants/ Loans, Presidential Instructions (*Inpres*), and the Hospital Operations and Costs. The *APBN* routine expenditure plan usually includes the List of Activities and Subsidy for Hospital Operational Costs.

Various reports have indicated that under funding is a key issue that compound health related problems facing Indonesian women. The MOH and NFPCB have implemented various related Safe Motherhood projects that involve resources from several sectoral units (including funds, manpower, and supplies and drugs). Yet, allocations for the health sector are still inadequate when faced with the magnitude of the reproductive health problems.

Health budget allocation

The budget allocation for health through *APBN* has increased every year but not in a consistent way. Despite the increases in the health budget, the overall proportion of development allocation for health is still small. For example, in 1999/2000 the allocated budget for health, accounted for only 4.2% of the overall state expenditures. Up to the 1997/1998 fiscal year, the funding from international loans or grants has decreased in real terms, but with the onslaught of the economic crisis required spending increased sharply to more than 200% in 1998. Although there have been budget increases, including increased funding for Safe Motherhood programs, they are still regarded as far below the inflation rate due to protracted economic crisis which devaluated the *rupiah* currency. This results in health sector budget actually declining in real terms.³²

Central government health expenditure (%) of the national budget for routine and development, fiscal years 1990/1991-1999/2000



Source: GOI-UNICEF, 2000

From the available sources, health budgets are usually allocated mainly for prevention and curative efforts (70% and 30% respectively). Although this expenditure pattern is similar over the years, comparisons with the budget patterns of 2 to 3 years ago indicate that the preventive budget has been increased. However, the MOH's budget allocation for specific Reproductive Health programs is difficult to measure because such program is considered inter-sectoral cross-program, with funding arriving from various other programs.

Health services in Indonesia, notably emergency obstetric services, concentrate substantial capital in urban medical centers, relying on patients to somehow make their way to the specialized facilities. This model tends to consume a large portion of

a poor nation's health budget, yet serve only a minute portion of its people, because complementary non-health infrastructure is so weak.³³

Because of chronically low health spending levels, Indonesia as regards government outlays continues to lag behind countries of similar per capita income. For example, per capita government health expenditure in China and India exceeded that in Indonesia, while outlays in Thailand and Malaysia are large multiples of the Indonesian figures.³⁴

Donor funding

Due to government fiscal limitations, many programs and projects are donor driven. The sources of funding are from international donor agencies in the form of loans (e.g. from the World Bank, the ADB), or grants (bilateral, multi-lateral, or MoU-based, with or without the common requirement for 'counter-part funding'). Some of these donor sources arrive from various UN agencies (WHO, UNICEF, UNDP, UNFPA, UNAIDS, ILO), American USAID, Canadian CIDA, Australian AusAID, Japanese JICA, German GTZ/KfW, French MSF, and others. In general, these donor programs work in different islands throughout Indonesia, with limited resources but addressing various reproductive health related issues, including safe motherhood and family planning, adolescent reproductive health, STI and HIV/AIDS, social mobilization and IEC, etc. Donor driven programs are often allocated comparatively substantial resources. However, such levels of allocation would not be able to be carried over by the local governments and thus not locally sustainable, especially in the light of decentralized services, and often puts at risk the donor program of being arrested once donor support is withdrawn.

Community insurance

The communities also generate some sources for funding. The sources of funding can be in the form of health insurance participation or the use of private health services. The proportion of community who have joined health insurance programs (government run or private insurance) is still very small, and more so for rural areas. The 1997 Susenas data shows that, among urban communities, only about 25% of the population join some sort of insurance scheme. Of these about 13% join the civil-servant health insurance plan (the *Askes*), about 4.6% join the workers insurance scheme (the *Astek*), and about 5% join the workers private insurance. Of the other portions of the population, less than 1% joined the Health Funds (*Dana Sehat*), about 0.8% join Healthy Card Program (*Kartu Sehat*) and 0.7% join other types of insurance plan. In the rural areas less than 10% join insurance plan.

Community maternal savings

In relations to the effort to hasten the decline of IMR and MMR, as well as to further motivate community participation, the government has since June 1996 initiated a program called Mother Friendly Movement (the *Gerakan Sayang Ibu*). This initiative is coordinated by the State Ministry for Women's Affairs (subsequently the State Ministry of Women Empowerment, since November 1999). There are two main components of activities in the program: the Mother Friendly Hospital, and Mother Friendly Sub-district. In the Mother Friendly Sub-district component, the community

has been encouraged to self-finance the cost of medical services, delivery, and transportation (*Tabungan Ibu Bersalin*, or *Tabulin*).

In this way, community is encouraged to pool their resources which will allow suffering and poor members to be cross subsidized and ensure their survival. Under this scheme, for example, a pregnant mother with obstetric complications who needed to be referred, can be immediately transported to the nearest hospital, and her medical costs can immediately be covered by the community funds, thus eliminating two crucial delays (due transport and cost of medical service). The Mother Friendly hospital scheme has been developed to encourage the provision of complicated obstetric care regardless of the service cost.

Strategic programs

Among the strategic policies by the Government were the placement of village midwives, along with the strengthening of referrals for emergency obstetric care, at district hospitals and health centers with beds, to increase ANC and deliveries by trained health providers. At the community level, the mother friendly movement was initiated in order to prepare communities to handle referrals for emergency obstetric care.

Prompted in part by the Safe Motherhood Initiative Conference in Nairobi in 1987 and the flaws of TBA training program, the Indonesian government initiated the community midwife program in 1989.³⁵ Under that program, community midwives were to be posted in villages, especially those areas not easily accessible by health services. Basically, the community midwife program is designed to gradually improve the accessibility and the quality of maternal health services. It was planned that 18,900 village midwives would be posted during 1989 to 1994, and another 34,000 village midwives would be posted during 1995 to 1996.³⁶ It was targeted that by 1995/96 there would be one village midwife per one village.³⁷ This program has achieved its target of placement and in many ways has contributed to the increases in MNH service coverage and FP participation at the community level.³⁸

Mother Friendly Movement

Recognizing the lack of preparedness of families (especially husbands) and birth attendants to cope with birth delivery complications, a collective initiative called the Mother Friendly Movement has officially been launched in 1996.³⁹ The initiative has focused on community movements including community mobilization to provide transportation for delivering pregnant women in need of referral and community savings scheme, supported by village heads, to finance the cost of specialized care. Recently, however, the continuity of such movements is questioned.

Health technologies to reduce levels of maternal mortality

The increased interest in Primary Health Care (PHC) since the Alma Ata Conference in 1978 offers a major improvement in the health system of developing countries, including Indonesia. Unfortunately PHC would have little impact on maternal mortality since the preventive measures adopted, including screening during antenatal

care, would not significantly avert hemorrhage and obstructed labor, the main causes of maternal deaths.⁴⁰ Health technologies for preventing maternal deaths have existed for decades: antibiotics for infections, cesarean section for obstructed labor, blood transfusion and oxytocin for hemorrhage, and magnesium sulfate for eclampsia, but they for various reasons are not accessible to most women in poor countries.⁴¹ The problem is not that the technology is not known; rather the health services suffer from lack of coverage and quality.

6. Adolescence Reproductive Health

Lifestyle, peer pressure, and curiosity are reasons, especially for young people, to engage in sex, smoking, alcohol drinking, and drugs, all which can affect dire reproductive outcomes.

Sexual Behavior

With more people postponing marriage, they are thus more likely to engage in premarital sex. This puts girls at more risk to unintended pregnancies, abortion, or birth among unmarried adolescents (children having children). Unsafe abortion is regarded as one of the major contributor or maternal death for women ages 15-19 years.

A survey conducted by the MOH, 1996, in West Java and Bali found that 1.3% of urban female respondents and 1.4% rural female adolescents in West Java, and 4.4% female respondents in urban Bali reported to ever had premarital sex. Another survey conducted by LIPI (1998) in Surabaya found that 2.3% of females and 7% of males senior high school students reported ever had premarital sex.

Qualitative studies conducted by the Laboratorium Anthropology FISIP-UI (1997), in urban Banjarmasin and rural Mandi air, South Kalimantan indicated that the mean interval between age at first sex and age of first marriage for males is around 8-10 years, and for females is 4-6 years. The expected age at first marriage for males was around 24-26 years while for females was around 20-22 years. In another qualitative study done in urban Medan and rural Pakis, North Sumatra it was found that the majority of young people has reportedly practiced intimate sexual behavior (petting, penetrative sex).

The survey implemented by the LDFE-UI and NFPCB (1998) in 20 districts of East Java, Central Java, West Java, and Lampung found that the expected age at first marriage for males was around 25 years, and for females was expected around 20-22 years. Among the respondents 0.4% unmarried girls reported already had sex, and 5% among the married women also reported ever had premarital sex. Similar patterns were found for both urban and rural adolescents. It was assumed that sex behavior among female adolescents may be under-reported since it is tied to perceptions of virginity for girls.

The CHR-UI and the MOH has conducted regular behavioral surveillance surveys (1996-2000) in 4 major provincial cities of Jakarta, Surabaya, and Manado/ Bitung.

Among the most salient findings were that: a) age at first sex can begin as low as 14 years, or during junior high school, b) average age of first sexual experience was 19 years, c) among the males, many had their first sex with a prostitute, d) many of the prostitute themselves had their first commercial sex before the age of 18, e) about half of them were commercially active in their 20s (CHR-UI, 2000). The regular BSS surveys also indicate that among the young female sex workers who ever experienced STIs, there was a range of 2-14% who reported ever experienced syphilis, and among them up to 30% reported ever experienced gonorrhea.

The most recent CHR-UI study (2003) supported by UNICEF was a survey among teenagers (in junior high school or SMP) in Papua. It found that many SMP students are already sexually active. Almost around half of all students reported ever had boy/girlfriend. Dating behavior commonly entails conversations, holding hands, and hugs. A third among them reported kissing (cheeks, lips). Some (17%) reported ever caressing genital areas, and a few (8%) went as far as petting without penetration. In terms of early sexual contact, more than a third (38%) of all SMP students reported having friend who ever had sex. Around 11% reported masturbating, and around 12% reported actually ever had sex themselves. First sexual contact among students can be as early as 8 years old. Among those who reported ever had sex, more than half reported first sex at the ages 13-15 years. First sex is often with their special friend and takes place outside their homes. The reported ages of their first sex partner are similar to the respondents (13-15 years old).

Data from existing studies clearly indicate that adolescents are at risk to reproductive health issues as their age of first marriage increases along with social changes and exposure to the mass media, as well as to the effects of modernization in general. Adolescents are also exposed to other risk-related behaviors. This includes substance use (smoking, alcohols, and drugs) and exposure to STI and HIV/AIDS.

Pregnancy during adolescence

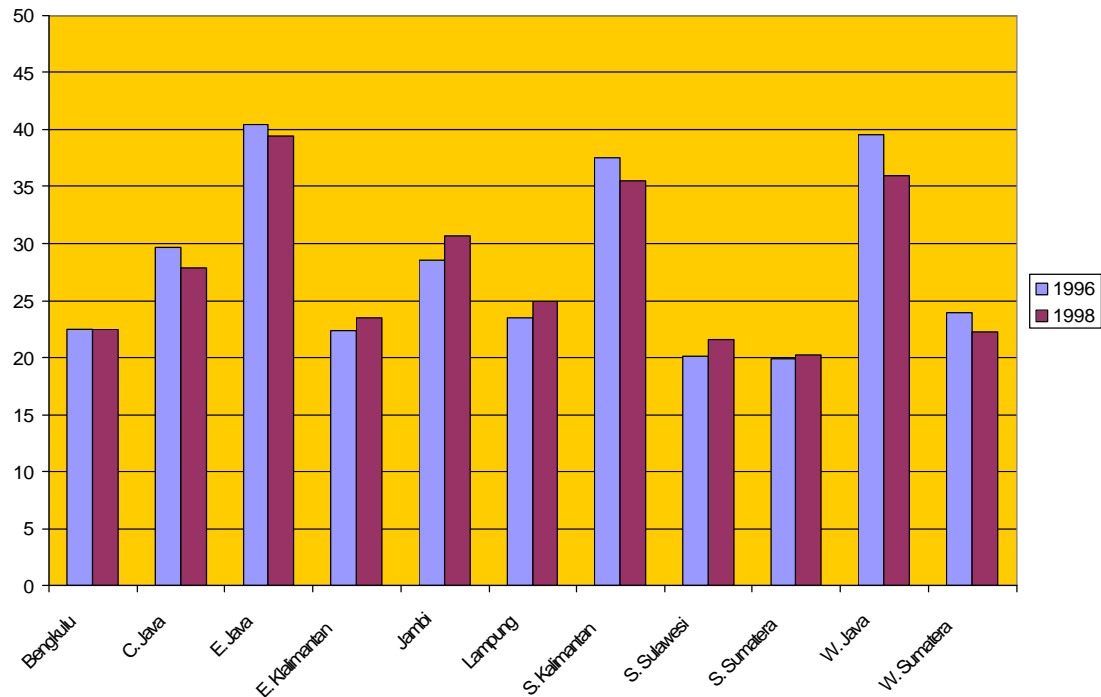
Problems of maternal mortality and morbidity are also contributed from adolescent groups. More than one-fifth of Indonesia's 206 million people are adolescents (ages 10-18 years). The 1997 IDHS data indicate that there are still young women (10% ages 15-19 years) who have children before they reach 20 years old (too young). The 1998 Susenas data indicate that in 8 out of 27 provinces, there were about 10% of women (25-34 years) who reported ever married before the age of 16 years. The proportion was found higher in West Java and South Kalimantan (more than 15%). In rural areas, girls tend to be married earlier compared to those in urban areas.

