

## Indonesia

### Stakeholder Report on Indonesia - Submission by World Vision Indonesia For Universal Periodic Review, 13<sup>th</sup> session, 2012

#### Child and Maternal Health and Nutrition

##### A) Scope of International Obligations

Concerning child and maternal health and nutrition, Indonesia ratified the Convention on the Rights of the Child in 1990, and acceded to the Convention on Economic, Social and Cultural Rights in 2006. Furthermore, Indonesia made the following commitment to the Every Woman, Every Child strategy of the UN Secretary-General:

"Indonesia will ensure all deliveries will be performed by skilled birth attendants by 2015. This universal access intervention is aimed at reducing the maternal mortality ratio from 228 per 100.000 live births in 2007 to 102 per 100.000 live births in 2015. In 2011, at least one and a half (1.5) million deliveries by poor women will be fully funded by the government. Central Government funding for health in 2011 will increase by USD 556 million compared to 2010. This fund will be available to support professional health personnel and to achieve quality health care and services in 552 hospitals, 8,898 health centres and 52,000 village health posts throughout Indonesia."<sup>ii</sup>

##### B) Constitutional and legislative Framework

Law No. 23 of the year 2002 on Child Protection, Article 44-47 outlines the child's basic right to health

##### C) Right to an adequate standard of living

###### I. Health Budget and Spending

The World Health Organisation recommends that States allocate 15% of the National Budget to the health sector. At present, Law No. 36/2009 on Health in Indonesia requires that District authorities allocate a minimum 10% of their district budget for Health.

Although the amounts of money allocated to the Health Function Budget in Indonesia have continuously increased, the actual percentage of the National Budget for health spending has decreased from 2.02 % in 2008, to 1.7 % in 2010. Despite Law 36/2009, a study carried out by FITRA (Forum Indonesia untuk

Transparansi Anggaran; Indonesia Forum for Budget Transparency) in 2010-2011 revealed that the average health budget was only 9% of total district budget, and that most of the budget is allocated for treatment rather than prevention of health concerns.

The biggest allocation of the health budget has been for public health insurance (Jaminan Kesehatan Masyarakat “Jamkesmas”), and for maternity insurance (Jampersal). Starting in 2010, Jampersal supports poor mothers to give birth with no charges, in government facilities or the lowest class of private facilities, and in 2011, this supported the births of 4.5 million children. Additional funds have supported family planning for Jampersal clients.

Measures have also been taken through the implementation of a procurement electronic system, to increase the accountability of health expenses, which has saved an estimated 20 million USD.

Since 2010, the Government of Indonesia has provided Health Operational Assistance (Bantuan Operasional Kesehatan) for more than 8000 Community Health Centres for maternal and child health, nutrition and communicable diseases.

### **Recommendations:**

- The Central and Regional Governments should allocate a minimum health budget of 5% from the National Revenues and Expenditures Budget and 10% of the Province Revenues and Expenditures Budget outside salaries, as mandated in Article 171 of Law No.36/2009 concerning Health. In particular, budget must be allocated to those interventions for which there is evidence of a reduction of maternal and child mortality and increase of maternal and child nutrition.

## **II. Maternal & Child Health**

The Indonesia Demographic and Health Survey of 2007 <sup>ii</sup>stated that the maternal mortality rate reached 228 deaths per 100,000 live births. Even though this rate has indicated a decrease compared to earlier years, the maternal health condition in Indonesia has not reached an adequate level. The situation for children’s health is of similar concern. Based on data from the same survey, the mortality rate of under-five children has significantly decreased compared with the rate in 1997, from 69 to 44 deaths per 1000 live births. However, this implies there are still more than 190,000 under-five children dying every year. Haemorrhage, eclampsia and infection are the direct causes of maternal deaths. In addition, premature births, pneumonia, and diarrhoea are the main causes of the under-five deaths.

The Health Equity Study<sup>iii</sup> found that the wider gap of infant and under-five mortality rates occurred in Nusa Tenggara, Moluccas and Papua group of islands, and the wider gap of neonatal mortality rates occurred in Kalimantan and Nusa Tenggara, Moluccas and Papua group of islands. As the neonatal mortality rate relates more to the quality of health services, particularly the health workers and health facilities, this situation relates to the lack of adequate distribution of qualified health workers to those groups of islands.

However, the same study indicated that the neonatal mortality rates in urban area are continuously higher than the rates in rural areas. Further study is needed to find the root-causes of this situation, as health services are more readily available in urban than in rural areas

The National Basic Health Research (RISKESDAS) of 2007<sup>iv</sup> indicates that only 55.4% of the babies in Indonesia are born in health facilities. These numbers vary from 8.7% in the Southeast Sulawesi Province, to 94.4% in DKI Jakarta Province – the capital of Indonesia, and 94.5% (DI Yogyakarta Province). The Health Equity Study<sup>v</sup> indicated that the percentage of babies being born in health facilities differs significantly from those in the lowest socio-economic status bracket (between 10-15%) to those in the highest socio-economic status bracket (more than 80%).

