

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

### **HIV/AIDS**

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

#### **Status and trends**

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

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

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

#### **Challenges**

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

#### **Policies and Programs**

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

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

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

## **Malaria**

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

#### Status and trends

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

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

#### Challenges

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

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

## Policies and Programs

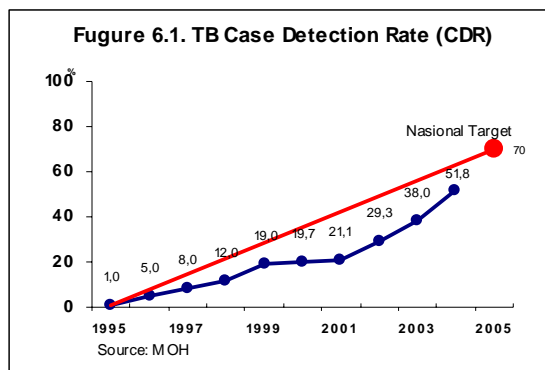
Malaria prevention is intensified through Roll Back Malaria (RBM) approach, which has been operational in *Gerakan Berantas Kembali* (Gebrak) Malaria since 2000. It is also intensified by using early detection strategy and appropriate treatment, active role of the community in preventing malaria, and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

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

## Tuberculosis (TB)

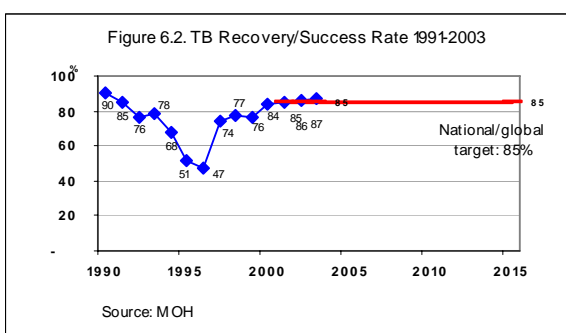
### Status and trends

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



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

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



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

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

### Challenges

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

### Policies and Programs

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

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

### Tobacco

#### Status and trends

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

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

## **Challenges**

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

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

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

## **Policies and Programs**

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

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

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