Present Context

In more than 30 years since 1967, Indonesia made **substantial progress**. A period of economic growth was experienced which successfully resulted in raising the per capita income from USD 50 in 1968 to USD 1,124 in 1996.

These achievements received a severe set back in mid-1997 when the Indonesian **economy collapsed**. The value of the currency plummeted, prices increased, and unemployment rose dramatically.

In addition, parts of the country suffered from relatively long droughts and extensive **forest fires**. As it forms the part of Pacific Ring of Fire, Indonesia is highly prone to natural disasters such as earthquakes, volcanic eruptions, tsunamis, floods, and drought.

In the period of 2001 through 2005, Indonesia faces an important transitional period. After over 25 years of highly centralized government, Indonesia is going through rapid democratization and **decentralization** of political and bureaucratic power.

There is a **large number of complex emergencies** currently in the country. Vast displacements of populations have taken place in West Timor, Malukus, and Aceh provinces causing the death of over 11,000 people and the displacement of 1.4 million persons.

In the **conflict and disaster affected areas**, several years of inter-communal violence, combined with the negative impacts of economic and social crises and frequent natural disasters, have increased public health risks for the general population in the country. The multi-dimensional crises in Indonesia have affected the health care system in different ways; almost all conflict-affected areas suffer from shortages of staff and necessary equipment, a breakdown of regular programmes, a weakening of primary health care (PHC) structures, and shortages of essential drugs (source: Indonesia CAP 2004). The conflict resulted in:

- Lack of experienced health staff especially managing emergency and essential public health care services;
- Existing community centres not functioning/shortage of essential medical supplies; difficulty in maintaining referral system due to accessibility and security;
- Reproductive health services not available; lack of ante and post-natal services for pregnant women; provision of nutritional support for the under 5 children;
- Children suffer more from respiratory infection, tuberculosis, measles, diarrhoea, dengue fever, gastroenteritis, skin infection, typhoid, malaria and trauma;
- Most of the affected communities suffer from psychosocial and mental disorders.

---

1 Source: report from WHO-EHA in Indonesia
Public Health Concerns

Health Status

Communicable diseases continue to be a major cause of morbidity and mortality in Indonesia. Technical strategies for communicable disease control have already been accepted, adapted and adopted to country-specific needs. However, the implementation of the accepted strategies needs improvement, especially under a decentralised health system. Many of these problems are related to the improvement and strengthening of the district health system.

- **Tuberculosis** is a major health problem. It is the second highest cause of death and the first killer for infectious diseases. It is estimated that 175,000 people die every year from tuberculosis. The DOTS strategy has been expanded to 225 districts (74.8%) out of a total at 311 districts, covering 88 out of the 210 million people.

- **Leprosy** is on the verge of being eliminated and current efforts focus on final campaigns.

- **Malaria** is still a public health problem. Approximately 1.5 million cases are detected annually. In 1997, the parasite incidence ranged from 0.12 per 1000 population in Java and Bali to around 40 per 1000 population, under 10 years of age in the outer islands. In 1998, there were malaria outbreaks in the highlands of Irian Jaya, and resurgence in Central Java.

- **Dengue** fever/dengue haemorrhagic fever usually occurs in epidemic proportions during the peak season, starting in November and peaking in May. In 1998, 30,000 cases were reported from cities and also from some rural areas.

- **STDs** remain a serious problem especially in high-risk groups and promotes the spread of HIV/AIDS. Control is complicated by social and cultural attitudes towards these diseases and their interventions. As of January 1999, the cumulative number of reported AIDS cases was 227, of which 113 AIDS patients died. The progression rate seems to increase slowly doubling in more than two years. However this may be due to under-diagnosis or under-reporting.

