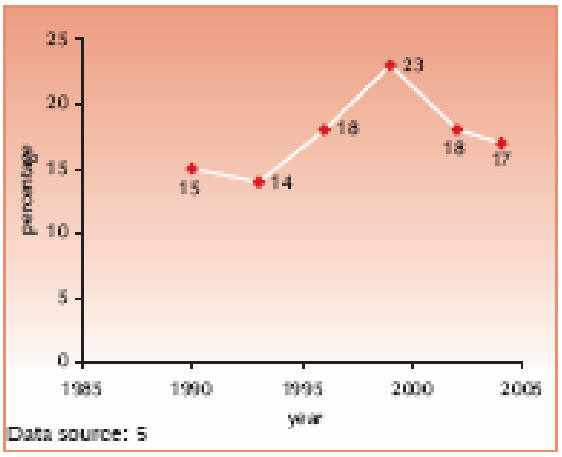
LAMPIRAN 1: Profil Kesehatan Indonesia

Indonesia

Basic information	Latest available value	Year	Source
Total population (million)	222.05	2006	{6}
Area (sq.km.)	1,860,360		{1}
Area as percent of world's total	1.37		{2}
Density of population (per sq.km.)	116	2005	{1}
Administrative divisions	33 provinces, 349 regencies and 91 municipalities		
Development	**Latest available value**	**Year**	**Source**
Gross national income (GNI) per capita (US$)	1280	2005	{4}
Highest in the world (GNI) – Norway	59590	2005	{4}
Highest in the Region – Thailand (GNI)	2750	2005	{4}
Population below poverty line – Intl.$1 per day (%)	7	2002	{5}
Lowest in the Region – Maldives	<1	2004	
Population below national poverty line (%)	17	2004	{6}
Lowest in the Region – Maldives	8	2004	
Adult literacy rate >15 years (%)	91	2004	{7}
Highest in the Region – DPR Korea	100	2005	
Net enrolment ratio – primary (%)	93	2002	{5}
Highest in the Region – DPR Korea	100	2005	
Human Development Index	0.711	2004	{8}
Highest in the Region – Thailand	0.784	2004	
Human Poverty Index (%)	18.5	2006	{8}
Lowest in the Region – Thailand	9.3	2006	
Gender-Related Development Index	0.704	2006	{8}
Highest in the Region – Thailand	0.781	2006	

Percentage of population below national poverty line



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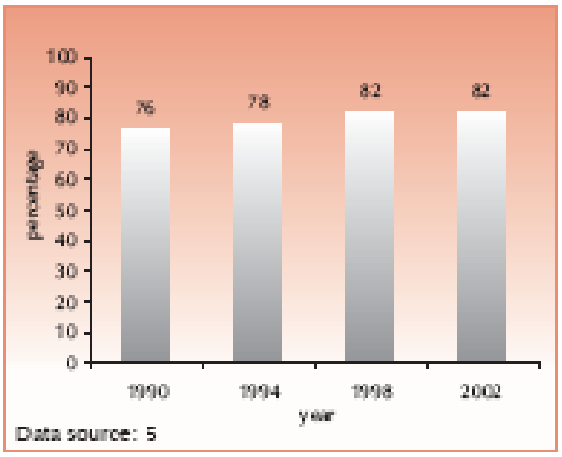
Percentage of pupils starting grade 1 who reached grade 5



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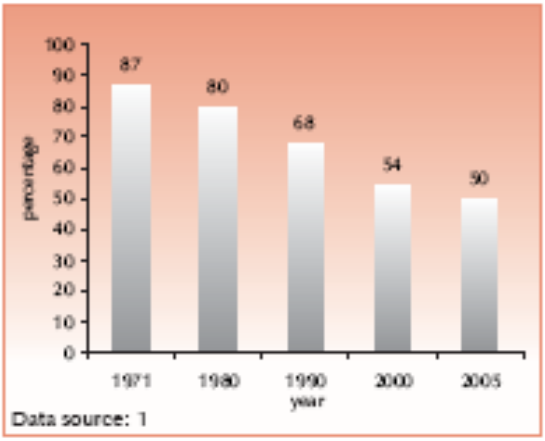
Salient basics

- Indonesia is a densely populated country with nearly 17000 islands.
- Percentage of the population below the poverty line increased in the 1990s. It has shown a decline recently.
- The Human Development Index at more than 0.7 is better than in many other countries of the Region.

Q1 What are the basic demographic features?

Indicators	Latest available value	Year	Source
Population			
Total population (million)	222.05	2006	{6}
Percentage of world's total	3.4	2006	{C}
Population growth rate per year (%)	1.34	2000-2005	{1}
Urban population (%)	48	2005	{1}
Age-sex structure			
Sex ratio (F/1000M)	994	2000	{9}
Children <15 years (%)	28	2005	{1}
Elderly >60 years (%)	7.5	2005	{1}
Highest in the world – Italy, Japan	26	2005	{10}
Highest in the Region – DPR Korea	12	2002	
Dependency ratio (<15 and 65+) (%)	50	2005	{1}
Fertility			
Birth rate (per 1000 population)	19.5	2005	{6}
Lowest in the world – Germany, Ukraine	8.0	2004	{11}
Lowest in the Region – Thailand	12.7	2002	
Total fertility rate (TFR) (per woman)	2.2	2005	{6}
Lowest in the world – Ukraine	1.1	2004	{12}
Lowest in the Region – Thailand	1.6	2000	
Contraceptive prevalence among married women of age 15-49 years – ever used (%)	74	2005	{1}
Gross mortaility			
Crude death rate (per 1000 population)	6.6	2005	{6}
Lowest in the world – UAE	1.0	2004	{11}
Lowest in the Region – Maldives	3.0	2005	

Dependency ratio



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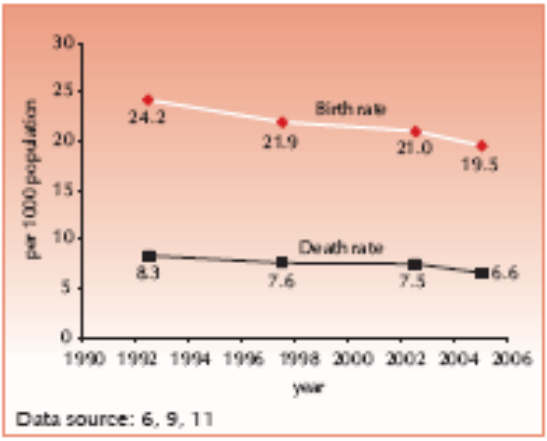
Birth and death rates



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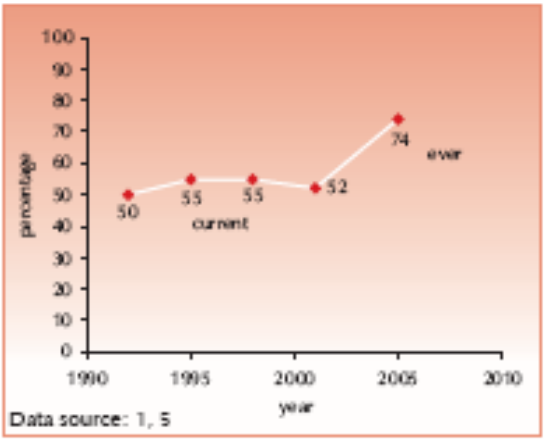
Contraceptive prevalence in 15-49 years women



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Salient demographic features

- Indonesia is more urbanized than some other countries in the Region.
- The dependency ratio is showing a steep decline as the population <15 years declined from 44% in 1971 to 28% in 2005. There is bulging population in the age-group 15-64 years.
- The net reproduction rate was close to 1 (1.03) in 2005.

