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Beyond 2014



# Universal Access to Reproductive Health Services: An Unfinished Business

WORLD POPULATION DAY | 11 JULY 2012 | JAKARTA, INDONESIA





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Reproductive health is defined as *a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity* [7]. The implications of this definition are far-reaching. Addressing RH demands a comprehensive approach that accounts for physical, mental, and social well-being, rather than focusing singularly on RH-related disease and deaths.

Universal access means *services and information are available, accessible, and acceptable to meet the different needs of all individuals*. In the context of RH, universal access entails services that are: (1) easily and safely accessible to all, including those with disabilities; (2) available at a low cost to the poor; and (3) considerate of social, cultural, religious, and other local values. These values must be embodied by a range of services encompassing information provision, prevention, diagnosis, counseling, treatment, and care.

## Universal access to reproductive health is central to human development

- **Reproductive rights are human rights**, on recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so, as well as the right to attain the highest standard of sexual and reproductive health (ICPD Programme of Action) [2].
- The reproductive age group (15-49 years old) is often the most productive of the population; their health status and well-being are imperative to human development and the growth of a nation. However, this has not been fully recognized, as **reproductive health problems remain the leading cause** of ill health and death for women of childbearing age worldwide [3].
- Reproductive health is a **critical component of human capital**. Investment in RH has been connected with lower fertility and lower maternal and child mortality, which consequently improves overall health and quality of life [6].
- **Investment in reproductive health creates significant dividends for economic development** by improving family and child health, protecting the environment, increasing security, and advancing women's rights [5].
- **As the fourth most populous country, Indonesia** faces both opportunities and challenges. Over 80 percent, or 123 million, of Indonesia's productive age population (ages 15-64) are at reproductive age. At least 50 percent of this group is female. Strong strategies to address their health and improve their potential are needed for the development of human capital [4]. A failure to recognize this opportunity will be a major loss for the country's development.

## A walk through time: The journey of RH from ICPD to the MDGs

Over six decades ago, global recognition of human rights began with the announcement of the Universal Declaration of Human Rights in 1948. This was followed by stronger global commitments, such as the landmark inclusion of reproductive health as a critical component of human rights, including access to RH services. Aligned with this global progress, in 2009 Indonesia passed legislation, Law No. 36, encompassing reproductive health in the National Health Laws.

- 1948 Universal Declaration of Human Rights issued.
- 1987 Safe Motherhood Initiative Conference held in Nairobi.
- 1989 Indonesia formed the *Bidan di desa* programme, educating and training over 54,000 midwives in villages throughout Indonesia.

- 1993 United Nations World Conference on Human Rights in Vienna affirmed women's rights as human rights.
- 1994 The International Conference on Population and Development (ICPD), held in Cairo, resulted in over 179 governments agreeing that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Concrete goals of the ICPD centered on providing universal access to education, particularly for girls; reducing infant, child, and maternal deaths; and ensuring, by 2015, there is universal access to reproductive health care, including family planning, assisted childbirth, and prevention of sexually transmitted infections, including HIV.
- 1994 Indonesia's National AIDS Commission established.
- 1996 Indonesia's National Reproductive Health Commission and Working Groups established.
- 2001 Introduction of the Integrated Essential Reproductive Health package, which integrates four essential components of RH, i.e. antenatal care and safe delivery, family planning, management of STIs/RTIs, and ASRH, to be provided in the primary health care clinics (*puskesmas*).
- 2001 The Millennium Development Goals (MDGs), including MDG 5 on maternal health, issued.
- 2004 The 57<sup>th</sup> World Health Assembly adopted the World Health Organization's first strategy on reproductive health.
- 2005 Endorsement of Indonesian National Strategy of Reproductive Health by the Ministry of Health.
- 2005 The World Summit adds universal access to reproductive health by 2015 as a strategy to attain development goals, including the MDGs.
- 2007 Integration of MDG Target 5B, "Achieve by 2015 universal access to reproductive health" within the revised MDG framework as a component of Goal 5, "Improve maternal health." The indicators under the target include contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning.
- 2009 Health Law No. 36, which includes a reproductive health component, is passed.
- 2010 MDG Review Summit renewed commitments to universal access to reproductive health by 2015, gender equality, and ending discrimination against women.
- 2012 Indonesia leads the Getting to Zero campaign in ASEAN, with the three goals of reducing to zero instances of new HIV infections, discrimination, and AIDS-related deaths.
- 2012 The London Summit on Family Planning will be held 11 July, at which Indonesia will share its successes and future challenges.

