This Policy Brief provides an overview of four key health areas related to the Millenium Development Goals (MDGs). While important efforts have been made to increase women’s access to health services, more needs to be done in maternal mortality, malnutrition, HIV/AIDS, and water and sanitation to meet the MDGs by 2015. To date, Indonesia is on track to achieve the target for malnutrition while maternal mortality is still lagging as women continue to use inappropriate services, there is an indication of an increasing proportion of adult women living with HIV in Indonesia and having difficulties in getting access to HIV prevention and treatment and water and sanitation targets are unlikely to be met with major concerted efforts.

**Current Status**

- **Maternal Mortality**

  Although 82.3% of births were attended by a professional health provider in 2010, a large number of women, especially but not exclusively the poor, continue to give birth at home without professional help and are at highest risk of dying.

  Even with the most recent estimate of 229 maternal deaths per 100,000 live births, Indonesia’s Maternal Mortality Rate (MMR) remains among the highest in East Asia, (Hogan et al, 2010). In 2007, deliveries in health facilities represented 46.1% of all deliveries (see Figure 1), (IDHS, 2007). The National Report on Basic Health Research (Laporan Nasional Riset Kesehatan Dasar/Riskesdas) (2010) reported an increase in attended deliveries in health facilities to 59.4%. The Making Pregnancy Safer strategy emphasized the importance of skilled birth assistance and policies to support the strategy – such as improving the availability of midwives through the introduction of the village midwife program in the early 1990s – have been successful in increasing skilled delivery from 36% in 1987 to 77.34% in 2009, (Susenas, 2009). Riskesdas (2010) also suggests an increase of skilled delivery at national level from 40.7% in 1990 to 82.3% in 2010. However, a large percentage of pregnant women (39.1%), continue to give birth at home, assisted by midwives or traditional birth attendants (TBAs), risking delivery complications that can lead to an emergency with often unpredictable outcomes, including death, (Riskesdas, 2010, p.46). The risk is highest when the TBA or midwife does not have the skill to recognize complications, nor to perform the necessary action to save the mother and/or the baby. In cases where the midwife does have the required skills, a lack of supplies may prevent the midwife from taking the required action. Home delivery also becomes more risky if it occurs in remote areas with difficult access to a functioning referral center. The disparity of births assisted by skilled...
health personnel among regions ranges from 98.14% in DKI Jakarta to 42.48% in Maluku (Susenas, 2009).

**Figure 1:** Home Delivery is Still Preferred (2007)

![Graph showing home delivery preference](image)

Inequities in skilled birth attendance between the richest and the poorest are narrowing, but the richest are more than four times more likely to have a facility-based delivery compared to the poorest.

The coverage of skilled birth attendance among the poorest quintile has improved during the last ten years from less than 20% in 1987 to slightly more than 60% in 2007, while the coverage of the richest quintile has been constant at around 80% (IDHS 2007). Although skilled birth attendance among the poor has increased, almost 90% of deliveries are still at home, compared to less than 20% among the richest quintile. The percentage of deliveries in health facilities in 2007 was higher in urban areas (70.3%) than in rural areas (28.9%). Mothers with no education are much more likely to deliver at home than mothers with secondary or higher education (81.4% and 28.2% respectively). Similarly mothers in the lowest wealth quintile were almost five times as likely to deliver at home as mothers in the highest wealth quintile at 84.8% and 15.5% respectively (see Figure 2). This suggests that the Community Health Insurance (Jaminan Kesehatan Masyarakat/Jamkesmas) has had little effect on facility-based deliveries. Some possible explanations include: (i) Jamkesmas reimburses both facility- and home-based deliveries; (ii) birth delivery at home is still culturally preferable; and (iii) some facility-based delivery costs are not covered by Jamkesmas (for example transport costs and costs for accompanying families).