What is the progress regarding some health-related MDGs?

Indicators	1990	2000	2005	2015 (Target)
Poverty and hunger				
Population below minimum level of dietary energy consumption (%)	70	74 (1999)	65 (2002)	35
Under-weight (<-2SD) children (%)	38 (1990)	25	28 (2003)	18
Child mortality				
Infant mortality rate (per 1000 live births)	68 (1990)	46 (1997)	32	23
Under-five mortality rate (per 1000 live births)	97 (1990)	58 (1997)	46 (2002)	32
One year olds immunized against measles (%)	45 (1997)	60 (1997)	77 (2004)	>90
Maternal health				
Maternal mortality ratio (per 100,000 live births)	390 (1990)	307 (2000)	N/A	≈100
Deliveries attended by health staff (%)	41 (1990)	67	72 (2004)	85
HIV/Malaria/Tuberculosis				
HIV prevalence in 15-49 years (per 100,000 population)	N/A	93	149	
Malaria incidence (per 100,000 population at risk)	N/A	850 (2001)	N/A	
Tuberculosis prevalence (per 100,000 population)	443	786 (1998)	262	
Tuberculosis detection rate under DOTS (%)	N/A	19	29 (2005)	
Water and sanitation				
Population with access to improved water source (%)				
Combined	69	76	88	86
Rural	N/A	N/A	87 (2004)	
Urban	N/A	N/A	89 (2004)	
Population with access to improved sanitation (%)				
Combined	54	66	78 (2004)	77
Rural	19 (1990)	52	69 (2004)	
Urban	58 (1990)	77	90 (2004)	

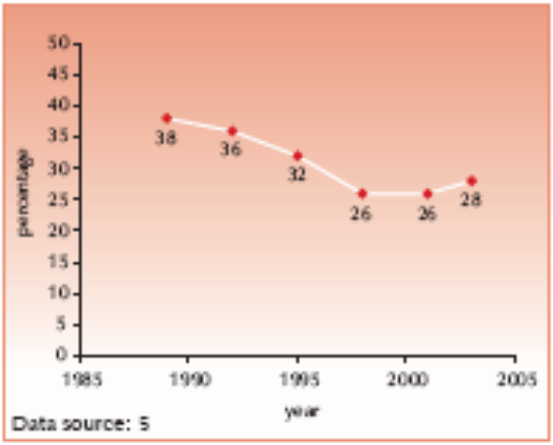
MDG progress

- There is good progress towards achieving targets for reducing child mortality.
- Progress to reduce malnutrition and in controlling priority diseases is slower.
- Targets for improved water and sanitation may have been achieved.

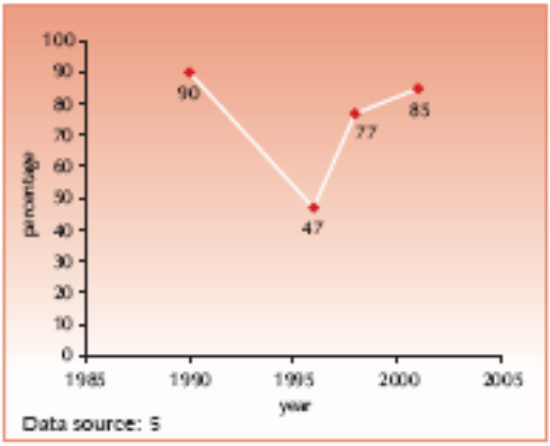
What are the major health problems?

Indicators	Latest available value	Year	Source
In children under-five years			
Stunted children (%)	42.2	2002	{26}
Lowest in the world – Croatia	1	1998-2004	{11}
Lowest in the Region – Sri Lanka	14	2000	
Under-weight children (%)	28	2005	{6}
Lowest in the world – Chile, Croatia, Ukraine	1	1998-2004	{11}
Lowest in the Region – Thailand	9	2005	
Childhood diseases			
Diarrhoeas – reported cases incidence (per 1000 children <5 years)	110	2002-2005	{14}
Acute Respiratory Infection – reported cases incidence (per 1000 children <5 years)	76	2002-2005	{14}
Other diseases			
Tuberculosis prevalence (per 100,000 population)	262	2005	{CC}
Malaria prevalence (per 100,000 population)	850	2001	{5}
HIV prevalence (per 100,000 population) 15-49 years	149	2005	{C}
Diabetes prevalence (per 100,000 population)	3883	2000	{15}
Comprehensive indices			
Expectation of healthy years lost (years)			
Male	7.5	2002	{16}
Female	9.1	2002	{16}
As % of expected life at birth (ELB) lost			
Male	11.5	2002	{16}
Female	13.4	2002	{16}

Percentage of under-weight children <5 years



Tuberculosis treatment success rate



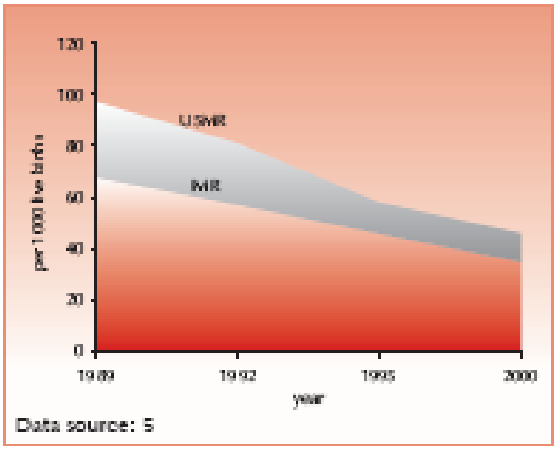
Major health problems

- Under-nutrition in children remians high.
- Infectious diseases exacerbated by malnutrition particularly tuberculosis and malaria – continue to be major problems.
- Noncommunicable diseases are emerging as a major threat.

