

FOREWORD

As a signatory to the Millennium Declaration in September 2000, Indonesia produced its Progress Report on the Achievement of the Millennium Development Goals (MDGs) in February 2004. The first report shows the position of Indonesia in terms of its achievement towards the MDGs from 1990 to 2003, as well as an analysis of the trend of achievement up to 2015.

Nowadays, MDGs have become an important reference in the development implementation in Indonesia, from the planning phase as it is stated in the Medium-term National Development Plan (RPJMN) to its implementation. In spite the constraints, the Government of Indonesia has committed to achieve its MDGs. Therefore, hard work and cooperation with all parties, including civil society, private sectors and donor community, are needed.

In order to face the upcoming UN General Assembly in September 2005, the agenda of which shall discuss the country's position in terms of its achievement of MDGs, the Government of Indonesia will present its first Progress Report in a brief, compact form. However, this report is accompanied with updated data that reflects the recent condition and a description on the Indonesian perspective regarding Goal 8 of MDGs is also attached. The purpose is that the society and all stakeholders will easily take MDGs as a baseline for the cooperation implementation in the future.

In the upcoming UN General Assembly, apart from presenting the brief report, the Government will also continuously support the effort of fulfilling the commitments of the developed countries and the developing countries regarding the quantity as well as the quality of Official Development Assistance (ODA), and will campaign on debt swap for developing countries and debt cancellation for the poor countries. This is in line with the spirit of the Jakarta Declaration regarding MDGs in Asia&the Pacific regions.

Last but not least, I am very grateful to all parties who have made this brief report possible. Let us hope that what we have done will be beneficial to us, and help the state and the nation advance further.

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Introduction

Brief history of Millennium Development Goals (MDGs)

The Millennium Summit. In September 2000, Heads of State and representatives of the Governments of 189 countries adopted the Millennium Declaration at the United Nations Summit in New York. The Declaration outlines the central concerns of the global community-peace, security, development, environmental sustainability, human rights and democracy-and articulates a set of inter-connected and mutually reinforcing goals into a global agenda for development. The goals, called the Millennium Development Goals, put human development as its main focus. Each goal has been translated into one or more targets and its benchmark indicators.

Indonesia's first Progress report on the MDGs was issued by the Indonesian government in 2004, describing the human development in regards to the first to the seventh goal; measuring the progress, recognizing the challenges; and reviewing the policies and programmes necessary to meet the targets. The report used 1990 or the closest data, wherever available, as a baseline. The main purpose of this report was to establish consensus and reach agreement on Indonesia's progress with its MDG targets and to set benchmarks for future work.

Indonesia: Context of Development

The economic development in the previous era had not only brought some significant improvement but also some pressing matters. The focus on high economic growth had resulted in the increasing income per capita, reducing poverty and unemployment rate, and general improvement of quality of life. However, such approach, which focused on the improvement of the national products was not supported by the enhancement of capacity of either public or private financial institutions, institutions had led to ineffective and inefficient resources allocation. Supported by a centralized and repressive system, the process of the economy development had even helped cripple some strategic institutions, such as the legal system, the political system, and the social system. The result of the development, in fact, had caused negative impacts in the form of social and regional gaps, and the discrepancy of incomes. Meanwhile, eroded and crippled systems and strategic institutions had brought about delicate condition vulnerable to either domestic or international tremors due to globalization.

The economic crisis during 1997-1998 was a costly lesson learnt for the country. The crisis has brought changes in the economic, political, social and law reforms. The reformations are expected to lead the country to a new fair, and sustainable system.

Some problems and challenges faced by Indonesia in the future are (i) slow economic growth, (ii) low quality of human resources, (iii) disintegration of environment protection activities and the exploitation of natural resources which can cause conflict of interests, (iv) disparity of regional development, such as between Java and outside Java, between Western Indonesia and Eastern Indonesia, and between urban and rural areas, (v) quality and services of infrastructure and the postponement of the development of new infrastructures, and (vi) the potentials of separatist movements and horizontal conflicts.

To address the challenges the government has developed three agendas in the medium term development plan 2004-2009: (i) to create safe and peace Indonesia (ii) to create fair and democratic Indonesia (iii) to increase people's welfare. In regards to the third agenda, the development priorities and policies are: eradicating poverty and unemployment; increasing foreign investment; revitalize agriculture, forestry and fishery; reducing disparity by rural development; increasing access to quality primary health and education service; establishing social safety net and developing infrastructures.

Population and MDGs

The total number of population has increased from 119 millions in 1971 to 179 millions in 1990 and it is estimated to reach 219 millions in 2005. The population growth rate has decreased from 2.32 percent during 1971-1980 to 1.48 percent during 1990-2000. The diminishing rate was attributed to the Indonesia's success in reducing the total fertility rate (TFR) from 5.6 children in 1971 to 2.6 children in 2003. The contraceptive prevalence also increased from 57.4 percent in 1997 to 60.3 percent in 2002-2003. Annual birth is estimated around 4 millions up to the year 2015.

Considering the fact above, Indonesia may not be able to achieve the goals of MDGs unless the demographic problems, including rights and universal access to reproductive health service, especially family planning are well addressed.

The government's commitment to achieve MDGs

Even though Indonesia is still facing many problems and challenges in the implementation of its development, the government is committed to achieve the target of MDGs in 2015. The national goals set for the poverty eradication as stipulated in the Medium-term Development Plan are more ambitious than the MDGs. Dialogues with all parties will be continually carried out in order to find mutual understanding and cooperation in the future. It is an important thing to do because it will be difficult to achieve MDGs without active participation of both private sectors and the public.

As the domestic resources are still not sufficient to finance the development, the government continuously tries to improve the quality of the implementation of the development cooperation through strategic management of foreign debts, coordination enhancement, monitoring and evaluation, encouragement of harmonious implementation of cooperation.

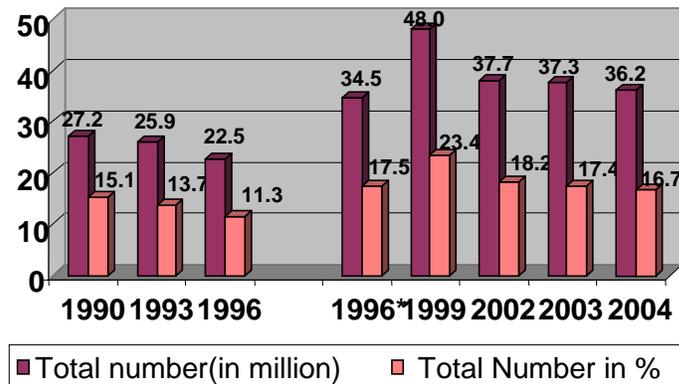
The Indonesian government is in enhancing its support to the regional partnership in the Asia-Pacific region. Economic cooperation and trade are potentially viable to be further developed in the region to pursue the achievement of the MDGs as well as to increase the global bargaining position.

GOAL 1: ERADICATING EXTREME POVERTY AND HUNGER

Target 1 : Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 per day

Status and trends

Figure 1.1 Total number of Poor Population in Indonesia

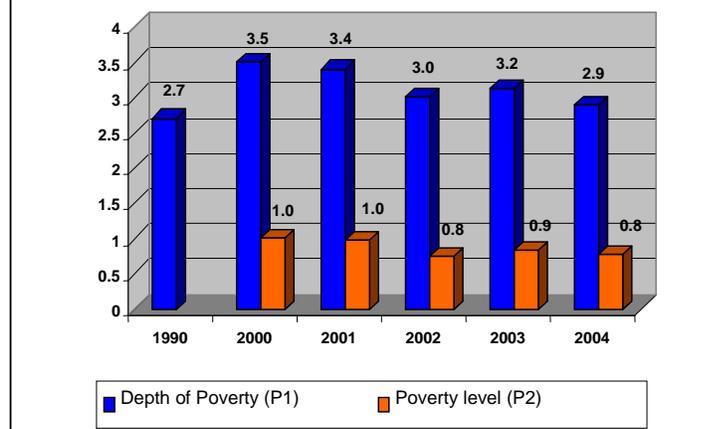


Indonesia has succeeded in lowering the poverty level which was previously increasing due to the economic crisis in 1999. The number of poor people dropped from 23.4 percent to 18.2 percent in 2002, 17.4 percent in 2003, and 16.66 per cent in 2004. Meanwhile, the total number of population whose daily income under \$ 1, also dropped from 9.2 percent in 2001 to 7.2 percent in 2002.

The declining number of poor people shows a positive trend to achieve the target of lowering the poverty level to 7.2 per cent in 2015. Therefore, it should be achieved by building cooperation among stakeholders and programmes in favour of the poor in implementing development programmes in Indonesia.

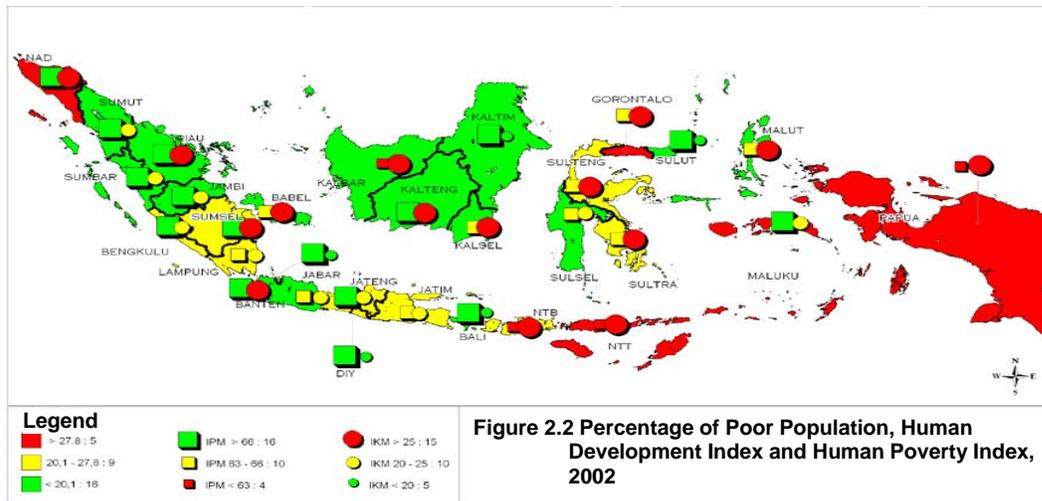
In addition, the level of poverty deepness (P1), in Indonesia that is, the discrepancy between poor people's expenditures and the poverty line, also tends to decline in 2004, compared to 2003 and 2002. The level of poverty absoluteness (P2) also declines. Graphic 2 illustrates the level of poverty deepness (P1) and poverty absoluteness (P2) during the 1999-2004 periods.

