



Indonesia: Health and well being for all travellers

A summary of recommendations:

All travellers should visit either their personal physician or a [travel health clinic](#) **4-8 weeks** before departure.

Immunisations:

Recommended for:

Typhoid

For travellers who may eat or drink outside major restaurants and hotels

Polio

One-time booster recommended for any adult traveller who completed the childhood series but never had polio vaccine as an adult

Japanese encephalitis

For long-term (>1 month) travellers to rural areas or travellers who may engage in extensive unprotected outdoor activities in rural areas, especially after dusk.

Hepatitis B

For travellers who may have intimate contact with local residents, especially if visiting for more than 6 months

Rabies

For travellers who may have direct contact with animals and may not have access to medical care

Measles, mumps, rubella (MMR)

Two doses recommended for all travellers born after 1956, if not previously given

Tetanus-diphtheria

Revaccination recommended every 10 years

Medications

[Travellers' diarrhoea](#) is the most common travel-related ailment. The cornerstone of prevention is *food and water precautions*, as outlined below. All travellers should bring along an antibiotic and an antidiarrhoeal drug to be started promptly if significant diarrhoea occurs, defined as three or more loose stools in an 8-hour period or five or more loose stools in a 24-hour period, especially if associated with nausea, vomiting, cramps, fever or blood in the stool.

A quinolone antibiotic is usually prescribed: either [ciprofloxacin \(Cipro\)\(PDF\)](#) 500 mg twice daily or [levofloxacin \(Levaquin\) \(PDF\)](#) 500 mg once daily for a total of three days. Quinolones are generally well tolerated, but occasionally cause sun sensitivity and should not be given to children, pregnant women, or anyone with a history of quinolone allergy.

Alternative regimens include a three-day course of [rifaximin \(Xifaxan\)](#) 200 mg three times daily or [azithromycin \(Zithromax\)](#) 500 mg once daily. Rifaximin should not be used by those with fever or bloody stools and is not approved for pregnant women or those under age 12. Azithromycin should be avoided in those allergic to erythromycin or related antibiotics.

An antidiarrhoeal drug such as loperamide (Imodium) or diphenoxylate (Lomotil) should be taken as needed to slow the frequency of stools, but not enough to stop the bowel movements completely. Diphenoxylate (Lomotil) and loperamide (Imodium) should not be given to children under age two.

Most cases of travellers' diarrhoea are mild and do not require either antibiotics or antidiarrhoeal drugs. *Adequate fluid intake* is essential.

If diarrhoea is severe or bloody, or if fever occurs with shaking chills, or if abdominal pain becomes marked, or if diarrhoea persists for more than 72 hours, medical attention should be sought.

Though effective, antibiotics are not recommended prophylactically (i.e. to prevent diarrhoea before it occurs) because of the risk of adverse effects, though this approach may be warranted in special situations, such as immunocompromised travellers.

[Malaria](#) in Indonesia: prophylaxis is not recommended for Jakarta Municipality, major cities (including Bogor, Bandung, Solo, and Surabaya), or the main resort areas of Java and Bali, which are the most common destinations. Prophylaxis is recommended for all areas of Irian Jaya (western half of the island of New Guinea), the temple complex of Borobudur, and rural areas in all other islands.

Either [mefloquine \(Lariam\)](#), [atovaquone/proguanil \(Malarone\)\(PDF\)](#), or doxycycline may be given. Mefloquine is taken once weekly in a dosage of 250 mg, starting one-to-two weeks before arrival and continuing through the trip and for four weeks after departure. Mefloquine may cause mild neuropsychiatric symptoms, including nausea, vomiting, dizziness, insomnia, and nightmares.

Rarely, severe reactions occur, including depression, anxiety, psychosis, hallucinations, and seizures. Mefloquine should not be given to anyone with a history of seizures, psychiatric illness, cardiac conduction disorders, or allergy to quinine or quinidine.

Those taking mefloquine (Lariam) should read the [Lariam Medication Guide](#) (PDF). Atovaquone/proguanil (Malarone) is a recently approved combination pill taken once daily with food starting two days before arrival and continuing through the trip and for seven days after departure. Side effects, which are typically mild, may include abdominal pain, nausea, vomiting, headache, diarrhoea, or dizziness. Serious adverse reactions are rare. Doxycycline is effective, but may cause an exaggerated sunburn reaction, which limits its usefulness in the tropics.