**Figure 2:** The coverage of skilled birth attendance across wealth quintile

![Graph showing coverage of skilled birth attendance across wealth quintile](image)

**The quality of the referral system in the case of obstetric complications is still poor.**

The quality of the referral system becomes even more important when a high percentage of birth deliveries still occur at home. Many problems in the referral system can be reduced by encouraging a facility-based delivery. Weaknesses in the referral system include, (World Bank 2010):

- delays in making referrals on the part of the birth attendant;
- the birth attendant does not have the necessary skills to stabilize the cases prior to referral;
- referral to a facility not equipped to deal with the emergency resulting in a loss of critical time to manage the complication;
• multiple referral – a case can be referred from one facility to another for various monetary and non-monetary reasons (such as clinic is full or attending physician is unavailable);

• refusal by the family to act on the referral, usually because of fears of increasing costs; and

• referral facility providers do not have the necessary skills to manage the complication.

The contraceptive prevalence rate (CPR) is pretty low. According to SKDI (Survey Kesehatan Dasar Indonesia) in 2007 the CPR is 57.8 %, whereas Riskesdas indicated a lower rate of 53.9 % in 2010. Riskesdas 2010 also identifies the unmet need of 14%. Unmet needs in family planning, including those among single women, contribute to unwanted pregnancy which, in turn, contributes to continuing utilization of abortion services. It is estimated that one to two million abortions take place in Indonesia each year, with many performed by unskilled providers in unsanitary conditions. (Hull et al., 2009). One community survey found that about 24 % of abortions are performed by TBAs (dukun) ranging from 15% in cities to 84% in rural areas, (Utomo et al., 2000). Sixty-six percent of women having abortions reported an induction abortion giving an estimated 1.3 million induced abortions annually. The induced abortion has the potential risk of premature births or low births weight for the subsequent pregnancies. The same study found that one-third of abortion clients were unmarried and half had never used contraception. These issues are politically and socially sensitive but in urgent need of resolution.

**Policy Issues**

The MDGs Road Map identified MMR as a key area where extra hard work is needed to achieve the target of 102 per 100,000 live births by 2015 (Bappenas, 2010). This is supported by the Government’s eight health development priorities for 2010-2014, which puts enhancement of the health of mother, babies, children under five and family planning as the highest priorities, (RENSTRA Ministry of Health, 2010, p.31 & pp.43-44). The other seven priorities covers different areas that can contribute to this, including community nutritional status; communicable and non communicable diseases and environmental health management; human resources development and empowerment; availability of and access to secure and well-qualified medicines and food; development of Jamkesnas system; disaster and health crisis management and community empowerment; and better primary, secondary and tertiary health services.

There are two critical measures identified for reducing MMR, i.e. improving the contraceptive prevalence rate and reducing unmet need. This is to be done through expanding access and improving quality of family planning and reproductive health services. Priorities will be focused on expanding better quality health
The National Government has seven important planned interventions to achieve the aforementioned MDGs target in 2015: (a) a consolidated vaccination program, (b) an integrated management for sick children under 5 years old (Managemen Terpadu Balita Sakit), (c) reinforcement on a focused nutritional programs, (d) reinforcement of the family’s role including communication strategies for behavioral change and promotion of clean and health behaviors (Perilaku Hidup Bersih dan Sehat-PHBS), (e) an improved health facilities management, (f) a reinforcement of related neonatal strategies, and (g) a reduced geographic, socio-economic and gender gaps in children’s health and nutritional status. In these key areas of interventions, increased access to health services for the poor and those from disadvantaged areas, border areas and islands will be prioritized, (RENSTRA, Ministry of Health, 2010).

**Recommendations**

- Ministry of Health (MoH) to increase demand for facility-based deliveries through behavior change communication towards pregnant women and their family.
- MoH to ensure access of the poor to facility-based delivery and encourage utilization of facility-based delivery by the poor by revisiting the Jamkesmas benefit package and providing better information and communication, as well as improve monitoring of Jamkesmas.
- MoH to improve the Continuum of Care that supports integrated service delivery for mothers and children from pregnancy to delivery, the immediate postnatal period and childhood.
- MoH to coordinate with sub-national health agencies to improve the quality of the referral network from the village to public and private referral centers.
- MoH to establish a quality assurance system for maternal health care based on certification and accreditation of providers and facilities.
- MoH and related agencies to revitalize family planning and address unmet needs through improving service delivery from family planning clinics, providing contraceptives particularly for the poor, and improving promotion and community mobilization through communications, education and promoting partnership with government, NGOs and the private sector.

**Current Status:**

- **Malnutrition**

  Indonesia continues to have serious stunting and wasting problems, with an almost twofold difference in prevalence seen across the provinces.