## Reproductive Health in Indonesia

### 1. ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE (EMOC) SERVICES

The huge gap in maternal mortality ratios (MMR) between countries suggests that the majority of complications and maternal deaths are preventable and manageable. It is estimated that around 15 percent of mothers suffer from complications during pregnancies and deliveries. One of the biggest problems is the unpredictable nature of the complications, putting every pregnant woman at risk of dying at any time during her pregnancy, delivery, and post-partum phase. The unpredictability of complications necessitates 24 hour access to a quality continuum of obstetric care at different levels of services, supported by an effective referral system. Access to skilled attendants and quality

EmOC (including effective referral) will save mothers' lives and prevent illness. Improving a mother's well-being directly improves family well-being and the lives of children.

Indonesia has successfully attained a high level of deliveries by professional attendants; however, comparatively little progress has been made in the reduction of MMR. The latest MMR figure of 228 out of 100,000 live births (IDHS 2007) is well above the targeted reduction to an MMR of 102 out of 100,000 live births by the year 2015, requiring a dramatic acceleration of efforts. The inconsistency between the high proportion of births attended by professional attendants and the high maternal mortality ratio might be explained by the lack of continuity in obstetric care and the lack of quality care at every level of service. Disparities of access by region, residence, and socioeconomic status exist and continue to be a major challenge in Indonesia.

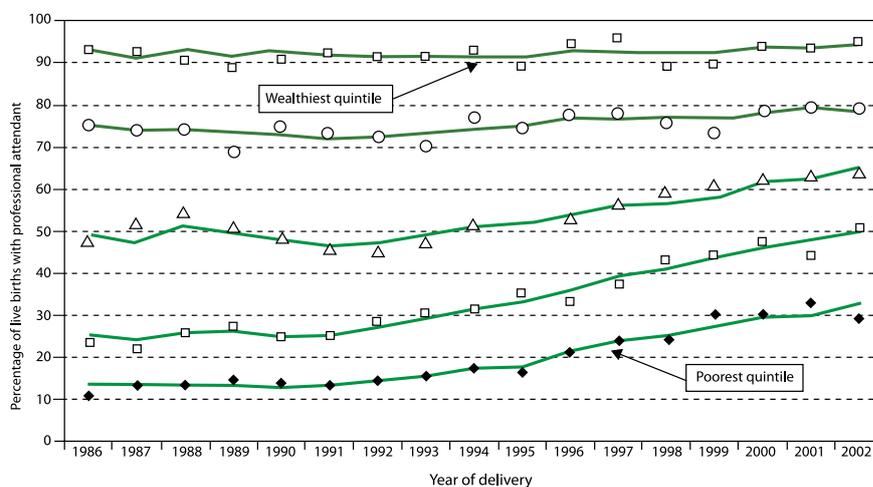
Since the 1990s, Indonesia has initiated the *Bidan di Desa* programme, placing a midwife (or skilled birth attendant) in each village across Indonesia. This program has been successful in increasing the coverage of deliveries by professional attendants, currently around 77.3 percent (Susenas 2009), and narrowing the gap between the poor and rich (Hatt 2007). However, this achievement is still lower than the national target of 90 percent by 2014, including the wide disparities that remain among provinces, evidenced by a ratio of 42.4 percent in Maluku and 98.1 percent in DKI Jakarta (Roadmap 2010). Despite increasing birth attendant rates, the 2007 IDHS results show that the coverage of deliveries in health facilities is still less than half (46.1 percent) of the total deliveries, with coverage in rural areas as low as 28.9 percent, as compared to urban areas at 70.3 percent (Roadmap 2010).

The Government deployed more than 60,000 midwives to villages through *Bidan di Desa*, yet but the programme was not able to maintain their availability; less than 50% of these midwives currently remain in villages. Many who remain lack skills and competency due to improper recruitment, unstandardized pre-service education, and lack of technical supervision. Review of the programme is needed, and if maintained, requires development of a full scale-up plan with appropriate supervision and in-service training. The recent World Bank report "'...and then she died...': Indonesia Maternal Health Assessment" (2010) concluded midwives are necessary but not sufficient by themselves to reduce maternal mortality.

Unlike relatively high access to professional attendants at birth, access to emergency obstetric care, such as caesarean sections, is very low, at less than 1 percent among the poorest, with little signs of increasing. It is estimated that around 5-15 percent of deliveries require a caesarean section to save a life, thus suggesting that a high proportion of the poor in need of caesarean sections are not getting the lifesaving services they need.

