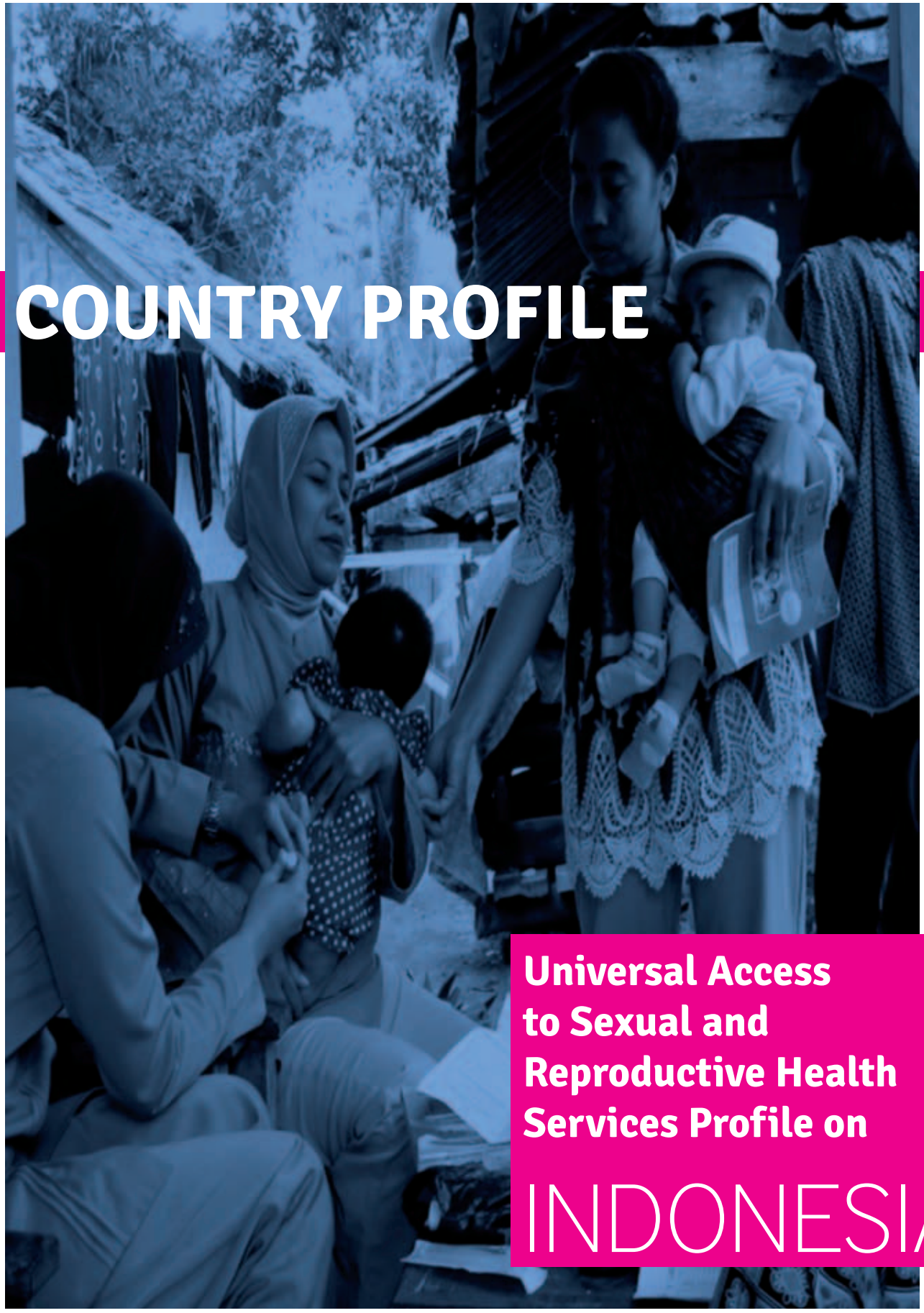


COUNTRY PROFILE

Universal Access to Sexual and Reproductive Health Services Profile on

INDONESIA

1. Introduction

Indonesia is an archipelago of approximately 17,000 islands, with a total population of 239 million people (2010 census).The country is home to about 1,340 ethnicities with different views on gender and sexuality issues and varying degrees of access to sexual and reproductive health and rights (SRHR), including relevant healthcare services. About 49.79% of the people live in urban areas, while 50.21% live in rural communities (Centre of Bureau Statistic website, 2014)(see Table 1).

Table 1.Population in Indonesia

Population	2010	2012
Total Population	239,871	249,866
Population density (per km)	126	131
Child dependency ratio	40	53
Old age dependency ratio	8	9
Proportion of youth (%)	18	20

Source: (Indonesia Demographic Health Survey [IDHS] 2012)

Decentralisation and Health Financing

Health financing is important, as this reflects government's financial resources development and allocation ratio on health systems. Health financing allocation helps to understand the level of government commitment to improve people's health.

In general, the overall health financing in Indonesia is complex. Public health service is financed by two types of budgets: government regular budgets and patients levy, paid by a combination of contributions from household/family, employers, and insurance payers (WHO, 2008a). Poor households or families often use less government public funds and public subsidies than rich households.

Indonesia's decentralisation of the government system, implemented in 2001, had huge implications to the health sector. Districts governments were granted the authority to allocate some of its budget and revenue to development sectors, including health. Funds were transferred directly to district governments that were highly expected to improve health systems. It was envisioned that at least 10% of the total district budget would be allocated to health. In the implementation, however, none of districts allocated the required 10%(WHO, 2008a). In 2004, the policy was revised and amended to include regulations to address gaps and barriers in the implementation of government decentralisation.

Indonesia's Total Health Expenditures

The health expenditure in Indonesia in 2005-2011 remained stagnant at less than 3% of the Gross Domestic Products (WHO, 2014). Overall, health spending is lower than it is stated in government regulation (Law No. 36/2009 on Health) which should be at least 5%.Around 60 to 70% of the health budget is allocated for government staff salary, and the remaining balance (30 to 40%) is for the program. Most of the program budget was allocated for providing curative services; only a small portion, about 10%, is allocated for prevention and promotion. This health spending pattern is against the health strategic program (*Indonesia Sehat*) introduced in 1998, which emphasised on promotion and prevention more than curative and rehabilitative services.