In Indonesia, most transmission occurs after dark in rural, forested areas not frequented by tourists, except in Papua (formerly known as Irian Jaya), where risk is widespread. Over the past few years, a significant increase in malaria has been observed in Central Java Province adjacent

to Yogyakarta Province. Antimalarial prophylaxis is recommended for all overnight visitors to these provinces, except for the cities of Semarang and Yogyakarta (see [ProMED-mail](#) for details).

Long-term travellers who will be visiting malarious areas and may not have access to medical care should bring along medications for emergency self-treatment should they develop symptoms suggestive of malaria, such as fever, chills, headaches, and muscle aches, and cannot obtain medical care within 24 hours. See [malaria](#) for details. Symptoms of malaria sometimes do not occur for months or even years after exposure.

Insect protection measures are essential.

For further information concerning malaria in Indonesia, go to the [World Health Organization - South East Asia Region](#) or to the [World Health Organisation](#).

Immunisations

The following are the recommended vaccinations for Indonesia:

[Hepatitis A](#) vaccine is recommended for all travellers over one year of age. It should be given at least *two weeks* (preferably *four weeks* or more) before departure. A booster should be given 6-12 months later to confer long-term immunity. Two vaccines are currently available [VAQTA \(Merck and Co., Inc.\) \(PDF\)](#) and [Havrix \(GlaxoSmithKline\) \(PDF\)](#). Both are well tolerated. Side effects, which are generally mild, may include soreness at the injection site, headache, and malaise.

Travellers who are less than one year of age, are pregnant, or have less than two weeks before departure should receive a single intramuscular dose of gammaglobulin (see [hepatitis A](#) for dosage) instead of vaccine.

[Typhoid](#) vaccine is recommended for all travellers, with the exception of short-term visitors who restrict their meals to major restaurants and hotels, such as business travellers and cruise passengers. It is generally given in an oral form ([Vivotif Berna](#)) consisting of four capsules taken on alternate days until completed. The capsules should be kept refrigerated and taken with cool liquid.

Side effects are uncommon and may include abdominal discomfort, nausea, rash or hives. The alternative is an injectable polysaccharide vaccine ([Typhim Vi; Aventis Pasteur Inc.\) \(PDF\)](#), given as a single dose. Adverse reactions, which are uncommon, may include discomfort at the injection site, fever and headache.

The oral vaccine is approved for travellers at least six years old, whereas the injectable vaccine is approved for those over age two. There are no data concerning the safety of typhoid vaccine during pregnancy. The injectable vaccine (Typhim Vi) is probably preferable to the oral vaccine in pregnant and immunocompromised travellers.

[Polio](#) immunization is recommended, due to recent reports of polio in Indonesia (see "Recent outbreaks" below). Any adult who received the recommended childhood immunizations but never had a booster as an adult should be given a single dose of inactivated polio vaccine.

All children should be up-to-date in their polio immunizations and any adult who never completed the initial series of immunizations should do so before departure. Side effects are uncommon and may include pain at the injection site. Since inactivated polio vaccine includes trace amounts of streptomycin, neomycin and polymyxin B, individuals allergic to these antibiotics should not receive the vaccine.

[Japanese encephalitis](#) vaccine is recommended only for long-term (1 month) travellers to rural areas or travellers who may engage in extensive unprotected outdoor activities in rural areas, especially in the evening, during shorter trips. Japanese encephalitis has been reported in animals from Kalimantan, Bali, Nusa Tenggara, Sulawesi, Mollucas, and West Papua, Lombok.

Human cases have been identified on Bali, Java, East Timor, and possibly Lombok. Transmission is by mosquito bites and probably occurs year-round, with peak risk usually from November to March, sometimes in June and July. Increased risk is associated with rainfall, rice cultivation and the presence of pigs.

The vaccine ([JE-VAX: Aventis Pasteur Inc.\) \(PDF\)](#) is given as a series of three injections on days 0, 7 and 30. If time is short, the third dose may be given on day 14. Mild side effects, including fever, headache, muscle aches, malaise and soreness at the injection site, occur in about 20% of those vaccinated. *Serious allergic reactions* including urticaria, angioedema, respiratory distress and anaphylaxis are reported in approximately 0.6% of vaccines and may occur as long as one week after vaccination.