The extent to which births are assisted by healthcare workers varies widely. The RISKESDAS research<sup>vi</sup> indicates that 82.2% of births are assisted at the national level, however this varies widely from as little as 26.2% in the North Moluccas Province, to 98.6% in DI Yogyakarta Province.

The Women Research Institute (2008)<sup>vii</sup> found that the distance from the delivering woman's household to the closest Community Health Center was sometimes more than 25 kilometers, and that not all villages have mid-wives. Nationally, the total number of midwives is close to the ideal ratio of 1:1000, but the lack of equitable distribution means that most midwives have to support more than one village. Since the 1990s, a Government regulation entitled "Basic Emergency Obstetric and Newborn Care (BEmONC), requires that at a minimum, birth delivery should take place in the Community Health Centers, and that there should be a minimum of 4 BEmONC Community Health Centres and 1 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) Hospital per 1 district. However, as of November 2011, only 1330 Community Health Centers have actively run BEmONC, representing just 66% of the target (1998 BEmONC).

The RISKESDAS research<sup>viii</sup> indicates that at the national level, the rate of neonatal visits are inadequate – only 31.3% receive the necessary minimum 3 visits. These figures vary from 4.3% in West Sulawesi Province, to 53.9% in DI Yogyakarta Province. The same research indicates that at the national level, only 53.8% of children aged 12-23 months receive full Immunization, varying from 29.2% in Papua Province, to 91.3% in DI Yogyakarta Province.

### **Recommendations:**

- The Government should ensure the implementation of high quality, safe and accessible antenatal, neonatal and under-five health services in remote areas, including during the emergency response.
- The Government must ensure the provision and addition of the number of high quality health workers at the village level.
- The Government must provide comprehensive, compulsory, safe and affordable immunization for every baby and child.

### **III. Breast Feeding**

The Law on Health No. 36 of 2009 stipulates that every infant has the right to receive exclusive breastfeeding (practice of feeding only breast-milk) from birth until the age of six months, except when it is impossible due to medical needs. However, only 15.3% infants under five months of age in Indonesia receive exclusive breastfeeding<sup>ix</sup>. This reality is troubling, considering the benefits of breastfeeding for children's life survival, growth and development.

There are a variety of factors that contribute to the low rate of breastfeeding in Indonesia. Often, traditional practices discourage good breastfeeding behaviour, where a lack of awareness about the advantages of breastfeeding enables these traditional practices to continue. As well, there are many marketing tactics that promote the use of formula milk over breastfeeding, although these violate existing regulations, including the WHO International Code of Marketing of Breast-Milk Substitutes (1981).

#### **Recommendations:**

- The Government should ensure compliance with the Article 83 of Law 13/2003 concerning Manpower, and Article 200 of Law 36/2009 concerning Health, and enact a Government Regulation on exclusive breastfeeding, to support the provision of exclusive breastfeeding, except upon a medical indication, to continue breastfeeding accompanied with supplementary food until the children reach two years of age at a minimum.
- The WHO International Code of Marketing of Breast-Milk Substitutes should be implemented, and central and local governments should develop policies to support breastfeeding and to control milk formula marketing.
- Central and local governments should develop strategies to protect, promote, and support breastfeeding, including the monitoring and evaluation of breastfeeding practices, and integrate breastfeeding policies into wider health and development policies
- Central and local governments should allocate more funds for training to enhance the skills of health- workers and community cadres to protect, promote, and support breastfeeding mothers. Local community self-help groups and community leaders should be involved in developing and promoting culturally-sensitive communication strategies regarding the need for breastfeeding, form breastfeeding mother support groups, and develop strategies to eliminate any hindrances to breastfeeding.
- Central and local governments should develop a policy and allocate funds to increase community participation in an effort to ensure the provision of good nutrition for mothers and families.
- Central and local governments should ensure that every mother has access to information and family planning services in order to continue breastfeeding and to increase spacing between pregnancies.

- Breastfeeding mothers must be given time and provided with facilities for breastfeeding at workplaces and public facilities.

#### **IV. Maternal and Child Nutrition, and Food Security**

The child nutrition situation in Indonesia, as measured by underweight (weight/age), has improved significantly in recent years. In 1989 the prevalence was 31%, whereas the latest data from RISKESDAS 2010 indicates that it is now reduced to 17.9%. The MDG target of 18.5% underweight children, a 50% reduction from 1989, was achieved in 2007.

In contrast, child under-nutrition as measured by child stunting (height/age) and wasting (weight/height) remains a significant problem. Stunting results from poor maternal health and an inadequate diet. Currently every village has the authority to establish their own village regulations around food security. These mostly reflect the different food taboos of ethnic groups, which sometimes limit an appropriate diet.

