

Political Economy in Medical Anthropology's Review on Hearing Impairment and Deafness Prevention's Program in Indonesia

Weny Lestari

Badan Riset dan Inovasi Nasional, Indonesia

Abstract: *Hearing impairment and deafness in Indonesia was still a problem. In 2013, Percentage of population with aged over 5 years who had low and moderate hearing impairment were 2,6 % , and deafness were 0,09 %. In 2007, the National Committee for Hearing Impairment and Deafness was held to achieve Sound Hearing 2030 which was one of the World Health Organization's target. This paper reviews the efforts and programs of hearing impairment and deafness prevention in Indonesia from the political economy in medical anthropology's point of view. The results showed that even on national and global issues, hearing impairment and deafness prevention program still get less attention. Health policy focused on another health problems which have direct effect on political economy on high risk level of morbidity and mortality. Health improvement programs focussed on international concerns. The conclusion was hearing impairment and deafness still not a priority program in Indonesia. Policies and insurances program already exist, but still needed a lot of budgeting when people need hearing aid or cochlear implant. Hearing impairment and deafness prevention's program from promotive, preventive, curative and rehabilitative, should be integrated on primary health cares, which was initiated by National Committee for Hearing Impairment and Deafness to achieve the goal of Sound Hearing 2030.*

Keywords: *Deafness, Hearing Impairment and Deafness Prevention's Program, Political Economy in Medical Anthropology*

Introduction

Ability to communicate with others depend on hearing health, that condition determine the quality of life. Due to the importance of hearing health, the Southeast Asia Regional World Health Organization (SEARO-WHO) has launched the Society for Sound Hearing with the program "Sound Hearing 2030, Action for Ear and Hearing Care for All". The program aims to improve the quality of life in Southeast Asian region by increasing the prevention and treatment of hearing and deafness in each countries' member.

Hearing impairment and deafness in Indonesia are still a public health problem. The result of the Senses Health Survey in seven provinces in Indonesia on 1994-1996 showed that the prevalence of hearing impairment was 16.8%, and about 50% of them were preventable disorders (Departemen Kesehatan RI, 2006).

¹ Correspondent Author E-Mail: weny716@gmail.com

Basic Health Research 2007 data showed that percentage of population in Indonesia aged over 15 years who had hearing problems, such as hearing normal sounds in a room was 5.9% and hearing people conversation in a quiet room was 5.3% (Kemenkes RI, 2008).

Basic Health Research 2013, based on a conversation test conducted on residents in Indonesia aged over 5 years, the percentage of the population who had mild and moderate hearing impairment were 2.6%, and deafness were 0.09% (Kemenkes RI, 2013).

The National Committee for Prevention of Hearing Impairment and Deafness (Komnas PGPKT) was formed in 2007 to achieve the Sound Hearing 2030 target. Although strategic plan has been made, the decreased cases of deafness in Indonesia is not significant. The Ministry of health as a government policy maker has not been able to overcome hearing impairment and deafness problems which can reduce the quality of life. Government focussed on other health problems that could increase the mortality.

This paper aims to explain the political-economic analysis from the Political Economy in Medical Anthropology (PEMA) point of view on hearing impairment and deafness program in Indonesia. Since the program was first launched in 2007 until 2022, it has received less attention. This paper discusses how the program for overcoming hearing impairment and deafness is related to the management of political and economic policies in health services at national and global levels.

Literature Review

Hearing impairment is an inability to hear more than 40 decibels (dB) in adults and more than 30 dB in children. People with hearing impairment and deafness generally occurred in low- and middle-income countries. One third of the population aged over 65 years suffered from hearing impairment and deafness (WHO, 2020).

The impact of hearing impairment and deafness can result in disturbances in various dimensions of human life, such as functional, socio-emotional, and economic. Functionally, hearing impairment and deafness can have an impact on an individual's ability to communicate with other individuals. Children with hearing impairment and deafness are detected late, will experience delays in handling and also experience delays in the recognition and development of sign language. The socio-emotional impact of hearing impairment and deafness that is not handled properly will make individuals excluded from the environment of daily life, which can lead to feelings of loneliness, isolation, and frustration. The economic impact of hearing impairment and deafness can unconsciously result in a country's economic burden. In developing countries, many children with hearing impairment and deafness do not get proper education. Likewise for adults, there are still many who have not received equality in getting a job. Increasing access to inclusive education for children with hearing impairment and deafness, assistance on the accessibility of health and public services, and increasing public awareness on the special needs of workers with hearing impairment and deafness are still very much needed in various sectors of life in society (WHO, 2020).