  The national prevalence of stunting is 35.6%, ranged from 22.5% in Yogyakarta to 58.4% in West Nusa Tenggara Province. The national prevalence of wast-
ing is 13.3%, ranged from 7.6% in Bangka Belitung to 20% in Jambi Province, (Bappenas, 2010, p.58). There is considerable maternal under-nutrition contributing to the relatively high level of low birth weight as well as stunting.

**Figure 3: Stunting and Wasting of Children Under five, 2007 & 2010.**

**Anaemia in women continues to be a key issue for nutrition.**

Although nationally representative data on anaemia in women is limited and dated, this still seems to be a problem. The National Household Health Survey in 2007 indicated the prevalence of anaemia among pregnant women was reduced from 40.1% in 2001 to 24.5% in 2007. Riskesdas 2007 found that 92.2% of women received iron and folic acid supplementation during the last pregnancy while IDHS 2007 reported that only 79.3% of women received iron supplements during pregnancy. Nevertheless, many mothers do not take sufficient supplements. A more recent study has suggested that 20% of early neonatal deaths could be attributed to a lack of iron and folic acid supplementation during pregnancy (Titaley C.R. et al, 2009 p 1–23). Despite a high coverage of antenatal care, only 33.8% of pregnant women receive a hemoglobin test.

**Infant and child feeding practices are far from adequate.**

Insufficient exclusive breast feeding, excessive use of infant formula, early complementary feeding and poor quality and frequency of complementary feeding after six months, contribute to wasting and stunting. Poor feeding practices are also contributing to micronutrient deficiencies. During the period 2002 to 2007, there was a drop in children less than six months of age being exclusively breastfed from 40% to 32.4% with a sharp increase of bottle-feeding from 17% to 28% among children of the same age cohort. As breast milk is the optimal source of nutrition for children, this puts young children at a severe disadvantage both nutritionally and for the prevention of illness (IDHS 2007). Only 43.9% of children start breastfeeding within an hour of birth and 64.6% receive a pre-lacteal feed. Young children receive complementary foods too early: at 4-5 months of age 52.9% are receiving some form of solid or semi-solid foods while 33.4% of children below two months receive infant formula. Complementary feeding should start from about six months and children should receive three or more food groups a minimum number of times according to their age group in addition to breast milk. Only 67% of mothers offer complementary foods the minimum number of times per age group per day in addition to breast milk, while 75% consume a sufficient number of food groups (IDHS 2007). Only 87.4% and 69.7% of 6-35 month old children were reported to have received Vitamin A and iron-rich foods respectively in the preceding 24 hours.

All districts are expected to provide supplies of Vitamin A supplements for children 6-59 months and postpartum women with the supplements for children to be
to involve relevant ministries in promoting exclusive breastfeeding, (Bappenas, 2010, p.113).

**Recommendations**

- MoH in coordination with sub-national health agencies to implement strategies that empower mothers to improve the nutritional status of their children and themselves rather than them becoming dependent on food supplementation to treat malnutrition, including counseling on breastfeeding, complementary feeding, iron supplementation during pregnancy and Vitamin A supplementation for infants and children.

- MoH in coordination with sub-national health agencies to strengthen support, including monitoring and evaluation, for increasing the nutritional status of pregnant mothers, lactating mothers, and babies, through among others, Nutrition care and Health of mother and Children Program (Program Bina Gizi and Kesehatan Ibu dan Anak).

**Current Status:**

- **HIV/AIDS**

  There is an indication of an increasing proportion of adults living with HIV in Indonesia.

  The number of HIV/AIDS cases reported in Indonesia is on the increase (see Figure 3). Although the total number of HIV infected individual is relatively low (0.17% of the population), the rate of increase is of concern, (Bappenas, 2010, p.146). Indonesia is considered to have the fastest growing of AIDS epidemic in Asia, (Global AIDS Report, 2008). The cumulative HIV/AIDS cases have been more than doubled from 8,194 in 2006 to 19,973 in 2009 and women now make 25%
of all cases reported. The new cases are concentrated in key populations such as sex workers (who are mostly women) and their male clients plus men who have multiple sex partners apart from their primary partner who are usually women (see Figure 4).

