INDONESIA PROFILE

GEOGRAPHY

The Republic of Indonesia is an archipelago with approximately 18,000 small and large islands. The chain of islands is spread over the equator of 6° North Latitude to 11° South one and from 95° to 141° East Longitude. These chains of islands are spread out over an area that is comparable to the size of Europe. Around two third (around 67%) is water territory and one third is land territory approximately is around 1.89 million square kilometers.

There are five big islands: Sumatra, Kalimantan, Java, Sulawesi, Papua and two small archipelagos: the Maluku and the Nusa Tenggara. The other islands are small ones and mostly unpopulated. Geographically Indonesia is situated between Asia and Australia; and between the Pacific and Indian Oceans. The north side neighboring countries are Malaysia, Singapore, Brunei Darussalam and the Philippines; Papua New Guinea in the East, Timor Leste and Australia in the South.

The decentralization policy that has been put into action in 2001 has amongst others impacted an increasing number of province and districts/municipalities. At present administratively there are 33 provinces, seven of them are practically new ones (Figure 1).

The 33 provinces are compromising of 399 kabupaten (districts) and 98 kota (municipalities). The next lower administrative units of districts/municipalities are sub districts (kecamatan): 6,652; villages (desa/kelurahan): 77,012 and hamlets (dukuh).

Figure 1. Map of Indonesia

DEMOGRAPHY AND LITERACY
The National Planning Body (Bappenas) estimated that the total population in 2005 counted 219,898,300, with 110,156,400 male and 109,741,900 females. In 2006, this was approximately a total of: 222,735,400 with 111,560,800 male and 111,174,600 female.

In the year of 2005, around 28.3% was in the age group of 0-4 years, 66.7% was in the age group of 15–64 years and around 5.0% was in the age group of more than 65 years. While in 2006 it was: 27.8%; 67.2% and 5.0% respectively. The growth rate was 1.49% annually during the period of 1990–2000 and dropped to 1.36% annually during the period of 2000–2005.

Java Island is the most populated one, although it covers only around 6% of total land of Indonesia. In 2000, 58.9% (121,293,200) of the total population was living in Java Island. This has decreased slightly to 58.1% in 2005, but Java is still counting more than half of the Indonesian population. Around 48.3% of the country’s population was urban in 2005 and it is estimated to be around 54.2% in 2010.

<table>
<thead>
<tr>
<th>Indonesian Island :</th>
<th>Prop of total pop</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Java</td>
<td>58.1 %</td>
<td>126,793,100</td>
</tr>
<tr>
<td>Sumatera</td>
<td>21.5 %</td>
<td>47,192,300</td>
</tr>
<tr>
<td>Sulawesi</td>
<td>7.3 %</td>
<td>15,997,700</td>
</tr>
<tr>
<td>Kalimantan</td>
<td>5.7 %</td>
<td>12,583,200</td>
</tr>
<tr>
<td>Bali/Nusa Tenggara</td>
<td>5.4 %</td>
<td>11,861,300</td>
</tr>
<tr>
<td>Papua</td>
<td>1.2 %</td>
<td>2,518,400</td>
</tr>
<tr>
<td>Maluku</td>
<td>0.9 %</td>
<td>1,593,200</td>
</tr>
</tbody>
</table>

The official national language is Indonesian language (Bahasa Indonesia); however there are more than 200 dialects are spoken in the country.

The illiteracy rate is 9.07%, while nation-wide 90.07% of the population can read Latin and 0.87% other letters. Rural areas had bigger number of illiterate population than urban ones, 12.16% compared to 4.91%. Female group had higher illiterate population than male one, 12.28% compared to 5.84%. Papua, West Nusa Tenggara and East Java were 3 provinces with highest illiterate population, 23.39%, 21.31% and 15.03% respectively. North Sulawesi, Jakarta and Gorontalo were 3 provinces with lowest illiterate population, 0.99%, 1.47% and 2.56% respectively.

**GOVERNANCE**

There were radical changes since 1998 in the Indonesian political system, affecting the role of the regions and re-definition of the relationship between the national government and the local level government bodies, provincial and district level.