4 What is the mortality profile?

Indicators	Latest available value	Year	Source
Mortality rates			
Neonatal mortality rate (NMR) (per 1000 live births)	20	2000	{CC}
Lowest in the world – Singapore	1	2000	{12}
Lowest in the Region – Maldives	8	2005	
Infant mortality rate (IMR) (per 1000 live births)	32	2005	{6}
Lowest in the Region – Sri Lanka	11	2005	
Under-five mortality rate (U5MR) (per 1000 live births)	46	2002	{5}
Lowest in the world – Iceland, Singapore	3	2004	{11}
Lowest in the Region – Maldives, Sri Lanka	16	2005	
Maternal mortality ratio (per 100,000 live births)	307	2000	{5}
Lowest in the Region – Thailand	14	2005	
Age at death			
Expectation of life at birth (ELB) (years)	69	2005	{6}
Highest in the world – Japan	82	2004	{10}
Highest in the Region – Maldives, Sri Lanka	73	1996-2001	
Deaths under-five years (% of total deaths)	13	2002	{C}
Lowest in the Region – Thailand	4	2002	
Causes of death (percentage of total deaths)			
Three major causes of child deaths (% of <5 years deaths)			
Diarrhoeal diseases	18	2000-2005	{17}
Pneumonia	14	2000-2005	{17}
Preterm birth	12	2000-2005	{17}
Three major causes of deaths (All ages) (% of total deaths)			
Ischaemic health disease	14	2002	{17}
Tuberculosis	8	2002	{17}
Cerebrovascular disease	8	2002	{17}
Tuberculosis death rate (per 100,000 population)	68	1998	{5}
Cardio-vascular diseases death rate – age standardized (per 100,000 population)	361	2002	{12}
Cancer death rate – age standardized (per 100,000 population)	132	2002	{12}
Malaria death rate (per 100,000 population)			
Male	11	2000	{5}
Female	8	2000	{5}

Infant and under-five mortality rates



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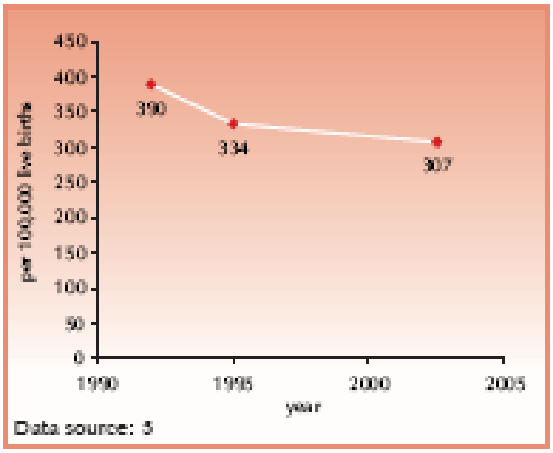
Maternal mortality ratio



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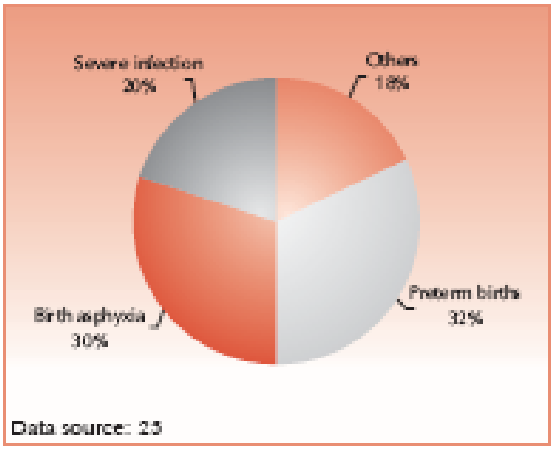
Causes of neonatal deaths



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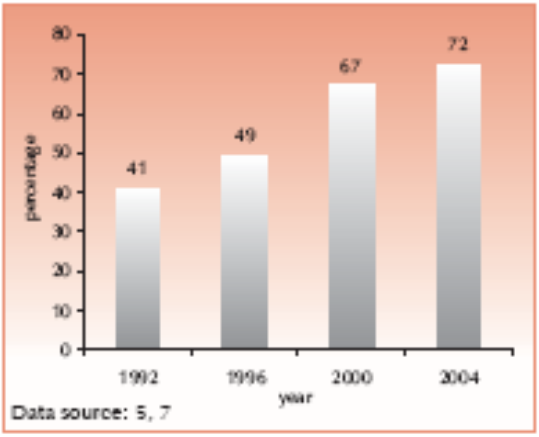
Mortality profile

- Neonatal mortality is higher than in some other countries in the Region although mortality in children 1-4 years old has substantially declined.
- Major causes of death in <5 years old are diarrhoeal diseases, pneumonia, and preterm births that account for nearly one-third of the neonatal deaths.
- In the total population (all ages), ischaemic heart disease is responsible for the death of one out of every seven Indonesians.

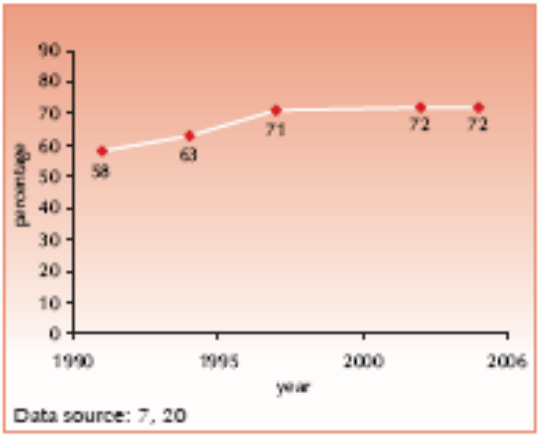
5 What resources are available for the health sector?