- Many of the traditional infectious diseases of children have been controlled through immunization. **Polio** is close to elimination and current efforts focus on surveillance and final provincial Immunization Days campaigns. *The last wild poliovirus isolated in Indonesia was in June 1995.*

Routine EPI coverage has been maintained above 80% nationally with donor assistance; however, rates are falling in pocket areas. New immunization programmes, such as hepatitis B, are being implemented. Other initiatives are the School Immunization Month, TT immunization campaigns in high-risk areas, and improving injection practices. However, with decentralization of the health system, renewed efforts will be needed to ensure that immunization coverage is sustained.

The health of women and children continues to be a problem. With five million pregnancies every year in Indonesia, *more than 20,000 women die annually* during pregnancy and delivery. The high number of maternal deaths is especially a problem in rural areas with limited access to delivery by skilled attendants and an inadequate referral system. Almost 50% of women give birth without skilled attendants and 70% have no postpartum care during the six weeks following delivery.

An important objective of the country is to reduce the IMR to less than 50 and the under-five mortality rate to 66 per 1000 live births. One of the strategies is the Integrated Management of Childhood Illness (IMCI).

As the life expectancy of Indonesians improves, the concern is shifting from communicable diseases to degenerative diseases. This *epidemiological transition* has presented the health care delivery system with a double burden. Chronic conditions include cancer, circulatory diseases, metabolic disorders, congenital disorders, tobacco dependence, mental health and neurological disorders. Since these diseases are expensive and difficult to cure, it is appropriate...
focus be put on prevention of non-communicable diseases, especially promoting healthy lifestyles with emphasis on reducing tobacco dependence.

Indonesians are increasingly exposed to health risks from environmental hazards. Cases of severe urban air pollution and massive air contamination of ground and surface water resources by industries and households are common. Many potentially harmful chemicals are readily available to the public and are regularly used at places of work in agriculture, industry and commerce. Food contamination of both microbiological and chemical origin is a major issue. The haze from the forest fires in Indonesia has had significant disruptive social and economic effects on people living in affected areas. However, there is low commitment, the main obstacles being the complexity of the issues and a lack of clear institutional responsibilities, both in the public and private sectors.

**Health System**

- Indonesia’s health system was facing severe problems even before the economic and political crises. Some basic changes in the health system were avoided because of the system inertia. The budget system consists of two major categories: the routine budget and the development budget. It is highly centralized, inflexible and fragmented.

- Every administrative level has a local budget, including a budget for health. However, at least 90% of government budget comes directly or indirectly from the central government so there is a heavy reliance on the centre. Based on the best available data, it is estimated that the total health development budget was 2.4% of the annual national development budget in fiscal year (FY) 1996/97 increasing to 3.0% in FY 1999/2000 or 0.4% of GDP in FY 1996/97 increasing to 1% in FY 1999/2000. The available budget fails to meet the health needs.

- Funds flow into the sector from a variety of sources; the major ones being allocation of government revenues - both central and local government, payments by households (fees for services, drug purchases); employer contribution to health care by employees; limited support from NGOs, and foreign loans and grants. In the period 1985-1995, on average 30% of the health care expenditure came from government sources, while 70% came from nongovernmental sources, including the organized private sector (employer and insurance) and out-of-pocket health expenditure from households.

- Besides the MOH, there is a National Agency for Drug and Food Control, which was not part of the Ministry of Health. The National Agency is, among others, responsible for the registration of medicines and medical supplies and inspection of manufacturers. The agency can, upon request and provided a justification is given, authorize the importation in Indonesia of drugs and medical supplies that are not registered in Indonesia. The National agency has branch offices in most provinces.

- Mobilization of internal and external resources to support development programmes comes under the responsibility of the National Development Planning Board. Environmental impact Analysis ensures that health aspects are included in all development activities.