Infectious diseases such as malaria, diarrhoea and tuberculosis are other causes of stunting, which is particularly serious for Indonesia which ranks third on the list of 22 high-tuberculosis countries in the world. In 2010 the RISKESDAS found that 35.6% of all under-five children in Indonesia were stunted using the new WHO growth standard as a reference. East Nusa Tenggara is the province with the highest prevalence of stunting in Indonesia with 58.4%.

Wasting rates are also high. A prevalence of over 15% wasting is considered an emergency situation with requirements for supplementary feeding programmes. In 2010, the national rate of wasting was 13.3%, which had decreased from 13.6% in 2007. Nine of Indonesia's 33 provinces have a wasting prevalence above 15%. Moreover, in 2010, 6.0% of children were severely wasted, which puts them at high risk of death. This rate had decreased from 6.2% in 2007.

#### **Recommendations:**

- The Government must complete the Provincial Action Plan for Nutrition and Food Security in 2011, as mandated by the National Action Plan and Mid-Term Development Planning Plan Document, to be the Road Map for the improvement in nutrition
- There must be increased coordination amongst cross-sectoral stakeholders, so the malnutrition is not limited to health sector but also becomes the responsibility of agriculture, education, village empowerment, women empowerment, social affairs and increased engagement of NGOs.
- The Government should increase community empowerment programs, particularly those which empower women, to ensure food security and local food management.
- National standards to bring harmony to the Village regulations about appropriate food should be introduced which would ensure that a standard balanced diet could be achieved, whilst reflecting traditional and cultural concerns around food.
- The Government must increase the budget at Central, Provincial, District/Municipal levels to ensure the right interventions are in place for maternal and child nutrition.

- More political space must be provided for community participation and the engagement of community leaders
- Local Government officials should be provided with training to improve their ability to budget adequately.

## **V. Strengthening an Integrated Health Service**

The RISKESDAS research of 2010 indicated that the village integrated health post (Posyandu) was the place which most used for the weighing of children under five (80.6%) and for the provision of immunization (55.8%). About 93.3% of U5 children were weighed, and 80.6% were weighed at this post. However, the utilization of the Posyandu has evidently not been optimised since there are only 27.3% of households in Indonesia utilizing it. The reasons were the incomplete services as the Posyandu mostly operates once a month only for growth monitoring, and the far distance people have to travel.

In 2007 the Minister of Home Affairs established an Operational Working Group to provide monitoring and supervision for the Posyandu at National, Provincial, District/Municipal and Sub District level and the establishment of Working Group to provide monitoring and supervision for Posyandu at the Village level. But only few District/Municipal that has established this Working Group, and most Provincial Working Groups just have the structure without a clear program.

### **Recommendations:**

- The village integrated health post should become the nearest health facility for the community to obtain basic services for check-up or improvement of the health and nutritional status of mothers and children.
- The Central and Provincial Governments, must endorse suitable policies and allocate sufficient resources in order to continue building the community health posts, both in quantity and quality, and to support the holistic village integrated health centre revitalization program reaching to all parts of the villages.
- The Heads of Provinces must provide appreciation to the mainly voluntary village integrated health post workers who deal with increased amounts of work, including administrative work. Although some financial support is provided, it is recommended that additional benefits such as medical insurance, certificates of appreciation from the local government, and regular capacity building is provided. They should be provided with continuous trainings on basic health services in order to enhance their knowledge and skills. The active involvement of the community must be sought to support the village integrated health post revitalization program.
- Cross-sectoral plans of the Ministry of Health, Education and Social must be realised to promote the creation of synergy between the village integrated health posts, early childhood education, development of health of children under-five, and reproductive health.

- The Posyandu Guideline of 2006 and Minister of Home Affairs Regulation No.19/2011 which provide for a “Full” Integrated Health Service at the village and national levels, should be fully implemented. The integration of health services, prioritising family planning, maternal and child health, nutrition, immunization, and preventing and controlling diarrhea, should be considered a priority for the overall improvement of health especially of women and children.
- The Government should embark on a public awareness campaign about maternal and child health, including information about the benefits of the village integrated health post, involving all sectors of Indonesian society.

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<sup>i</sup> <http://everywomaneverychild.org/commitments/governments>

<sup>ii</sup> Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. 2008. *Indonesia Demographic and Health Survey 2007*. Calverton, Maryland, USA: BPS and Macro International.

<sup>iii</sup> UNICEF 2011

<sup>iv</sup> National Basic Health Research (RISKESDAS) [www.litbang.depkes.go.id](http://www.litbang.depkes.go.id)

<sup>v</sup> Supra note iii

<sup>vi</sup> Supra note iv

<sup>vii</sup> The Women Research Institute (2008) [http://wri.or.id/id/publikasi/Penerbitan%20Buku?q=id/publikasi\\_buku/](http://wri.or.id/id/publikasi/Penerbitan%20Buku?q=id/publikasi_buku/)  
Target MDGs Menurunkan Angka Kematian Ibu

<sup>viii</sup> Supra note iv

<sup>ix</sup> National Basic Health Research, (RISKESDAS) 2010