Indicators	Latest available value	Year	Source
Expenditure on health			
Percentage of GDP	2.8	2005	{CC}
Highest in the world – USA	15.2	2005	{18}
Highest in the Region – Timor-Leste	9.6	2005	
Per capita (US$)	33	2005	{CC}
Per capita (Intl.$)	118	2005	{CC}
Highest in the world – USA (Intl.$)	5711	2005	{18}
Highest in the Region – Maldives (Intl.$)	364	2005	
Food			
Average dietary energy consumption (kcal/day/person)	2880	2001-2005	{19}
Services			
Health centres (per 100,000 population)	3.6	1998	{5}
Antenatal care coverage (at least four visits) (%)	81		{CC}
Deliveries by qualified attendant (%)	72	2004	{7}
Children immunized (%)			
BCG	82	2005	{27}
DPT-3	70	2005	{27}
Polio-3	70	2005	{27}
Measles	72	2005	{27}
Beds (per 10,000 population)	6.0	2002	{5}
Highest in the world – Monaco	196	1995	{12}
Highest in the Region – DPR Korea	132.0	2002	
Human resources			
Doctors of modern system (per 10,000 population)	2.0	2001	{CC}
Highest in the world – Cuba	59	2002	{15}
Highest in the Region – DPR Korea	32	2005	
Nurses (per 10,000 population)	13.0	2001	{CC}
Highest in the Region – DPR Korea	37	2005	
Midwives (per 10,000 population)	2.0	2004	{15}
Dentists (per 10,000 population)	0.3	2004	{15}
Pharmacists (per 10,000 population)	0.3	2004	{15}
Public and Environmental Health Workers (per 10,000 population)	0.3	2004	{15}
Community Health Workers (per 10,000 population)	3.6	2004	{15}
Lab Technicians (per 10,000 population)	2.5	2004	{15}
Other Health workers (per 10,000 population)	1.0	2004	{15}

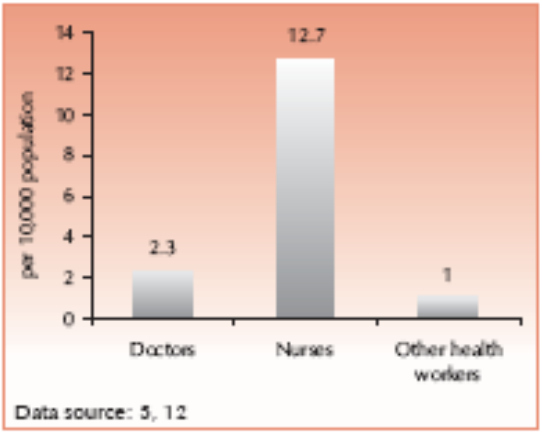
Percentage of births by qualified attendant



Percentage of measles vaccination coverage 12-23 months



Human resources per 10,000 population



Health resources

- At 3.1% of GDP, the public expenditure on health is low.
- The situation with regard to human resources for health (doctors, nurses and health workers) is still not adequate compared to some other countries in the Region.

Q 6 What is the system of health governance?

Organization

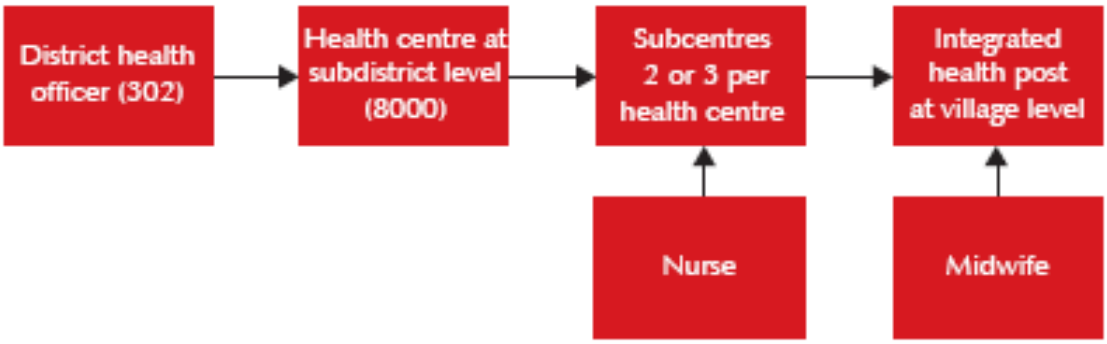
The Ministry of Health has the following offices:

- Secretary-General
- Inspector-General
- Directorate-General of Community Health
- Directorate-General of Medical Care
- Directorate-General of Communicable Disease Control and Environmental Health
- Directorate-General of Pharmacy and Medical Devices Services
- National Institute of Health Research and Development
- National Institute of Health, Human Resource Development and Empowerment

Indonesia has 33 provinces, each with a Provincial Health Office, and 349 districts, each having a District Health Officer, looks after government hospitals in the district.

For basic health services, each sub-district (3625 in 2003) has at least one Primary Health Centre where one or more doctors, a public health nurse, midwives and other paramedics are posted. There were nearly 8000 health centres in 2000 – one per 26,000 population. Each centre is supported by two or three sub-centres, generally headed by a nurse.

The Integrated Health Post provides preventive and promotive services at the village level. A midwife is deployed at this level. This post covers 50-100 households.



In addition, there are hospitals including teaching hospitals at the apex level, central hospitals, provincial hospitals and district hospitals. In 2002, there were 1215 hospitals.

Private sector

Other than the public health system, there are numerous private clinics and hospitals providing health care.

Traditional system

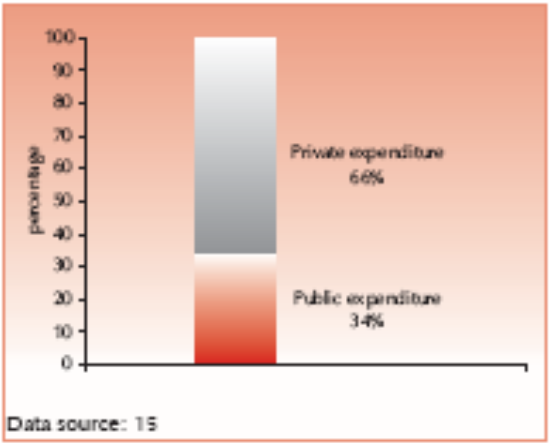
Traditional medicine practitioners include herbalists, cicumcisers, bonesetters, etc. A Ministry of Health in the 1990s survey reported 281,492 practitioners of traditional mediine. Of these, 122,944 are traditional birth attendants. They attend more than 50% of the births in the country.

The Centre for Traditional Medicine Research provides training in traditional medicine. There are separate training programmes for traditional practitioners of accupressure for primary health care.

7 Who pays for health care?

Indicators	Latest available value	Year	Source
Government expediture on health			
Out of total health expenditure (%)	34	2004	{CC}
Per capita (US$)	11	2005	{18}
Per capita (Intl.$)	40	2005	{18}
Highest in the world – Monaco (Intl.$)	3403	2005	{18}
Highest in the Region – Maldives (Intl.$)	324	2005	
Private expenditure on health			
Out of total health expenditure (% of total expenditure on health)	66	2005	{CC}
Per capita (US$)	21	2005	{C}
Per capita (Intl.$)	78	2005	C
Lowest in the Region – DPR Korea	0.4	2004	
Out-of-pocket expenditure (% of private expenditure on health)	74	2005	{18}
Per capita (US$)	16	2005	{C}
Per capita (Intl.$)	58	2005	{C}
Lowest in the world – Tuvalu	13	2005	{18}
Lowest in the Region – Timor-leste	26	2004	
Insurance coverage			
Social security expenditure on health out of general government expenditure on health (%)	10	2005	{18}

