Report on the Basic Survey of Population and Development in Southeast Asian Countries
– Indonesia –

FEBRUARY 1987

The Asian Population and Development Association (foundation)

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THE ASIAN POPULATION AND DEVELOPMENT ASSOCIATION, 1987

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Courtesy visit to the Chairman, Dr. Haryono Suyono, National Family Planning Coordinating Board.

Discussion on survey outline at the Ministry of Transmigration. From right: Mr. Sembiring, Mr. Sayekti, Mr. Oetoyo, Mr. Manurung, Dr. Toshio Kuroda (Chairman) and Ms. Keiko Ono.

With persons subject to research at Grogol RW01 district.

Visit to Warna Agung (company). Receiving explanation about corporate health and welfare service.

Foreword

This report presents the findings of a basic survey of population and development in Indonesia in 1986. The Asian Population and Development Association (APDA) was entrusted with a survey called the "Basic Survey of Population and Development in Southeast Asian Countries" by the Ministry of Health and Welfare and Japan International Corporation of Welfare Services. APDA selected Indonesia as the country to conduct its field survey. The field survey and analysis of the resultant findings were conducted by APDA's survey committee (Chairperson, Dr. Toshio Kuroda, Director Emeritus, Population Research Institute, Nihon University). In order to make effective population policy in Southeast Asia and other areas, it is necessary to carefully define population dynamics, such as population growth, disease, mortality, reproduction, population distribution and internal migration, as well as defining static population data including family structure and population structure. In addition, the effects of these factors on living standards, welfare and medical care must be reviewed.

The objective of the survey was to contribute to solving problems related to population and development in Asian nations by conducting a detailed survey of population dynamics, living standards, and health and medical care in Southeast Asian countries.

The field survey was conducted with the guidance and cooperation of His Excellencey Mr. Martono, Minister of Transmigration, Mr. Toshiaki Muto, the Japanese Ambassador to Indonesia, and Mr. Kazuo Hirayama, First Secretary of Embassy of Japan. Also, the officials of the Ministry of Transmigration contributed to the field survey in various ways. In Japan, members of the Minister's Secretariat Policy Planning and Evaluation Division, the Ministry of Health and Welfare, and Aid Policy Division, Economic Cooperation Bureau, the Ministry of Foreign Affairs cooperated in arranging for the field survey. I would like to express my heartfelt gratitude to all of them.

In conclusion, I sencerely hope that this report will contribute to the further advancement of the population and development program in Indonesia as well as to the effectiveness of the Japanese Government's cooperation with Indonesia.

Furthermore, I would like to add that the responsibility of this report lies with APDA and does not necessarily reflect the views or policies of the Ministry of Health and Welfare or the Japanese Government.

February 1987
Tatsuo Tanaka, Chairman
The Asian Population and
Development Association

C O N T E N T S

CHAPTER 1 SUMMARY

In Indonesia, there are a number of challenging, crucial and difficult problems regarding such matters as the huge and increasing population, economic development, and the raising of living standards. In spite of these troubles, however, Indonesia has been achieving great success in these fields, thus offering instructive lessons as a developing nation.

In 1985, Indonesia's population exceeded 166 million and it is estimated that it will reach 211 million in 2000, and 273 million by 2025 (1984 estimates by the United Nations)(*1). Indonesia has abundant natural resources, as well as the labor force necessary for their exploitation. Self sufficiency in food has been accomplished through outstanding productivity increase. However, there are still serious problems left. An important immediate tasks to be achieved is to decrease the birth rate in order to moderate population growth, to redress the extreme imbalances in the distribution of population, and to promote development. The comprehensive approaches taken to solve those problems are mainly based on the concept of "PANCASILA", five principles which are basic background ideologies of the national foundation of Indonesia and the spirit of mutual support in a local community which is called "Gotong Royong".

Indonesia is a very unique nation. Its 1985 population of 166 million, makes it the fifth largest nation in the world, after the U.S. Indonesia consists of more than 13,600 islands. There are five main islands: Kalimantan, Sumatera, Irian Jaya, Sulawesi and Jawa. Each of these islands, excluding Sulawesi and Jawa is bigger than Japan. Kalimantan is the largest, with approximately 540,000 km^2, one and a half times Japan's 370,000 km^2.

Indonesia entire area is 1,920,000 km^2, approximately 5.1 times that of Japan. Its population density of 84 people per square kilometer is no more than 1/4 of Japan's population density (*2).

One goal of Indonesian population policy is to deal with the unbalanced geographical distribution of Indonesia's population. 100,560,000 out of 166 million people, or 60.9% of the total population live on Jawa, which has only 6.9% of country's land area. Therefore, the population density there is as high as 690 per square kilometer, or more than twice the Japanese density of 325 per square kilometer. At the same time, the population density on the other islands is very sparse. For example, on Kalimantan, the biggest island only 12 people live in each square kilometer, while on Irian Jaya, only 5 people do. The population density on irrigated agricultural land in Jawa is 2,000 people per square kilometer, which is equivalent to Japanese population density on agricultural land (it is 2,183 people per square kilometer of arable land in 1982). The reason for the concentration of the population in Jawa is her fertile volcanic soil. Consequently, in spite of the remarkable increase in the agricultural population, it has been

possible to maintain or even increase labor productivity by adding more labor. However, there is a limit to the potential for absorbing population increase. Gradually, labor productivity got lowered and farm household income has dropped. "In 1980, an estimated 47 percent of rural Jawanese were below the absolute poverty line, compared with 28 percent of the rural population of the other islands."(*3)

Reflecting the serious over-population in Jawa and the poverty in rural villages, it became very important to promote population migration to the sparsely populated islands. A migration policy had already been adopted under Dutch rule. In 1950, after independence, the Indonesian government has strongly promoted a program called "transmigration". The details of the transmigration policies of the Indonesian government will be discussed in Chapter 3-4. Needless to say, Indonesian transmigration policies function not only as a population re-distribution policy, but also as a development policy.

The second goal of Indonesian population policy is family planning and controlling population increase. In Indonesia the family planning program was started in 1969 and has been successful in decreasing the birth rate by means of strong governmental organization and direct and intensive control over lower administration units. It is worthy of special mention that high international esteem is given to the organization and the activities of BKKBN (Badan Koordinasi Keluarga Berencana Nasional, which means National Family Planning Coordinating Committee) which plays the role of the coordinator within the governmental system. According to U.N. statistics(*4), the 1985 birth rate is 32 while the death rate is 13. The natural rate of increase of population thus comes to 1.9%. This shows a remarkable drop in the rate of population growth compared to the approximately 3% rate before the family planning program began.

The rate of population growth varies considerably by region (*5). For example, in 1983-1984, in Jawa the rate was 1.88%, 3.23% in Sumatera, and 2.91% in Kalimantan. The same kind of gap is recognized within Jawa, Jakarta has the highest rate with 3.80%. Lampung in Sumatera has a higher record of 5.57%. It goes without saying that the rates in Jakarta and Lampung are mainly affected by population inflow to those cities. In Bali, however, it is 1.50%, which is extremely low. Several surveys explain that this comes from the drop in the birth rate because of successful family planning.

We will look closely at family planning policy in Indonesia in Chapter 3-2.

The third point to be mentioned is the specific characteristic of the labor population: regular permanent employees account for less than 30% of the labor force while the so-called informal sector is larger in absolute numbers of workers. According to Director General in

charge of the Ministry of Manpower, the informal sector accounts for 52 % of the entire Indonesian labor force and reaches 56% in Jakarta (*6). In other words, it is not appropriate to talk about the Indonesian economy and Labor problems without taking account of informal sector. Furthermore, in the field survey, we found out that the income of workers in the informal sector is not necessarily lower than that of regular workers.

In the field survey in Jakarta that we conducted with the cooperation of the Ministry of Transmigration, we could compare the communities where people in the informal sector live with several private companies. I would like to add that this excellent idea of including private companies as control groups was based on the Indonesian counterpart of the survey.

The purposes and methodology of the survey are explained in Chapter 5-1, and the results of the survey are analyzed in Chapter 5-2. The survey does not represent all population of Jakarta completely in terms of the scale and the scope of the objects of study. Moreover, it is likely that some parts of the results are statistically questionable and the analysis are incomplete because the survey was conducted in an extremely limited period. However, due to the very efficient execution and cooperation by the Indonesians, such as proper choice of the sample regions and careful preparations prior to the survey, the survey went well and I think the results are suggestive and valuable. These results are better understood and interpreted by professionals in Indonesia than by us, who are not familiar with Indonesia. On the other hand, however, we do hope that our point of view is not totally useless. It sometimes happens that the analysis of Japanese conditions by foreigners teaches us things that we have never noticed nor known, just because we are Japanese.

I would appreciate it if our analysis, in spite of its imperfection, is taken in this way, as one interpretation of Indonesia from a Japanese point of view.

Notes

(*1) Population Newsletter, Number 38/39, the Population Division, Department of International Economic and Social Affaris, July 1986.

(*2) The areas are from Statistik Indonesia 1984 (Statistical Pocketbook of Indonesia), Bureau Statistics Indonesia, 1985.
The population is from Population Newsletter, Number 38/39, July 1986.

(*3) World Development Report, The World Bank, 1984, p. 99.

(*4) United Nations World Population Chart 1985.

(*5) The following rates of population increase by region are based on Statistik Indonesia 1984, Bureau Statistics Indonesia.

(*6) According to the census of the population in 1980, the informal sector occupies 74.1% of male labor and 80.4% of female labor in agricultural villages, and 39.1% of male labor and 51.5% of female labor in the cities.
Humala Tambunan, Payaman J. Simanjuntak, and Prijono Tjiptoherijanto, The Importance of the Informal Sector in Labor Market and Manpower Planning, paper presented at the International Conference on Manpower Planning and Development, Bangkok, April 1986, pp. 7 - 11.

CHAPTER 2 GENERAL SURVEY OF INDONESIA

1. The Land and People

(1) Natural Condition

Indonesia is an archipelago consisting of over 13,000 islands. Its five major islands are; Kalimantan (539,000 square kilometers) which occupies two-thirds of Borneo, Sumatera (474,000 square kilometers), Irian Jaya (422,000 square kilometers) which occupies the western half of Papua New Guinea, Sulawesi (189,000 square kilometers), and Jawa (132,000 square kilometers). As a great volcanic zone runs along the Indian Ocean, the islands of Sumatera and Jawa abounds in volcanoes.

Indonesia is a vast country with 1,919,443 square kilometers of land area (5.2 times that of Japan) and 3,166,000 square kilometers of territorial waters. The country is located between 6 8' north latitude and 11 15' south latitude and between 94 45' and 141 65' east longitude.

Although the climate differs from region to region, the country generally belongs to tropical rain forest climate. Influenced by monsoon rainfall patterns, it has four seasons; June-September (dry season), October-November (intermediate), December-March (rainy season) and April-May (intermediate). In general, the climate is hot and humid throughout the year.

The country is rich in mineral resources including oil, natural gas, tin, bauxite and iron ore.

(2) People

The total population of Indonesia in 1984 was about 160 million. It is characterized not by a single racial group, but by a multiplicity of racial and ethnic groups, which is particularly important in understanding the country. Of more than 13,000 islands, only about 6,000 are inhabited and about 63% of the total population lives in the islands of Jawa and Bali.

Major ethnic groups and languages (in parentheses) are as follows:

<Jawa>

(1) Jawanese (Jawanese) - live in central and western Jawa and consist of 60% of the population of Jawa
(2) Sundanese (Sundanese) - live in western Jawa and consist of 20% of the population of Jawa

<Madura>

(3) Madurese (Madurese)

<Sumatera>

(4) Acehs (Acehs)
(5) Bataknese (Bataknese)
(6) Minangkabauan (Minangkabauan) - the largest group in Sumatera
(7) Malaysian (Malay)

<Lesser Sunda Islands>

(8) Balinese (Balinese)
(9) Sasaks (Sasak)
(10) Ambonese

<Kalimantan>

(11) Dayaks (Dayak)

<Sulawesi>

(12) Torajas
(13) Buginese
(14) Makasarese

<West Irian>

(15) Papuans
(16) Negritos

Besides the above-mentioned indigenous people of the Malaysian race, there are about 2,500,000 Chinese (Overseas Chinese), about 150,000 Europeans, and about 80,000 Indians and Arabs.

As there are over 300 different ethnic groups, including minorities, with various different languages spoken, the national unification was not an easy task. Along with the rise of nationalism in the 1910s and 1920s, the movement of language unification also progressed. With the enactment of the constitution of 1945, the present Bahasa Indonesia, which evolved from the language of Malay and was widely used during the Sriwijaya era (7-14th century), was accepted as an official national language.

From the time it was colonized by the Dutch in 1602, Indonesia remained under colonial rule for about 350 years. During this period, the cultivation of cash crops such as indigo, sugar, coffee, pepper, tobacco, tea, cotton and clove was forced, and a colonial agriculture was formed, centered on large-scale plantations. The production of rice, the cornerstone of the local agriculture, was suppressed. Therefore, from earlier days, there had been repeated protests against the Dutch rule. Because of the Dutch divide and rule policy, however, no

effective independence movement was formed until the early 20th century.

In 1908, a nationalist organization named Budi Utomo Association (meaning high endeavor) was founded. This was the first organized nationalism leading to national unification and the anti-colonial movements in later days. In 1928, a well-known "Youth Oath" was taken by the Indonesia Youth Association formed by young people from various ethnic groups. They thus declared; "we, the Indonesian young men and women, acknowledge the one and only people of the Indonesian people. We acknowledge the only language as the Indonesian language." The song of Indonesia Raya (meaning great Indonesia) was also sung, and it was later designated the national anthem in the constitution of 1950. This gave great support for national unification and independence movements which later led to wide spread nationalistic movements by students, intellectuals and political activists.

In January 1942 the Japanese army invaded Indonesia, evicted the Dutch army, and occupied the country. Japan surrendered on August 14, 1945 and three days later, on August 17, Soekarno, Hatta and other leaders proclaimed the independence of Indonesia. Then, after a few years of postwar negotiations, the Netherlands finally approved Indonesian independence at the Round Table Conference at The Hague of 1949.

Thus, the Indonesian people underwent the long experience of being under colonial rule and the struggle for national unification and independence. Even now, as a multiracial, multi-language and geographically dispersed and decentralized country, Indonesia is faced with difficulties of unification. It should be noted, however, that there has so far not been any separation and independence movements by any particular ethnic groups (except in the islands of Timor and West Irian, which have long been separated from the unification movements).

Furthermore, there exists a strong antipathy towards the Chinese merchants who dominated commercially from the colonial days. After the independence, there has been a number of anti-Chinese riots stimulated by political and economic incidences.

2. Government and Administration

Indonesia is a republic with the president as the head of state. The present constitution is the one enacted on August 18, 1945. It was first replaced by the Provisional Constitution of United States of Indonesia in 1949, and then by the Provisional Constitution of the Republic of Indonesia in 1950. However, as a result of the presidential decree of July 5, 1959, which decided to return to the constitution of 1945, 'the constitution of the Republic of Indonesia of 1945' again became the national constitution.

The present constitution declares independence and the five national tenets of Pancasila in its preamble, and stipulates the doctrine of popular sovereignty, the People's Consultative Assembly, the presidential government, the Supreme Advisory Council, local autonomy, the House of Republic Representatives, finance, justice, people, religion, defense, education and social welfare in its text. The constitution adopts the principle of the separation of the three powers, with the People's Consultative Assembly and the House of Republic Representatives as the legislative organs, the presidential body as the administrative organ and the Supreme Court as the judicial organ. The constitution, however, consists of only 37 articles (4 transitional clauses) and does not provide for basic human rights.

The government structure of Indonesia is based on the Memorandum of the House of Republic Representatives (DPR), which lays down the administrative structure of the Republic of Indonesia, the origin of laws and the sequence of laws and regulations. It was accepted by the People's Consultative Assembly (MPR) in 1966. According to this, the five tenets of Pancasila the ideological basis of the country. They are: (1) belief in the one Supreme God, (2) just and civilized humanity, (3) the unity of Indonesia, (4) democracy, and (5) social justice. These tenets are expressed in: (1) the Declaration of Independence of 1945, (2) the presidential decree of July 5, 1959, (3) the constitution of 1945, and (4) the presidential order of March 11, 1966, which are considered the origins of the state power. Laws and regulations, with the constitution of 1945 of the Republic of Indonesia at the top, are sequenced in the following order: decisions by the People's Consultative Assembly, laws decided by the House of Republic Representatives and regulations as substitute for the laws, general orders, presidential decisions, and other regulations. The overall structure of the government formed under the national consensus, is shown in Figure 1.

Although taking a two-chamber system, it is not like that of Japan. The People's Consultative Assembly (MPR) is the supreme power. It has 920 members half of which (460) consists of all members of House of Republic Representatives and the other half of the provincial representatives (in proportion to the population, appointed by the chairman of the District House of People's Representatives), proportional representatives (decided as a result of the general election of the House of Republic Representatives), and representatives of various functional groups (appointed by the president). The People's Consultative Assembly is responsible for enacting and revising the constitution, determining the guidelines of state policy, and appointing the president and vice-president. The House of Republic Representatives (DPR), on the other hand, consists of 360 members elected by the general election, and 100 members appointed by the president. It is a legislative assembly responsible for drafting all the laws other than the constitution. The House of Reublic Representatives and the president have the right to introduce bills. A meeting of the House of Republic Representatives

must be held at least once a year.

The terms of office of the MPR and DPR members and the president is five years. The general election, the political highlight of the country, was last held on May 4, 1982 and the five-year term of the MPR and DPR members started from October 1, 1982, and that of the president from March 1983. The next election is scheduled to be held next year in 1987.

Under President Soeharto and Vice-President Umar, the present administration consists of 21 ministries, 37 ministers and junior ministers and 3 ministry-equivalent organs (Figure 2). The present cabinet is called 'the Fourth Development Cabinet'.

The local administration of Indonesia is under the jurisdiction of the Ministry of Home Affairs. The country is divided into provinces (propinsi), districts (kabupaten), subdistricts (kecamatan), villages (desa), and the three special districts of Jakarta D.K.I. Yogyakarta, and Aceh. Besides, these special districts which are equivalent to propinsi, there are also municipalities (Kata Madya) equivalent to kecamatan and towns (Kelurahan) equivalent to desa.

All local governments have heads appointed by the centeral government (except the heads of desa, who are locally elected), and assemblies which are elected by the people. Their revenue sources include subsidies from the central government, local taxes, and revenues from local public works.

3. Economy and Economic Policies

The Indonesian economy can be characterized by its heavy dependence on agriculture and mining, which together consist of over 40% of the country's GDP. The country's per capita income of US$590 in 1984 was the lowest among the ASEAN countries. As the importance of primary commodities i.e., agriculture and mining is shown in Table 1, manufacturing accounts for only 12% of the GDP, whereas agriculture accounts for 25% and mining 18%.

After the so-called '30th September Movement' in 1965, Indonesia had fallen into political and economic disorder for some time. It was not until 1969, when the economic development plan was introduced, that full-scale economic development was started. So far the first (1969-73), second (1974-78), and third (1979-83) 5-Year Development Plans were implemented and the fourth (1984-88) is now under way. From the beginning, the Indonesian government attached utmost importance on increase of food production to achieve self-sufficiency (especially that of rice), and the improvement of the industrial infrastructure. At the same time, the government had actively promoted the development of oil and other

resources.