Early marriage contributes to the high rates of maternal mortality indirectly through: lack of education and information of reproductive health, family planning, and related services, high levels of unwanted pregnancies and illegal abortions.

Pregnancy during adolescence period will increase the risk of maternal death by 2-4 times. The analysis of 1998 Susenas data estimated that death of infants born to adolescent mothers was 30% higher than those born to mothers aged 20 years old or more. Young unmarried girls who become pregnant face numerous social pressures compared to young but married girls. In any case, these indirect problems of maternal

mortality can be regarded as violations of their rights to survival and development.⁴² There is yet to be developed specific data for population groups between the ages of 13-18 years old for all areas. Indonesian adolescents face nutrition problems as well as life-style related problems that potentially affect their reproductive health status.

Proportion of child marriages (less than 16 years) among women aged 25-34 in provinces with high incidence of child marriages, 1998.*



Source: National Socio-Economic Survey (Susenas) 1996 and 1998.

* There were 11 provinces indicating early marriages more than 20% among those ever married.

Smoking

Cigarette smoking has been linked to various diseases and infections. But smoking is also among the lifestyle choices taken by young people. Young girls who smoke during pregnancy run the risk of having low birth weight babies, miscarriages, stillbirths or infant deaths. Data indicate that Indonesia is known as having the highest number of young cigarette smokers (29%) compared to other developing countries.⁴³

The 1995 Susenas data indicate that 9% of cigarette smokers began their smoking before 14 years old and more than 53% began before reaching the age of 19 years old. The pattern was confirmed by a survey on tobacco use prevalence by CHR-UI (2001). The 1996 MOH report indicate that in young girls in West Java in urban areas (7.5%) and rural areas (1.3%) are smoking. The 1999 LDFE-UI and NFPCB survey in 4 provinces of Java and Lampung reported around 8% young girls and 81% males (all ages 15-24 years) smoked. Although smoking is banned in schools, there are no state laws that protect young people from being targeted by tobacco companies.

The recent survey by CHR-UI and UNICEF found that smoking is the most common life-style related risk faced by teenage students in Papua. Many SMP students (20%) reported they started smoking when they were still in their early teens, 11 to 13 years old. Some began smoking as early as 6 years old.

Substance abuse

Alcohol can also cause birth defects. The 1999 LDFE-UI and NFPCB survey in 4 provinces of Java and Lampung reported that around 1% young girls and 28% among the young men reported drinking alcohol, while in Bali a study reported 6% of young girls drink alcohol.⁴⁴

Similarly, the CHR-UI and UNICEF survey in Papua found that some teenage SMP students (11%) already reported ever got drunk with alcohol, and a few reported sniffed dangerous fumes (glue, kerosene), and used dangerous drugs. Family members with risk behaviors (drug abuse, IVDUs) may influence the choices of these teenage students to also try drugs.

Substance abuse is also rising among young people. Cocaine and marijuana can cause fatigue, anxiety, sleep disturbance, weight loss, and poor scholastic performance. Many young people who have used drugs have dropped out of school or have been arrested. The majority of users are adolescents in the 16-24 years age bracket. Most users are male (90%) and they often start at very young ages (around 13 years old). Many have had multiple drug use experience with marijuana, psychotropic pills, and other drugs (opiate based *putaw* and amphetamine based *shabu-shabu*). Lifestyle, peer pressure, and curiosity are reasons often cited by young people for engaging in drugs. Yet, information about drugs and their effects are scarce, while harm reduction programs that aim to impede the spread of HIV/AIDS and Hepatitis-C infections among drug users are severely lacking.

Patients treated for drug addiction in hospitals for drug-addiction, 1996-1998

Sex & Age	1996		1997		1998	
	Out-patient	Hospitalized	Out-patient	Hospitalized	Out-patient	Hospitalized
Total	1,779	311	3,652	655	5,008	733
Male	1,629	294	3,349	575	4,483	654
Female	150	17	303	80	525	79
Age groups						
< 15 years	225	10	172	6	139	6
16 – 19	759	123	1,563	239	1,937	252
20 – 24	468	103	1,322	277	2,048	336
25 – 29	194	43	401	85	626	107
30 – 34	87	17	117	33	144	16
> 34	46	15	77	15	114	16

Source: RSKO, Jakarta, 1996-1998

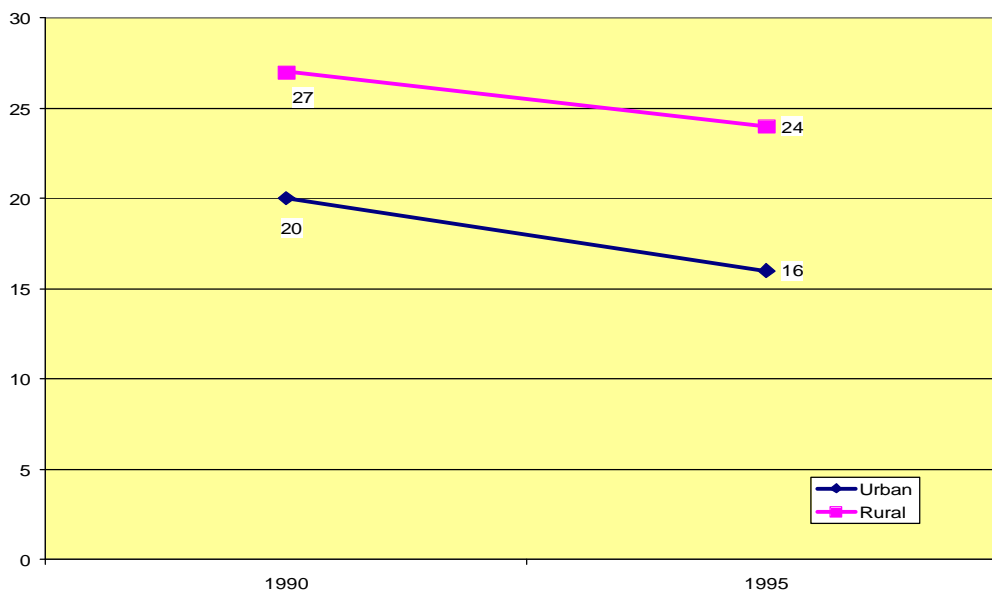
7.Fertility and Family Planning

There have been dramatic decline in the pattern of fertility contributed by the Indonesian family planning programs since 1967. But since the economic crisis, the prevalence of active family planning participants did not significantly increase.

Increasing age at first marriage

The age at first marriage has been increasing, and now there were fewer women who married at ages younger than 17 years old, both in rural and urban areas. In 1980 there were 33% in the rural area and 25% in the urban whose age of marriage were less than 17 years old. By 1995 it declined to 24% in the urban and 16% in the rural areas. Data from the 1998 Susenas indicated that about 26% of female adolescents were already married at the age of 10-16 years old and about 28% were reportedly married at the age between 17 and 18 years old. The 2002/3 IDHS shows that although the prevalence of young marriages remained high, in general median age of marriage has increased, from 17.7 years in 1991 to 19.2. years in 2003/23 (IDHS 2002/3:101).

Proportion of early marriages (less than 16 years) in urban-rural areas



Source: CBS, 1998 Population and Welfare Indicators.

Fertility and Contraceptive Prevalence Rate

It was estimated that between 1967/70 and 1995/1997 periods the total fertility rate (TFR) has declined from 5.6 down in 1968 down to 2.6 births per woman, or a drop of around 50%. The 1997 IDHS data indicate that TFR was at 2.78, and in the 2002/3 IDHS, TFR was standing at 2.6.

Nationally, the level of contraceptive prevalence rate (CPR) has increased over the period of time from 52% (1994) to 55% (1997). The 1997 IDHS data indicate that women in urban areas tend to have fewer children (2.4) compared to women in rural areas (3.0).

During the period 1994-1997, the level of various types of contraceptive usage that were accessed from different services tends to increase. However, the level of contraceptive access at CHCs and government sources seem tend to decline due to increasing role of midwives (*bidan*) and private practices in the community in providing such services. The effects of the crisis may interrupt several well-documented trends most likely contribute to a further slowing down in the decline in Total Fertility Rate (TFR), but at the present time the degree of this effect is unknown.

Percentage of currently married women (15-49 years) using specific contraceptive method

Method	1991 IDHS	1994 IDHS	1997 IDHS	2002/3 IDHS
Any Method*	50	55	57	60
Pill	15	17	15	6
Injection	12	15	21	28
IUD	13	10	8	6
Implants	3	5	6	4
Female sterilization	4	3.1	3	4
Male sterilization	0.6	0.7	0.4	0.4
Condom	0.8	0.9	0.7	0.9

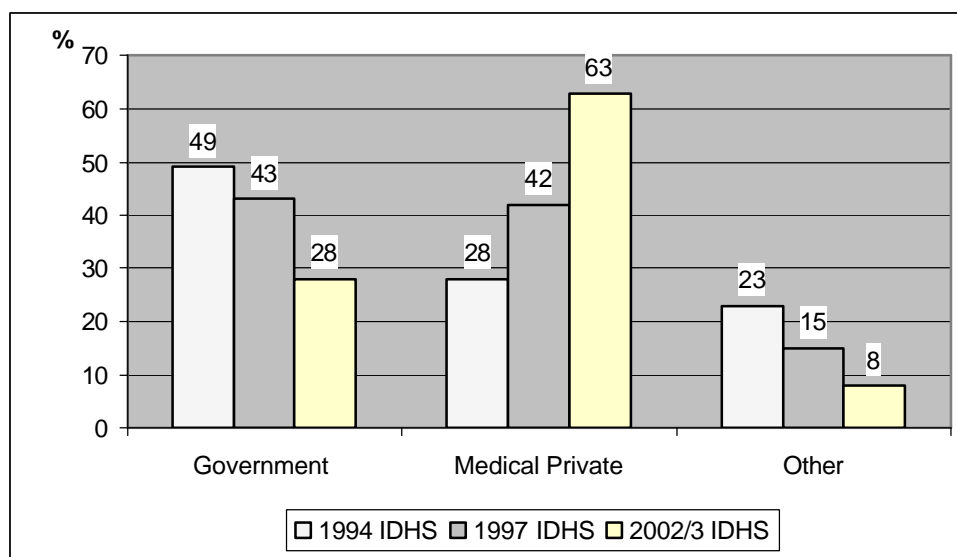
Source: 1997, 2000 IDHS. Note: *Any methods include all of the above and periodic abstinence, withdrawal, and other traditional methods.

As indicated from the IDHS data, between 1994 and 1997, contraceptive prevalence rates (CPR) increased from 52.1 per cent to 54.7 per cent, with injectables and oral contraceptives being the most widely used methods. Other modern methods in the current contraceptive method mix include the IUD, and implants. Permanent methods such as sterilization (male and female) remain low as is the use of condoms. In the three years post 1997 crisis, it seems that little change was seen in the method mix, although use of the IUD was already beginning to fall. Results from the 2002/3 IDHS indicate that 57 per cent of ever-married women and 60 per cent of currently married women use modern methods. Besides modern methods, there were some who reported using traditional methods of contraception (2.7% in 1997 IDHS and 3.6% in 2002/3 IDHS).⁴⁵

In 1997 IDHS, the contraceptive prevalence rate amongst currently married women is slightly higher in urban than in rural areas (60 and 57 per cent). The urban-rural disparities in CPR have gradually disappeared in the 2002/3 IDHS (61 and 60 per cent respectively). Nevertheless, the mix of methods used remains significantly different. As in the 997 IDHS data from 2002/3 IDHS suggest that more women in urban areas relative to rural areas opt for IUD and female sterilization. In contrast, the use of injectables and implants are higher in rural areas. It is worth noting that the use of injectables as the most commonly used method of contraception in both rural and urban areas in had shown notable increase from 1997 to 2002/3. In 1997, injectables were used by 21 per cent of currently married women in both rural and urban areas. In 2002/3, the figure rose to 29 per cent of rural and 26 per cent of urban currently married women.