Any person who receives the vaccine should be observed in the doctor's office for at least 30 minutes following the injection and should complete the full series at least 10 days before departure. There are no data concerning the safety of Japanese encephalitis vaccine during pregnancy. In addition to vaccination, strict attention to *insect protection measures* is essential for anyone at risk.

[Hepatitis B](#) vaccine is recommended for travellers who will have intimate contact with local residents or potentially need blood transfusions or injections while abroad, especially if visiting for more than six months. It is also recommended for all health care personnel. Two vaccines are currently licensed in the United States: [Recombivax HB \(Merck and Co., Inc.\) \(PDF\)](#) and [Engerix-B \(GlaxoSmithKline\) \(PDF\)](#).

A full series consists of three intramuscular doses given at 0, 1 and 6 months. Engerix-B is also approved for administration at 0, 1, 2, and 12 months, which may be appropriate for travellers departing in less than 6 months. Side effects are generally mild and may include discomfort at the injection site and low-grade fever. Severe allergic reactions (anaphylaxis) occur rarely.

[Rabies](#) vaccine is recommended only for those at high risk for animal bites, such as veterinarians and animal handlers, and for long-term travellers who may have contact with animals and may not have access to medical care. In Indonesia, stray dogs most often transmit rabies, though cats and monkeys may also be responsible. A rabies outbreak was reported on the island of Flores in June 2000 (see [ProMED-mail](#)).

A complete pre-exposure series consists of three doses of vaccine injected into the deltoid muscle on days 0, 7, and 21 or 28. Side effects may include pain at the injection site, headache, nausea, abdominal pain, muscle aches, dizziness, or allergic reactions.

Any animal bite or scratch should be thoroughly cleaned with large amounts of soap and water and local health authorities should be contacted immediately for possible post-exposure treatment, whether or not the person has been immunized against rabies.

[Tetanus-diphtheria](#) vaccine is recommended for all travellers who have not received a tetanus-diphtheria immunization within the last 10 years.

[Measles-mumps-rubella](#) vaccine: two doses are recommended (if not previously given) for all travellers born after 1956, unless blood tests show immunity. Many adults born after 1956 and before 1970 received only one vaccination against measles, mumps, and rubella as children and should be given a second dose before travel. MMR vaccine should not be given to pregnant or severely immunocompromised individuals.

[Cholera](#) vaccine is not generally recommended, except for relief workers, because most travellers are at low risk for infection. Two oral vaccines have recently been developed: [Orochol \(Mutacol\)](#), licensed in Canada and Australia, and [Dukoral](#), licensed in Canada, Australia, and the European Union. These vaccines, where available, are recommended only for high-risk individuals, such as

relief workers, health professionals, and those travelling to remote areas where cholera epidemics are occurring and there is limited access to medical care.

The only cholera vaccine approved for use in the United States is no longer manufactured or sold, due to low efficacy and frequent side-effects.

[Yellow fever](#) vaccine is *required* for all travellers arriving from a yellow-fever-infected country in [Africa](#) or [the Americas](#) or from a country in the [endemic zones](#), but is not recommended or required otherwise.

Yellow fever vaccine ([YF-VAX: Aventis Pasteur Inc.](#)) ([PDF](#)) must be administered at an approved [yellow fever vaccination center](#), which will give each vaccine a fully validated International Certificate of Vaccination. Yellow fever vaccine should not in general be given to those who are younger than nine months of age, pregnant, immunocompromised, or allergic to eggs. It should also not be given to those with a history of thymus disease or thymectomy.

Recent outbreaks

A total of 53 human cases of H5N1 [avian influenza](#) ("bird flu"), 41 of them fatal, have been reported from Indonesia since July 2005. In May 2006, a cluster of eight cases was reported in an extended family from the village of Kubu Sembelang in the Karo district of North Sumatra.

This has raised concerns that the virus might have become more capable of passing from human to human. However, DNA analysis indicated that there had not been any significant mutations in the virus. There is no evidence at present that the outbreak in North Sumatra has spread beyond the initial family cluster.