Understanding people with hearing impairment and deafness were seen as problem even in worldwide. In developed country as United State, only few healthcare providers had prioritizing to understanding of hearing levels (Sydlowski et al., 2022). In developing country as India, hearing impairment and deafness also seen as a high burden. India also developed

program about prevention and rehabilitation, to increase man power skill of understanding in health care provider (Garg et al., 2009).

Political Economy in Medical Anthropology (PEMA) reviews focuses on determinants of macro-social that had impacts on health. The approach put attention on the economic and political structures that exist in the social production of morbidity, or the rate of disease occurrence within a population group. Morgan defines a political-economy in medical anthropology approach as a macro-analytic, critical and historical perspective to analyzed the distribution of disease and health services under various economic's systems, with particular emphasis on impacts of social stratification, politics, and economic relations in global economic systems (Morgan, 1987). The political-economy in medical anthropology (PEMA) according to Baer (1982) has two points of views, from disease and health services (Baer, 1982). On both sides of the point of view, it could be seen that hearing impairment and deafness program in Indonesia.

Methodology

This paper datas were collected based on a review of documents from various sources which related to Hearing Impairment and Deafness Program in Indonesia. The analysis of hearing impairment and deafness programs is associated with policy management and health services at the national and global levels of from Political Economy in Medical Anthropology (PEMA) point of views.

Political Economy in Medical Anthropology (PEMA) reviews focuses on determinants of macro-social that had impacts on health. The approach put attention on the economic and political structures that exist in the social production of morbidity, or the rate of disease occurrence within a population group. Morgan defines a political-economy in medical anthropology approach as a macro-analytic, critical and historical perspective to analyzed the distribution of disease and health services under various economic's systems, with particular emphasis on impacts of social stratification, politics, and economic relations in global economic systems (Morgan, 1987).

Findings & Discussion

Global Situation of Hearing Impairment and Deafness

World Health Organization (WHO) stated that there were 466 million people in worldwide (5% of the world's population) suffered from hearing impairment. Of the 466 million people, which consist of 432 million adult cases and 34 million child cases. This number has increased significantly in two decades, 120 million in 1995, and 250 million in 2001. It means that within twenty years the number has increased almost 400 percent. WHO estimated that by year of 2050, the number of people with hearing impairment will reach 900 million in the world (WHO, 2020).

Hearing impairment and deafness caused by genetics, complications during delivery baby, infectious diseases, chronic ear infections, use of certain drugs, exposure to loud noises, and aging. 60% of hearing impairment and deafness in childhood could be prevented. 1.1 billion people in the age 12-35 years were risked of hearing impairment and deafness caused by exposure to loud noises at recreation or entertainment places. Untreated hearing impairment and deafness will cause an average global economic loss of 750 billion dollars annually.

Prevention of early detection and treatment of hearing impairment and deafness could reduce costs (cost effectiveness) and provide benefits to individual's quality of life. People with hearing impairment and deafness would get benefit if they got early detection, by providing hearing aid interventions, cochlear implants, or others, such as providing sign language lesson, social support and inclusive education. The current situation showed that there is a gap between the need and use of hearing aids, from 83% the need of hearing aids, only 17% users which provided of hearing aids. The more time delayed in early provided of hearing aid, would be less function of benefits that hearing aids could be provided (WHO, 2020).

In fact, 50% cases of hearing impairment and deafness could be prevented by assessing public health. 60% of hearing impairment and deafness on children under 15 years were preventable causes. Prevalence in low- and middle-income countries (75%) were higher compared to high-income countries (49%). Preventable causes of hearing impairment and deafness in children include: (1) infectious diseases such as mumps, measles, rubella, meningitis, cytomegalovirus, and chronic otitis media (31%), (2) complications at birth, Low Birth Weight (LBW), premature birth, and jaundice (17%), (3) use of ototoxic drugs in pregnant women and infants (4%), (4) others (8%) (WHO, 2020).

Situation of Hearing Impairment and Deafness in Indonesia

Based on Sense Health Survey conducted in 1994-1996 in seven provinces in Indonesia showed prevalence rate of hearing impairment was 16.8%, deafness 0.4%, ear morbidity 18.5%, external ear disease (6.8%), middle ear disease (3.9%), presbycusis (2.6%), ototoxicity (0.3%), sudden deafness (0.2%), and deafness (0.1%). Common causes of external ear morbidity was cerumen prop (3.6%), and common cause of middle ear morbidity was chronic otitis media suppurative (3.0%). Cerumen prop and chronic otitis media suppurative were potentially caused of hearing impairment, these could be overcome by general practitioners or primary health care doctors (Departemen Kesehatan RI, 2006).