In 2006, government expenditure contributed 50.4% of the whole health budget, while private health sector expenditurescontributed49.6%. Providing almost half of the total health expenditures, the private health sector plays an important role in providing health services to the general population, including the poor (Chee, Borowitz, &Barraclough: 2009).

Chart 1. Share of Health Expenditure to Total National Budget and Gross Domestic Product

Source: (Dwicaksono & Setiawan, 2013)

A review of private sector expenditures on health shows out-of-pocket payments, including costs, make up the largest portion of private expenditures (66.3% in 2006), with a small part divested into private prepaid healthcare plans (9.7%), and the rest is spent by NGOs and private companies(WHO, 2008b). Out-of-pocket expenditure is the main source of revenue for pharmaceuticals on either volume

or value estimation. Pharmaceuticals account for approximately 50% of medical insurance costs (Chee, Borowitz, & Barraclough: 2009). This means 20% of the poor population receives less than 10% of total public health subsidies, compared to the richest quintile that absorbs almost 40%. In addition, there are serious regional and socioeconomic inequities in the health system, as people in rural areas and the urban poor have less access to the health system (WHO, 2008a; the World Bank, 2014).

Table 2.Health Expenditures

	1996	2003-2005	2011/2013
Total expenditure on health (THE) as % of GDP	1.9	2.2 (2003) 2.1 (2005) 2.2 (2006)	2.72 (2011) 2.8(2013)
General government expenditure on health (GGHE) as % of THE	41.9	42.0 (2003) 40.1 (2004) 46.7 (2005) 50.4 (2006)	36.1(2013)
Private health expenditure (PvtHE) as % of THE	58.1	58.0 (2003) 59.9 (2004) 53.3 (2005) 49.6 (2006)	49.1 (2011) 63.9(2013)
GGHE as % of GGE	4.3	4.8 (2003) 4.5 (2004) 5.1 (2005) 5.3 (2006)	7.75 (2011)
Social security funds as % of GGHE	9.3	4.8 (2003) 4.8 (2004) 20.7 (2005) 20.0 (2006)	
Out of pocket (OOP) health expenditure as % of THE			38.25 (2011)
OOP health expenditure as % of PvtHE	62.0	69.7 (2003) 69.2 (2004) 66.4 (2005) 66.0 (2006)	75.13 (2011) 75.8? (2013)

Source: (FPSB Indonesia, 2014; WHO, 2008b; WHO, 2013b)

Out-of-pocket expenditure is the main source of revenue for pharmaceuticals on either volume or value estimation. Pharmaceuticals account for approximately 50% of medical insurance costs (Chee, Borowitz, & Barraclough: 2009).

2. Status of Sexual and Reproductive Health Services

Contraception

The International Convention on Population and Development (ICPD) Programme of Action states that people have the right to satisfied and safe sex and to reproduce and have freedom to decide if, when, and how regular to do so. The ICDP Programme of Action reiterates the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice.[1]

In this section we discuss three key indicators:

- Total Fertility Rate (TFR), as an indicator of reproductive health status, i.e., high fertility rate (>5 births) represents high reproductive risk;
- Contraceptive Prevalence Rate (CPR), as a proxy measure to access reproductive health service, assuming there is a freedom to accept birth control and freedom to choose contraceptive use where male involvement is promoted via government family planning program; and
- Unmet Need for Contraception, as a proxy indicator to access reproductive health services.[2]

Total Fertility Rate

TFR declined from 2.9 (1994-1996) to 2.6 (in 2012). Trends show that fertility has declined modestly since 1994 and remains at 2.6 since 2003. TFR in rural areas (2.8births per woman) is higher compared to urban areas (2.4 births per woman). Education attainment contributes to declining TFR, as couples with higher educational attainment tend to preferto have less number of children (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Table 3.TFR, CPR, and Unmet Need for Contraception

Contraception	1994-96	2003-05	2012
TFR	2.9	2.6	2.6
CPR	54.7	60.3	61.9
Unmet need for contraception	15.3	13.2	11.4

Source: IDHS, 2012.

The findings ofa qualitative study conducted by *Rumah Kitab,* an NGO that works on religious issues, shows that contraception use is influenced by religious beliefs. People with strong Islamic beliefs tend to refuse modern contraception. Islamic Fundamentalist groups believe more children will get more blessings from God. They also believe that Islam will be stronger if every Muslim has as many children in their house (Rumah Kitab, 2013).

Contraceptive Prevalence Rate

Contraceptive prevalence is defined as the proportion of married women age 15-49 who are using family planning methods. Contraceptive prevalence rate (CPR) indicates women's access to contraceptives, and eventually, the success rate of family planning program implemented in the country.

According to Indonesia's Demographic Health Survey (IDHS 2012), CPR increased from 54.7% during 1994-1996, to 60.3% in 2003-2005.Yet, the CPR is about the same at 61.9% in 2012, when there are more married women who use modern contraceptives than traditional methods (58 percent and 4 percent, respectively). Injectables are the most commonly used method (32%), followed by pills (14%). The use of long-term methods such as intrauterine device (IUD) has declined significantly, from 13.3% in 1991 to 3.9% in 2012 (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

1 ICPD Programme of Action. Para 7.2.

2 See ARROW' An Advocate's Guide: http://www.arrow.org.my/publications/AdvocateGuide_Final_RN_Web.20131127.pdf.

Table 4. Use of Contraception

Method	1991	1994	1997	2002 /03	2007	2012
Any method	49.7	54.7	57.4	60.3	61.4	61.9
Pill	14.8	17.1	15.4	13.2	13.2	13.6
IUD	13.3	10.3	8.1	6.2	4.9	3.9
Injectables	11.7	15.2	21.1	27.8	31.8	31.9
Condom	0.8	0.9	0.7	0.9	1.3	1.8
Implants	3.1	4.9	6.0	4.3	2.8	3.3
Female sterilization	2.7	3.1	3.0	3.7	3.0	3.2
Male sterilization	0.6	0.7	0.4	0.4	0.2	0.2
Periodic abstinence	1.1	1.1	1.1	1.6	1.5	1.3
Withdrawal	0.7	0.8	0.8	1.5	2.1	2.3
Other	0.9	0.8	0.8	0.5	0.4	0.4
Number of women	**21,109**	**26,186**	**26,886**	**27,857**	**30,931**	**33,465**