Figure 1.2. Depth of Poverty (P1) and Level of Poverty (P2) in Indonesia



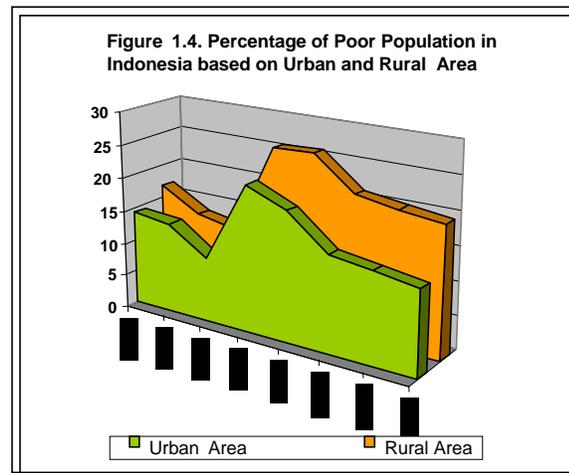
Challenges

Poverty problem in Indonesia is also characterized by poor quality of its community life. This can be indicated in the Human Development Index of Indonesia in 2002, i.e. 0.692. In ASEAN, this figure is lower than Thailand's and Malaysia. Meanwhile, Human Poverty Index of Indonesia in 2002 was 0.178, which is higher than the Philippines' and Thailand's. In addition, gender gap in Indonesia is relatively higher than other ASEAN countries.



Even though the national proportion of poor people tends to decline, the disparity among regions in terms of their Human Development Index and the fulfillment of basic rights still exists. (As shown in Figure 1.3).

The other challenge is the disparity between urban and rural areas. The proportion of poor people in rural areas is relatively higher than that in urban areas. (See Figure 1.4.) The data from the economic census in 2004 shows that around 69 per cent of people in rural areas are poor, and most of them work in agriculture sector.



In addition to that, challenges also include poverty among women shown by the low quality of life and of their roles, high violence against women and children, and low Gender-related Development Index (GDI) and Gender Empowerment Measurement Index (GEM).

The other challenges are poverty among women, shown by the low quality of life and of their roles, violence acts towards women and children, and the Gender-related Development Index (GDI) and Gender Empowerment Measurement Index (GEM)

Another challenge is regional autonomy that has impacts on the improvement of regional administration's role in dealing with poverty. As such, the role of the region is very important in making poverty eradication a success nationally, especially in providing basic services to community.

Policies and Programmes

The mainstream of poverty eradication in Indonesia is that of placing poverty eradication program as a main priority in the national development policy. The policy of poverty eradication has become an agenda in the 2004-2009 Medium-term Development Plann, and elaborated in more detail in the Annual Government Work Plan (RKP) and used as a reference for ministries/ institutions and regional administration in their annual development programme. Policies in the 2004-2009 Medium-term Development Plann, are expected to lower the percentage of poor people to 8.2 per cent by 2009.

In order to realize a mutual movement in eradicating poverty and to achieve MDGs, a National Strategy for Poverty Eradication has been compiled by the participation of all stakeholders in Indonesia. The document employs right-based approach as its main approach, and it highlights progressive realization in respecting, protecting and fulfilling the basic rights of the people; paying attention to gender equality, as well as the acceleration of regional development. In addition, around 60 per cent of regional administrations have established the Regional Committee for Poverty Eradication (KPKD), and have compiled the Regional Strategy for Poverty Eradication (SPKD) as the basis to mainstream poverty eradication in the regions and to encourage social movement in poverty eradication.

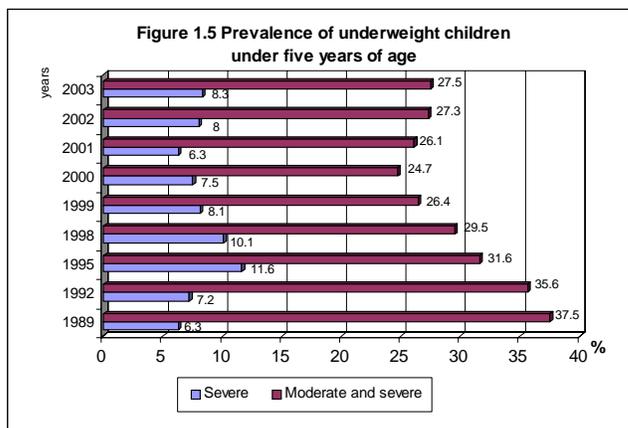
The Short-term priorities include the followings. *First*, in order to narrow down the discrepancy among regions, (i) the provision of irrigation, clean water and basic sanitation shall be prioritized, ultimately in the region which lack of clean water sources; (ii) construction of roads, bridges, and ports in isolated and poor region shall be carried out; and; (iii) funding to the regions with low income, by using the instrument of Special Funding Allocation (DAK) shall be redistributed. *Secondly*, extending employment opportunity and opening business are conducted through allocation of stimulating financial assistant for opening business by giving easier access to micro credit and UKM, vocational training for improving the manpower quality, improving investment and industrial revitalization, including labour-intensive industry, community based infrastructure and facility development. *Third*, for fulfilling the rights of the poor population some services are provided directly, such as (i) free education for accomplishing the programme on the 9 Year Compulsory Education Programme for students of the poor family and its supports; and (ii) free health services for the poor family at Puskesmas (community health centres) and Grade 3 service in hospitals.

In order to achieve all those three priorities, community empowerment and active involvement of the poor community shall be introduced to the development process in Indonesia, starting from development planning, policy making and budgeting, as well as in the implementation process, monitoring and evaluation..

Target 2:

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Status and trends



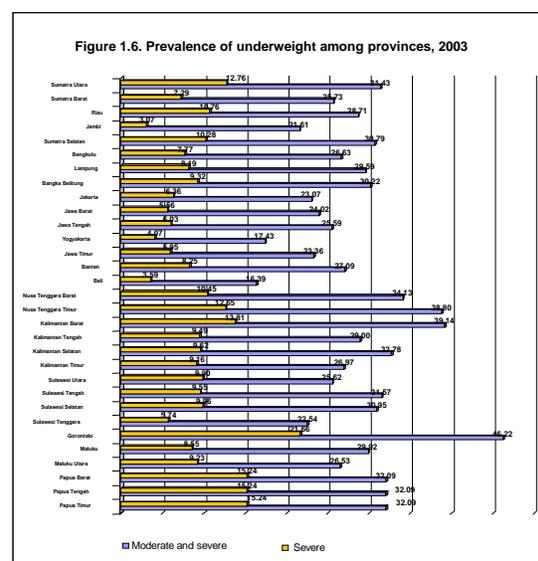
The prevalence of malnourished children was decreasing during the period of 1989-2000 and it was slightly increasing during the period of 2001-2003 (see Figure 1.5). Meanwhile, the number of malnourished children went up from 24.7 per cent in 2000 to 27.5 per cent in 2003.

Challenges

The prevalence of malnourished children is caused by the low consumption of nutritious food and infections. Indirect factors include low-purchasing power and unavailability of nutritious food, especially for mother and children under five. The ratio of children with sufficient nutrition among the region also shows high discrepancy (See Figure 1.6)

Policies and programmes

In order to deal with malnourished children, the following have been done: (1) addressing those with protein-energy malnutrition as well as micro-nutrient deficiencies; (2) empowering society to realize nutrition-aware families, (3) providing food subsidy for



Sumber : BPS, Tahun 2003

the poor; (4) improving the participation of Posyandu, and (5) providing nutrition services for pregnant mother and for children under five who especially from the poor families.

The success of the programmes and policies are not only because of the government's role, but also the participation of business community and community members in supporting.

GOAL 2: ACHIEVING UNIVERSAL BASIC EDUCATION

Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete basic education

Indonesia defines basic education as nine years of primary education (ages 7 to 12 years) and three years of junior secondary education (ages 13 to 15 years). Indonesia's MDG target is therefore more ambitious than the international target of universal primary education. Indonesia's Nine-Year Compulsory Basic Education Programme is targeted at achieving the gross enrolment ratio (GER) of 90 per cent at junior high school level by 2008 at the latest. In this report, the term "primary and junior secondary schools" includes public and private schools (under the Ministry of National Education) and Islamic schools (under the Ministry of Religious Affairs).

Status and trends

Access to education at primary level. The Susenas (National Socio-Economic Survey) 2004 data shows that access to primary level is high. The Net Enrolment Ratio (NER) for primary schools (SD) and Madrasah Ibtidaiyah (MI) has risen from 88.7 per cent in 1992 to 93 per cent in 2004 years (Graphic 2.1). The NERs are significantly different from the Gross Enrolment Ratio (GER). According to Ministry

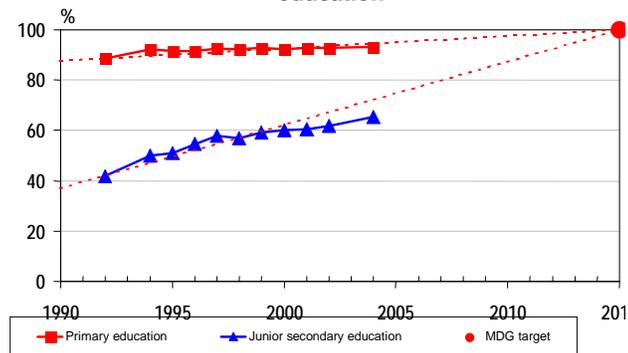
of National Education (MoNE) data of 2002, the GER at primary schools has reached 112 per cent, significantly greater than the NER, which only reaches 94 per cent. This indicates that there is a number of children aged below 7 years (underage) and those whose age is more than 12 years (overage) are still at elementary schools. The Ministry of National Education data shows that primary school students whose age is less than 7 years share 10.3 percent and those whose age are over 12 years are 5 per cent.