Figure 1.1. (Hatt, et al. 2007)

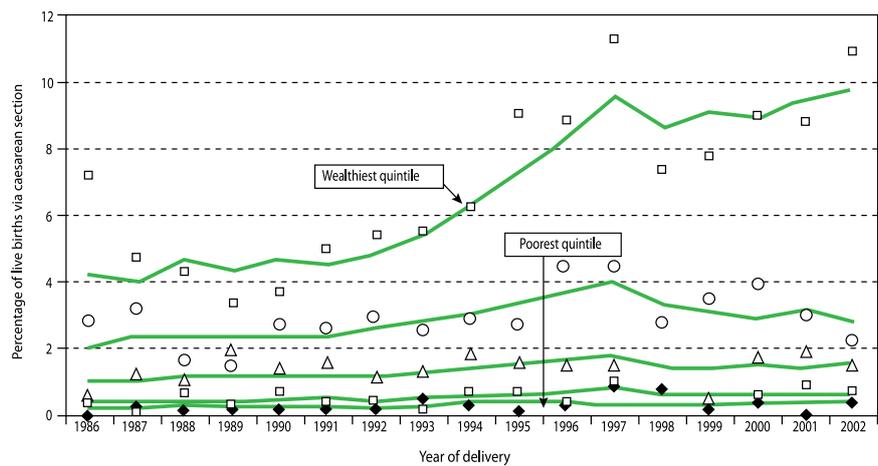
Trends in rates<sup>a</sup> of professional attendance in Indonesia 1986-2002, by wealth quintile



<sup>a</sup> Predicted rates were calculated from the adjusted logistic regression model and overlaid on observed rates, by quintile and year. Source: Demographic and Health Surveys, Indonesia, Reference 15.

**Figure 1.2.** (Hatt, et al. 2007)

Trends in rates<sup>a</sup> of caesarean section in Indonesia 1986-2002, by wealth quintile

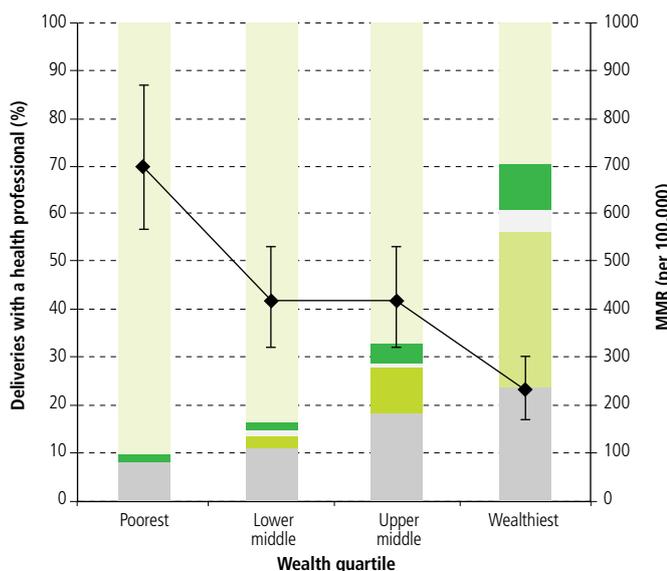


<sup>a</sup> Predicted rates were calculated from adjusted logistic regression model and overlaid on observed rates, by quintile and year. Source : Demographic and Health Surveys, Indonesia, Reference 15.

Access to EmOC is also challenged by ineffective referral mechanisms that create delays in obtaining adequate care. A thorough study examined the types of delays experienced in 104 maternal deaths in two districts in Indonesia. The study revealed that delays happen at every level of the system, and that sometimes one woman may experience multiple delays (D’Ambruso 2009). The primary delays occur in decision-making (45%); reaching the care (66%); and receiving quality care (44%). Another study in the same districts conducted a qualitative assessment on the quality of services provided by midwives and concluded that clinical care was sub-standard, thus contributing to the late identification of complications and late decision-making for referral (D’Ambruso 2008).

**Figure 1.3.**

**Birth assisted by a health professional at home or in a health facility and maternal mortality ratio, by wealth quartile range, Serang and Pandeglang districts, Java, Indonesia, 2004-2006**



No health professional 
  Hospital 
  Clinic/health centre 
  Midwife's home 
  Midwife at woman's home  
 MMR 
  95% confidence interval

MMR, maternal mortality ratio.

The issue of quality of care is highlighted in the study below comparing births attended by professional attendants, either at home or in a health facility, and the maternal mortality ratio. Results show that MMR among the poorest was double that of the wealthiest. However, even the MMR among the richest is still relatively high (232 per 100,000 live births), indicating the existence of quality of care problems. The results also show that the poorest primarily deliver their babies with non-professional birth attendants. Only a small percentage of poor women who delivered in hospitals suggest they went to hospitals only after serious problems arose. These women may have experienced delays reaching the hospital, reducing their opportunity to receive appropriate care (Ronsmans 2009).