- Each sub-district in Indonesia has at least one health centre headed by a doctor, usually supported by two or three sub-centres, the majority of which are headed by nurses. Health centres mainly provide 8 programs. Most are equipped with four-wheel drive vehicles or motorboats to serve as mobile health centres and provide services to underserved populations in urban and remote rural areas. At the village level, the integrated Family Health Post provides preventive and promotive services. These health posts are established and managed by the community with the assistance of health center staff. To improve maternal and child health, midwives are being deployed to the villages.
Current humanitarian Health Priorities

- Improve health services and assist in peace-building efforts
- Strengthen health systems; improve health of communities
- Control of disease outbreaks and strengthening of disease surveillance system
- Improve mental health services and reduce mental health morbidity
- Strengthen the emergency preparedness and response programme

National development in Indonesia will use a health-oriented national development approach - "Healthy Indonesia 2010". The new mission of the National Health Development Programme is:

- To lead and initiate health-oriented national development;
- To maintain and enhance health of individuals, family and community, along with their environments;
- To maintain and enhance quality, equitable and affordable health services; and
- To promote public self-reliance in achieving good health

Other Humanitarian priorities

- The provinces of Maluku, North Sumatra and Madura Island continue to face problems of remaining IDPs. In Maluku alone there are over 188,000 IDPs requiring assistance. In Madura, some 130,000 IDPs are not able to return to their villages in Central Kalimantan.
- Significant pockets of displacement exist in different parts of the country. Without financial support from the central government, provincial authorities cannot effectively end the plight of the displaced.
- In Papua, socio-economic conditions have deteriorated over the past several years, and 55% of Papuans live below the poverty line. The province has the highest infant mortality rate in the country, as well as the highest and fastest growing prevalence of HIV/AIDS.
- Another major problem is a lack of development activities carried out by UN agencies and international NGOs. Although there are no indications now of acute humanitarian needs in Papua, early warning indicators suggest that increased UN and NGO activities can reduce the risk of an emerging humanitarian situation.

Gaps and Challenges

- Lack of access, hampering accurate and reliable information on the humanitarian situation, especially in the Aceh and West Timor province because of the insecurity;
- Weakening status of IDPs i.e. the reclassification by the government of IDPs as "vulnerable groups", meaning no longer funding from central government;
- Delay in the launch of the CAP, affecting funding for humanitarian activities carried out by UN agencies and NGOs;
- Major donors’ reluctance to support humanitarian access, fearing this might jeopardize their relationship with Indonesia.
Sector Actors

CARDI, CARE INT, CCF - Indonesia, CRS, FAO, ICMC, IOM, MCI, OCHA, OXFAM, PBI, PCI, SC - US, SC UK, SIL, UNDP, UNDP/UNSECO, ORD, UNFPA, UNICEF, WFP, WV

Disclaimer

The emergency country profiles are not a formal publication of WHO and do not necessarily represent the decisions or the stated policy of the Organization. The presentation of maps contained herein does not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or areas or its authorities, or concerning the delineation of its frontiers or boundaries.

Contact Details

Dr Georg Petersen
WHO Representative to Indonesia
Tel: +62 21 520 11 66; 43 49
Fax:+62 21 520 11 64
Email: who@who.or.id

Office of the UN Resident and Humanitarian Coordinator for Indonesia
UNDP Office in Indonesia
Jakarta
Tel: +62 21 314 24 93
Fax: +62 21 310 01 58
Email: bo.asplund@undp.org

Dr A. Sujudi
The Minister of Health
Ministry of Health
JL. H. Rasuna Said kav. X 5 No.: 04-9
Jakarta 12950, Indonesia
Tel: +62 21 520 1587/ 1590/ 1591/4396
Fax: +62 21 520 1591

Mr Jae-Hyuk Chang
Avenue Appia 20, Building C, Room 240
CH-1211 Geneva 27, Switzerland
Phone: + 41 22 791 13051
Email: changj@who.int

Dr Luis Jorge Perez, Regional Adviser, EHA SEARO
World Health Organization
South-East Asia Regional Office
New Delhi, India
Phone: +91 112 337 0804 or 337 8805
Fax: +91 112 337 8438
Email: perezl@who.sea.org

Key Readings

UN-CAP-Indonesia 2004
WHO Web site of the Regional Office for South-East Asia: http://www.searo.who.int/eha
WHO Web site of Headquarters: http://www.who.int/disasters
# Annexes