Health expenditure



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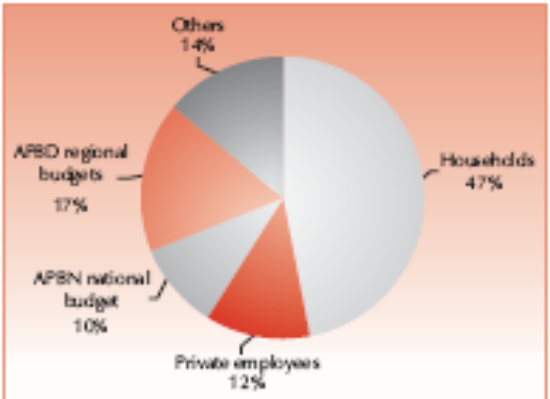
Health expenditure by category, 2002



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Health expenditure

- Nearly one-third of the total expenditure on health is public expenditure, with per capita public expenditure at 40 Intl.$.
- Three-fourths of private expenditure is out-of-pocket.
- Social security expenditure out of the general government expenditure is at 10%, which is relatively higher than the some other countries of this Region.

Q 8 What are the recent reforms and achievements of the health system?

Health sector reforms

- "Healthy Indonesia 2010" envisages health as a shared responsibility between all strata of society, all government departments and the private sector. The mission is to maintain and enhance the health of individuals, family and the community, along with their environments; and promote quality, equity and affordability of health services.
- Indonesia has undergone a process of decentralization in the health sector. This has shifted the responsibility for service delivery and implementation of health programmes to the district level with the national government providing policy guidance, setting of standards, and epidemic control.
- The country has started a programme called Askesin. This is a form of health insurance under which the government pays premia for 60 million of its poorest population to provide free access to medical care.
- The strategy for National Health Development includes (i) initiating health-oriented national development, (ii) professionalism, (iii) community-managed health care programmes, and (iv) decentralization.
- Health paradigm introduced in 1998 focused on health promotion and prevention rather than on curative and rehabilitative services.
- The National Health Information System (HIS) has been reformed to support the 'Healthy Indonesia 2010' vision. Adequate infrastructure has been provided from the national down to the sub-district level. Regional Autonomy Implementation will

consider HIS as an important support for the health provider in convincing other related sections about the usefulness of HIS in decision making.

- The National Social Safetynet Programme (1998) supports routine MCH services, and ensures funding for basic service provision.
- A framework for Health Priorities for Indonesia has been developed. This outlines the guidelines for all programmes of the Ministry. Donor assistance will also focus on supporting the priority programmes identified in the document.

Achievements

- From 60% of the population being below the poverty line in 1970, Indonesia has made great strides to reduce it to around 17% in 2004. The Literacy rate among children 10 years or more increased from 61% in 1971 to 91% in 2002. Thus, social indicators have shown tremendous improvement.
- The infant mortality rate has gradually declined from 142 in 1968 to 50 in 1998 and 32 in 2005.
- Leprosy has been eliminated with prevalence <1 per 10,000 population.

Legislation

- Health Law No. 23 (1992) stipulates the goal of the health programmes to increase awareness, willingness and ability of everyone to live a healthy life. The law emphasizes decentralisation of operational responsibility and authority to the local level as a prerequisite for successful and sustainable development. The law envisages that health systems are implemented by the community with the government only as a facilitator. Also, that the private sector plays an active role in the health sector.
- Law No. 23 on Child Protection (2002) aims to ensure better and more opportunities for children to live healthy lives. This

states that every child has the right to obtain health services and social security according to his/her physical, mental, spiritual and social needs.

- Renewed efforts have been made by the government to address implementation issues by revising the legislation governing decentralization in 2004.
- In 2000, People's Assembly amended the 1945 Constitution to include the right of every citizen to live in a healthy environment and have access to health services and social insurance.

9 What are the constraints and challenges of the health system?

Financial constraints

- The total health expenditure was at 3.1% of GDP in 2003.
- General government expenditure on health was 36% of the total health expenditure in 2003.

Expertise and other physical constraints

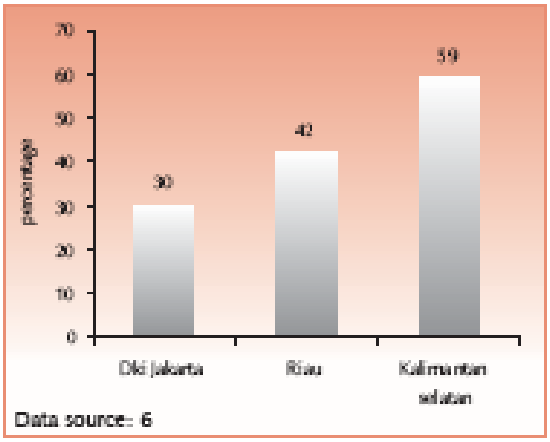
- Availability of health personnel is limited, especially in remote areas.
- In the wake of decentralization, the new roles for all levels are to be fully developed and defined. The main constraint is inadequate managerial expertise at various levels and willingness to assume responsibilities conferred through the decentralization process.

Social constraints

- Two-third of male adults are regular smokers

Indicators	Latest available value	Year	Source
Inequalities – Gender			
Expectation of life at birth F:M	1.06	2002	{1}
Female share in employment (non-agricultural sector) (%)	28.3	2002	{5}
Seats held in parliament – F (%)	8.8	1999	{5}
Ratio of girls to boys in primary schools (%)	100	2002	{5}
Inequalities – Spatial			
Measles immunization (%)			
Urban	78	2002	{5}
Rural	66	2002	{5}
Infant mortality rate (per 1000 live births)			
West Nusa Tenggara	74	1998-2002	{5}
Yogyakarta	20	1998-2002	{5}

Percentage of safe drinking water by region



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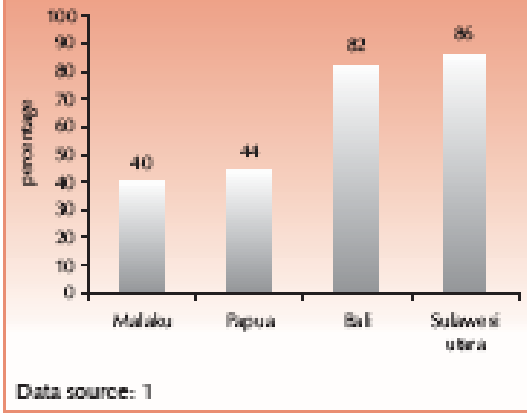
Percentage of contraceptive prevalence



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Health sector constraints

- Limited effective mechanism for financing health care, procurement and distribution of essential commodities, delivering basic services, providing access to the most vulnerable sections, and for surveillance and monitoring the results.
- Low utilization of public health facilities despite vast investment. One of the reasons is poor quality of services, partly due to the fact that most health professionals provide private services after office hours, creating conflict of interest.
- The concept of autonomous hospitals, launched in 1988, allows hospital managers to retain part of the revenue. This may have improved the quality of services. Since the fees are usually high, access to services by the poor is even more difficult.