## 2. MEETING PEOPLE'S NEED FOR FAMILY PLANNING

In Indonesia, more than 126 million people are of reproductive age (15-49 years old); half are women (BPS Census 2010). This large number of people at reproductive age presents potential benefits and challenges to Indonesia, ultimately affecting the quality of human resources. Three of the four **MDG 5B indicators** target this demographic, **namely the contraceptive prevalence rate (CPR), unmet need for family planning, and adolescent pregnancy rate.**

### Contraceptive Prevalence Rate (CPR)

Women of reproductive age must be empowered to have easy and affordable access to safe and effective FP services, enabling them to control and plan their own reproductive lives, such as the timing and spacing of their children. Increased access to FP services will lead to a reduction of unintended or unwanted pregnancies and unsafe abortions, ultimately leading to fewer maternal deaths. Contraceptive prevalence rate (CPR) is an important indicator in measuring access to FP services. The national target of CPR for 2014 is 65.0 percent (NMTDP 2010-2014); however, current rates are estimated at only 57.4 percent for modern methods and 61.4 percent for "any method" (IDHS 2007). One alarming trend is the declining rate at which CPR is increasing: From 2002 to 2007, there was a 1.1 percent increase for all methods and 0.7 percent for modern methods. Previously, CPR increases were around 3% from 1991 to 2002/03. Given the large national population at reproductive age, this trend warrants national attention.

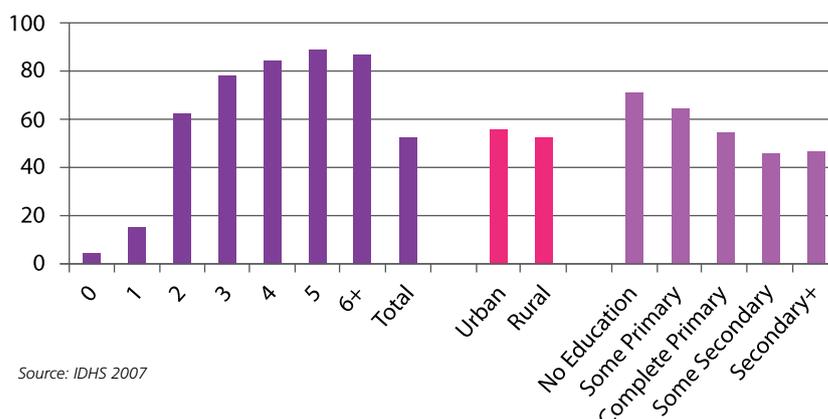
### Unmet Need for Family Planning

While CPR indicates access to FP services, the unmet need for FP indicates the extent to which programmes are meeting the population's demand for services. Unmet need for family planning is defined as *the percentage of currently married women who either do not want any more children or want to wait before having their next birth, but are not using any method of family planning.*

Maternal deaths can be cut by one-fourth simply by meeting unmet needs for modern family planning and maternal and newborn healthcare. If all women who want to avoid pregnancy used modern family planning, unintended pregnancies would sharply decline (Freedman 2005). Between 1991 and 2007, unmet need decreased from 12.7 percent to 9.1 percent. However, it is important to note any trends of small increases, such as that between 2002/03 and 2007, during which time the rate increased from 8.6 percent (IDHS 2002/03, 2007). Even a small percentage increase is a concern because it reflects an absolute number of women who cannot meet their FP needs. Despite some recent success, current rates are still far from the national target for unmet FP need of 5 percent by 2014.

Furthermore, unmet need is large among those with two or more children. The percentage of currently married women who want to cease childbearing increases sharply from 15.2 among those who already have one child to 61.8 percent among those with two children. That figure grows to

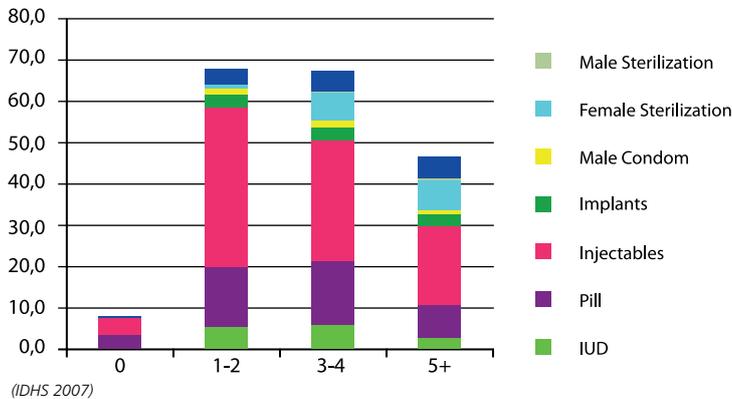
**Figure 2.1.** The percentage of currently married women wanting no more children, by number of children, urban/rural, and education level



Source: IDHS 2007

89.3 percent among those who have 5 children. Unmet needs are also higher among rural and less educated women. Geographically, unmet need varies greatly across provinces, with the lowest rate in Bangka Belitung (3.2 percent) and the highest in Maluku (22.4 percent). Among women not practicing contraception, 18 percent cited side effects and 11% cited health problems.

**Figure 2.2.** Contraceptive Method Used by Currently Married Women 15-49, by Number of Children still Living



The challenge appears even greater upon a more detailed assessment of the contraceptive methods used. Results show that among modern methods, short-term methods have a higher likelihood of failure as compared to long-term methods, yet short-term methods are more commonly used. In addition, short-term methods such as injectables and pills are more frequently used even among those who already have three or more children. The figure below indicates a “hidden unmet need” which is access to long-term or more secure methods, such as sterilization and implants, for couples who do not want to continue to have children.