**Figure 4:** Concise summary of indicators on HIV/AIDS

![Image showing a pie chart with various categories such as General Males, General Females, Direct Sex Workers, Indirect Sex Workers, Clients of Sex Workers, MSM, M&M, Women, Male IDUs, Female IDUs, indicating proportions.](source.png)

*Source: Wilson, David et al., 2011*

**Figure 5:** New Infections in 2010

<table>
<thead>
<tr>
<th>Number of:</th>
<th>In 2010</th>
<th>Forecasted in 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults living with HIV/AIDS</td>
<td>234,529</td>
<td>320,161</td>
</tr>
<tr>
<td>New HIV/AIDS Infections</td>
<td>16,721</td>
<td>19,793</td>
</tr>
<tr>
<td>HIV/AIDS-related deaths</td>
<td>4,805</td>
<td>5,713</td>
</tr>
<tr>
<td>Adults eligible for first-line ART</td>
<td>4,805</td>
<td>85,362</td>
</tr>
<tr>
<td>Adults requiring second-line ART</td>
<td>92,066</td>
<td>17,299</td>
</tr>
<tr>
<td>Children exposed to HIV</td>
<td>3,150</td>
<td>4,799</td>
</tr>
<tr>
<td>Children infected with HIV</td>
<td>3,105</td>
<td>2,009</td>
</tr>
</tbody>
</table>

*Source: Wilson, David et al., 2011*

**Female sex workers have a higher risk of HIV infection compared to male sex workers and have less access to HIV testing.**

While most sex workers in Indonesia are female, a higher percentage of male sex workers (79.1%) reported using a condom with their most recent client compared to 66.6% of female sex workers. The proportion of male sex workers (57.2%) who had received an HIV test at the time of the UNGASS survey was twice as high as for female sex workers (27.8%), (UNGASS Report, 2009).

The coverage of anti-retroviral treatment among HIV-positive pregnant women is very low.

As of December 2009, there were an estimated 5,170 HIV-positive pregnant women in Indonesia. Of that number, only 3.8% received anti-retroviral treatment to reduce the risk of HIV transmission from mother to child indicating that Prevention of Mother to Child Transmission (PMTCT) programs are not yet well established, (UNGASS Report, 2009). Identified constraints include lack of information, lack of facilities for PMTCT and the stigma and discrimination HIV-positive pregnant women face when accessing health care services in hospitals, clinics and other health centers.
Policy Issues

The MDGs Road Map identified the proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS and the rate of condom used among high risk population as areas that requires special attention. This is especially true with increasing evidences of HIV/AIDS infection through unprotected sex, particularly in Papua where HIV/AIDS has become a generalized epidemic.

The National Government has been active in HIV/AIDS prevention and treatment since the first case in Indonesia, setting-up the National AIDS Commission in 1987 and expanding it under Presidential Instruction No 75/2006 and signing the Declaration on HIV/AIDS (UNGASS) in 2001 and Sentani commitment in 2004. The most recent Presidential Instruction No 3/2010 on equitable development was issued, among other reasons, to accelerate the achievement of HIV/AIDS target of controlling the HIV/AIDS prevalence to <0.5% by 2014, (Bappenas, 2010, p.145). The National AIDS Strategy 2010-2014 promoted scaling up coverage for prevention; increasing and expanding care, support and treatment services; improving access to and use of programs for impact mitigation; strengthening partnerships, health systems, and community systems; and increasing coordination among stakeholders and resource mobilization at all levels.

In 2011, supported by AusAID and the World Bank, the MoH and National AIDS commission introduced the HIV in Indonesia Model (HIM). The model is useful to define and assess the past, present and future trends of the unique epidemiology, behaviors, populations and geography for practical evaluation as well as development of policies and program in Indonesia. The HIV/AIDS prevention and care efforts have involved several line ministries and relevant national bodies (such as the Coordinating Ministry of Social Welfare, MoH, Ministry of Home Affairs/MoHA, Ministry of Social Affairs, Ministry of National Education, Ministry of Religious Affairs, the National Bureau for Family Planning), the House of Parliament, and local government. The target for coverage for safe behavior is 80% for key population and 60% population by 2014. This will be a challenge particularly in relation to PMTCT centers that need to scale-up, particularly considering that only 4 to 15% of HIV-positive pregnant women received medical treatment in 2008 (WHO/UNAIDS/UNICEF, 2009). Stigma, discrimination and gender inequality remain the major challenges, (Bappenas, 2010, p.156).