The prevalence of ear morbidity was highest at school age's children (7-18 years). rate of deafness in children under-five years (0-4 years) was 0.4%, higher than the pre-school and school age groups. This needs special attention considering that this age is a critical period of speech and language development. This incidence could be reduced through early detection of hearing impairment in children under five years. Previous study showed that there were five diseases and the risk of causing hearing impairment and deafness which could be prevented (1) Chronic Suppurative Otitis Media (CSOM), (2) Noise Induced Hearing Loss (NIHL), (3) Presbycusis (deafness in elderly), (4) Congenital deafness (deafness from birth), and (5) Cerumen obstruction (ear wax) (Departemen Kesehatan RI, 2006).

Chronic Suppurative Otitis Media is a chronic inflammation of the mucous tissue of middle ear and mastoid cavity, with perforation of the tympanic membrane and the discharge of clear fluid or pus from ear's canal. Generally, patient with CSOM think that is a normal thing that can heal itself without treatment (Wirawan et al., 2020). Noise Induced Hearing Loss is hearing impairment and deafness caused by noises in an environment for a long time and continuously (Salawati, 2013). Presbycusis is a sensorineural hearing impairment in elderly due to the degeneration of the hearing organ that occurs slowly and symmetrically on both sides of ears (Fatmawati & Dewi, 2016). Congenital deafness is deafness in infants from birth, caused by nutritional deficiencies during pregnancy, bacterial or viral infections (Toxoplasma, Rubella,

Cytomegaly virus, Herpes Simplex and Syphilis (TORCHS)), the use of ototoxic and teratogenic drugs has the potential to cause hearing impairment (Direktorat P2PTM Kemenkes RI, 2018). Obstruction cerumen (earwax) is a product of sebaceous and apocrine glands present in the skin of ear canal that accumulates and hardens. Obstruction cerumen can result in hearing impairment of up to 40 dB (Money et al., 2018).

The risk of hearing impairment and deafness has a tendency to increase in the future. The increasing life expectancy that the elderly population has consequence of increasing the prevalence of degeneration. Lifestyles such as listening to loud music, a workplace environment with high noise levels are also suspected to be the cause of an increased risk of hearing impairment and deafness.

Basic Health Research 2013 data showed that there were eleven provinces where the population aged five years and over experienced mild and moderate hearing impairment (North Sumatra, Papua, Yogyakarta, West Sulawesi, East Java, North Maluku, South Sumatra, South Sulawesi, Java Central, Lampung and East Nusa Tenggara). The prevalence is equal to and/or above the national average of 2.6% (Kemenkes RI, 2013), as shown in Figure 1 below:

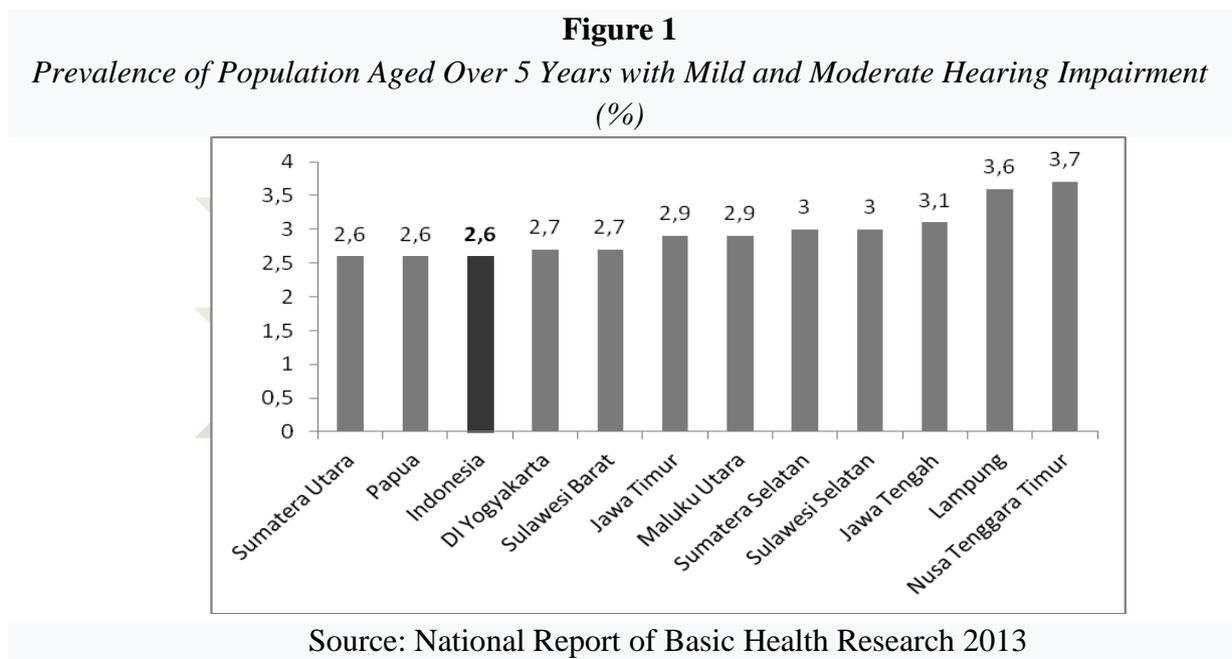
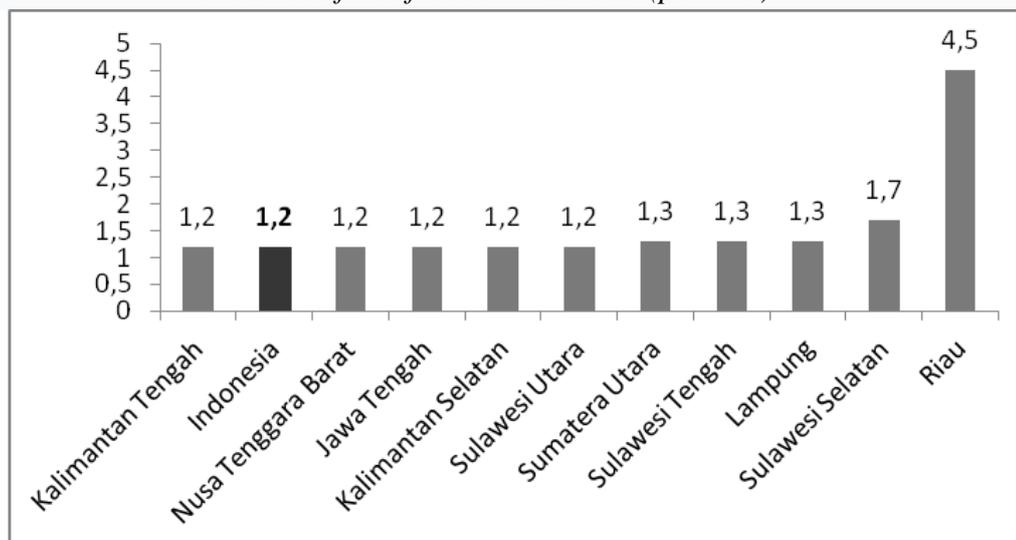


Figure 1 showed that there were 6.5 million people aged over five years in Indonesia had mild and moderate levels of hearing impairment. If it did not handled properly and too late it would be deafness.

Basic Health Research 2013 showed that the highest prevalence of deafness in Indonesia is in Riau Province, reaching 4.5 per mill, above the national average which only 1.2 per mill. As shown in Figure 2 below:

Figure 2
Prevalence of Deafness in Indonesia (per mill)



Source: National Report of Basic Health Research 2013

Figure 2 showed that there were 1.125 million people aged over five years had deafness in Indonesia. It is a huge case, even though it could be prevented with early detection and family education in the community for awareness of hearing impairment and deafness prevention.

Political and Economic Policies related to the Prevention of Hearing Impairment and Deafness in Indonesia

Based on the Law of the Republic of Indonesia Number 8 of 2016 about people with disabilities in article 12 stated that people with disabilities have the right to health. Health rights for people with disabilities include the right to obtain: (a) easily accessible information and communication in health services; (b) equality and opportunity access to resources in the health sector; (c) equality and opportunity for safe, quality, and affordable of health services; (d) equality and opportunity to independently and responsibly determine the health services needed for themselves; (e) Medical Aids based on their needs; (f) quality drugs with low side effects; (g) protection from attempted medical trials; and (h) protection in health research and development which involving humans as subjects. The Law for deafness specified in Article 41, stated that the national and regional governments in organizing and/or facilitating inclusive education and special education. As referred to in Article 40 paragraph 2 that government was obligated to facilitate people with disabilities to learn basic skills needed for independence and full participation in education and social development. The basic skills include sign language skills and the promotion of linguistic identity people with hearing impairment and deafness (Republik Indonesia, 2016). The law of the Republic of Indonesia Number 8 of 2016 articles 12 and 41 clearly describe the rights of persons with disabilities to obtain health services and the rights to receive inclusive or special education.