Male participation in family planning remains low. This is reflected in the low proportion of condom use, which has increased by only 0.4% in the past decade, from 0.9% in 1994 to 1.3% in 2007 (IDHS). Expert analysis attributes the low use of condoms to stigma from association with ‘negative’ behaviors. As for male sterilization, while it is well-recognized that as a proportion of all contraceptive use it has never been large, the figure has steadily dropped from 0.7% in 1994 to 0.2% in 2007.

### Access of adolescents to ASRH education and services

The Sexual and Reproductive Health (SRH) of adolescents and young people<sup>1</sup> is of growing concern today. The Programme of Action adopted at the International Conference on Population and Development, held in Cairo in 1994, stresses the importance of addressing adolescent SRH issues and promoting responsible sexual and reproductive behavior (United Nations 1994). Various studies and surveys highlight the needs of SRH programs and services among adolescents in Indonesia.

Indonesia’s adolescents and youth number over 71 million people, or 30% of the population. Although a majority have general knowledge of family planning and have heard of AIDS, their “comprehensive knowledge,” a metric that consists of knowing how to prevent sexual transmission of HIV and rejection of major misconceptions, has dropped from 22% in 2007 to 20% in 2011 (IBBS 2011). This is reflected in the fact that nearly 40% of new cases of confirmed AIDS are between the ages of 20-29, meaning the likely age of initial HIV infection occurred between the ages of 15-24.

As in many other places, adolescents in Indonesia face enormous challenges to maintaining their reproductive health. Based on the 2007 Indonesian Young Adult Reproductive Health Survey (IYARHS), the incidence of premarital sex increased slightly over the previous four years by 1.3 percent among girls and 6.4 percent among boys. The 2007 Indonesian Demographic and Health Survey (IDHS) data indicate that the age-specific fertility rate (ASFR) for the 15-19 and 20-24 age groups remains constant at 51 and 135, respectively, per 1000 women. The 2010 Greater Jakarta Transition to

<sup>1</sup> WHO defines “adolescents” as individuals 10-19 years old and “youth” as those 15-24 years old. These two overlapping age groups are combined in the term “young people,” covering age range of 10-24 years old.

Adulthood Survey reported that among respondents aged 20-34 years old (n=3006), 14 percent of males and 7 percent of females currently dating are having sex with their boyfriend/girlfriend.<sup>2</sup> Additionally, in absence of any existing data regarding abortion, it has been estimated that about two million abortions occurred in Indonesia in 2000. This estimate translates to an annual rate of 37 abortions for every 1,000 women of reproductive age (15-49 years old). This rate is high compared with that of Asia as a whole: Regionally, about 29 abortions occur for every 1,000 women of reproductive age (15-49 years)<sup>3</sup>. Based on several qualitative studies among various groups, it has been shown that premarital abortions are becoming more common among young adults. Data from ten Indonesian Planned Parenthood Association (IPPA) clinics located in cities throughout Indonesia showed that the percentage of abortions performed on females ages 15-24 increased from 9 percent in 1992 to 35 percent in 1993.<sup>4</sup>

In Indonesia, there is a large gap between knowledge and use of contraceptives. Among unmarried young people, knowledge is generally strong (95 percent of females and 91 percent of males could name various methods of contraception).<sup>5</sup> However, the majority of sexually active young people do not use any protection. Only 47 percent of married adolescents are currently using any method of contraception, lower than their 20-24 year-old counterparts. Although the vast majority of young people (90% of females, 85% of males) think that contraceptive services should be provided to them, none are available due to legal restrictions on the provision of contraception to unmarried people. The provision of contraceptives to unmarried young people is not included in national programs. Law No. 52 of 2009, the Population and Family Development Law, states that family planning services are only to be provided to married couples.

Without access to comprehensive sexual and reproductive health education and services, young people, especially girls, face daunting reproductive and sexual health problems: unintended pregnancy, unsafe abortion, maternal mortality and morbidity, violence, and sexually transmitted infections, including HIV.

Thus, it is vitally important that information and services on SRH be made available to both married and unmarried adolescents. To equip them with adequate skills, knowledge must be built at an early stage through both formal and non-formal education.

Adolescent girls worldwide face enormous challenges. Such challenges include unintended and unwanted pregnancies, STIs, especially HIV-AIDS, and the consequences of their reproductive decisions for their future. Confronting these challenges demands a comprehensive understanding of the environment that puts this group at risk and a deeper understanding of their needs, including RH services. Information and services on RH must be accessible, affordable, and of adequate quality for this demographic. In many countries, gender-based discrimination and lack of schooling prohibit adolescent girls' access to the information, services, and decision-making power they need to exercise their right to reproductive health.