According to the World Health Organisation, the H5N1 virus is considered firmly entrenched in poultry throughout much of Indonesia. Unless the outbreak is urgently controlled, more human cases can be expected.

Most travellers are at extremely low risk for avian influenza, since almost all human cases have occurred in those who have had direct contact with live, infected poultry, or sustained, intimate contact with family members suffering from the disease.

The World Health Organisation and the Centres for Disease Control do not advise against travel to countries affected by avian influenza, but recommend that travellers should avoid exposure to live poultry, including visits to poultry farms and open markets with live birds; should not touch any surfaces that might be contaminated with faeces from poultry or other animals; and should make sure all poultry and egg products are thoroughly cooked.

The currently available influenza vaccines do not protect against avian influenza. Anyone who develops fever and flu-like symptoms after travel to Indonesia should seek immediate medical attention, which may include testing for avian influenza. For further information, go to the [World Health Organisation](#), [Health Canada](#), the [Centres for Disease Control](#), and [ProMED-mail](#).

Outbreaks of [dengue fever](#), a flu-like illness sometimes complicated by haemorrhage or shock, occur regularly in Indonesia. Almost 8000 cases were reported from the city of Jakarta during the first three months of 2006, including 14 deaths. An outbreak was reported in January 2006 from the Bantul regency, which is next to the ancient city of Yogyakarta, a popular tourist destination. An outbreak was also reported from the city of Semarang in November 2005.

A major dengue outbreak occurred in 2004, affecting all 30 provinces and causing almost 60,000 cases and more than 600 deaths, chiefly in Java (especially DKI Jakarta), Jawa Barat, Jawa Tengah and Jawa Timur (see the [World Health Organization](#)).

Aedes mosquitoes, which bite primarily in the daytime, transmit dengue and favour densely populated areas, though they also inhabit rural environments. In Indonesia, peak transmission

usually occurs from May to July, though the disease is observed year-round. An unusually large number of cases was reported in 1998, possibly due to climatic changes related to El Niño. No vaccine is available at this time. The cornerstone of prevention is [insect protection measures](#), as outlined below. For further information on dengue in southeast Asia, go to the [World Health Organization - South-East Asia Region](#).

Outbreaks of [cholera](#) were reported from the Jayawijaya and Yahukimo regencies in Irian Jaya in April 2006, from Ciomas subdistrict, Bogor, West Java province in May 2006, and from the highlands region of Wamena in the Far East of Indonesia, also in May 2006. See [ProMED-mail](#) (May 1 and 5, 2006) and [Doctors Without Borders](#) for further information. The main symptoms of cholera are profuse watery diarrhoea and vomiting, which in severe cases may lead to dehydration and death.

Most outbreaks are related to contaminated drinking water, typically in situations of poverty, overcrowding, and poor sanitation. Most travellers are at extremely low risk for infection. Cholera vaccine, where available, is recommended only for certain high-risk individuals, such as relief workers, health professionals, and those travelling to remote areas where cholera epidemics are occurring and there is limited access to medical care. All travellers should carefully observe *food and water precautions*, as below.

A [measles](#) outbreak was reported in February 2006 from the southern part of Papua, a province in the Far East of Indonesia. See [Doctors without Borders](#) for further information. All travellers born after 1956 should make sure they have had either two documented measles immunizations or a blood test showing measles immunity. Those born before 1957 are presumed to be immune. Although measles immunization is usually begun at age 12 months, consider giving an initial dose of measles vaccine to children between the ages of 6 and 11 months who will be travelling to Indonesia.

An outbreak of [polio](#) was reported in May 2005, resulting in a total of 303 cases. The outbreak began in West Java and Banten Provinces on the island of Java, then spread to Central Java, East Java, and Jakarta provinces on Java, as well as Lampung, North Sumatra, South Sumatra, Aceh, and Riau provinces on the island of Sumatra. In addition, a polio outbreak caused by the attenuated virus found in oral polio vaccine was reported from Madura Island, East Java province.

These are the first cases of polio seen in Indonesia since 1995. The government responded by initiating a massive nationwide immunization campaign. The outbreak appears to be declining. Only two cases were reported during the first four months of 2006. See [Polio Eradication](#) website, [NATHNAC](#), and the [World Health Organization](#) for further information. A one-time polio booster is recommended for any adult traveller who received the recommended childhood immunizations but never had polio vaccine as an adult. Children should be fully immunized against polio before travelling to Indonesia.