There is an increasing number of students aged below 7 years who start their education at primary level, especially in urban areas. On the other hand, the existence of 12-year-old students in elementary schools is of two reasons. Firstly, the children were late to start their school, or they started after they were 7 years old. 42.18 per cent out of 3,433,220 new students at elementary schools in 2002/2001 were over 8 years old. Secondly, some students had to repeat classes so that they had to finish after they were over 12 years old.

With regard to the educational participation, there are no significant differences between rural and urban areas, between men and women, and between economic groups in the community. However, it also reveals that participation at primary level varies by province.

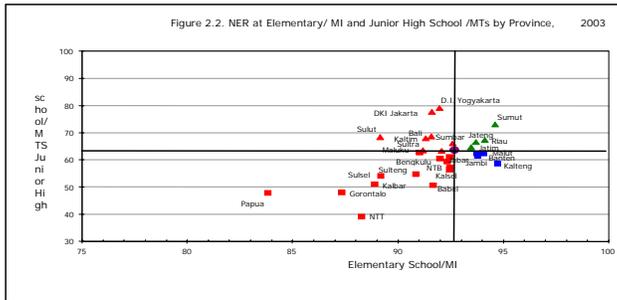
Access to junior secondary school. Access to junior secondary school is increasing significantly during the implementation of 9-Year Compulsory Basic Education

Figure 2.1 Net enrolment ratios, primary and junior education



Source: Susenas

Program. The NER at junior high level (general junior high school) and Madrasah Tsanawiyah/SMP/MTs increased from 41.9 per cent in 1992 to 65.2 per cent in 2004 (Graphic 2.1), while the GER increased from 65.7 per cent in 1995 to 81.1 per cent in 2003. However, the number of participation is not high enough to achieve 90 per cent of GER as a target for the completion of the 9-Year Compulsory Basic Education Program by 2008.

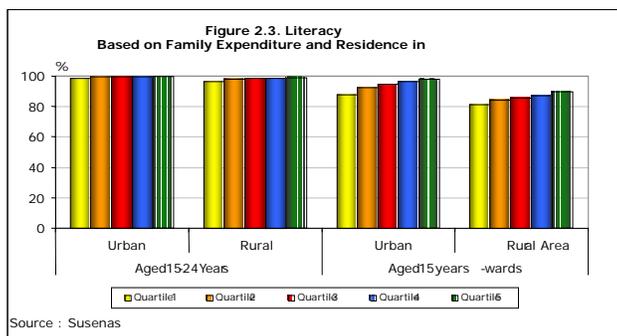


Unlike the primary level, participation at junior secondary level varies among groups in society, such as between rural and urban areas, the rich and the poor, and by province. However, the disparity of participation between men and women is not apparent. In 2004, the NER at new rural areas reached 60.1 per cent, and it was 72.7 per cent in urban areas. With regard to GER, it

was 75.9 per cent in rural areas, and 91.4 per cent in urban areas. A significant disparity occurred between the rich and the poor. In 2004, the GER of 20 per cent of the poorest people (quintile 1) was 63.8 per cent, while that of the richest was 97.6 per cent. In addition, the participation at junior high level varies in the regions. (Graphic 2.2)

The literacy rate. The 2004 Susenas data shows that the level of literacy in Indonesia has improved. At the national level, the literacy level of people aged 15-24 increased from 96.2 per cent in 1990 to 98.7 per cent in 2004. However, the level has been stagnant since 1998. It is because the level of literacy of the age group has been already high enough and those who are still illiterate are the ones who live in the places with poor educational facilities or the disabled. The improvement of literacy level at younger age groups is due to the increasing participation at the primary level and the increasing proportion of primary school students who can continue up to the fifth grade.

With wider age coverage, it is apparent that the number of literate people aged over 15 years is higher than that of 15-24 age-group (Graphic 2.3). This is due to the low level of literacy among older group. However, the number of literate people aged over 15 years increased from 84.2 per cent in 1995 to 90.38 per cent in 2004. Therefore, it can be deduced that disparity of literacy levels among groups of society still exists.



Challenges

The main challenges in Indonesia's educational development are as follows:

- a. Educational attainment of Indonesian population is still low
- b. Dynamics in the population structure has not been fully solved in education development.
- c. There is still wide discrepancy in terms of educational attainment among groups in the community, such as between the poor and the rich, between men and women, between urban population and rural population, and in the regions.

- d. Educational facilities are not yet available evenly, ultimately in rural or remote areas and small islands, so that children might be prevented from accessing education facilities.
- e. The quality of education is still relatively low and does not meet the competency need of the students.
- f. Educational management does not perform efficiently and effectively due to fact that the decentralization of education has not been fully well-implemented. This is characterized by the fact that, among others, responsibilities and duties of the local government and central government are not well defined yet. This includes their contribution in allocating educational budget.

Policies and Programmes

Based on the existing condition and problem faced, the policy of basic education shall be formulated as follows:

- a. Improvement of access and extension of learning opportunities for all school-age children, targeting mainly at those in poor, isolated and remote areas. Starting from the academic year of 2005/2006, the government has provided a huge amount of operational fund as the first step to the implementation of free basic education.
- b. Improvement of quality and relevance of basic education by implementing educational standard nationally as reference and legal guidance for improving the quality of national education, which also covers the quality of teachers and educational staff, the quality of school facilities and infrastructures, competency of the graduates, educational budget and educational evaluation.
- c. Increasing educational budget so that it reaches 20 per cent of the state or regional budget, which is in accordance with the stipulation in 1945 Constitution and Law No. 20 Year 2003 on National Education System. In order to achieve figure of 20 per cent, the government has committed to increase its educational budget gradually. Even, in the last five years time, education budget in the state budget has been the biggest allocation among the development sectors.
- d. Promoting the implementation of regional autonomy and decentralization in the management of education to the education unit level regarding the administration of education.
- e. Strengthening management of educational services in order to develop reliable, efficient, productive, and accountable services through good governance by strengthening educational institution.
- f. Improving public participation in educational development, which also covers the improvement of role and functions of school committee and educational councils in running school and community based education. This includes the planning, monitoring and evaluation of the implementation of educational development programme.

The programme implemented is to run basic education service which is good in quality and accessible to all segments of community. This programme is focused on (i) improving the participation of children who have not been reached by basic education services; (ii) maintaining educational performance already achieved, by decreasing drop-out rates and repetition rate and (iii) providing additional services for children who cannot continue their education to secondary level.

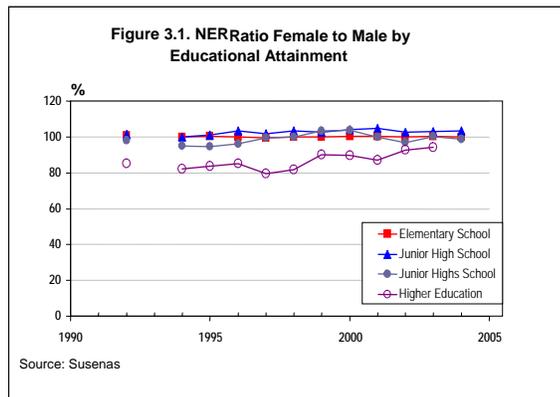
GOAL 3: PROMOTING GENDER EQUALITY AND EMPOWERING WOMEN

Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015

Status and trends

Indonesia has made a progress in improving gender equality and equity with regards to education for both men and women. It can be seen from, among others, the improvement of educational participation and literacy rates men over women, contribution of women in non-agricultural sectors, and women's participation in politics and legislature. However, some problems are to be faced in the future, such as women's low quality of life and roles, high rate of violence against women, some laws and regulations tend to be gender biased and/or discriminative against women, and weak institutionalization and networking for gender mainstreaming, in particular in district/municipality level.

Access to basic education. In general, Indonesia has made a significant progress in achieving gender equality in the field of education (Graphic 3.1). At the basic level, the net enrolment ratio (NER) between men and women is always around 100. However, the Net Enrolment Ratio (NER) of women to men at junior high school level since 1994 has always been more than 100 percent, with the position at 103.4 percent in 2004. By using the gross enrolment ratio (GER) of women to men, it can be seen that women's participation at junior high schools is higher than men, with the ratio of 103.1 percent in 2003. It shows that women's participation is higher than men's. Further analysis shows that women population is bigger than men.

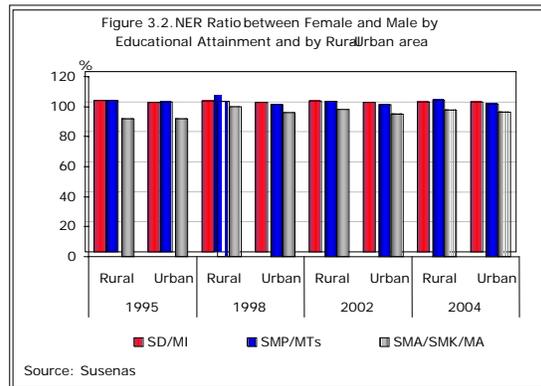


Access to middle and higher education The NER of women to men at middle level of education was fluctuating from 95.2 per cent in 1994 to 103.7 per cent in 2000, and dropped to 98.7 per cent in 2004. The sharp decrease from 1998-2000 was allegedly due to the weakening of economy which had driven male students to drop out and work. At the higher education level, the ratio of women's participation to men's rose from 85.1 per cent in 1992 to 94.3 per cent in 2003, and slightly went down to 93.2 per cent in 2004. . Even though the NER is high, but in terms of absolute number, it shows that the participation at middle and higher levels is still low, both for men and women. In 2004, the NER at the middle level was 43 per cent and the GER at the higher level was 8.6

per cent. Meanwhile, the NER at secondary education was 54.4. per cent and the GER at higher education level was 1.8 per cent. One of the constraints was limited accessibility. The number of schools and universities is limited and the long distance is assumed to be the factor. Early marriage is also the reason behind the drop out.