Source: (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013)

From 1994 to 1997, the use of implants increased, mainly due to a successful campaign on long-term contraceptive methods, conducted in several districts where women were offered free IUD and implants by the government. In 2012, in some provinces (like Central Java), these kinds of campaigns were banned. Besides that, Law No. 29/2004 on Physician Practice stipulates that midwives are prohibited to insert IUD and implants (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

In fact, there is not much difference in contraceptive use by women in urban and rural areas at 62.1% and 61.6% respectively. Contraceptive use increases with educational level (67% of women with tertiary education; 55.8% with secondary education). Also, there is no difference between wealth quintiles. The difference in socioeconomic background does not significantly influence contraceptive use. (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Unmet Need for Contraception

Despite increasing CPR, unmet need for contraception remains, although this has been relatively declining. There is a direct correlation between unmet need level sand knowledge on availability of contraception and services among married women and girls. This is particularly high among poor women.

Amnesty International's 2010 research found that there are significant differences on accessing family planning information and services among women depending on marital status. Unmarried women are less likely to avail of family planning information and services because of a lack of knowledge and awareness. This relates to the requirement of husband's consent, birth control for married women, freedom of making decision by women to have children (Amnesty International, 2010).

IDHS 2007 and 2012 show that the total unmet need for contraception declined from 13% to 11.4%; 6.9% of whichis for birth control and 45% is for birth spacing. The total unmet need rises accordingly with age, peaking at 16% among married women age 45-49. Most of unmet need for contraception among women under 25 years is for birth spacing; while for 35 years and older is for birth control. The total percentage of unmet need also increases according to the number of children, as high as 21% among women with five or more children, implying that most of unmet need among women with three children and above is for birth control. The total unmet need for contraception is only slightly higher for rural than urban women (11.8%compare to10.9%), but does not vary greatly across educational categories (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Chart 2. Unmet Need for Contraception, 1991-2012

Source: (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013)

In 2007, the Government of Indonesia revitalised its family planning program, by allocating resources to strengthen services through capacity building of health personnel, improving the supply chain and logistics management, and improving family planning clinics. In addition, there are also efforts to improve the demand for family planning through advocacy attempts, behaviour change communication, and community mobilisation at the grassroots level.

NFPCB implemented the *KB Kencana* program to revitalise family planning activities, starting in North Sumatra, West Kalimantan, West Java, and East Nusa Tenggara. The program follows a comprehensive approach to develop innovative strategies at national and district levels. *KB Kencana* has been put in high priority of the government agenda to show seriousness in moving forward a national coordinated effort to revitalise the family planning program.

Systematic advocacies to influence high-level decision makers have led to the approval of a budget for the national family planning program similar with those of the previous tears. To counter reduced donor support, the government involved the private sector, which now contributes 73% to total family planning services.

Maternal Health

The ICPD Program of Action called for the promotion of women's health and safe motherhood by achieving a rapid and substantial reduction in maternal morbidity and mortality as well as in the number of deaths and morbidity from unsafe abortion.[3]

In this section we discuss about key indicators pertaining to women's health:

- Maternal mortality rate (MMR), which reflects safe birth delivery of women;
- Infant mortality rate (IMR), which reflects optimal maternal health, nutrition and care during delivery, and prenatal mortality rate (PMR), which is an indicator of both status of maternal health and nutrition and quality of obstetric care;
- Antenatal care coverage (ANC), as an indicator of women's access to healthcare services.
- Percentage of births attended by skilled birth attendants, which helps to understand the extent of government investments in developing human resources to ensure safe delivery and prevent maternal deaths; and
- Availability of basic emergency obstetric care (PONED) and comprehensive emergency obstetric care (PONEK) to ensure safe delivery and prevent maternal deaths.

3 ICPD Programme of Action.Para 8.20a.

Table 5.Maternal Health Situation

Maternal Health	1994-96	2003-05	2012
MMR	420	270	359
Perinatal Mortality Ratio		24	26
Infant Mortality Rate	44.9	31.4	32
Prop of birth attended by SBA	49.7	66.3	83
Availability of EmOC			
Basic (PONED)			1579
Comprehensive (PONEK)			378
Coverage of postpartum care			80
Antenatal Care coverage			
At least one visit	82.3	91.5	96.2
At least four visits	63.1	81	87.8

Sources: Statistics consolidated from WHO, 2000; IDHS, 2012; UN MDG Data, 2012; Kementerian Kesehatan RI, 2011; and SDKI, 2012.

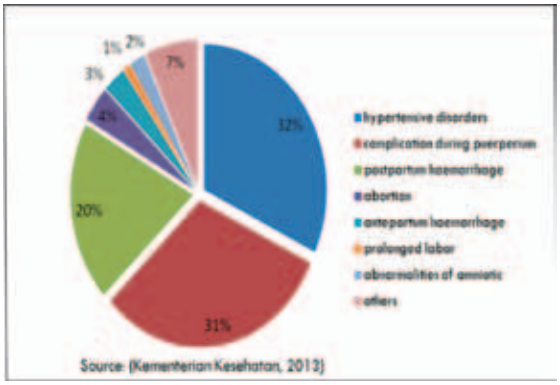
Maternal Mortality Ratio

MMR is also an indicator of a well-functioning healthcare system. MMR trends were in decline until 2007, but sharply increased in 2012 (from 228 in 2002 to 359 in 2012). The number of maternal deaths was highest in the age groups 25-29, 30-34, and 35-39 (Central Bureau of Statistics, NFPCB, MOH, & ICF-International, 2013).