An [anthrax](#) outbreak was reported from a village near Bogor, West Java, in October 2005, resulting in six deaths and possibly affecting as many as 65 people. The outbreak was related to the consumption of infected goat meat. For further information, go to the [U.S. Embassy](#) website.

A [tetanus](#) outbreak was reported in January 2005 from tsunami-affected areas in Indonesia, including Banda Aceh, Meulaboh, and Sigli. As of January 15, a total of 67 cases had been identified. According to Médecins Sans Frontières (Doctors Without Borders), "People are becoming infected when they search for corpses or useful objects in the rubble left by the tsunami.

The tetanus bacteria can infect wounds on their arms and legs when they walk through the mud. Since the disease has an incubation period of between two and 60 days, most cases took some time to show. A tetanus booster is recommended for all adults who haven't had tetanus shot within the last 5 years. For further information, go to [Médecins Sans Frontières](#).

Outbreaks of *Chikungunya fever*, a mosquito-borne illness characterized by fever and incapacitating joint pains, have recently been reported from Indonesia. In December 2002, an outbreak was reported from West Java, spreading to West Timor and Central Sulawesi.

In December 2003 and January 2004, outbreaks were reported from East Java and Central Java. In April 2005, an outbreak occurred in West Lombok. In July of the same year, an outbreak occurred in Tangerang. See [ProMED-mail](#) for details. The disease is rarely fatal, but may be complicated by protracted fatigue and malaise.

Other infections

Murine typhus, which is transmitted by fleas, has been reported in travellers returning from Indonesia (see P. Parola et al., [Emerging Infectious Diseases](#), vol. 4 no. 4, Oct-Dec 1998).

[Bubonic plague](#) was reported in six people from the village of Sulorowo in Pasuruan district, East Java, in 1997. This was the first cluster of human plague in Indonesia since 1970. Travellers should avoid areas containing rodent burrows or nests, never handle sick or dead animals, and follow *insect protection measures*, as described below.

HIV (human immunodeficiency virus) infection is reported, but travellers are not at risk unless they have unprotected sexual contacts or receive injections or blood transfusions.

Other infections include:

- [Hepatitis E](#) (transmitted by contaminated food or water)
- [Schistosomiasis](#) (*Schistosoma japonicum* reported from central Sulawesi; avoid swimming, wading, or bathing in bodies of fresh water, such as lakes, rivers, or streams)
- [Leptospirosis](#)
- [Anthrax](#) (declining incidence; occurs in cows, carabaos, and horses; human cases reported from West Nusa Tenggara, East Nusa Tenggara, West Java, and Central Java)
- [Brucellosis](#) (reported from West Java; see [ProMED-mail](#))
- [Lymphatic filariasis](#) (see the [World Health Organization - South-East Asia Region](#) for further information)
- *Scrub typhus* (rural areas; transmitted by chigger bites)
- *Melioidosis*
- *Filariasis* (scattered cases)
- *Strongyloides*
- *Fasciolopsiasis* (giant intestinal fluke)
- *Cyclosporiasis* (parasitic intestinal infection; outbreak reported among microbiologists at scientific meeting in Bogor in September 2001; see [Emerging Infectious Diseases](#))

For further more detailed information concerning the incidence of malaria, dengue fever, and many other infectious diseases, go to the [Ministry of Health](#) website. For a country health profile of Indonesia, go to the [World Health Organization](#).

Food and water precautions

Do not drink tap water unless it has been [boiled, filtered, or chemically disinfected](#). Do not drink unbottled beverages or drinks with ice.

Do not eat fruits or vegetables unless they have been peeled or cooked. Avoid cooked foods that are no longer piping hot. Cooked foods that have been left at room temperature are particularly hazardous. Avoid unpasteurized milk and any products that might have been made from unpasteurized milk, such as ice cream.

Avoid food and beverages obtained from street vendors. Do not eat raw or undercooked meat or fish. Some types of fish may contain poisonous biotoxins even when cooked.

Barracuda in particular should never be eaten. Other fish that may contain toxins include red snapper, grouper, amberjack, sea bass, and a large number of tropical reef fish.

