# INDONESIA
# HEALTH SECTOR REVIEW

**August 1999**

**Report of the Technical Advisory Group**

**to**

**Australian Agency for International Development**

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## Report of the Technical Advisory Group

**Krishna Hort**
**Lucy Mize**
**Lea Shaw**
**James Blogg**
**Michael Douglas**

This report represents the views and findings of the Health Sector Technical Advisory Group and not necessarily those of AusAID

## ACKNOWLEDGMENTS

The study team gratefully acknowledges the support and contributions of all those who assisted in the health sector review. In particular, the AusAID officers of Canberra and Jakarta, Ms Latifa Bay and Mr. Harro Salim, who facilitated the travel arrangements and assisted with their translation skills, the representatives of the Government of Indonesia, at National, Provincial and District level, Agency and community representatives (including those of donors, multilateral and non-government organisations), and the many personnel currently engaged in AusAID projects.

The manner and generous nature of the assistance throughout the study tour at every level of organisation and consultation was exemplary. The study team is most appreciative of the assistance provided.

## GLOSSARY

| | |
|---|---|
| ADB | The Asian Development Bank |
| AIDS | Acquired Immune Deficiency Syndrome |
| AIMRI | Australia Indonesia Medical Research Institute |
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| AusAID | Australian Agency for International Development |
| Bappeda | Badan Perencanaan Pembangunan Daerah (Agency for Regional Development) |
| Bappenas | Badan Perencanaan Pembangunan Nasional (National Planning and Development Board) |
| BDD | Bidan di Desa (Village Midwife) |
| BKKBN | Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board) |
| BMI | Body Mass Index |
| CDC | Communicable Disease Control |
| DALY | Disability Adjusted Life Years |
| DepKes : | Departemen Kesehatan (Ministry of Health) |
| DHS | Demographic and Health Survey |
| Dinas | Provincial / District government agency |
| DOTS | Directly Observed therapy, Short course |
| EPI | Expanded Program of Immunisation |
| FP | Family Planning |
| Gebrak malaria | Malaria movement |
| GOI | Government of Indonesia |
| GSI | Gerakan Sayang Ibu (Mother Friendly Movement ) |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illness |
| IRC | The Indonesian Red Cross |
| IUD | Intrauterine Device |
| JHPIEGO and | Johns Hopkins Program for International Education For Gynaecology Obstetric. |
| JPKM maintenance | Jaminan Pemeliharaan Kesehatan Masyarakat ( Community health insurance) |
| Kanwil | Provincial office of central agency |

| | |
|---|---|
| KPA | Komisi Penananggan AIDS (National AIDS Commission) |
| KPAD Commission) | Komisi Penananggan AIDS Daerah (Provincial /District AIDS |
| MCH | Maternal and Child Health |
| Menperta | Ministry of Women's Affairs |
| NCD | Non-communicable Disease |
| NGO | Non-Governmental Organization |
| NTT | Nusa Timur Tenggara |
| NTB | Nusa Timur Barat |
| PKK | Program Kesejahteraan Keluarga (Family Welfare Programme) |
| PKBI | Perkumpulan Keluarga Berencana Indonesia (Indonesian Plan Parenthood Association) |
| POD | Pos Obat Desa (Village medicine post) |
| POLINDES: | Pos Bersalin Desa (Village Birthing Hut) |
| POSYANDU: | Pos Pelayanan Terpadu Integrated Health Post |
| PPKM Centre) | Pusat Pelayanan Kesehatan Masyarakat (Community Health Service |
| Puskesmas | Pusat Kesehatan Masyarakat (Community Health Center) |
| Pustu: | Puskesmas Pembantu Auxilary Health Center |
| Rp. | Rupiah |
| SM | Safe Motherhood |
| STD | Sexually Transmitted Disease |
| Susenas | Survey Ekonomi Sosial Nasional (National Socio Economic Survey) |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendants |
| UNAIDS | United Nations Bureaus for AIDS |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| USD | United States of America Dollar |
| WATCH | Women and their Children's health |
| WHO | World Health Organization |

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# EXECUTIVE SUMMARY

## 1. PURPOSE

The following report documents a review of the health sector in Indonesia undertaken by the Technical Advisory Group, in order to provide future directions for AusAID grant assistance. The objectives of the review were to:

- Review current Government of Indonesia (GOI) health sector policies and identify GOI priority areas for development assistance;
- Provide an assessment of how current AusAID activities contribute to priority areas
- Provide an overview and assessment of other donor activities to indicate areas of complementarity, overlap and gaps in donor assistance programs;
- Provide an assessment of the areas where Australia has the technical capacity to contribute to GOI development needs;
- Prepare Terms of Reference to allow pre-feasibility/feasibility studies to be readily commissioned and undertaken for specific priority activities identified.

## 2. METHOD

The review was undertaken by a team of five consultants. The team reviewed available documentation from Government of Indonesia, AusAID, other donor organisations, in addition to local and international literature. Health data from various national and local sources were reviewed. A set of criteria was developed to identify priority areas for assistance, based on health need, institutional context, potential effectiveness of interventions, donor involvement and Australian capacity. In-country consultations were held with the following:

- Heads of key central agencies in the health sector, including Director Generals of Community Health, Food and Drug administration and Communicable Diseases in the Ministry of Health; Deputy Planning and Analysis Bureau of the National Family Planning Coordination Board (BKKBN); Assistant 1 Minister for Women's Affairs; Secretary to Director General, Directorate of Local area development, Ministry of Home Affairs; and the Coordinating Minister for Social Welfare.
- Major donors, such as UNICEF, WHO, World Bank, ADB
- Representatives of DepKes, BKKBN and local governments in the provinces of Irian Jaya, South-East Sulawesi , South Sulawesi, NTT, NTB, Bali and West Java.
- Project team leaders and members of projects funded by AusAID, including HIV/AIDS, Healthy Mothers Healthy Babies, UNICEF Safe motherhood projects, AIMRI, Alor Community Based health project, and WATCH in Jayawijaya.

Efforts were made to consult widely and to collect and analyse information from a wide variety of sources, but opportunities were limited by the available time. The conclusions and recommendations of the review must be seen as broad general directions, requiring further confirmation and exploration in the future.

## 3. INDONESIA CONTEXT

In recent years, Indonesia has experienced, and continues to experience, major social, economic and political change. This has resulted in an increase in poverty, and considerable uncertainty for the present and future, but also new opportunities. A climate of reform has delivered responsibility for health to district level, and seen fundamental shifts in the approach to health care, now favouring an approach of prevention.

Epidemiological shifts have been witnessed, with rising contribution from non-communicable diseases and injury to morbidity and mortality. Maternal mortality, however, remains persistently high, and new or resurgent communicable diseases (eg HIV, Tuberculosis) pose a real threat to the gains in health status of recent years. Similarly, nutrition, and poor access to safe water are major concerns.

## 4. PRIORITY HEALTH ISSUES FOR ASSISTANCE

Based on consultation, and criteria of health need, institutional needs, donor context and Australian capacity, the review has identified the following priority health areas for assistance:

| Rank | Priority Area | Justification |
|---|---|---|
| 1 | HIV/AIDS | Although current prevalence is low, it is increasing and brings the potential for a future epidemic. Donor support is necessary to develop & maintain activities and program, and has the potential to build on the current project. |
| 2 | Tuberculosis | A major preventable cause of mortality and morbidity, there is a need for greater community participation in the TB program, and expansion of the effective DOTS strategy as part of an integrated approach to TB. |
| 3 | Child health & nutrition | Recent evidence of some worsening in child health & nutrition on top of pre-existing relatively high child mortality levels. Existing effective interventions need to be strengthened and better integrated. |
| 4 | Environmental health | Access to clean water and use of latrines still low, with impact on diarrhoeal illness and child / maternal health.<br><br>Program needs to be better integrated with MCH, and further promotion of the sanitarian as a community facilitator. |
| 5 | Youth health | Increasingly large proportion of the population, youth have also been adversely impacted by the economic crisis, with increases in school drop-out rates, unemployment, and associated social and health problems. Reproductive health services for youth a priority, but there is currently limited donor support for this area. |
| 6 | Non -communicable disease | Policies and strategies to address these problems are only in the early stages of development. Opportunity for relatively small investment in policy development to assist future needs. |
| 7 | Malaria | Malarial transmission and incidence increasing. Interventions (bed nets, case management) could be strengthened by |

## 5. PRIORITY ASSISTANCE ACTIVITIES

These priority areas require support at different levels (national, provincial or district) and in different ways, depending on needs and the current stage of development of the program. The following activities are recommended:

- Implement a second HIV-AIDS project based on a new design focusing on high risk groups and locations. Prompt action on preparing the design is needed to maintain continuity with the current program.
- Expand assistance to the national TB program, based on a needs assessment, following a review of the current national situation and an evaluation of the current AusAID-WHO TB project in December 1999.
- Implement a program to support and develop district level planning capability, in areas such as community needs assessment, data analysis, strategy development and planning in selected districts of priority provinces. Priority provinces are identified on the basis of national health, social and economic data, as the eastern provinces of Indonesia (East Timor, NTT, NTB, Irian Jaya, Maluku). This activity would identify and develop additional activities to provide appropriate integrated support in priority areas such as child health and nutrition, reproductive health, environmental health and youth which would then be funded according to priorities and resources available, as well as strengthen community participation in planning and implementation.
- Provide technical assistance in policy development in priority areas at the national office of the Ministry of Health, to support and develop the capacity of central level managers to collect and analyse data, and develop policy and strategy. Potential priority areas include non-communicable disease (especially tobacco and injury, areas in which Australia has some expertise), rational drug use, and nutritional strategies.