Challenges

Nutrition

- Reaching the poor, especially children and women, and providing them adequate and nutritious food at an affordable price.

Health services

- Decentralization of health services has created confusion regarding the roles of different levels of administration in health development, particular by at the provincial level.

- Improving health seeking behaviour for pregnancy, safe delivery and appropriate care after birth is more difficult compared to the direct causes of infant and under-five deaths. Recent data show that midwifery services to the vulnerable groups has decreased.
- Urban-rural and regional disparities are wide.
- Indonesia has been successful in mobilizing resources for health. The challenge now is to strengthen the capacity to absorb and utilize these resources.
- Health needs are rapidly increasing due to: (i) increase in population, (ii) ageing, and (iii) increased awareness of health issues. Epidemiological transition toward noncommunicable diseases has added to the burden of disease, associated with high levels of morbidity. It is not limited to the affluent population in urban settings alone but is also affecting poorer people, reducing their earning capacity, and, as such, contributing to further impoverishment.

Lifestyle

- In 2001, 62% of male adults were smoking regularly with the percentage increasing to 67% in rural areas. The smoking habit in the younger population is increasing.

What does the country hope to achieve in the near future in health?

- The goal of 'Healthy Indonesia 2010' is to initiate and provide a health dimension to national development. It hopes to maintain and enhance individual, family and public self-reliance in improving the environment, maintain and enhance quality, equitable and affordable health services, and promote public self-reliance in achieving good health.
- Food and nutrition policies aim at empowering poor families and other vulnerable groups to develop self-sufficiency in food through community-based activities. They also stipulate strengthening of the early warning system for food and nutrition; improve the quality of nutrition and food services and integrate them in poverty reduction programmes; and enforce laws on regulation of food and nutrition.
- The National Development Programme hopes to improve in reproductive health services, achieve better control of communicable diseases, improve in basic and referral health services, reduce chronic diet energy deficiency and reduce in anaemia among women.
- Indonesia hopes to arrest the decreasing trend in immunization in certain pockets. The coverage is not only to be sustained but improved as well.
- Indonesians are increasingly exposed to health risks from environmental hazards such as air pollution, water contamination, free availability of potentially harmful chemicals, food contamination, and forest fires. The people hope the government will lay clear guidelines on responsibilities of various institutions in both the public and private sector in view of the complexity of such issues.

- There are strong political movements towards good governance and reforms in the functioning of the public sector. Changes in these areas may have a major effect on the health sector.
- Projects such as *Askesin* are expected to allieviate some of the fianancial barriers in access to medical care for the poor.
- In March 2006, the Ministry of Health issued a new Strategic Plan 2005-2009 emphasizing the new vision 'self-reliant communities to pursue healthy living' and its mission 'to make people healthy'. The values underlying the vision and mission include: being people-oriented, providing rapid and appropriate response, fostering team work, high integrity, transparency and accountability.

Q 11 How is WHO collaborating with the country?

Policy development and planning

- WHO is a member of the UN country team and is actively involved in the UN development assistance framework (UNDAF). It is currently a lead agency for a number of UNDAF outputs related to improved health and nutrition. In order to achieve these outputs, WHO will help coordinate activities closely with other UN agencies working in health, in particular with UNICEF, UNFPA, ILO and FAO.
- WHO support is focused on the development and adoption of standards and norms, implemented through technically sound health interventions. Support being provided to develop a more equitable and efficient health system.
- Support is also being provided for developing responses and taking a pro-active stance on issues of decentralization, privatization, civil services reform, poverty reduction and other elements of overall reform.
- Donor-assisted initiatives to improve health is being supported. Many projects focus on innovations rather than routine programmes. Technical support is provided to facilitate their work.

Health system management

- Much of WHO efforts are concentrated on background work % analysing current data and providing papers on these areas and on key policy issues. Where necessary, limited field trials or training are undertaken to pilot appropriate changes.
- Considering motivational and performance factors among health care personnel, technical support has been enhanced to health care services and training models developed, which could be implemented in many parts of the country.
- There has been detailed involvement in supporting the government on work relating to health system strengthing and decentralization.

- Programme evaluation, assessment for identifying current needs, and short-term technical training for all health units have been supported.
- Expert advice and the best technical practices has been provided at short notice when necessary to facilitate access to decision and policy-makers in the Ministry.

Promotion of healthy lifestyles and settings

- As indonesia is prone to both natural and man-made emergencies, technical support and assisting government's coordination efforts are deemed important to mitigate the health impact of emergencies.
- Support to health promotion activities in areas such as tobacco-free initiative and control of occupational diseases, and help in developmental efforts in these areas have been provided.

Prevention and control of priority diseases

- WHO, together with FAO, is taking a lead role in coordinating the UN approach to support national capacity to respond to avian influenza and pandemic preparedness, and to build necessary capacity.
- Technical support is being provided to high priority diseases such as sexually transmitted diseases and HIV/AIDS, tuberculosis control and integrated management of childhood illnesses (IMCI), for developing new guidelines and protocols, and their testing.
- Communicable disease control programmes, including EPI are being strenghtened, at the district level.
- There is a increase emphasis on control of vector-borne diseases, especially malaria, dengue, and filariasis.
- Health laboratory services are being strenghtened.

Tsunami consequences

- The tsunami in December 2004 killed an estimated 121,000 people in Indonesia. Nearly 114,000 were reported missing. Within days, cases of pneumonia and respiratory tract infections were reported. WHO led the country-level planning and activities and assisted with logistics, resource mobilization, international communications and inter-agency coordination.
- WHO is an active member of the UN technical working group for disaster risk reduction which aims to improve UN coordination and facillitate support to manage risk for, and respond effectively to, disasters.

Sources

(1) Selected Indicators: Social-Economic of Indonesia, July 2006, Badan Pusat Statistik, Indonesia.

(2) http://en.wikipedia.org/wiki/earth

(3) Indonesia Health System Profile - January 2005. WHO, SEARO.

(4) World Development Report 2007. World Bank, Washington, DC. http://econ.worldbank.org

(5) Indonesia: Progress Report on the Millenium Development Goals, February 2004.

(6) Selected Indicators of Indonesia. Ed. Directorate of Statistical Dissemination, June 2006, Badan Pusat Statistik, Indonesia. http://www.bps.go.id/leaflet/leaflet-jul-06-eng.pdf

(7) Welfare Statistics 2004. National Socio-economic Survey, Indonesia, Badan Pusat Statistik, Indonesia.

