

HIV/AIDS Situation in Indonesia (1994)

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INTRODUCTION

The Republic of Indonesia, situated between the Asian and Australian continents, is an archipelago consisting of 13,000 islands. The unevenly distributed population lives in about 6,000 islands, particularly in five big islands namely : Sumatra, Java, Kalimantan, Sulawesi and Irian Jaya. The total population in 1993 is about 187 million, with more than 60% living in Java islands which is only 6% of the total land area. The proportion of rural and urban population is 35/65, literacy rate is 84.1%, birth rate is 27.9, death rate 8.9 per 1,000 population, and per capita income is US \$ 650. As the fourth biggest nation in the world, Indonesia consists of about 300 ethnic groups with their own languages, but nationally the Indonesian language (which is basically similar to Malayan language) is used. Administratively, the republic consists of 27 provinces, covering 302 Regencies/Districts and about 6,000 subdistricts (the lowest official/governmental level of administration),

The first AIDS case reported in Indonesia was a Dutch tourist from Bali in April 5, 1987. ADB (Asian Development Bank) predicted that the number of HIV/AIDS in Indonesia in the year of 2000 would be 5,000 AIDS and 50,000 HIV(+). The direct and indirect cost of those AIDS cases would be as high as US \$ 81,000,000.

HWO predicted that by the year 2000, 30% of the total HIV/AIDS cases in the world (30-40 millions) will be from ASEAN countries, including Indonesia.

RULES AND REGULATIONS REGARDING TO HIV/AIDS

After AIDS was first reported in 1987, the Ministry of

Health took an immediate response by legislating a Decree No. 339/IV/1988 about the National AIDS Control Committee to control further spread. The objectives of this Committee during the First Term Plan (FTP) were to establish infrastructural facilities such as laboratories, training of workers in laboratory aspects and case management of AIDS. MTP (Mid Term Plan in 1991-1996) objectives are : consolidation, extension and expansion of AIDS control activities, screening of blood donors, development of surveillance system, improvement of laboratory facilities and strengthening of STD control programs.

From 1988 to 1993, many government officials still did not care much about the impending epidemic of HIV/AIDS in Indonesia. Sometimes argument arise in the ground that Indonesia is unlike other countries. The Indonesian socioculture and religious disciplines would be able to prevent the spread of the fatal disease. Other communicable diseases which is still prominent especially among children and pregnant women is still considered in higher priority in health program rather than HIV/AIDS. HP//AIDS prevention campaign was not allowed through mass media, street billboard, many leaflet designed for limited target group were considered pornographic, condom promotion is very limited.

However, realizing that HP//AIDS is a disease of many factors, exponentially increased overtime, and predicted to have an impact on economic and nation development programs, in 1994 there was a strong political agreement on control of HIV/AIDS. Presidential Decree No. 36, 1994 on the Commission on AIDS Control were declared which would involve many ministries and would work to control HIV/AIDS through multi-

sectoral approach under the Ministry of Coordination on People Prosperity.

The basic principles of this decree are as follows :

- a) AIDS Control Program should be based on the existent laws and regulations and should follow the principles of AIDS Control Program by the United Nations.
- b) To increase AIDS Awareness in the community and to increase prevention and control of AIDS activities through multi sectoral, coordination, integrated and comprehensive approach.

Person with HIV or AIDS should be reported to the government based on The Ministry of Health Instruction No. 72/1988 on AIDS Case Compulsory Report, which stated:

- a) All health personnel who know and/or find someone with AIDS must report to the nearest health facilities as soon as possible with respect to individual confidentiality.
- b) Health facilities which found an AIDS case must report with confidentiality and according to the assigned procedures to the Director General of CDC&EH, Ministry of Health.

Another regulation which is commonly broken, even by medical professionals, and newspaper journalists, is the concern on the privacy of a person with HIV and AIDS is Law no. 10 1966 on Medical Confidentiality. This law clarify that medical confidentiality mean that anything learned by health personnel while performing their professional job should be kept confidential. Health worker, medical students, student conducting medical examination or treatment and other persons appointed by the Ministry of Health are subject to this regulation.