Health financing for the prevention of hearing impairment and deafness were covered to National Health Insurance, as stated in the regulation of the Health Social Security Administration Number 7 of 2018 about management of health facility claims administration in the implementation of health insurance. Article 17 states that claims for the benefits of

advanced level referral health services consist of: (a) Advanced Outpatient; (b) Advanced Inpatient Care; (c) drugs for chronic diseases and chemotherapy drugs; (d) medical aids which hearing aids included; (e) Ambulance service; and (f) Continuous Ambulatory Peritoneal Dialysis (CAPD). Article 17 guaranteed outpatient, inpatient, medication, and hearing aids for people with hearing impairment and deafness. The procedure for claiming hearing aids was described in Article 23 point c. The supporting documents for filing a claim for medical aids services are as follows: (c) claims for hearing aid services are accompanied by: 1. prescription for hearing aids; 2. results of audiometric examination; and 3. proof of receipt of hearing aids containing the price of hearing aids (BPJS Kesehatan, 2018).

In addition, there are also Ear, Nose and Tracheal (ENT) emergencies guaranteed under national insurance, including: (1) Abscesses in the ENT and head-neck area, (2) unidentified objects in laryngeal/tracheal/bronchial and throat, (3) unidentified objects in ear and nose, (4) Dysphagia, (5) Jackson grade II/III upper airway obstruction, (6) Jackson grade IV upper airway obstruction, (7) Acute otalgia (whatever cause), (8) Acute facial paresis, (9) Bleeding in the field of ENT, (10) Shock due to abnormalities in the field of ENT 11 Trauma (acute) in the field of ENT, Head and Neck (NH), (11) Sudden deafness (BPJS Kesehatan, 2014).

Efforts to overcome hearing impairment and deafness that were carried out among the ENT-NH practitioners (Perhati) in 2010, have increased since the formation of hearing impairment and deafness of national committee held in 2007. Practitioners reached to 50 people in Indonesia. Although this number when compared with the total population in Indonesia is lack, there is only one ENT-NH surgeon for five million people (1 : 5 million). Based on Indonesia's health profile in 2017 data showed that the number of ENT hospitals in Indonesia is seven hospitals (Pusat Data Indonesia, 2018).

Cohlear Implant (CI) technology of ear surgery could already be done in Indonesia, especially in DKI Jakarta, including post-surgery rehabilitation treatment. This CI surgery is taken when the Hearing Aid is no longer able to help. With CI devices, it is possible to restore hearing ability up to 80-90 percent, but the cost is still very expensive, which is around Rp. 200,000,000.00 – Rp. 300,000,000.00, in 2010. Hearing aids in 2010 cost per year units are still in the range of Rp. 10,000,000.00 – Rp. 15,000,000.00. These devices are quite expensive because they are still imported from abroad, and enter Indonesia in the category of electronic devices with a higher entry fee tax than if they are included in the category as medical devices. This is very different from that in developed countries where hearing aids can be obtained free of charge from the government. It is conceivable that only a handful of Indonesians have access to hearing aids, let alone to get Cochlear Implant (CI) services with low income per capita and Indonesia is still classified as a developing country (Rifati et al., 2010). BPJS Health coverage in 2018 for hearing aids is a maximum of only Rp. 1,000,000.00, the shortfall must still be borne by the patient (BPJS Kesehatan, 2018).

Contradiction with the high cost, Rifati, et al. (2010) showed that from primary health care with ENT's services in Jakarta had patients ranges from 25-30 visitors/per day. It had two assumptions as (1) growing public awareness of the importance of ENT's health or, (2) there were many ENT cases among the middle to lower class people (Rifati et al., 2010).

The number of Primary Health Care (PHC) with ENT services were lack of ENT practitioners. There were general practitioners who receive training from ENT practitioners'

organizations to handle ENT cases with or without proper ENT's medical equipments (Rifati et al., 2010).

Rifati et al. (2010) result also showed that PHC did not have a special ENT polyclinic in Jakarta, it is stated that there were many cases of ear disorders had mild cases that can be handled with limited medical equipment, such as Corpus Allienium/Copal (insertion of objects into the ear), cerumen (ear wax), and severe CSOM. If they could not be handled by PHC, they will be referred to the nearest hospital. However, sometimes patients did not want to be referred because they did not have the money, and returned to PHC. The lack of information on health financing coverage to the cases that could be served at advanced health services causes the failure of health care referrals (Rifati et al., 2010).

In 2017, Hearing impairment and deafness national committee had effort to 1) Establish regional committees as an programs/activities' expansion, 2) PHC development and continuous program in ear and hearing health services, and 3) Training of midwives for early detection of congenital deafness in an effort to prevent and control the worst effects of deafness on infants. These were the main programs of national committee to achieve Sound Hearing 2030. Based on main programs of national committee, in 2017 there were 142 regional committees which consisted of 25 Provinces and 117 Regencies/Cities committees. Training of PHC doctors and earkit donation were improving hearing impairment and deafness health services. Goals of sustainability on programs starting from promotion/prevention, early detection, treatment, rehabilitation and referral, especially the five diseases that cause deafness. PHC training conducted by regional committees were targeted for completion in 2025. The target of 1000 PHC per year has been successfully implemented in 2014. PHC development is a reference activity with a target that by 2025 all PHCs have implemented programs avoiding of hearing impairment and deafness (Komnas PGPKT, 2017).