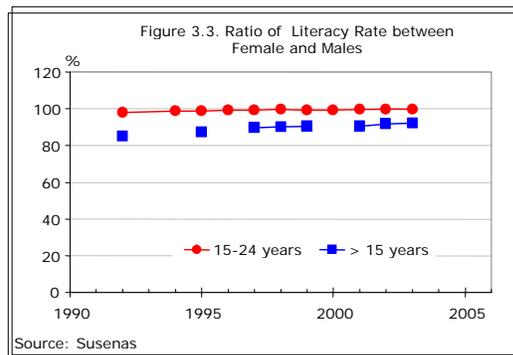
Disparity of family expenditures. The hypothesis that the lower the expenditure of families, the lower women’s participation is not true at elementary and middle levels of education. The census in 2004 shows that the NER of women from poor families (Quartile 1 or lowest 20 per cent by the family expenditure) is similar or slightly higher than that of men. By assumption, it is because of the factor of poverty which leaves men with no choice but to work. But it is a different condition for 20 per cent of the richest groups (quantile 5 or 20 per cent of the richest), with the participation of men is higher than women at all levels of education. Analysis to the GER shows the same trend. However, if the number of educational participation of rich population is compared to the poor, it can be concluded that the participation of the poor is still far below the rich, especially at the middle to the higher levels, both for men and women.

Disparity of urban and rural areas. The NER is not different from that of gross enrolment ratio (GER) between rural and urban areas at basic and middle/ secondary levels. However, the disparity of participation in the rural areas is lower, with the NER of 97.8 per cent for rural areas, compared to 96.4 in the urban areas . (Graphic 3.2)



View of gender bias. Gender segregation in a department or study program as a form of voluntarily discrimination is still to be found. Choosing a department for female students is associated with domestic functions, while male students are expected to support the economy of the family, so they have to choose "hard" study program, such as technology or industry. Majoring at middle level of education still shows stereotypes in the educational system in Indonesia which leads to unhealthy competition by gender. For example, social sciences are dominated by male students, and technical sciences are dominated by male students. In the calendar year of 2000/2001, the percentage of female students studying at industrial technological high school was only 18.5 per cent, agriculture and forestry 29.7 per cent, and in business and management was 64.6 per cent

The level of literacy. An improvement in literacy level, as shown by the increasing number of literate people, indicates that the number of literate people aged between 15-24 increased from 96.2 per cent in 1990 to



98.7 per cent in 2003. (Graphic 3.3) The disparity of literate men and women is decreasing, as shown by the increasing ratio of literate female to male aged 15-24 from 97.9 per cent in 1990 to 99.7 per cent in 2004. If the people aged over 24 are taken into account, the disparity will be greater, namely 92.3 per cent.

Disparity of literacy level by family expenditures. The level of literacy of women increases significantly at all group of family expenditures. In addition to the 15-24 year aged group, there is no difference regarding the level of literacy between men and women. Data of 2004 shows that the ratio of literacy figure between women and man is 99.2 per cent for the poorest group and 99.9 per cent for the richest group.. However, if the range of age is expanded to 15 year, the disparity will be more apparent, with the ratio of 89.1 per cent in the poorest group, and 96.4 per cent in the richest group.

Disparity of literacy level between urban and rural areas. It can be generally concluded that the level of literacy of the people aged 15-24 in the rural areas is not significantly different from than that of in the urban areas. It is shown by the fact the number of literate people aged between 15-24 in the urban areas is only slightly higher the number in rural areas. If the age range is expanded to over 15 years, it will be known that in 2004, the ratio of literacy level between men and women in rural areas is 90.1 .8 per cent and 94.9 per cent in urban areas.

Disparity of literacy level by province. The literacy levels of people aged between 15-24 in 2003 are varied. The range was between 94.2 per cent to 99.8 per cent with the average of 98.6 per cent. The ratio of literate women to men in average in 2003 reached 100. However, if it is separated by province, the ratio is still great, with the range between 89.6 (in Papua) to 103.1 (in Gorontalo). If the range is expanded to over 15 years, the disparity by the province will be greater, with the range between 83.2 (in West Nusa Tenggara) and 99.9 (in North Sulawesi).

Achievement disparity between women and men. Based on the 2004 Human Development Report, the Human Development Index (HDI), the *Gender-related Development Index* (GDI) and the Gender Empowerment Measurement (GEM) are 65,8, 59,2 and 54,6 respectively. Gaps between HDI and GDI shows that the success in human resource development as a whole is not followed by the success in gender and development (GAD). Meanwhile, low GEM rate shows that the participation and opportunity of women is still low, especially in politics, economy and decision making. Indonesia's GDI rate ranks 90, and is much lower than that of ASEAN countries. The 2004 Sakernas (National Labor Force Survey) reveals that women labor force participation rate is lower (49.2 percent), than their male counterpart (86.0 percent). Female wages in non-agricultural sector remains low in 2002 (28,3 percent).

Women participation in public sectors. Women employment participation in Indonesia, especially in public sectors is low. Women representation as decision makers in the executive, judicial and legislative is not significant enough in the process of decision making. Although Act No. 12 Year 2003 on General Election stipulates the affirmative action, i.e. 30 per cent quota for women in the political party, women representation in

the parliament remains low. The proportions of women in the House of Representatives (DPR RI) were 12.0 percent (1992-1997), 9.9 percent (1999-2004), and 11.6 percent (2004-2009). Women representation in DPD (established in 2004) still remains low, i.e. 19.8 percent. Female civil servants who hold structural position such as Echelon I, II, and III also show the same trends of 12 percent. Such low condition is applies in the judicative, 20 percent as ordinary judges and 18 percent as judges in the Supreme Court in 2004.

Challenges

The challenges faced in the efforts to reduce gender gap include: (i) improving the quality of life and the role of women in all development fields, mainly in education, health, economy and decision making; (ii) revising legislations that are gender biased and/or discriminative against women; (iii) increasing women employment and participation in politics; and (iv) implementing gender mainstreaming strategy in all level of government structure (national, provincial and district/ municipality level). In the field of education, the challenges faced by women, among others, include: (i) improving the quality and relevance of education; (ii) providing varied and wider educational services; and (iii) revising educational materials to be gender-sensitive.

Policies and Programs

Gender mainstreaming in all development fields and activities has been determined as one of the mainstream in the Annual and Medium-Term Development Plans. Policy development for the next 5 years are to (i) improving women involvement in political process and public position; (ii) improving education and health services along with other development areas to improve women's quality of life, (iii) revising legal instruments to protect women against violence, exploitation, and discrimination, (iv) empowering gender mainstreaming machineries, coordination, and networking in planning, implementation, monitoring and evaluation of all policies, programmes and activities, including gender statistics and data. In order to improve public access to quality education, the policy should be directed to the implementing the Nine-Year Compulsory Basic Education Programme, reducing the number of illiterate people significantly, and improving educational fairness and equality among the community groups.

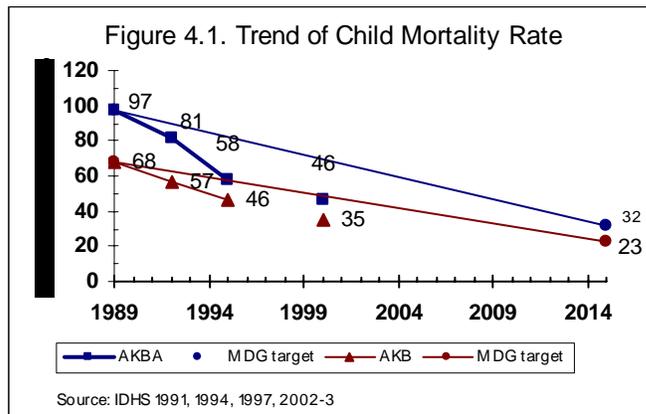
Annual and medium-term development programmes are continuously developed toward gender-sensitiveness. Those programmes shall be targeted to the improvement of women's quality of life and protection, especially in education, health, law, labor, social welfare, politics, environment, and economy. Efforts shall be done to strengthen gender mainstreaming institutionalization, especially in district/ municipality level.

GOAL 4: REDUCING CHILD MORTALITY

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

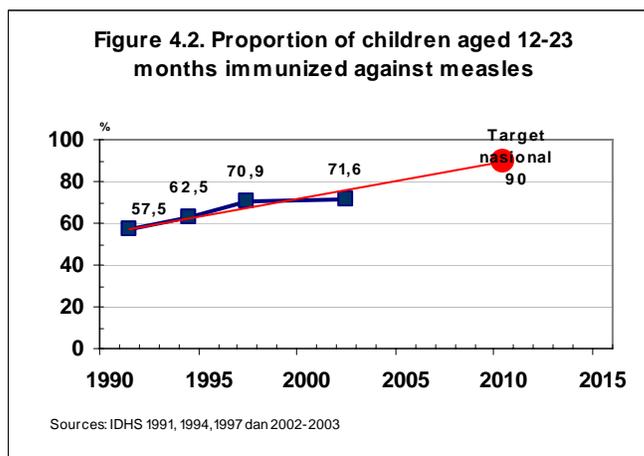
Status and trends

Child mortality rate. In 1960, the under-five mortality rate was still high, at 216 per 1000 live births. The Indonesia Demography and Health Survey in 2002-2003 showed the decreasing number of under-five mortality rate to 46 per 1000 live births during the period of 1998-2002. The decreasing number of under-five mortality rate in average during the 1990s was 7 percent per year, which was higher than the number during the previous decade with only 4 percent per year. By 2000, Indonesia was reaching the target set during the World Summit for Children (WSC).