On the supplier side, there were further notable shifts concerning sources of modern methods of contraceptives. Over the years, reliance on the medical private sector as suppliers of contraceptive needs has increased. While data from the 1997 IDHS indicate that the share of government and private medical providers of contraceptive service is virtually equal (43 and 40 per cent), the share of private medical providers sharply increases to 63 per cent in 2002/3 as the government share fell to 28 per cent. The remaining 8 per cent of women obtain family planning services from other sources such as *posyandu*, *polindes*, family planning posts, family and friends. Most of current users (46 per cent) obtained contraceptives access through village midwives or nurses /midwives. Those who go rely to the government center, mostly access government health centers (20 per cent of all current users).

Distribution of current users of modern contraceptive methods by source of supply 1994 – 2002/3



Source: 1997 IDHS and 2002/3 IDHS

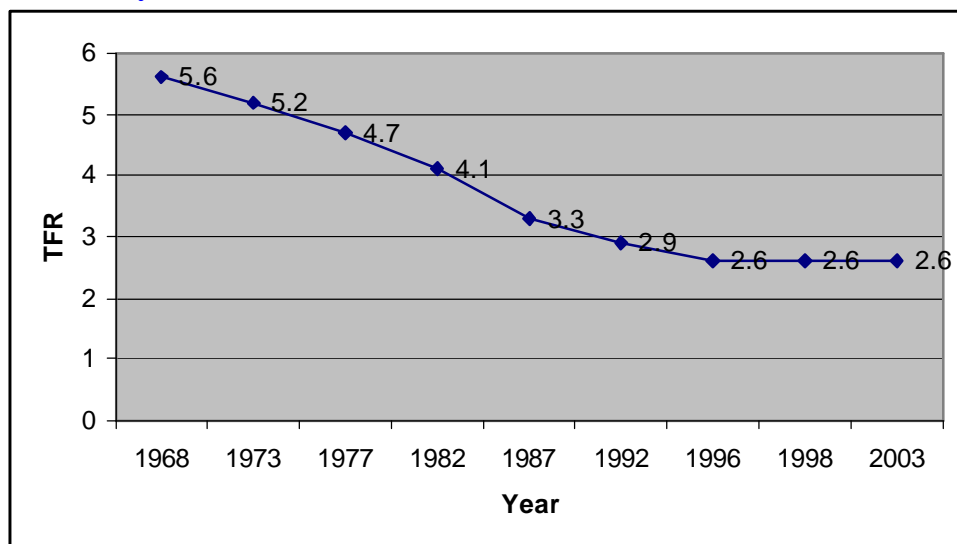
Where regional data on residency and poverty breakdowns are available (1998 Susenas and the 100 Villages Survey) it appears that there may be some difference between the impact of the crisis on family planning use by any of these variables.⁴⁶ Analysis suggest that although the decline in CPR itself is not great, the data point to a greater change in the access to and utility of private providers in urban than rural areas. This conclusion needs to be taken with caution, since the decline is very slight, and the data do not allow an assessment of the sustainability of the decline.

Unmet need

Over the years, the total fertility rate in Indonesia has fallen from 5.6 in 1998 to 2.6 in 2003. Yet, there are still many aspects of women's reproductive health needs that remain unmet. The 2002/3 IDHS data indicate that while around 80 per cent of births to currently-married women in the five years preceding the survey (including current pregnancies) were wanted, a further 9.6 per cent were wanted at a later time, and about 7.2 per cent were unwanted (1997 IDHS data indicate 8.3 per cent of births were unwanted). There were around 8.6 per cent of currently married women who

wanted to limit or delay pregnancies but are not using contraceptive (compared to 13 per cent in 1991). The 2002/3 data also indicate that among those women who have used contraception many (21 %) have chosen to discontinue within 12 months after beginning its use. The common reasons given include: wanting to become pregnant (34%) and side effects (14.4%).

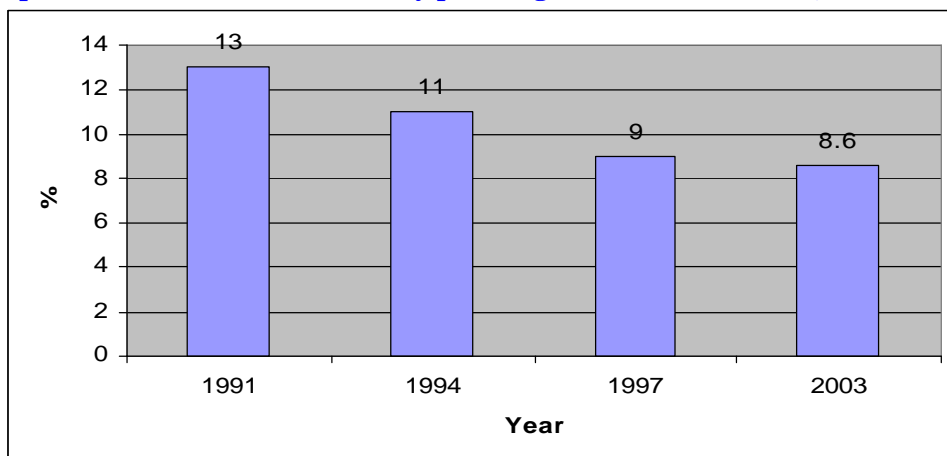
Total Fertility Rate (TFR) in Indonesia: 1968-2002



Source: 1997 IDHS and 2002/3

Unmet need for contraception remains substantial. Estimates based on the 1997 IDHS data on unmet needs for family planning services in general indicate that there has been a decline from 13% in 1991 to 9% in 1997. The government has, over the years, addressed the challenge in meeting the needs of family planning services. In 2002/3 IDHS, unmet needs for family planning amongst currently married women is estimated to be 8.6 per cent

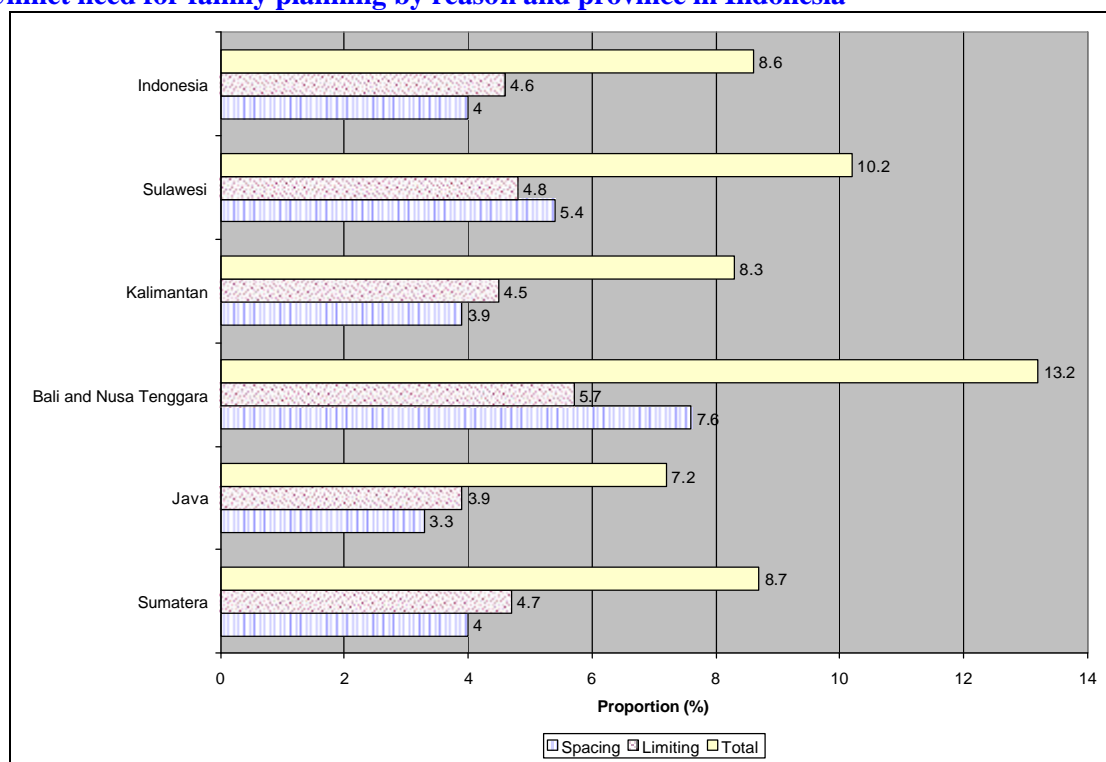
Proportion of unmet need for family planning services in Indonesia, 1991-2003



Source: 1997 IDHS and 2002/3 IDHS

The 1997 IDHS data reveals that one out of 11 women who wants to avoid pregnancy is not using contraception. The proportion of currently married women who do not wish to have more children (limiting) ranges between 8-10 per cent. Those women who want to wait before having another child (spacing) but are not using any contraceptives range between 3-6 per cent. In 2002/3 unmet needs due to desire to limit children accounts for 4.6 per cent, while unmet needs due to spacing takes up the remaining 4 per cent.

Unmet need for family planning by reason and province in Indonesia



Source: IDHS 2002/3:226

The needs of women for family planning differ markedly between provinces and also reflect a rural-urban variation. It seems that younger women are more interested in spacing birth further, while older women want to limit the total number of births.

There are several reasons that together may explain why many women who prefer to avoid pregnancy nevertheless do not use contraception. Data from the findings of surveys and in-depth studies indicate that the reasons can include:

- Difficulties of access to, and quality of, family planning supplies and services
- Health concern about contraceptives and side effects
- Lack of information
- Opposition from husbands, families, and communities
- Little perceived risk of pregnancy.

Male participation in family planning

In most cases family planning programs and services seldom target the male population, yet many men have significant decision power in determining and in supporting their spouse, as well as the men themselves, in using or continuing contraceptive use.

The 1997 and 2002/3 IDHS data both indicate that the use of condom and male sterilization were low (less than 1% and 0.4% respectively). A study in Lombok indicated that men (especially with lower socio-economic status) have significant decision power in determining contraceptive use of their spouses as well as in supporting their spouse in continuing contraceptive use.⁴⁷

A recent survey to gain an understanding on capacities to provide essential reproductive health services was conducted by CHR-UI (2002) covering more than 2100 respondents in 4 provinces.⁴⁸ The CHR-UI survey found that in general, the level of knowledge on family planning (FP) was already good in the community. There still remained gender bias relating FP knowledge, with around 74% of women know 3 types of FP methods compared to less than 60% males who can mention 3 types of FP methods. The gender gap is even more obvious when looking at the current users, with more than 61% were females and only 3% were males.

The CHR-UI study also found that in relation to decision making of FP usage, almost 70% of the all respondents mentioned that the decision making of contraception was self-determined by the wife rather than by the husband. Similarly, 72% of female respondents reported that decision for selecting a FP method was their own compared to 46% of male respondents. Thus, more women are now able to self-decide their own preferred FP method compared to males. This indicates that although male participation in FP was low, the men do give significant freedom to their spouses to use FP method of their choice. The data was supported by the fact that 51% of the male respondents who did not use contraception said that it is 'my wife's business.'