Efforts of hearing impairment and deafness programs would be more efficient if prevention is carried out against the risk of five diseases that cause disorders (CSOM, NIHL, Cerumen Obstetrics, Congenital Deafness and Presbycusis). Early prevention is better than cure. Introduction to early detection of hearing impairment and deafness could minimize the risk of hearing impairment and deafness.

Risk of Unconscious Hearing Impairment and Deafness

Globalization has contributed to increasing rates of chronic disease and risk in complex ways. Changing population's lifestyle associated with urbanization, globalization, nutritional transition and economic growth have a direct and rapid impact to individuals and communities's health (Hashemian & Yach, 2007). Improvement of technologies to adjust of human life styles such as music players, vehicles/transportation, cell phones, household electronic equipment could risk to human hearing health. The human ear has a hearing threshold, such as the following Audiogram Hearing Impairment Levels: (1) Normal Hearing: 0-20 decibels ISO (example: silence in the library, the sound of birds chirping), (2) Mild Hearing Impairment: 20-45 decibels ISO (example: the sound of a refrigerator engine), (3) Moderate Hearing Impairment: 45-60 decibels ISO (example: human conversation), (4) Moderate Severe Hearing Impairment: 60-75 decibel ISO (example: the sound of crickets, vacuum cleaner), (5) Severe Hearing Impairment : 75-90 decibels ISO (example: big cc motorcycle, music player with

maximum volume headset), (6) Severe Hearing Impairment : above 90 decibel ISO (example : jet plane 25 m distance, music concert with loudspeakers, road concrete drills) (Suwenta, 2010).

The dangers of deafness could happen to anyone due to the noise that occurs. Police on the highway, employees of entertainment venues, musicians, transportation drivers, employees of train stations and airports, factory employees, babies and children who are brought by their parents to the mall in a noisy game area, if exposed in periods of time, exceed threshold that is accepted by the human ear will be prone to suffer from hearing impairment and deafness.

Hearing impairment and deafness could affect anyone by the risk of lifestyle in global. Awareness should be included in health services in terms of promotive and preventive, before the occurrence of disorders that require curative and rehabilitative. However, promotive and preventive were lack, many people who do not care about the risk of hearing impairment which can cause permanent deafness in the future. Also the exposure to infectious diseases of the ear such as CSOM which is can cause deafness if not treated immediately.

Global Influence in Politics and Economics of Health Policy related to the Prevention of Hearing Impairment and Deafness in Indonesia

In September 2000, Indonesia with 189 countries attended the Millennium Summit in New York and signed the Millennium Declaration. The declaration contains the commitment of each country and the international community to achieve the 8 Millennium Development Goals (MDGs), as a package of measurable goals for development and poverty alleviation. The eight MDGs targets were (1) end poverty and hunger, (2) universal education, (3) gender equity, (4) child health, (5) maternal health, (6) combat HIV/AIDS, (7) Ensure environmental sustainability, (8) global partnership (United Nations, 2010).

Global commitment directs policy programs in Indonesia, including health policy programs. The achievement of the MDGs is the main program that becomes a priority for health development in Indonesia, so that in making health programs at the policy-maker level there were priority and non-priority programs.

Hearing impairment and deafness were considered as non priority program, if it is embedded in to MDGs targets, which tend to focus on reducing maternal and child mortality, malaria and HIV/AIDS. Global funds were also channeled for the needs of priority programs, as well as national funds. Even though WHO has launched Sound Hearing 2030 in Southeast Asia, including Indonesia in 2004, four years later after the launch of the MDGs, program seems to be slow, including the declaration of a strategic plan for the Prevention of Hearing Impairment and Deafness in 2007.

According to Raphael and Bryant (2006), health promotion can be successful if there is strong support from sustainable health policy makers, so that the influence of public awareness increases. This is also the case with policy commitments for overcoming hearing impairment and deafness in Indonesia (Raphael & Bryant, 2006).

The political-economy in medical anthropology (PEMA) according to Baer (1982) has two points of views, from disease and health services (Baer, 1982). On both sides of the point of view, it can be seen that hearing impairment and deafness in Indonesia, both in terms of disease and health services, still unoptimal. There is still a lack of concern, both in terms of diseases that do not look exist physically, but in very influential on a person's quality of life if

not detected early. Policy products that regulate are also lack, efforts to overcome not maximized to reach a global agreement "sound hearing 2030".