The first oil crisis in 1973, which quadrupled the oil price, brought about an 'oil boom' to the country. Together with the worldwide price increase of other primary commodities, the Indonesian economy with abundant resources rapidly expanded. In addition, massive economic aid from the Inter-Governmental Group on Indonesia (IGGI) greatly contributed to the Indonesian economic development. The rapid economic expansion during the 1970s, also brought about increased imports of foodstuffs, machinery and equipment related to development, and consumer goods due to rising living standards.

As a result of the second oil crisis in 1979, Indonesia's foreign exchange earnings from exports again increased. The GDP increase over the previous year recorded 6.3% in 1979, 9.9% in 1980, and 7.9% in 1981. However, because of prolonged worldwide recession caused by the second oil crisis and US economic policies, oil exports became stagnant, and the exports of other primary commodities decreased. The Indonesian economy slowed down, and the GDP increase dropped to 2.2% in 1982, and 3.3% in 1983. It was during the third 5-Year Development Plan, which had set growth targets by industry were set (Table 2) with the three main goals of high economic growth, fair distribution of the development results, and the stabilization of the country. All industries except agriculture were not able to achieve the targets. In particular, mining recorded a -1.7% annual increase in contrast to a targeted 4.0% increase, reflecting the short-lived 'oil boom' after the second oil crisis and serious aftereffects of sluggish export and declining prices. Nonetheless, it should be noted that during the third 5-Year Development Plan, rice recorded an annual production of 23.96 million tons, finally achieving food self-sufficiency.

The achievement of food self-sufficiency had been the national goal since the independence of the country. The government had carried out a number of projects including Bimas (mass guidance of food supply), Inmas (mass intensive cultivation project), Bimas-Gotong-Royong, and Improved Bimas. These projects promote increased production nationwide through the introduction of high-yield varieties, fertilizer and agricultural chemicals, the modernization of agricultural technology, the expansion of agricultural credit, and the expansion of cultivated areas. In addition, large-scale irrigation projects and regional development projects in eastern and central Jawa, Sumatera, and other areas have expanded farmland and increased productivity. At the same time, Japanese economic aid for the Brantas River Comprehensive Development Project, several increased food production projects and others have also contributed greatly to Indonesia's agricultural development. With the self-sufficiency in food, the country's food policy has now entered a new stage.

The fourth 5-Year Development Plan, which was started in 1984, is

now under way. Succeeding the basic goals of the third Plan, it sets the development targets by industry as in Table 2. Although self-sufficiency of rice has been reached, the economy has been stagnant due to overall sluggish exports of oil and other primary commodities. Because of the sharp decline in the price of oil from 1985 to 1986, the country's foreign exchange earnings decreased significantly and oil tax which shares 60% of government income is insufficient by a large margin. The government, therefore, was forced to tighten its budget by restraining development projects and reducing subsidies.

Though rich in resources, the living standard of the country is still not high because of its large population etc. As close economic relations exist between Indonesia and Japan, it is expected that Japanese economic cooperation contribute to Indonesia's effective use of its rich resources, and the distribution of benefits from the economic development among the Indonesian people.

Table 1 Gross Domestic Production by Industry (current value).

(one billion rupiah)

Industry \ Year	1983	(%)	1984	(%)	1985	(%)
Agriculture, forestry & fishery	17,696	24.0	21,424	24.9	22,650	23.6
Mining	13,652	16.5	15,218	17.7	15,609	16.3
Manufacturing	8,528	11.6	10,318	12.0	12,983	13.5
Electricity, gas & water	524	0.7	700	0.8	781	0.8
Construction	4,597	6.2	4,883	5.7	5,107	5.3
Wholesale & retail	12,009	16.3	13,372	15.6	14,815	15.4
Transportation & communication	3,978	5.4	5,002	5.8	6,279	6.5
Finance	2,039	2.8	3,068	3.6	2,802	2.9
Real estate	1,962	2.7	2,211	2.6	2,493	2.6
Public works	5,712	7.7	6,310	7.3	8,152	8.5
Service	3,001	4.1	3,408	4.0	4,395	4.6
GDP total	73,698	100.0	85,914	100.0	96,066	100.0
Per capita income (US dollar)						
Indonesia	560		590			
Thailand	810		890			
Philippines	760		730			
Malaysia	1,870		2,020			
Singapore	6,620		7,360			

Source: Report for the FY1984/85, Bank Indonesia, et al.
For per capita income figure, Keizai Kyoryoku no Genjo to Mondaiten (White Paper on Economic Cooperation) FY1985, Ministry of International Trade and Industry.

Table 2 Growth Targets in the Development Plans and Results (annual average in real terms)

(Unit: %)

	Third Plan (1979-83)		Fourth Plan (1984-88)	Economic growth rate		
	target	result	target	1983	1984	1985
Agriculture	3.5	4.2	3.0	1.9	5.9	3.4
Mining	4.0	-1.7	2.4	0.7	7.0	-5.6
Manufacturing	11.0	8.9	9.5	3.5	12.8	5.9
Construction	9.1	8.7	5.0			
Transportation & communication	10.1	7.7	5.2			
Other	8.1	7.7	5.0			
Total GDP	6.5	6.0	5.0	3.3	5.8	1.9

Source: (1) President's annual message, August 1984.
(2) Report for the Financial Year 1984 85, Bank Indonesia, et al.

Table 3 National Budget

R E V E N U E

(one billion rupiah)

Item	1984-85 performance	(%)	1985-88 budget	(%)	1986-87 budget	(%)
DOMESTIC REVENUE	15,905	82.1	18,678	81.0	17,833	83.2
Oil and natural gas tax	10,430	53.8	11,160	48.4	9,738	45.5
Oil	8,937	46.1	9,480	41.1	8,146	38.0
Natural gas	1,493	7.7	1,680	7.3	1,593	7.5
Non-oil and natural gas tax	4,788	24.7	6,786	29.4	7,141	33.3
Income tax	2,121	10.9	3,074	13.3	2,881	13.4
Value-added and luxury tax	878	4.5	1,666	7.2	2,143	10.0
Import tax	530	2.7	717	3.1	580	2.7
Bourse transaction tax	873	4.5	963	4.2	1,055	4.9
Export tax	91	0.5	102	0.4	79	0.4
Land tax	157	0.8	167	0.7	284	1.3
Other taxes	138	0.7	97	0.4	119	0.6
Non-tax revenue	687	3.5	732	3.2	954	4.4
DEVELOPMENT ASSISTANT REVENUE	3,478	17.9	4,368	19.0	3,589	16.8
TOTAL REVENUE	19,383	100.0	23,046	100.0	21,422	100.0

E X P E N D I T U R E

(one billion rupiah)

Item	1984-85 performance	(%)	1985-88 budget	(%)	1986-87 budget	(%)
CURRENT EXPENDITURE	9,429	48.7	12,399	53.8	13,126	61.3
Personnel expenses	3,047	15.7	4,117	17.9	4,213	19.7
Non-personnel expenses	1,183	6.1	1,530	6.6	1,367	6.4
Local subsidies	1,883	9.7	2,590	11.2	2,640	12.3
Debt redemption expenditure	2,776	14.3	3,559	15.4	4,223	19.7
Domestic	39	0.2	30	0.1	40	0.2
Overseas	2,737	14.1	3,529	15.3	4,183	19.5
Others	540	2.8	602	2.6	683	3.2
DEVELOPMENT EXPENDITURE	9,952	51.3	10,647	46.2	8,296	38.7
Government	224	1.2	257	1.1		
Defense & security	702	3.6	714	3.1		
Education & culture	1,421	7.3	1,719	7.5		
Health & welfare	320	1.7	413	1.8		
Housing	224	1.2	438	1.9		
Religion & labor	482	2.5	740	3.2		
Economy	5,265	27.2	5,009	21.7		
Regional, company & environmental development	1,313	6.8	1,357	5.9		
TOTAL EXPENDITURE	19,381	100.0	23,046	100.0	21,422	100.0
BALANCE	+2	-	0	-	0	-
TOTAL	19,383	100.0	23,046	100.0	21,422	100.0

Source: Based on Report for the Financial Year 1984/85, Bank Indonesia.

Figure 1 Government Structure of the Republic of Indonesia

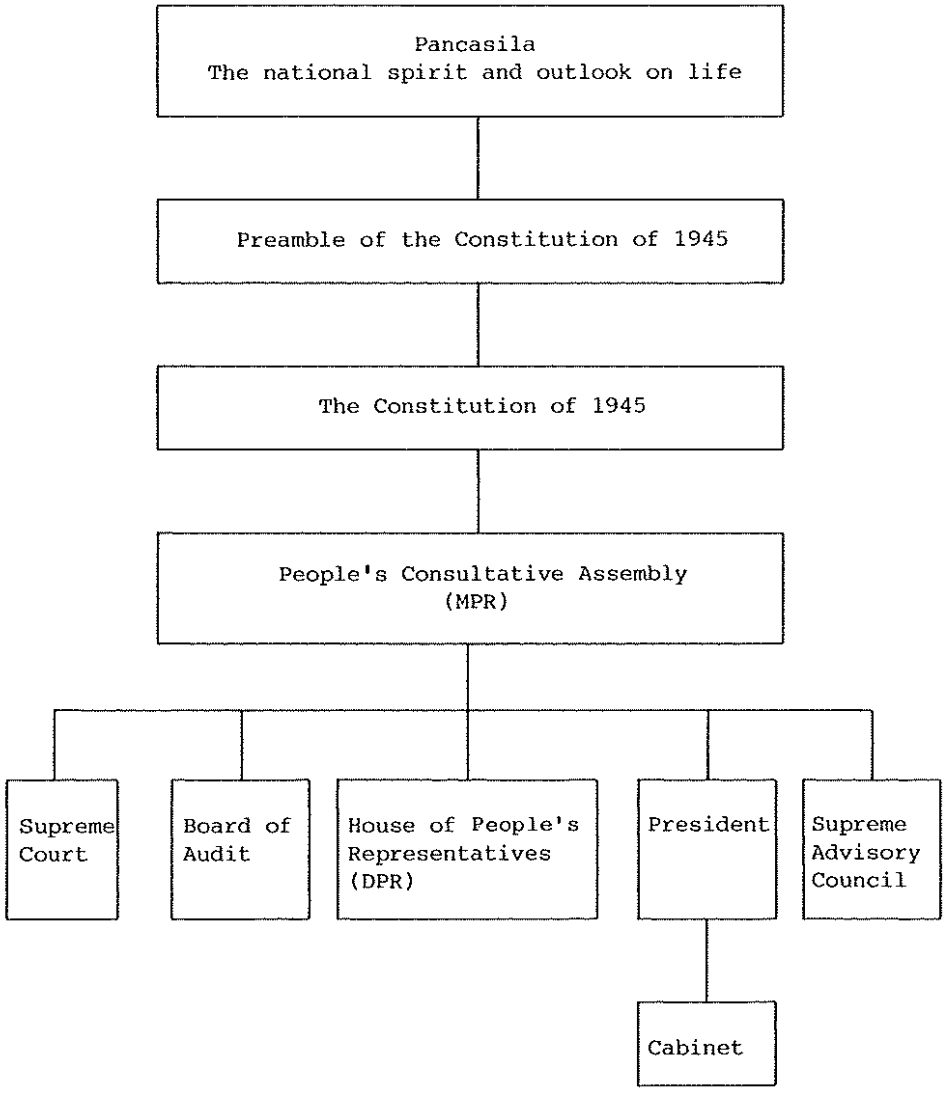
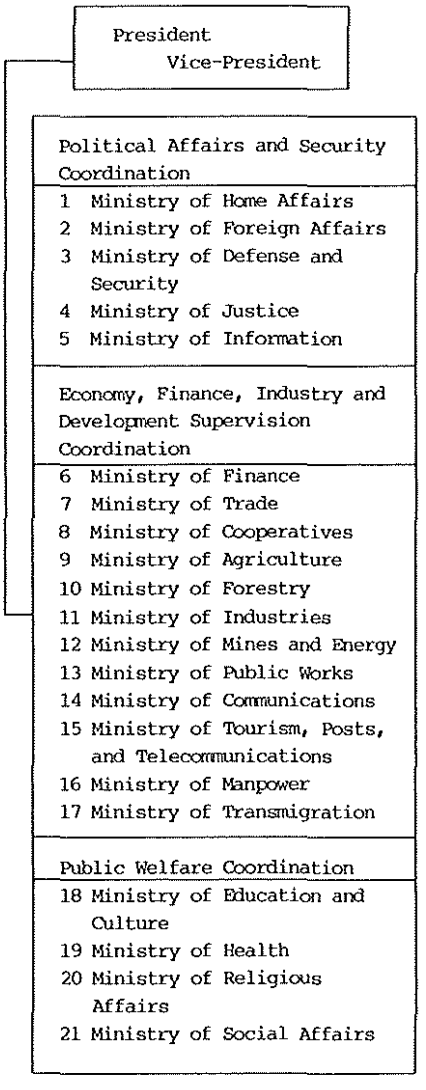


Figure 2 Administrative Structure and Ministerial Posts
(As of 1984)

(1) Administrative Structure



(2) Ministerial Posts
(Fourth Development Cabinet)

Ministers of 21 ministries
Minister Coordinator of Political Affairs and Security
Minister Coordinator for the Economy, Finance, Industry and Development Supervision Coordination
Minister Coordinator for Public Welfare
State Minister and Secretary of State
State Minister for National Development Planning and Chairman of the National Planning Agency
State Minister for Research and Technology and Chairman of the Institute for the Study and Application of Technology
State Minister for Population and Environment
State Minister for Housing
State Minister for Youth Affairs and Sports
State Minister for Administrative Reform and Deputy Chairman of the National Planning Agency
State Minister for the Role of Women
Junior Minister (Cabinet Secretariat)
Junior Minister (home product promotion, Cabinet)
Junior Minister (increased food production, Ministry of Agriculture)
Junior Minister (estate products promotion, Ministry of Agriculture)
Junior Minister (livestock and fishery, Ministry of Agriculture)
Attorney-General (Minister-equivalent)
Governor of the Central Bank (Minister-equivalent)
Commander-in-Chief of the Armed Forces (Minister-equivalent)

CHAPTER 3 INDONESIA'S POPULATION

1. Trends in Population

(1) Increases in Population

Indonesia, according to the results of its 1980 census, had a population of 147.49 million, the fifth largest in the world. It continued to increase, reaching 163.88 million in 1985 (Table 1).

Indonesia's censuses in the past, including those conducted in 1905 and 1920, however, have only been reliable for the total population of Jawa and not for that of other regions. The 1930 census gives reliable information on the nationwide population, then 60.70 million, but does not indicate population by age, which is an indispensable factor for demographic analysis. Records on population after 1930 have been scarce, especially due to Japan's occupation from 1942 to 1945 and the independence war from 1945 to 1949. It was only in 1961 that a modern census providing information which was fit for analysis was first conducted.

The 1961 census reported Indonesia's population to be 97.09 million, and indicated a relatively mild annual growth of 1.5% between 1930 and 1961. The population thereafter reached 119.21 million in 1971, with an annual growth of 2.1%. In 1980, the population reached 147.49 million with a higher annual growth of 2.4%. The annual growth rate then slightly dropped to 2.1% between 1980 and 1985.

(2) Declines in Death Rate

Indonesia's population has been increasing rapidly since 1961 with an annual growth rate of over 2%, due to demographic transition common in numerous developing countries with the decline in the death rate having considerable effect.

With the introduction of new health and sanitation technology in the beginning of the 1950's, many endemics were eliminated, and the illness and death rates declined. For example, the crude birth rate which was approximately 23‰ between the end of the 1950's and the beginning of the 1960's declined to 18 - 19‰ during the first half of the 1970's and further to around 16‰ in the latter half of the 1970's.

The accelerated growth of the population was obviously caused by the decline in the death rate, which is, in past, a major feature of demographic policy in all nations; Indonesia's progress here can also be seen as a result of successful demographic policy. It is desirable that the rate be further improved. Actually, the crude death rate of 16‰ is still high compared to those of the advanced countries, and is anticipated to decline further in the future.

(3) Trends in Birth Rate

Birth rate, in addition to the death rate, is an important factor that affects increases in population. For today's Indonesia, rapid increases in the population are major obstacles for her development, and the appropriate restraint is an urgent task. Consequently, our attention must be directed toward Indonesia's birth rate trends.

Accurate data on the prewar birth rate in Indonesia could not be found. However, based upon the researches of specialists, it is estimated that the birth rate was at quite a high standard during the prewar period. It slightly declined during World War II and the independence war. However, it began to rise again at the beginning of the 1950's, and the crude birth rate reached the extremely high level of 46.8‰ between 1950 and 1955 and 46.5‰ between 1955 and 1960. It started to decline at the end of the 1960's.

Several factors brought about this decline in the birth rate, the major factor being the wide diffusion of the modern contraceptive methods among the people. Family planning in this country was initiated as a private activity around 1953. However, the role played by the National Family Planning Coordinating Board (BKKBN), established later as an organization with the aim of coordinating and planning measures related to the family planning movement for the entire nation, is especially significant.

(4) Domestic Migration and Urbanization

Biased regional distribution of the population stands out as an important demographic characteristic of Indonesia. As shown in Table 2, out of the nation's total population of 163.88 million in 1985, 99.50 million resided in Jawa, accounting for 61% of the overall population. However, the area of Jawa is only 7% of the entire country, making it an extremely densely populated island. Next to Jawa, Sumatera has the second largest population (32.67 million) followed by Sulawesi (11.60 million).

Understanding this imbalance and the details of migration have become the center of interest of demographers and staffs in charge of development plannings. Demographic surveys conducted in 1971 and 1980 clarified the situation concerning the lifetime migration. The 1971 survey made clear that the number of migrants to Sumatera was greater than that to other regions, and that Jawa and Bali always occupied important positions as the places from where people emigrated. This is because Jawa and Bali, already intensely overpopulated, had no room for expansion of agricultural production. However, the population survey conducted in 1980 clearly indicated that Kalimantan and Sulawesi are increasing in importance as destinations for emigrants from Jawa and Bali, rather than Sumatera.

Transmigration policy centering on regional development is an important issue of Indonesia's demographic policy, and is explained later in detail.

Furthermore, the progress of urbanization of the population is remarkable in Indonesia. The urban population of 20.50 million in 1971, grew to be 32.90 million in 1980, and the ratio of the urban population to the total population also rose from 17.3% to 22.4%. Such rapid increases in the urban population continue to surpass the population capacity of urban areas, and as a result are causing various problems in terms of housing and environmental sanitation.

Economic problems seem to be the major cause of the inflow of population to urban areas. Shortages of land and employment opportunities in rural areas are causing young labor force to settle in medium- or large-scale cities. However, sufficient employment opportunities are not necessarily provided in urban areas, either, and many have to be content with working for low wages. Cyclic migrants, who return to their respective home villages to support parents, brothers and sisters with the money earned while working away from home, comprise most of this migrant population.

According to the result of the demographic survey conducted in 1980 (Table 3), urban population accounted for 22.4% of the total population, while rural population amounted to 77.6%. The percentage of the urban population was relatively high for the younger generation of age 15 to 34, indicating that a greater number of young people migrate to urban areas as mentioned previously. However, it is noteworthy that the differences in the percentages of the urban population by age are not so substantial. This is probably related to the fact that many of the immigrants to urban areas in this country are cyclic migrants.