One important indicator is the adolescent birth rate, defined as the number of births per 1,000 women between the ages of 15 and 19. This indicator suggests opportunities available to individual girls and the vulnerabilities they experience during, and beyond, their adolescence.

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**2** Utomo, I.D., McDonald, P., and Hull. T. 2011. "Reproductive Health Services for Single Young Adults. Policy Brief No. 5: The 2010 Greater Jakarta Transition to Adulthood Study," Australian Demographic and Social Research Institute, Australian National University, Canberra.

**3** Sedgh, G. and Ball, H., 2008, Abortion in Indonesia, In Brief, New York: Guttmacher Institute, No. 2; Sedgh, G. et al., Induced abortion: estimated rates and trends worldwide, *Lancet*, 2007, 370(9595):1338-1345.

**4** Adolescent and Youth Reproductive Health in Indonesia: Status, Issues and Policy Programmes, Policy Project 2003.

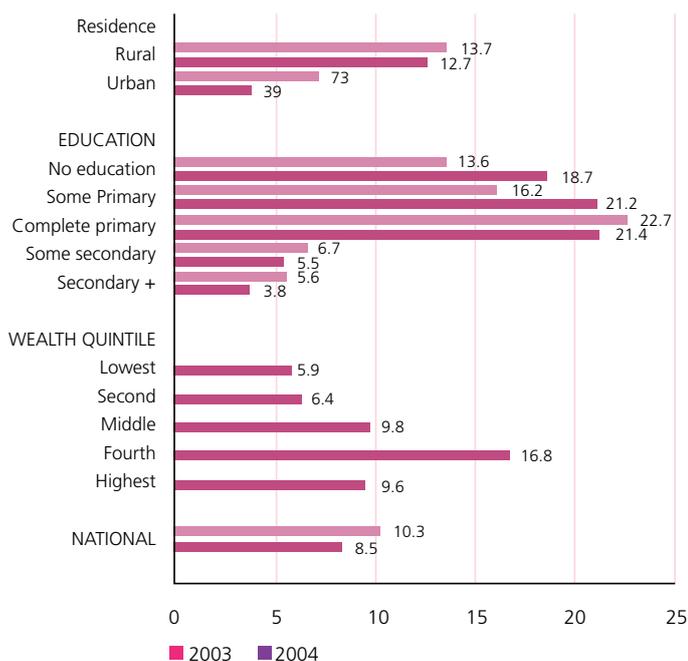
**5** Central Bureau of Statistics, 2007, "Young Adult Reproductive Health Survey."

For Indonesia, the adolescent birth rate is critical because of the large demographic of adolescent girls, around 10 million in 2010 (BPS PS 2010). This reason alone demands major attention and action to prevent potential reproductive health risks. According to the National Midterm Development Plan 2010-2014, the national target for 2014 aims for 30 births per 1000 women aged 15-19 in 2014. In 2007, the adolescent birth rate leveled off at 35 births per 1000 women aged 15-19, a sizeable decrease from 1991 figures showing 67 births per 1000 women aged 15-19. It should be noted that these figures do not account for births by unmarried women and girls.<sup>6</sup>

**A high adolescent birth rate** can be caused by a lack of access to quality reproductive health services and reliable information on sexual and reproductive health. According to the 2007 IDHS, the percentage of married women ages 15-19 who use contraceptives is 45.4 percent. However, the main concern is the 14 percent of adolescent girls ages 15-19 are or have previously been married, accounting for 1,460,516 adolescent girls. Even among those aged 10-14, around 53,000 of them are or have previously been married.

**Figure 3.1. Percentage of Women Aged 15-19 Who Have Begun Childbearing, by Background Characteristics, Indonesia 2002/03 and 2007**

The high adolescent birth rate is caused by lack of access to quality reproductive health services and reliable information on sexual and reproductive health. According to IDHS 2007, the share of married women aged 15-19 who use contraceptives is 45.4 percent, with 44.8 percent of them using modern methods, and 0.7 percent relying on traditional methods. This rate is the lowest rate after the 45-49 age group.



Source: BPS, IDHS 2002/2003 dan IDHS 2007.

<sup>6</sup> The age-specific fertility rate (ASFR) measures the annual number of births to women of a specified age or age group per 1,000 women in that age group. The numerators of the ASFR are calculated by summing the number of live births that occurred in the period 1 to 36 months preceding the survey (determined by the date of interview and the child's date of birth) and classifying them by age groups (in five-year brackets) of the mother at the time of birth (determined by the mother's date of birth). The denominators of the rates are the number of woman-years lived in each of the specified five-year groups during the 1 to 36 months preceding the survey. Since only women who had ever married were interviewed in the IDHS, the numbers of women in the denominators of the rates were inflated by factors calculated from information in the Household Questionnaire on "populations ever married" to produce a count of all women. Never-married women are presumed not to have given birth (IDHS 2007:48).