Based on Eun Jung Kim, et al. (2017) in developed countries like the UK still had the economic gap between people with hearing impairment and deafness and people without hearing impairment and deafness. People with hearing impairment and deafness have lower incomes, have greater difficulty making ends meet, cannot pay for unexpected expenses, and are less likely to have jobs. In the UK there is still discrimination against people with hearing impairment and deafness (Kim et al., 2018). It showed that both in developed and developing countries, economic disparities still occur in people with hearing impairment and deafness. The economic burden of people with hearing impairment and deafness is greater than that of people without hearing impairment and deafness.

Global burden has been increasing since the outbreak of the COVID-19 pandemic which began at the end of 2019, until 2022, the world still combat with the COVID-19 pandemic. The burden of handling hearing impairment and deafness during the COVID-19 pandemic is also increasing. The limitations of reading the lips of the interlocutor are hampered by the use of masks, the activities of meetings, both school and work that turn into online activities, there are also obstacles for students or people with hearing impairment and deafness. Utilization and development of technology that is friendly to individuals with special needs is very much needed during this COVID-19 pandemic. Health services, which are currently all focusing on priorities for handling the COVID-19 pandemic, also place a burden on the prevention of hearing impairment and deafness, at the national and global levels.

Conclusions

At national and global levels, hearing impairment and deafness is not more important than other health problems that rates of morbidity and mortality are higher. Political and economically that health improvement programs only focus on priority issues, which was a global spotlight (MGDs). Cases of hearing impairment and deafness are still not a priority, because the physical disability is not visible, and the morbidity is very low. However, if the losses are calculated over a long period of time, because usually deaf people still survive, the losses will be greater. The impact of hearing impairment, ranging from a decrease in the quality of life, hampered opportunities to get education and jobs, to access to good health services such as getting hearing aids and cochlear implants surgery, and other general health services.

Health services for prevention of hearing impairment and deafness, from promotive, preventive, curative and rehabilitative, could be integrated to basic health services at PHC along with health financing. Priority or non-priority programs, hearing health is very important. Even it is not a priority and not the main focus of the Millennium Development Goals (MDGs), even though directly if hearing impaired so the possibility of getting a good education equally (target MDGs 2) is also disrupted, and not getting a job equally which could lead to no income that leading to poverty (MDGs target 1 is not achieved). Politics (policy), economy and health are closely related to each other.

Global or national conditions must not distinguish between priorities and not priorities for any health program policies, including its relation to the prevention of hearing impairment and deafness. With global and national commitments already in place for the prevention of hearing impairment and deafness, it should not compete with other commitments at the

implementation level. For this reason, intensive and continuous coordination is needed between the government, the private sector and non-governmental organizations in order to realize the division of roles of existing commitments. The sustainability of the hearing impairment and deafness prevention program from the central level to the basic service level in the community, especially at the promotive and preventive levels for the prevention of hearing impairment and deafness.

Preventing and tackling the occurrence of hearing impairment and deafness economically the burden will be lighter than the handling of events that have occurred or have been handled too late because they are not detected earlier. Addressing the root causes of hearing impairment and deafness is better done. Overcoming the occurrence of diseases and lifestyle behaviors that can lead to hearing impairment and deafness can be improved. Early detection and intervention for preventing preventable hearing impairment and deafness can minimize future impacts functionally, socially, emotionally, and economically for individuals, families and communities, both at regional, national and global levels.

It is important that the handling COVID-19 pandemic will not eliminate other promotive and preventive efforts in the national health service system, including efforts to overcome hearing impairment and deafness in the incidence of diseases and situations that can be prevented and/or minimized. So that the achievement of Indonesia's commitment to the “sound hearing 2030” can be reached properly, no one left behind.