Two new laws were passed in 2001: a) Law No.22/1999 on Regional Governance and b) Law No. 25/ 199 on Fiscal Balance Between the centre and the Regions. Public services including health were drastically reorganized. The introduction of the new laws and the short preparation time led to much confusion.
Obstacles related to decentralization remain having an impact on program implementation in Indonesia. These include issues such as: insufficient financial information and in adequate planning system causing severe under-funding of public services, including health; the lack of implementation guidelines cause major confusion on roles and responsibilities at provincial and district levels; low involvement of local communities.

ECONOMY

Agriculture is fundamental to Indonesia’s economy with rice as the main crop. Java, Bali and Sumatra are the biggest contributors to national GDP. The successes of national development over the last five years were reflected in several important indicators. The Human Development Report (HDR) 2009 revealed that the Indonesian Human Development Index (HDI) has increased from 0.711 in 2004 to 0.734 in 2007 (UNDP, 2009). However, HDI improvement did not lead to higher rank for Indonesia. In 2009, Indonesia was still ranked 111 out of 182 countries. The national income per capita has been growing from USD 1.186 in 2004 to USD 2.271 in the end of 2008 (Bappenas, 2010), which moved Indonesia to become part of the lower middle income countries group. Accelerating economic growth has further contributed to the declined in poverty level.

Based on the poverty line, poverty level has declined from 16.7% (36.1 million people) in 2004 to 14.1% (or 32.5 million people) in March 2009 (Bappenas, 2010). However, we can not rest content with merely applying the poverty indicator based on the national poverty line, which cover population of daily income under 1 USD. Some countries have established a national poverty line of daily income under 2 USD. Using higher poverty line, about 49% of population is still living with daily income under 2 USD per day in the year 2007 (UNDP, 2007). This fact shows that there is a high proportion of people who live near to the poverty line or close to the vulnerable group. These people are highly susceptible to any changes in their economic situation, i.e. catastrophic disease, that will pull them down into poverty with an average income of less than 1 USD per day. Therefore, the biggest challenge for Indonesia is how to reduce the number of poor people by referring to the average number of people with daily income of less than 2 USD per capita.

HEALTH SITUATION

Health and nutritional status of a population are generally expressed in life expectancy, maternal mortality rate (MMR), infant mortality rate (IMR), and the prevalence of malnutrition among under five children which has shown improvement over the last few years (Bappenas 2010). Maternal health is indicated by a significant decrease of maternal mortality ratio in the last few years. However, to pursue the MDGs target to 102 maternal mortality ratio per 100,000 live birth by 2015, Indonesia still needs to pursue continued efforts to achieve it. Low access and quality of maternal health services remains the main cause of high maternal mortality, as shown by low proportion of deliveries assisted by skilled birth attendants. A high disparity in the proportion of deliveries assisted by skilled birth attendants was evident between provinces, with the highest proportion in Jakarta (amounting to 97.6%) and the lowest in North Maluku (38.0% per year) (Balitbangkes, 2007).
Life Expectancy
The life expectancy is currently estimated to be 69.8 years in the period of 2005–2010 (2007). The last 3 decades have shown improvement from 52.41 (1980) to 63.48 (1995) to 67.8 (2002).

Provinces with highest life expectancy rate were D.I. Jogjakarta (72.4 years), DKI Jakarta (72.3 years) and North Sulawesi (70.9%). Provinces with lowest life expectancy rate were West Nusa Tenggara (59.3 years), South Kalimantan (61.3 years) and Banten (62.4 years).

Health facility
Nationally, the number of healthcare facilities is continuously increasing, however, the accessibility to healthcare in the poor, remote and borderline areas and islands, especially among the poor, is still limited. In 2007, the ratio of health center (Pusat Kesehatan Masyarakat or Puskesmas) to population is 3.6 per 100,000 population. The number of satellite health centers (Puskesmas Pembantu) and mobile health centers (Puskesmas Keliling) are increasing. Public access to reach basic health care facilities is reasonable with 94% of the people having good access to health care facilities within less than 5 kilometers (Riskesdas, 2007). In spite of good community access to healthcare facilities such as Puskesmas and its networks, quality of healthcare services still needs Improvement, especially for preventive and promotive healthcare. In the remote areas of Eastern Indonesia, however, many people still faces barriers to access healthcare facilities, due to distance and time to reach the facilities. This problem is exacerbated by road condition, limited mode of transportations and limited availability of electricity.