All travellers should bring along an antibiotic and an antidiarrhoeal drug to be started promptly if significant diarrhoea occurs, defined as three or more loose stools in an 8-hour period or five or more loose stools in a 24-hour period, especially if accompanied by nausea, vomiting, cramps, fever or blood in the stool. Antibiotics which have been shown to be effective include [ciprofloxacin \(Cipro\)](#), [levofloxacin \(Levaquin\)](#), [rifaximin \(Xifaxan\)](#), or [azithromycin \(Zithromax\)](#).

Either loperamide (Imodium) or diphenoxylate (Lomotil) should be taken in addition to the antibiotic to reduce diarrhoea and prevent dehydration.

If diarrhoea is severe or bloody, or if fever occurs with shaking chills, or if abdominal pain becomes marked, or if diarrhoea persists for more than 72 hours, medical attention should be sought.

Insect and tick protection

Wear long sleeves, long pants, hats and shoes (rather than sandals). For rural and forested areas, boots are preferable, with pants tucked in, to prevent tick bites. Apply [insect repellents](#) containing 20-35% DEET (N,N-diethyl-3-methylbenzamide) or 20% picaridin (Bayrepel) to exposed skin (but not to the eyes, mouth, or open wounds). DEET may also be applied to clothing.

Products with a lower concentration of either repellent need to be re-applied more frequently. Products with a higher concentration of DEET carry an increased risk of neurologic toxicity, especially in children, without any additional benefit. Do not use either DEET or picaridin on children less than two years of age. For additional protection, apply permethrin-containing compounds to clothing, shoes, and bed nets. Permethrin-treated clothing appears to have little toxicity. **Recommendations for DEET based insect repellents are the same for pregnant women as for other adults.**

Don't sleep with the window open unless there is a screen. If sleeping outdoors or in an accommodation that allows entry of mosquitoes, use a bed net, preferably impregnated with insect repellent, with edges tucked in under the mattress.

The mesh size should be less than 1.5 mm. If the sleeping area is not otherwise protected, use a mosquito coil, which fills the room with insecticide through the night. In rural or forested areas, perform a thorough tick check at the end of each day with the assistance of a friend or a full-length mirror. Ticks should be removed with tweezers, grasping the tick by the head. Many tick-borne illnesses can be prevented by prompt tick removal.

General advice:

Bring adequate supplies of all medications in their original containers, clearly labelled. Carry a signed, dated letter from the primary physician describing all medical conditions and listing all medications, including generic names. If carrying syringes or needles, be sure to carry a physician's letter documenting their medical necessity. Pack all medications in hand luggage.

Carry a duplicate supply in the checked luggage if flying or stored aboard the vessel if sailing. If you wear glasses or contacts, bring an extra pair. If you have significant allergies or chronic medical problems, wear a medical alert bracelet.

Make sure your health insurance covers you for medical expenses abroad. If not, supplemental insurance for overseas coverage, including possible evacuation, should be seriously considered. If illness occurs while abroad, medical expenses including evacuation may run to tens of thousands of dollars.

Bring your insurance card, claim forms, and any other relevant insurance documents. Before departure, determine whether your insurance plan will make payments directly to providers or reimburse you later for overseas health expenditures. Medicare and most health funds do not pay for medical services outside Australia.

Pack a personal [medical kit](#), customised for your trip (see description). Take appropriate measures to prevent [motion sickness](#).

Avoid contact with stray dogs and other animals. If an animal bites or scratches you, clean the wound with large amounts of soap and water and contact local health authorities immediately. Wear sun block regularly when needed. Use condoms for all sexual encounters. Ride only in motor vehicles with seat belts. Do not ride on motorcycles.

The recommendations outlined above regarding food and water precautions and insect protection measures must be scrupulously followed at all times.

Snakebites are more likely after natural disasters. Never attempt to kill or handle a snake. In the event of a venomous snakebite, move the victim a safe distance from the snake and place him or her at rest, with the affected extremity immobilised and kept below the level of the heart.

Remove constrictive clothing and jewellery. Apply a pressure bandage that does not impede blood flow. Avoid tourniquets, which are no longer recommended. Bring the victim immediately to the nearest medical facility for administration of antivenom and supportive care. To reduce the risk of snakebites, wear boots and long pants and avoid perfumes and cologne.