References

- Baer, H. (1982). On the Political Economy of Health. *Medical Anthropology Newsletter*, 14(1), 1–17. <http://www.jstor.org/stable/648038>
- BPJS Kesehatan. (2014). *Panduan Praktis Penjaminan Pelayanan Kesehatan Darurat Medis di Faskes yang Tidak Bekerjasama dengan BPJS Kesehatan*. BPJS Kesehatan.)
- BPJS Kesehatan. (2018). *Peraturan BPJS Kesehatan No. 7 Tahun 2018 tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan dalam Penyelenggaraan Jaminan Kesehatan*. BPJS Kesehatan. <https://bpjs-kesehatan.go.id/bpjs/arsip/detail/1134>
- Departemen Kesehatan RI. (2006). *Kepmenkes RI NOMOR 879/Menkes/SK/XI/2006 Tentang Renstranas PGPKT Untuk Mencapai Sound Hearing 2030*. Departemen Kesehatan RI.
- Direktorat P2PTM Kemenkes RI. (2018). *Apa Penyebab Tuli Kongenital*. Infographic. <http://p2ptm.kemkes.go.id/infographic-p2ptm/gangguan-indera-fungsional/page/3/apa-penyebab-tuli-kongenital>
- Fatmawati, R., & Dewi, Y. A. (2016). Karakteristik Penderita Presbiakusis di Bagian Ilmu Kesehatan THT-KL RSUP DR . Hasan Sadikin Bandung Hospital Bandung Period January 2012 - December 2014. *JSK*, 1(4), 201–205. http://jurnal.unpad.ac.id/jsk_ikm/article/download/10381/4745
- Garg, S., Chadha, S., Malhotra, S., & Agarwal, A. K. (2009). Deafness: burden, prevention and control in India. *The National Medical Journal of India*, 22(2), 79–81.
- Kemenkes RI. (2008). *Laporan Nasional Riset Kesehatan Dasar tahun 2007*.
- Kemenkes RI. (2013). *Risikesdas 2013 Dalam Angka*.
- Kim, E. J., Byrne, B., & Parish, S. L. (2018). Deaf People and Economic Well-Being Findings from the Life Opportunities Survey. *Disability & Society*, 33(3), 374–391. <https://doi.org/10.1080/09687599.2017.1420631>

- Komnas PGPKT. (2017). *Selayang Pandang Program dan Kegiatan Komnas PGPKT Menuju Sound Hearing 2030*. Web Page. <http://komnaspkpt.blogspot.com/p/tentang.html>
- Money, P., Naftali, Z., & Marliyawati, D. (2018). Hubungan Antara Penggunaan Cotton Bud dengan Serumen Obsturan. *Jurnal Kedokteran Diponegoro*, 7(2), 892–905. <http://ejournal3.undip.ac.id/index.php/medico>
- Morgan, L. M. (1987). Dependency Theory in the Political Economy of Health: An Anthropological Critique. *Medical Anthropology Quarterly*, 1(2), 131–154. <https://doi.org/https://doi.org/10.1525/maq.1987.1.2.02a00010>
- Pusat Data Indonesia. (2018). *Data dan Informasi Profil Kesehatan Indonesia 2017*.
- Raphael, D., & Bryant, T. (2006). Maintaining Population Health in a Period of Welfare State Decline Political Economy as the Missing Dimension in Health Promotion Theory and Practice. *Promot Educ.*, 13(4), 236–242. <https://pubmed.ncbi.nlm.nih.gov/17410974/>
- Republik Indonesia. (2016). *Undang-Undang RI Nomor 8 Tahun 2016 Tentang Penyandang Disabilitas*. Republik Indonesia.
- Rifati, L., Rahajeng, E., Rukmini, U., Zainar, S., Indrawati, L., Lestari, W., Putra, S., & Turaeni, T. (2010). *Analisis Situasi Penanggulangan Gangguan Penglihatan-Kebutaan dan Gangguan Pendengaran-Ketuliaan di Indonesia sampai Tahun 2010*.
- Salawati, L. (2013). Noise-Induced Hearing Loss. *Jurnal Kedokteran Syiah Kuala*, 13(1), 45–49. <http://jurnal.unsyiah.ac.id/JKS/article/download/2744/2592>
- Suwenta, R. (2010). *Komnas PGPKT*. <http://www.ketuliaan.com/>
- Sydowski, S. A., Marinelli, J. P., Lohse, C. M., & Carlson, M. L. (2022). Hearing Health Perceptions and Literacy Among Primary Healthcare Providers in the United States: A National Cross-Sectional Survey. *Otology & Neurotology*, 43(8), 894–899. <https://doi.org/10.1097/MAO.00000000000003616>
- United Nations. (2010). *United Nations Millennium Development Goals*. Web Page. <http://www.un.org/millenniumgoals/>
- WHO. (2020). *Deafness and Hearing Loss*. Web Page. <https://www.who.int/news-room/factsheets/detail/deafness-and-hearing-loss>
- Wirawan, T. H. (FK U., Sudipta, I. M. (FK U., & Sutanegara, S. W. D. (FK U. (2020). Karakteristik Penderita Otitis Media Supuratif Kronik di Rumah Sakit Umum Pusat Sanglah Denpasar Periode Januari-Desember 2014. *Jurnal Medika Udayana*, 9(3), 43–47. <https://doi.org/10.24843.MU.2020.V9.i3.P09>

About the Author:

Chief Researcher
Weny Lestari <i>National Research and Innovation Agency, Indonesia</i>