## 6. GEOGRAPHICAL FOCUS

Future project activity will continue to focus predominantly in the eastern provinces, with other provinces considered on a case by case basis according to specific project need. Justification for this focus is found in current health and social indicators, existing project activity, and in other donor activity.

## 7. PROGRESSION OF RECOMMENDATIONS

Following consultation with the Government of Indonesia, the recommendations for future activities will be progressed by:

- a design mission for the HIV-AIDS project
- review of the WHO-TB project and a needs assessment in December 1999
- pre-feasibility missions for the district health planning project and the national level technical assistance.

This is summarised in the following table:

| Priority Health Need | Suggested Activities | Next Steps |
|---|---|---|
| HIV/AIDS/STDs | Advocacy and support at National level<br>Target high risk groups e.g. sex workers, injecting drug users in key locations<br>Integrate HIV/STD awareness into existing and proposed projects | Design Study |
| Tuberculosis | Expand TB activities to support identified need, and high prevalence provinces | Review of AusAID-WHO TB project to be undertaken in December 1999 by Health TAG |
| National Policy Development | Technical Assistance with Health Promotion policy and program development at National level e.g. anti-smoking project, prevention of unintended injury/ accidents, rational drug use | Pre-feasibility Study |
| District Level Health Planning & Development | Support district and community levels to assess health needs, plan and manage interventions; integration of health interventions to improve health outcomes;<br>Community participation in health planning and health promotion; | Pre-feasibility Study |

# 1. INTRODUCTION

## 1.1 BACKGROUND

The Australian Government has a strong commitment to development assistance to Indonesia. The Indonesian program is estimated to be $127 million in 1998-99 and is second in size only to the PNG program. The health sector is regarded as one of the priorities, and currently makes up 23% of the program. The program has reached a point where decisions are needed on extending or revising current projects, while the economic, political and health situation in Indonesia has recently undergone major changes. It was considered opportune to review the health sector in Indonesia, with a view to identifying Indonesia's needs over the medium term, and better focusing Australia's assistance.

### 1.1.1 AusAID health sector policy and strategy

The objective of the Australian development assistance program is "to advance Australia's national

interest by assisting developing countries to reduce poverty and achieve sustainable development". Health is one of the priority sectors identified in the program, together with education, agriculture and rural development, infrastructure and governance. The main objectives of health aid are to:

- Improve the basic health of those most in need. Primary health care, disease prevention and health promotion are priorities.
- Improve the quality of health service delivery...strengthen capacity to deliver effective, sustainable health services
- Address the health effects of natural disasters and emergencies.

### 1.1.2 Context of the Health Sector review: AusAID assistance to Indonesia

A review of the Indonesian Development Cooperation Strategy was undertaken in October 1998 in the light of the economic and social crises experienced by Indonesia since late 1997. The review recommends that the objective of the Australian aid program to Indonesia over the period until December 1999 should be to contribute to economic and social stability by assisting Indonesia to:

a) alleviate the social impacts of the economic crisis on the most vulnerable groups in society,

b) return to sustainable growth and development.

As a part of the short assistance, program activities are to focus on:

- support for social safety net initiative
- strengthening of civil and economic governance
- protecting and building the platform for the resumption of sustainable growth and development, including health, education, rural development and environment.

Australian aid in Indonesia has a geographic focus on West Nusa Tenggara, East Nusa Tenggara and East Timor, with secondary foci on other eastern Provinces (eg Irian Jaya). It seeks integration of activities between projects and sectors, so that activities complement and reinforce one another, thus magnifying the aggregate benefits.

Water supply is seen a major constraint to development in the eastern provinces. Thus, the water and sanitation sub-sector is proposed as the lead sub-sector or entry point for the program around which complementary interventions in health, environment, education and rural development can be designed.

Currently there are eight projects in the health sector in Indonesia:

- HIV/AIDS and STD Prevention and Care Project
- AusAID - UNICEF Safer Motherhood Project
- Healthy Babies, Healthy Mothers Project
- Women's Health and Family Welfare Project (about to start)
- AusAID-WHO Tuberculosis Control Project
- Jayawijaya WATCH Project
- Indonesia Australia Medical Research Project
- Alor Community Health Project

This review of the health sector has built upon these short term principles, in the context of the

Government of Australia's umbrella aid program. This report provides an overview of the National issues that are of significance to the health sector. A brief profile of health indicators is provided, and priority provinces identified. Through identification of priority health issues, a determination of need is presented. Donor activity is examined. The potential projects for which AusAID may offer assistance are outlined, and the next steps in fulfilling these projects/programs are given.

## 1.2 METHODOLOGY

The health sector review was undertaken during June/July 1999 by the Health Sector Technical Advisory Group.

### 1.2.1 Objectives

The aim of the review is to provide clear advice for Australian development assistance in the of health in Indonesia over the medium term (5 to 10 years). Specific objectives are to:

- Review current Government of Indonesia (GOI) health sector policies and identify GOI priority areas for development assistance;
- Provide an assessment of how current AusAID activities contribute to priority areas
- Provide an overview and assessment of other donor activities to indicate areas of complementarily, overlap and gaps in donor assistance programs;
- Provide an assessment of the areas where Australia has the technical capacity to contribute to GOI development needs;
- Prepare Terms of Reference to allow pre-feasibility/feasibility studies to be readily commissioned and undertaken for specific priority activities identified.

### 1.2.2 Strategic framework

Following the desk briefing, a framework was developed which provided scope for

- assessment of GOI policy, need and institutional capacity
- Current AusAID activities at national provincial and district level.
- Multilateral and bilateral Donor and NGO activity
- Opportunities for Australian assistance

Key reports and documents were examined. These included the past health sector reviews, outline of other donor activity, current health sector project documentation, current AusAID policies and other relevant literature.

### 1.2.3 In-country activities

A briefing was provided on arrival by AusAID; support and opportunity was provided to develop concepts throughout the in-country visit. A departure meeting with AusAID affirmed the approaches proposed within the aide memoir (attached). Central and provincial visits encompassed:

- Central agencies (including Community Health, Food and Drug administration and Communicable Diseases in the MoH, Deputy Planning and Analysis Bureau of the National

Family Planning Coordination Board [BKKBN], Ministry for Women's Affairs; Directorate of Local Area Development, Ministry of Home Affairs; and the Coordinating Ministry for Social Welfare).

- Major donors, multilateral organisations and NGOs
- Project team leaders and members of projects funded by AusAID, including HIV/AIDS, Healthy Mothers Healthy Babies, UNICEF Safe motherhood projects, AIMRI, Alor Community Based health project, and WATCH in Jayawijaya.
- In the provinces of Irian Jaya, South-East Sulawesi , South Sulawesi, NTT, NTB, Bali and West Java, meetings were conducted with key GOI, NGO and other personnel to determine need, identify other donor activity in the respective provinces, and seek potential opportunities for future assistance. Inquiry pursued was consistent with the framework described above.

In addition, the team reviewed the latest available data on the health situation, as well as data from various local surveys and studies. A set of criteria was developed to identify priority areas for assistance, based on health need, institutional context, and potential effectiveness of interventions, donor involvement and Australian capacity.

