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REPRODUCTIVE HEALTH *at a* GLANCE

INDONESIA

May 2011

Country Context

Despite infrastructural setbacks resulting from recent natural disasters, Indonesia has continued to make strides in education, literacy and health goals. Mortality for men and women has decreased and life expectancy has increased. Between 1971 and 2007, the literacy rate increased from 61 percent to 93 percent overall. The government established a policy in 2001 to involve men in the health care of their wives and children. Men are expected to be involved in making decisions relating to family planning, antenatal care, preparation for delivery, and children's immunization and nutrition.[1] Poverty levels remain high, however, as 29 percent of the population subsists on less than US $1.25 per day.[2]

Indonesia's large share of youth population (27 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession and the country's exposure to high volatility in commodity prices.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3]

In Indonesia, the literacy rate among females ages 15 and above is 89 percent. Approximately equal numbers of girls are enrolled in secondary schools compared to boys with a ratio of female to male secondary enrollment of 99 percent.[2] Over half of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Indonesia ranks 94 of 157 countries in the Gender-related Development Index.[4]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Indonesia: MDG 5 Status

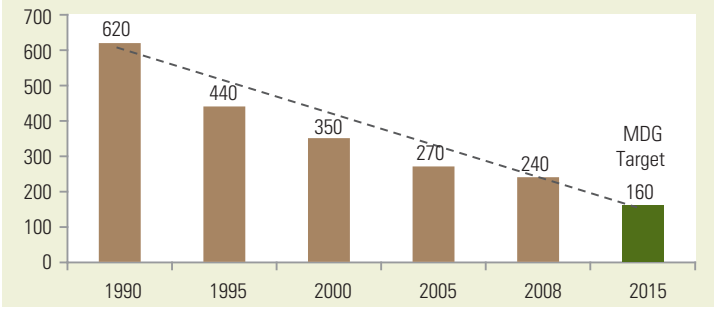
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	240
Births attended by skilled health personnel (percent)	73.0
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	61.4
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	39.2
Antenatal care with health personnel (percent)	93.3
Unmet need for family planning (percent)	9.1

Source: Table compiled from multiple sources.
[a] The 2007 DHS estimate is 228.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Indonesia has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Indonesia

The Bank's new ***Country Assistance Strategy*** Progress Report under preparation (P123200) was approved by the Bank's executive Board on February 24, 2011.

Current Project:
P113341 ID-Health Professional Education Quality ($77.82m)

Pipeline Projects:
P124364 ID-Jamkesmas Refinancing Appraisal date 5/11/2011
P122774 ID-Additional Financing for HPEQ Project Appraisal date 5/9/2011

Previous Health Project:
P073772 ID-Health Workforce & Services (PHP 3)

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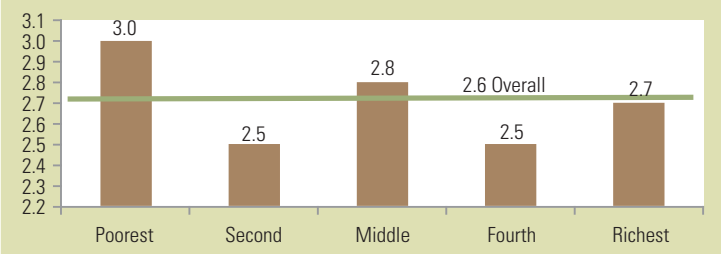
Key Challenges

Fertility

Fertility has been declining over time but remains slightly higher among the poorest. Total fertility rate (TFR) decreased from 3.0 births per woman in 1991 to 2.6 births per woman in 2002-03 but has since stalled with a TFR of 2.6 in 2007.[1] Fertility is 3.0 among the poorest Indonesians and 2.5–2.8 births per woman among the other wealth quintiles (Figure 2). TFR is slightly lower for urban dwellers (2.3) than for rural-dwelling women (2.8).[1]

Figure 2 ▪ Total fertility rate by wealth quintile

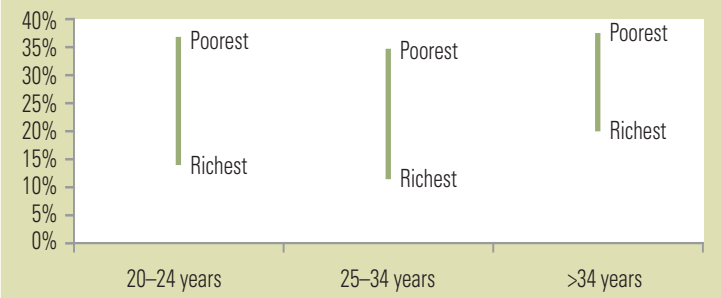


Source: DHS Final Report, Indonesia 2007.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 6] In Indonesia, adolescent fertility rate is moderate at 39.2 reported births per 1,000 women aged 15–19 years.

Early childbearing is more prevalent among the poor. While 37 percent of the poorest 20–24 years old women have had a child before reaching 18, only 14 percent of their richer counterparts did (Figure 3).