Recommendations

1. Improve the size estimates of populations at risk by improving surveillance and information systems, which includes sexually transmitted infections (STIs) among women, to better understand gender issues in HIV epidemics.

2. Intensify Information, Education and Communication (IEC) that has gender sensitivity to address existing inequalities.

3. Improve access of vulnerable populations to preventive, treatment and care services that recognize different gender needs.

4. National and sub-national AIDS Commissions to continue and improve surveillance and information systems, which includes sexually transmitted infections (STIs) among women, to better understand gender issues in HIV epidemics and improve the size estimates of populations at risk of HIV/AIDS.

5. National and sub-national AIDS Commissions to continue to work closely with NGO to intensify
create a more conducive environment by reduc-
ing stigmatization and discrimination and human
rights violations in implementation of HIV/AIDS
programs.

6. National and sub-national AIDS Commissions to
continue to work closely with NGO sector to im-
prove sensitivity of IEC to ensure that the whole
community is properly educated about HIV/AIDS,
including the different risks and impacts of con-
tacting the virus for women and men, and to re-
duce stigma and discrimination.

7. National and sub-national AIDS Commissions to
further improve access of vulnerable populations
to preventive, treatment and care services that rec-
ognize different needs of women and men.

8. MoH to further improve PMTCT programs through
providing better information, improving facilities
for PMTCT and eliminating the stigma and discrim-
ination HIV-positive pregnant women face when
accessing health care services in hospitals, clinics
and other health centers.

Current Status:
• Clean Water and Sanitation

Indonesia’s performance in water and sani-
tation is not sufficient to meet MDGs targets
and community demands.

There has been some progress in expanding access
to clean water supply, though less success with
sanitation and improved hygiene. Currently 47.7%
of the population has access to an improved water
source while 51.2% have access to basic sanitation fa-
cilities with geographical variations, (Bappenas, 2010,
p.211). More than half provinces (19 out of 33) have
improved water access at less than the national aver-
age while improved sanitation is lower than the na-
tional average in half (17) the provinces. Open defeca-
tion remains widespread (26% of the total population,
with 36% rural and 16% urban), (UNICEF/WHO, 2010).
The trends suggest that 56% of the rural population
will have safe access by 2015 while access to improved
sanitation in rural areas could remain stagnant at
around 38%. Community demand for improved ser-
VICES is apparent with women in particular consistent-
ly prioritizing improved water and sanitation as part
of the Musrenbang and other development planning
activities such as National Community Empowerment
Program (PNPM).

Inadequate coverage and quality of water
and sanitation significantly affects the poor,
particularly poor women.

It is estimated that poor households without access
to improved water are at times paying ten to twenty
times more for their water or have to cover the costs
of fuel to boil their water so it is fit to use, (Bappenas,
2010, p.211). Furthermore the quality and quantity of
drinking water in urban areas has declined while inade-
equate urban sanitation presents risks of increased fe-
cal contamination of the water sources, both of which
particularly affect poor families. Some 30% of Indone-
sians still suffer from waterborne diseases, including
cholera, diarrhea, and typhoid fever, (Bappenas, 2010,
p.211). Women contend with higher risks for infant
and child mortality (with diarrhea still one of the top
five causes of infant mortality) due to lack of clean
water and basic sanitation, as well as physical injuries
from carrying heavy water containers and slipping on
muddy river banks.
Climate change threatens to increase women's burden in water and sanitation.

Climate change threatens to further increase women’s domestic work by undermining the effectiveness of sanitation and drinking water systems through longer periods of drought and more intense periods of rainfall and flooding of water and increasing breeding environments for mosquitoes.

When access is improved, women and children in particular receive significant benefits.

Riskesdas 2007 indicates that the number of women (49.7%) responsible for fetching water is slightly higher than men (43.2%), followed by children (7.2% comprising 4% boys and 3.2% girls). Increasing access to improved water will save their time, which for women, allows them to be more involved in income generating, caring for children and participating in community decision making. Access to clean water improves family health and supports better hygiene practices which in turn reduces women’s burden in caring for sick family members with water borne illnesses and leads to increased family income through reduced health costs and lost work days. Girls who have reached menstrual age are better able to participate in education when they have access to proper water and sanitation facilities and hygiene education schools.