Discussions throughout confirmed the impact of the economic crisis of the past two years, the rapidity of political change, and the uncertainty created by that change and the impending changes brought on by policy shift (eg decentralisation, Health Paradigm. There is enthusiasm for Australia's continued involvement in the health sector, and an expectation that Australia will continue to work in the eastern provinces, as well as an acknowledgment of the opportunities provided by the current changes.

#### 1.2.4 Limitations

While the review team were able to visit a number of provinces, and consult with many provincial and national managers, there are inevitable limitations on the information which can be gained during a four week visit. In particular, the review team had only very limited opportunity to consult with government officials and managers at district level or below, or with community leaders at village level. It was thus necessary to rely on potentially unreliable data collections and service reports to a considerable extent, supplemented with the results of surveys and research where possible. The conclusions reached by the team must be regarded as broad directions, which will require further exploration and confirmation both by the team in subsequent visits, and by pre-feasibility and design missions.

# 2. THE NATIONAL CONTEXT

## 2.1 POLICY AND DIRECTIONS

### 2.1.1 National Planning

The Sixth five-year development plan (Repelita VI) which encompasses the period 1993 - 1998 remains current. The plan was extended with medium to long term national planning on hold since the onset of the economic crisis in August 1997. While some sectors have commenced developing plans for Repelita VII, it remains uncertain at this time how further planning will be

managed.

In the most, the targets set within Repelita VI have been difficult to achieve. Reductions in maternal mortality rate (to 225/100,000 live births), infant mortality rate (to 50/1,000 live births) and Low Birth Weight (to 10% of all births) have failed to meet their targets. Reduction in general fertility rate has been more successful, with a current achievable target of replacement level (2.2 - 2.3) by the year 2000.

### 2.1.2 Economic Crisis

The Indonesian economy has been in deep crisis since August 1997. Macroeconomic indicators, including budget deficit, annual inflation rate and the value of the currency (Rupiah) were at their worst in early 1998, with gradual improvement since September 1998. Inflation is currently estimated to be between 8 and 10%, and the Rupiah exchange rate stabilised at around Rp 7,000 to 1 USD.

In the social and health sectors, the crisis has had significant effects. Poverty has been exacerbated. While inflation has increased, real earnings of the poor have decreased sharply; those living in poverty were estimated to have increased from 11.3% of population in 1996 to 24% (49.5 million people) by the end of 1998. Underemployment and unemployment have increased since the crisis. By March 1999, 15% of the workforce were without any employment.

There has been an increase in malnutrition, most notably among the women and children, particularly in peri-urban areas. The deficiencies have been primarily in micronutrients (Iron, Vitamin A). Some improvement is noted since January 1999. There has been no increase in communicable diseases reported. There has been a report of increased overall attendance at Puskesmas and hospitals, although the association is not clarified. A comprehensive 'crisis' report will be released by DepKes in July 1999.

The broad response by the Government has been to sustain food production, maintain enrolment levels in education and provide accessible health services. Specific action has included re-vitalisation of the Food and Nutrition Surveillance system, distribution of infant weaning food through Posyandu (UNICEF), and the establishment of a 'social safety net' (World bank and ADB loans). The latter provides free basic health services at puskesmas (to holders of cards); payment for midwives for maternity services, payment of premiums for basic health insurance, and food supplementation for mothers and babies.

DepKes has taken action to protect the health of the poor and vulnerable through maintaining access to essential curative, reproductive health and family planning services. It has revitalised the immunisation and communicable disease programs, and nutrition programs (surveillance, supplementation, community nutrition programs, and programs for pregnant and nursing mothers).

### 2.1.3 Reformation

Consistent with broader Government reform, the Ministry of Health has adopted the following approaches to reform:

- Health sector financing, including health insurance (JPKM)
- Decentralisation
- Drug reform (including rational drug use)
- Health manpower reform
- Health services reform (including hospitals and health centres)

- Good governance

Reformation has led to a new inclination to review policy and consider changes. Collaboration with non-government organisations and private sector is being encouraged.

### 2.1.4 Decentralisation

The Decentralisation Law (22/1999) was passed through parliament in June 1999, with regulations to be prepared by May 2000 and effective by May 2001. Under this law provinces, municipalities and districts are all at the same administrative level (adjusting previous lines of authority). Central government will set policy and retain authority in areas of national interest (eg religions, foreign affairs, defence, judicial and finance). National assets and resources (eg mining) revenue will be collected centrally and distributed within agreed principles. Local governments at district and city level will have the authority to manage the majority of government programs, including health, education and welfare, in their areas, and be able to set their own policies in line with national policy. They will be able to manage locally collected revenue and enter agreements directly with foreign donors for loan or grant funds.

Health administration will be affected insomuch as District level managers will be independently responsible for the district, without need for provincial networking. At provincial level, Kanwil offices will be abolished and integrated into local government structure. The Provincial support role for districts will be maintained until the districts are capable of managing their services effectively.

### 2.1.5 Healthy Indonesia 2010

In April 1999, the Minister for Health announced the policy “Healthy Indonesia 2010”. The new paradigm emphasises preventative and promotive health programs, rather than curative and rehabilitative, with a vision of health as the foundation of national development. The strategies encompasses the issues of health promotion, professionalism, community managed health care and decentralisation.

There are ten programs identified as priorities:

- Immunisation
- Safety and occupational health
- Motor vehicle trauma prevention
- Communicable diseases prevention
- Healthy lifestyle (including food and nutrition)
- Environmental program (physical, mental, social)
- Healthy settlements
- Reproductive health (including family planning and population program)
- Anti tobacco, drugs and alcohol
- Management financial health policy and health regulations

## 2.2 NATIONAL LEVEL AGENCY ASSESSMENT AND NEEDS

Health services in Indonesia are provided by a mix of Government financed, and privately financed modern services, and traditional healers. The Government contribution is relatively small, about 30% of the total costs, or about 1.9% of total government expenditure, compared to 6.8% in Malaysia and 3.3% in the Philippines.

While this review focuses on government services, the role of private services, and of private contributions for government services is very important. The Indonesian Department of Health has recognised the need to support and develop linkages with private services, especially with the JPKM (managed care health insurance) program. Assistance in the health sector needs to consider the total range of services provided, including the private sector, when planning interventions.

### 2.2.1 Department of Health (DepKes)

The Ministry of Health has traditionally had a large central bureaucracy, with programs organised vertically, and poor coordination or integration between programs. The vertical program structure is duplicated at provincial and district levels, and is really only integrated at the subdistrict (Puskesmas or health centre) level and below.

The new minister, and new appointments to top positions, have brought a new vision and approach to DepKes, but face considerable challenges in implementing these new ideas, as well as dealing with decentralisation and the demands of reformation. Efforts have been made to improve coordination, but administrative constraints have resulted in the creation of new structures, such as coordinating "Geraken" or national movements, and multi-disciplinary taskforces, rather than changes to the existing structures.

Currently there is also considerable uncertainty at national level, with the possibility of the disbanding and/or amalgamation of ministries, transfer of many central staff to provincial and district level, and further changes with a new government.

The economic crisis has also impacted on DepKes services in varying ways, including:

- Reduction in operating funds, reducing the ability to conduct supervisory visits, attend training or staff development, and maintain or repair equipment and facilities.
- Further deterioration of the salary positions of government employees compared to the cost of living, with pressure to supplement income with private practice or other activities
- Additional funds for the Puskesmas and Bidan di Desa from the social safety net payments for services provided free to poor people
- Shortages of some medicines and disposable equipment
- Reduced number and availability of volunteers, and increased drop out of volunteers, resulting in difficulty in maintaining posyandu.

Discussions with DepKes central managers identified that the priority was still in the traditional areas of maternal - child health and nutrition, and communicable disease, particularly as the impact of the current economic crisis continues. At national level, assistance in the development of national nutrition policy, and a comprehensive review of the functions and role of the Puskesmas, were suggested as priorities.

### 2.2.2 National Family Planning Coordination Board (BKKBN)

BKKBN has also experienced major change, with the appointment of a new minister, and a change in staff in upper positions. Discussions with the Deputy in charge of the Division of Planning and

Analysis, indicated a change in BKKBN focus back to more traditional family planning concerns, and an effort to encourage more initiative at provincial and district levels, rather than the traditional hierarchical management.

Priorities for assistance identified included:

- Emergency supply of contraceptives, especially for oral contraceptive pills and injections over the period July to September, when a World Bank loan would become available.