Decision for selecting FP methods and satisfaction of selection in four provinces, 2001

Decision and satisfaction of selected FP method (%)	South Sumatra	West Java	West Kalimantan	NTT	Total
N	435	630	422	634	2121
Who determined your choice of contraceptive method?					
▪ I choose by myself	67.6	75.9	69.9	58.5	69.4
▪ Husband	14.2	18.5	17.8	15.5	16.9
▪ FP provider	16.5	4.8	11.0	22.3	12.0
▪ Mother/mother in law	1.1	-	1.2	1.0	0.7
▪ Other	-	0.8	-	0.5	0.4
▪ Not answer	0.6	-	-	2.1	0.5
Where did you get contraceptive method?					
▪ Drugstore	2.3	5.0	5.5	1.0	3.7
▪ Integrated health service	1.1	3.6	4.3	7.8	4.2
▪ Village clinic	1.7	7.3	11.7	11.4	7.9
▪ Community health service	35.2	23.5	33.7	65.8	36.9
▪ Midwife clinic	46.0	52.1	25.8	5.2	35.9
▪ GP clinic	2.3	1.4	-	0.5	1.1
▪ Private clinic	4.5	0.8	4.9	1.0	2.4
▪ Hospital	3.4	2.2	3.7	3.6	3.0
Are you satisfied with your contraceptive choice now?					
▪ Yes	90.3	90.8	84.0	86.0	88.4
▪ No	3.4	4.2	3.7	5.2	4.2
▪ So so/just the same	0.6	1.4	1.8	2.1	1.5
▪ Not yet known	4.0	2.8	9.2	3.1	4.3
▪ Don't know	1.7	0.8	1.2	3.6	1.7

Questions asked to married women. Source: CHR-UI, 2002 based on baseline ERH survey 2001.

Male participation in family planning program is necessary and can be improved. There are innovative voluntary sterilization programs for men being tested along with increased IEC programs to encourage men to be more actively engaged in FP programs, to be able to encourage their families and other community members in as FP acceptors, to be more aware of women reproductive health and rights (including of their wives, daughters, female cousins, and other women), and to be able to help in eliminating all kinds of violence against women.

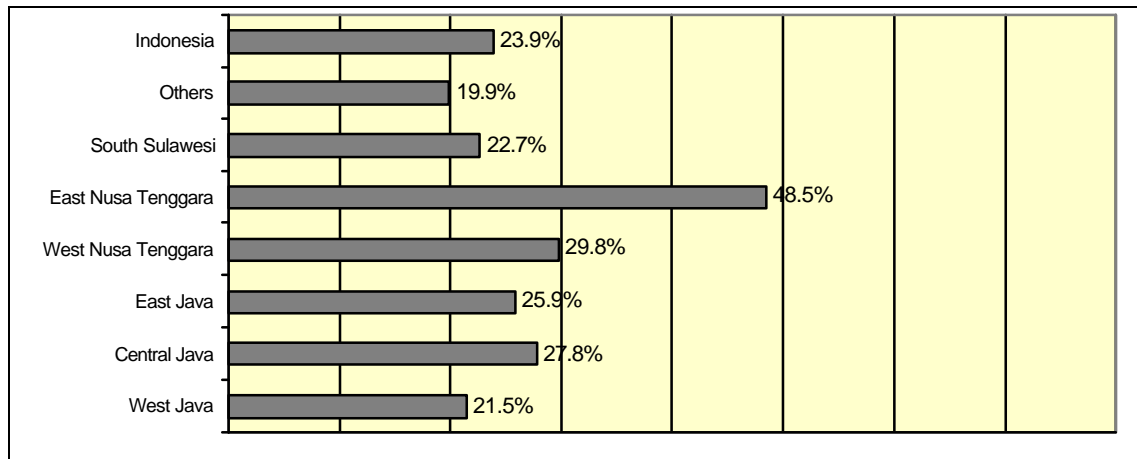
Nutrition status

Nutrition status also contributes to the level of maternal mortality. Around 14.5% of married women in five provinces (West Java, Central Java, East Nusa Tenggara, Maluku and Irian Jaya) showed a chronic under nutrition as indicated by an average body mass index (BMI) of less than 18.5 kg/m².⁴⁹

The BMI measure can reflect maternal malnutrition since it is a reliable indicator of population food insecurity as women usually reduce their food intake before reducing that of their children and/or their husbands. The 1995 Survey on Maternal and Child Health reveals that about 24% of women of reproductive age have chronic energy malnutrition or an upper arm circumference (UAC) of less than 23.5 cm (the normal cutoff point). By province, 72% of women in East Timor have UAC less than 23.5 cm.⁵⁰

The 1997 crisis has worsened this situation, as found in a survey from six provinces.⁵¹ When data from 1996 were compared to 1998, a year after the crisis, the mean BMI among women in rural Central Java had decreased from 21.5 kg/m² to 21.0 kg/m². Consequently, it was concluded that the prevalence of maternal malnutrition has increased from 15% to 17.5%.⁵²

Percentage of Chronic Energy Deficiency (UAC<23.5cm) among women of reproductive age in Indonesia by province



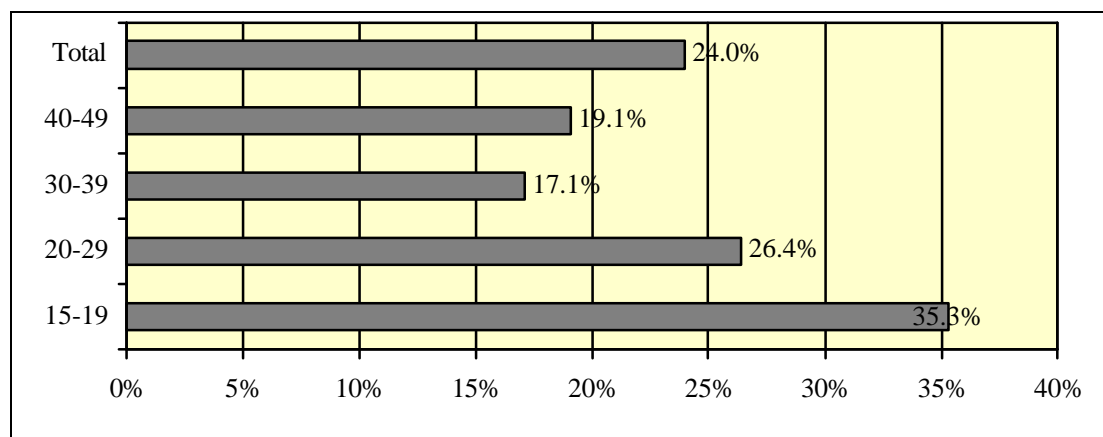
Source: 1995 Maternal and Child Health Survey (SKIA)

It would be more meaningful to have three benchmarks before we can infer that the crisis has ‘significantly’ reduced the mean BMI of women in the study’s provinces, but these results are suggestive of the crisis effects on BMI.

The 1995 maternal and child health survey (using the 1995 Supas and 1996 Susenas sampling frame with an additional sample in seven provinces) found that among different age groups of women of reproductive age, approximately 62% of chronic energy deficiency (CED) cases occur in adolescents 15-19 years and young female adults 20-29 years.

A more recent post-crisis health and nutrition survey funded by the Social Safety Net (SSN) program was conducted in East Java with 19,850 men and women (equal proportions) as respondents.⁵³ Data collection was conducted between December 1998 and January 1999, one-and-a-half years after the mid-1997 economic crisis. Findings indicate that 18.4% of the women suffered from chronic under-nutrition as indicated by an average BMI of less than 18.5 kg/m². This percentage is higher than the pre-crisis 1995 HHS finding of 14.5%.⁵⁴ The survey also found that the average BMI for pregnant women was 21.4 kg/m² and 20.5 kg/m² for lactating women. Both measures indicate that, on average, pregnant and lactating women of poor families in East Java are not yet suffering from chronic under-nutrition since the average BMI is still above the normal cut-off point of 18.5kg/m².

Percentage of Chronic Energy Deficiency (UAC<23.5cm) among women of reproductive age in Indonesia by age



Source: 1995 Maternal and Child Health Survey (SKIA)

The 1995 HHS showed that 39.5% of women of reproductive age suffer from anemia (with Hb<12g/dL).⁵⁵ Data from 1990 shows that 30% of women workers suffer anemia, and that this condition reduces their productivity by about 20%. The high rate of anemia in women workers is probably closely linked to their wages, which constrain their ability to buy nutritious foods.⁵⁶

The 1995 HHS data also shows that 51% of pregnant women and 45% of post-partum women suffer from anemia. Anemia in pregnant women affects both the mother and the child, increases the rate of miscarriage, pre-maturity and low birth weight (LBW), and increases maternal and infant mortality. A study in West Java (1997) found that 25.7% of pregnant women suffered from mild anemia, 35.9% suffered from moderate anemia, and 0.7% suffered from severe anemia.⁵⁷

These high anemia rates among pregnant women are associated with the high rate of low birth weight (<2.5kg) babies (7.9% in the 1995 HHS, and 7.7% in the 1997 IDHS), although the number of low birth weight babies is below the Ministry of Health targets.⁵⁸ Within the context of the economic crisis, if more women suffer chronic energy malnutrition and elevated anemia, then it is likely that the rates of low birth weight babies will increase.

There are no pre-crisis data on the proportion of women in need of special nutrition supplement and rest. The prevalence of LBW babies (8% in 1997) indirectly presents the magnitude of the problem. With the crisis, this problem is perhaps overwhelming and out of the capacity of the MOH to control.

A survey in Central and East Java in 1998, right after the beginning of the crisis (mid-1997), presents a picture of how many women are part of families categorized as 'pre-welfare' (*Keluarga Pra-Sejahtera or Pra-S*) and 'welfare stage I' (*Keluarga Sejahtera I or KS-I*). Families in these two categories fail to meet one out of the 23 indicators to measure the five stages of family welfare, which specifically is measured as: "do not eat eggs, meat or fish at least once a week".

Information from 931 married women aged 15-49 years who had at least one child were compared with the local family welfare registration data of BKKBN. Results show a big disparity between the two data sets. While only 10% of families were considered *Pra-S* by BKKBN data, the survey found 33.5% of families were in this stage, and while only 17% of families were considered *KS-I* by BKKBN data, the survey found 47.5%.⁵⁹ Pregnant women who were members of these 81% *Pra-S* and *KS-I* families could not afford to eat eggs, meat or fish at least once a week. Prior to the crisis households consumed 4.1 eggs per week. This has fallen to about 2.3 eggs per week since the onset of the crisis. The decline in egg consumption will not be felt equally by all members of the household. Poor mothers are affected the worst. Prior to the crisis, almost all mothers ate an average of one egg per week; the percentage that did not consume egg was less than 0.2 %.

Violence against women

Violence occurs in many women's lives, within and outside of formal relationships. Yet, data are limited because it has only been recently recognized. Violence against women affects women's control over their sexuality and their sexual health (including injuries, STIs, unwanted pregnancies, unsafe abortions, and mental disorders).

In a mostly paternalistic society, the women (as wives, daughters, etc.) generally follow a household role, while the men are involved in the larger public role. As a result, socio-economic opportunities are limited for women, and women often have to face further violence at home. The imbalance of status and opportunities can significantly effect women's reproductive health status. The 1997 Susenas data indicate that women in fact headed 13% of households in Indonesia. Most of these women (81%) were divorced or widowed, and the majority among these women heads of households (65%) also has to work. The 1997 Susenas data showed that half among the unmarried women and 73% among divorced women were active in the labor force. A study has shown that the participation of women in the labor force has increased dramatically in the last three decades from 29% (1961) to 40.5% (1990) and was estimated to reach 44% in 2000.⁶⁰ Unfortunately, many companies and businesses often urge their women workers to quit from their jobs when they are pregnant or deemed unproductive, thus avoiding companies to pay for health, maternity leave or pregnancy care.