The number of general hospital (RSU) has been increased from 625 (2004) to 667 (2007) and from 621 to 652 for public and private hospitals, respectively. In 2007, the ratio of hospital bed to population was 63.3 beds per 100,000 population (Profil Kesehatan, 2007). This ratio was still below the national target in 2009, which was 75 hospital beds per 100,000 population. Despite the increase in healthcare utilization, referral system is still not optimum.

The number, types and quality of healthcare workers are improving, but they are not equally distributed. The ratio of health workers per 100,000 population for medical doctor, specialist, nurse and midwives from 2004 to 2008 have increased. Compared to other countries in the South-East Asia region, the number and ratio of medical doctors per 100,000 population in Indonesia is relatively low. Their distribution is concentrated in Java-Bali islands. The gaps in number and ratio are even wider when comparing between urban and rural areas.

TB situation in Indonesia
Indonesia is ranked fourth among the highest TB burden countries in the world. The estimated prevalence of all types of TB cases is 690,000 and the estimated incidence is 450,000 new cases per year (WHO, 2011). The estimated number of deaths due to TB is 64,000 deaths per year (WHO, 2011). Among the Asia countries, Indonesia has the highest increase of number of HIV epidemic. The HIV epidemics is concentrated, except in Papua where the HIV prevalence has reached 2.5% (generalized epidemic). The national estimation of HIV prevalence among adult population was 0.2%. A total of 12
provinces have been declared as priority provinces for HIV intervention. It is estimated that there are 190,000 to 400,000 people living with HIV in the whole country. The estimated HIV prevalence among new TB cases is 2.8%. The estimated number of MDR-TB cases among new TB cases in Indonesia was 2%, which was lower than the regional estimate (4%) and 20% among retreatment cases. Every year, the estimated number of MDR-TB cases is 6,300.

Despite having the highest burden of TB cases, Indonesia was the first country among the high burden countries (HBC) in the WHO South-East Asian region which successfully reached the global TB targets for case detection and treatment success since 2006. In 2010, 302,861 TB cases were notified and treated and 183,366 cases were smear positive. Therefore, Case Notification Rate for smear positive TB was 78/100,000 (Case Detection Rate 78.3%). The averaged treatment success rate over the last four years was 90% and for the 2009 cohort, the treatment success rate was 91%. The achievement of this global target is a milestone in the national TB control program.

Although the implementation of TB control program at the national level shows positive progress in case detection and treatment success, its achievement at the provincial level illustrates disparity among the regions. Based on achievement in 2010, Twenty five provinces in Indonesia have not achieved 70% CDR and only 8 provinces are able to meet the targets of 70% CDR and 85% treatment success.

**Organization of the National TB Control Program**

Administrative management of TB control in Indonesia is currently under three different Directorate Generals in the Ministry of Health: Medical Service, Community Health, and Center for Disease Control. TB Sub-directorate is under the Directorate General of Disease Control, while Puskesmas (Health center) is under the Directorate General of Community Health and hospital is under the Directorate General of Medical Service. Health centers and hospitals are practically out of reach from the TB sub-directorate and the majority of hospitals have not yet adopted DOTS strategy. TB services are also conducted in private providers, prisons, military service and companies. Therefore, partnership between Directorate Generals and effective coordination by TB sub-directorate are needed to ensure integrated management of TB control. In 2010, restructurization within the Ministry of Health to integrate the Directorate of Medical Service and the Community Health was in progress. Health services at district level are designated as the backbone for TB control. Each district is supported by primary health care facilities (microscopic centers, satellite health centers, and independent health centers). Currently, Indonesia has 1,649 microscopic health centers, 4,140 satellite health centers, and 1,632 independent health centers. Other health facilities such as hospitals, prison, and clinics, are also implementing DOTS strategy. A total of 5,735 health center doctors, 7,019 TB workers, and 4,065 laboratory technicians have been trained on DOTS strategy. At the district level, the Head of District Health Office is responsible for implementing health programs, including planning, budgeting and service monitoring. Under the district level CDC, a wasor (TB supervisor) is responsible for the program monitoring and supervision, treatment register, and drug availability. Health facilities are responsible for the diagnosis, treatment and treatment monitoring, supported by family member as treatment observer. At the provincial level, a core DOTS team consisting of Provincial Project Officer (PPO) and Health Office staff is established, especially in high burden provinces. In provinces with large geographical area and substantial number of health care facilities, a district cluster system has started to be
developed with a primary aim to improve quality implementation of DOTS strategy in hospitals. To some extent, prisons, jail, and work places have also been linked to TB control program networking at the district level and health centers.