This dramatic increase of MMR may have been due to a sampling error or wrong respondent selection, because the questionnaires about maternal death for IDHS 2007 when were only distributed to married women age 15-49; while IDHS 2012 covered all women age 15-49 (Central Bureau of Statistics, NFPCB, MOH, & ICF-International, 2013). In short, efforts have been made to improve maternal health, yet MMR remains stubbornly above 200 over the past decade (UNICEF-Issue Briefs, 2012).

Population Census2010 shows that 90% of maternal deaths occur during or immediately after delivery. The high percentage of MMR caused by haemorrhage has not changed in the last decade. Although the data shows that abortion only contributes to about 1% of maternal deaths, the real figure can be much higher, as high as 11%to 15%.This is because many cases of unsafe abortion from complications during delivery are recorded as infection and haemorrhage (Yuliandari, 2006; and Swaminathan, Matsumoto, & Nugent, 2010).

Chart 3.Major Causes of Maternal Deaths



Infant and Prenatal Mortality

Indonesia is doing much better in reducing infant- and under-five mortality. The 1990s showed steady progress in reducing under-five mortality rate, together with its components, infant mortality, and neonatal mortality rates. In recent years, however, the reduction of neonatal mortality appears to have stalled.

Table 6.Demographic and Information System

Under five population (2012)	24,622,394
Number of births (2012)	4,736,042
Birth registration coverage	53
Coverage of vital registration on causes of deaths	-

Sources: Statistics consolidated from UN, 2012 and WHO, 2013b.

Most of child deaths in Indonesia involve new-borns, i.e., babies in the first month of life. The probabilities of a child dying at different ages are 19 per thousand for the neonatal period; 15 from 2 to 11 months and 10 from age one to five years. As happens in other developing countries attaining middle income status, child mortality caused by infections and other childhood illnesses has declined, because of improvements in mothers' education level, household and environmental hygiene, income, and access to health services. Neonatal mortality is now the main hurdle in reducing further child deaths. Most causes of neonatal deaths are in fact preventable.

Table 7. Health Status Indicators

Stillbirth rate per 1,000 total births (2009)	15.0
Neonatal mortality rate per 1,000 live births(2012)	15.0
Number of neonatal deaths(2012)	72,437
Infant mortality rate per 1,000 live births (2012)	25.8
Number of under five deaths (2012)	124,977
Under-five mortality rate (2012)	31.0
Number of under-five deaths (2012)	151,605

Sources: Statistics consolidated from WHO, 2013b and UNICEF, WHO, World Bank, UN Pop Div., 2013.

Meanwhile, infant mortality in the years2008 to 2012 is at 32 deaths per 1,000 live births. This means one of thirty-two children born in Indonesia die before reaching their first birthday. About 60% of infant deaths occur at the age of 0 month, with neonatal mortality rate at19 deaths to 1,000. Some 80% of child deaths occur between the ages of 1 to 11 months, with post-neonatal mortality at13 deaths to 1,000(NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013). The three major causes of infant mortality are acute respiratory infections, perinatal complications, and diarrhoea (WHO, 2008a).

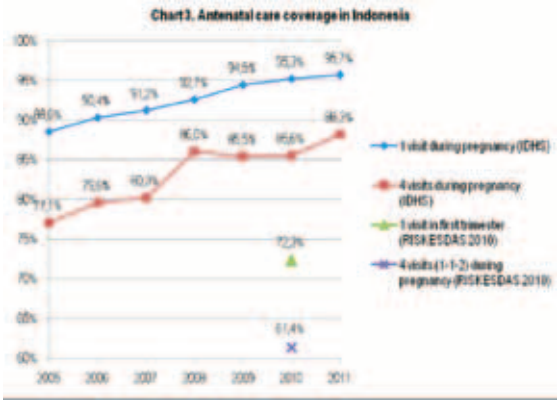
In 2012-2013, a new program has been initiated that aims to reduce under-five mortality, focused on the first 1000 days after birth, and involved scaling up of nutrition and immunisation programs.

Antenatal Care

Antenatal care coverage can become a good indicator of women's access to reproductive health services. In order to save mother and baby, four antenatal care visits should be arranged to provide a range of interventions. Over nine-tenths of pregnant women receive ANC from skilled medical personnel (doctor, nurse, or midwife), 88% from whom are recommended to have four or more visits. Women in urban areas prefer receive four or more ANCs than those in rural areas (93% and 83%, respectively) (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Though falling short of the 90% target set by the MoH, 83% of births are assisted by skilled medical personnel (doctor, nurse midwife, or village midwife). The percentage of women who delivered in health facilities improved from 46%in 2007to 63% in 2012 (IDHS, 2007 and 2012). While 97% percent of women in the wealthiest quintile delivered with skilled health personnel, only 57.5%of women in the poorest quintile obtained such assistance. The same data show that 44% of pregnant women are anaemic and face higher risk of preterm delivery, having babies of low birth weight, and still births (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Chart 4. Antenatal Care Coverage



The government of Indonesia launched JAMPERSAL (*Jaminan Persalinan*), an insurance program that provides free antenatal, delivery, and postnatal services to pregnant women. This scheme can be accessed without health insurance and free childcare for the new-born baby until 28 days, yet, maternal mortality reduction efforts remain a challenge (Directorate of Child Health, Ministry of Health, 2012 cited in Central Bureau of Statistics, NFPCB, MOH, & ICF-International, 2013).

Postnatal Care Coverage within 48 hours of Delivery by Skilled Birth Attendants

The IDHS 2012 shows that 80% of mothers receive postnatal care within the first two days of delivery. About 78% of mothers receive postnatal care from a skilled birth attendant. Only 2% of women received postnatal care from traditional birth attendants, which usually includes mothers with low educational attainment and mothers who had home delivery (7%).

The percentage of postnatal care during the first two days by mothers age 20-34 having first experience of delivery is higher than those having their second and third delivery, as second and third deliveries usually involve skilled birth attendants as do births by mothers living in urban areas. Mothers who have completed primary or higher education (45-58%) are more likely to receive postnatal care compared to mothers with no education (21%). About 58% of births in the highest quintile have postnatal examinations, compared to 35% in the lowest quintile (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013).