Several times, newspapers exposed the initial name, identification of sex, place and name of village, etc. of a person with HIV/AIDS that resulted on stigmatization and isolation.

HIV SEROSURVEY DATA

Serosurvey was started in 1987, on migrant workers before they left for Arab Countries. Since then surveillance of various groups in Indonesia has been conducted in provinces with high incidence of HIV/AIDS (Table 1). The total amount of specimen collected for serosurvey until June 1994 were 1.916.158, 228 out of them were HIV positives.

The highest positive rate was among referral cases - 1% (123/1.333) followed by high risk groups such as commercial sex worker (CSW)-0.04% (47/104.880) and the lowest are from low risk groups such as blood donors - 0.0004% (8/1.808.870). Thai sailors working near West Irian has the prevalence of 4% (48/1.075).

HIV/AIDS CASES IN INDONESIA

The first AIDS case reported in Indonesia was a Dutch tourist from Bali in April 5, 1987. Until December 1994 the number of HIV/AIDS cases reported to the Department of Health has increased to 275; 67 of them were AIDS cases (**Figure 1**).

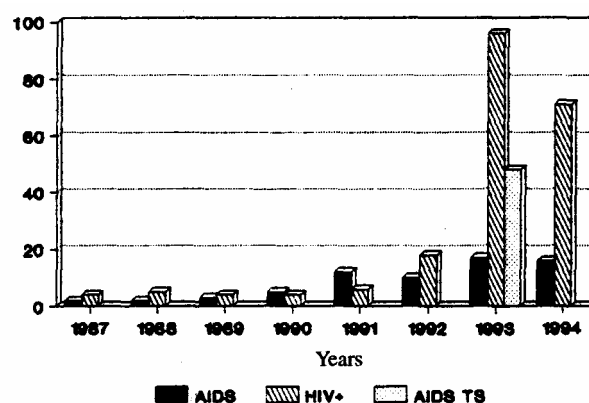
The number of HIV/AIDS cases in Indonesia has reached the second phase of epidemic, the early exponential increase, which started in 1993. By using AIDS model, in the medium transmission scenario, the cumulative number of HIV/AIDS

Table 1. Prevalence of HIV in Various Groups in Indonesia 1987 – 1994 (June) Reported by CDC

Year	Target Population	No. Specimen	HIV Positive		Prevalence HIV +
			Elisa	W. Blot	
1987	Low risk group				
	Migrant Worker	46.682	41	1	0.0020
1987-1991	Blood Donor	177.072	16	0	0
1992	Blood Donor	359.449	281	3	0.0008
1993	Blood Donor	555.712	444	2	0.0004
1994 (Mar)	Blood Donor	669.951	397	2	0.0003
		1.808.870	1.179	8	
	High risk				
1988	Cross Sectional	7.912	1	1	0.013
1989	Cross Sectional	14.045	2	1	0.007
	Sentinel	4.114	0	0	0
1990	Cross Sectional	3.296	0	0	0
	Sentinel	2.105	0	0	0
1991	Cross Sectional	22.377	5	3	0.013
1992	Cross Sectional	22.134	140	14	0.063
1993	Cross Sectional	20.741	200	20	0.096
1994 (Jun)	Sentinel	8.056	8	8	0.099
		104.880	356	47	
1987-1993	Referral	1.333	125	123	
1993	Thai Sailor	1.075	63	48	4.5
	Total	1.916.158	1.723	228	

Source: Dir.Jen CDC & EH

Figure 1. Number of HIV/AIDS cases in Indonesia each year, 1997 - 1994 (Dec)



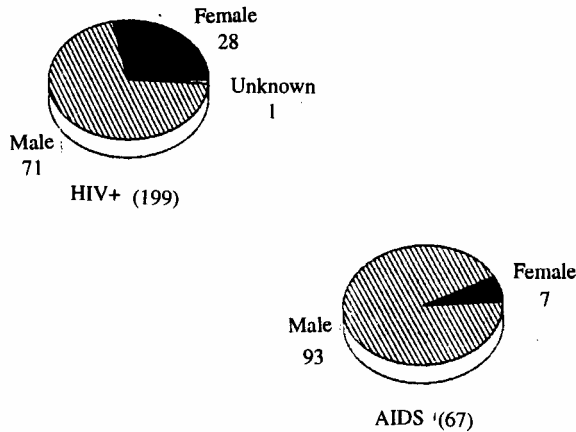
Source : CDC&EH

infections in Indonesia in 1995 is estimated at 175,000 and a prevalence of 0,085%. Without adequate interventions, the cumulative number in 2000 will reach 600,000 (prevalence

0,29%) and in 2005 will become 1,400,000 (prevalence 0,62%).