Policy Issues

The role of women in water and sanitation is articulated in the Dublin-Rio Principles which recognizes that “Women play an essential role in the provision, management, and protection of the water supply”. This is reflected in the 2003 national policy on the Community-Based Supply and Environmental Sanitation, developed by a cross-sectoral working group involving National Development Planning Agency/BAPPENAS, MoHA, Ministry of Settlement and Regional Infrastructure (MoSRI), MoH and Ministry of Finance/MoF. One of the key principles adopted in the policy is a non-discriminatory approach, including those based on gender, recognizing that “there is a greater chance of sustainability when women actively participate in the Water Supply and Environmental Sanitation (WSES) development decision-making process”. Nonetheless, women continue to be poorly represented in policy and decision making at national, sub-national and village levels regarding allocation of resources and development and management of improved water, sanitation and hygiene education services.

Government’s efforts to meet the MDGs target of reducing by half the total population that lacks access to safe water supply and basic sanitation by 2015 have included a number of large-scale donor supported Wa-
ter Supply and Sanitation (WSS) programs. However, local investment remains poor as they have yet to recognize water and sanitation as a policy or budgetary priority that can reap significant social and economic as well as health benefits. Economic losses resulting from poor WSS service provision are substantial. A Water and Sanitation Program (WSP)-World Bank study indicates that in 2006 Indonesia lost an estimated IDR 56 trillion (USD 6.3 billion) due to poor sanitation and hygiene, equivalent to approximately 2.3% of GDP, (WSP-WB, 2008, p.1). Substantial efforts have been made to improve government coordination through national and local institutions such as the Task Force on Drinking Water and Environmental Health (Kelompok Kerja Air Minum dan Penyehatan Lingkungan/Pokja AMPL) and to harmonize good practices for sustainable WSS in cooperation with external development partners. However, a study on water and sanitation in 2008 reveals that the average allocation for sanitation was at approximately 2.3% of the total 2003-2005 district budget, which is higher than the 0.18 % at provincial level and 0.036 % at national budget, (Buhl-Nielsen, et al, 2009, p.58).

There is substantial global and national evidence that participatory approaches involving women and the poor result in more sustainable results for water and sanitation and improves water governance, (WSP-WB, 2008). But local governments have been slow in adopting participatory approaches, despite the known benefits and lessons learnt from large scale national WSS programs such as Water and Sanitation for Low Income Community (WSLIC) 1 and 2, (Water Infrastructure Sanitation for Low Income Community, MoH). Currently there are no national or local government guidelines for gender mainstreaming in the WSS sector and little capacity building of relevant local government personnel, including from offices of Public Works and Health. Monitoring of gender participation and outcomes for water and sanitation is similarly weak, as is monitoring in the sector more generally. More research is required to better understand the impacts of improved (or lack of) access to water and sanitation on women and girls’ lives across different regions to inform development plans, including improving linkages between water and sanitation programs and livelihood programs.

**Recommendations**

- The Task Force on Drinking Water and Environmental Health (Pokja AMPL) to take a lead role in promoting gender equity in WSS by providing and monitoring use of gender mainstreaming guidelines for development of district water and sanitation Master Plans, village development of WSS services, Musrenbang and other village level development processes and household financial decision making.

- Pokja AMPL to promote and oversee improved capacity building for gender mainstreaming at government and community level, including incentives to promote equal opportunities for women and men in policy making and implementation through government and donor funded programs.

- MoHA to increase its capacity building and advocacy to local governments (Pemberdayaan Masyarakat Desa/Rural Community’s Empowerment) to support women’s leadership, particularly of poor women, to strengthen prioritizing of water and sanitation at district, sub district and village levels and increase budget commitments to WSS priorities.

- Pokja AMPL and sectoral agencies to collaborate in developing adequate monitoring and evaluation systems which provides for collection and use of
sex disaggregated data that demonstrates the value of gender equity as part of an evidence-based approach to investment planning and policy reform.

- MoHA to give increased attention to the policy linkages between improved water and sanitation services and economic development opportunities for women and poor.

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