(8) Human Development Report 2006. United Nations Development Programme, New York. http://hdr.undp.org/hdr2006/

(9) Population Census, Indonesia, 2000. http://www.bps.go.id/sector/population/pop2000.htm

(10) World Population Prospects 2004 Revision. http://esa.un.org/unpp

(11) The State of the World's Children 2006. UNICEF, New York. http://www.unicef.org/sowc06/

(12) World Health Statistics 2006. World Health Organization, Geneva. http://www.who.int/whosis/whostat2006/en/index.html

(13) The Millenium Development Goals for Health: A review of the indicators. WHO, Indonesia.

(14) Indonesia Demographic and Health Survey 2002-2003. Statistics Indonesia, December 2003. http://www.measuredhs.com/pubs/search/search_results.cfm

(15) WHO Diabetes Programme. http://www.who.int/diabetes/facts/world_figures/en/index5.html

(16) World Health Report 2004. World Health Organization, Geneva. http://www.who.int/whr/2004/en/index.html

(17) WHO Mortality Country Fact Sheet 2006. http://www.who.int/whosis/mort/profiles/mort_searo_idn_indonesia.pdf

(18) World Health Report 2006. World Health Organization, Geneva. http://www.who.int/whr/2006/en/index.html

(19) FAOSTAT. http://faostat.fao.org

(20) Summary of the burden of enteric diseases in Indonesia based on government data, 1990-2001. http://220.93.120.88:10002/source/meta/Indonesia/Summary%20govt%20data%20Indonesia.doc

(21) Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review. WHO, 2001. http://whqlibdoc.who.int/hq/2001/WHO_EDM_TRM_2001.2.pdf

(22) Country Cooperation Strategy: Indonesia, 2000. WHO.

(23) Health action in crises – Indonesia. http://www.who.int/hac/crises/international/asia_tsunami/one_year_story/en/index.html

(24) Household Health Survey 2001. (Country comments).

(25) Subnational health system performance assessment, MoH-WHO, 2005 (Country comments).

(26) WHO Country Cooperation Strategy for Indonesia 2006-2011. WHO Indonesia Country Office, 2007.

(27) South-East Asia Region EPI Fact Sheet 2005

LAMPIRAN 2:

Health in the Millennium Development Goals

Health Targets		Health Indicators
Goal 1: Eradicate extreme poverty and hunger		
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education		
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	
Goal 3: Promote gender equality and empower women		
Target 4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015	
Goal 4: Reduce child mortality		
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
Goal 5: Improve maternal health		
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases		
Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among pregnant women aged 15-24 years 19. Condom use rate of the contraceptive prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 8	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short-course)
Goal 7: Ensure environmental sustainability		
Target 9	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29. Proportion of population using solid fuels
Target 10	Halve by 2015 the proportion of people without sustainable access to safe drinking-water and sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural
Target 11	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of population with access to improved sanitation, urban and rural

Goal 8: Develop a global partnership for development

Target 12	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	
Target 13	Address the special needs of the least developed countries	
Target 14	Address the special needs of landlocked countries and small island developing states	
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	
Target 17	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	

Sources: "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270 (31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/56/326 (6 September 2001); United Nations Statistics Division, Millennium Indicators Database, verified in July 2004; World Health Organization, Department of MDGs, Health and Development Policy (HDP).

LAMPIRAN 2:

Health in the Millennium Development Goals

Health Targets		Health Indicators
Goal 1: Eradicate extreme poverty and hunger		
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education		
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	
Goal 3: Promote gender equality and empower women		
Target 4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015	
Goal 4: Reduce child mortality		
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
Goal 5: Improve maternal health		
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases		
Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among pregnant women aged 15-24 years 19. Condom use rate of the contraceptive prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 8	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short-course)
Goal 7: Ensure environmental sustainability		
Target 9	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29. Proportion of population using solid fuels
Target 10	Halve by 2015 the proportion of people without sustainable access to safe drinking-water and sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural
Target 11	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of population with access to improved sanitation, urban and rural

Goal 8: Develop a global partnership for development

Target 12	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	
Target 13	Address the special needs of the least developed countries	
Target 14	Address the special needs of landlocked countries and small island developing states	
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	
Target 17	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	

Sources: "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270 (31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/56/326 (6 September 2001); United Nations Statistics Division, Millennium Indicators Database, verified in July 2004; World Health Organization, Department of MDGs, Health and Development Policy (HDP).

LAMPIRAN 3:

WHA58.28 eHealth

The Fifty-eighth World Health Assembly,

Having considered the report on eHealth;[1]

Noting the potential impact that advances in information and communication technologies could have on health-care delivery, public health, research and health-related activities for the benefit of both low- and high-income countries;

Aware that advances in information and communication technologies have raised expectations for health;

Respecting human rights, ethical issues and the principles of equity, and considering differences in culture, education, language, geographical location, physical and mental ability, age, and sex;

Recognizing that a WHO eHealth strategy would serve as a basis for WHO's activities on eHealth;

Recalling resolution WHA51.9 on cross-border advertising, promotion, and sale of medical products through the Internet;

Stressing that eHealth is the cost-effective and secure use of information and communications technologies in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research,

1. URGES Member States:

(1) to consider drawing up a long-term strategic plan for developing and implementing eHealth services in the various areas of the health sector, including health administration, which would include an appropriate legal framework and infrastructure and encourage public and private partnerships;

(2) to develop the infrastructure for information and communication technologies for health as deemed appropriate to promote equitable, affordable, and universal access to their benefits, and to continue to work with information and telecommunication agencies and other partners in order to reduce costs and make eHealth successful;

(3) to build on closer collaboration with the private and non-profit sectors in information and communication technologies, so as to further public services for health and make use of the eHealth services of WHO and other health organizations, and to seek their support in the area of eHealth;

(4) to endeavour to reach communities, including vulnerable groups, with eHealth services appropriate to their needs;

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[1] Document A58/21.