Distribution of HIV/AIDS cases according to sex in Indonesia were shown in **Figure 2**. In 1987-1992 most HIV/AIDS cases were male. But this picture has been changing since 1993 where female AIDS cases were found 7% among the total AIDS cases and 28% female HIV cases were found among the total HIV cases.

Figure 2. Sex distribution of HIV and AIDS cases in Indonesia, 1987.1994 (Dec)



Source: CDC & EH

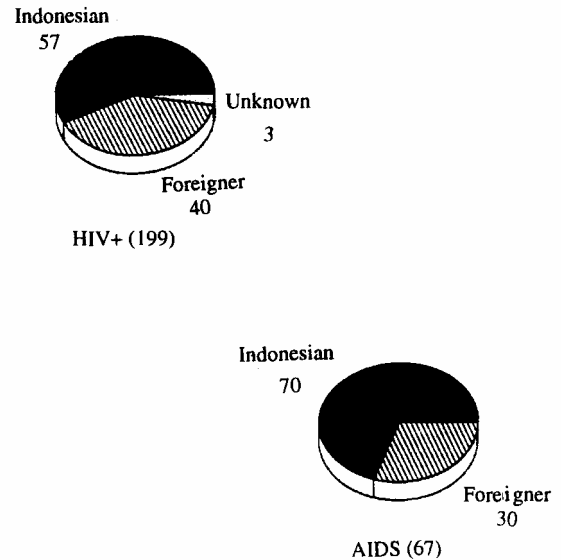
Nationality of HIV/AIDS cases in Indonesia were shown in **Figure 3**. In the beginning, HIV/AIDS cases were mostly among foreigners visiting Indonesia as tourists or expatriates. The cumulative number in 1994 shows that the percentage of AIDS cases with Indonesian nationality were higher than in HIV cases (70% compared to 57%). But the total number of HIV cases with Indonesian nationality were still much higher. There has been a transition of HIV/AIDS cases from foreigner to Indonesian as more cases of Indonesian nationality reported each year.

The mode of transmission are (**Figure 4**): for HIV cases : 69% heterosexual, 13% homosexual/bisexual; and for AIDS cases : 18% heterosexual, 62% homosexual/bisexual, 5% others and 15% unknown.

Heterosexual was the predominant transmission mode in Indonesia for HIV (recent infection) and homosexual/bisexual was the predominant transmission mode for AIDS (late infection).

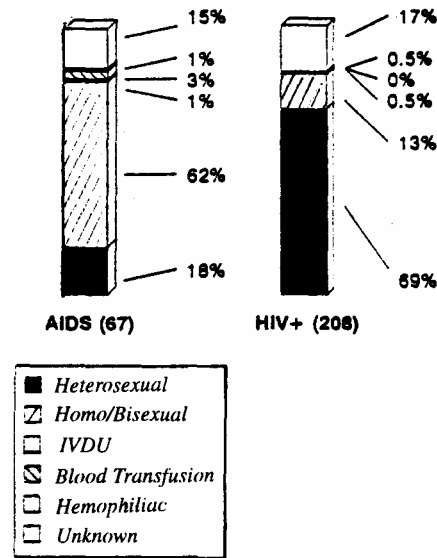
The AIDS cases are mostly in productive age group of 30-39 years old and for HIV are in 20-29 years old (**Figure 5**). The youngest age group for HIV are 15-19 years old and the oldest are more than 60 years old. Apparently there is no children detected as HIV positive.