- Support for the review and development of family planning and family welfare information systems at kabupaten and provincial level (They have received support from the Exim bank in the USA for information systems at kecamatan level).

- Support for training (IUD insertion, sterilisation, inter-personal communication) and some equipment (IUD kit, motorcycles) for the family planning program.

#### 2.2.3 Ministry of Women's Affairs (Menperta)

The Ministry of Women's Affairs have been supporting efforts to reduce maternal mortality by coordinating the Gerakan Sayang Ibu (Mother friendly movement). Recently Menperta expanded this approach with activities which target husbands and men as the main decision makers, in a program called Suami Siaga (Siap, Antar Jaga) or Husbands on watch. This has been trialed in three provinces (Sulsel, Hatim, Sumut), and will be evaluated shortly for possible expansion to other provinces.

Areas of potential assistance identified

- Programs to reduce maternal mortality, especially targeting youth / adolescents

- Expansion of Suami Siaga program (following evaluation)

## 2.3 IMPLICATIONS FOR AUSTRALIAN ASSISTANCE

The Health sector in Indonesia is in the midst of a transformation, both in terms of vision and strategies, and in organisation and management. Managers of health services face considerable challenges in developing new approaches and responding to social and economic change, as well as organisational change. There will be a period of uncertainty and flux while these changes are progressed.

While assistance needs to focus on the province and particularly district level in view of the decentralisation of authority to these levels, there remain considerable needs and opportunities for technical assistance in policy and strategy development at national level.

# 3. PROVINCIAL LEVEL

## 3.1 PROVINCIAL FEATURES

The Provinces of Nusa Tenggara Timur (NTT), Nusa Tenggara Barat (NTB), West Java, Bali, Irian Jaya, South Sulawesi and South-east Sulawesi were visited in the course of the review. National and provincial epidemiological and demographic data were considered in the course of these reviews. While some common features were noted, there was a diversity of health issues and social characteristics. More detailed reports are available in Appendix 5.

### 3.1.1 West Java

Despite a large population (42 million) and proximity to industrial centres in Jakarta and Bandung, socio-economic indicators in West Java are poor, with a high proportion of households in poverty, and low levels of education. Traditional cultural preferences remain strong, resulting in early marriage, and reluctance to use modern health services.

Relatively poor health indicators, with high infant and maternal mortality rates. Government health facilities relatively well developed, but generally under-utilised. Poor access to clean water and sanitation.

Provincial priorities included:

Need to improve health program performance through development of benchmarking procedures, and developing services which were more sensitive and responsive to community needs and attitudes.
Integrated program to improve nutritional status of under 5 children
Expansion of a comprehensive water and sanitation based environmental health program.

### 3.1.2 Nusa Tenggara Timur (NTT)

The population is scattered over 400 islands, often in small remote communities, on land with poor agricultural potential and little water supply. Considerable cultural differences between different communities. One of the poorest provinces in Indonesia.

Health indicators are poor, with high infant and maternal mortality. Access to health services poor due to problems of geography and transport. Difficulty attracting and supervising staff in remote facilities.

Provincial priorities identified were:

Improving the access to and quality of services provided by district hospitals and Puskesmas
Improve control of communicable disease, through surveillance, and immunisation
Improve the quality and coverage of maternal and child health services
Community health education
Development of health service personnel capabilities.

### 3.1.3 Nusa Tenggara Barat (NTB)

The province consists of two islands, with a more densely populated and generally conservative population on Lombok, and a more scattered, better educated and more open society on Sumbawa. Overall socio-economic status is poor, with high levels of poverty and low levels of education.

Health indicators are poor, with the highest infant mortality in Indonesia, and relatively high maternal mortality. Services are reasonably well developed, but access is limited by geography, and community preference for traditional approaches.

Priorities identified by the province were:

Community health education supporting the Gema Prima approach of the provincial government
Improving health service personnel capabilities
Support for maintenance and construction of rural health facilities
Improving quality assurance in the MCH program
Developing and expanding the Integrated Management of the Sick Child approach

### 3.1.4 Irian Jaya

Low population and large land area, but limited land suitable for housing and agriculture. Large

recipient of transmigrants from Java and Bali. Despite considerable wealth in natural resources, much of population tribal and low socio-economic status.

Health indicators poor, with high infant mortality, and very high maternal mortality. Communicable diseases, malaria, diarrhoea and respiratory infection major causes of mortality. Potential risk for spread of HIV from visits of foreign fishermen. Health services rudimentary, major problems of access due to geography, and difficulty attracting suitable staff.

Priorities identified by the Province were:

Improvements in access to health services, and expansion of UNICEF Safe Motherhood districts
Environmental health, especially water supply and sanitation
Development of health service personnel capabilities
Reproductive health, including reproductive health information for youth, and STD services
Intersectoral activities and community empowerment
Surveillance and response to communicable disease

### 3.1.5 South Sulawesi

Socio-economic indicators are relatively better in this province, but high rates of child malnutrition in peri-urban areas have become evident since the economic crisis.

Broad health indicators are similar to the national profile. Communicable diseases of most concern are diarrhoeal illness, ARI, tuberculosis, malaria and Dengue Fever. There are reports of an increasing problem with injecting drug use

Priorities identified by the province

### 3.1.6 South-East Sulawesi ( Sulawesi Tenggara)

South-east Sulawesi has a considerably higher population than South Sulawesi, but similar socio-economic indicators. There have been recent problems with evacuees from neighbouring Maluku.

Infant mortality is relatively high, with communicable disease (malaria, TB, leprosy, rabies and Filariasis) and nutrition (iodine and Vitamin A deficiencies) of most concern.

Priorities identified by the province include:

Control of communicable disease, especially through improved surveillance, and development of STD services
Maternal and child health, with expansion of the Healthy Mothers Healthy Babies activities to more districts
Nutrition, particularly iodine and vitamin A deficiency, through revitalisation of the posyandu.
Improvement of the referral system through development of district and provincial hospitals.
Improvements in access to safe water and sanitation.

### 3.1.7 Bali

Socio-economic indicators in Bali are among the highest in Indonesia, with a high proportion of urbanisation and well educated population.

Fertility, mortality and life expectancy are better than the national average and the health worker/ population ratio is relatively high, but there is a high prevalence of sexually transmitted diseases and increasing use of injected drugs.

Priorities identified by the province

Upgrading of Denpasar hospital to international standards
Improving the referral system and facilities at district hospitals to reduce maternal mortality
Improved control of communicable diseases, particularly those with potential to affect the tourist

industry, such as food borne illness.
Health education directed towards non-communicable diseases.

## 3.2 GEOGRAPHICAL FOCUS

### 3.2.1 Diversity

The series of provincial outlines, while necessarily brief, indicates the range of socio-economic and health conditions across Indonesia, and the differing priorities for assistance. While there are some commonalities in the health conditions faced, such as communicable disease, nutrition, and maternal death, the differences in socio-economic and cultural conditions in the community, and the capabilities and facilities of the health services, require different approaches and strategies in different areas.

While the review team did not have the opportunity to explore in detail differences between districts within provinces, this is also clearly quite marked, and it is likely that there would be different priorities, and different needs among different districts. Decentralisation of authority to the district level will increase the need to respond to district level priorities.

Australia's assistance program will need to be able to respond to this diversity, and this will present challenges to the current need for detailed designs before implementation. If a project is to be implemented across several districts, this will result in a considerable burden for design teams.

### 3.2.2. Priority provinces.

Australia's aid program in Indonesia has focussed predominantly on the eastern provinces. The focus of future assistance will be contingent upon a number of factors. These include health and social need, the development of working relationships at provincial and district level, proximity to Australia, ability of the province to accommodate assistance (eg political stability, social unrest), the activity of other donors, amongst others.

A very simple ranking by several social and health indicators endorses the emphasis on the eastern provinces. This is shown in appendix 4. The provinces of most need, according to this scoring system, are the provinces of West Nusa Tenggara, East Nusa Tenggara, West Kalimantan and Irian Jaya. The next priority provinces are Java (West, east and Central), South Sumatra, East Timor, South-east Sulawesi and Riau.

Bearing in mind the advantages of building on existing contacts and familiarity with AusAID projects in current provinces, the review team recommends that the focus on eastern provinces for health sector assistance be maintained.

# 4. PROJECT CONTRIBUTIONS

The TAG visited project sites and consulted with project staff to discuss the effectiveness of interventions, to assess issues of sustainability and feasibility and to identify risks to successful project intervention. Detailed review of projects was not undertaken.