### 3. HIV/AIDS

Sexual transmission is currently the main vector of infection in Indonesia, according to statistical data and mathematical modeling. This trend shows no signs of changing in the future. Reports from the Indonesian Ministry of Health suggest that as of 30 June 2010, HIV transmission through sex accounts for 53% of all cases reported. Condom use remains low among the general population, causing a high prevalence of STIs. Such conditions have led to the increase in HIV infections in Indonesia.

Since 2000, HIV prevalence has been consistently over 5% in several key populations. Findings of the Integrated Bio-Behavioral Surveillance (IBBS) studies conducted by the Ministry of Health and the Central Bureau of Statistics from 2002 and 2004-2007 indicate that the persistence of unsafe behavior in sexual intercourse poses risks to all key population groups.<sup>7</sup> The 2011 IBBS found HIV prevalence among key populations as follows: direct sex workers, 9.3%; indirect sex workers, 3.1%; transgender individuals (*waria*), 23.2%; clients of sex workers, 0.7%; men who have sex with men, 12.4%; and injectable drug users, 42.4%. This has led to classification of the epidemic in Indonesia as “concentrated.”

The Ministry of Health acknowledges that **heterosexual transmission accounts for 54.8 percent of all reported AIDS cases**, cumulatively. This figure reflects the shift to heterosexual sex as the main vector of HIV transmission that occurred since 2007, before which injectable drug use accounted for 50 percent of all cases.

The current number of cumulative reported AIDS cases caused by heterosexual transmission increased sharply from 37% between 2001-05 to 71% in 2011; whereas among injectable drug users this number decreased from 53% to 34%. The prevalence of HIV among PWIDs (People Who Inject Drugs) is also decreasing from 52% in 2007 to 36% in 2011 (IBBS). It is possible that the decreased rate of syringe and needle sharing among this group (13%) has played a role.

As of 2007, clients of sex workers and their partners are the two largest groups considered “at risk” of contracting HIV. In 2009, the Ministry of Health estimated there were 3,169,928 clients of sex workers and 1,938,650 partners of sex workers’ clients vulnerable to HIV. In the two easternmost provinces, Papua and West Papua (collectively, *Tanah Papua*), the HIV epidemic is generalized, a situation worrying situation driven by unprotected commercial sex and concurrent sexual partnerships. Adult HIV prevalence in the Papuan provinces reached 2.4 percent in 2006; currently AIDS prevalence is 15 times higher than national average, and the main vector is heterosexual transmission.<sup>8</sup>

Although the prevalence of HIV among those aged 15-49 in Indonesia is relatively low, 0.27%, the epidemic trend is disturbing, because the cumulative number of cases has been increased steadily. A sharp increase of new cases has been noted since 2010, with over 21,000 new cases reported per year. The cumulative number of reported HIV infections as of March 2012 stands at 82,970 (CDC MOH 2012). Using mathematical models to estimate the HIV epidemic, it is predicted that, in the absence of accelerated prevention efforts, 541,700 people will suffer HIV infections by 2014, while around 6.4 million will be considered at risk (NAC 2012).

<sup>7</sup> PWID, sex workers, MSM, high-risk men, and prisoners

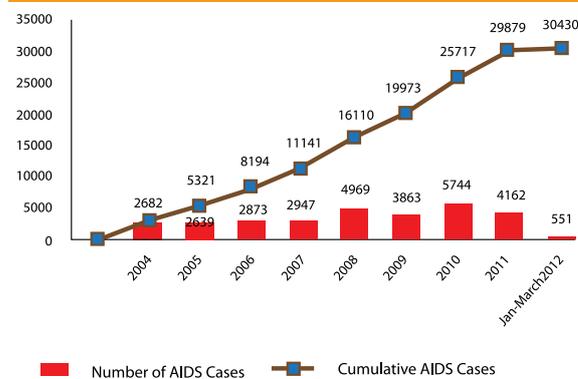
<sup>8</sup> Central Bureau of Statistics & Ministry of Health (2007), “Risk Behavior and HIV Prevalence in Tanah Papua,” Jakarta. Based on data collected in 2006.

The cumulative number of AIDS cases reported by March 2012 was over 30,000. Unlike HIV, the number of new AIDS cases has been noticeably decreasing since 2010. Possible explanations are the increasing availability of ARV and earlier detection, which improves survival and quality of life. The case fatality rate (CFR) has also decreased from 40% in 1987 to 0.2% in 2012.

**Figure 4.1.** The Yearly and Cumulative Number of HIV cases



**Figure 4.2.** The Yearly and Cumulative Number of AIDS cases



### Prevention

Slowing the HIV/AIDS epidemic in Indonesia requires a comprehensive approach covering prevention, as well as infection control and care, at various sites of intervention, thus ensuring behavior change of all those involved.