Figure 3. Nationality of HIV and AIDS cases in Indonesia, 1987.1994 (Dec)



Source: CDC & EH

Figure 4. HIV/AIDS risk factors distribution in Indonesia 1987.1994 (Dec)

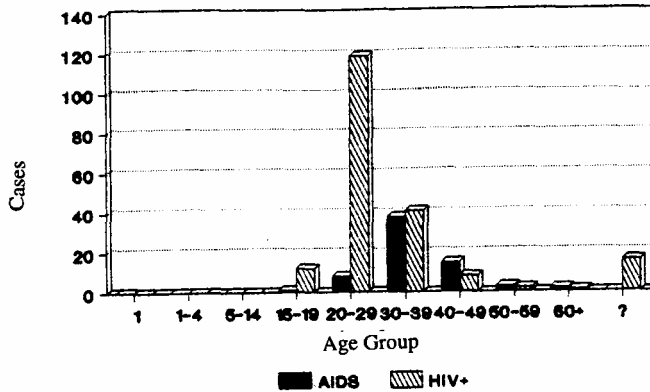


Source: CDC&EH

First AIDS cases were reported from Bali Province in 1987, since then, spread to 15 provinces in the island of Java, Sumatera, Kalimantan, Irian Jaya, Bali, NTB and Maluku (**Figure 6**). The increase of HIV/AIDS cases is mainly in Java.

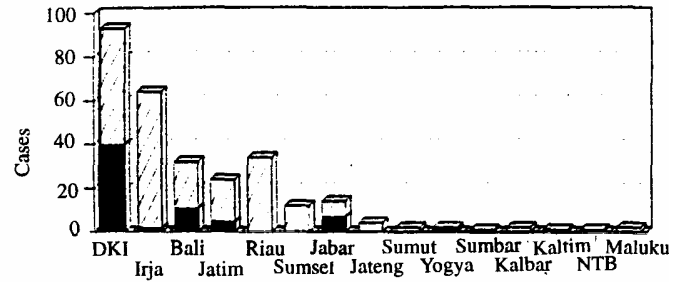
The number of AIDS cases and death by provinces is shown in **Figure 7**. DKI Jakarta (the capital city of Indonesia), Bali

Figure 5. Age group distribution of HIV/AIDS cases in Indonesia, 1987/1994 (Dec)



Source: CDC&EH

Figure 7. Number of AIDS cases and death and prov. in Indonesia, 1987/1994 (Dec)

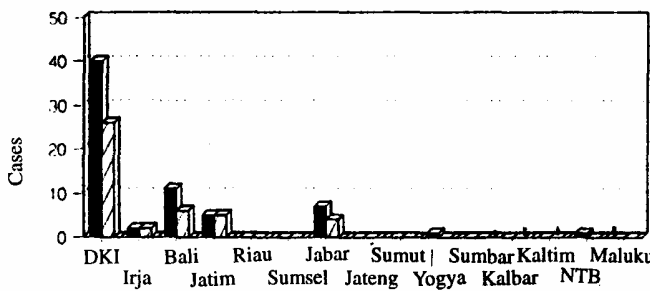


Thai SL		50														
HIV	▨	53	62	21	19	34	12	7	4	2	1	1	2	1	0	2
AIDS	■	40	2	11	5	0	0	7	0	0	1	0	0	0	1	0

Provinces

Source: CDC&EH

Figure 6. Number of HIV/AIDS cases by provinces in Indonesia, 1987/1994 (Dec)



AIDS	■	40	2	11	5	0	0	7	0	0	1	0	0	0	1	0
Death	▨	26	2	6	5	0	0	4	0	0	0	0	0	0	0	0
Thai SL		50														

Provinces

Source: CDC&EH

(the number one tourist resort) and Jabar and Surabaya (the second largest city) have the highest number of AIDS and deaths.

OPPORTUNISTIC INFECTIONS

Opportunistic infections detected among hospitalized AIDS cases were tuberculosis, pneumocystis carinii pneumonia,

candidiasis, cytomegalovirus retinitis, cryptococcus meningitis, cerebral toxoplasmosis, herpes zoster and bacterial sepsis. Wasting syndrome, dementia, and neurological symptoms are frequently encountered.