The Projects visited included:

- Women's Health and Family Planning - Provinces of Phase 1 (NTB, NTT)
- UNICEF Safe Motherhood Initiative (West Java)

- Healthy Mothers Healthy Babies Project (South-east Sulawesi)
- HIV/AIDS and STD Care and Prevention Project (Bali, NTT, South Sulawesi)
- Alor Community Based Health Project (NTT)
- Jayawijaya WATCH Project (Irian Jaya)
- Indonesia Australia Medical Research Project

A brief assessment was made of the contribution of projects to the GOI program at national, provincial, district and community levels, for those projects which have been implemented over a sufficient length of time for some assessment to be made. It must be stressed that these assessments are preliminary, and do not constitute a full review of the projects.

**4.1 Women's Health and Family Planning Project** has been completed and Phase II is about to begin. Feedback from Provincial and District health staff on the contribution of the project was mainly positive:

National level: little impact, focus was more on implementation of national programs at provincial level.
Trial of kangaroo method of care for LBW adopted by Perinasia

Provincial level: Improved capacity of MCH managers in DepKes, with some project initiatives being progressed, such as Quality Assurance (in NTB), on-the-job Training at the Puskesmas and bidan-dukun collaboration (in NTT). BKKBN managers more aware and supportive of inter-personal communication and counselling as part of provision of family planning services.

District level: Some activities progressed in one district of NTT (TTU), although not in the other (Belu). Improved capability and coverage of maternity services in district hospitals and Puskesmas of project districts.

Community level: Reports indicate greater use of ANC and trained attendant for delivery in NTB. UPPKS groups in NTB used as model for training of other groups, and continue to function well. Problems with referral system continue to impede prompt care of high risk mothers.

Issues: Activities for implementation in Phase 2 project (Women's health and family welfare) have been included in DIP for 1999/2000. Phase 2 activities need to commence promptly in order to use these counterpart funds.

**4.2 UNICEF Safe Motherhood Initiative** has been revised following mid-term review. Comments are based on activities in West Java, where implementation has been proceeding for 18 months.

National level: Good links with central office, with a trial of a new Safe Motherhood management approach developed by the central office in project areas. UNICEF have adopted the logframe approach used by AusAID for planning of other projects.

Provincial level: Advocacy to provincial government resulted in supporting funds for BDD. Safe motherhood team of key resource persons formed at provincial level.

District level. Development of planning skills of Bappeda and district office staff through use of KHPPIA framework and Safe Motherhood management approach.

Community level. Not visited

Issues: Difficulties reconciling UNICEF and AusAID planning and reporting requirements, particularly when activities were changed following UNICEF mid-term review.

Some concern about the capacity of Bappeda and managers at district level to use the KHPPIA framework even in its current simplified form. The addition of a log-frame approach may make this more difficult.

**4.3 HIV/AIDS and STD Care and Prevention Project** focuses on institutional strengthening at the national, provincial and district levels, and development/support of NGOs at community level, and is near completion.

National level: The project has provided significant assistance to the national AIDS commission (KPA) in developing its organisation and management capacities. The project is closely involved in planning and developing strategies for HIV/AIDS in the next 5 year plan.

Provincial level: The project has also contributed significantly to the development and function of the provincial AIDS commission (KPAD) in the provinces of work. Only provinces aided by the project have functioning KPAD. Project assistance has developed a commitment to HIV/AIDS among provincial managers, and the planning and implementation of provincial IEC strategies. Project activities with NGO's have developed linkages between provincial managers and NGO's and improved relationships between government agencies and NGO's.

District level: Not assessed

NGO's: Project assistance has contributed significantly to the development and function of NGO's at provincial level, and the provision of services by NGOs to high risk groups.

Issues: The effectiveness of the community IEC approach needs to be evaluated.

**4.4 Healthy Mothers Healthy Babies**

Despite considerable difficulties at start-up the project has commenced activities in 3 provinces.

National level: The project is trialing the use of the Integrated Management of Sick Children program for Bidan di desa, in conjunction with national level.

Provincial level. The project has developed considerable provincial level support.

Issues:

Uncertainty about the future of the Bidan di Desa, a key figure in the project's strategies
Training competency standards specified in the design which are not appropriate to Indonesia.

**4.5 Alor Community Based Health Project** appears to have achieved some success in preventing malaria, providing water supplies and supporting the village level health services (posyandu, POD, kaders, TBAs and BDDs), but has had difficulty gaining district management commitment and support.

National level. Results with the use of impregnated bed nets has been presented at national level and are being used by national program managers. National managers are closely involved, and assist the project in some technical aspects such as malaria surveys.

District level. There has been only limited support from the district DepKes manager , and some concerns expressed by DepKes about the strategies used by the project. Subdistrict (Puskesmas) staff and doctors appear to be more supportive. However, its difficult to assess the contribution of the project to the DepKes program.

Community level. The project has focussed on this level, and achieved considerable community ownership and participation in a range of activities, including water and sanitation, mosquito control, and use of medicines.

**4.6 Jayawijaya WATCH Project**

National level. The project created a model for community development, necessary to bridge the large gap between DepKes services and the primary health needs in the isolated highland

communities.

District level. The model has been further developed in other parts of Jayawijaya by other NGOs since the 1996 drought. The project has had a coordinating role for the limited number of NGOs working in the Jayawijaya district.

Issues: The project has identified the need for improved disease surveillance in Jayawijaya.

### 4.7 Australian Indonesia Medical Research Project

The project has had considerable success in contributing to the national program in the following ways:

Development of national research capabilities, through seconded staff and postgraduate students from other Indonesian institutions (currently 13 Indonesian and 3 international postgraduate scholars)
Development of a national network of collaborating scientists, through links with other Universities and higher education institutions in Indonesia.
Provision of advice and administration of a national research grants program with funds from Bappenas, and from DepKes.
Developing standards for research support, by requiring international standards of reliability and quality from local suppliers.

This brief review of projects currently supported by AusAID illustrates the diversity of contribution at national, provincial , district and community level. In many cases the full extent of the contribution has not been identified, and in some cases, not even recognised in the project design and reporting.

Implications for Australian assistance are:

More attention needs to be given in project design and reporting to identifying the contribution projects can and do make to GOI programs at each level.

The contribution of larger bilateral projects has been largely on provincial and district level institutional and program development, with relatively little impact on national or community level. The smaller community level projects have been more successful with community level impact, but have had more difficulty gaining institutional support, or contributing to government program development.

Projects which have focused at national level appear to have been able to make a significant contribution at that level.

# 5. PRIORITY HEALTH ISSUES

## 5.1 CRITERIA FOR IDENTIFYING PRIORITY HEALTH AREAS

Priority health areas were identified by examination of:

1. Health need
2. Institutional needs
3. Donor context
4. Australian capacity

### 5.1.1 Health need

There are a number of parameters to be considered in assessing health need. These include mortality (death), morbidity (illness), fertility amongst others. The capacity to assess these is severely curtailed by the type and quality of data available in Indonesia at present. In the absence of comprehensive births and deaths registers, and health services which remain out of reach of many population groups, compounded by a heath information system which does not field data from all facilities or providers, alternative measures have been undertaken. The most routine of these is the National Household Health Survey (Susenas), which makes specific inquiry of morbidity and mortality from households.

Communicable diseases remain the primary cause of preventable death in Indonesia. There has, however, been a progressive increase (from 24% of all deaths in 1986 to 45% in 1995) in the proportion of deaths due to non-communicable diseases (cardiovascular disease, respiratory disease, cancer) and injuries. Deaths from communicable diseases, maternal, peri-natal and nutritional causes have fallen to 44%. In 1995 the top five causes of death were cardiovascular disease (19%), respiratory disease (16%), tuberculosis (10%), other infections (8%) and diarrhoeal illness (7.5%).

When the burden of illness was estimated by calculation of Disability Adjusted Life Years (DALYs) lost, communicable, maternal and perinatal conditions were responsible for 45.6% of total burden, non-communicable disease for 42.3% and injuries 12.1%.