2. Projections on Future Population and Demographic Policy

(1) Projections on population

According to the recent United Nations document on future population estimate, Indonesia's population is estimated to increase to 173.53 million in 1990, 198.69 million in 2000 and to 246.86 million in 2025 (Table 4). These figures are based on the assumption that the crude birth rate will decline to 28.5‰ between 1985 and 1990, 23.4‰ between 1995 - 2000 and to 16.1‰ between 2020 and 2025, and that the crude death rate will also decrease considerably to 13.1‰, 10.9‰ and 9.1‰ in the respective periods. Furthermore, the age composition of the population of Indonesia is young, and thus has a potential for population increase. It is therefore anticipated that an extremely large population easily exceeding 200 million will appear in the next century.

This projection indicates the following concerning the age composition of Indonesia's population: those 0 - 14 years of age will amount to 34.0%, the 15 - 64 year-olds, 62.1%, and those 65 and over, 3.8% by 1990; the above age brackets will account for 30.7%, 64.7%, and 4.7%, respectively, by 2000, and then 22.5%, 69.5% and 7.9% by the year 2025. Due to declines in the birth and death rates, the proportion of the young population will decrease, while the proportion of the old population will increase. It is noteworthy, however, that the productive age group will increase in number. According to this, it can be expected that Indonesia's human resources will increase, contributing to development. To effectively utilize these resources, however, the promotion of developmental policies becomes necessary.

According to Table 4, it is expected that the urbanization of the population will continue in the future and that early in the next century, urban areas will share more than half the total population. It is also expected that this will lead to the intensification of the urban problems, and the need for policies concerning both urban and rural areas.

(2) Demographic Policy

In 1965 it was recognized that the rapid increase in Indonesia's population were significant restrictions for its development. In the Repelita (the first 5-year plan) initiated in 1969, a target for economic development was set taking into consideration the population increase and of correcting the biased regional distribution. Policies regarding the issue of the birth rate, death rate and migration were set out. It was expected that the death rate would decline with economic development, and it was thus deemed necessary to exert efforts to lower the birth rate in a short period so as to suppress the increase in population. Thus, in 1970 it was determined to implement family planning program as a national policy. This program was orginally carried out with an emphasis on Jawa and Bali, but then was gradually applied nationwide.

The objectives of the family planning program were not merely to lower the birth rate and slow the growth rate of the population, but also to modify the existing traditional sense of values and standards on the family scale. Simultaneously, a health program was strengthened and propagated nationwide, the main objective being to improve the quality of the population, giving preference to the health of the labor force and mother and child. In addition, a systematic plan was drawn up to motivate as many workers as possible to migrate to areas other than Jawa, but its aim was not only to ease the population pressure felt in Jawa and Bali, but also to promote regional development by providing young labor force to exploit undeveloped resources.

Thus, the demographic policy considers the population problems that

Indonesia currently faces from various viewpoints and its ultimate objective is to improve the quality of the population, and balance regional distribution by means of development. It is important to note that it was drawn up and implemented as a comprehensive policy.

1) Policy concerning the birth rate

-- Family planning policy --

A movement to provide the general public with contraceptives was initiated as early as in the latter half of the 1950's as a part of the mother and child health program. However, since the government did not favorably consider the family planning program, the program was instead implemented by the Indonesian Planned Parenthood Association, supported by the International Planned Parenthood Federation (IPPF). After 1965 the new government adopted a positive attitude towards the promotion of the family planning program. In 1967, President Suharto signed the U.N. declaration on population, and decided to initiate a family planning program as a national measure. In 1970, the National Family Planning Coordinating Board (BKKBN) was established as the highest organ to carry out comprehensive coordination and planning of the family planning program of the entire nation and to promote the family planning policy.

Originally, importance was attatched to Jawa and Bali the most densely populated areas. Then, during the second 5-year plan on family planning initiated in 1975, it was decided to spread the program to other regions. Although at first the achievement rate was low, it gradually improved. The program succeeded to persuade only 200,000 people to use contraceptives during the first 3 years, but after propagation in rural areas, and introduction of a target-setting system, the number of persons using contraceptives rapidly increased.

New strategies were increasingly developed after 1979, and the organization of the National Family Planning Coordinating Board was altered. It was decided to expand the family planning movement and, therefore, an integrated and comprehensive national population policy was drawn up and the various movements to support the traditional family planning were reciprocally involved and implemented. Under this strategy, it was determined to continue the conventional publicizing and advertisement of family planning and to distribute contraceptives, and, further, introduce those who had used contraceptives and had side effects to hospitals and clinics. It was also agreed upon to implement various measures so as to prevent the alienation of women using contraceptives. Groups of women using contraceptives were formed in every village, and their interests on family planning were enhanced through activities such as guidance on child-rearing and nutrition. Moreover, a system was established to honor couples who continued to carry out family planning for more than 10 years, and the staffs in charge of programs who achieved excellent results.

Methods to distribute pills and condoms to couples were improved, and village-based Distribution Centres were established enabling couples living in the villages to obtain contraceptives. These centres are managed by rotating teams dispatched by health centers. In addition, as all-village incentives, villages achieving outstanding results in promoting the family planning program were provided with compensations such as water supply facilities, construction and repair of meeting halls and road repairs as per the requests of the respective villages.

The extent as to which the family planning program, implemented in such a comprehensive manner, has actually affected the birth rate then because the issue at hand. The ordinary birth rate which was approximately 44‰ in 1971 was reduced by about 10‰ to approximately 35‰ in 1980, and it cannot be denied that the program has made a great contribution towards this.

2) Policy on the death rate

Since the initiation of the Repelita (the first 5-year plan), systematic efforts have been exerted in improving the health services. The infrastructure of the health activities was strengthened, and the number of hospitals was increased from 824 in 1970 to 1,239 in 1982. The number of beds was also increased from 80,236 to reach 102,374. The number of health centers established in villages also grew substantially from 1,058 to 4,949. Further, the number of doctors increased from 3,234 in 1970 to 12,931 in 1981, and similarly, the number of nurses increased from 3,473 to 17,084. The number of midwives increased from 3,529 to 15,770, and 35,520 health nurses were newly trained to implement a health program in each village. In 1980, the new concept of "Nationwide Health System" was introduced to secure the links among the various health services. Health services are being gradually improved under the theme of "making all the people healthy by the year 2000."

Thus, it is true that policies for lowering the death rate have been implemented and that the number of facilities has been increased. However, the illness and death rates are currently still high, especially the death rate of babies. This is due to the fact that numerous environmental factors have not been sufficiently controlled by the public sanitary policies, and malaria, diseases caused by parasites and epidemics are still found in abundance.

Taking these points into consideration, the following planned targets were established anew in the recent program so as to exert further efforts towards improving the following conditions, namely to raise the average life expectancy which was approximately 56 years in 1980 to 63 years by 1990, to lower the death rate of babies from 98‰ to 60‰ and to lower the death rate of children under age 5 from 40‰ to 32‰. Work objectives concerning the nutrition program and other health programs were established to these ends. Thus, it is expected that the

ordinary death rate will decline further in the future, and the rate which was approximately 14‰ in 1980 is expected to drop to about 10‰ by 1990.

3) Policy on the urbanization of population

The policy of population migration had been implemented systematically since the 1930's in order to alleviate the concentration of population in Jawa. Although it was temporarily discontinued during World War II, it was resumed after the War and has been implemented to the present. This represents a major demographic problem for Indonesia, and the government is exerting special efforts to solve this problem as stated in the next section.

Alongside this problem or, in a way, apart from this issue, exists the problem of the urbanization of population.

The population of Jakarta, the capital of Indonesia, was 530,000 in 1930. It grew remarkably to reach 4.58 million in 1971. Under these circumstances, policies were implemented without success, to restrict the inflow of population, such as the declaration to close the city of Jakarta (1970), establishment of areas into which "beca" are prohibited to drive, and banishment of street vendors. The population of Jakarta continued to increase to 6.50 million in 1980 and to exceed 7.80 million in 1985.

Actually, the increase in Jakarta's population is representative for the remarkable phenomenon of urbanization of the population in Indonesia, numerous actual examples of the serious urban problems common to many developing countries being found there.

There are, however, substantial differences in the urbanization of the population amongst the different regions in Indonesia, and the example of Jakarta falls under one of the categories. The cities of Indonesia and increases in population in these urban areas can be divided into 4 categories (Hirosuke Mizuno, "Indoneshia - Noson no Jinko Fuyoryoku to Toshika (Indonesia - Power to Support Population of Villages and Urbanization)" in ed. by Tokue Shibata and Hirokatsu Kano Daisan Sekai no Jinko Ido to Toshika (Migration and Urbanization in the Third World)).

Type A: Jawa Island north shore - metropolitan growth areas

Type B: Jawa Island inland area - stagnant area in which cities remain of small and medium size

Type C: Developed outer islands - area of rapidly increasing population

Type D: Outer island Oceanic cities not included in Type C

During the 1960's, while population increased in Type A large cities such as Jakarta and Surabaya the population of Type B small and medium cities were stagnant. However, in the 1970's, while Type A continued to grow and Type B remained stagnant, Type C achieved remarkable growth.

Thus, there are substantial regional differences in the urbanization of population in Indonesia. For the time being, however, the most serious issues remain increases in population of Type A cities such as those in Jawa, where population is already concentrated and the population density remains high. In the past, a large part of the population of Jawa lived in rural villages and were engaged in agricultural operations. This is closely related to the fact that a great amount of labor force was required under the labor-intensive technology system centering on growing rice. However, demographic pressure was felt due to increases in population and reduction in the demand for labor force due to the introduction of new agricultural technology and caused people to migrate to urban areas, this becoming the cause for the increase in the population of Type A cities. This trend is expected to grow in the future.

For this, policies to solve the urban problems, such as creation of employment opportunities and consolidation of the living environment in metropolitan areas are required, and such policies are actually being implemented. Concurrently, policies to suppress the increase in population are also being implemented. A target has been set to keep the population of Jakarta roughly below the level of 12 million by 2005, and to this end, the promotion of the family planning program and migration policies are considered to be effective. In addition, it is necessary to correct the population distribution in the city of Jakarta, and in this respect, plans to develop the eastern and western districts of the city were made.

3. Transmigration Policy of Indonesia

The transmigration policy of Indonesia, promoting voluntary movement of people, has the longest history and operates on the largest scale in the world. This section describes a history of the transmigration policy, an outline of the implementation of the transmigration projects, their achievements, and the flow of migrants.

(1) History of the Transmigration Policy

Indonesian transmigration policy started in 1905 by sending 155 households residing in Jawa to Gedong Tataon, Lampung, in the southern part of Sumatera. At that time, the Dutch government was ruling over

Indonesia, and formed a migration project, due to concern over a decline in the standard of living and a reduction in available farmland caused by the rapid increase in population of Jawa (*1). In the end, however, the main reason was to secure labor to engage in the cultivation of export crops (rubber, pepper, coffee and others) by sending excess manpower in Jawa to Lampung as a part of the so-called "Colonization Plan" (Sugii, 1984). The number of migrants from Jawa to Lampung is estimated at 173,959 from 1905 to 1941.

During the independence movement following World War II, this migration policy was termed from "Colonization Plan" to "Transmigration Plan" which was based upon the 5 principles of the founding of the country, "PANCASILA" spirit. The transmigration project during the 1950's was characterized by being promoted as a part of social policies to relieve poverty in Jawa. The Indonesian government focused its energy upon improving the standard of living for Jawa farmers who are mostly poor landed tenants under the share-cropping system, by moving them to the southern part of Sumatera and, providing them with fixed amount of farmland. In this regard, the government worked out highly motivated plans, one after another, which were, however, unfeasible, setting unreachable goals (*2). During the 1960's, the government projected the migration of 390,000 households during 1960 and 1968, but due to political disorder caused by the change of regime at this time, these were hardly implemented.

Ever since Suharto took power in 1968 and set out policies emphasizing economic development, the transmigration plan has been definitely recognized as part of the state development strategy as it is conceived today. According to Statute No.3 of 1972, the transmigration plan has the following 7 objectives: 1) the improvement of living standards; 2) regional development; 3) a balance in population distribution; 4) equitably distributed development through Indonesia; 5) the utilization of natural and human resources; 6) national union and unity, and 7) a strengthening national defense and security. Regional development in areas other than Jawa and Sumatera has especially been concentrated upon since Repelita II (the Second 5-year National Development Program, 1974-78) was implemented. It aimed at the overall improvement of the infrastructure, agriculture and communities in target areas of transmigration, with a goal of regional prosperity.

(2) Outline of the Implementation of the Transmigration Plan

What steps are taken in order to enforce the transmigration plan?

First, a program is worked out to set up target areas. During this process, the governor of each province takes the lead, and those areas which have no problems of ownership are selected. Selected areas are classified into staged development area units (SWP) to implement development programs according to potentiality and living capacity of

the land. The next step is to reinforce the infrastructure. Trunk roads are constructed, land is surveyed and houses for immigrants are built, followed by construction of public facilities such as a clubhouse and a school.

At the time of the area selection, a campaign of inviting migrants is conducted. Young and healthy farmers in the lower income brackets have been given priority. Recently, however, the doors were opened to engineers who are expected to contribute to newly-established communities, thus improving the life of migrants.

After settlement, immigrants are provided with 2.0 hectares of land (*3) per household along with food support for one to one and a half years, seedlings and fertilizer for 3 years, as well as farm appliances, clothing and kitchenware without charge. Guidance and training in the land utilization program and agricultural technology are given to them several times before and after they settle down. They also receive education on such as health and sanitation, marketing, organization of a co-op, and women's movement. It is not rare that such services are provided to local residents and spontaneous migrants (*4) as well. For instance, 10% of reclaimed land is supposed to be given to local residents. These programs are meticulously worked out, taking into consideration that immigrants are able to fully stand on their own legs within 5 years of their settlement. Moreover, it is considered that this project can contribute to the improvement of local residents' lives.

(3) Achievements

Table 5 shows target numbers of families resettled at the beginning of each migration program in and after 1960 (*5), their realization and percentages realized to the targets. The increase in the number of immigrant households in the latter half of Repelita I led the government to announce an inordinate target of making 250,000 households resettle during the 5-year period of Repelita II. In reality, however, enforcement of the project was badly behind schedule due to financial stringency, and most of budget being exhausted in making provisions to receive immigrants. Low rates of the results to the targets of Repelita II are attributed to these factors. Later on, targets were alternated repeatedly and at the end, slashed to 82,959 households.

As for Repelita II, the number of households which actually migrated, increased by more than 50% compared with that of Repelita I. During the period of Repelita III, it increased markedly by about 7 times. Although some differences exist between the actual result of each year, this table proves that the transmigra-tion projects have been implemented successfully. On top of this, the number of spontaneous migrants who resettled without receiving any public support, counting on relatives or friends already settled down successfully, is estimated at

604,000 from 1950 to 1972, and 221,000 from 1975 to 1980 (H.W. Arndt, 1983). Considering these figures with the number of migrants under the transmigration plan, it can be clearly imagined on what a grand-scale population flow has taken place.

This population flow, despite its massive scale, was unable to produce any remarkably good results in curbing the rise in population of Jawa, which was the initial goal of the trans-migration program. In other words, the outflow of popula-tion meant almost nothing for Jawa which has grown in population at a rate of 1.5 million every year, an average of 2.02% (1975-80) annually.

It might be more to the point to seek the significance of the project in regional development, which is the current purpose of the project. According to Arndt (1983), 2-3 million people have already settled in the mountainous regions of Sumatera, Kalimantan and Sulawesi and succeeded in facilitating irrigation for a rice crop. Using statistics, he also proved that Lampung and South Sumatera, with a long history of immigration, have achieved a high rate of increase in rice production, nearly twice as much as Jawa. He evaluated it as the result of the transmigration policy.

(4) Flow of Migrants

What are special features found in places where migrants came from and settled down under the government's program. Table 6 shows the number of households classified according to place of origin. Those who moved out of Central or East Jawa, where income level is relatively lower than other areas of Jawa predominate by about 25% respectively in Repelita III. Next to Central Jawa, Yogyakarta sent out many migrants in the 1960's and the relative ratio has been on the decrease from the 1970's onward. Repelita III was marked by the point that local residents who moved from other places in the same state (APPDT) account for 10% of all.

Many tribes in Indonesia are engaged field-burning agriculture and have no fixed abode. The government had intended to make those people resettle within the framework of the transmigration plan. In this context, resettlement of 43,854 households was carried out during the period of Repelita III.

The migration from Jakarta has been apparently small. This may be because there were few farmers who are the target of the program, it being much easier to get a job in the city, and cultural and social pull factors hold people from being motivated to migrate.

In the current Repelita IV program, migration from West Jawa, Lombok and Madura has been also encouraged. It is expected that target areas, where the emigration campaign is actively conducted, will be

further extended in coming years.

Table 7 shows places where migrants have settled down. Since the beginning of the migration program in 1905, until the early 1970's most of migrants had moved to Lampung or South Sumatera. For instance, during the period from 1951 to 1974, 96,754 households, about 68% of the total, moved to those two states.

It is worthy of attention that the areas where people settled have been expanding and the migration distance has increased since the mid-1970's, corresponding with the fact that the government has promoted local development as the main purpose of the transmigration project. As for Repelita III, the number of settlers especially in North Sumatera, Kalimantan, Central and South Sulawesi has increased drastically.

Under Repelita IV project, East Nusatenggara was designated by the government as a new area of destination. From the viewpoint of resource development and local development, Maluku and Irian Jaya are also promising for new settlements.

(5) Summary

The Indonesian transmigration program, boasting on 80-year history, has been contributing to local development and the improvement of the living standard of migrants as well as local people, though its initial role has been changing. The number of transmigrants, varying to some extent every year, has remarkably increased as a whole. At the same time, target areas of settlement have become remote and diversified. Relaxing the restrictions on qualifications for migrants, the government has been focusing its efforts on the overall social and economic development of the settlements.

On the other hand, it is true that the government is facing a lot of problems, e.g. problems caused by 1) differences in agricultural systems in settlements from that in a former dwelling places, 2) friction between natives and migrants who have completely different living customs and cultural standards from each other, 3) issues of health and sanitation in a settlement such as frequent occurrence of malaria and other infectious diseases, 4) a rapid increase in population with which old settlements like Lampung are confronted, and 5) more important than everything else -- tight financial conditions. In order to cope with financial difficulties, the government is promoting a campaign of inviting spontaneous migrants receiving no official aid under the Repelita IV plan. It can be said that the scale of spontaneous migration is directly influenced by a degree of success that past migrants have achieved. Consequently, it is not too much to say that success or failure of the program lies on how much the present program can contribute to the improvement of the living standard of migrants as well as natives.

Notes

(*1) Minisastro Wijojo estimated the average annual rate of increase in population of Jawa from 1895 to 1900 at 2.24%

(*2) For instance, Burhandin Harahap administration planned the settlement of 100,000 households for 5 years since 1951. In reality, however, only 28,000 households actually moved due to a shortage of the government budget and lack of a proper reception setup for immigrants.

(*3) Of the total 2.0 ha, 0.25 ha is for a housing site, 1 ha for plowed land and the rest 0.75 ha must be brought under cultivation by the settler himself. For reference, one farm family in Jawa runs an average of 0.6 ha land.

(*4) Government migrants obtain financial support from the government such as transportation expense, while spontaneous migrants are guaranteed no public aid in principle.