Medical facilities

Only Indonesian doctors are allowed to treat patients in Indonesian medical facilities. However, International SOS has an expatriate consultant physician on the premises most of the time, and Global Doctor offers telemedicine appointments with a consultant in Perth. For a guide to other physicians and health facilities in Indonesia, go to the [U.S. Embassy](#) website.

Routine medical care is available in major cities, but not elsewhere. Many doctors and hospitals will expect payment in cash, regardless of whether you have travel health insurance. Serious medical problems will require air evacuation to a country with state-of-the-art medical facilities.

Travelling with children

Before you leave, make sure you have the names and contact information for physicians, clinics, and hospitals where you can obtain emergency medical care if needed.

Because of a recent polio outbreak, all children travelling to Indonesia should be fully immunized against polio. All children should be up-to-date on routine childhood immunizations

Children who are 12 months or older should receive a total of 2 doses of MMR (measles-mumps-rubella) vaccine, separated by at least 28 days, before international travel. Children between the ages of 6 and 11 months should be given a single dose of measles vaccine. MMR vaccine may be given if measles vaccine is not available, though immunization against mumps and rubella is not necessary before age one unless visiting a country where an outbreak is in progress. Children less than one year of age may also need to receive other immunizations ahead of schedule (see the [accelerated immunization schedule](#)).

The recommendations for [malaria](#) prophylaxis are the same for young children as for adults, except that (1) dosages are lower; (2) Malarone is not recommended for children weighing less than 25 pounds; and (3) doxycycline should be avoided. DEET-containing insect repellents are not advised for children under age two, so it's especially important to keep children in this age group well covered to protect them from mosquito bites.

When travelling with young children, be particularly careful about what you allow them to eat and drink (see [food and water precautions](#)), because diarrhoea can be especially dangerous in this

age group and because the vaccines for [hepatitis A](#) and [typhoid fever](#), which are transmitted by contaminated food and water, are not approved for children under age two.

Baby foods and cows' milk may not be available in developing nations. Only commercially bottled milk with a printed expiration date should be used. Young children should be kept well hydrated and protected from the sun at all times.

Be sure to pack a [medical kit](#) when travelling with children. In addition to the items listed for adults, bring along plenty of disposable diapers, cream for diaper rash, oral replacement salts, and appropriate antibiotics for common childhood infections, such as middle ear infections.

Travel and pregnancy

International travel should be avoided by pregnant women with underlying medical conditions, such as diabetes or high blood pressure, or a history of complications during previous pregnancies, such as miscarriage or premature labour. For pregnant women in good health, the second trimester (18–24 weeks) is probably the safest time to go abroad and the third trimester the least safe, since it's far better not to have to deliver in a foreign country.

Before departure, make sure you have the names and contact information for physicians, clinics, and hospitals where you can obtain emergency obstetric care if necessary. In general, pregnant women should avoid travelling to countries that do not have modern facilities for the management of premature labour and other complications of pregnancy. As a rule, pregnant women should avoid visiting areas where [malaria](#) occurs. Malaria may cause life-threatening illness in both the mother and the unborn child.

None of the currently available prophylactic medications is 100% effective. Mefloquine (Lariam) is the drug of choice for malaria prophylaxis during pregnancy, but should not be given if possible in the first trimester. If travel to malarious areas is unavoidable, [insect protection measures](#) must be strictly followed at all times.

Strict attention to [food and water precautions](#) is especially important for the pregnant traveller because some infections, such as listeriosis, have grave consequences for the developing foetus. Additionally, many of the medications used to treat travellers' diarrhoea may not be given during pregnancy. Quinolone antibiotics, such as ciprofloxacin (Cipro) and levofloxacin (Levaquin), should not be given because of concern they might interfere with foetal joint development. Data are limited concerning trimethoprim-sulfamethoxazole, but the drug should probably be avoided during pregnancy, especially the first trimester.

Options for treating travellers' diarrhoea in pregnant women include azithromycin and third-generation cephalosporins. For symptomatic relief, the combination of kaolin and pectin (Kaopectate Donnagel) appears to be safe, but loperamide (Imodium) should be used only when necessary. *Adequate fluid intake* is essential.