The infant mortality rate also sharply decreased to 3.5 per 1000 live births during the period of 1998 to 2002. However, the number is still high as compared to other ASEAN nations, which was 4.6 times higher than Malaysia, 1.3 times than the Philippines and 1.8 times than Thailand. The disparity of infant mortality rate by the province is still high, with the highest rate found in West Nusa

Tenggara, which is 5 times higher than the number in Yogyakarta.



Measles immunization. The coverage of measles immunization keeps increasing, but in the urban tends to be higher. The disparity of coverage by province is also still high, with the highest in Yogyakarta (91.1 percent). The lowest percentage of coverage is in Banten (44.0 percent).

Challenges

The cause of child mortality. The three main causes of infant mortality were acute respiratory infections, prenatal complication and diarrhea. Together, the three accounted for 75 percent of infant deaths. The pattern of the main causes of under-five mortality is similar, namely acute respiratory infection, diarrhea, neural diseases - including meningitis, encephalitis - and typhoid.

Neonatal and maternal health. The high mortality rate of infant aged up to one year was associated with the low health status of the mother and the newborn infant, low quality and access to health services, and un-conductive care-seeking behavior of pregnant women, families and communities.

Health protection and services for the poor and the vulnerable groups living in villages and remote areas, as well as in the slums in urban areas is one of the strategic keys to reduce the child mortality rate. The infant mortality rate among the poorest groups is 61 per 1000 live births, which is quite higher than those of the richest group which is 17 per 1000 live births. The infections as the cause of infant mortality, such as acute respiratory infection, diarrhea and tetanus are commonly found among the poorest groups. The health status of this group is low because they have limited access to services due to cost barriers, geographic constraints and poor transportation.

The health decentralization remains a great challenge for health services because institution and personnel roles have not yet been fully addressed. Moreover, a cost-effective intervention and cross-sectoral cooperation in poverty eradication will contribute to the improvement of health status of mother and child.

Policies and Program

Reducing the infant and under-five mortality rate is one the priorities in the health development program as mentioned in the National Development Program 2001-2004. The actual effort in reducing the infant mortality rate during the crisis time has been done through social safety net program and reduction of oil subsidy compensation program, in the form of providing access to primary health services, basic obstetric care, nutrition improvement, revitalization of integrated service post (posyandu), diseases control, and revitalization of food and nutrition surveillance system.

With the implementation of Law No 40/2004 about National Social Security System, improved access to health services will be enhanced by health protection program for the poor, using insurance system with the premiums being paid by the government. With the system, around 36.1 million of poor population will be able to enjoy health services at the health centers and their networks such as sub health centers and village midwives, and the services at the third class hospitals free of charge.

In order to provide the people with an easy access to health service facilities, the focus of health development policy in the 2004-2009 Medium-term Development Plan is directed

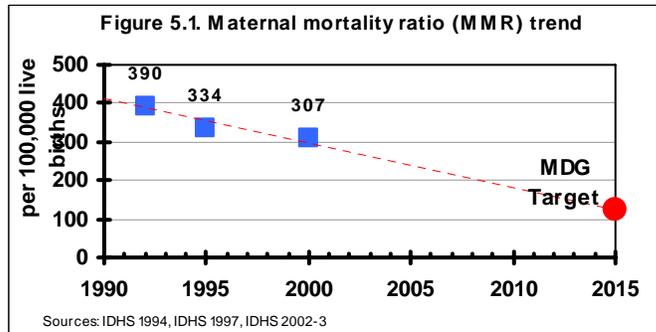
toward the improvement of access, networking and quality of health centers, the improvement of quality and quantity of medical personnel (such as doctors and nurses), and the development of health insurance system, especially for the poor.

Other efforts to reduce the infant mortality rate are to develop community-based health activities, such as integrated service post (posyandu), eradication of protein energy malnutrition, the provision of safe water and basic sanitation, as well as the prevention and eradication of diseases through surveillance and immunization.

GOAL 5: IMPROVING MATERNAL HEALTH

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Status and trends



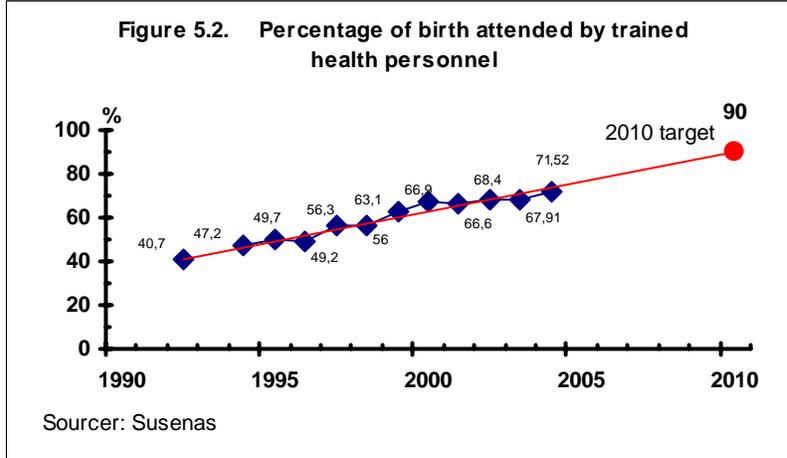
The maternal mortality ratio in Indonesia has dropped to 307 per 100,000 live births (1998-2002). But with 20,000 mothers die each year due to complication during pregnancy and delivery, the MDG's targets will not be achieved unless an intensive effort made to speed up the declining trend.

The disparity of maternal mortality between regions in Indonesia remains high. It also among the highest within ASEAN countries, for example, the life time risk of a mother dying related to childbirth in Indonesia is 1 in 65, compared to 1 in 1,100 in Thailand.

Direct causes. Maternal mortality is mainly caused by hemorrhage, eclampsia, obstructed labor, complication due to abortion, and infections. Hemorrhage contributes to 28 percent to maternal death, eclampsia 13 percent, unsafe abortion 11 percent, and sepsis 10 percent. Modern contraception plays an important role in reducing unwanted pregnancy. In 1997, contraceptive used of married women aged 15-49 was 57.4 percent, and increased to 60.3 percent in 2002-2003 (Indonesia Demographic and Health Survey 2002-2003)

Underlying causes. The risk of maternal mortality is greater due to anemia, chronic energy deficiency, and infectious diseases, such as malaria, tuberculosis, hepatitis, and HIV/AIDS. In 1995, for example, the prevalence of anemia among pregnant women reached 51 percent, and 45 percent among post-partum mothers. In 2002, 17.6 percent of women of reproductive age were suffering from chronic energy deficiency. The levels of socio-economy and education, cultural factors, and access to health facilities, poor transportation, and uneven distribution of trained medical personnel, especially midwives, also indirectly contributed to maternal mortality.

The delivery attended by trained health personnel was increasing, reaching 71.5 percent in 2004. However, the proportion varies among the provinces. The proportion also varies according to the level of income. While 89.2 percent of wealthy women deliver with trained health personnel, only 21.3 percent of poor women do so, highlighting the financial inequalities in accessing health services.



Challenges

Population structure in the future, characterized by higher proportion of reproductive women, will result in increasing demand for health services. Health decentralization has not yet clearly defined the role and responsibility of the central and regional

government. The regions with low financial capability will have difficulties in allocating adequate budget for health programs.

Limited capacity and budget. The latest data shows that the number of village midwives has decreased. Therefore, it will be more difficult for the poor and vulnerable groups to get access in safe delivery. In addition, limited household financial capabilities also make it difficult to get access to basic services. Therefore, innovations in mechanism to address financial constraints at household level are needed in order to guarantee access to services.

Policies and Programs

National priority. As stated in National Development Program (Propenas), reducing the maternal mortality has become the main priority of health development. In order to achieve the purpose, the focus of health development policies will mainly on the improvement of quantity, network, and quality of health centers and the improvement of quality and quantity of health personnel. The policy is expected to make the facilities of medical services closer and accessible to the people. The coverage and the quality of reproductive health services including family planning services shall be improved.

Referring to ‘Healthy Indonesia 2010’, Making Pregnancy Safer campaign has been launched. It focuses on an integrated and systematic planning approach in clinical intervention with the emphasis on partnership. The campaign is done by improving access and coverage of medical services for mothers and new-born babies, developing effective partnership through cross-program and cross-sectoral cooperation, encouraging women and family empowerment, and encouraging people involvement.

In order to improve poor people’s access to health services, the policy is to develop a system of health insurance. The method has been tried since the economy crisis in 1998, through Social Safety Net Program, which offered free services to poor people. In the 2004-2009 National Medium-term Development Plan, the program will be continued and

improved by implementing a system of health insurance with premiums being paid by the government. All poor people can get free medical services at health centers and their network and at third-class hospitals, including services for pregnant women, and delivery, be it normal or difficult delivery. To make people easily access the service, recruitment and deployment of medical staff at hospitals and health centers (especially doctors and midwives) will be done.

GOAL 6. COMBATING HIV/AIDS, MALARIA, AND OTHER DISEASES

HIV/AIDS

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Status and trends

The prevalence of HIV/AIDS among the people aged between 15 and 29 is estimated to be below 0.1 percent. But the prevalence at high-risk groups is more than 5 percent. By June 2005, all provinces have reported HIV infections and 3,358 AIDS cases had been officially reported. But it is estimated that real number is 103,971. The number is smaller than the number of HIV-infected people in Thailand, Myanmar and Vietnam, but bigger than the number in Malaysia and the Philippines. The spread is usually through needles (47.2 percent), heterosexual intercourse (36.4 percent), and homosexual intercourse (5.8 percent).

The use of condoms at the latest commercial sex intercourse in 2004 reached 59.7 percent, or increasing from 41 percent at the previous year. But the survey in 3 cities shows that only 10 percent of 7-10 millions male sex customers use condoms consistently. The use of condom as contraceptives among women in their reproductive age (15-49 year) is very low, 0.7 percent in 1997 and 0.9 percent in 2002-2003 (Indonesia Demographic and Health Survey 2002-2003).