(*5) Target figures are frequently changed due to circumstances by the President's address.

Table 1 Indonesia's Population

(Unit: million persons)

Year	Overall population	Growth rate
1930	60.7	1.5%
1961	97.1	2.1
1971	119.2	2.4
1980	147.5	2.1
1985	163.9	-

Note: Figures for 1930, 1961, 1971 and 1980 were taken from the respective censuses, while that for 1985 is an estimate.

Table 2 Regional Distribution of Indonesia's Population

(Unit: 1,000 persons)

Region	1961	1971	1980	1981	1982	1983	1984	1985
Sumatera	15,739.4	20,808.1	28,016.2	29,027.9	29,961.5	30,928.5	31,927.9	32,666.6
Jawa	63,059.7	76,086.3	91,269.5	93,340.3	95,103.4	96,892.9	98,711.8	99,502.4
Nusatenggara	5,557.7	6,619.1	8,487.2	8,675.6	8,835.1	8,996.2	9,159.8	9,338.1
Kalimantan	4,101.5	5,154.8	6,723.2	6,942.2	7,142.9	7,350.0	7,563.6	7,781.3
Sulawesi	7,079.4	8,526.9	10,409.5	10,665.4	10,887.0	11,112.2	11,341.0	11,597.7
Maluku	1,547.9	2,013.0	2,584.9	2,663.2	2,731.8	2,802.9	2,875.4	2,989.9
Irianjaya								
Nationwide	97,085.6	119,208.2	147,490.3	151,314.6	154,661.7	158,082.7	161,579.5	163,875.9

Note: Same as in Table 1.

Table 3 Urban and Rural Population in 1980

(Unit: 1,000 persons, %)

Age	Urban	Rural	Total	Percentage		Sex ratio		
				Urban	Rural	Urban	Rural	Nation-wide
0 - 4	4,521	16,670	21,191	21.3%	70.7%	1.06	1.04	1.04
5 - 9	4,234	16,998	21,232	19.9	80.1	1.05	1.04	1.04
10 - 14	3,911	13,708	17,619	22.2	77.8	1.03	1.09	1.08
15 - 19	4,116	11,167	15,283	26.9	73.1	0.94	0.98	0.97
20 - 24	3,544	9,458	13,002	27.3	72.7	0.96	0.81	0.85
25 - 29	2,765	8,579	11,344	24.4	75.6	1.05	0.96	0.98
30 - 34	1,889	6,278	8,167	23.1	76.9	1.02	0.96	0.97
35 - 39	1,832	6,718	8,550	21.4	78.6	1.01	0.95	0.96
40 - 44	1,571	5,849	7,420	21.2	78.8	1.02	0.95	0.97
45 - 49	1,223	4,927	6,150	19.9	80.1	0.93	0.97	0.96
50 - 54	1,085	4,326	5,410	20.1	79.9	1.01	1.01	1.01
55 - 59	699	2,691	3,390	20.6	79.4	1.04	1.03	1.03
60 - 64	588	2,640	3,229	18.2	81.8	0.91	0.94	0.93
65 - 69	328	1,386	1,714	19.1	80.9	0.88	0.91	0.90
70 - 74	266	1,264	1,531	17.4	82.6	0.75	0.83	0.82
75 and over	271	1,254	1,525	17.7	82.3	0.67	0.86	0.82
Unknown	4	16	20	20.0	80.0	0.97	1.24	1.18
Total	32,846	113,931	146,776	22.4	77.6	1.00	0.98	0.99

Source: 1980 Population Census.

Table 4 Projections on Indonesia's Population

(Unit: 1,000 persons, %)

Description	1985	1990	1995	2000	2010	2020	2025
Total population	160,658	173,530	186,650	198,687	220,015	238,378	246,855
Age 0 - 14	36.6	34.0	32.5	30.7	26.5	23.4	22.5
Age 15 - 64	59.9	62.1	63.3	64.7	68.1	70.0	69.5
Age 65 and over	3.5	3.8	4.2	4.7	5.4	6.6	7.9
Urban population	22.4	25.2	28.4	32.3	40.2	48.1	52.0
Rural population	77.6	74.8	71.6	67.7	59.8	51.9	48.0

Source: Demographic Indicators of Countries: Extimates and Projections as Assessed in 1980, U.N.

Table 5 Target Number of Families Resettled, Realization and Percentage Realized under the Government's Project: 1960 - 1985

(Unit: household)

		Target	Realized	Percentage realized
1960 - 1968		390,000	44,216	11.3
Repelita I	1969/70	5,844	3,986	68.2
	1970/71	4,115	4,298	104.5
	1971/72	4,600	4,946	107.5
	1972/73	10,513	16,503	157.0
	1973/74	15,887	22,392	141.0
Repelita II	1974/75	30,000	11,000	36.7
	1975/76	40,000	6,900	17.3
	1976/77	50,000	13,957	27.9
	1977/78	60,000	22,949	38.3
	1978/79	70,000	26,900	38.4
Repelita III	1979/80	50,000	50,000	100.0
	1980/81	75,000	75,000	100.0
	1981/82	100,000	91,591	91.6
	1982/83	125,000	95,436	76.3
	1983/84	150,000	59,641	39.8
Repelita IV	1984/85	125,000	56,853	45.5
	1985/86	135,000	194,048	143.7

Source: Research and Development Center, Ministry of Transmigration, 1986.

Table 6 Number of Families Resettled by Place of Origin under the Government's Project: 1969 - 1983

(Unit: household)

	Repelita I 1969-73 (%)	Repelita II 1974-78 (%)	Repelita III 1979-83 (%)
Jawa			
Jakarta D.K.I.	500 (1.1)	3,155 (3.8)	4,362 (1.3)
West Jawa	7,984 (17.3)	15,010 (18.1)	51,179 (15.1)
Central Jawa	11,702 (25.3)	27,434 (33.1)	86,695 (25.6)
Yogyakarta	7,259 (15.7)	6,180 (7.4)	17,277 (5.1)
East Jawa	13,184 (28.5)	23,830 (28.7)	85,564 (25.2)
Bali	5,339 (11.5)	4,470 (5.4)	10,872 (3.2)
West Nusatenggara	300 (0.6)	2,880 (3.5)	7,285 (2.1)
APPDT	-	-	32,163 (9.5)
Resettlement	-	-	43,854 (12.9)
Total	46,268 (100)	82,959 (100)	339,251 (100)

Source: Research and Development Center, Ministry of Transmigration, 1986.

Table 7 Number of Families Resettled by Area of Destination under the Government's Project: 1969 - 1983

(Unit: household)

	Repelita I 1969-73	Repelita II 1974-78	Repelita III 1979-83
Sumatera			
Aceh	-	2,060	9,471
North Sumatera	200	500	7,492
West Sumatera	450	4,850	4,475
Riau	500	2,950	32,971
Jambi	2,450	13,114	17,599
South Sumatera	7,808	14,595	79,329
Bengkulu	1,700	5,500	11,427
Lampung	14,230	6,100	46,547
Kalimantan			
West Kalimantan	952	3,760	22,400
Central Kalimantan	624	790	16,933
South Kalimantan	2,190	6,100	18,993
East Kalimantan	2,175	3,500	13,135
Sulawesi			
North Sulawesi	1,500	1,410	4,184
Central Sulawesi	3,852	7,700	10,814
Southeast Sulawesi	2,712	4,330	17,811
South Sulawesi	4,475	3,750	4,593
Maluku	350	200	7,200
East Timor	-	-	100
Irian Jaya	100	750	12,476
West Nusatenggara	-	-	1,246
Total	46,268	82,959	339,251

Source: Research and Development Center, Ministry of Transmigration, 1986.

CHAPTER 4 GENERAL CONDITION OF HEALTH AND MEDICAL CARE

1. Statistics on Mortality and Health and Medical Care

Statistics on mortality and morbidity in Indonesia are not necessarily accurate. Based on the Presidential Decree No. 52/1977 on population registration, all occurrences of births and deaths within Indonesia are required to be reported within stipulated period. The registration system is not yet operating as good as it should be (*1). Statistics on medical care are compiled based upon reports from hospitals and health centers. Both national and private hospitals submit reports. Report from the health centers covers only government facilities. Private practices or clinics have not yet been covered (*2).

The death rate of Indonesia is at a higher level than in other nations. Figure 1 shows changes in the death rate of ASEAN countries and Japan. Though the death rate has steadily declined in Indonesia, it has stayed at the highest level among ASEAN countries.

Table 1 shows statistics concerning death rate among ASEAN countries and Japan. Both death rate and infant mortality rate have decreased for the past 20 years in ASEAN countries. But the level of these rates of Indonesia is still higher, and the life expectancy of both male and female is the lowest for Indonesia.

Such higher death rate is reflected in the situation of the medical care of the country. Table 1 also shows that the number of beds of hospital, doctors, nurses and midwives is small proportionately to population. Infant mortality rate of Indonesia is twice the number of that of Thailand and the Philippines. Medical facilities for delivery and child health have not been fully set up, which seems to affect the higher rate of infant mortality. Furthermore, there are not enough medical staff in comparison with population. Under such circumstances, the health and medical care system should be enforced as early as possible.

2. Medical Organization and Medical Staff

(1) Health and Medical Care Facilities

Health and medical services are conducted under the network of hospitals, clinics, health centers and maternal and child health centers. The improvement of health facilities and implementation of prevention and treatment measures through the network were included in the 5-year development plan and have been carried forward.

During Repelita II(1974/75-1978/79), 4,353 health centers were newly established with health facility development aid ordered by President. As a result, it was achieved that every district now has at least one health center (*3). A health center in Indonesia, having a

function of a bedded clinic (10-20 beds) whose system is basically the same faculty as that of a Japanese health center, provides local people with the latest overall health services. The lowest standard of each center is prescribed to consist of one midwife, one nurse, two specialists of infectious diseases prevention and one staff engaged in sanitation work (*4). As for the percentage of those centers having a doctor, it was intended to dispatch a doctor to 50% of the health centers of Jawa and Bali and 40% to areas other than Jawa and Bali during the period of Repelita II. By 1978, 87% of health centers all over the country had had a doctor (*5).

Table 2 shows changes in medical facilities in each state from 1971 to 1980. Though the rate of increase in the number of hospitals is low, the number of health centers newly established seems to have been increasing. Consequently, it seems that deficiencies in local medical service have been filled up by the activities of health centers. The rate of increasing number of hospitals is highest in Jawa, which also has the highest population density. Population per hospital or health center is also highest in Jawa, so that medical service is not sufficient.

In those areas where population has been rapidly increasing because of transmigration policy (Sumatera and Kalimantan), the declining rate of population per hospital or health center is low in comparison with the rapid increase in population.

Number of hospitals is the largest in Jakarta, which means the gravitation of medical system towards the town.

(2) Conditions of Receiving Medical Care

As mentioned above, local medical care is provided through the activities of health centers. Table 3 shows the number of patients classified by medical facilities, in comparison between two censuses - 1971 and 1980. Table 3 shows that the coefficient in the utilization of the health centers has increased drastically, which is the result of the government's policy placing emphasis on the reinforcement of health centers.

As Table 4 indicates, the rate of those who are sick and receive medical treatment has been increased. A quarter of those who are aware of their sickness do not take any treatment and another quarter treat themselves without consulting a doctor. Then there remain the problems of the medical system on the side of those who receive treatment.

Table 5 shows number and percentage of patients in 1972 and 1980, which is very important to consider the current conditions of medical system. Those who answered that they do not need medical treatment amount to one third at both points of time. This indicates that they

have little interest in medical care. In 1972, the main reason, other than uselessness of medical treatment, was a long distance between home and a medical facility, while high medical expenses were the main reason in 1980.

It was due to the progress of setting up a health center in every district that the problem of long distance was dissolved. It means that a health center has been performing its duty of primary health care directly connected with the local residents.

Table 6 shows the number of patients and the average cost per outpatient care by place of treatment. Since medical cost is related to the degree of severity of disease, it is difficult to make a sweeping statement here. It is considered, however, that medical cost per day-patient at a hospital is high and a big burden on the patient. Taking into consideration the lower cost at a health center comparing with that of hospitals, besides it being close to community, the number of visitors to a health center will be increasing further.

3. Types of Diseases

According to Table 7, diarrhoea and respiratory infection take precedence over other causes of death in Indonesia. Figure 2 shows causal complex underlying infant and child death. As is the case in other developing countries, there are observed undernourished and suffer from protein deficiency in Indonesia. Due to scarcity of serum protein, one loses one's strength and resistance to disease, and becomes susceptible to diarrhoea and respiratory infection. Moreover, the recuperative power of body tissues decline. Consequently, diarrhoea and respiratory infection often become cause of death.

Table 8 shows mobidity pattern of hospitals by cause of death. Diseases related to pregnancy and delivery held the top in 1973 and 1980. About 70% of pregnant women in Indonesia bear their babies at home and about 50% for Jakarta (*6). Taking into account that only few people can receive medical treatment at a hospital, the number of diseases connected with pregnancy and delivery appears to be much more. Therefore, the death rate of pregnant women is probably high. Infectious and parasitic diseases stand the second. Among chronic infectious diseases, tuberculosis is the main cause of death, and among acute infections, epidemic diseases such as malaria. The percentage of those who are ill from phthisis accounts for 0.2-0.6%. It is estimated that hundreds of thousands people suffer from malaria every year, diseases occurring most frequently in such areas as Kalimantan, Sulawesi, and Nusa Tenggara (*7). In order to cope with this morbidity pattern, the government took measures placing emphasis on lung diseases in Repelita IV and V, as shown in Table 9.

4. Environmental Sanitation

On the problems of health and sanitation, it becomes crucial to improve environmental conditions. Especially in Indonesia where there is a very high rate of suffering from epidemics such as cholera and typhoid fever, as well as parasitic disease, and the death rate from infectious diseases is also high, it is very important to take effective measures to cope with problems of drinking water and sewage disposal.

Table 10 shows sources of drinking water. The rate of diffusion of piped water and pumps is relatively high in Jakarta, but extremely low in other areas.

Toilet facilities classified into private, shared and public types are relatively common in Jakarta as shown in Table 11, but not so in other areas. Other type of toilet facilities in the table can be considered that people seem to dispose of raw sewage in rivers or irrigation ponds, which may be the same place as the source of water supply. Therefore, there probably exists a vicious cycle in the sanitation.

For health and its surrounding environment, it is important to improve the overall conditions of health and environment and to dissolve regional differences in them.

Notes

(*1) Southeast Asian Medical Information Center, SEAMIC Health Statistics 1984, P.125

(*2) Ibid., pp.126-127

(*3) Indoneshia Dai-san-ji Gokanen Keikaku (Rencana pembangunan lima tahun ketigu, 1979/80-1983-84) Vol.2 (Translated by Indoneshia Kyokai), P.22

(*4) Masami Hashimoto and others ed., Sekai no Koshu Eisei (Public Health of the World), Nihon Koshu Eisei Kyokai), P.215

(*5) Ibid., pp.22-23

(*6) Ibid., P.207

(*7) Ibid., pp211-212

Table 1 Indexes Concerning Medical and Health Treatments in ASEAN Nations (1983)

Index / Nation	(1) Death rate (‰)	(2) Percentage change (1965-83) (%)	(3) Infant mortality rate (per 1000 births)	(4) Life expectancy at birth (years) Male	(4) Life expectancy at birth (years) Female	(5) Number of hospitals	(6) Number of beds per 10 thousand population	(7) Number of physicians per 10 thousand population	(8) Number of nurses and midwives per 10 thousand population
Indonesia	13	-37.3	101	52	55	1,246*	6.7*	0.9**	3.6**
Japan	6	-15.5	7	74	79	9,515	120.6	14.2*	47.7*
Malaysia	6	-46.8	29	65	69	96	17.7	2.9*	19.2*
Philippines	7	-43.7	49	63	66	1,706	-	9.2	5.0
Singapore	5	-9.1	11	70	75	238	39.2	10.0	33.7
Thailand	8	-35.5	50	61	65	729*	15.4*	1.6*	-

Note: * - 1982, ** - 1980

Sources: (1) - (4) World Development Report 1985, World Bank.
(5) - (8) SEAMIC Health Statistics 1984, Southeast Asian Medical Information Center.

Table 2 Indexes Concerning Medical and Health Treatments by State (1971 and 1980)

State	Population				Person-hospital ratios			Person-health center ratios		
	1971 (1)	1980 (2)	Growth rate 1971-80 (%)	Population density (person/km²)	1971 (3)	1980 (4)	Growth rate 1971-80 (%)	1971 (5)	1980 (6)	Growth rate 1971-80 (%)
Sumatera	20,808,148	28,016,160	34.6	59	98,617	93,387	-5.3	55,936	28,100	-49.8
D.I. Aceh	2,008,595	2,611,271	30.0	47	62,769	137,435	119.0	26,086	16,020	-38.6
Sumatera Utara	6,621,831	8,360,894	26.3	118	68,266	65,319	-4.3	153,996	36,194	-76.5
Sumatera Barat	2,793,196	3,406,816	22.0	68	199,514	68,136	-65.8	96,317	28,156	-70.8
Riau	1,641,545	2,168,535	32.1	23	91,197	77,448	-15.1	51,298	23,830	-53.5
Jambi	1,006,084	1,445,994	43.7	32	167,681	120,500	-28.1	62,880	24,508	-61.0
Sumatera Selatan	3,440,573	4,629,801	34.6	45	104,260	132,280	26.9	47,786	36,455	-23.7
Bengkulu	519,316	768,064	47.9	36	103,863	153,613	47.9	28,051	14,770	-48.8
Lampung	2,777,008	4,624,785	66.5	139	462,835	201,078	-56.6	32,671	30,227	-7.5
Jawa	76,086,327	91,269,528	20.0	690	322,400	147,925	-54.1	66,977	40,673	-39.3
DKI Jakarta	4,579,303	6,503,449	42.0	11,023	130,837	39,177	-70.1	104,075	55,585	-46.6
Jawa Barat	21,623,529	27,453,525	27.0	593	415,837	288,984	-30.5	71,601	47,682	-33.4
Jawa Tengah	21,877,136	25,372,889	16.0	742	352,857	148,379	-57.9	145,648	36,041	-75.3
D.I.Yogyakarta	2,489,360	2,750,813	10.5	868	165,957	137,541	-17.1	40,151	31,619	-21.2
Jawa Timur	25,516,999	29,188,852	14.4	609	354,403	176,902	-50.1	44,147	38,406	-13.0
Bali/Nusat Tenggara	6,619,074	8,487,110	28.2	96	106,759	116,262	8.9	114,122	26,522	-76.8
Bali	2,120,322	2,469,930	16.5	444	111,596	189,995	70.3	151,452	37,999	-74.9
Nusa Tenggara Barat	2,203,465	2,724,664	23.7	135	183,622	209,590	14.1	115,972	34,058	-70.6
Nusa Tenggara Timur	2,295,287	2,737,166	19.3	57	74,042	101,377	36.9	91,811	20,580	-77.6
Timor Timur		555,350		37		27,768	-	-	13,223	-
Kalimantan	5,154,774	6,723,086	30.4	12	67,826	81,001	19.4	31,624	14,036	-55.6
Kalimantan Barat	2,019,936	2,486,068	23.1	111	72,141	226,006	213.3	63,123	17,885	-71.7
Kalimantan Tengah	701,936	954,353	36.0	18	83,812	39,765	-37.7	26,998	10,487	-61.2
Kalimantan Selatan	1,699,105	2,064,649	21.5	83	80,910	98,317	21.5	27,405	15,761	-42.5
Kalimantan Timor	733,797	1,218,016	66.0	34	45,862	45,112	-1.6	17,065	10,322	-39.5
Sulawesi	8,526,901	10,409,533	22.1	55	113,692	92,120	-19.0	32,299	21,375	-33.8
Sulawesi Utara	1,718,543	2,115,384	23.1	111	85,927	302,198	251.7	39,966	21,154	-47.1
Sulawesi tengah	913,662	1,289,635	41.2	18	101,518	17,195	-83.1	41,530	14,329	-65.5
Sulawesi Selatan	5,180,576	6,062,212	17.0	83	152,370	505,184	231.6	30,120	24,543	-18.5
Sulawesi Tenggara	714,120	942,302	32.0	34	59,510	49,595	-16.7	26,449	18,846	-28.7
Maluku/Irian Jaya	2,013,005	2,584,881	28.4	5	35,947	117,495	226.9	69,414	11,438	-83.5
Maluku	1,089,565	1,411,006	29.5	19	68,098	74,263	9.1	45,399	18,218	-64.3
Irian Jaya	923,440	1,173,875	27.1	3	23,086	43,232	87.3	184,688	8,445	-95.4
Nationwide	119,208,229	147,490,298	23.7	77	166,492	122,095	-26.7	59,014	31,031	-47.4

Sources: (1) For 1971 Census, Statistik Indonesia 1975, Central Bureau of Statistics, Jakarta.
(2) For 1980 Census, Statistik Indonesia 1982, Central Bureau of Statistics, Jakarta.
(3) For general and special hospitals including governmental and private hospitals of 1972, Statistik Indonesia 1975, Central Bureau of Statistics, Jakarta.
(4) For figures of 1980, Statistik Indonesia 1982, Central Bureau of Statistics, Jakarta.
(5) For figures of 1971/72, Statistik Indonesia 1975, Central Bureau of Statistics, Jakarta.
(6) For figures of 1980/81, Statistik Indonesia 1982, Central Bureau of Statistics, Jakarta.