Findings from the TB prevalence survey in 2004 highlighted the facts that TB patients sought care in health facilities other than health centers, such as in hospital, lung clinics, and private practitioners. Pilot study, implementation and acceleration of DOTS strategy in these facilities as part of the Public-Private Mix initiatives has been started in 1999-2000. In 2007, all lung clinics, and nearly 30% of hospitals have implemented DOTS strategy. Less well-developed was the implementation of DOTS strategy in private sectors, although a model of private practice involvement in DOTS strategy has been piloted in Palembang in year 2002 and in Yogyakarta and Bali in year 2004-2005.

To foster acceleration of hospital involvement in DOTS, 750 out of 1,645 hospitals has been trained in DOTS strategy with funding from Global Fund Round 1, Round 5 and USAID. With funding from TBCAP/USAID through KNCV, several provinces were supported by Technical Officers who specifically deal with DOTS expansion in hospital. Coordination at central level with the Directorate General of Medical Service has significantly intensified. Two guidelines have been developed, namely the Managerial Guideline for TB service provision with DOTS strategy in hospital and Guideline for TB diagnosis and treatment in hospital. In addition, the Directorate General of Medical Service has conducted assessment to several DOTS hospitals. Efforts to integrate implementation of DOTS strategy into the current hospital accreditation system is underway.

**Partnership**

TB partners are every person or group who has awareness, willingness, ability and high commitment to support and contribute toward TB control in their own capacity and potentials. These potentials are further optimized for successful implementation of TB control. Every partner shares the same understanding of the purpose of partnership, i.e. successful acceleration of TB control in an effective, efficient and continuous manner.

**Gerdunas (Gerakan Terpadu National or National Integrated Movement)** is a cross-sector movement formed in 1999 at central and local government level in order to promote acceleration of TB control measures through an integrated approach, involving hospitals, private sectors, academia, NGOs, funding agencies, and other stakeholders. Following the high level meetings held during 2002, Gerdunas provincial chapters were established in nearly all provinces, despite various commitment. The function of partnership can be grouped into three categories: (1) planning and stewardship; (2) financing, resource allocation and use; and (3) service provision. The following table describes potential TB partners at the national level that may be referred to in the identification of partners when situation and condition permits.

<table>
<thead>
<tr>
<th>Function of partnership</th>
<th>Partner organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy, planning, stewardship, structure:</td>
<td>WHO, KNCV</td>
</tr>
<tr>
<td>TB technical assistance</td>
<td>MSH</td>
</tr>
<tr>
<td>Drug management and procurement</td>
<td>Medical Service Directoral General,</td>
</tr>
<tr>
<td>Hospital DOTS</td>
<td></td>
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</tbody>
</table>

Partnership Categories and Functions (as of 2010)
<table>
<thead>
<tr>
<th><strong>Data analysis</strong></th>
<th>Ministry of Health, Indonesian Medical Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy and communication</td>
<td>NIHRD, UI, UGM, Center of Health Promotion, Center of Public Communication, PPKMI</td>
</tr>
</tbody>
</table>

2. Financing, allocation:

External assistance GFATM, TBCAP (USAID)

3. Service provision:

Health care provider linkages (Professional associations) IDI, IDAI, IBI, IRSPI, PAPDI, PDPI, PERSI, PPNI

Government sectors Department of Health, Department of Justice, POLRI, TNI, Department of Social, Department of Communication and Information

Community-based TB PP Aisyiyah, CARE, Hope Worldwide Indonesia, LKC, PP Muhammadiyah, LPK NU, PKPU, PELKESI, PERDHAKI, PKK, PPTI, World Vision Indonesia, Pamali, LPMI

Business PT Kaltim Prima Coal, PT Freeport, Jamsostek

TB-HIV collaboration FHI, Spiritia, HIV/AIDS NGOs