## Annex 1: Health Profile

### General Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2004)</td>
<td>222,611,000</td>
</tr>
<tr>
<td>Refugees</td>
<td></td>
</tr>
<tr>
<td>Internally Displaced Persons(^3)</td>
<td>Over 500,000</td>
</tr>
<tr>
<td>Healthy life expectancy at birth m/f (years)</td>
<td>65/68</td>
</tr>
<tr>
<td>GNI (Gross National Income) per capita (US $, 2002)(^4)</td>
<td>710</td>
</tr>
<tr>
<td>Infant Mortality rate (deaths/1000 live births)</td>
<td>39</td>
</tr>
<tr>
<td>Under-five mortality rate (deaths/1000 live births)</td>
<td>50</td>
</tr>
<tr>
<td>Total adult literacy m/f % (2000)</td>
<td>92/82</td>
</tr>
<tr>
<td>Population using improved drinking water sources</td>
<td>78%</td>
</tr>
<tr>
<td>Population using adequate sanitation facilities</td>
<td>55%</td>
</tr>
<tr>
<td>UNDP's Human Development Index ranking(^5)</td>
<td>111/177</td>
</tr>
</tbody>
</table>

### Health Systems Profile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>2.4</td>
</tr>
<tr>
<td>Total per capita health expenditure (US $)</td>
<td>16</td>
</tr>
<tr>
<td>Nurses rate per 100,000 population</td>
<td>50.0</td>
</tr>
<tr>
<td>Physicians rate per 100,000 population</td>
<td>16.0</td>
</tr>
<tr>
<td>Hospital Beds per 1000 population</td>
<td>0.7</td>
</tr>
</tbody>
</table>

### Tuberculosis

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence per 100,000</td>
<td>742</td>
</tr>
<tr>
<td>Mortality rate per 100,000</td>
<td>67</td>
</tr>
</tbody>
</table>

### HIV/AIDS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult prevalence of HIV/AIDS (15-49 years)</td>
<td>0.1</td>
</tr>
<tr>
<td>Estimated number of adults living with HIV/AIDS (2001)</td>
<td>110,000</td>
</tr>
<tr>
<td>Reported number of people receiving antiretroviral therapy (15-49 years)</td>
<td>NA</td>
</tr>
<tr>
<td>Orphans due to AIDS</td>
<td>1500</td>
</tr>
</tbody>
</table>

### Malaria

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality rate per 100,000</td>
<td>4</td>
</tr>
</tbody>
</table>

### Immunization (2002)\(^6\)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>77%</td>
</tr>
<tr>
<td>DPT3</td>
<td>75%</td>
</tr>
<tr>
<td>Measles</td>
<td>76%</td>
</tr>
<tr>
<td>Polio</td>
<td>74%</td>
</tr>
<tr>
<td>Pregnant women receiving tetanus vaccine</td>
<td>81%</td>
</tr>
</tbody>
</table>

### Women's Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate</td>
<td>2.4</td>
</tr>
<tr>
<td>% of antenatal care coverage</td>
<td>89</td>
</tr>
<tr>
<td>% of skilled attendant at delivery</td>
<td>~50</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>230</td>
</tr>
</tbody>
</table>

---

\(^2\) WHO/CDS baseline statistics unless indicated otherwise  
\(^3\) http://www.db.idp-project.org/Sites/idpSurvey.nsf/wCountries/Indonesia  
\(^4\) The World Bank Annual Report, 2003  
\(^5\) UNDP Human Development Report 2004  
\(^6\) http://www.unicef.org/infobycountry/indonesia_statistics.html
Annex 2: Populations of humanitarian concern

Source: Provincial Profiles of Potential Health Problems Due to disaster in Indonesia 2001

7 WHO/CDS baseline statistics unless indicated otherwise
Annex 3: Overview of Humanitarian priorities (province by province, as of June 2004)