Table 3 Number and Percentage of Patients by Place of Treatment (1971 and 1980)

Place of Treatment	1972		1980	
	Number of patients	Ratio (%)	Number of patients	Ratio (%)
Hospitals	400	16.8	689	10.3
Public Health Center/ Polyclinics/Maternal and Child Health Centers	583	24.6	2,483	37.2
Private (Including Own Account Medical Practitioners)	1,391	58.6	3,494	52.4

Source: 1972 and 1980 Household Health Survey, Ministry of Health, in Statistical Profile of Children and Mothers in Indonesia 1980 - 1981, Central Bureau of Statistics, Jakarta.

Table 4 Morbidity by Kind of Treatment (1972 and 1980)

Population	1972		1980	
	Number of persons	Ratio (%)	Number of persons	Ratio (%)
1. Surveyed Persons	111,689	100.0	121,129	100.0
2. Did not Complain Sick	106,142	95.0	107,288	88.6
3. Complained Sick	5,547	4.9	13,841	11.4
a. No treated	2,442	44.0	3,620	26.2
b. Treated	3,105	56.0	10,221	73.8
i. Medically	2,122	38.3	6,021	43.5
ii. Non-medically	252	4.5	613	4.4
iii. Self	705	12.7	3,551	25.7
iv. Others	26	0.5	26	0.2

Source: 1972 and 1980 Household Health Survey, Ministry of Health, in Statistical Profile of Children and Mothers in Indonesia 1980 - 1981, Central Bureau of Statistics, Jakarta.

Table 5 Number and Percentage of Patients Not Treated by Reason (1972 and 1980)

Reason for not treating	1972		1980	
	Number of patients	Ratio (%)	Number of patients	Ratio (%)
1. Cost	312	26.8	1,547	42.6
2. Distance	289	24.8	185	5.1
3. Did not need	385	33.1	1,304	35.9
4. Others	178	15.3	594	16.4
Total	1,164	100.0	3,630	100.0

Source: 1972 and 1980 Household Health Survey, Ministry of Health, in Statistical Profile of Children and Mothers in Indonesia 1980 - 1981, Central Bureau of Statistics, Jakarta.

Table 6 Number of Patients and Average Cost per Outpatient by Place of Treatment (1980)

Place of Treatment	Number of patients	Average cost (Rp.)
1. Hospitals	503	4,851.1
2. Public Health Center	1,059	418.2
3. Maternal and Child Health Centers	82	601.9
4. Polyclinics	952	613.7
5. Own Account Practitioning Doctors	1,221	3,575.3
6. Nurse Practice	1,109	717.7
7. Midwives Practice	113	588.9
8. Maternity Clinics		3,103.0
9. Tradtional Medical Men	521	918.9

Source: 1980 Household Health Survey, Ministry of Health, in Statistical Profile of Children and Mothers in Indonesia 1980 -1981, Central Bureau of Statistics, Jakarta.

Table 7 Percentage of Deaths by Cause of Death (1972 and 1980)

(Unit: %)

Cause of death	1972	1980
1. Lower Respiratory Tract Infection	12.0	19.9
2. Diarrhoea	17.0	18.8
3. Cardiovascular Disorders	5.1	9.9
4. Tuberculosis	6.0	8.4
5. Tetanus	4.6	6.5
6. Diseases of Nervous System	5.1	5.0
7. Liver Disorders	-	4.1
8. Injuries & Accidents	2.1	3.5
9. Neoplasm	-	3.4
10. Typhoid	2.1	3.3
11. Other Infection & Parasitic Diseases	-	3.0
12. Complications of Pregnancy & Delivery	2.2	2.5
13. Neonatal Conditions	2.4	-
14. Others	41.3	6.9
15. Not Clear	-	4.8
Total	100.0	100.0

Note: Diseases were categorized into the 10 major diseases, "not clear" for figures of 1972, and the 14 major diseases, "not clear" for 1980, respectively. Sample size: 583 for 1972; 905 for 1980.

Source: 1972 and 1980 Household Health Survey, Ministry of Health, in Statistical Profile of Children and Mothers in Indonesia 1980 - 1981, Central Bureau of Statistics, Jakarta.

Table 8 Morbility Pattern of Hospitals by Cause Group (1973 and 1980)

Cause Group	1973		1980 1)	
	% of discharges	Ascending order	% of discharges	Ascending order
Infectious and Parasitic Diseases	23.9	2	19.0	2
Neoplasm	3.0	8	2.2	10
Endocrine, Nutritional & Immunity Disorders	1.2	12	0.9	14
Diseases of Blood & Blood Forming Organs	0.5	15	0.6	17
Mental Disorders	1.9	11	1.3	12
Diseases of Nervous System & Sense Organs	2.6	10	1.6	11
Diseases of Circulatory Systems	2.9	9	2.5	9
Diseases of Respiratory Systems	8.6	4	6.9	5
Diseases of Digestive Systems	6.6	5	5.6	6
Diseases of Genital Organs	3.4	7	3.3	8
Complications of Pregnancy, Delivery & Puerperium 2)	26.8	1	22.5	1
Diseases of Skin & Subcutaneous Tissues	1.0	13	0.7	15
Diseases of Musculoskeletal System & Connective Tissues	0.8	14	0.6	16
Congenital Anomalies	0.4	16	0.4	18
Certain Conditions Originating in the Perinatal Period	0.3	17	1.2	13
Symptoms, Signs and Illdefined Conditions	4.4	6	3.6	7
Injuries and Poisoning	11.7	3	9.2	4
Supplementary Classification for Factors Influencing Health Condition 3)	-	-	17.9	3
Total	100.0		100.0	

Notes: 1. Based on Sample of 2 weeks discharges (January 1-7 and July 1-7, 1980).
2. Include normal deliveries.
3. Include liveborn babies.

Source: Statistical Profiles of Children and Mothers in Indonesia 1980 -1981, Central Bureau of Statistics, Jakarta.

Table 9 Comparisons in Measures against Diseases between Repelita III and Repelita IV

(million persons)

Measure \ 5-year plan	Repelita III	Repelita IV
1. Measure against malaria		
a. Disinfection	16.5	23.0
b. Treatment for patients	40.0	50.0
2. Measure against tuberculosis		
Short- and long-term treatment	0	120.0
3. Measure against cholera Treatment		
for patients	1.1	27.7
4. Measure of BCG	16.5	23.8
5. Measure against malnutrition	36,000	64,448

Source: Dai 4-ji Kaihatsu 5-ka-nen Keikaku (Rencana pembangunan lima tahun ketiga) 1984/85 - 1988/89, Indonesia (Translated by Taniguchi Kenkyujo (Taniguchi Research Institute)).

Table 10 Sources of Drinking Water Supply by Area (1978)

	Water supply sources (%)							Number of households (thousand)
	Piped water	Pump	Well	Spring	River	Rain	Others	
1. DKI Jakarta	39.8	27.3	29.7	0.0	0.1	0.0	3.1	1,014
2. Jawa Barrat	1.6	1.1	64.8	20.6	10.4	0.1	1.4	5,517
3. Jawa Tengah/ D.I. Yogyakarta	3.5	1.1	65.5	20.2	7.5	0.7	1.5	5,664
4. Jawa Timur	6.7	0.9	67.8	16.2	4.2	0.2	4.0	6,173
5. Sumatera	4.0	0.9	64.2	10.0	15.5	4.1	1.3	4,718
6. Kalimantan	3.9	2.5	23.1	1.6	55.0	13.3	0.6	1,257
7. Sulawesi	3.3	2.3	73.3	11.2	8.9	0.0	1.0	1,860
8. Other Islands	6.9	2.3	41.0	30.7	14.9	0.0	4.2	1,574
Nationwide	5.4	2.2	61.5	16.1	11.1	1.5	2.2	27,777

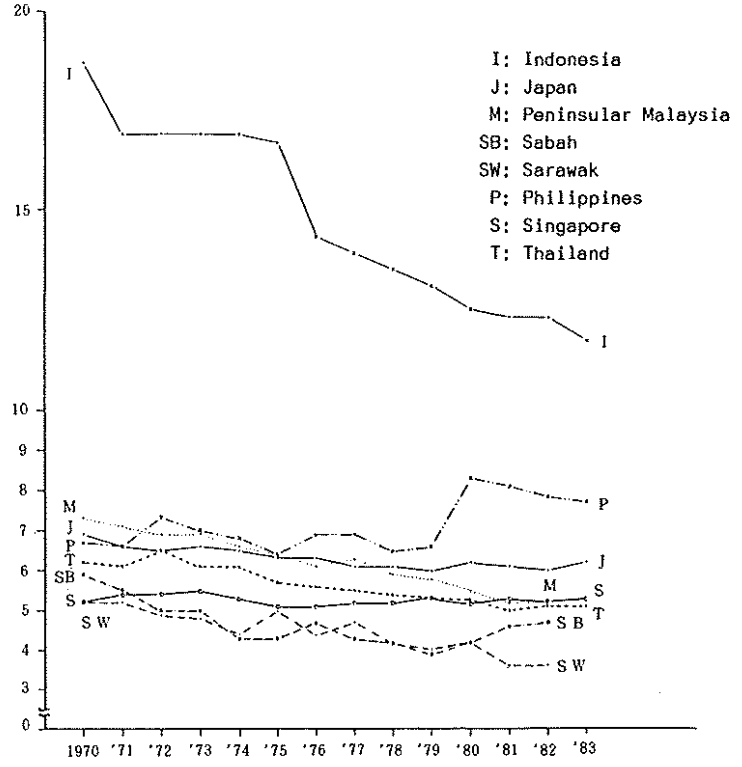
Source: 1978 National Socio-Economic Survey, Central Bureau of Statistics, in Statistical Profile of Children and Mothers in Indonesia, 1980-1981, Central Bureau of Statistics, Jakarta.

Table 11 Percentage of Households by Province Island and Type of Toilet Facilities (1978)

	Type of toilet facilities (%)				Number of households (thousand)
	Private	Shared	Public	Others	
1. DKI Jakarta	58.4	9.0	15.0	17.6	1,014
2. Jawa Barat	13.7	11.3	7.0	68.0	5,517
3. Jawa Tengah/ D.I. Yogyakarta	35.5	3.6	4.4	57.5	5,664
4. Jawa Timur	40.5	11.2	2.9	45.4	6,173
5. Sumatera	40.9	5.8	4.6	48.7	4,718
6. Kalimantan	28.7	14.7	9.8	46.8	1,257
7. Sulawesi	35.3	6.5	2.3	55.9	1,860
8. Other Islands	22.5	4.6	2.5	70.4	1,574
Nationwide	32.8	8.1	5.0	54.1	27,777

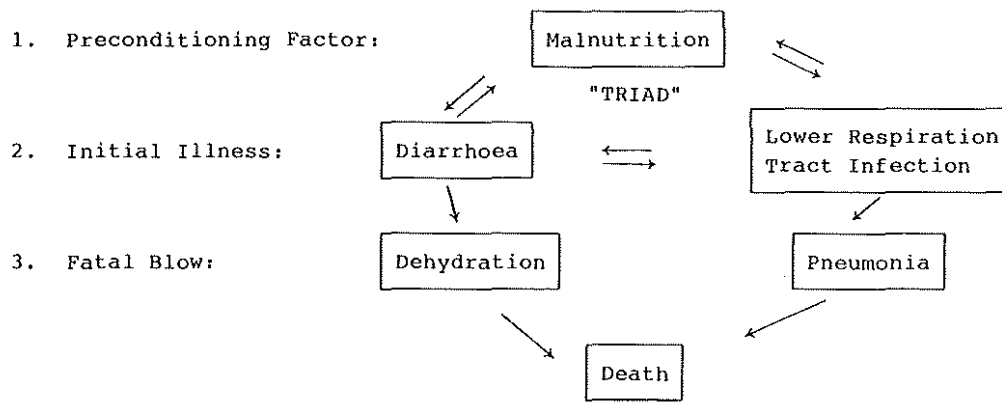
Source: 1978 National Socio-Economic Survey, Central Bureau of Statistics, in Statistical Profile of Children and Mothers in Indonesia, 1980-1981, Central Bureau of Statistics, Jakarta.

Figure 1 Annual Change of Crude Death Rate (per 1,000)



Source: SEAMIC Health Statistics 1984, Southeast Asian Medical Information Center, Tokyo.

Figure 2 Casual Sequence on Causes of Death



Source: Terence H. Hull & Jon E. Dohde, Prospects for Rapid Decline of Mortality Rates in Java, Population Institute, Gudjah Mada University Yogyakarta, 1978.

CHAPTER 5 REPORT ON FIELD RESEARCH IN INDONESIA

1. Objective and Method of Research

(1) Objectives

Population problems in Indonesia show that its population is the 5th largest in the world and that it is concentrated on Jawa Island. The birth rate has tended to decline gradually over the last several years. Indonesia consists of 13,000 islands, and about 80% of its population are rural population. There still exists the difference in birth rate between urban and rural areas. As regards to urban population, there were 7,371,603 inhabitants in Jakarta in 1985, which means that it is the largest city in Southeast Asian countries.

In order to improve imbalances in its urbanization, Jakarta has been pursuing the Kampong Improvement Program. People flowing into Jakarta build their houses along the canal or on vacant land. Thus new urban problems have arisen: lack of space for vehicle traffic; sewage systems and schools can not be adequately built. Thus Jakarta started its improvement of Kampong, under the Kampong Improvement Program, aiming at "improvement for quality of life" in cooperation with the World Bank. Its main objectives included: development of the roads in the area, improvement of toilet facilities, construction of dikes to prevent the inundation of canals, construction of schools such as primary schools, construction of waterworks, implementation of measures against diseases, spread of family planning services and construction of 4-storied apartment houses. This work was conducted mainly on the northern and western regions where many informal sectors reside.

The flow chart of work execution is as follows:

Jakarta DKI
↕
Mayoral 5 districts (Central, North, West, South and East Jakarta)
↕
District (Kecamatan)
↕
Sub-district (Kelurahan) population: about 50,000
(One office, one clinic and primary school)
↕
R.W. (Community association)
↕
R.T. (Neighborhood association) 50-60 households

The Kampong Improvement Project has been proceeding according to the above flow. The improvements have been promoted not only through the unilateral action by the municipal government of Jakarta but also in cooperation with inhabitants in "Gotong Royong", the spirit of mutual help unique in Indonesia. For example, water is controlled by the representative at the R.T. level after the installation of a pump. Finding out needs of inhabitants concerned, he makes his proposal to the sub district through the R.W., and this settles the matter.

Concerning the Kampong Improvement Program, Mr. Darrundono, Project Manager, the Kampong Improvement Program, explained, using slides, that there has been big changes effected during the period from 1970's to the present. The slide films showed the condition before and after the improvement.

Many companies (P.T.) in Jakarta develop welfare services for their employees as Japan used to do immediately after the war (called "New Life Movement" in Japan). Their welfare system includes promotion of family planning, welfare allowance, group medical examinations, and free lunch at their companies.

The purpose of the research this time was to study the above-mentioned Kampong Improvement Program, the life and welfare level of company employees by means of interview, the progress in family planning and trends of population flowing into the cities, in order to get an idea on problems of the urban population and its development.

(2) Method of Research

The same research had already been conducted in two countries: in Bangkok, Thailand, and in New Delhi and Haryana state, India. The subject of research in either case was population flowing into cities from villages. This time too, the subject was population flowing into Jakarta. But for the first time the people subject for research were classified into two categories, that of company employees, and that of inhabitants involved in Kampong Improvement Program.

This research was initiated with the consent of Mr. Martono, Minister of Transmigration of Indonesia, who attended "the Asian Parliamentarians' Meeting on Population and Development," already held twice in the past under the auspices of the Asian Population and Development Association(APDA). Minister Martono appreciated the previous population researches conducted by APDA in China, India and Thailand, and thus decided to also make the Indonesian people happy by conducting research according to social and scientific approaches to be made by the APDA in Indonesia in view of the new developments there.

With the assent of Transmigration Minister Martono, the research cooperative team for Indonesia was organized immediately. This team

consisted of one chief, one coordinator, nine researchers and several counters. They studied contents of a questionnaire (individual one) presented by the APDA. In addition, they, the team, trained researchers on how to fill out the questionnaire.

In the research, the questionnaire can be divided into 17 items. Sample research was conducted in two places at the Kampong level and at four companies.

The research subject at the Kampong level totaled 100 households, 50 each at two places, and 100 households, 25 each at four companies.

The selection of the Kampong district and the companies was left to the judgement of the Indonesian research collaborators.

The researchers conducted interviews with the heads of each family, not only during the day time, but also at night when they finished work. The research coordinator was engaged in training, taking the results of research already done in Thailand and India into consideration. Without devoted efforts, wholehearted cooperation and understanding of those collaborators, this research would not have been successful.

As to the period required for research in Indonesia, the Japanese members had in May sent the draft of an interview questionnaire to Indonesia. The Indonesian team had studied the questionnaire, conducted the research with it, and already completed the interview with 200 households consisting of 100 at Kampong and 100 at companies, even finishing the simple counting work when the Japanese research team (headed by Dr. Toshio Kuroda) visited Indonesia. In addition, the Indonesian team went through the length of making summary explanation of the district, using OHP and slides.