Knowledge about HIV/AIDS. 65.8 percent of women and 79.4 percent of men aged 15-24 have heard about HIV/AIDS (Indonesia Demography and Health Survey 2002-2003). Among women of reproductive age, the majority (62.4 percent) had heard of HIV/AIDS, but only 20.5 percent knew that using condom every time would prevent them from HIV/AIDS.

Challenges

The threat of HIV/AIDS epidemic can be seen from the data of increasing HIV infection, especially among at-risk groups. It is estimated that in 2003, there were 90,000-130,000 people was infected with HIV/AIDS and in 2010 it is estimated that around 100,000 will suffer from or die of AIDS, and 1-5 million will be infected. This data shows that HIV/AIDS is a serious threat for Indonesia.

Policies and Programs

HIV/AIDS prevention, especially among at-risk groups, has been the main focus of the government development program. Handling HIV/AIDS in Indonesia includes

prevention, that is improved quality and access of reproductive health services and knowledge about reproductive rights, treatment and support for the people living with HIV/AIDS and surveillance. Prevention is also aiming at high risk groups such as commercial sex workers and their partners, infected persons and their spouse, drug users, and medical staff who are exposed to HIV/AIDS.

The accessibility of sufferers to medical services will be improved by extending referred hospitals to be 50 hospitals, and 10 hospitals will be appointed as rehabilitation centers for drug users. In the districts where the prevalence of HIV/AIDS is 5 percent or more, a consistent collaboration with the eradication of tuberculosis will be done. The government will also give full subsidy of anti retroviral medicines, tuberculosis medicines, HIV test reagent, and diagnose/treatment through reference hospitals.

Malaria

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Status and trends

Malaria prevalence. In 2001, it was estimated that malaria prevalence was 850 per 100,000 people, and the malaria-specific death rate was 11 per 100,000 among men and 8 per 100,000 among women. More than 90 million people in Indonesia are living in malaria endemic areas. It is estimated that there are 30 million cases of malaria each year, but only 10 percent of which will be treated at health facilities. The highest burden of malaria diseases is in the eastern provinces of Indonesia, where malaria is endemic. Most rural areas outside Java and Bali are also endemic areas. In some other places, malaria is a re-emerging disease.

Among children under five years who experienced clinical symptoms of malaria, an estimated 4.4 percent received anti-malarial drugs, while the vast majority was given other drugs to reduce fever (67.6 percent). About half of cases reported are diagnosed only by clinical symptoms with no laboratory confirmation, which leads to inaccurate and inappropriate treatment.

Challenges

Relation with poverty. High prevalence of malaria reflects financial and cultural constraints in preventing and treating malaria appropriately and effectively. Malaria is linked to poverty as both cause and effect. For example, prevention efforts are focused on minimizing the number of contacts between humans and mosquitoes by using bed nets and residual house spraying. Insecticide-treated mosquito bed nets are an effective way to prevent malaria, particularly for the most vulnerable groups, i.e. pregnant women and children under five years old. But, nationally, about one in three children under the age of five years sleep under a bed net (32.0 percent). Another factor which makes it worse is natural disasters and high mobility of people.

Human resources and Resistance. Since the economic crisis in 1997, some medical staff has retired without replacement, including Village Malaria Workers in Java and Bali, who play an important role in detecting and treating malaria. Resistance is reported to have happened in all provinces, both for existing drug regimes and also for insecticides. This is mainly due to inappropriate treatment and the high mobility of people.

Policies and Programs

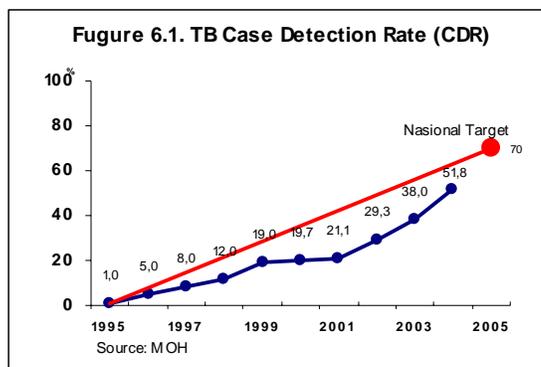
Malaria prevention is intensified through Roll Back Malaria (RBM) approach, which has been operational in *Gerakan Berantas Kembali* (Gebrak) Malaria since 2000. It is also intensified by using early detection strategy and appropriate treatment, active role of the community in preventing malaria, and improvement of concerned personnel' capability. Another important way is an integrated approach of malaria prevention with other activities, such as integrated management of sick children and health promotion.

The malaria control program in Indonesia currently include eight activities, namely early diagnosis and prompt treatment, insecticide-treated bed nets, indoor spraying, surveillance of active and passive case detection, mass fever survey and migrant surveillance, epidemic detection and control, and other measures, such as larvaciding and source reduction, and capacity building. To reduce the problem of chloroquine-resistant strains of malaria, the government will use combination of new combination of drugs to improve treatment success.

Tuberculosis (TB)

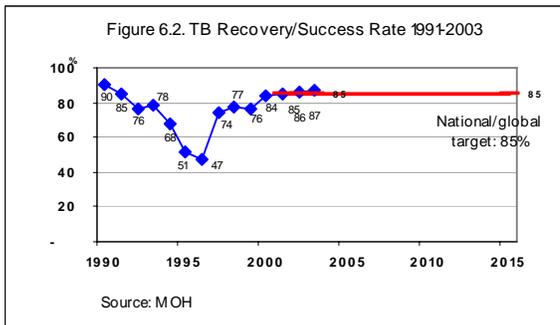
Status and trends

Prevalence. In 1998, national prevalence of tuberculosis was 786 per 100,000 population (new and existing cases); 44 percent were sputum smear positive (SS+). In 2004, the national rate of SS+ dropped to 104 per 100,000 populations, consisting of 59 per 100,000 populations in Java and Bali, 160 per 100,000 population in Sumatra, and 189 per 100,000 in eastern Indonesia.



Incidence. Indonesia ranks third in contributing the highest number of tuberculosis cases to the world's burden, with an estimated 582,000 new cases each year, among which 259,970 SS+ pulmonary cases. The incidence of SS+ for Java-Bali region is 63 per 100.000 and for Outside Java-Bali are 172 per 100.000 populations, with national figure of 110 per 100.000 populations.

The national death rate in 1998 was estimated to be 68 per 100,000 populations. In 2003, the national case fatality rate associated with SS+ is 2 percent. Case detection rate has also increased from 29.3 percent in 2002 to 51.8 percent in 2005.



Directly observed treatment success rate. Cohort analysis shows that 86.7 per cent of cases successfully completed treatment in 2003.

The rate has reached the national and global target of 85 percent in 2000, even though big disparity is still in a number of regions.

Challenges

The challenges in eradicating tuberculosis include increasing government political commitment, accurate diagnosis through sputum microscopy, directly observed treatment success rate (DOTS) compliance, provide uninterrupted drug supply, and how to build the system of reporting and recording.

Policies and Programs

Gerdunas. The Indonesian government considered tuberculosis control a national health priority. In 1999, Minister of Health launched “Gerdunas” (National Integrated Movement for Control of Tuberculosis) in order to promote the acceleration of tuberculosis control measures with integrative approach, involving hospitals and private sectors and other, stakeholders including patients and community representatives. In 2001, all provinces and districts have established Gerdunas, even though not all were fully operational.

In order to build the foundation of sustainable tuberculosis eradication, the 2002-2006 Tuberculosis Control Strategic Plan has been developed. The Indonesian government also contributes considerably to financing tuberculosis control programs. Since 2005, the effort has been supported by free medical services, including medical examination, medicines and free medical treatment for the poor.

Tobacco

Status and trends

Tobacco use is a major contributor to ill health among the poorest families in Indonesia. In 2004, 34.4 percent of people aged above 15 smoked, with the higher prevalence in rural areas (36.6 percent) compared to 31.7 percent in urban areas. The number was an increased from 31.5 percent in 2001. About 77.9 percent of smokers said that they had starting smoking since they were 19 years old, during a time when they may not have the capacity to evaluate the health risks of smoking and the highly addictive nature of nicotine. Given that the vast majority of smokers’ ages above 10

years smoke at home (91.8 percent), it is estimated that 43 million Indonesian children are regularly exposed to passive smoke.

Challenges

Health and economy. In Indonesia, tobacco use accounted for a large proportion of total burden of disease. One of two smokers dies of their habit, and half of these deaths occur during economically productive years. At the social level, tobacco not only affects the cost of health treatment, but also reduces the productivity of the smokers.

Poor groups are the one who are at disadvantage due to tobacco use. In 2001, the poorest households spent 9.1 percent of their monthly expenditure on tobacco, compared to 7.5 percent of the rich groups. Spending scarce household resources on tobacco products instead of food or other essential needs can have a significant impact on the health and nutrition of poor families.

Limited resources. With such a burden, financial support for tobacco controlling is still relatively low. Apart from important analytical support from the WHO and World Bank, there are no other donors that support tobacco controlling in Indonesia, and resources from the government to deal with the problem is very limited.

Policies and Programs

One of the policies made is to maintain the high price with high taxation. It is estimated that 10 percent increase of price will reduce global demand about 4 to 8 percent. Increasing tax and price is an effective strategy to reduce effect of tobacco on health.

In addition, limitation of advertising, promotion and sponsorship of tobacco product is on place. Limitation on advertisement is applied on TV by forbidding cigarettes commercial during the day and at some hours in the evening.

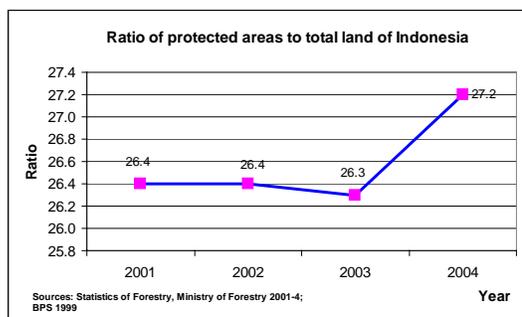
The government also keeps promoting healthy and clean life-style, such as encouraging the people not to smoke. The effort is enhanced by free-smoke movement in certain places, such as offices and public places.