The recent economic crisis has probably not changed this situation very much. DepKes reports of child nutrition have demonstrated small increases in the proportion of under-weight children. More accurate surveillance by the Helen Keller Institute has demonstrated some impact of the crisis on the nutrition of women (an increase in the proportion with Body Mass Index below 18.5 from around 14% up to 20% in some urban areas). In children under 5 the proportion with wasting was found to have increased from 6% to 10-12% also in some urban areas. However, the main impact has been on micronutrient intake, with rises in the proportion of children and women with anaemia (up to 70% of children and 22% of women). Reported communicable disease (to Puskesmas) has not increased. (See appendix 3)

### 5.1.2 Institutional needs

Assessment of the institutional needs related to the potential priority areas involved consideration of the following factors:

1. GOI priority at some level (national, provincial or district)

While in some cases a health issue may be seen as a national priority, rather than a provincial or district priority (eg HIV/AIDS), endorsement as a priority by the GOI at some level is necessary for a health issue to be considered a priority for assistance.

2 Need for development or piloting of effective interventions

For many of the traditional vertical programs, effective interventions have already been developed. This situation applies in maternal child health, where the problem is applying and implementing what is already known to be effective. In some areas, notably in non-communicable diseases, and in HIV-AIDS, interventions still need to be developed for the Indonesian context.

3 Need for development of national policy / program guidelines / political support

In some areas, appropriate national policy and programs have been developed, as in the area of safe motherhood, and communicable disease (TB). In other areas, policy and strategy need to be revised (eg HIV-AIDS) or developed (non communicable diseases, youth ).

4 Need for development of training program / materials or IEC materials

In most areas, national training programs and materials have been developed, but these need to be adapted to local needs and capacities.

5 Need for development of management / supervision / training skills at provincial or district level

In most areas, this is one of the key needs, particularly at district level. Program management skills need to be comprehensive and not just focused on one program. The hierarchical management structure of GOI agencies has not encouraged the development of comprehensive planning or management capacity, but this will be needed with the advent of decentralisation.

6 Need for development of program skills in program staff

Most support and program development has focused on this area, with the conduct of inservice training programs. There is a need for better integration of training programs, and improved in the quality of training to ensure that program staff do develop the skills required, at the appropriate standard.

7 Need for development of community awareness / skills / participation

Most programs seem to have difficulties in communicating with the community, and developing awareness and support from the community. This is often expressed as a need for health education, without an appreciation of the community's perspective on the health issue. Community participation in health is often defined as contributions to the cost of services, and real participation, where communities are assisted to understand the causes of local health problems and are involved in decisions on what interventions should be applied, is largely untried.

8 Need for development of intersectoral support

Many program managers recognise the need for intersectoral support, but have few strategies to develop support or collaboration. It is often seen as a role for the local government planning coordination unit, Bappeda, but involvement of Bappeda in every coordination effort quickly overwhelms their capacity. Program managers need to be pro-active in developing and supporting intersectoral collaboration.

### 5.1.3 Donor context

Donor assistance provides a substantial proportion of the health budget, which has risen with the economic crisis from 17% in 1997/98 to 27% in 1998/99. Donor assistance consists of large multilateral loans (World Bank, ADB), bilateral programs, and many smaller international NGO activities. However, the coordination and linkage among donors, and between donors and the national health program remains weak. A table of donor activity in priority areas is included as appendix 7.

Other weaknesses in the current donor program are:

Tend to promote a vertical, hierarchical structure and management

Develop capacity to implement agreed programs, rather than capacity to assess, analyse, prioritize and plan new activities or strategies in managers.

Tend to consist of the development of a number of "pilots" in different sites, with little adoption at national level or replication

Has not been successful in changing the managerial "culture" of DepKes

Has not been successful in developing intersectoral coordination

Has had difficulty in dissemination and replication of lessons learnt, or innovations piloted

Has failed to develop meaningful community participation in health

### 5.1.4 Australian Capacity

The number of persons with expertise or experience in each of the priority areas in Australia was considered, particularly in reference to previous development assistance provided by Australia in Indonesia or in other developing countries.

Availability of this expertise is more difficult to estimate, but where several projects are currently being implemented in a given area (eg maternal health) it was considered that this would limit availability.

In most areas it was felt that Australia had persons with the required expertise and experience, although few with Indonesian experience. It may be necessary to consider greater involvement of Indonesian nationals working beside Australian advisers to overcome the difficulties of lack of Indonesian experience.

Comments on capacity for specific priority areas are included in the discussion of each area.

## 5.2 PRIORITY HEALTH AREAS IDENTIFIED

[A more detailed discussion is contained in Appendix 4]

The following program areas provide scope for assistance; these are ranked in order (highest to lowest) of considered priority (according to the criteria developed above).

1. HIV/AIDS and Tuberculosis
2. Child health / nutrition
3. Reproductive health
4. Environmental health
5. Youth health and STD
6. Non-communicable disease

7. Malaria

### 5.2.1 HIV-AIDS

While the number of cases to date (1,000 reported, 51,000 estimated) is lower than earlier estimates (up to 250,000 by the year 2000), there is an increasing trend, and the potential for epidemic spread remains. There is a high incidence of sexually transmitted diseases (STD's), an active sex industry, and land and water transport routes, which could facilitate spread. The Government of Indonesia has developed a national strategy and inter-sectoral organisational structure for the HIV/AIDS program. However the current activities are heavily dependent on contributions from donors, and have only begun to develop sustainable programs. Further strengthening of political commitment, services and education for at risk groups, surveillance, and raising community awareness are required.

USAID and AusAID are the major donors in this area, and the current AusAID funded project is near completion. There is a good opportunity to build on the work of this project, and a risk that without donor support, the program gains already made will be lost.

A more detailed paper, which identifies the potential areas of assistance is attached (appendix 8). In brief, this encompasses Surveillance (local or national), information and risk reduction measures especially for likely transmitters, development of the capability and role of NGOs as service providers and advocates, development of political support and community awareness, and the development of STD services as part of integrated reproductive health approach.

Australia has considerable experience and pool of suitably qualified people in the areas of HIV/AIDS and STD programs, development and involvement of NGOs, although few with experience in the somewhat different Indonesian context.

*Potential assistance:*

All aspects of the HIV-AIDS program continue to require assistance, from the national level to community level. There is the possibility of building on the current HIV-AIDS project with a second project, following a review and re-design.

### 5.2.2 Tuberculosis

Tuberculosis is ranked as the number one infectious disease in Indonesia, estimated to be responsible for 450,000 new cases and 175,000 deaths per year. The Government of Indonesia have adopted the Direct Observed Treatment Strategy (DOTS) as national policy, and have launched a national movement (Gerdunas) to support this. However, there are inherent problems with the implementation of current programs. Diagnosis is frequently not made or unable to be confirmed. The community is reluctant to present for therapy if Tuberculosis is suspected. Active case surveillance is not undertaken in most provinces. Treatment schedules are not implemented, and volunteer supervisors of treatment can be difficult to find. WHO is supporting the national program, with AusAID and ADB supporting activities in a number of provinces. Some provinces do not receive donor support.

While detailed assessment of future support in TB was not undertaken, it is necessary that TB remains a priority, given its current prevalence estimates, the likely potential for large epidemic and the weaknesses in the current program. It is expected that pending detailed appraisal in late 1999, assistance will be required in national surveillance, support for diagnosis and treatment, and the conduct of sociological research.

*Potential assistance:*

Further support for the national TB program, particularly at provincial and district level, and the development of laboratory support. This could take the form of an expansion of the current AusAID-WHO project, or implementation of a separate project in conformity with the national program.

### 5.2.3 Malaria

Malaria is a significant cause of illness and can cause death especially in young children, and pregnancy. WHO estimates 6 million cases and 700 deaths per year. Malaria mainly affects provinces outside Java-Bali and has been increasing over recent years. The Government of Indonesia has developed control strategies, and a program (Gebrak Malaria). However, access to treatment, use of impregnated bed nets, and mosquito control activities are limited in most areas. There is currently little donor activity in this area, except for the ADB Communicable disease project in 6 provinces.

Australia has capacity to contribute using personnel with experience in management of malaria control programs, especially in the context of PNG.

*Potential assistance*

Potential activities include improved surveillance and reporting of malaria (in an integrated communicable disease reporting system), improved diagnostic ability (eg strengthened laboratory facilities in conjunction with TB), a strengthened sanitarian (environmental health officer) program, especially in community participatory approaches, and the development and dissemination of community based programs (of case management and bed net use).

### 5.2.4 Reproductive Health
### (Maternal, Family Planning, Reproductive tract infections, Sexually transmitted diseases).

The maternal mortality rate in Indonesia is alarmingly high, and much higher than other neighbouring SE Asian countries. About 22,000 women die of pregnancy related complications each year. Recent surveys have shown high rates of undiagnosed and untreated reproductive tract infections in women (30 - 60%).