Thanks to the wholehearted cooperation of Transmigration Minister Martono and other Indonesian collaborators, the preparation, the selection of research districts, the execution of the interview research, the counting, and the summary explanation of the districts could all be completed in a month.

2. Research Districts and Outline of the Companies

As mentioned above, the subjects of the research this time were the two districts in Kampong, Jakarta, and four companies. The Japanese research team had an opportunity for visiting two districts in Kampong and three of the four companies.

(1) Two Districts at Kampong

1) Kulurahan Grogol

Grogol (sub district) is located along the Tersan Banji canal in the northwestern area of Jakarta DKI, and has population of 26,978, an area of 1.23km^2, and a total of 4,558 households.

This district consists of 10 RW's (community association) and the whole district consists of ordinary residence areas. A bus terminal is located at the southwestern end of this district. Therefore, this district is an easily accessible place.

There are three primary health centers (PHC) with 13 doctors including 6 medical specialists and 13 midwives. But these medical professionals are not full-timers but work on a shift basis. There are 20 primary schools, 7 junior high schools and 2 senior high schools.

The research team visited one of the above-mentioned PHCs. This PHC has one doctor, one nurse, one midwife and 2 clerks, and is engaged in medical activities for the inhabitants. Major diseases are influenza and bronchitis, and especially, there are many children of the ages of 0-5 suffering from diarrhea. The center gathers and advises inhabitants on family planning once a month. The major methods of contraception were use of the pill and the IUD. In some cases, the condom, injectable and norplant are also used. For the spread of family planning service, officials in charge keep records of contraception methods and birth by keeping a card for each individual.

The interview research was conducted at the RW01 district of Grogol (1) which was a community consisting of 523 households along the Tersan Banji canal. The RW01 is the district involved in the Kampong Improvement Program (KIP). Inhabitants of this district had lived next to the canal before, but all the inhabitants moved when the dike constructed under the KIP. Most houses are built of cement, and some of wood. At RW01, there is a meeting hall constructed by the inhabitants, which is utilized for medical and family planning services and meetings. One doctor is permanently stationed as a responsible person for maintenance of this hall. The inhabitants at RW01 are mainly of the informal sector (irregular work force).

2) Kulurahan Jelambar

Jelambar (sub district) is located in the northwestern area of Jakarta DKI, and is a neighboring district of Grogol. It has a population of 104,846, an area of 5.61km^2, and 17,500 households surrounded by the canal in the east and west.

This district features developed commercial quarter along the canal

and a road to the port, which makes the community vibrant with life and energy. On the other hand, part of the district is the residence area of the informal sector. If it rains, houses situated along the canal get flooded beneath the floors.

The subject district this time was district A in Jelambar with a population of 2,500 consisting of 456 households. The district representative is a female leader. Most residents of this district are of the lower income brackets. According to the leader's explanation, sanitary and housing problems remain unsolved, and it is hard to gather inhabitants to participate in inhabitant activities. As to family planning activities, Family Planning Workers (FPW) make their rounds, controlling each family by card. The FPW also conduct nutritional and hygienic guidance. As to contraception, a fire bell made of wood is installed in the district, and those concerned take pill every morning when the bell rings.

Water for drinking is partly supplied by water peddlers hawking in the streets, carrying five-liter cans on a bicycle cart.

As to educational facilities, there is a private primary school in the district.

As to public sanitation, if it rains, most of the district is flooded beneath the floors, and poorly drained. Under these circumstances, the leader of this district listens to inhabitants, collects their needs, and makes petitions to the district office for improvement.

(2) Companies

The research commission had the opportunity to visit three of the four companies which were the subjects of the interview research this time.

1) Warna Agung (P.T.)

This company was a paint manufacturing company (P.T.) established in 1970. The total number of employees is 210, consisting of 186 males and 24 females.

The average age of employees was about 40, and the two oldest employees were 70 and work as guards. This company has no age-limit system and employs ex-servicemen. Monthly wage is Rp.47,000 at its lowest and Rp.170,000 at its highest. Transportation expenses and lunch fees are paid separately.

As a medical service for employees, a tuberculosis examination is conducted once a year. There is a clinic in this company where seven docotrs work in shifts, and one nurse is permanently stationed.

Family planning is under direct instruction by the BKKBN (National Family Planning Coordinating Board), and contraceptive devices and sterilization are at company's expense, namely free of charge for employees. But free-of-charge service, however, is limited to employees having three or fewer than three children. In addition, the BKKBN conducts research in the execution ratio of family planning.

An athletic meeting and recreation are held at company's expense, as welfare to the families of the employees.

2) Hoechst (P.T.)

This company was established in 1972 as a pharmaceutical company, and started to manufacture chemical products such as plastics in 1974. Employees total 500, consisting of 350 males and 150 females. The monthly average wage is Rp.80,000. Traffic expenses are paid separately. Lunch is available in a messroom for employees free of charge.

As for the medical service, one doctor and one nurse stay in the clinic at the company, and employees can get examination at any time. Employees can get an overall medical examination once a year free of charge.

As regards to family planning service, the BKKBN reserves contraceptive devices in the company and distributes them to employees free of charge. Families of emplouyees can obtain family planning services at the primary health center (PHC) of the district.

(Interview with employees)

o Mr. S, 33 years old

Mr. S comes from Surakarta in central Jawa. His wife is 33 years old. They married 7 years ago. The family consists of four, including a daughter of three and half and a boy of one and half. They live in a 2DK (2 rooms and a dining room) apartment and have a color television, a radio, an electric fan and a motor cycle. They say that as educational expenses and commodity prices are high, two children are enough to have.

They knew of family planning (contraception) before their marriage, and obtained more knowledge from guidance at the company. As regards to general medical service, they visit the company clinic and also see a practising doctor in the city.

o Mrs. M, 33 years old

Her husband is 43 years old. The family consists of three, including a daughter under Mrs. M's parents' care in Semarang, where Mrs. M comes from. She says that she wants one more child. She lives

in a rented house equipped with a toilet and running water in Jakarta. She doesn't have a television set, but has a radio. She subscribes to a newspaper.

3) Gaya Motor (P.T.)

This company is an automobile assembly company established in 1969. Employees number 1,243, including 5 females. They work in two shifts, and the age-limit system of age 55 applies to both males and females. Pension is paid after retirement. Monthly wages range from Rp.68,000 to Rp.260,000, and traffic expenses are paid separately. Meals are available free of charge.

This company has a fully-equipped clinic with three doctors and two paramedics stationed permanently there. Employees receive a tuberculosis examination once a year. As regards to family planning, contraceptive devices are distributed for free. The government gives courses in family planning to families of the employees (to wives). The recreational activities of the employees and their families are enjoyed enthusiastically. The employees' play volleyball, soccer and tennis.

More than 80% of the employees originated in the central, western and eastern regions of Jawa.

3. Analysis of the Sample Survey Results

This chapter analyzes the data accumulated on surveys conducted in the two districts, Grogol and Gelambar, and on four companies. The number of samples extracted for these surveys are notably small, consisting of 50 households from each of the two districts, totaling 100 households (the total number of household members being 578 persons), and 25 households from each of the four companies, totaling 100 households (total number of household members being 465 persons). Moreover, the samples for the districts are "cluster samples" which are derived from a public area in Jakarta, whereas the samples for the companies are extracted from respective company employees who have academic backgrounds and incomes higher than average, and are thus represented as "stratified samples". In other words, it should be taken into account beforehand that there are differences of economic and social characteristics among these sample populations in this analysis, though the samples for the two groups are listed in the same table.

(1) Age and Sex Composition and Family Type

First of all, the male and female age compositions of all the household members of both district and company samples are shown in Table 1. The sex ratio (male/female) of district samples was 116, and that of company samples was 110, which both represent higher values than

that of Jakarta D.K.I., 107 (*1).

Regarding the age structure, the dependency ratio of child population on the economically active population (population under 15 years/population 15-59 years) was 69.9% for the district samples, and 85.4% for the company samples. The aged dependency ratio (population aged above 60/population of age 15-59 years), in contrast, was 2.7% for the district samples and 1.2% for the corporate bodies' samples. For reference, according to the 1980 census, the child dependency ratio was 67.5% and the aged dependency ratio was 5.4% in Jakarta. Thus, the district samples show a population structure more similar to that of Jakarta. Of these indices, it is noteworthy that the age structure is young and that there exist significant social and economic burdens for the young population. Much cannot be deducted from these indices alone, because changes in fertility, mortality, and migration collectively cause resulting changes in age structure. However, it seems apparent that the problem of supporting the child population is by far more serious than the problem of the aged population in Jakarta, as seen in many other developing countries.

Next comes the question of what type of family pattern is found among the sample households surveyed. For the Sundah people, which dominate the society in Jakarta, the most common family pattern is the nuclear family, consisting of husband, wife and unmarried children. In principle, the conventional dwelling pattern after marriage is an independent dwelling (*2). This trend wes also confirmed among the survey samples. The proportion of nuclear families for all the households was 86.0% for the district samples and 77.0% for the company sample. Single households were not found in either of these samples. On the other hand, extended families, which are multi-generation families including collateral relatives, account for 8.0% in district samples and 20.0% in company samples.

Distribution of the number of family members is indicated in Table 2. Concerning district samples, the number of family members per household shows an extensive distribution with a concentration seen mainly in a range of 5 - 8 persons. And the households of more than 7 persons account for 37%. In company samples, on the other hand, number of family members varies mainly 4 - 6 persons, and the households of more than 7 persons represent a mere 10% share of the total. When comparing these situations in terms of the average number of family members, the average number was 5.7 persons for the district samples, and 4.7 persons for the company samples. This seems to imply that the households of company employees have a relatively smaller number of family members than the average households in Jakarta D.K.I.

(2) Educational Standard

Educational standard is a factor determining an individual's living

standard and lifestyle. From a demographic point of view, it also affects the level of fertility as well as mortality. In this connection, it is not an exaggeration to say that expansion of primary education is essential for sound development of any particular society. Bearing these factors in mind, the education levels by age of both husbands and wives above age 20 were investigated in this analysis (see Table 3).

At present, only a six-year primary school education is compulsory in Indonesia. Of all the samples, 68.4% of the husbands in the district samples and 97.0% of those in the company samples had completed primary school or higher education. Concerning the wives, 52.2% district samples and 88.0% of company samples had educational backgrounds of primary school or higher. Both husbands and wives in the company samples showed higher educational levels than in the district samples. As clarified in the explanations given at the time of visiting the surveyed companies, it seems that such differences between the two samples could be attributed to the differences in population characteristics; company samples composed of employees who are qualified by having achieved a certain educational standard. Furthermore, it is considered that there is a positive correlation between the education levels of husband and wife.

Next, by analyzing the education levels by age groups, it is apparent in both samples that the education levels increased with recent generations. In the case of district samples, 58.8% of the husbands aged 40 and over had completed the compulsory education, whereas, the figure for the husbands in their 20's was 85.0%, indicating a substantial rise in education level. Regarding higher education, only 11.8% of the husbands aged 40 and over completed high school or more, while 25.0% of the husbands in their 20's fall in the same category.

As for the educational standards of females, though some improvements are being recognized, the rate of increase seems to be somewhat lagging. Again among the district samples, 41.4% of the wives aged 40 and above had completed the compulsory education, and the same figure for wives in their 20's was 58.5%. Obviously the rate of increase in the educational levels of the wives was smaller than that of the husbands. Furthermore, among husbands in their 20's, 20.0% completed junior high school and high school education, both with a period of 3 years, but only 6.5% of their wives completed this level of education. Thus, education gaps were evident between males and females in this analysis.

(3) Employment and Living Standards

Populations essentially consisting of company employees were extracted as survey samples for the company smaples. Accordingly, in Table 4, the working situation of heads of household only in the

district samples were shown by their income level. In the district samples, only one out of 100 heads of household was unemployed. Of the workers, as a whole, wage workers and those self-employed shared 30% and 29.0%, respectively, followed by employees of 21.0%. Regarding the level of incomes of household head, those working as casual wage laborers were shown to have relatively lower incomes. Meanwhile, the distribution of income levels were extensive among the self-employed. This could be attributable to the fact that the self-employed include the informal sector workers such as a Beca-driver/merchant (a man who rides a bicycle drawing a cart, selling goods or giving a person a lift), fruit stall merchants, Kerupuk (Shrimp-tasting cracker) sellers, with the large gap in income-level among them.

The average income of household heads in the district samples was 123,480 Rps./month. The company samples indicated a rather higher figure of 142,356 Rps./month. However, they were not yet at the level of 159,816 Rps./month, which is the minimum required wage (KFM) (*3) in Jakarta recommended by the Government (as of 1985, for households with three children). As a matter of fact, in Indonesia the levels of miscellaneous allowances other than salaries vary greatly from one industry or corporation to another. It is not appropriate therefore to discuss the standard of living by merely pointing out nominal income.

In Table 5, the relation between income and education level is indicated. Concerning the district samples, the higher the education levels of householders are, the larger the proportion of householders in the higher income brackets. For instance, 44.4% of the householders with the educational backgrounds exceeding that of high school education have an income of 200,000 Rps./month or more. On the other hand, 59.4% of those householders who had not completed primary education were subjected to the low income level of 100,000 Rps./month or less.

Next, not only employment situations of the householders but also those of household members, as a whole, should be discussed. First, the proportion of laborers among those aged 10 and above was 38.8% in the district samples and 44.2% in the company samples. Moreover, the unemployment rate in the same population was 6.6% and 2.6%, respectively, higher in the district samples. Table 6 shows household incomes and the number of workers within households for the district samples. The households in which only the householders worked represent the largest ratio of 54.0% of the total. In case of "the households which had worker besides the householder," which indicated a ratio of 27.0%, 70% of them were by wives. It is thus inferred that the working of married women is commonly found and that, at the same time, wives' earnings are a substantial part of household income.

In the same table, the distribution of household income show a concentration in the range of 100,000 - 149,999 Rps./month, while average household income was 160,360 Rps./month. This seems to imply

that there are large gaps in household incomes among the district samples. In this connection, about 60% of household income in the company samples, was distributed in the range of 100,000 - 199,999 Rps./month. The average household income was 175,500 Rps./month.

In closing, the situation on the possession of durable consumer goods according to household income levels should be studied in order to know of the effects of household incomes on actual living conditions (see Table 7). In this study, six items, namely TVs, refrigerators, radios, sewing machines, motorcycles, and electric fans were chosen as the consumer goods. It is apparent that the proportion of possession of any of these items increased as the income level increased. A radio as well as a TV indicated a high rate of possession. Even among those people in the low income levels (or monthly household incomes less than 100,000 Rps.), the rate of possession was as high as 59.1% for radio and 54.5% for TV. For reference, a radio can be puchased for about 70,000 Rps., while a TV can be had for about 400,000 Rps. The prices of sewing machines and refrigerators are almost the same, around 150,000 Rps. However, in terms of the rate of possession, sewing machines showed a far higher percentage. As a whole, it is considered that people tend to purchase these items according to the following order of priorities, radio, TV, sewing machine, motorcycle, and refrigerator, as their incomes become higher.

(4) Health and Medical Treatment

One of the major objectives of this survey was to inquire about details on the present health and medical services in the surveyed area. In this section, an attempt has been made to grasp the actual conditions on the possession of latrine and drinking water facilities, diagnosticians at times of disease, childbirth delivery facilities, and birth attendants.

First, Table 8 shows the situation regarding the possession of latrine and drinking water facilities according to household income level amongst the 200 households of both the district and company samples. A general tendency can be observed in the table that the rate of the possession of private latrine increased as the income level increased. However, 22.9% of the households with a monthly household income of 200,000 to 299,999 Rps. and 21.1% of those with income exceeding 300,000 Rps. are still using public toilet facilities. This stagnated growth in the possession rate may be attributed to such factors as housing location and the education level of householders independent of income levels. In other words, in a city like Jakarta where population density is high, the residential space has generally been very densely settled and people are obliged to live in inferior environments such as riverbeds. Installation of toilet facilities may obviously be logically defficult, even if they may have a certain level of income.

A tendency similar to the possession of toilet facilities was identified also with regards to the possession of drinking water facilities. The possession rate of a privately piped water supply increased in proportion to the increase of monthly household income. However, even among the households with household income exceeding 200,000 Rps., 70% are still obtaining drinking water from public waterworks or wells. In addition, although not included as a question item in the survey this time, many citizens of Jakarta are usually buying canned drinking water. All these facts imply the necessity of administrative provision of latrine as well as drinking water facilities for the people in Jakarta.

Next, the use of medical facilities shall be examined. Table 9 indicates the survey results regarding diagnosticians for all household members for the district samples and the company samples. It should be noted beforehand that there are conspicuous differences in availability of medical supplies between these two sample groups. As it was explained in the interviews for employees, companys surveyed have their own dispensary and health guidance room and are moreover, providing for regular medical checkups and extending medical services to the family members, promoting the consolidation of overall health control. In short, family members of company employees can enjoy the benefits of good medical services more easily than people of district samples.

According to the data collected, it was found that 98.5% of all household members of the company employees consulted doctors for diagnosis at times of illness. Similarly, an overwhelming rate of 81.8% were also asking for a doctor's diagnosis in the district samples, but 11.1% judged on the basis of own self-diagnosis. Furthermore, as to the characteristics of those samples which responded as "self-diagnosis", it was found out that although there were no evident difference between the male and female. Further, they were mostly composed of either uneducated people or those who did not complete primary school education. Their average household income was 108,810 Rps., which was conspicuously lower than the average household income of whole district samples, 160,360 Rps.

Also, all the household members were questioned about where they had been born and who had attended their births. The results are shown in Table 10. Though it may be inappropriate to generalize a tendency from the survey results, because of the very small sample size, the substantial improvements are observed on the use of services related to birth deliveries during the past 20 years. For instance when analyzed by birth cohort, assuming conditions of delivery of the present 20-year-old adult represent the conditions of those 20 years ago, deliveries at home would have then by far exceeded deliveries at medical facilities prior to 1966. For example, the cohort born in 1957-66, 67.3% of deliveries were performed at home and only 29.2% at medical institutions. To be compared, responding figures for the cohort born in 1977-

86, were 46.2% and 49.4%, slightly exceeding the deliveries at home.

In regard to birth attendants, prior to 1966, deliveries made with Dukun-Bayi (traditional birth attendance) was dominant. However, during the past decade, a majority of 54.5% indicated births were performed with a Bidan (qualified midwife).

These tendencies were even more obvious among the company samples, which had more access to medical services and also had relatively higher educational backgrounds. For births at the company employees' households during the past 10 years, 91.7% used medical facilities, and 73.9% were assisted by midwife, followed by doctor's attendance, which was 22.9%.

(5) Family Planning

The Indonesian government has been promoting the family planning programs led by the government since 1968, as it considers that such population control will form the basis for economic and social development. However, any decisions on birth control have in fact been fully entrusted to the will of each married couple. The extent of family planning executed by married couples should be examined in this survey, by designating married women of age 20 and over as specific samples. It must be noted, however, that there are differences between the district samples and the company samples concerning their involvement in family planning movements promoted by the government as seen with medical services. In other words, the policlinics or Health Centers (*4) of the local community are principally providing family planning education and contraceptives at the district levels. Besides, among companies, in cooperation with the BKKBN, unique family planning services are being offered not only to employees but also to their spouses.