TUBERCULOSIS

According to World Bank Study in Indonesia, tuberculosis infection and tuberculosis disease continue to be a widespread problems. More than 50% of Indonesians are infected with TB.

The Annual Risk of Infection (ARI) of tuberculosis is at 2.5%. Knowing that there will be an increasing number of adults who will become HIV(+), the situation might increase the risk for premature death due to TB and for transmitting TB to others.

The nationwide prevalence of smear positive pulmonary TB cases were as follows :

No. of Smear Positive Pulmonary TB Cases	Year
21,549	1989
34,733	1990
60,933	1991
52,331	1992
73,655	1993
23,673	Sept.1994

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KOREKSI DAN TAMBAHAN

Dalam artikel **Keefektifan Paduan Obat Ganda Bifasik Anti Tuberkulosis Dinilai Atas Dasar Kegiatan Anti Mikrobial dan Atas Dasar Kegiatan Pemulihan Imunitas Protektif. 2. penilaian atas dasar kegiatan antimikrobial paduan obat oleh RA Handojo, Sandi Agung, Anggraeni Inggrid Handojo**, yang dimuat dalam **Cermin Dunia Kedokteran no. 115, 1997** terdapat beberapa kekurangan/kekeliruan, yang kami perbaiki sebagai berikut:

1. hal. 17 baris 6 dari bawah:
obat yang digunakan asal kasus TB yang terkait tidak pernah memperoleh obat anti TB sebelumnya. Perpanjangan kurun waktu..... dst.
2. hal. 18 kolom 1 alinea 4:
Dari segi kegiatan antimikrobial. khemoterapi anti TB bertujuan untuk memperoleh dahak negatif (sputum negativity) dan yang lebih penting, memperoleh konversi dahak (sputum conversion). Kenegatifan dahak adalah ... dst.
3. hal. 22:
Tabel 9. Kegiatan antimikrobial. Golongan keseluruhan
4. hal. 23 kolom 1, bab Diskusi, baris ke 14:
punyai NKB sebesar 2 karena INH maupun RMP mempunyai NKB sebesar 1 dan... dst.
5. hal. 23 kolom 1, bab Diskusi, baris ke 19:
mempunyai NKB sebesar 11/2
6. hal. 23 kolom 2, antara baris ke 7 dan ke 8:
Golongan A-B terdiri dari 3 subgolongan, yaitu:
7. hal. 24 kolom 1, alinea 3, baris ke 12:
bahwa pada penggunaan paduan obat HR/5-8H₂R₂ oleh kasus TB yang belum pernah memperoleh obat anti TB, pemeriksaan... dst.
8. hal. 24 kolom 1, alinea 4, baRIs ke 6:
.....dan golongan keseluruhan kasus yang memperoleh paduan obat HS/11H₂S₂
9. hal. 24 kolom 1, alinea 5, baRIs ke 3:
bulan (HS/11H₂S₂) (Tabel 9)... dst.

RALAT

Dalam artikel **Peranan Kader dalam Menunjang Program ISPA di Jawa Barat** oleh Enny Muchlastriningsih yang dimuat dalam **Cermin Dunia Kedokteran no. 115, 1997 halaman 52-55**, terdapat tabel yang (mungkin) kurang jelas.

Untuk itu, kami terbitkan kembali tabel-tabel tersebut dalam bentuk sebagai berikut:

Tabel 2. Persentase kader ISPA yang mengatakan apakah anak penderita ISPA boleh diberi obat batuk (n = 20)

Frekuensi pemberian	Ringan		Berat	
	I	II	I	II
Ya, selalu	80	100	30	100
Kadang-kadang	15	0	10	0
Tidak boleh	5	0	60	0
Jumlah	100	100	100	100

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Frekuensi pemberian	Ringan		Berat	
	I	II	I	II
Ya, selalu	80	100	30	100
Kadang-kadang	15	0	10	0
Tidak boleh	5	0	60	0
Jumlah	100	100	100	100

Keterangan : I : sebelum pelatihan
II : sesudah pelatihan

Mohon maaf atas kekurangan-kekurangan tersebut.