Availability of Emergency Obstetric Care (EmOC)

To address high MMR, the MoH released Decree No. 1457/Menkes/SK/X/2003, which establishes the minimum standards for maternal and child health (MCH) care. Indicators have also been formulated as goals that need to be achieved at the district and municipality level. Each district/municipality must provide at least four PONED(*Pelayanan Obstetri-Neonatal Emergensi Dasar,* i.e., Basic Obstetric and Neonatal Emergency Care) in the community health centres or *Puskesmas* (Rahman, 2007). In 2011, there were around 1,579 PONED Puskesmas; while the number of PONEK (*Pelayanan Obstetri-Neonatal Emergensi Komprehensif*, i.e., Comprehensive Obstetric and Neonatal Emergency Care) hospitals increased from 358 in 2010 to 378 in 2011. With the existence of PONED *Puskesmas*, it is expected maternal and newborncomplications during childbirth would decrease. In cases when complications of childbirth cannot be resolved at the PONED Puskesmas, mother or baby can be referred to PONEK Hospital (Kementerian Kesehatan RI, 2011).

However, majority of skilled birth attendants do not meet PONED compliance and PONEK standards. Only 20% of *Puskesmas* offer PONED and 80% of public hospitals offer irregular PONEK. There are only limited data reported on the availability of referral systems for emergency obstetric and neonatal care, particularly in rural areas (WHO, 2006). Moreover, about 65% of them do not have a blood transfusion unit and this means they do not comply with the requirements for basic caesarean surgery (Yuliandari, 2006).

Adolescent Sexual and Reproductive Health

The ICPD Programme of Action urges governments to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted infections including HIV/AIDS. It also calls for the reduction in adolescent pregnancies.

In 2005, Indonesia implemented an adolescent reproductive health (ARH) program, focused on giving information and counselling for adolescents on reproductive health issues. Recently, the program was integrated in the family planning program. Today, ARH is part of a national reproductive health policy and strategy, which covers communication, counselling and provision of services. Adolescent-friendly reproductive health services are being implemented through the Youth-Friendly Health Care program in a few centres on a pilot basis and introduced in a limited number of communities.

In this section, we look at indicators that reflect the status of adolescent SRHR in Indonesia:

- Adolescent birth rate and
- Availability of adolescent SRH services.

Adolescent Birth Rate

Increasing teenage pregnancy has driven NGOs to provide reproductive health information and services to young people. In collaboration with the IPPA (the family planning association) and NFPCB, the UNFPA supports production of educational materials to reach parents, policymakers, and community leaders. An examination of the education materials reflect a conservative position in addressing issues related to adolescent SRH.

There has been an increase in the age of first marriage over the past two decades, with women with higher education marrying at later ages. In 2002-03, the median age of marriage has increased from 17 to 20 years (NFPCB, Central Bureau of Statistics, MOH, & ICF-International, 2013). The percentage of women age 15 to 19 years who begin childbearing increased from 9% in 2007 to10% in 2012(WHO, 2006; Central Bureau of Statistics, NFPCB, MOH, & ICF-International, 2013). Marriage at a young age is still relatively occurring, especially in rural and slums areas. A study conducted in 2009 found that there were 690,000 marriages involving children (under the age of 18), sometimes as young as 13. Despite of their young age, many of them had their first child shortly after being married. Early childbearing varies from province to province (Amnesty International, 2010).

The adolescent birth rate (ABR), per 1000 women declined from 64.2 in 1995 to 48.0 in 2010.Marriage at an early age often leads to early childbearing, increasing health risk of both mother and new-born. When childbearing is postponed, health outcomes for both women and their new-borns tend to be better. The government (through the BKKBN) conducted a campaign against early marriage for both women and men, recommending a minimum marriage age of 21 years for women and 24 for men. This policy contradicts CEDAW which requires equal rights for women and men (WHO, 2006).

Availability of Adolescent SRH Services

Adolescents and young people's access to comprehensive sexuality education and youth-friendly SRHR services are hindered by strong religious and cultural norms that believe in marriage, family formation, and childbearing as common values that need to be publicly promoted. SRHR services for unmarried people is generally discouraged and not provided. This goes against the government ratification of various international conventions to provide SRHR services for all citizens. Even reproductive health education is regarded as "sensitive" (Utomo, Mc Donald, Anna Reimondos, & Utomo, 2012).

Knowledge of adolescents about reproductive health and sexuality is low. Less than a half of adolescents know about the human reproductive process and less than 30% know about HIV/AIDS prevention (WHO, 2006). There have also been continuous debates about the need for comprehensive sexuality education and safe sex knowledge in school. Parents and religious leaders do agree with such education in schools(Utomo, McDonald, Anna Reimondos, & Utomo, 2012).

Evidence shows that unmarried adolescents are unable to access reproductive health services. Although some clinics provide these services, young women at the age 15-19 report to have more problems in accessing healthcare than older women. Around 38.3% of women ages 15-19 reported having difficulties accessing healthcare (2003) for the following reasons:

- **Costs** of services;
- **Fear** of stigma from family and friends;
- **Waiting times** for services and results;
- **Lack of privacy** and confidentiality;
- Traditional **norms of gender inequality**;
- **Taboo** surrounding unmarried women accessing sexual and reproductive health services.

Many of these barriers particularly affect girls and young women living in rural areas (IPPF; UNFPA; and the Global Coalition on Women and AIDS, 2009).

The Law No. 52/2009 on Population and Family Welfare states that government family planning and reproductive health services are provided only for married women (Utomo, Mc Donald, Anna Reimondos, & Utomo, 2012). Information on reproductive health and family planning are only provided to married couples, which is why knowledge of contraception among young women is poor. The Adolescent reproductive health program for unmarried young people age 10-24 years emphasise on moral issues and promotes abstinence (WHO, 2006).