Now the question arises, where do the wives obtain knowledge or serivces on family planning? According to the results shown in Table 11, three-fourths of the total people in the district samples are depending on the Primary Health Centers or Public Information Papers. Regarding company samples, in spite of the fact that companies themselves have been participating in the promotion of family planning programs, those who depend on the services from the company account for less than 10%, with the highest rate of Health Centers and Public Information Papers.

Next, what factors determine the family planning practice? The proportion of those currently practicing family planning among the surveyed married women was 52.6% for the district sample and 80.8% for the company samples. Table 12 indicates the rate of family planning practice according to level of education and present number of their children. As to the correlation between educational backgrounds and practicing rate, it is generally considered that the execution ratio

rises as education level increases. Nevertheless, the survey has failed to provide results which would apparently demonstrate such correlation either in the district or in the company samples. When comparison was made among the women in low educational standards, who had not completed primary education, the wives in company samples aged 30 years old and over showed a near-perfect practicing rate. However, as the number of samples was extremely small, it could not be shown that these achievements were due to the propagation of family planning programs unless a more detailed investigation were made.

Next, as a question concerning the number of children ever born was not included in this survey, the attempt was made instead to identify its relationships with the family planning practicing rate by means of computing the existing number of children. In both samples, the execution rate tended to increase as the number of existing children increased. Among company samples, as many as two-thirds of the mothers who have one child are practicing family planning. For reference, the desired number of children for both samples averaged 3.1. Therefore it could be stated that married women in Jakarta have a high awareness of family planning and also have a clear will to reduce the number of children.

Table 13 indicates a study on what types of contraceptive methods are used among those practicing family planning. The family planning program of the Indonesian government has been introducing the "cafeteria style" in which the selection of contraceptive methods is left to the preferences of individuals. Incidentally, according to statistics made available by Jakarta City in 1985, it was found that pill users show the largest proportion of 39.6%, followed by IUD users, which is 27.5%.

The results of the survey this time indicated that among those who are practicing family planning in the district sample, 36.5% were using the pill and 30.8% the IUD. In the company samples, IUD users accounted for 38.8%, which was slightly larger than pill users, which was 35.0%. Furthermore, according to the age of the wives, a large number of the wives in their 20's used the pill (47.4% for district samples, 44.4% for company samples), and they are replaced by IUD users as age increases. The reasons may be that those in their 20's have a stronger desire for childbirths and prefer the pill which allows them to voluntarily discontinue contraception. Descriptions of other contraceptives, which accounted for 16.3%, are not specifically shown. However, based on explanations by the Public Health Center at the time of visiting the site surveyed, it seems that there are considerable use of the injection method, following pill and IUD.

Lastly, no particular correlation was found between methods of contraception and educational backgrounds.

(6) Movements

Indonesia is no exception among all Asian countries where urbanization have been extremely conspicuous. It is well known that such rapid increases in urban populations are caused not only by natural growth but are also by other major social factors, such as the migration from rural to urban areas. Accordingly, in this survey, a series of questions were established to elicit the background and present state of the in-migration in Jakarta.

Table 14 shows the distribution of birth places and last places of residence only for the householders. As far as the collected data show, distributions of birthplace and that of last places of residence are quite similar; the immigrants from West and Central Jawa, geographically the closest to Jakarta City, represent nearly 60% of the total number of households. Those who were born in Jakarta City accounted for about 21.5%. Immigrants from East Jawa and Yogyakarta are relatively less in number.

Next, the total samples have been classified into those from urban areas and those from rural areas, with the number of migrations before migration into the present community is shown in Table 15. In the samples, as a whole, those from urban areas including those born in Jakarta City show a proportionate rate of 36.7% and those from rural areas account for 63.3%. 61.8% of those from rural areas had only moved one time to move into the present community. As for those from urban areas, those who had moved once and those who had never moved before showed 38.7% and 30.7%, respectively. Thus, it was considered that "step migration", was found to be less frequent among the householders surveyed. In other words, a majority of the people will continue to dwell at the place where they have moved from their birth places.

Next, let us turn our discussion to reasons for migration. As a whole, those who moved for reasons of marriage could hardly be found, probably because the questions were directed only to the heads of household. Regarding those from urban areas, those pointing out economic reasons accounted for 30.3%, those following parents or family was 26.3%, and education for a reason accounted for 18.4%. On the other hand, among those from rural areas pointed out economic reasons with a high rate of 67.5%. This confirms the fact that considering the economic advantage in the life of capital city and contrasting poverty in the rural areas, local farmers migrate into Jakarta to look for employment opportunities.

Furthermore, householders' income should be compared with that of people who migrated from rural areas and from urban areas, and their lives following the migration should be investigated. It is also apparent in Table 2-15, that the income level of migrants from rural areas remains at a lower level when compared to that of those from urban

areas. It is considered that although farmers migrated into Jakarta because of economic motives, having poor skills and low educational background, they have not been favored with employment opportunities even in cities, thus limiting themselves to low incomes. Nonetheless, the 20.3% of migrants from rural areas remit to the family living in rural areas.

Lastly, let us figure out the migration pattern and their life by taking one example among householders of rural origine. Born in a rural village in Central Jawa, he migrated into Jakarta City via urban areas of Central Jawa, Yogyakarta. He was motivated to move because of economic reasons. At present, he and one of his sons are working as employees, earning household income of 130,000 Rps./month. The married couple with seven children are living in the three rooms. As for valuable durable consumer goods, they only have a TV and a bycicle. In these conditions, they are sending about 50,000 Rps/year to their relatives living in rural areas.

(7) Summary

Noteworthy points resulting from this survey could be summarized as follows:

1) In the city of Jakarta, the proportion of child population is large, and from a medium to long-term point of view, the problem of labor supply for this population will become serious.

2) Improvements in education levels in recent years has been noteworthy and the school enrollment rate at the primary education level is high. However, gaps still exist between the education level of boys and girls.

3) As far as work patterns are concerned, a large number of people work as casual wage laborers or are self-employed. Wage labores have relatively lower incomes, and those of self-employed range in great.

4) Remarkable progress has been seen in the use of medical services for the health of mothers and children. The number of cases that women have childbirths at medical institutions with attendance of mid-wife has been increasing. However, on the other hand, improvements in aspects of public sanitation such as latrine and drinking water facilities are lagging behind.

5) The knowledge of family planning among married women is widely accepted in Jakarta. The practicing rate was correlated with the number of existing children.

6) Most of the people migrating into Jakarta D.K.I. come from the

neiboring rural areas. They are in many cases moving directly into Jakarta, with the expectation of leading an improved economic life.

As described in the introduction, the number of samples studied in this survey was small with the surveyd samples taken from the districts and companies, which show different socio-economic characteristics. Thus, it is not appropriate to ascertain a conclusive tendency based only on the results of this survey. Nevertheless, it is evident from the limited results of this analysis that the use of health services for mothers and children is improving and the knowledge on family planning have been highly accepted in recent years. Needless to say, these have been the fruits of the admnistrative efforts represented by Jakarta D.K.I. It can be further attributed to the fact that these measures have been readily and effectively accepted in the city like Jakarta. It is nevertheless true that there are problems peculiar to urban areas. As the results of this survey show, improvements in the public health and sanitation aspects are expected as soon as possible, especially for densely populated residential areas.

Notes

(*1) Penduduk Indonesia 1985 Menurut Provinsi, Biro Pusat Statistik, 1986.

(*2) Edited by Koentjaraningrat, Indoneshia no Shominzoku to Bunka (Cultures and Ethnic Groups in Indonesia), Mekon Shobo, Tokyo, 1980, p.382.

(*3) Kebutuhan Fisik Minimal, the recommendation value determined for each district by the government's wage conference in consideration of land prices, etc.

(*4) As of 1984, there were 3,569 maternal hospitals, 336 maternal and child health centers, and 376 family planning policlinics in Jakarta City.

Table 1 Age Structure

Age	District samples		Company samples	
	Male	Female	Male	Female
0 - 4	38	33	43	30
5 - 9	45	39	47	35
10 - 14	44	35	25	29
15 - 19	39	34	10	15
20 - 24	33	35	15	22
25 - 29	23	22	30	45
30 - 34	18	23	27	25
35 - 39	17	14	28	11
40 - 44	15	13	13	2
45 - 49	12	10	5	2
50 - 54	8	5	1	1
55 - 59	11	3	-	1
61 +	8	1	-	3
Total	311	267	244	221

Table 2 Number of Family Members

Number of family members	2	3	4	5	6	7	8	9 and over	Total	Average number of family members
District samples	4	8	7	19	15	17	14	6	100	5.7
Company samples	10	10	18	24	18	6	2	2	100	4.7

Table 3 Age and Educational Standard of Husband

Educational standard \ Age	District samples			Company samples		
	20-29	30-39	40 +	20-29	30-39	40 +
No schooling	-	-	6 (11.8)	-	-	-
Elementary school not completed	3 (15.0)	7 (26.9)	15 (29.4)	-	1 (1.8)	2 (10.5)
Elementary school	7 (35.0)	6 (23.1)	16 (31.4)	-	9 (16.7)	3 (15.8)
Junior high school	5 (25.0)	6 (23.1)	8 (15.7)	5 (18.5)	13 (24.1)	6 (31.6)
Senior high school	4 (20.0)	7 (26.9)	5 (9.8)	19 (70.4)	27 (50.0)	7 (38.9)
Academy/university	1 (5.0)	-	1 (2.0)	3 (11.1)	4 (7.4)	1 (5.3)
Total	20 (100.0)	26 (100.0)	51 (100.0)	27 (100.0)	54 (100.0)	19 (100.0)

Note: Figures in parentheses are percentages.

Age and Educational Standard of Wife

Educational standard \ Age	District samples			Company samples		
	20-29	30-39	40 +	20-29	30-39	40 +
No schooling	2 (6.5)	3 (9.4)	5 (17.2)	-	-	-
Elementary school not completed	11 (35.5)	11 (31.3)	12 (41.4)	6 (10.3)	5 (13.5)	1 (20.0)
Elementary school	11 (35.5)	10 (31.3)	7 (24.1)	16 (27.6)	7 (18.9)	2 (40.0)
Junior high school	5 (16.1)	8 (25.0)	4 (13.8)	16 (27.6)	9 (24.3)	2 (40.0)
Senior high school	2 (6.5)	-	1 (3.4)	19 (32.8)	14 (37.8)	-
Academy/university	-	-	-	1 (1.7)	2 (5.4)	-
Total	31 (100.0)	32 (100.0)	29 (100.0)	58 (100.0)	37 (100.0)	5 (100.0)

Note: Figures in parentheses are percentages.

Table 4 Income of Household Head by Working Situation (District samples only)

Monthly income (Rp./month)	Working situation						
	Employer	Employee	Self-employed	Helper	Wage labor	Others	Total
0- 49,999	1		3(1)		5		9(1)
50,000- 99,999	1	5	8(1)	2(1)	11	4	31(2)
100,000-149,999	1	8	6		12	3	30
150,000-199,999	1	3	7		4		15
200,000-249,999	1	5	1			1	8
250,000-			4		1	1	6
Total	5	21	29(2)	2(1)	33	9	99

Note: Figures in parentheses refer to cases where the wife is the main wage earner.

Table 5 Income of Household Head by Educational Standard

Income of household head \ Educational standard	District samples			
	No schooling or elementary school not completed	Elementary school	Junior high school	Senior high school or more
0-100,000	18 (59.4)	15 (48.4)	5 (26.3)	3 (16.7)
100,000-149,999	9 (28.1)	9 (29.0)	9 (47.4)	2 (11.1)
150,000-199,999	2 (6.3)	6 (19.4)	3 (15.8)	5 (27.8)
200,000-	3 (9.4)	1 (3.2)	2 (10.5)	8 (44.4)
Total	32(100.0)	31(100.0)	19(100.0)	18(100.0)

Income of household head \ Educational standard	Company samples			
	No schooling or elementary school not completed	Elementary school	Junior high school	Senior high school or more
0-100,000	1 (33.3)	4 (33.3)	4 (16.7)	10 (16.4)
100,000-149,999	1 (33.3)	3 (25.0)	9 (37.5)	24 (39.3)
150,000-199,999	-	4 (33.3)	8 (33.3)	17 (27.9)
200,000-	1 (33.3)	1 (8.3)	3 (12.5)	10 (16.4)
Total	3(100.0)	12(100.0)	24(100.0)	61(100.0)

Note: Figures in parentheses are percentages.

Table 6 Number of Workers in the Household by Household Income

Household income (Rp./month) \ Number of workers	Only household head	Household head plus 1 person	Household head plus 2 persons	Household head plus more than 3 persons	Total
0- 99,999	18 (2)	4 (4)			22 (6)
100,000-149,999	18	12 (9)	4 (3)		34 (12)
150,000-199,999	8	8 (4)	3 (2)		19 (6)
200,000-	10	3 (2)	6 (3)	4 (2)	25 (6)
Total	54 (2)	27 (19)	13 (8)	4 (2)	100 (30)

Note: Figures in parentheses refer to the cases where the wife is the main wage earner.

Table 7 Possession of Durable Consumer Goods by Household Income

(unit: %)

Household income (Rp./month) \ Goods	T.V.	Refri-gerator	Radio	Sewing machine	Motor-cycle	Electric fan
0- 99,999	54.5	4.5	59.1	40.9	4.5	9.1
100,000-149,999	64.7	8.8	88.2	32.3	20.6	17.7
150,000-199,999	79.0	21.1	94.7	47.3	36.8	21.1
200,000-	92.4	32.5	92.4	63.4	48.9	27.7

Table 8 Possession of Latrine & Drinking Water Facilities by Household Income

Facilities \ Household income (Rp./month)	0 - 99,999	100,000 - 199,999	200,000 +	Total
(Latrine)				
Private latrine	11 (36.7)	74 (63.8)	41 (75.9)	126
Public latrine	18 (60.0)	38 (32.8)	12 (22.2)	68
None	1 (3.3)	4 (3.4)	1 (1.9)	6
Total	30(100.0)	116(100.0)	54(100.0)	200
(Drinking Water)				
Private piped water	2 (6.7)	27 (23.3)	17 (31.5)	46
Common piped water	15 (50.0)	47 (40.5)	17 (31.5)	79
Private well	9 (30.0)	39 (33.6)	17 (31.5)	65
Common well	5 (16.7)	13 (11.2)	4 (7.4)	22
Total	30(100.0)	116(100.0)	54(100.0)	212

Note: Includes some multiple answers.

Table 9 Persons Who Diagnose Diseases

	District samples	Company samples	Total
Self-diagnosis	87 (11.6)	-	87
Parents/relatives	16 (2.8)	3 (0.7)	19
Traditional healer	22 (3.8)	4 (0.9)	26
Doctor	473 (81.8)	458 (98.5)	931
Total	578(100.0)	465(100.0)	1,043

Note: Figures in parentheses are percentages.

Table 10-1 Place to be Delivered by Current Age (Ased of all household memebers)

Age / Place	0 - 9	10 - 19	20 - 29	30 - 39	40 +	Total
(Company samples)						
Home	10 (6.4)	21 (26.3)	59 (55.1)	50 (5.3)	19 (65.5)	159
Medical institution	144 (91.7)	59 (73.8)	46 (43.0)	43 (45.7)	9 (31.0)	301
Other	3 (1.9)	-	2 (1.9)	1 (1.0)	1 (3.4)	7
Total	157(100.0)	80(100.0)	107(100.0)	94(100.0)	29(100.0)	467
(District samples)						
Home	72 (46.2)	66 (44.6)	76 (67.3)	52 (72.2)	71 (82.6)	337
Medical institution	77 (49.4)	71 (48.0)	33 (29.2)	19 (26.4)	13 (15.1)	213
Other	7 (4.5)	11 (7.4)	4 (3.5)	1 (1.4)	2 (2.3)	25
Total	156(100.0)	148(100.0)	113(100.0)	72(100.0)	86(100.0)	575

Note: Figures in parentheses are percentages.

Table 10-2 Person Who Attended the Births by Current Age (Asked of all household members)

Age / Attendant	0 - 9	10 - 19	20 - 29	30 - 39	40 +	Total
(Company samples)						
Doctor	36 (22.9)	5 (6.3)	7 (6.5)	4 (4.3)	-	52
Midwife	116 (73.9)	59 (73.8)	40 (37.4)	28 (29.8)	9 (31.0)	252
Traditional birth attendant	5 (3.2)	16 (20.0)	60 (56.1)	62 (65.9)	20 (69.0)	163
Non-professional	-	-	-	-	-	-
Total	157(100.0)	80(100.0)	107(100.0)	94(100.0)	29(100.0)	467
(District samples)						
Doctor	27 (17.3)	18 (12.2)	11 (9.7)	2 (2.8)	3 (3.5)	61
Midwife	85 (54.5)	74 (50.0)	36 (31.9)	22 (30.5)	11 (12.8)	228
Traditional birth attendant	43 (27.6)	55 (37.2)	66 (58.4)	48 (66.7)	72 (83.7)	284
Non-professional	1 (0.6)	1 (0.7)	-	-	-	2
Total	156(100.0)	148(100.0)	113(100.0)	72(100.0)	86(100.0)	575

Note: Figures in parentheses are percentages.

Table 11 Place Where Family Planning Information and Services can be Obtained

	District samples	Company samples
Primary Health Center	44	30
Public clinic	10	14
Company	-	10
Public Information Paper	32	26
Others	13	18
Total	101	107

Table 12 Contraceptive Use by Educational Standard and Number of Existing Children for Married Women

(Unit: %)

	District samples			Company samples		
	20 - 29	30 - 39	40 +	20 - 29	30 - 39	40 +
Educational standard						
No school or elementary school not completed	69.0	71.3	35.3	83.3	100.0	100.0
Elementary school	45.5	55.6	45.5	81.3	100.0	100.0
Junior high school	80.0	62.5	75.0	75.0	66.7	100.0
High school or above	50.0	0.0	100.0	55.0	86.7	-
Number of existing children						
0	0.0	0.0	0.0	10.0	0.0	-
1	20.0	100.0	0.0	69.2	66.7	-
2	60.0	33.3	0.0	88.2	84.6	100.0
3	85.7	72.7	33.3	91.7	100.0	100.0
4	60.0	50.0	40.0	83.3	100.0	100.0
5 +	75.0	72.7	66.7	-	80.0	100.0
Average percentage using some method of contraceptions	61.3	62.5	41.4	71.0	89.0	100.0

Table 13 Method of Contraception by Age of Wife

Age / Method	District samples			Company samples		
	20 - 29	30 - 39	40 +	20 - 29	30 - 39	40 +
Sterilization	1 (9.1)	-	-	3 (6.7)	2 (6.7)	2 (40.0)
Pill	9 (47.4)	7 (35.0)	3 (25.0)	20 (44.4)	8 (26.7)	-
I.U.D.	4 (21.1)	8 (40.0)	4 (33.3)	11 (24.4)	17 (56.7)	3 (60.0)
Condom	-	-	1 (8.3)	1 (2.2)	1 (3.3)	-
Others	5 (26.5)	5 (25.0)	4 (33.3)	10 (22.2)	3 (10.0)	-
Total	19(100.0)	20(100.0)	12(100.0)	45(100.0)	30(100.0)	5(100.0)

Notes: 1. Excludes women who are not practicing family planning.
2. Figures in parentheses are percentages.