Cases of reported violence against wives at NGOs in Indonesia

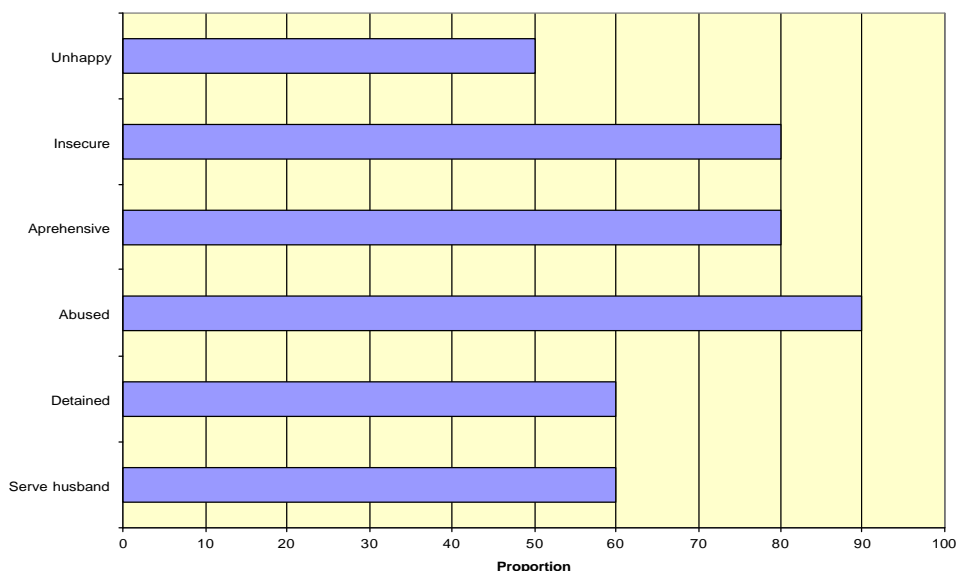
Location	NGOs	Reporting year	No. cases
Yogyakarta and Central Java areas	Rifka Annisa	1994 – 2000	944
Surabaya and East Java areas	Savy Amira	1997 – 2000	130
Semarang, Central Java (north)	HK3JHAM	2000	176
Greater Jakarta area	Mitra Perempuan	2000	192
Aceh, North Sumatra	KKTGA	1998 – 1999	3
Makasar, South Sumatra	LBHP21	1999 – 2000	81
Kupang, NTT	Rumah Perempuan	1999 – 2000	9

Source : Cited in Habsari, 2003 from Hakimi, et al, 2001 : 28

At home, many women of reproductive ages also face domestic violence. A study on husband-wife domestic relations with 339 male and 362 female respondents showed that around 20% of the men admitted have psychologically intimidated their spouses, and 11% have abused their own wife, while around 16% of the women reported have been beaten, kicked (9%), and other physical abuses.⁶¹ Another study indicated that domestic violence against wives is quite prevalent.⁶² Collated data based on reported domestic violence against wives at various safe-houses and NGOs throughout major cities in Indonesia shows that the numbers can be high per year. The NGO in Jakarta and Semarang or Surabaya recorded more than 100 cases for year 2000 alone, and these numbers does not include other forms of violence against women at home.

A survey among 1144 women on their self esteem and their perception on the impact of violence from their spouses at home indicated that many women have low self-esteem and many feel insecure in their homes.⁶³ The data revealed (from multiple responses) that 6 in 10 women said they were often detained or held, against their will, to stay home, around 60% reporting having to be subservient to their husbands, 9 in 10 reported ever experienced abuse (sexual, discrimination, violence, harassment), around 40% said they were not able to voice their own opinions, around half of the surveyed women reported as unhappy, and most were apprehensive or insecure with themselves.

Women's perceptions of self-esteem and impact of violence from spouses at home



Source: Aura, 2000.

Indonesia does not yet recognize violence against women in its legal system. There are some regulations relating to criminal violence (rape, vice, prostitution, murder, battery) as reflected in the Criminal Code (KUHP). There are plans that will address domestic violence against women (the proposed law RUU/1998 *Anti Kekerasan Dalam Rumah Tangga*) but which have not yet been realized. The state did, however, ratified the contents of the convention on the discrimination against women (CEDAW) through Law (UU No. 7/1984).

Indonesian society do not condone violence against women, but various cultures often implicitly and explicitly support dominating and aggressive male behavior which can lead to violence. Society at large also may be inactive to stop violence through legal channels, as laws, concepts, penal codes, and services are non-existent or very limited.

Female Circumcision

Female circumcision (FC) practices have long existed in Indonesia. Although the links between Islamic mandate and FC are still subjected to debates, FC practices have been associated as an act of faith amongst the Muslim communities. In a study conducted by the Population Council covering several major ethnic groups in 2003, it is found that the general Muslim communities perceive FC as both a societal custom and a religious duty. It should be noted however, that parents and religious leaders interviewed in the study did not exhibit adequate knowledge on the formal links between FC and Islam. Rather, the study observed that the “practice of FC in Indonesia is essentially a tradition that has been passed from one generation to the next with little questioning about its meaning or its basis in Islamic history or law”.⁶⁴

Covering 1694 households in eight different sites to represent the major ethnic groups of Minang, Sunda, Banten, Jawa, Madura, Bugis, Makassar, and Gorontalo, the study found both male and female circumcision as a universal practice. Among children aged 15-18, 86 to 100 per cent of the girls and 100 per cent of boys were reported

circumcised. Age at circumcision for girls ranged between newborn and 9 year old, with 49 per cent of the 2215 reported FC cases taking place under the age of 1. Traditional providers, including both traditional birth attendants and traditional circumcision practitioners, were the major facilitators of FC, performing 68 per cent of reported cases. The remaining 32 per cent of FC were performed by health care providers (HCP)/midwives. FC practices in the study were classified into two groups. The first represents symbolic acts where no incision and excision is performed. These include rubbing or scrapping or pricking or piercing the outer part of the clitoris, and accounted for 28 per cent of reported cases of FC. The second types include potentially harmful acts of incision, found in 49 per cent of the cases, and excision (22%). While the study finds no clear immediate nor long-term physical and psychological impacts of FC, direct observations suggested that FC practices generate real pain and genital cutting in 75 per cent of the cases. Contrary to expectations, traditional providers are not necessarily at fault for imposing greater risks of complications from FC due to unhygienic practices. The study found that trained medical providers were more likely to perform more invasive practice of incision and excision than traditional providers. That is, since midwives tend to use scissors instead of penknives commonly used by the traditional providers, the medicalization of FC imposes danger as it increases the likelihood of cutting of the clitoris. Further, although there is no authorised and standardized procedure for FC operations, maternity clinic midwives are increasingly promoting FC as part of their birth delivery package.

FC practices in Indonesia is a reproductive health concern as it is done without consent of the girl in most cases, while exhibits no established health benefits nor clear religious mandates. However, the continuation of FC practices is strongly supported by the communities. This is indicated by 92 per cent of the families surveyed who are inclined to perform FC for both their daughters and female grandchildren. To augment the situation, the Indonesian government should promote policies to reduce FC practices in mass media campaigns and incorporate the issues into midwifery training programs.

8. Maternal health

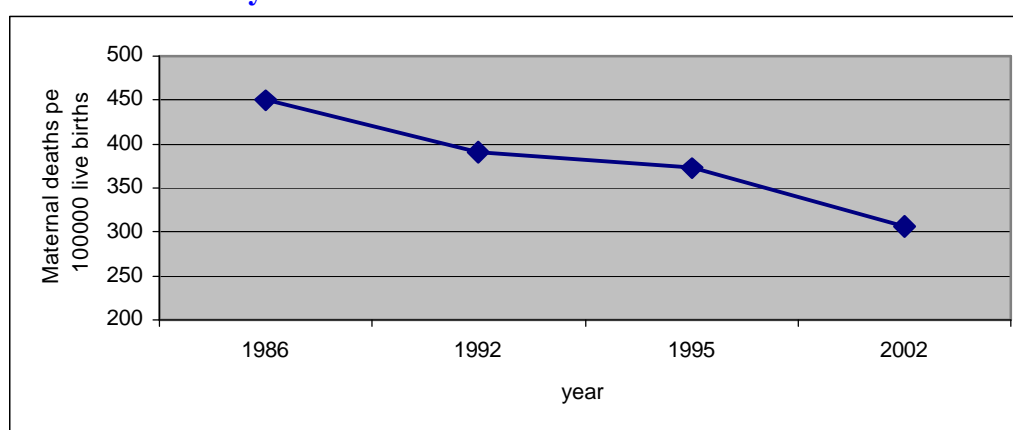
The high levels of maternal mortality in Indonesia show the low levels of welfare of its people and are indicative of the Government's negligence to its commitments to the ICPD.⁶⁵ Other factors conducive to high maternal mortality in Indonesia include limited resources and incapability of the infrastructure.

Maternal mortality according to WHO is 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes'.⁶⁶ Around 12% to 15% of pregnant women in developing countries suffer serious life-threatening complications. A mother's death will have profound consequences for her family, and her children under the age of 5 will have a greater chance of death.⁶⁷

The state of maternal mortality

The issue of high maternal mortality remains in the top of health care agenda in Indonesia. Different studies report a wide range of estimates of the maternal mortality ratio from a couple hundred to four times that level, but a range of estimates of 350 to 400 maternal deaths per 100,000 live births has been generally accepted as the prevailing level.⁶⁸ This level means that in Indonesia a woman dies every hour from pregnancy complications during delivery, late referral to hospital services or poor emergency obstetric care.⁶⁹

Maternal mortality in Indonesia



Source: based on data collated by GOI-UNICEF, 2000 and IDHS 2002/3:189.

Data from the 1995 Household Health Survey (HHS) estimated national MMR was 373 per 100,000 live births.⁷⁰ The national policy prior to the 1997 social-economic crisis that befall Indonesia, was to reduce the national MMR of 450 (1995) to 225 by 1999. In some regions, like West Java, West Nusa Tenggara, and Papua, they have been judged to indicate higher rates of maternal death than the others. Ironically the data on which that judgment rests is remarkably unreliable. The analysis of the 1995 HHS data shows that there is a substantial variation in MMR between provinces. For example, in Central Java the MMR was estimated at 248 while in West Java it was 686. In outer Java areas the level of MMR is still high, for example in NTT the estimated MMR was estimated at 554, and in Papua it was estimated at 1025.⁷¹

Maternal Mortality Ratio and PMDF* in 5 provinces

	West Java	Central Java	NTT	Maluku	Papua
PMDF	19.8	15.6	25.2	31.0	34.2
MMR	686	248	554	796	1025

Source: Soemantri et. al., 1999: 13 (Table 3) based on the 1995 Household Health Survey. *PMDF: The Percentage of deaths from maternal causes among deaths from all causes for women 15-44 years or women 15-49 years.

While it is difficult to infer trends of maternal mortality in Indonesia due to the limited data availability and the inconsistency of maternal mortality estimates, the recent survey data, coupled with the evidence of lack coverage and quality of emergency obstetric services, suggest that maternal mortality has been stagnantly high during the past decade.⁷² It is not yet possible to draw conclusions on the effects of the crisis on maternal mortality in Indonesia due to the absence the data before and after the crisis.

In contrast to Indonesia, maternal mortality ratios in developed countries are very low, only 7 to 15 maternal deaths per 100,000 live births.⁷³ Thus, the risk of maternal death in Indonesia is very high, 45 times higher than the developed countries. For one maternal death, many more suffer from chronic, even serious maternal morbidity complications.⁷⁴ Studies in India and Bangladesh suggested 17 to 70 episodes of serious illnesses related to pregnancy and childbirth for every maternal death.⁷⁵

Maternal death is not only a tragedy for the victim, but also has a devastating effect on the remaining members of her family, especially among her children. In many cultures, including Indonesia, a mother occupies a pivotal position in the family, particularly to the survival and fate of young children often depends on their mothers.⁷⁶ Two studies in Bangladesh reported that 90 to 95 per cent of newborn infants whose mothers died in childbirth would have died within one year of birth.⁷⁷ For every dead mother, an average two children will be left motherless.⁷⁸ Documentation of the fate of motherless children is scanty, but motherless children will obviously receive much less optimal care and health protection than children whose mothers survive. Thus, one potential impact of the prevention of maternal deaths is the better care and more ensured survival of infants.

Causes of maternal mortality

It is known that all pregnant women are at some risk of maternal death. The major direct causes of maternal deaths in the developing countries include hemorrhage, infection, obstructed or prolonged labor, unsafe abortion, and hypertensive disorders of pregnancy.

The 1995 HHS data indicate that the major causes of maternal deaths are attributed to hemorrhage, eclampsia, infections, and obstructed labor. These causes often occur during or immediately after delivery. In many cases the deliveries were made by untrained *dukun* (TBAs) or family members. Often too the women simply did not receive the essential obstetric care that may save them. The 1995 HHS data indicated that the prevalence of maternal morbidity is quite significant (23%).⁷⁹ The estimated morbidity during pregnancy was around 10%, while during delivery it was estimated at 14%. The 1995 HHS data also shows that there is a wide variation in the prevalence between provinces. For example, in NTT it was around 40% while in Central Java it was around 16%.

Prevalence of maternal morbidity during pregnancy, delivery and post-partum in 5 provinces

Prevalence	West Java	Central Java	N NT	Maluku	Papua	Total
N*	847	744	454	564	292	2901
Maternal morbidity	17.1	15.9	39.9	27.1	22.6	22.8
Morbidity at pregnancy	6.5	3.4	22.9	13.1	7.5	9.7
Morbidity at delivery	10.5	12.5	20.5	15.8	16.4	14.2
Morbidity at postpartum	3.5	1.2	8.4	2.1	2.1	3.3

*Women with pregnancy in the past five years. *Note*:: Maternal morbidity has different durations for the three time periods - nine months of pregnancy, typically 12-24 hours of delivery (intra-partum), and six weeks of postpartum.
Source:1995 HHS.