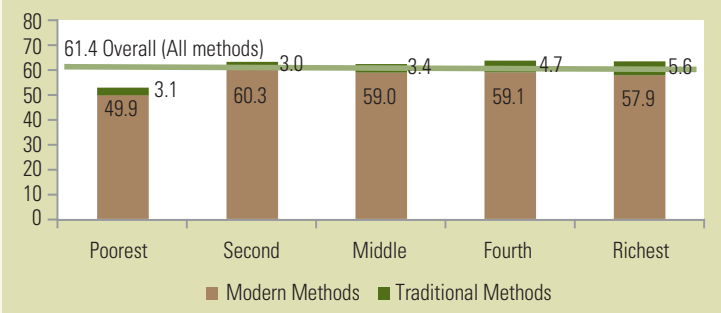
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: DHS Final Report, Indonesia 2007 (author's calculation).

Use of modern contraception is increasing. Current use of contraception among married women was 61 percent in 2007, an increase from 57 percent in 1997 and 50 percent in 1991.[1] More married women use modern contraceptive methods than traditional methods (57 percent and 4 percent, respectively). Injectables are the most commonly used method (32 percent), followed by the pill (13 percent). Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 58 percent among women in the wealthiest quintile and 50 percent among those in the poorest quintile (Figure 4).[1] Similarly, just 40 percent of women with no education use modern contraception as compared to 58 percent of women with secondary education or higher. Rural and urban dwellers have similar usage of modern contraception, at 57 and 58 percent, respectively.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Indonesia 2007.

Unmet need for contraception is moderate at 9.1 percent[1] indicating that women may not be achieving their desired family size.[7]

Approximately 760,000 births (17 percent) are unwanted or mistimed, illustrating an unmet need for contraception. In Southeast Asia, it is estimated that there are 130 hospitalizations for every 1,000 women having an unsafe abortion.[8]

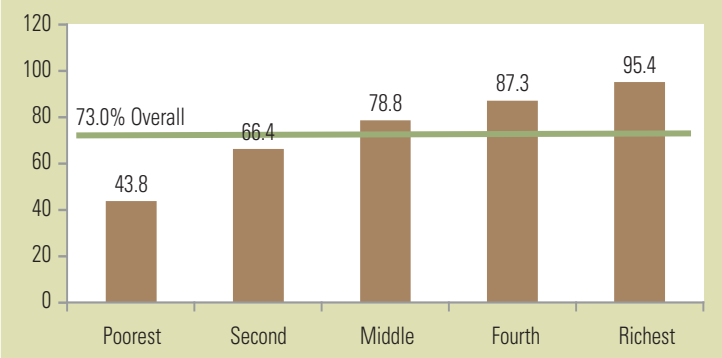
Fear of side effects or health concerns are the predominant reasons women do not intend to use modern contraceptives in future, not including fertility related reasons (such as menopause and infecundity). Twelve percent not intending to use contraception cited fear of side effects as the main reason and ten percent cited health concerns. Five percent expressed opposition to use, primarily by their husband/partner or by themselves.[1] Cost (2.5 percent) and access (0.4 percent) are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While the majority of pregnant women use antenatal care, institutional deliveries are less common. Over nine-tenths of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife) with 82 percent having the recommended four or more antenatal visits.[1] A smaller proportion, 73 percent deliver with the assistance of skilled medical

personnel (doctor, nurse midwife, or village midwife). The proportion of women who deliver at health facilities is lower at 46 percent. While 95 percent of women in the wealthiest quintile delivered with skilled health personnel, only 44 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 44 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9]

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: DHS Final Report, Indonesia 2007.

Among all women ages 15–49 years who had given birth, 70 percent received post-natal care from a skilled birth attendant within two days of delivery, but 17 percent received no postnatal care within 6 weeks of delivery.[1]

One quarter of ever-married women report that getting money needed for treatment was a big problem in accessing health care (Table 1).[1] Fifteen percent of women report that distance to the facility was a big problem in accessing health care.

Human resources for maternal health are limited with only 0.1 physicians per 1,000 population and 0.82 nurses and midwives per 1,000 population.[2] Most midwives do not have the requisite skills for basic emergency obstetric care. Further, there are relatively few obstetricians and anesthesiologists.

Table 1. ▪ Barriers in accessing health care (women aged 15–49)

Reason	%
At least one problem accessing health care	40.9
Getting money needed for treatment	25.1
Distance to health facility	15.3
Having to take transport	13.3
Not wanting to go alone	12.1
Concern no female provider available	10.6
Knowing where to go for treatment	5.4
Getting permission to go for treatment	4.2

Source: DHS final report, Indonesia 2007.

HIV prevalence is low in Indonesia and knowledge of transmission and risk reduction is poor but increasing

HIV prevalence is low in Indonesia at 0.2 percent of the population ages 15–49 years.[2] Of all adults aged 15 years and over with HIV, only one fifth are female.