Table 14 Birth Place and Last Residence of Household Head

	Birth place	Last residence
Jakarta	43 (21.5)	43 (21.5)
West Jawa	57 (28.5)	58 (29.0)
Central Jawa	59 (29.5)	53 (26.5)
Yogyakarta	7 (3.5)	6 (3.0)
East Jawa	13 (6.5)	18 (9.0)
Outside Jawa	21 (10.5)	22 (11.0)
Total	200(100.0)	200(100.0)

Note: Figures in parentheses are percentages.

Table 15 Migration Frequency, Reasons for Migration, and Income of Household Head by Place of Origin

	Place of origin	
	Urban	Rural
Number of moves		
0	23 (30.7)	3 (2.4)
1	29 (38.7)	76 (61.8)
2	8 (10.7)	22 (17.9)
3	7 (9.3)	7 (5.7)
4	4 (5.3)	7 (5.7)
5 or more	2 (2.7)	5 (4.1)
No answer	2 (2.7)	3 (2.4)
Total	75(100.0)	123(100.0)
Reasons for moving*		
Marriage	1 (1.3)	2 (1.6)
Accompanying parents/families	20 (26.3)	26 (21.1)
Economic reasons	23 (30.3)	83 (67.5)
Change in job posting	2 (2.6)	3 (2.4)
Education	14 (18.4)	5 (4.1)
Others	3 (3.9)	1 (0.8)
No answer	13 (17.1)	3 (2.4)
Total	76(100.0)	123(100.0)
Income of household head		
0 - 99,999	16 (21.4)	44 (35.8)
100,000 - 149,999	25 (33.3)	40 (32.5)
150,000 -	34 (45.3)	39 (31.7)
Total	75(100.0)	123(100.0)

Note: * 1 The figures for reasons for moving include some multiple answers.
2 Figures in parentheses are percentages.

CHAPTER 6 SURVEY MEMBERS AND ITINERARY

I. Members of the Survey

1. Survey Members

(1) Japanese Committee

Dr. Toshio Kuroda (Chairman)	Director Emeritus Nihon University Population Research Institute (Head, Field Research Team)
Dr. Yoichi Okazaki	Professor College of Law, Nihon University
Mr. Hiroaki Washio	Senior Researcher Economic Cooperation Department The Institute of Developing Economies
Ms. Keiko Ono	Research Associate Nihon University Population Research Institute (Member, Field Research Team)
Mr. Junji Funatsu (Coordinator)	Councilor The Asian Population and Development Association
Mr. Masaaki Endo	Senior Programme Officer The Asian Population and Development Association (Member, Field Research Team)
Ms. Yuiko Nishikawa	Research Worker The Asian Population and Development Association

2. Cooperators

(1) Embassy of Japan in Indonesia

Mr. Toshiaki Muto	Ambassador
Mr. Kazuo Hirayama	First Secretary

(2) Ministry of Transmigration

H.E. Mr. Martono	Minister of Transmigration

Mr. Soedjino Hs	Assistant Minister of Transmigration for Foreign Affairs
Mr. A. S. Napitupula	Expert of the Minister for Transmigration
Mr. G. Djoko Oetoyo	Chief of International Cooperation Division

(3) Research and Development Center

Mr. V. Manurung	Chief of the survey
Mr. Ir. Thomas Sembiring	Survey coordinator
Drs. Siswoyo Suwandi	Survey staff
Ms. Arum Sayekti	Survey staff
Drs. Gunardi	Survey staff
Drs. Nelson Manurung	Survey staff
Mr. Ir. Sri Daswati	Survey staff
Drs. Sugeng Riswanto	Survey staff
Drs. Rumondang Napitupulu, BSC.	Survey staff
Drs. Sudirman, BSC.	Survey staff
Dra. Indrati	Survey staff

(4) National Family Planning Coordinating Board

Dr. Haryono Suyono	Chairman

(5) Jakarta Municipal Government

Mr. Durrundono	Project Manager Kampung Improvement Programme

(6) Ministry of Population and Environment

Dr. Kartomo Wirosuhardjo	Assistant Minister

(7) Communities and enterprises in Jakarta

Kelurahan Grogol
Kelurahan Jelambar
Unilever Indonesia P.T.
Warna Agung P.T.
Hoechst Pharmaceutical of Indonesia P.T.
Gaya Motor P.T.

(8) Demographic Institute, Faculty of Economics, University of Indonesia

Dr. Prijono Tjiptoherijanto	Director
Dr. M. Djuhari Wirakartakusumah	Associate Director
Dr. Rozy Munir	Associate Director

(9) Ministry of Manpower

(10) United Nations Fund for Population Activities (UNFPA)

Ms. Kazuko Kano	Deputy Representative and Senior Advisor on Population

(11) Central Bureau of Statistics

Dr. Made Mamas	Director, Bureau of Social and Population Statistics

II. ITINERARY

(July 17 - 28, 1986)

Date	Outline of the Survey
July 17 (Thu.)	◦ Leave Narita, arrive in Jakarta.
18 (Fri.)	◦ Pay Courtesy Call to Ambassador Toshiaki Muto, Embassy of Japan. ◦ Discuss with Mr. Kazuo Hirayama, First Secretary Embassy of Japan. ◦ Discuss on the field survey and receive outline of survey areas by Mr. Thomas.
19 (Sat.)	◦ Briefing on the Kampung Improvement Programme of Jakarta by Mr. Durrundono, Project Manager, Jakarta Municipal Government. ◦ Briefing on the collected data of questionnaires by Mr. Thomas.
20 (Sun.)	◦ Observation of the suburbs of Jakarta.
21 (Mon.)	◦ Briefing on UNFPA activities in Indonesia by Ms. Kazuko Kano, Deputy Representative of UNFPA. ◦ Pay Courtesy Call to Dr. Haryono Suyono, Chairman, NFPCB and briefing on activities of NFPCB. ◦ Pay Courtesy Call to Dr. Kartomo Wirosuhardjo, Assistant Minister of Population and Environment and briefing on population in Indonesia.
22 (Tue.)	◦ Observation of district office and Primary Health Center in Grogol where covered questionnaires. ◦ Briefing on outline and health activities of Grogol by Head of Grogol. ◦ Observation of community improvement activities and houses at RW01 of Grogol. ◦ Observation of disctrict office in Jelambar where covered questionnaires.
23 (Wed.)	◦ Observation of Warna Agung P.T. (Company) and briefing on health and welfare service to employees by Mr. Soeharto. Observation of Hoechst P.T. (Company) and briefing on health and welfare services to employees by the Director. ◦ Observation of Gaya Motor P.T. (Company) and briefing on health and welfare services to employees by Mr. Armand Darwin.

Date	Outline of the Survey
	◦ Briefing on the research of urban population in Indonesia by Dr. Prijono, Director of Demographic Institute, Faculty of Economics, University of Indonesia.
24 (Thu.)	◦ Briefing on population statistics in Indonesia by Dr. G. Made Mamas, Director, Bureau of Social and Population Statistics, Central Bureau of Statistics. ◦ Discussion on the collected data of questionnaires.
25 (Fri.)	◦ Briefing on labor population in Indonesia by the Director of Ministry of Manpower. Data arrangement
26 (Sat.)	◦ Final check of the collected data and questionnaires.
27 (Sun.)	◦ Leave Jakarta
28 (Mon.)	◦ Arrive Narita

CHAPTER 7 QUESTIONNAIRE SAMPLE

DATE OF INTERVIEW _____ ,1988

COMMUNITY SURVEY QUESTIONNAIRE (JAKARTA-INFORMAL SECTOR)

1. I.D. number _____
2. Name of respondent (Head of household) _____
3. Address _____
4. General situation : total number in a household _____ persons
5. Name of community _____
6. Ask all the member of family

		①	②	③	④ ~ ⑤	⑥
Q1	relationship of household *enter name and relationship name	head of household				
	relationship	himself				
Q2	sex *encircle with applicable number 1.male 2. female	1 2	1 2	1 2		1 2
Q3	age *enter the acutual age					
Q4	marital status *encircle with applicalbe number 1.never married 2.married 3.divorce 4.separated 5.widower/widow because spose is dead	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
Q5	what religion do you belong to? 1.Muslim 2.Christianity 3.Hindoism 4.Buddhism 5.Confucianism 6.Others	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
Q6	type of activity what is your main activity during last one year? *encircle with applicable number 1.for a person engaged mainly in work 2.for a person engaged partly in work besides engaging in home duties,attending school, and so on. 3.had no job but seeking one 4.engaged in home duties 5.attended school — (State the grade in the parentheses) 6.others (infant or aged etc.)	1 ┐ enter col.07 & Q8 2 ┘ 3 4 5 ( ) 6	1 ┐ enter col.07 & Q8 2 ┘ 3 4 5 ( ) 6	1 ┐ enter col.07 & Q8 2 ┘ 3 4 5 ( ) 6		1 ┐ enter col.07 & Q8 2 ┘ 3 4 5 ( ) 6

07	situation of working *encircle with applicable number 1.employer other than household enterprise 2.employee 3.worked (self-employed)in household enterprise 4.worked as helper in household enterprise 5.worked as casual wage labour 6.others	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
08	name of establishment *state the name of the office, factory, shop in which person worked. if no name, state the personal name of employer or self employed					
09	income per month * enter income and/or expenditure in last month in Rupiahs	income. _____ Rps. expend. _____ Rps.	income. _____ Rps. expend. _____ Rps.	income. _____ Rps. expend. _____ Rps.		income. _____ Rps. expend. _____ Rps.
10	level of education 1.no schooling 2.elementary school not completed 3.elementary school 4.junior high school 5.senior high school 6.academy/university	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
11	medical care 11-1. In case of illness who diagnosed? 1.self-diagnosis 2.parents / relatives 3.traditional healer 4.doctor	1 2 3 4	1 2 3 4	1 2 3 4		1 2 3 4
	11-2.where is your place of delivery? 1.home 2.medical institution 3.non-medical institution 4.others	1 2 3 4	1 2 3 4	1 2 3 4		1 2 3 4
	11-3.who attended at birth? 1.doctor 2.midwife 3.traditional birth attendant 4.non professional person 5.not stated	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
12	family planning 12-1.how many children are ideal in your opinion? *enter your ideal number	_____ son(s) _____ daughter(s)	_____ son(s) _____ daughter(s)	_____ son(s) _____ daughter(s)		_____ son(s) _____ daughter(s)
	12-2.are you practicing / have you practiced family planning? 1. yes 2.no	1 2	1 2	1 2		1 2
	12-3.if yes, how long have you practiced family planning? * state the period (years)	_____ years	_____ years	_____ years		_____ years
	12-5.if yes, what kind of method do you accept? 1. sterilization 2.pill 3.IUD 4. condom 5.others	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
	12-6. where do you get information & tools of family planning? 1.primary health center 2.public clinic 3.public information paper 4.others(specify)	1 2 3 4 ( )	1 2 3 4 ( )	1 2 3 4 ( )		1 2 3 4 ( )

7. Ask the head of the household

13. durable goods
do you have following goods?
*encircle with applicable number (if yes, encircle 1. if no, encircle 2.)

1.T.V.set	1.yes	2.no
2.refrigerator	1.yes	2.no
3.air conditioner	1.yes	2.no
4.radio	1.yes	2.no
5.sewing machine	1.yes	2.no
6.gas range	1.yes	2.no
7.motorcycle	1.yes	2.no
8.car	1.yes	2.no
9.others(specify)	1.yes	2.no

14.living environment
14-1. how many rooms are there in your house?
_____room(s)

14-2. do you have latrine
*encircle with appricate number
1. yes (private latrine) 2.yes (common latrine) 3.none

14-3. what kind of water do you use for drinking?
*encircle with appricate number
1. private piped water 2.common piped water 3.private well 4. common well

15. financial support
what means of financial support will you expect wh you are old?
*encircle with appricate number
1. help from children 2.help from other family
3. saving / income from business farm or other property
4. pension / social security 5.none
6. others (specify_____)

16. migration
16-1.what is your birth place?
(1) rural urban differentials
*encircle with applicalbe number
1. rural 2.urban
(2)province
*encircle with applicalbe number
1.Jakarta 2.West Java 3.Central Java 4.Yogyakarta 5.East Java
6.outside Java (name of the province _____)

16-2.where were your living before coming here?
(1) rural urban differentials
*encircle with applicalbe number
1. rural 2.urban
(2)province
*encircle with applicalbe number
1.Jakarta 2.West Java 3.Central Java 4.Yogyakarta 5.East Java
6.outside Java (name of the province _____)

16-3. how many times have you migrated before coming here?
_____ times

16-4. will you stay in Jakarta permanently?
1. yes 2. no

16-5. if no, when and where will you plan to move?
when: _____
where: 1. go back to base place
2.others (specify the name of place _____)

16-6. why do you move into this community?
1.marriage 2.followed parents/family 3.job/economic reason (other than p.)
4.posting 5.education 6.others

16-7.who helped you to move?
1.family/relatives 2.community members 3.neighbours
4.friends 5.no one (independently) 6.others

16-8.if you have any member of family in other area, do you remit to them?
1.yes 2.no
if yes, how much do you send per year? _____ rps.

17. degree of satisfaction of your community
17-1. are you satisfied with this community?
*encircle with appricable number
1.yes, satisfied
2.more or less satisfied
3.more or less dissatisfied ___ enter co).17-2
4.no, dissatisfied
5.not stated

17-2. why are you dissatisfied?
1.housing condition is not adequate
2.educational facility is not adequate
3.medical care is not adequate
4.transportation service is not adequate
5.others (specify _____ _____)

DATE OF INTERVIEW _____ ,1988

COMMUNITY SURVEY QUESTIONNAIRE (JAKARTA-COMPANY EMPLOYEE)

1. I.D. number _____
2. Name of respondent (Head of household) _____
3. Address _____
4. General situation : total number in a household _____ persons
5. Name of company _____
6. Ask all the member of family

		①	②	③	④ ~ ⑨	⑩
01	relationship of household enter name and relationship name	head of household				
	relationship	himself				
02	sex encircle with applicable number 1.male 2.female	1 2	1 2	1 2		1 2
03	age enter the acutual age					
04	marital status encircle with applicable number 1.never married 2.married 3.divorce 4.separated 5.widower/widow because spouse is dead	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
05	what religion do you belong to? 1.Muslim 2.Christianity 3.Hinduism 4.Buddhism 5.Confucianism 6.Others	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
06	type of activity what is your main activity during last one year? encircle with applicable number 1.for a person engaged mainly in work 2.for a person engaged partly in work besides engaging in home duties, attending school, and so on. 3.had no job but seeking one 4.engaged in home duties 5.attended school — (State the grade in the parenthesis) 6.others (infant or aged etc.)	1, 2 → enter col.07 & 08 3 4 5 6	1, 2 → enter col.07 & 08 3 4 5 ( ) 6	1, 2 → enter col.07 & 08 3 4 5 ( ) 6		1, 2 → enter col.07 & 08 3 4 5 ( ) 6
07	situation of working encircle with applicable number 1.employer other than household enterprise 2.employee 3.worked (self-employed)in household enterprise 4.worked as helper in household enterprise 5.worked as casual wage labour 6.others	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
08	name of establishment mstate the name of the office, factory, shop in which person worked. If no name, state the personal name of employer or self employed					
09	income per month m enter income and/or expenditure in last month in Rupiahs	income. _____ Rps. expend. _____ Rps.	income. _____ Rps. expend. _____ Rps.	income _____ Rps. expend _____ Rps.		income _____ Rps. expend. _____ Rps.
10	level of education 1.no schooling 2.elementary school not completed 3.elementary school 4.junior high school 5.senior high school 6.academy/university	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6		1 2 3 4 5 6
11	medical care 11-1. in case of illness who diagnosed? 1.self-diganosis 2.parents / relatives 3.traditional healer 4.doctor	1 2 3 4	1 2 3 4	1 2 3 4		1 2 3 4
	11-2.where is your place of delivery? 1.home 2.medical institution 3.non-medical institution 4.others	1 2 3 4	1 2 3 4	1 2 3 4		1 2 3 4
	11-3.who attended at birth? 1.doctor 2.midwife 3.traditional birth attendant 4.non professional person 5 not stated	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
12	family planning 12-1.how many children are ideal in your opinion? menter your ideal number	_____ son(s) _____ daughter(s)	_____ son(s) _____ daughter(s)	_____ son(s) _____ daughter(s)		_____ son(s) _____ daughter(s)
	12-2.are you practicing / have you practiced family planning? 1. yes 2.no	1 2	1 2	1 2		1 2
	12-3.if yes, how long have you practiced family planning? m state the period (years)	_____ years	_____ years	_____ years		_____ years
	12-5.if yes, what kind of method do you accept? 1. sterilization 2.pill 3.IUD 4. condom 5.others	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5
	12-6. where do you get information & tools of family planning? 1.primary health center 2.public clinic 3.company 4.public information paper 5.others(specify)	1 2 3 4 5 ( )	1 2 3 4 5 ( )	1 2 3 4 5 ( )		1 2 3 4 5 ( )

7. Ask the head of the household

13. durable goods

do you have following goods?

*encircle with appricale number (if yes, encircle 1. if no, encircle 2.)

1.T.V.set	1.yes	2.no
2.refrigerator	1.yes	2.no
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4.radio	1.yes	2.no
5.sewing machine	1.yes	2.no
6.gas range	1.yes	2.no
7.motorcycle	1.yes	2.no
8.car	1.yes	2.no
9.others(specify)	1.yes	2.no

14.living environment

14-1. how many rooms are there in your house?

_____room(s)

14-2. do you have latrine

*encircle with appricale number

1. yes (private latrine) 2.yes (common latrine) 3.none

14-3. what kind of water do you use for drinking?

*encircle with appricale number

1. private piped water 2.common piped water 3.private well 4. common well

15. Financial support

what means of financial support will you expect who you are old?

*encircle with appricale number

1. help from children 2.help from other family

3. saving / income from business farm or other property

4. pension / social security 5.none

6. others (specify_____)

16. migration

16-1.what is your birth place?

(1) rural urban differentials

*encircle with applicalbe number

1. rural 2.urban

(2)province

*encircle with applicalbe number

1.Jakarta 2.West Java 3.Central Java 4.Yogyakarta 5.East Java

6.outside Java (name of the province _____)

16-2.where were your living before coming here?

(1) rural urban differentials

*encircle with applicalbe number

1. rural 2.urban

(2)province

*encircle with applicalbe number

1.Jakarta 2.West Java 3.Central Java 4.Yogyakarta 5.East Java

6.outside Java (name of the province _____)

16-3. how many times have you migrated before coming here?

_____ times

16-4. will you stay in Jakarta permanently?

1. yes 2. no

16-5. if no, when and where will you plan to move?

when: _____

where: 1. go back to home place

2.others (specify the name of place _____)

16-6. why do you move into this community?

1.marriage 2.followed parents/family 3.job/economic reason (other than p.)

4.posting 5.education 6.others

16-7.who helped you to move?

1.family/relatives 2.community members 3.neighbours

4.friends 5.no one (independently) 6.others

16-8.if you have any member of family in other area, do you remit to them?

1.yes 2.no

if yes, how much do you send per year? _____ rps.

17. degree of satisfaction of your community

17-1. are you satisfied with this community?

*encircle with appricable number

1.yes, satisfied

2.more or less satisfied

3.more or less dissatisfied ——— enter col.17-2

4.no, dissatisfied

5.not stated

17-2. why are you dissatisfied?

1.housing condition is not adequate

2.educational facility is not adequate

3.medical care is not adequate

4.transportation service is not adequate

5.others (specify _____)