The 1995 HHS data reported several types of morbidities during pregnancy, during delivery, and during the post-partum period, as follows:

Percentage of morbidities during pregnancy, delivery, and post-partum

Morbidities	Pregnancy	Delivery	Postpartum
Pale, dizziness, fatigue	9.8		
Hypertension	0.9		
Jaundice	0.5		
Dysuria	0.7		
Edema	2.5		
Convulsions	0.3	0.2	0.2
High fever	5.4	2.4	7.5
Hemorrhage	2.5	4.4	0.9
Prolonged labor	N/a	9.2	N/a

Source: 1995 Household Health Survey

Timing of pregnancies and maternal health

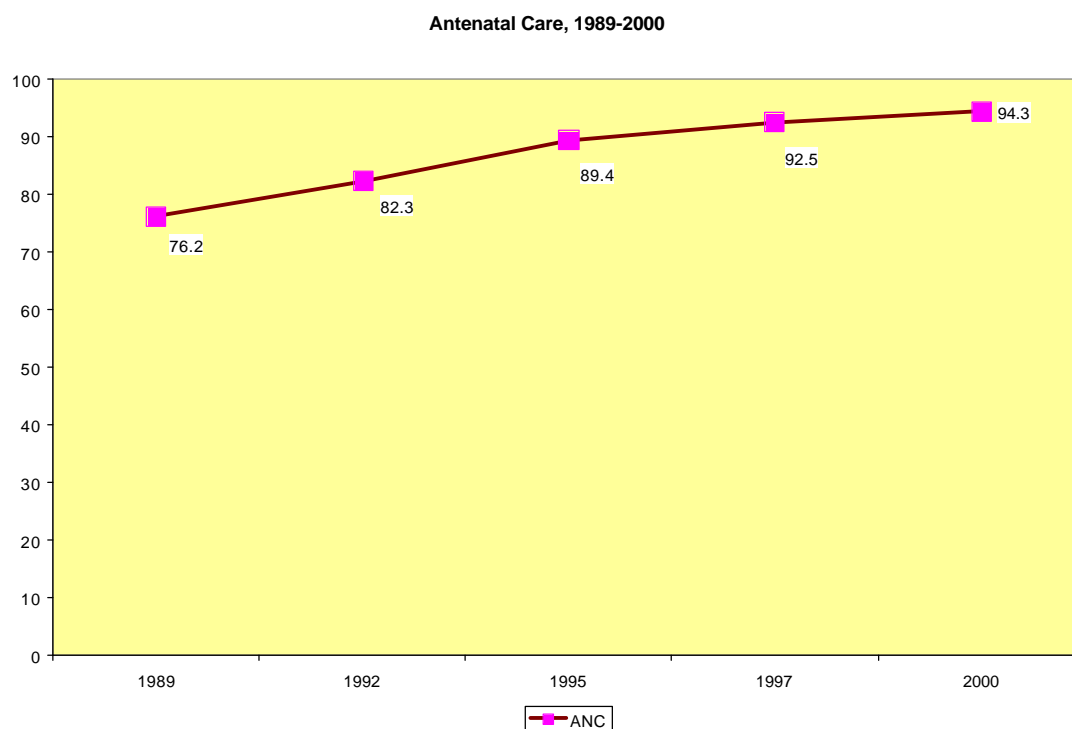
In all pregnancies, there are risks of complications which rise during childbirth. The risk is more apparent if the mother does not really want to have a child or if the women are too young, the births of children are too closely spaced, the women already have too many children, or the women are simply too old.

Among pregnant women, one of the main contributors to maternal deaths is too-close spacing of pregnancies. Data from the 1997 IDHS indicate that around 15% of pregnant women still have closely spaced pregnancies (i.e. birth intervals of less than two years (too close). In 2002/3 closely spaced pregnancies amount to 5.2 percent of birth in the five years preceding the survey or 8 per cent of currently married women. Among women of reproductive ages, about 22 per cent reported have had 4 children or more (too many) according to IDHS 1997. In the 2002/3 IDHS, 6.7 percent of

currently married women have had more than 3 births. The data also indicate that around 13.5 per cent who reported gave birth beyond the age of 34 (too old).

Antenatal care (ANC)

Antenatal care in Indonesia encompasses services such as height and weight measurement, blood pressure examination, iron tablets, tetanus toxoid immunization, and abdominal examination.⁸⁰ Data from the 2002/3 IDHS indicate improvements in women seeking maternal care. Compared to 76 per cent in 1989, more than 90 per cent of women who had live birth in the five years preceding the survey reported seeking ANC from a health professional in 2002/3. It can be presumed that the village midwives program that has been implemented since 1993 has given its contribution to the improvement of ANC services, especially in rural areas. The likelihood of receiving ANC from medical professionals is higher for women experiencing third or lower-order birth and who live in urban areas relative to women in higher-order birth and live in rural areas. Further, the recommended minimum numbers of ANC visits, that is one visit each in the first and second trimester, and two visits in the third trimester, is more likely to be completed by urban women (72 per cent) relative to rural women (57 per cent).



Source: IDHS, 2002/3. Data includes at least one check up during pregnancy

Antenatal care is a necessary component of maternal health as complications of pregnancy such as excessive bleedings, fever, and convulsions are often identified during ANC visits. Nevertheless, the 2002/3 IDHS data finds no significant variations of reported pregnancy complications on women who received ANC and those who did not in their last birth. Similarly, prevalence of pregnancy complications is not significantly affected by the number of ANC visits.

Delivery care

The rates of prolonged labor and infection were associated with the type of birth attendant and place of birth in Indonesia.⁸¹ Home births by traditional birth attendants (TBAs) are more likely to lead to fever and infection since TBAs often do not follow the timing of each stage of labor. By not intervening early in the case of prolonged labor, there is an increased risk of infection.

Although around 66% of women (who had live birth in last 5 years) reported delivery done by a health provider, less than 40% reported delivered in health facility. This indicates that the role of alternative providers (including TBAs) and home delivery is still predominant. Many of these women still sought the services of traditional birth attendants (TBAs), including services to terminate pregnancy.

In many cases, TBAs practice unsafe methods and often risk women to infections and inability to refer the mothers on time when complications arise. Nevertheless, the proportion of women seeking health providers has improved significantly over the years (from 32% in 1991 IDHS).

Deliveries by types of attendants*

Most qualified person	Urban	Rural
General Practitioner	3.6%	0.9%
Obstetrician/Gynecologist	16.6%	4.6%
Nurse/Midwife/Village Midwife	61.8%	49.7%
TBA/Other	19.9%	41.6%
Relative/Other	0.5%	1.9%
Other	0.1%	0.4%
Missing	0.5%	1.0%
Total number of births	7029	8059

* Tabulation only considers the most qualified person in cases where respondents mentioned more than one person attending the delivery

Source: IDHS 2002/3: 128

Complications during delivery may take the form of prolonged labor, excessive bleeding, fever and maternal convulsions. The 2002/3 IDHS indicates 64 per cent of mothers experienced no complications during the last of all births occurring in the 5 years previous to the survey. Prolonged labour remained the largest form of delivery complications, and was experienced by 31 per cent of the births.

Postpartum care

An important component of maternal health is postpartum care (between delivery of placenta until 6 weeks following childbirth), where both mother and child are treated for complications and newborn care advice is provided to the mother. The 2002/3 IDHS provided data on postpartum care for women who had their most recent live birth in the last five years outside a health facility. The majority, of 62 per cent,

reported that although a health provider did not perform the delivery, they received postpartum care within 2 days of delivery. Among these women, more educated women are more likely to receive postpartum care. While almost 11 per cent of women with higher than secondary schooling qualification did not have any postnatal checkup following non-institutional delivery, the figure is slightly higher for women in no education at around 24 per cent.

Technical efforts to reduce maternal mortality

To negate maternal mortality, the Indonesian government had implemented technical strategies addressing the management of pregnancy and delivery complications.⁸² The strategies aim to develop each district level with a comprehensive unit of maternal care where the different levels of health care providers in the district function as referral facilities. At the first level, community midwives are targeted as first aid provider in the case of obstetric and neonatal emergencies, such as hemorrhage, eclampsia, prolonged labour, infection etc. At the second level, with assistance from the district hospital, health centers with inpatient cares are designed to accommodate 24 hours Basic Emergency Obstetric and Neonatal Care (BEONC). BEONC services include the supply of oxytocin, antibiotics, sedatives and parenteral; curettage/digital on abortus incompletes and manual removal of placenta; delivery assistance per vaginam with vacuum/forceps extraction.⁸³ At the last level, district hospital is expected to serve as a referral center where Comprehensive Emergency Obstetric and Neonatal Care (CEONC) is accessible for 24 hours. As the last stage in the referral process, CEONC consists of the ability to perform blood transfusion and caesarian section in addition to all BEONC services.

Currently, Indonesia is still regarded in a state of socio-economic crisis, and in the absence of recent data from the protracted crisis period, there is no way to indicate the current levels of morbidity and mortality, and thus no conclusions can be drawn on the effects of the crisis on maternal morbidity and mortality. However, it has been hypothesized that there may have been some negative effects, especially in the more remote areas and in hardest hit regions, including in major urban locations on maternal morbidity, as many essential services have been constrained.⁸⁴

Abortion

Improved access to family planning services will likely reduce the rates of abortion and they will eliminate the demand for abortion services. In practice, however, a significant proportion of women who do want pregnant still do not use any contraceptive method.

In Indonesia, abortion and unwanted pregnancies are complex problems that involve controversial moral, religious, and ethical issues. These problems are aggravated by absence of legal clarity. The Law (UU No. 23/1992) on Health is rife with ambiguities and even discourages attempts to control dangerous practices or to promote improvements in the quality of reproductive health care. The Indonesian Doctors' Association (IDI) refer to abortion as the medical definition of interruption or

termination of pregnancy before the resulting fetus attains viability, or before the pregnancy reaches 20 weeks, and the fetus is still below 500 grams in weight.⁸⁵

Estimates

Previous studies indicate that abortion levels are high. A study in 1993 estimated that the total number of abortion in Indonesia range from 750,000 and can reach up to 1 million per year.⁸⁶ This is a rate of 18 abortions per 100 conceptions (assuming 4.5 million live births in Indonesia in 1989). The MOH data from hospitals in 1980s indicated that abortion rate is around 18% in 27 provinces. In the context where abortion is still illegal, many women (adolescents, unmarried and sexually active married) still seek abortion services (from TBAs, midwives, doctors, or other medical providers) or attempt abortion themselves (drinking herbal *jamu*, massaging).⁸⁷ A survey by the IPPA in 1994 found that more than half (58% out of 2558) recorded abortion cases were by young girls aged 15-24. The majority (62%) was unmarried and often they delayed seeking early abortion.⁸⁸

Adolescent girls who have engaged in sex within or outside of marriage are at higher risk of maternal mortality compared to pregnant women over 20 years old. Adolescent girls giving birth are also faced with higher infant mortality, about 30% higher for infants born to girls aged 15-19 years than for those infants born to women aged 20 years or older.⁸⁹ Adolescent girls who are pregnant also face psycho-social pressures from their families and friends. They become afraid, shamed, and socially alienated so that many seek abortion, which is illegal. Often too, the abortion services are unsafe and ill-equipped to deal with complications. Although it is known that adolescent girls are ill-prepared to face reproductive health issues and they are oblivious to the knowledge about planned-parenthood, efforts towards serving these needs (e.g. reproductive health education) are still limited.

Occurrence among women

Abortion is not limited to adolescents or unmarried women. Studies in the late 1970s indicate that it also occurs among married sexually active women, who do not want more children and do not use contraception or experience contraceptive failure.⁹⁰ A study in Bali indicated that 71% of women seeking abortion were married.⁹¹ The care and treatment of women who have suffered an illegal and unsafe abortion remains an under-studied area in Indonesia.