Knowledge of HIV prevention methods is increasing slightly. 36 percent of Indonesian women and 49 percent of men know that condoms can help reduce risk of transmission. Further, knowledge of mother-to-child transmission through breastfeeding has increased from 34 percent of females and 46 percent of males in 2002–03, to 40 percent of females and 48 percent of males in 2007.[1]

Technical Notes

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated

National policies and strategies that have influenced reproductive health

Indonesia is lagging behind neighboring countries in the implementation of policies that support access to RH. The laws relating to RH, the Population and Family Law (N. 52/2009) and the Health Law (N. 36/2009) stipulate that only married women have access to family planning and contraception; excluding both adolescent and unmarried women from RH services, places them at greater risk of unwanted pregnancies and sexually transmitted infections.

The health Law 36/2009 prohibits abortion and considers induced abortion a crime, except to protect the life of the mother and the infant, and in the event of rape.

The Indonesian Health Insurance Program for the Poor and near-poor, Jamkesmas, has been providing financial coverage for a number of RH services– for family planning, antenatal care, skilled-birth attendance, care for normal and complicated deliveries, and postnatal care—since 2008.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing maternal mortality

- To reduce maternal mortality there are two key focus area on which it is critical to act: improving access to maternal health services, both physical and financial, and improving demand for quality maternal care.
- Increase overall funding for maternal health and ensure timely and sufficient availability of resources at the local government level for locally specific maternal health interventions;
- Increase the geographic coverage and community understanding of health insurance including the eligibility criteria, and enhance the benefit package to promote utilization of facility based delivery;
- Improve the quality of referral system of obstetric and neonatal complications by (i) improving the quality of birth delivery and management of emergency cases by the midwives, (ii) establishing locally appropriate provider referral networks and (iii) improving quality of care at referral hospitals including by increasing the supply of obstetricians and anesthesiologists in underserved areas;
- Revitalize family planning and address unmet needs including those of unmarried single women;
- Improve maternal and neonatal death surveillance system and its use for policy development and decision making at all administrative levels;

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.

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INDONESIA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births/woman ages 15–49)	2007	2.6	Population, total (million)	2008	227.3
Adolescent fertility rate (births/1,000 women ages 15–19)	2008	39.2	Population growth (annual %)	2008	1.2
Contraceptive prevalence (% of married women ages 15–49)	2007	61.4	Population ages 0–14 (% of total)	2008	27.4
Unmet need for contraceptives (%)	2007	9.1	Population ages 15–64 (% of total)	2008	66.8
Median age at first birth (years) from DHS		—	Population ages 65 and above (% of total)	2008	5.9
Median age at marriage (years)	2007	19.8	Age dependency ratio (% of working-age population)	2008	49.8
Mean ideal number of children for all women		—	Urban population (% of total)	2008	51.5
Antenatal care with health /sonnel (%)	2007	93.3	Mean size of households	2007	4
Births attended by skilled health /sonnel (%)	2007	73.0	GNI/capita, Atlas method (current US$)	2008	1880
Proportion of pregnant women with hemoglobin <110 g/L)	2008	44.3	GDP/capita (current US$)	2008	2246
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	620	GDP growth (annual %)	2008	6.1
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	440	Population living below US$1.25/day	2007	29.4
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	350	Labor force participation rate, female (% of female population ages 15–64)	2008	53.3
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	270	Literacy rate, adult female (% of females ages 15 and above)	2006	88.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	240	Total enrollment, primary (% net)	2008	98.7
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	160	Ratio of female to male primary enrollment (%)	2008	97.3
Infant mortality rate (per 1,000 live births)	2008	30.7	Ratio of female to male secondary enrollment (%)	2008	99.2
Newborns protected against tetanus (%)	2008	79	Gender Development Index (GDI)	2008	94
DPT3 immunization coverage (% by age 1)	2008	77	Health expenditure, total (% of GDP)	2007	2.2
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	<1	Health expenditure, public (% of GDP)	2007	54.5
Prevalence of HIV (% of population ages 15–49)	2007	0.2	Health expenditure/capita (current US$)	2007	41.8
Female adults with HIV (% of population ages 15+ with HIV)	2007	20	Physicians (per 1,000 population)	2003	0.1
Prevalence of HIV, female (% ages 15–24)	2007	0.1	Nurses and midwives (per 1,000 population)	2003	0.82

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2007	3.0	2.5	2.8	2.5	2.7	2.6	0.3	1.1
Current use of contraception (Modern method)	DHS	2007	49.9	60.3	59.0	59.1	57.9	57.4	–8.0	0.9
Current use of contraception (Any method)	DHS	2007	53.0	63.3	62.4	63.8	63.5	61.4	–10.5	0.8
Unmet need for family planning (Total)	DHS	2007	12.8	8.6	8.9	7.3	8.2	9.1	4.6	1.6
Births attended by skilled health personnel (percent)	DHS	2007	43.8	66.4	78.8	87.3	95.4	73.0	–51.6	0.5

Development partners support for reproductive health in Indonesia

UNFPA: Reproductive health and rights, family planning and gender.

UNICEF: Child protection; under-5 mortality

USAID: Maternal and neonatal care; promotion of facility based delivery, strengthening response to complications.

AUSAID: Health systems strengthening; qualities of care, emergency obstetric care.