GOAL 7: ENSURING ENVIRONMENTAL SUSTAINABILITY

Target 9 : Integrate the principles of sustainable development into national policies and programmes and to reverse the loss of environmental resources

Status and trends

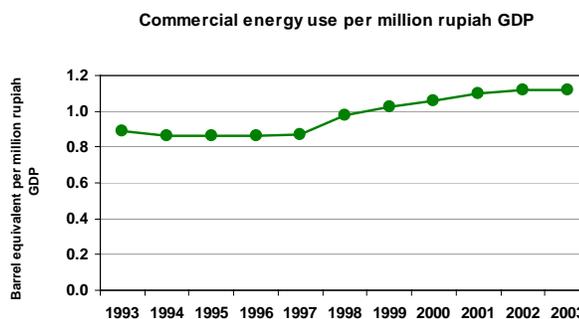
The proportion of forest areas to land has reduced to 63.0 percent in 2004 from 67.7 percent in 1993 and 64.2 percent in 2001. The reduction was caused by illegal logging, bush fires, and forest conversion for development activities, such as mining and road construction and settlement. Indonesia has the biggest forest areas as compared to other ASEAN countries. However, along with the Philippines, Indonesia has the highest rate of deforestation. The deforestation rate during the period of 1985-1997 was 1.6 million hectares per year, and it increased to 2.1 million hectares during the 1997-2001 periods.



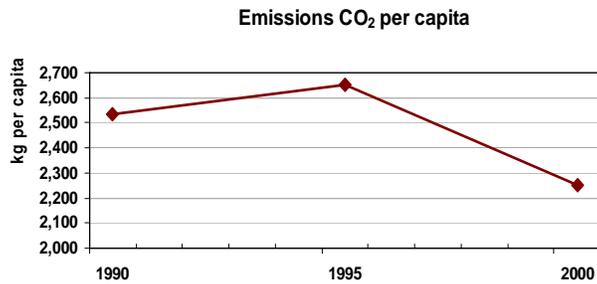
The ratio of conservation areas to the overall land area during the 2001-2004 periods tend to increase. The management of conservation areas faces great challenges, such as illegal cutting of trees in national parks, illegal logging and the violation of borders of conservation areas.

The ratio of energy usage per domestic product tends to increase. It shows that energy usage is not efficient. On the other hand, non-renewal energy resources are limited. It may cause energy crisis in the future.

Indonesia is one of the participant countries of ozone depleting substances (ODS) phase-out programme under the Montreal Protocol since 1992. Even though import of CFC and CFC-related stuff has been banned since 1998, the fact that fulfilling the demand for CFC indicates the existence of illegal import of ODS. Enforcing the ban is difficult in large archipelago like Indonesia.



Sources: Economy and Energy Statistics 2000, Department of Energy and Nature Resources; Indonesia Energy Outlook and Statistics 2004; and BPS



Source: National Strategy Study on Clean Development Mechanism in Indonesia 2001
 Note: emission values after 1994 are projections
 Population data from 1990 and 2000 censuses and 1995 inter-censal survey

First Indonesian National Communication in 1994 inventoried all major greenhouse and related gases, including CO₂, CH₄, N₂O, NO_x, and CO₃. Energy-demand sectors are the biggest contributors to the greenhouse gas emission and their increase to the next two decades. Forestry sector is

expected to contribute 11-13 percent and agricultural sector about 12 percent to the total emission.

Challenges

In the future, there will be four challenges in sustainable development and the restoration of depleted natural resources, namely economy recovery, decentralization, good governance, and globalization. Economy recovery is expected to improve the economy of one-third of the population in forest conservation areas so that the illegal cutting can be reduced. Decentralization is expected to give an opportunity for the restoration of natural resources, conservation, and efficiency, but also poses risks for biodiversity, which may be regarded as a source of regional governments' revenue. Good governance should support sustainable development programs. Globalization also offers an opportunity for sustainable development.

Policies and Programs

In the 2005-2009 National Middle-term Development Plan, the development policies are directed toward the balance management of natural resources and the environment, between their function as the capital of economic growth and as life support system, in order to guarantee the sustainability of the national development program.

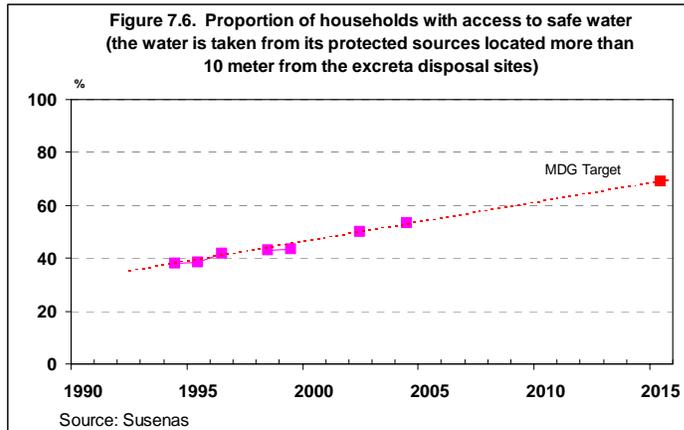
The steps taken and to be taken by the government are as follow. Eradication of illegal logging in a number of regions in order to maintain the number of protected forests and conservation areas. The government has also launched the national movement of forest rehabilitation in order to rehabilitate critical areas. The government is promoting energy-saving movement and the use of alternative, efficient, and environmentally-friendly energy, such as natural gas and bio-diesel. Through the ozone protection program, the government will keep reducing ODS until it will be no longer used by 2010.

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Safe drinking water

Based on the definition that safe water is the water taken from its protected sources located more than 10 meter from the excreta disposal sites, the access to drinking water in Indonesia in 2002 was only 50 percent, where 18 percent was through the piping system. In 2004, it increased to 53.4 percent.

It shows that the access to safe drinking water has improved. However, there is a big amount of fund needed to achieve the MDGs targets by 2015.

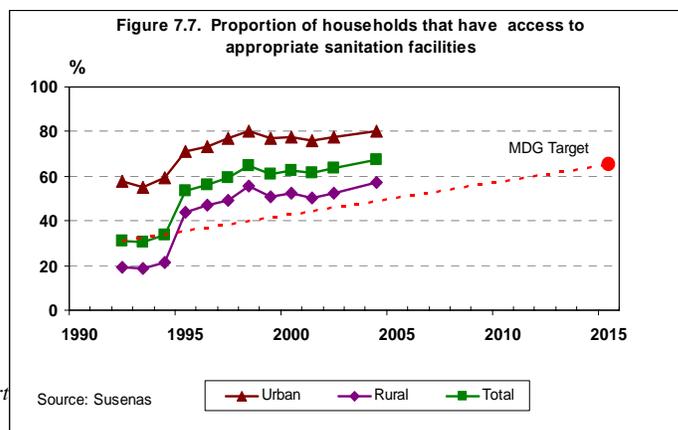


The relatively low access to safe water is the result of the low commitment of the government (both central and local) to build water facilities, low technical-financial-managerial capabilities of Regional Drinking Water Enterprise (PDAM), vague water sector investment regulations which lead to low community and private sector participation in water sector development. Moreover, most of built facilities are not well-maintained and some are no longer operational. The condition worsened by the unavailability of accurate data which is agreed by all stakeholders so that the policy making is not optimal.

Water sector development policies are directed to increase service coverage in order to meet the demand of the community. The improvement of service coverage can be reached by fostering the participation of all stakeholders, Regional Drinking Water Enterprise's performance improvement, regionalization of water management, and regulations improvement. In addition, community-based rural water facilities development also conducted.

Basic Sanitation

Household's access to basic sanitation facilities increased from 63.5 percent in 2002 to 67.1 percent in 2004. Access to basic sanitation has shown major improvement, but most of the facilities don't



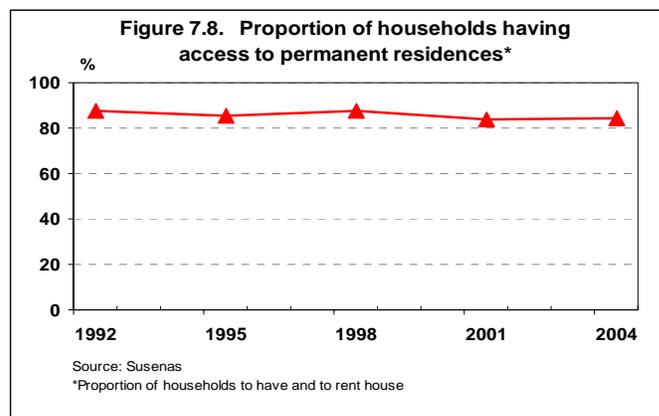
meet appropriate sanitation standards.

The high proportion of households in rural areas without appropriate sanitation facilities is caused by lack of awareness of the community, low priority of the government and legislatures, and low participation of the private sectors in wastewater management.

The policies on basic sanitation development are directed to improve community's access to sanitation facilities by enhancing community's awareness towards healthy life-style, fostering the participation of all stakeholders, and developing community-based sanitation facilities.

Target 11: By 2020, to have achieved a significant improvement in the life of slum dwellers

In 2001, around 17 % of 52 million households (at least 8,8 million households) that still don't have house or live in rented houses. Most of them are live in urban area. In 2004, this proportion have reduced to 16 % or 8,7 million out of 55 million households. This condition worsened by the fact that most of the houses are in poor condition and built on slum areas.



The condition is the result of unsatisfactory housing management, unavailability of supporting regulations, and non-operational of housing management institutions. In addition, the land status is also a big problem.