The most recent study on abortion involved a survey of SDPs in 10 major cities in 10 provinces was completed by a consortium led by CHR-UI (2001).⁹² The study, which employed a method combining SDP social mapping and verification, gave a national estimate of 2 million abortion cases, including spontaneous abortion, per year in the country. This means that there were 43 abortion cases per 100 live births,⁹³ or 37 abortion cases per year per 1,000 women aged 15-49 years.⁹⁴ This is a conservative estimate, given that not all abortion SDPs, which widely spread in the study sites, could be identified and listed at the mapping. To compare, previous estimates from studies conducted in health facilities in Indonesia showed a range of 5 to 35 abortions per 100 live births.⁹⁵

Incidence of abortion

The CHR-UI study found that abortion incidence is much higher in urban than in the rural areas. Of the 2 million cases of abortion per year, 53% or over one million occurred in the urban areas, which represent only 42% of the total country land. It was possible, however, that the lower abortion incidence in the rural areas might also be associated with the higher degree of underreporting as SDPs in rural areas were more spread and less accessible. This study revealed different pattern of abortion providers between urban and rural areas. In city or urban area, obstetrician, midwife, maternity hospital, and family planning clinic accounted to 73% of abortion cases. Nevertheless, TBA still accounted to 15% of abortion cases in the cities under study. In district or rural areas, TBA played a dominant role in providing services for abortion; 84% of abortion cases in the districts under study were associated with TBA.

Incidence of abortion in Indonesia and its distribution by type of SDP, 2001

Type of SDP	City	District	Total
Estimated number of abortion cases	1,051,470	931,410	1,982,880
All SDPs	100.0	100.0	100.0
Government General Hospital	2.9	1.3	2.7
Private General Hospital	5.1	6.3	5.3
Maternity Hospital	10.3	4.6	9.5
FP Clinic	7.4	0.2	6.4
Obstetrician	40.8	2.2	35.6
General Physician	4.00	0.8	3.6
Midwife	14.2	0.7	12.4
TBA	15.3	83.7	24.4
Others	0.1	0.3	0.1

Source: CHR-UI, 2001:Tables 3 and 4

9. STIs and HIV/AIDS

Sexual relations and reproduction should ideally be free of infections. But sexually transmitted infections (STIs) are related to both health and sexual behaviors, including early initiation of sexual activity, sex with multiple partners, commercial sex, and specific sexual practices. Other health related behaviors can also effect STI patterns, including health seeking, compliance to treatment, and use of contraceptives. STIs also influence the spread of HIV, the virus that cause AIDS.

Knowledge and behaviors related to STIs

The level of knowledge surrounding HIV/AIDS, although still not satisfactory, has improved over the past years. The 2002/3 IDHS data indicate that 59 per cent of ever-married women reported that they have heard of AIDS. The figure was 38 per cent in 1995. The level of knowledge of AIDS is higher in men at 73 per cent in 2002/3 IDHS. However, both women and men in urban areas exhibit higher awareness of AIDS than those in rural areas. While 74 per cent of women and 86 per cent of men in urban areas have heard of AIDS, the figure is lower in rural areas at 46 and 61 per cent for women and men respectively.

Similarly, the IDHS 2002/3 results suggest that knowledge of STIs is higher in urban areas. Overall, approximately 73 per cent of ever-married women have no knowledge of symptoms associated STIs. With 60 per cent of ever-married women in urban areas, and 80 per cent in rural areas reporting no knowledge of STIs, the prevalence of relevant knowledge is considerably low, hence suggesting the need for information services on reproductive health.

Sexually transmitted infections (STIs) in Indonesia have been observed since the 1950s under the WHO supported program for the eradication of treponematosys. Since then, there has been a routine surveillance system STI control program for syphilis but conducted specifically among sex workers (SWs). It was only in early 1988 that the STI surveillance program among high-risk groups was expanded and then integrated within the HIV/AIDS surveillance projects.

The most common types of STIs being monitored are syphilis and gonorrhoea. Around 5,000 to 10,000 cases of syphilis, and between 20-30,000 cases of gonorrhoea, are reported each year from community health centers (CHCs) and hospitals throughout Indonesia. But data indicate that the types of STIs are not limited to these two. For example, reported incidence of STIs from selected training hospitals in East Java and Central Java indicate that gonococcal infections, non-specific urethritis, and condyloma accuminata tend to predominate among patients, both male and female.⁹⁶

Several risky sexual behavioral surveys, as well as clinical studies of STIs, have found that most of the sex workers male clients were married, often buy sex from sexual workers, and among them (3%-30%) reported ever had STIs.⁹⁷ These high-risk groups are not the only ones vulnerable. Those in the high-risk groups are also the 'bridges'

of infection to the larger population. Now, there are also adolescents, married women in reproductive ages, workers, school aged children, as well as abused or exploited young people, in the population who are increasingly at risk.

Incidence of STIs in selected training hospitals, East Java and Central Java, 1998

STIs	East Java				Central Java			
	Surabaya		Malang		Yogya		Semarang	
	Male	Female	Male	Female	Male	Female	Male	Female
Gonococcal infection	160	137	63	28	123	32	88	19
Non spec. urethritis	170	275	35	3	27	52	47	71
Condiloma Accu.	54	91	21	21	12	15	26	58
Herpes Simplex	14	18	9	5	10	6	5	4
Syphilis	9	9	5	9	0	2	19	25
Chancroid	6	1	2	0	0	0	2	3
Trichomoniasis	0	48	0	1	0	1	0	16
Lymphogran. Ing.	7	0	0	0	0	0	0	2

Source: DirGen CDC-MOH. 2002. Collated from Report on STI, HIV, and AIDS epidemiology and consensus on HIV case estimation for Indonesia, 2001. Jakarta: 20

Various recent studies among the women in low risk population, in both urban and rural areas, also indicated that there was a surprisingly high level of STIs. A study in South Kalimantan, for example, indicated that there was a high prevalence of gonorrhoea and chlamydia 'for what was expected to be a low risk population (married women in a relatively remote province, of whom 92% claimed to have only one lifetime partner)'. Different studies in urban areas also indicated that there were high prevalence of gonorrhoea and chlamydia in low risk population (i.e. women seeking ANC at SDPs).

In the cities of Surabaya and Semarang, different studies, albeit with different testing methods, have indicated that among pregnant women presenting at ANC or FP clinics there was a high incidence of chlamydia (around 3% to 8%), and trichomoniasis (around 4% to 6%). The incidence of syphilis was also high among women who attended FP clinics. These various studies have indicated that relevant STI services for low risk women are also very much needed.

Prevalence of gonorrhoea and chlamydia from studies of maternal health populations

Author	Sample	N	Gonorrhoea (%)	Chlamydia (%)
Cohen and Zasri, 1997	MWORA seeking ANC/ Obgyn at 3 hospitals, S. Kalimantan	349	4.3	7.7
Joesoef et al. 1996	Pregnant women at ANC clinics, Jakarta and Surabaya	745	3.2	19.5
Joesoef et al. 1996	Women seeking prenatal care at clinics, Surabaya	599	0.8	8.2
Joesoef et al. 1993	Women seeking prenatal care at clinics, Jakarta	697	0	N/a
Susanti, 1989	Women seeking early abortion at FP clinics (IPPA), Bali	695	1	5.2
Population Council, 1997	Women clients at FP clinics, Jakarta	312	0.3	10.3

Source: Cohen and Zasri, 1998:241.⁹⁸

Data shows that small cities are not immune to STIs. As indicated by the limited data from Jombang, although the reported incidences are small, the prevalence of identified STS+ among both high risk women and low risk women are comparatively high. In the district of Jombang there were only 3 surveillance activities done over the period of 1994-2001. For the period 1994/95, although the district of Jombang in East Java shows the lowest number of reported cases, it has a high proportion of positively screened syphilis cases. The same pattern can be seen in the period of 1998/99 before all surveillance activities were halted.

Some district officials tend to deny the existence of localization and sex industry in their areas. For example, since Jombang is known as a religious *santri* area, the data indicate that the area is, in fact, not risk free to STI and HIV/AIDS. As such, since the onset of the economic crisis, there were no surveillance activities conducted in Jombang. One reason was because since there is no government sanctioned localization site, there was no services (including surveillance) need to be made available. But no surveillance or no localization site do not mean that there are no STIs.

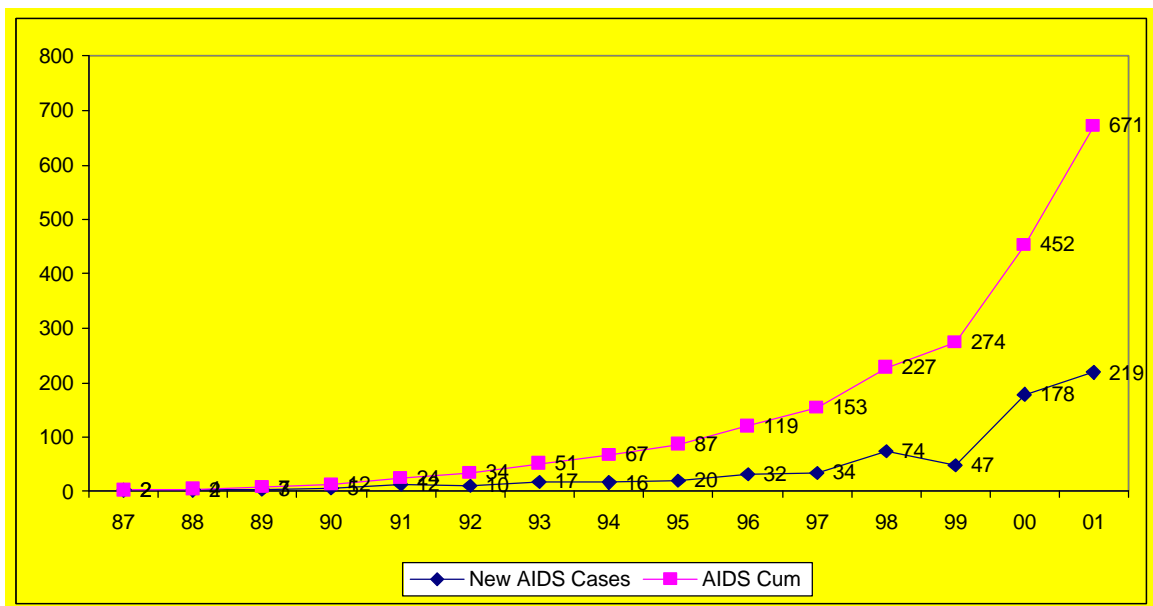
Women are at risk when they engage in unprotected sexual activity with their partners. The 1997 IDHS data indicate that condom use is very low (less than 1% in 1997). Women infected with STI face both health and social consequences, and so too their children. But STIs are often asymptomatic. Data, although incomplete, seem to indicate that the prevalence of chlamydia, gonorrhoea, trichomoniasis, and genital herpes may be higher than reported. On the other hand, existing information from CHCs are also incomplete (recording only numbers of syphilis and gonorrhoea cases) and cannot be used to estimate prevalence.

HIV/AIDS

Each month, the number of reported HIV/AIDS cases has been increasing and the trend of the epidemic growth is even more obvious. The numbers of HIV/AIDS cases are still relatively small, and they reflect only the tip of the epidemic ice-berg which is yet to be determined. Recent national estimates based on available data on the size of

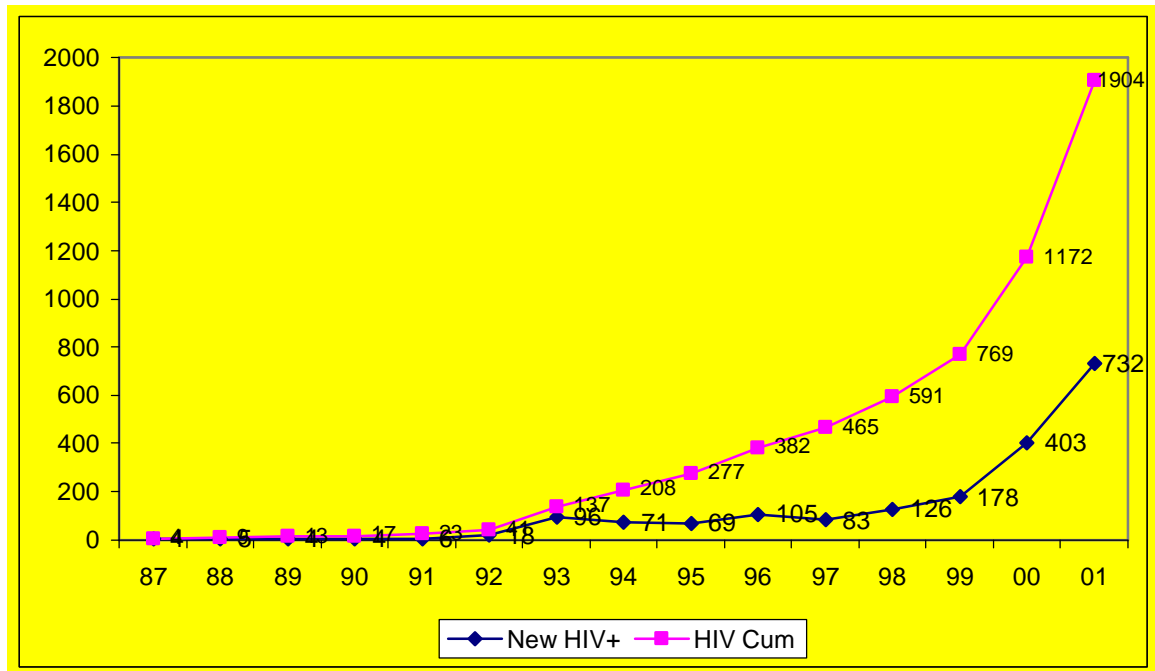
sex industry, indicate that there may be around 185,000-273,000 commercial sex workers currently active. Of these, around 8000 are estimated to have been infected by HIV. Since sex workers are able to cater to more than two guest per night, it was also estimated that the number of male clients of sex workers can reach between 6.6 – 9.6 million. Of these male clients, the estimated HIV infection was 32,000 individuals.⁹⁹ The national HIV/AIDS surveillance data indicate that, as of December 31, 2001, there were already 671 cumulative reported AIDS cases and 1904 reported HIV cases. Sharp increases occurred since 1998, and there was a dramatic jump of 219 new reported AIDS cases and 732 new reported HIV cases in 2001.