**Aceh**
- Humanitarian issue: assistance to population affected by conflict with separatist movement
- No. of IDPs: 6,946 (down from 122,000 in 2003)
- Security phase: 3 in Banda Aceh, 4 outside
- Access: very restricted through 'Blue Book' procedure, max. 2×14 days, limited number of ICRC and UN staff only

**North Sumatra**
- Humanitarian issue: displacement from Aceh
- No. of IDPs: 120,000
- Security phase: 1
- Access: no limitations

**West Kalimantan**
- Humanitarian issue: displacement from Sambas
- No. of IDPs: 78,000
- Security phase: 1
- Access: no limitations, but some areas remote and inaccessible during rainy season

**Madura**
- Humanitarian issue: displacement from Central Kalimantan
- No. of IDPs: 130,000
- Security phase: 1
- Access: no limitations

**Central Sulawesi**
- Humanitarian issue: displacement from Poso and Tentena
- No. of IDPs: 36,000 (down from 143,000)
- Security phase: 1 in Palu, 2 in Poso
- Access: no limitations

**North Sulawesi**
- Humanitarian issue: displacement from North Maluku
- No. of IDPs: 33,000
- Security phase: 1
- Access: no limitations

**Maluku**
- Humanitarian issue: displacement within the province
- No. of IDPs: 188,000
- Security phase: 4 in Ambon Island, 3 other regions
- Access: limitations under civil emergency were lifted. Now, UN security limitations and physical limitations due to geography
**Papua**

- Humanitarian issue: separatist movement, natural disasters, poverty
- No. of IDPs: 7,000 (resettled)
- Security phase: 2
- Access: free access to provincial capital, police permission required for visits outside

**West Timor**

- Humanitarian issue: former refugees
- No. of IDPs: 28,000
- Ethnic origin: East Timor
- Security phase: 4 (downgraded from 5, as of 10 June)
- Access: UN imposed limitations
Annex 4: Security and logistics

Security: Capital: Jakarta (Phase I). PHASE IV is in effect for Aceh Province, Ambon Island in Maluku Province (the remainder of Maluku Province remains at Phase III) and West Timor. PHASE III is in effect in Banda Aceh, Mala Hayat/Payakameng to the east of Banda Aceh and the airport and the main road from Banda Aceh, Sibree Town to the South of Banda Aceh and Lhonga Town to the west, Sunda Islands of Aceh Province, North Malaku and Maluku Province. PHASE II for Irian Jaya Province, the Poso area of Central Sulawesi. PHASE I for West Kalimantan, the islands of Bali and Lombok and the rest of Indonesia. No travel should commence to Bali or Lombok without prior security clearance from the Designated Official. All official and nonofficial travel to and within Indonesia should be confined to essential journeys only. Staff required to transit through Bali and required to stay overnight are advised to travel directly to their hotel and avoid clubs, bars and other establishments frequented by foreigners. In order to provide greater authority to the field and to enhance operational capacity, UNSECOORD is delegating authority to the Designated Official to grant security clearance for entry and travel into PHASE IV areas of Indonesia. Mr. Bo Asplund, UN Resident Coordinator/UNDP Resident Representative is the Designated Official, tel: 62-21-3142493, cell: 62-811-900 877, fax: 62-213100158/3145251. Regional FSCO based in Jakarta, Indonesia: Mr. William Simpson, tel: 62-21-3190-3158, fax: 62 21 3190 3157, email: bill.simpson@undp.org. Duty Officer, Field Security Unit, tel: 62-811-17-4745.

Accessibility and Essentials for Logistics

Dry season: Between June and September. Dry winds blowing from Australia (low moisture) Rainy season: Between December and March there is the wet (high moisture) wind from Asia and Pacific, and passed through several oceans

Routes of access: Railways: Total 6,458km Highways: Total 342,700 km (paved 158,670 km) Airports: 453 (2000 est.), 136 of these 453 with paved runways Waterways: 21,579 km total


\(^8\) UNSECOORD, 22 July 2004