The Government of Indonesia has focussed the efforts of the health service on reducing Maternal Mortality, with the Safe Motherhood initiative, and a national 'mother friendly movement' (Gerakan Sayang Ibu). In spite of the development of effective strategies, and the placement of the Bidan di Desa in all villages, the community continue to be reluctant to use services, and there is poor integration between maternity care, family planning, and reproductive tract / sexually transmitted infection services.

While the family planning program has had considerable success in reducing the total fertility rate, there is still a high level of unmet needs, and problems with providing services to certain groups, particularly youth and young couples. The economic crisis has reduced the ability of the GOI to purchase contraceptives and resulted in some shortages of certain contraceptives.

There is currently a plethora of donors supporting programs in this area, although few are supporting a comprehensive reproductive health approach. AusAID have a number of projects also in this area, and this may limit the capacity of Australia to provide further suitably qualified or experienced personnel.

*Potential assistance*

Potential activities include the development of an integrated reproductive health approach by working with district managers to identify opportunities to "add on" services (eg STD screening, FP post partum), and reproductive services for youth. There is an emergency short term need for contraceptives, especially oral contraceptive pill and injectables in period July to September. (Proposal to AusAID in February)

### 5.2.5 Child Health

Infant mortality (deaths between 0 and 12 months) and under five mortality (deaths between 0 and 5 years) are high in Indonesia compared to neighbouring countries. The main factors involved are:

- low birth weight, prematurity due to poor maternal nutrition and anaemia
- birth asphyxia due to poor care during childbirth
- poor nutrition of children, due to dietary inadequacies
- childhood infections, including vaccine preventable infections (measles, whooping cough), pneumonia and diarrhoeal illness.

The Government of Indonesia conduct a series of vertical programs which address these issues, including a national immunisation program (EPI), control of respiratory diseases (ARI), control of diarrhoeal disease (CDD), and nutrition program. The posyandu plays an important role in integrating and delivering these services at village level. A program to integrate these activities as the Integrated Management of Childhood Illness (IMCI) has been developed by WHO, and implementation of this program has commenced in some provinces.

Recent data suggest a deterioration in child nutrition as a result of the economic crisis, and lower immunisation coverage rates than had been previously reported. Poor maternal nutrition, and lack of birth spacing, will also impact on child health. UNICEF has long been a major donor in this area, and has developed the KHPPIA inter-sectoral approach to address the many factors which impact on child health. However, following review, UNICEF is reducing the spread of its program, and this may leave some provinces with less support. AusAID has been working with WHO to pilot IMCI in the Healthy Mothers, Healthy Babies project.

*Potential assistance*

Review of the EPI (including coverage and the cold chain), surveillance of infectious diseases and support for childhood nutrition. This is best approached in an integrated way looking at both nutrition and infectious disease, including household hygiene habits, and the health of the mother, working from district level or below. Linkage with water supply projects could build on reduced workloads for women in the household, and the opportunities for household kitchen gardens.

### 5.2.6 Youth Health

Youth make up an increasing proportion of the population (nationally 22% of the population is aged 10 to 19 years) and attention has increasingly focused on their health problems. These include:

- anaemia and poor nutrition, especially of girls
- sexual activity, sexually transmitted disease, and early pregnancy / marriage
- tobacco (e.g. one survey reveals 46% youth smoke)
- mental illness.

The recent economic crisis has exacerbated these problems as youth are unable to continue schooling, or find suitable employment.

The Government of Indonesia has developed several programs targeting youth, including campaigns to delay the age of marriage, and reproductive health information for youth. However the approaches focus on information provision, and do not provide services or address youth risk taking behaviour.

There are few donors in this area. UNFPA are trialing youth clinics through the Indonesian Planned Parenthood Association in 6 cities. Australia has considerable expertise in developing appropriate programs for youth, particularly in the area of reproductive health.

*Potential assistance*

Potential activities include an increased involvement of youth in other health projects (eg HIV/AIDS, safe motherhood / family planning activities; environmental health; perhaps as observers for DOTS), and development of specific youth services in collaboration with the private sector and NGOs.

### 5.2.7 Environmental Health

Access to clean water (currently about 65% nationally) and use of latrines (about 45%) is low and contributes to high rates of diarrhoeal illness, worm infestation, and a burden for women which leads secondarily to poor maternal and child health.

Provision of rural water supply and sanitation programs are the responsibility of the Department of Health. Although donor funded activities have repeatedly demonstrated the effectiveness of community participation in these activities, the current DepKes program does not allocate resources to this aspect, and consequently tends not to be very effective. Subsidies are currently provided for latrine construction, but a more integrated approach is required to change behaviour and produce a sustained impact on health. There is a need to "market" to communities the health and convenience benefits of water and sanitation facilities.

There is considerable donor involvement in water supply, but less so in environmental sanitation or in the accompanying community participation / health education. Australia does have personnel with expertise in this area.

*Potential assistance*

Upgrading the skills and role of the sanitarian as a community facilitator rather than inspector, and support for the development of community based models of latrine construction and water supply maintenance. National level assistance in developing the role of environmental health staff in the assessment of health impacts of environmental hazards and pollution is also justified.

### 5.2.8 Non-Communicable Disease

Cardiovascular disease, respiratory disease, injuries and cancer are identified as major contributors to mortality and illness. The contribution of non-communicable disease (NCD) has been increasing, and this trend is likely to continue. While these diseases are often considered diseases of the "wealthy", most studies in developed countries have shown that they are more common among the poor. Premature mortality from maternal and communicable disease in developing countries may over shadow the importance of NCD among the poor at this time. However, risk factors for these diseases are more prevalent among the poor, and will result in increased mortality and morbidity in time.

Risk factors for NCD include tobacco smoking, occupational risks, motor traffic hazards, diet and lifestyle, and environmental factors, including exposure to harmful chemicals, tobacco smoke amongst others.

The significance of NCDs on the national burden of illness has been recognised in the recent DepKes strategies, such as the "Healthy Paradigm". However, policy or program development has progressed much further than these strategies at this time. There is some uncertainty about the relative priority to be given to NCD in the future, particularly if there is a change in government and minister of health.

There is currently little donor activity in this field, although WHO are keen to expand their program of national technical advisors. Australia has considerable expertise and experience in the area of non-communicable disease control, health promotion strategies, and tobacco control, and would be well placed to assist in this area.

*Potential assistance*

Potential activities include provision of technical assistance at National level in the development of

policy, conduct of needs assessment or data collection and analysis to support policy development, especially in areas of tobacco control and injury prevention.

## 5.3 PRIORITY ASSISTANCE ACTIVITIES

Based on a consideration of the Priority Health Areas above, and the potential activities for assistance, the following activities are proposed as priorities for assistance in the health sector:

### 5.3.1 HIV-AIDS

A second HIV-AIDS project be implemented, based on a review of the current project and situation in Indonesia, with a new design. Terms of Reference for the development of a new design are developed (see appendix 9). Prompt action on preparing the new design is needed to maintain continuity with existing activities.

### 5.3.2 Tuberculosis

A review of the AusAID WHO TB project, and a situational analysis of TB (nationally) be undertaken by the Health TAG in late 1999. On the basis of this information, a recommendation for further assistance to the national TB program be prepared by the Health TAG.

### 5.3 3. District planning and integrated health program.

**To cover activities in the priority areas of child health, reproductive health, environmental health, youth health, and malaria.**

Assistance in these areas needs to focus on the development and implementation of an integrated approach, appropriate to the specific needs of districts in the eastern provinces of Indonesia.

In view of the decentralisation of authority for these health programs to the district level over the next 1 - 2 years, it is considered most appropriate to determine priorities for individual activities through a district level planning process.

This can be achieved through needs assessment and analysis, prioritization and planning within each district. It is anticipated that community participation in planning would be the major approach used in guiding planning, and that mechanisms would be developed to support community needs analysis and strategy development. Such a process provides the opportunity to strengthen and develop the capacity of district level staff in data assessment and planning, ensuring support for future program development at the district level, and enabling communities to take more responsibility for their own health.

The needs analysis and planning will require support from a specific project team, responsible for

developing and supporting the planning capacity of the selected districts, and assisting districts in collecting and analysing data over a period of one to two years. Technical program support will be introduced as identified by district/s.