Cumulative and Reported AIDS Cases in Indonesia, 1987-2001



Source: DepKes Routine HIV/AIDS Case Reporting, January 2002

Cumulative and Reported HIV Cases in Indonesia, 1987-2001



Source: DepKes Routine HIV/AIDS Case Reporting, January 2002

A substantial proportion of these new HIV/AIDS cases (since 2000) were among the IVDUs. Of the 671 cumulative reported AIDS cases found in Indonesia up to December 2001, more than 50% were infected heterosexually, 13% were from homosexual transmission, and 21% were from intravenous drug users (IVDUs). Moreover, there were already 9 perinatal infections and 3 infections from blood transfusion (DepKes Routine HIV/AIDS Case Reporting, January 2002). In relation to the four provinces, as of December 31, 2001, the national reporting data indicated that there were 38 reported cumulative AIDS cases in West Java, one in NTT, one in West Kalimantan, and one in South Sumatra. West Java made up the 4th largest province with reported cumulative AIDS cases after Jakarta (264), Papua (218), East Java (63). Most of the infections were heterosexually transmitted. Infections through IVDU have recently grown alarmingly. Of the 140 cases infected through IVDUs reported in December 2001, 81% were found in Jakarta, and 9% in West Java.

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Notes

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- ³ Koblinsky, McLaurin, Brown, Gorbach, 1995.
- ⁴ GOI-UNICEF, 1995, MOH-PusdaKes, 1998.
- ⁵ BPS. 2003. *Statistics Indonesia*. Jakarta.
- ⁶ BPS-UNICEF. 2000. *Challenges for a new generation: situation of children and women in Indonesia, 2000*. Jakarta.
- ⁷ BPS-UNICEF 2000: *ibid.* cf. Annexes of indicators and trends.
- ⁸ Policies and guidelines are determined at the national level through the MOH, while program management is implemented at the provincial level through the Health Services. At the community level, operations are managed through the district health services.
- ⁹ Iskandar, M.B., S. Ilyanto, Y. Azwar, and N.G. Dharmaputra (1994:5), '*Facts and circumstances surrounding EPI service quality*', Executive summary, Paper presented at UNICEF, June 16, 1994, Center for Health Research University of Indonesia, Depok.
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- ¹² Cited in World Bank (1994:10), *Ibid.*
- ¹³ Iskandar et al. (1994), *Ibid.*
- ¹⁴ Tinker and Koblinsky (1993:10), *Ibid.*
- ¹⁵ Maine and Allman (1990:33), *Ibid.*
- ¹⁶ DepKes RI-Pusdakes (1998), *Profil Kesehatan Indonesia 1998*, Jakarta.
- ¹⁷ Iskandar et al. (1996), *Ibid.*
- ¹⁸ BPS-UNICEF (1995), *Maternal and Child Survival Development and Protection 1995-2000: Master Plan of Operations*, Jakarta.
- ¹⁹ The training topics on maternal and neonatal health include: Essential Obstetric and Neonatal Clinical Care; Life Saving Skills; Clinical Post-partum Care; and Post-partum Hemorrhage. The various topics on Family Planning Training includes: Infection Prevention on IUD and Implant Insertion. The training to improve skills in FP service delivery includes: Training on Implant and IUD Tsc 380A Insertion. While the topics on STI Training includes: STI Management using Syndromic Approach, Periodic Comprehensive STI Services for High Risk Women Group, and Standard Operating Procedure for STI case management.
- ²⁰ Including Physiology of Pregnancy, Delivery, Puerperium, and Newborn; Pregnancy with risk factors, complications during pregnancy, delivery and post-partum; surgical procedure in obstetrics, and Reproductive System diseases),
- ²¹ Covering Obstetric Management on Normal Pregnancy, Normal Delivery and Post-partum, Pregnancy and Delivery with Complications, and Obstetric Management on Post-partum Hemorrhage);
- ²² Including Obstetric Management of Menstrual Disturbances, Reproductive Tract Diseases, Breast Tumor, Reproductive Tract Tumor, Infertility and Management of Climacterium and Menopause);
- ²³ In 1994, a packet of new manuals for village midwives and new modules of life saving skills for midwives were produced. See Departemen Kesehatan Republik Indonesia (1994), '*Buku pegangan bidan di desa*' (contained 14 manuals), Direktorat Jenderal Pembinaan Kesehatan Masyarakat, Direktorat Bina Kesehatan Keluarga, Jakarta; Departemen Kesehatan Republik Indonesia (1994), '*Pedoman penanganan kegawat-daruratan obstetri dan neonatal*' (contained 10 modules), Direktorat Jenderal Pembinaan Kesehatan Masyarakat, Direktorat Bina Kesehatan Keluarga, Jakarta. (These modules were adapted from M.A. Marshall and S.T. Buffington, *Life Saving Skills for Midwives*).
- ²⁴ Gunawan, Nardho (1993), *Ibid.* A report from the field, however, showed that the practice was not always in line with the plan. For example, some village midwives in north Sumatra who had been posted for one year never received any financial supports for their accommodation and transportation (*Kompas*, 8 April 1995: 15). In remote villages in West Java, some village midwives reported that they had to provide extra outlay to cover their transportation expenses (*Kompas*, 24 Mei 1994).

- ²⁵ Departemen Kesehatan Republik Indonesia (1994), 'Pedoman penyelenggaraan penyegaran ketrampilan kegawat-daruratan obstetri dan neonatal bagi bidan tahun 1994/1995', Jakarta.
- ²⁵ Soemantri (2003), Ibid.
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- ²⁷ *Report of the National Commission for Women. 2002. Peta kekerasan, pengalaman perempuan Indonesia. Jakarta: Komnas Perempuan. Also in the report by GOI-UNICEF. 2000. Challenges for a new generation: the Situation of Children and Women in Indonesia, 2000. Jakarta: GOI-UNICEF.*
- ²⁸ BPS, 1999b:34.
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- ³⁰ Filmer et al., 1998.
- ³¹ The World Bank Report. 1998. Cited in GOI-UNICEF, 2000:11.
- ³² JHPIEGO-MNH, 1999.
- ³³ The Indonesian Minister of Health's statement on health budgeting (Kompas, 4 May, 1995:3).
- ³⁴ World Bank (1994:3), *Indonesia's health work force: issues and options*, Report No. 12835-IND, Population and Human Resource Division, Country Department III, East Asia and Pacific Regional Office, Washington.
- ³⁵ Departemen Kesehatan Republik Indonesia (1989), 'Panduan bidan tingkat desa', Bagian 2, Jakarta; Gunawan, Nardho (1993), 'Penempatan bidan di desa dan penelitian', Pertemuan Penelaahan Gerakan KB Nasional 1993/94 di Jakarta, 21 September 1993.
- ³⁶ It seems difficult to produce so many village midwives in a relatively short time. In West Java, for example, not only public, but also private hospitals are utilized to provide training for the procurement of new village midwives (Kompas, 13 November 1993). Such a quantitative orientation would be likely to compromise the training quality. In realizing the plan, a study by Pusat Penelitian Pranata Pembangunan (1993) showed that 4,000 new village midwives were produced in 1989/1990 and another 4,760 new village midwives were produced in 1990/1991.
- ³⁷ Gunawan (1993:1), Ibid.
- ³⁸ Cf. BPS-UNICEF (2000) Enad Decade Statistical Report. Jakarta.
- ³⁹ Cholil, Abdullah, Meiwita B. Iskandar, and Rosalia Sciortino (1998), *The Live Safer: The Mother Friendly Movement in Indonesia*, The State Ministry for the Role of Women and the Ford Foundation, Jakarta.
- ⁴⁰ Rosenfield, Allan and Deborah Maine (1985), 'Maternal mortality-a neglected tragedy: where is the M in MCH?', *Lancet*, 2, 8, 446:83-85.
- ⁴¹ Maine, D. and Allman (1990:34), 'The demography of maternal and child health in developing countries', in H.M. Wallace and K. Giri (eds.), *Health Care of Women and Children in Developing Countries*, Third Party Publishing Company, Oakland, pp. 26-35.
- ⁴² These issues, however, are regarded to contravene the Convention for the Rights of Child (CRC). Cf. GOI-UNICEF, 2000:154.
- ⁴³ WHO, 1998
- ⁴⁴ MOH, 1996.
- ⁴⁵ Op. cit. CBS, NFPCB, MOH, and MI, 1995:74; CBS, NFPCB, MOH, and MI, 1998:70.
- ⁴⁶ Surbakti, S. *Survei Seratus Desa*. Jakarta, BPS, 1999.
- ⁴⁷ Kollman, 1997.
- ⁴⁸ CHR-UI. Center for Health Research, University of Indonesia. 2002. *Results of Baseline Survey on Essential Reproductive Health Package in South Sumatra, West Java, West Kalimantan, and NTT*. Jakarta. CHR-UI-UNFPA.
- ⁴⁹ Setyowati and Utomo, 1999:36. The study was conducted by the Faculty of Public Health and West Java Health Office.
- ⁵⁰ BPS, DepKes and UNICEF, 1995:22.
- ⁵¹ Based on the survey with a total sample size of 30,000 households, as indicated by the result of a MOH data analysis conducted by Helen Keller International (HKI) and Diponegoro University.
- ⁵² HKI, October 1998:1.
- ⁵³ JPS and Airlangga, June 1999:3.
- ⁵⁴ Setyowati and Utomo, 1999:36.
- ⁵⁵ DepKes RI-Balitbangkes, 1997.
- ⁵⁶ DepNaKer RI et al., 1997:2-3.
- ⁵⁷ WHO categories for anemia: Mild = 10.0 to 10.9 gr/dl; Moderate = 7.0 to 9.9 gr/dl; Severe < 7.0 gr/dl.
- ⁵⁸ Depkes RI-Balitbangkes, 1997:48; CBS, NFPCB, MOH and MI, 1998:154.

- ⁵⁹ Faturochman, Hull and Dwiyanto, 1998:33-55.
- ⁶⁰ YLKI and Ford Foundation, 1997.
- ⁶¹ In Kollman, 1998
- ⁶² Habsari, 2003.
- ⁶³ Results of the survey on Indonesian women self-esteem. Aura and the Bodyshop Inc. Jakarta.
- ⁶⁴ Budiharsana et al. 2003:viii, *Female Circumcision in Indonesia: Extent, Implication, and Possible Interventions to Uphold Women's Health Rights*, Research Report, Population Council, Jakarta.
- ⁶⁵ Statement by Director Yayasan Kesehatan Perempuan, quoted in article 'Amandemen UU Kesehatan dan hak reproduksi perempuan', in Kompas 3 November 2003:41.
- ⁶⁶ WHO-SEARO. *Regional Health Report 1998: Focus on Women*. New Delhi: WHO-SEARO, 1998.
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- ⁷³ Lettenmaier et al., 1988:2.
- ⁷⁴ McCarthy, J. and D. Maine. 1992. 'A framework for analyzing the determinants of maternal mortality', *Studies in Family Planning*, 23, 1: 23-33.
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