Since unmarried women and girls are discriminated by the law, this has caused regulation and practice to limit unmarried women's to access contraceptive information and services. They are at high risk of unwanted pregnancies, sexually transmitted diseases, and human rights abuses. For example, unmarried adolescents who are pregnant are often forced to stop schooling. They are not accepted socially, leading them to decide to, or are often forced to, get married. Else, they may seek abortion, despite its accompanying health risk, including serious health problems and even death (Amnesty International, 2010).

Indonesian Mothers Survive Childbirth More Often with Support from Husbands, Community, Faith-based Groups

When Siti Aminah started bleeding profusely during the birth of her second child, she did not become another grim statistic in a country where about two women die each hour as a result of pregnancy and childbirth. Instead Siti was rushed to the health facility by her husband and family in a village ambulance where she received blood donated by her neighbours and friends.

A comprehensive five-year safe motherhood programme involving the U.S. Agency for International Development (USAID), the Indonesian government, the World Health Organization, the National Family Planning Coordinating Board, and several non-governmental organisations led to the coordinated response that saved Siti's life. The Maternal and Neonatal Health (MNH) Program is made up of several public awareness campaigns, including Suami Siaga (alert husband), Bidan Siaga (alert midwife) and Desa Siaga (alert village).

JHPIEGO, an affiliate of Johns Hopkins University, and Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programmes (CCP) help implement the programme in Indonesia. According to CCP researchers, a midline survey found that 60 percent of women exposed to the Bidan Siaga campaign recommended the use of a midwife to others in their community.

Suami Siaga began in 1998 to get husbands more involved in pregnancy and delivery to ensure the safety of the mother. DesaS iaga focuses on how to get the entire community more involved in safe motherhood. Siti Aminah lives in a Desa Siaga and her alert community responded appropriately during her crisis. Bidan Siaga was launched in 2002 to promote the use of midwives and their skills. The concept of shared responsibility for healthy mothers is the foundation of the USAID-supported MNH programme in Indonesia.

"We believe it does indeed 'take a village' to make sure mothers survive to raise their children," said Donna Vivio, JHPIEGO's Deputy Director of the MNH Programme. "The MNH Programme has been remarkably successful in engaging everyone in the village, from the husbands to faith-based groups."

Indonesia is a predominately Muslim society and Muslim organisations played a key role in increasing acceptance of the Siaga campaigns.

The MNH programme takes place primarily in two provinces, West Java and Banten, which have a combined population of 42 million. Suami Siaga, Bidan Siaga, and Desa Siaga use radio, television, print materials, special events, and training programmes to reach Indonesian families and communities with the concept of being alert for emergencies during childbirth.

At the community level, individual citizens are encouraged to help arrange for transport to the hospital, provide funds, donate blood, and recognise danger signs. Husbands are taught to prepare for the delivery and potential complications, while midwives are trained to know when to send women to health facilities.

The 2003 Demographic and Health Survey for Indonesia reported a drop in the maternal mortality ratio to 309/100,000 births from 390/100,000 reported in 1994.

Source: Gianelli, Leslie. 2004. *Indonesian mothers survive childbirth more often with support from husbands, community, faith-based groups.* Retrieved from: www.jhpiego.org/media/releases/nr20040505.htmI.

HIV/AIDS

The prevalence of HIV among different population and the number of cases among people living with HIV or AIDS indicates to the status of sexual health in the population.[4] In this section, we look at indicators

- HIV prevalence and obstacles, and
- Availability of services for HIV and AIDS.

HIV Prevalence and Burden

According to UNICEF, every 25 minutes one person is newly infected of HIV and one out of five of those newly infected is below 25 years of age. The MoH projection shows that without acceleration of HIV prevention programmes, over half a million people will become HIV positive by 2014. This epidemic is primarily caused by sexual transmission and drug injecting drug (UNICEF Indonesia, 2012).

Initially, the transmission of HIV/AIDS was mainly due to injection by drug users. After few years, the main transmission mode shifted to sexual transmission. In 2012,HIV/AIDS is primarily transmitted through hunsafe sex, at 77.4%. Based on the estimates by the MoH, at least 3.3million men buy sex, 80% of whom were reluctant to use condoms. This has made women vulnerable, with about2.2millionwomen get married to men who buy sex (Lampost.com, 2013).

In 2011, 18%of young people ages 15 to 24 were reported to be newly infected with HIV. Young people make up around 30% of the most at risk population, where HIV prevalence is dominant. According to 2011 estimates, prevalence rates of IDUs is at 36%, 22% of them are transgender or *waria*, 10% are female sex workers, and 8.5% are men who have sex with men (UNICEF Indonesia, 2012).

Availability of Services for HIV/AIDS

Voluntary and confidential testing (VCT) services of HIV/AIDS have increased throughout the country. However, knowledge about service availability is limited. In 2010, only 6% of the population older than 15 years knew about VCT services. This proportion is the same for women and men, at4% in rural areas. People in the higher wealth quintiles were better informed on both VCT services and HIV prevention. In December 2011, the MoH reported 500 active VCT sites in 33 provinces, an increase from 156 VCT sites in 27 provinces in 2009. Confidentiality issues and fear of stigma and discrimination has been hindrance to increase VCT (UNICEF Indonesia, 2012).

The National AIDS Commission highlights difficulties faced by children infected by HIV/AIDS. Their access to education and health services is limited by stigma and discrimination issues and their family's financial difficulties due to the illness, besides taking care of the sick parent. The estimated number of infected children increased from 1,070 in 2008 to 1,590 in 2014 (UNICEF Indonesia, 2012). Among 33, 114 people living with HIV who received antiretroviral until March 2013, 96% were adults(31,682 people) and4% were children (1,432 people). The use of the regimen was 95.4% (31 589 people) are the first liners and 4.6% (1,525 persons) are the second liners(MoH RI, 2013b).

Antiretroviral therapy has been fully subsidised by the government for people living with HIV, although it is not always available in all areas. Healthcare services for people living with HIV are scarce, but there are few NGOs that provide such services, such as telephone hotlines for the general population(including young people) to get information and advice on HIV/AIDS and other sexual and reproductive health issues.