Fulfilling the demand for affordable, appropriate and safe housing is done comprehensively with the focus on poor and low-income people. Some of the efforts taken were the launching of One Million Houses Development National Movement, improving basic facilities in simple and healthy housing areas, and community-based housing development. In addition, there will be some efforts to develop housing micro credit schemes, new subsidy scheme, and setting up an institution that will responsible for housing development in order to increase low-income people ability to improve or build their own houses. In line with these, secondary mortgage facility (SMF) will be established and new supporting regulations will be developed to increase alternative housing financial resources

GOAL 8: DEVELOP GLOBAL PARTNERSHIP IN DEVELOPMENT

The targets to reach in the Goal 8 include further development of trade and open financial system based on clear, certain, and non-discriminative regulations (including the commitment of good governance and poverty eradication, nationally and internationally), comprehensive settlement of foreign debts through international agreements, and cooperation with private sectors in utilizing technology, especially information technology and communication. The first progress report of MDGs in 2004 did not include description of the Goal 8. Thus the following summary will present the Indonesian Government's views on the focus of the Goal.

Global development aids. According the analysis from the UN, global development aids should be increased in order to help the poor and underdeveloped countries reach the targets of MDGs. As stated in the report of UN General Secretary, any developed country that has not yet fulfilled its ODA commitment should set the time frame to reach the target of 0.7 percent of its GNP before the year of 2006, and reach 0.5 percent in 2009. The increase should be started with allocating fund through international financial facilities, and other innovative financial resources.

Foreign debts. Due to limited domestic financial resources, Indonesia still relies on ODA finance, which is given through foreign debts mechanism, as one of alternative financial resources for development. Up to March 2005, the total of the Government's foreign debts was US\$67.12 billion. The huge amount requires the Government to manage it selectively and carefully. The priority is to make a strategy to manage the foreign debts. The strategy includes the focus of priority on utilizing the debts to achieve the MDGs, improving institutional performance, and reducing the dependency on foreign debts through gradual reduction of debts so as to maintain fiscal sustainability.

In order to reduce the dependency of poor and developing countries on foreign debts, a systematic and sustainable support from the developed countries and international financial institutions is essential. Therefore, Indonesia is supportive of steps taken by international community to cancel poor countries' debts. However, Indonesia still urges the developed countries and donor organizations to expand and intensify the mechanism of debt swap for achieving MDGs.

Trade. As far as trade is concerned, quota-free and duty-free access to export should be given to the less developed countries. Therefore, the Doha round about trade negotiations should fulfil its development commitment. Indonesia has not seen any significant progress in terms of access to international trade. Moreover, intellectual rights have become a hindrance in the flow of technology, knowledge about cheap medicine and other products needed by developing countries. The issue of fair trade should be the main focus in the global development plan, including the national development program. An open and non-discriminative trade system is indispensable.

Partnership. For Indonesia, the implementation of the Goal 8 is one of the requirements to achieve goals 1 to 7. In order to enhance global cooperation in development, the international community should focus on influential issues on

development implementation, such as investment and trade, improvement in terms of quantity as well quality of ODA, foreign debts reduction, and technology transfer.

Global partnership should be based on genuine partnership and cooperation between the developed countries and the developing countries, involving all stakeholders, namely the government, private sectors, and the civil society. The partnership and cooperation offered by Indonesia is that debt swap for MDGs should fully supported. The concept will be more effective in finding a way out for foreign debt problems.

Regional cooperation. Jakarta Declaration stresses on the importance of partnership and regional cooperation in order to achieve MDGs in trade, investment, capacity building, technology support, the infrastructure development, such as transportation, ICT, and environmental sustainability.

Indonesia hopes that the developed countries, donor institutions and international organizations can do scaling up in fostering further global partnership and cooperation in order to help achieve MDGs at global level. Indonesia welcomes some positive initiatives that has been carried out to help achieve MDGs by 2015 and after, be it bilaterally and regionally or globally. As a developing country, Indonesia has made every effort to help other developing countries, including the least developed countries through foreign technical cooperation and triangular cooperation with developed countries. Indonesia also actively participates and helps other developing countries through Non-alignment Movement Centre for South-South Technical Cooperation (NAM CSSTC) in Jakarta. The NAM Centre has been appointed training centre for the implementation of Bali Strategic Plan, United Nations Environment Program (UNEP).

Last but not least, Indonesia believes that without global partnership and cooperation, the global development goals would not be achieved, and without development there would be no prosperity, and without prosperity the global peace would not remain in tact.

SUMMARY OF ASEAN DATA

	Year	Brunei	Cambodia	Indonesia	Laos	Malaysia	Myanmar	Philippines	Singapore	Thailand	Vietnam
HDI rank	2002	33	130	111	135	59	132	83	25	76	112
HPI rank	2002	..	74	35	66	..	45	28	6	78	41
GDI rank	2002	..	105	90	107	52	..	66	28	61	87
Goal 1. Eradicating Extreme Poverty and Hunger											
Proportion of population living below \$1 per day (%)	1990-2002	..	34.1	7.5	26.3	<2	..	14.6	..	<2	17.7
Proportion of population living below National poverty line (%)	1990-2001	..	36.1	27.1	38.6	15.5	..	36.8	..	13.1	50.9
Share of income or consumption - poorest 20% (%)	..	..	6.9 (data 1997)	8.4 (data 2002)	9.7 (data 1997)	4.4 (data 1997)	..	5.4 (data 2000)	5 (data 1998)	6.1 (data 2000)	8 (data 1998)
Children underweight for age (% under age 5)	1995-2002	..	45	26	40	12	35	28	14	19	33
Goal 2. Achieving Universal Basic Education											
Net primary enrolment ratio (%)	2001/02	..	86	92	83	95	82	93	..	86	94
Children reaching grade 5 (%)	2000/01	93	70	89	62	..	60	79	..	94	89
Adult literacy rate (%)	2002	93.9	69.4	87.9	66.4	88.7	85.3	92.6	92.5	92.6	90.3
Youth literacy rate - ages 15-24 (%)	2002	99.1	80.3	98.0	79.3	97.2	91.4	95.1	99.5	98.0	..
Goal 3. Promoting Gender Equality and Empowering Women											
Net primary enrolment (ratio of female to male)	2000/01	..	0.93	0.99	0.92	1.00	1.00	1.02	..	0.97	0.94
Net secondary enrolment (ratio of female to male)	2000/01	..	0.60	0.95	0.81	1.10	0.94	1.20	..	..	..
Gross tertiary enrolment (ratio of female to male)	2000/01	1.77	0.40	0.86	0.57	1.09	1.75	1.29	..	1.09	0.76
Youth literacy (female rate as % of male rate)	2002	..	90	99	85	100	100	101	..	100	..
Seats of parliament held by women (% of total)	..	..	10.9	8.0	22.9	16.3	..	17.2	16.0	9.6	27.3
Goal 4. Reducing Child Mortality											
Infant mortality rate (per 1,000 live births)	2002	6	96	33	87	8	77	29	3	24	30
Under-five mortality rate (per 1,000 live births)	2002	6	138	45	100	8	109	38	4	28	39
One-year-olds fully immunised (%)	2002	99	52	76	55	92	75	73	91	94	96
Goal 5. Improving Maternal Health											
Maternal mortality ratio (per 100,000 live births) - reported	1985-2002	0	440	380	530	30	230	170	6	36	95
Births attended by skilled health personnel (%)	1995-2002	99	32	64	19	97	56	58	100	99	70
Contraceptive prevalence rate (%)	1995-2002	..	24	57	32	..	33	47	62	72	78
Goal 6. Combating HIV/AIDS, Malaria and Other Diseases											
Condom use at last high risk sex - women (% ages 15-24)	2002	..	43	..	..	..	..	..	..	..	..
Condom use at last high risk sex - men (% ages 15-24)	2002	..	..	..	..	..	..	..	..	..	..
Malaria cases per 100,000 people	2000	..	476	920	759	57	224	15	..	130	95
Children under age 5 with insecticide treated bed nets (%)	2001	..	..	0	..	..	..	..	..	..	16
Children under age 5 with fever treated with anti-malarial drugs (%)	2001	..	..	4	..	..	..	..	..	..	7
Tuberculosis cases per 100,000 people	2002	58	734	609	359	120	176	540	44	179	263
Tuberculosis cases detected under DOTS (%)	2002	121	52	30	43	78	73	58	39	73	82
Tuberculosis cases cured under DOTS (%)	2001	56	92	86	77	79	81	88	88	75	93
Population with sustainable access to affordable essential drugs (%)	1999	95-100	0-49	80-94	50-79	50-76	50-79	50-79	95-100	95-100	80-94
Goal 7. Ensuring Environmental Sustainability											
GDP per unit of energy use (1995 PPP US\$ per kg of oil equipment)	2001	..	..	3.7	..	3.6	..	6.8	2.9	4.8	4.0
Carbon dioxide emissions (metric tons per capita)	2000	..	..	1.3	0.1	6.2	0.2	1.0	14.7	3.3	0.7
Carbon dioxide emissions (% share of world total)	2000	..	..	1.1	..	0.6	..	0.3	0.2	0.8	0.2
Population with sustainable access to an improved water sources (%)	2000	..	30	78	37	..	72	86	100	84	77
Population with sustainable access to improved sanitation (%)	2000	..	17	55	30	..	64	83	100	96	47
Goal 8. Partnership for Development											
Telephone mainlines (per 1,000 people)	2002	256	3	37	11	190	7	42	463	105	48
Cellular subscribers (per 1,000 people)	2002	401	28	55	10	377	1	191	796	260	23
Internet users (per 1,000 people)	2002	102.3	2.2	37.7	2.7	319.7	0.5	44.0	504.4	77.6	18.5
Total debt service as % of GDP	2002	..	0.5	9.8	2.7	8.5	..	11.8	..	15.6	3.4
Total debt service as % of exports of goods and services	2002	..	0.8	24.8	9.0	7.3	2.9	20.2	..	23.1	6.0

Source: UNDP, Human Development Report 2004