(5) to mobilize multisectoral collaboration for determining evidence-based eHealth standards and norms, to evaluate eHealth activities, and to share the knowledge of cost-effective models, thus ensuring quality, safety and ethical standards and respect for the principles of confidentiality of information, privacy, equity and equality;

(6) to establish national centres and networks of excellence for eHealth best practice, policy coordination, and technical support for health-care delivery, service improvement, information to citizens, capacity building, and surveillance;

(7) to consider establishing and implementing national electronic public-health information systems and to improve, by means of information, the capacity for surveillance of, and rapid response to, disease and public-health emergencies;

2. REQUESTS the Director-General:

(1) to promote international, multisectoral collaboration with a view to improving compatibility of administrative and technical solutions and ethical guidelines in the area of eHealth;

(2) to expand the use of electronic information through the submission of regular reports, to document and analyse developments and trends, to inform policy and practice in countries, and to report regularly on use of eHealth worldwide;

(3) to facilitate the development of model eHealth solutions which, with appropriate modification, could be established in national centres and networks of excellence for eHealth;

(4) to provide technical support to Member States in relation to eHealth products and services by disseminating widely experiences and best practices, in particular on telemedicine technology, devising assessment methodologies, promoting research and development, and furthering standards through diffusion of guidelines;

(5) to facilitate the integration of eHealth in health systems and services, including in the deployment of telemedicine infrastructure in countries where medical coverage is inadequate, in the training of health-care professionals, and in capacity building, in order to improve access to, and quality and safety of, care;

(6) to continue the expansion to Member States of mechanisms such as the Health Academy, which promote health awareness and healthy lifestyles through eLearning;[1]

(7) to provide support to Member States to promote the development, application and management of national standards of health information; and to collect and collate available information on standards with a view to establishing national standardized health information systems in order to facilitate easy and effective exchange of information among Member States;

(8) to support in the area of eHealth regional and interregional initiatives or those among groups of countries that speak a common language;

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[1] eLearning is understood in this context to mean use of any electronic technology and media in support of learning.

(9) to submit to the Executive Board, at its 117th session, a list of proposed specific activities upon which the Secretariat will focus, which should be entirely aimed at tools and services that Member States can incorporate into their own national solutions or adapt as necessary, and an outline of the budgetary implications of proposed activities.

(Ninth plenary meeting, 25 May 2005 –
Committee A, seventh report)

LAMPIRAN 4:

INDIKATOR INDONESIA SEHAT 2010

A. DERAJAT KESEHATAN

INDIKATOR	TARGET 2010
MORTALITAS:	
1. Angka Kematian Bayi per-1.000 Kelahiran Hidup.	40
2. Angka Kematian Balita per-1.000 Kelahiran Hidup.	58
3. Angka Kematian Ibu Melahirkan per-100.000 Kelahiran Hidup.	150
4. Angka Harapan Hidup Waktu Lahir	67,9
MORBIDITAS:	
5. Angka Kesakitan Malaria per-1.000 Penduduk	5
6. Angka Kesembuhan Penderita TB Paru BTA+	85
7. Prevalensi HIV (Persentase Kasus Terhadap Penduduk Berisiko)	0,9
8. Angka "Acute Flaccid Paralysis" (AFP) Pada Anak Usia <15 Tahun per-100.000 Anak	0,9
9. Angka Kesakitan Demam Berdarah Dengue (DBD) per-100.000 Penduduk	2
STATUS GIZI:	
10. Persentase Balita Dengan Gizi Buruk	15
11. Persentase Kecamatan Bebas Rawan Gizi	80

B. HASIL ANTARA

INDIKATOR	TARGET 2010
KEADAAN LINGKUNGAN:	
12. Persentase Rumah Sehat	80
13. Persentase Tempat-tempat Umum Sehat	80
PERILAKU HIDUP MASYARAKAT:	
14. Persentase Rumah Tangga Berperilaku Hidup Bersih dan Sehat	65
15. Persentase Posyandu Purnama & Mandiri	40
AKSES & MUTU PELAYANAN KESEHATAN:	
16. Persentase Penduduk Yang Memanfaatkan Puskesmas	15
17. Persentase Penduduk Yang Memanfaatkan Rumah Sakit	1,5
18. Persentase Sarana Kesehatan Dengan Kemampuan Laboratorium Kesehatan	100
19. Persentase Rumah Sakit Yang Menyelenggarakan 4 Pelayanan Kesehatan Spesialis Dasar	100
20. Persentase Obat Generik Berlogo Dalam Persediaan Obat	100

C. PROSES MASUKAN

INDIKATOR	TARGET 2010
PELAYANAN KESEHATAN:	
21. Persentase Persalinan Oleh Tenaga Kesehatan	90
22. Persentase Desa Yang Mencapai "Universal Child Immunization" (UCI)	100
23. Persentase Desa Terkena Kejadian Luar Biasa (KLB) Yang Ditangani <24 jam	100
24. Persentase Ibu Hamil Yang Mendapat Tablet Fe	80
25. Persentase Bayi Yang Mendapat ASI Eksklusif	80
26. Persentase Murid Sekolah Dasar/ Madrasah Ibtidaiyah Yang Mendapat Pemeriksaan Gigi dan Mulut	100
27. Persentase Pekerja Yang Mendapat Pelayanan Kesehatan Kerja	80
28. Persentase Keluarga Miskin Yang Mendapat Pelayanan Kesehatan	100
SUMBERDAYA KESEHATAN:	
29. Rasio Dokter Per-100.000 Penduduk	40
30. Rasio Dokter Spesialis Per-100.000 Penduduk	6
31. Rasio Dokter Keluarga 1.000 Keluarga	2
32. Rsio Dokter Gigi Per-100.000 Penduduk	11
33. Rasio Apoteker Per-100.000 Penduduk	10
34. Rasio Bidan Per-100.000 Penduduk	100
35. Rasio Perawat Per-100.000 Penduduk	117,5
36. Rasio Ahli Gizi Per-100.000 Penduduk	22
37. Rasio Ahli Sanitasi Per-100.000 Pddk.	40
38. Rasio Ahli Kesehatan Masyarakat Per-100.000 Penduduk	40
39. Persentase Penduduk Yang Menjadi Peserta Jaminan Pemeliharaan Kesehatan	80

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INDIKATOR	TARGET 2010
40. Rata-rata Persentase Anggaran Kesehatan Dalam APBD Kabupaten/Kota	15
41. Alokasi Anggaran Kesehatan Pemerintah per-Kapita per-tahun (ribuan rupiah)	100
MANAJEMEN KESEHATAN:	
42. Persentase Kabupaten/Kota Yang Mempunyai Dokumen Sistem Kesehatan	100
43. Persentase Kabupaten/Kota Yang Memiliki "Contingency Plan" Untuk Masalah Kesehatan Akibat Bencana	100
44. Persentase Kabupaten/Kota Yang Membuat Profil Kesehatan	100
45. Persentase Provinsi Yang Melaksanakan Surkesda.	100
46. Persentase Provinsi Yang Mempunyai "Provincial Health Account"	100
KONTRIBUSI SEKTOR TERKAIT:	
47. Persentase Keluarga Yang Memiliki Akses Terhadap Air Bersih	85
48. Persentase Pasangan Usia Subur Yang Menjadi Akseptor Keluarga Berencana	70
49. Angka Kecelakaan Lalu-lintas per-100.000 penduduk	10
50. Persentase Penduduk Yang Melek Huruf	95