Chart 5.Population with HIV/AIDS

In Indonesia, National PMTCT guidelines were adapted in 2005. Every pregnant woman is offered testing, particularly in areas infected by epidemics. The testing is conducted for VCT and PMTCT in mother and child clinics. Yet, the proportion of pregnant women who get tested and HIV-positive persons receiving antiretroviral therapy are very low. Less than 1% of pregnant women were tested HIV in 2008. In 2011, only 15.7% of pregnant women living with AIDS received ARV to reduce mother-to-child transmission. It is still unclear why majority of HIV-positive pregnant women do not receive treatment. Possible factors include fear of stigma and leakage of confidentiality; lack of support from the husband, family and community; poor quality of services at first contact,

4 Joint United Nations Programme on HIV/AIDS. (2012). Global Report: UNAIDS Report on the Global AIDS epidemic: 2012. [Geneva]: UNAIDS. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf.

and unsympathetic health providers(UNICEF Indonesia, 2012).

The availability and access to condoms is still an issue, although condom use in Indonesia has more than doubled from 2006. Two Laws, the Population and Family Development Law (No. 52/2009) and the Health Law (No. 36/2009), stipulate that SRHR services are provided only to married couples. This makes it difficult for unmarried people to access contraception or family planning services from government clinics. However, condoms can easily be obtained from nearby markets, but not in remote areas (UNICEF Indonesia, 2012).

Fear, stigma, and discrimination against people living with HIV still pose formidable barriers. Families and children living with HIV/AIDS are subject to stigma and discrimination, which translates to reduced access to services, loss of dignity, and a greater degree of poverty and deprivation. In Tanah Papua, only 20.2%of young people in school and 15% of out-of-school youth had acceptable attitudes towards people living with HIV. Fear among people creates resistance to HIV testing, embarrassment about seeking treatment, and in some cases, reluctance to receive information. All these make it difficult to control the epidemic.

Availability of Sexual and Reproductive Health Services at Different Levels of Care

Indonesia has 33 provinces and each province is divided into districts and each district into sub-districts. Since the government's decentralisation, 349 districts and 91 municipalities are now the key administrative units. Each sub-district has at least one health centre headed by a medical doctor, usually supported by two or three sub-centre clinics, the majority of which are headed by a nurse(Amnesty International, 2010).

SRH services are available at the primary care to the secondary level hospital (district hospital) and tertiary care level (provincial hospital). However, the services are not always accessible for every person, especially unmarried women and girls. Midwives, government staff, and doctors do not provide reproductive health services for unmarried women and girls, including contraception and family planning (Amnesty International, 2010). Although health workers do not directly refer to the law (Population and Family Welfare Law No. 52/2009), they explained that family planning provisions are only intended for married couples. District health officers and other government officials also confirmed that contraception and family planning services are intended solely for married people in accordance with laws and policies.

The establishment of adolescent-friendly services in Indonesia is still in its pilot phase and not yet implemented throughout the country. Adolescent SRH information and services at national and provincial levels appear to be either lacking or inadequate. There is no quality standard for youth centres, training of peer educators and peer counsellors, or acceptance of minimum substantial content. The primary focus of information and counselling for adolescents tends to emphasise morality and promote abstinence. The content of information, education, and communication materials and counselling are not adequate to address adolescents SRH and young people's sexuality issues(WHO, 2006).

Access to health services is considered adequate, although there are shortages in numbers, distribution of health workers and professionals may be further improved. With more than 8,000 public health centres (1 for every 23,000 people), a broad outreach system, and more than 1,250 public and private hospitals, access to services is available to all people except in remote areas. However, infrastructure quality, functionality, and availability of equipment and SRH commodity supplies are often key problems. The country in general suffers from lack of general practitioners (39 per 100,000 people), specialist doctors (10.5 per 100,000 people), and nurses (158 per 100,000 people) (FPSB Indonesia, 2014), particularly in rural and remote areas (World Bank, 2008). Not only are there too few doctors and specialists, they are also very inequitably distributed across Indonesia.

3. Recommendations

Contraception

- Eliminate gaps of access to quality contraceptive services for all, with focus on population groups, including the lowest wealth quintiles, adolescents, and in remote and under-served areas.
- Strengthen contraceptive commodity security system to prevent running out of stock, especially in the context of universal health coverage implemented in 2014.
- Revitalise the community staff of family planning and involve more religious institutions.

Maternal Mortality

- Improve availability of quality maternal health services. This includes high standard pre-service training for doctors and midwives, recruitment, placement, clear job description and guidance/ supervision of all health personnel, minimum standards for health facilities and accessible referral systems according to local needs and situation.
- Enact regulation on the implementation of the Health Law No. 36/2009 to protect health providers who perform abortion services for those rape cases, including marital rape which is recognized in Law No. 23/2004 on the Elimination of Domestic Violence. Abortions are a significant contributor to maternal deaths in Indonesia, although the exact figures are not known. Abortion is allowed until six weeks for rape cases.
- Monitor maternal health package included in the universal health coverage (National Health Insurance Scheme) introduced January 2014.
- Strengthening EmOC, including human resources and funding should be identified.
- Review quality of services at institutions, including death audits for each maternal death.

Adolescents and Young People's Sexual and Reproductive Health

- Amend the Marriage Law No. 10/1974 to revise the minimum age at marriage for both women and men.
- Support empowering activities for adolescent and young people SRHR in order to prevent risky behaviour, infection by HIV, and/or teenage pregnancies.
- Include comprehensive sexuality education programmes in all school curricula, in both state-owned schools and private or religion-based schools.
- Strengthen commitment and promote participation of young people at all levels of programme and policy development, implementation, and monitoring and evaluation

HIV/AIDS

- Ensure that every HIV positive person has access to healthcare and services without any discrimination on the basis of their HIV status.
- Ensure access to affordable, gender-sensitive range of SRH services for all individuals without stigma and discrimination, upholding individuals' rights to privacy and confidentiality of services provided.
- Provide access to safe abortion and post-abortion care services for women and young girls in need.
- Enact legislations addressing violence and all forms of harmful practices against women and young girls and ensure the strict implementation of respective legislations.
- Evaluate, strengthen, and scale up current efforts to integrate SRH and HIV services.
- Improve access to quality services for pregnant women with HIV, and efforts should be made to reduce the stigma and discrimination faced in accessing life-saving emergency services for these women.
- Establish comprehensive and rights-based integrated response to HIV, where discrimination and stigma are reduced and service providers recognise the rights of people living with HIV/AIDS.