Commitment by the Government of Indonesia to reduce the prevalence of HIV/AIDS has been evident, especially in the last 10 years. This commitment is demonstrated through various efforts, including the erection of various policy instruments; establishment of the National AIDS Commission in 2004, a multisectoral body directly responsible to the President, and the follow-on establishment at the provincial and district/city levels; and an increase of national budget allocations to HIV/AIDS efforts (NAC 2012). To accelerate the reduction of HIV/AIDS prevalence, the President of the Republic of Indonesia issued Presidential Instruction (Inpres) No. 3/2010 on Equitable Development Programmes that address HIV/AIDS by increasing counseling and testing, increasing access to antiretroviral therapy, improving HIV/AIDS efforts at the district level, and increasing condom use among key groups (Roadmap 2010).

While the priority of the national response remains focused on key population such as IDUs, sex workers, transgender (*waria*), and men who have sex with men, prevention efforts need to be broadened to reach other population group such as HIV positive pregnant women; female intimate partners of high risk men; migrant workers; and young people at risk in order to prevent HIV from spreading to the general population.<sup>9</sup> Realizing the increasing number of HIV positive women and the potential threat to the outcome of the pregnancies, the PMTCT (Prevention of Mother To Child Transmission) programme is receiving greater priority. It was estimated that by the end of 2011, as many as 8,170 pregnant women are HIV positive in Indonesia.

Early diagnosis and treatment of HIV infection has been proven to improve quality of life and increase survival. The number of the sites for HIV counseling and testing (Voluntary Counseling and Testing, or VCT) has gained significant attention, increasing from 25 sites in 2004 to 500 sites in 2011, and providing coverage for counseling and testing of more than 70% of key affected populations.

<sup>9</sup> National AIDS Commission, Republic of Indonesia, "Country Report on the Follow up to the Declaration of Commitment to HIV/AIDS," UNGASS, reporting period 2008-2009.

## HIV-SRH linkages

Recognizing that HIV/AIDS is linked to various aspects of life, the “Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health” was issued in New York in 2004. The Call notes that

The overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth, and breastfeeding; that both sexual and reproductive health initiatives and HIV/AIDS initiatives must be mutually reinforcing; that both HIV/AIDS and sexual and reproductive ill-health are driven by many common root causes, including gender inequality, poverty, and social marginalization of the most vulnerable populations (UNFPA 2004:1).

The linkage of HIV/AIDS and SRH will yield numerous benefits for both HIV/AIDS and SRH improvement, including improved access to HIV/AIDS and SRH services, specifically better access for people living with HIV to SRH services tailored to their needs; reduced HIV-related stigma and discrimination; enhanced programme effectiveness and efficiency; improved quality of care; and mutually reinforcing legal and policy frameworks.

## 4. REPRODUCTIVE HEALTH IN EMERGENCY SETTINGS

Indonesia experiences natural disasters of all scales and kinds, creating a challenging situation necessitating where preparedness and rapid responses to emergencies are in high demand. Reproductive health is a relatively neglected consideration in such contexts. Proper preparation includes access to safe pregnancy and delivery services and emergency obstetric care; access to effective contraception in emergency situations; access to information and services for prevention of STIs and HIV/AIDS; and access to treatment and counseling for the effects of sexual and gender-based violence. Programmes must ensure sensitivity to various religious and ethical values and cultural backgrounds.

In the aftermath of the 2005 tsunami in Aceh, the Indonesian Government implemented for the first time a Minimum Initial Service Package (MISP) for Reproductive Health (RH) during emergencies that programmatically attempts to: (1) Identify (an) organization(s) and individual(s) to facilitate the coordination and implementation of the MISP; (2) prevent and manage the consequences of sexual violence; (3) prevent excess neonatal and maternal morbidity and mortality; (4) reduce HIV transmission; and (5) plan for comprehensive RH services in the early days and weeks of an emergency.

The MISP is most effective when implemented in the early days of an emergency, saving lives and averting illness, particularly among women and girls. It requires no prior assessment, as its use has been justified by sufficient evidence. The MISP includes pre-packaged kits containing drugs and supplies aimed at facilitating implementation of priority RH services in the early phase of a crisis (Women’s Commission for Refugees, Women, and Children, February/March 2005).

The MISP has been implemented in other major disasters Indonesia has since experienced: the 2006 earthquake in Yogyakarta, the 2007 earthquake and tsunami in Pangandaran, West Java, the Jakarta flood of 2007, the 2007 NTT landslide, the 2009 earthquakes in

West Java and West Sumatra, the 2010 earthquake in Mentawai, West Sumatra, the 2010 volcanic eruption of Merapi, and flash floods in Papua in 2010.

Indonesia has also adopted the Interagency Field Manual on Reproductive Health in Humanitarian Settings, and built capacity of and equipped nine regional centers for disaster response, enabling delivery of the MISP in emergency situations.