Priority provinces for these activities were identified on the basis of national health data as: NTT, NTB, Irian Jaya, East Timor, Maluku.

A pre-feasibility mission is required to assess the practicality and opportunity for such an approach.

*Potential benefits and risks*

Support for the development of district capacity in needs analysis, data collection, planning and prioritising will address the needs of management in the era of decentralisation. Activities identified as a result of this process will be more appropriate to the needs of individual districts, and will provide an opportunity to develop and test innovative strategies to deal with locally specific problems. The broader comprehensive approach to planning will encourage the integration of programs and activities, and enable efficiencies from the identification of duplication and opportunities to link together and build on programs and activities, in government, private and NGO sectors. This process will also provide an opportunity to explore and develop more genuine community participation in planning than has been possible through the current annual cycle of government planning.

It will be difficult to ensure this longer process of needs assessment and analysis can be matched with GOI annual planning cycles. There may be disappointment at the lack of implementation of specific activities during the initial planning and analysis phase of activities.

*Alternative options*

- Undertake program based assistance in priority areas in selected districts of priority provinces without involvement in a needs assessment or planning process. This will require the feasibility / design teams to identify priority areas and select districts.

  This approach requires a prolonged visit by a design team in order to visit and investigate a number of districts. Information obtained even during a prolonged visit will necessarily be limited, and restrict the ability to consider a wide range of options. This design process also limits the involvement of district or provincial counterparts, and does not use the opportunity to develop their capacities in the assessment, prioritising and planning process. Further, it limits the ability to investigate problems in depth, and identify appropriate and potentially innovative approaches.

- Review and revise current or proposed projects to expand activities to include identified priorities, or improve integration.

  While it may be possible to provide recommendations to revise or expand activities of current projects during review visits in the future, extensive review or addition of activities will seriously hamper current implementation.

### 5.3.4 Technical Assistance for National policy development

The review identified the need for technical assistance in policy and strategy development at national level in a number of areas, including:

- health promotion policy and strategy development
- NCD prevention strategies, especially in areas of smoking and injury
- rational drug prescribing
- role and function of the sanitarian
- intersectoral nutrition strategies

This approach could be developed through any of the following approaches:

- Placement of technical advisers in specific program areas through WHO, similar to the position of the TB medical officer.
- Identification of policy development projects at national level in specific areas, and support policy development through technical advisers and some operational funds data collection and analysis etc.
- Placement of a small team of generalist policy technical advisers, with skills in areas of policy development, social marketing, epidemiology etc. The team to assist policy development by undertaking specific tasks or developing specific skills in different policy areas as needs are identified by national policy managers during policy development.

These options need to be further explored by the Pre-feasibility mission.

*Potential benefits and risks*

Involvement in national policy development will enable AusAID to play a significant role in future health policy, and be in a good position to identify and respond to needs as they arise. It could place Australia in a good position to assist in some of the cross-cutting issues such as good governance. National policy advisers could assist projects in the field by providing both technical advice and liaison with national policy, so that project activities could contribute to and be informed by national policy development. It is clear that there will be considerable organisational and policy change over the next two years, and national policy advisers will be in a position to keep AusAID informed of developments.

The outcome of policy development is difficult to predict, and is dependent on political changes and support from key higher levels. Efforts to develop policy may not lead to the endorsement or implementation of the policies. It will be difficult to identify the outputs and outcomes of the activities in advance, and this may require a more flexible approach to design and monitoring of this type of activity.

*Alternative options*

- Wait until organisational and policy changes have settled down, and then review the situation to determine needs. The option excludes AusAID from the potential benefits of involvement in policy development.
- Undertake a program related project with national level policy activities, as well as activities at provincial and district level (eg in non communicable diseases). The current state of uncertainty and minimal development of policy precludes the design of such an intervention at this stage.
- Confine activities to traditional areas of maternal and child health, and avoid involvement in policy development in new areas. The option is not addressing the future health or institutional needs of Indonesia. In addition, the traditional vertical program type projects are not appropriate to the era of decentralisation.

## 5.4 OTHER PROGRAMS CONSIDERED FOR ASSISTANCE

[For more detail see appendix 4]

### 5.4.1 Urgent response to economic crisis.

The information obtained by the review does not indicate a need for further urgent responses beyond what is currently planned. This includes the provision of a second round of assistance for purchase of drugs and contraceptives, which the TAG supports. However, its is possible that further needs for

short term assistance will occur in the area of nutritional support for young children and mothers. depending on the duration and development of the current economic crisis.

It is recommended that the TAG continue to review information on the health impacts of the economic crisis, particularly in the area of nutrition, during periodic visits, and provide advice for further assistance as appropriate.

### 5.4.2 Drug procurement and distribution assistance

The TAG reviewed the proposal submitted by the adviser with the Emergency Medical Supplies project for further activities to support the procurement and distribution of drugs, and rational drug use. Discussions were held with the Director General of the Food and Drug Section of DepKes and his staff, and with the WHO pharmaceuticals adviser. These discussions clarified that the priority problems for DepKes are:

- Supply and distribution of drugs from the district drug warehouse to Puskesmas, particularly with the increased responsibilities following decentralisation.
- Implementation of rational drug prescribing.

Assistance in the management of drug supply and distribution at district level can be incorporated into the district planning and capacity development activities proposed by the review team. It is recommended that the area of development of rational drug use policies be included in consideration for involvement by national policy technical assistance.

### 5.4.3 Collaboration with larger multilateral donors

The issue of collaboration or co-financing of projects with larger multilateral donors such as the World Bank, Asian Development Bank, UNICEF and WHO was discussed.

There was clearly scope for and enthusiasm for further collaboration with WHO in the area of appointment of national advisers. This mechanism would have the advantage of linking the adviser into the international policy developments of WHO, and using a reasonably flexible system of placement and support, without having to negotiate with Bappenas separately for each position. This option can be explored in the pre-feasibility mission on national policy technical assistance.

Collaboration with UNICEF in the safe motherhood area is being attempted in the UNICEF projects in West Java, Maluku and Irian Jaya. Experience in West Java has demonstrated the difficulties over working with another administrative and management system, and supporting only a part of the overall UNICEF KHPPIA activities in a province. A decision on further collaboration with UNICEF should await a review of the current projects. However, there is the potential to build on the KHPPIA project capacity development at district level in the proposed district planning activities.

In discussions with the World Bank and the Asian Development Bank, the issue of collaboration and co-financing with AusAID was raised, and received some support. WHO collaborates with these two institutions by providing technical advice at national level for their projects. The World Bank is currently preparing a district level support project in health, and there may be possibilities for involvement from AusAID. The national level advisers proposed by this review would be in a position to monitor the planning of this and other multilateral projects, and identify possible roles for Australian assistance.

# 6. CONCLUSION

The Study team considers the review has been undertaken at an appropriate time. The recent rapid changes on the socio/political/economic landscape have both created threats to the health status of the population of Indonesia, and opportunities for important discrete and institutional development.

Areas of need are identified in traditional areas of support, as well as in adoption of new approaches. In the former, communicable diseases, most specifically HIV and Tuberculosis represent emerging epidemics which warrant continued intensive and expert assistance in order to minimise the potential impact of these illnesses. Nutrition/maternal and child health/environmental health are similarly considered a priority for assistance, yet are to be addressed with a new approach. This approach gives emphasis on a thorough situational analysis which aims to build capacity at provincial and district level, facilitating subsequent targeting of technical areas as required on a local basis. New approaches are suggested in developing National policy support, which will strengthen Australia's ability to address broad national agenda and cross cutting issues as need arises within the National level.

These priorities have been determined in accordance with need, with donor activity, with the capacity that the Australian community has to respond with the relevant expertise, and in light of the likelihood of successful intervention. It is advised that the health sector continue to focus predominantly, though not exclusively on the eastern provinces.

It is recommended that a design mission be undertaken shortly to ensure continuity of the current HIV/STD project, and that pre-feasibility be undertaken to explore program/project development in district level integrated health sector strengthening, and National policy support. Further assessment will be required by the study team to examine the scope of activity in tuberculosis, and ongoing monitoring of the short term needs arising from the current economic crisis.

## APPENDIX

1. Health Sector Review terms of Reference
2. Itinerary/Meetings
3. Health Needs assessment
4. Priority health areas
5. Provincial reports
6. Project reports
7. Tables of Donor activity
8. HIV/AIDS - issues paper
9. Terms of Reference - HIV/AIDS; District level program; National level technical support
10. Bibliography