Availability of Sexual and Reproductive Health Services

- Increase health financing to ensure availability of resources for health, especially SRH services and continue advocacy with all stakeholders in both public and private sectors to gradually increase public financing to at least 5% from national state budgets.
- Ensure access to SRH counselling and information and services for all adolescents. Comprehensive sexuality education curricula both in and out of school should be institutionalised. Age limits affecting children set by different legislations to ensure that they conform to the principles and provisions of international conventions should be reviewed.

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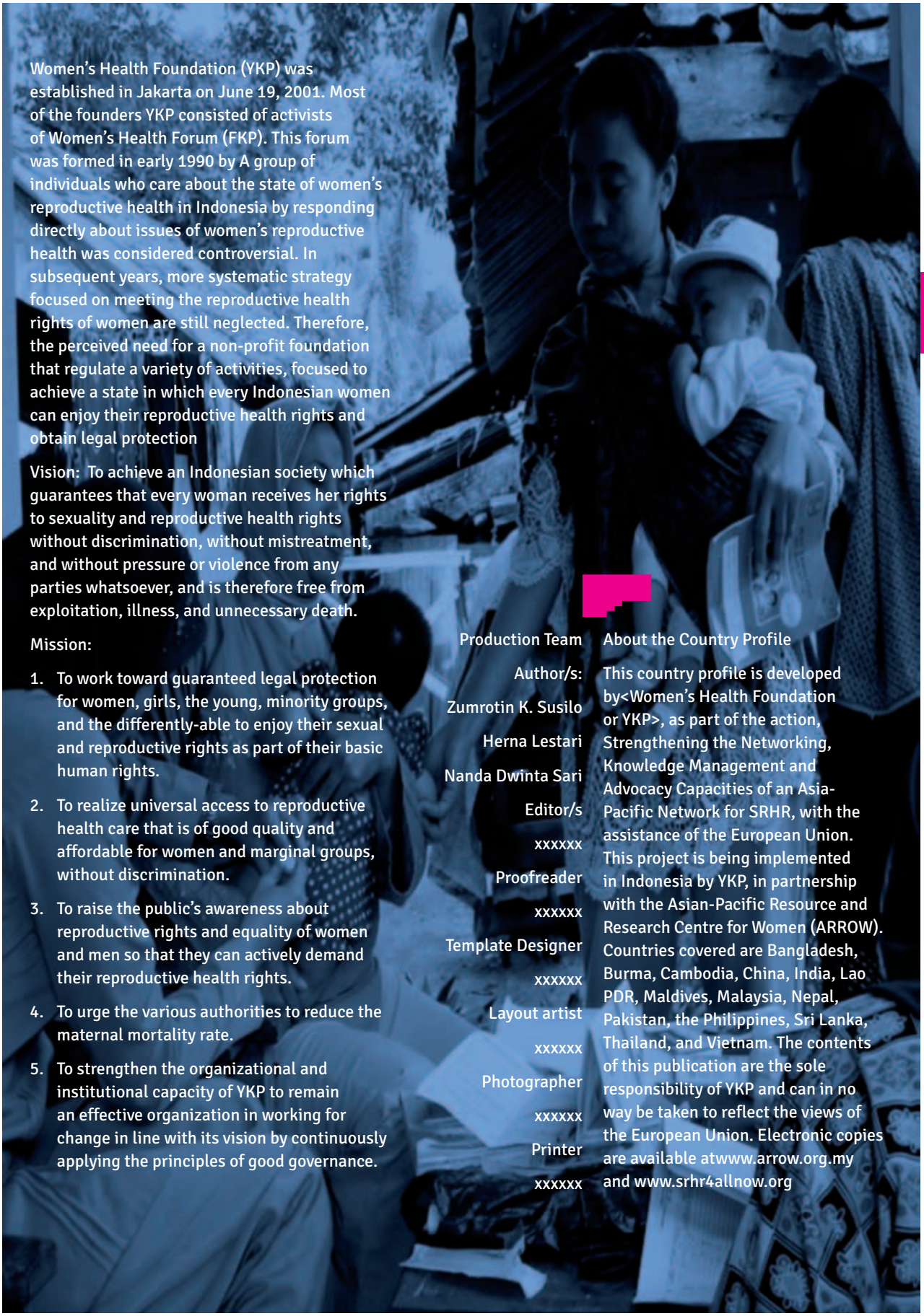

Women's Health Foundation (YKP) was established in Jakarta on June 19, 2001. Most of the founders YKP consisted of activists of Women's Health Forum (FKP). This forum was formed in early 1990 by A group of individuals who care about the state of women's reproductive health in Indonesia by responding directly about issues of women's reproductive health was considered controversial. In subsequent years, more systematic strategy focused on meeting the reproductive health rights of women are still neglected. Therefore, the perceived need for a non-profit foundation that regulate a variety of activities, focused to achieve a state in which every Indonesian women can enjoy their reproductive health rights and obtain legal protection

Vision: To achieve an Indonesian society which guarantees that every woman receives her rights to sexuality and reproductive health rights without discrimination, without mistreatment, and without pressure or violence from any parties whatsoever, and is therefore free from exploitation, illness, and unnecessary death.

Mission:

1. To work toward guaranteed legal protection for women, girls, the young, minority groups, and the differently-able to enjoy their sexual and reproductive rights as part of their basic human rights.
2. To realize universal access to reproductive health care that is of good quality and affordable for women and marginal groups, without discrimination.
3. To raise the public's awareness about reproductive rights and equality of women and men so that they can actively demand their reproductive health rights.
4. To urge the various authorities to reduce the maternal mortality rate.
5. To strengthen the organizational and institutional capacity of YKP to remain an effective organization in working for change in line with its vision by continuously applying the principles of good governance.

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About the Country Profile

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