Republic of Indonesia

NATIONAL AIDS COMMISSION

Republic of Indonesia Country Report on the Follow up to the Declaration of Commitment On HIV/AIDS (UNGASS)

Reporting Period 2008 - 2009

National AIDS Commission Republic of Indonesia
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Table of Content

Table of Content i
List of Tables ii
List of Figures ii
List of Abbreviations iv
Foreword vi
Executive Summary vii

I. Status at a Glance 1
1.1. Participation of stakeholders in the report writing process 1
1.2. The status of the epidemic 1
1.3. Policy and Programmatic Response 2008-2009 3
1.4. UNGASS indicator data in an overview table 6
II. Overview of the AIDS Epidemic 13
2.1. AIDS amongst Most-at-Risk Populations 16
2.1.1. Injecting Drug Users 16
2.1.2. Sex Workers 17
2.1.3. MSM 18
2.1.4. *Waria* (transgender) 19
2.1.5. High Risk Men (HRM) 20
2.2. HIV in Prisons 21
2.3. HIV in Tanah Papua 23
2.4. HIV among Women and Children 25
III. National Response to the AIDS Epidemic 27
3.1. National Commitment and Action 28
3.2. National Program Indicators 37
3.3. Knowledge and Behavior Indicators 51
3.4. Impact Indicators 61
IV. Best Practices 72
4.1. Bringing art to life in Kerobokan Prison, Bali[1] 72
4.2. Local Commitment toward Program Strengthening[2] 75
V. Major Challenges and Remedial Actions 79
VI. Support from the Country's Development Partners 84
VII. Monitoring and Evaluation Environment 88

List of Annexes 90
Annex 1: Completed Questionnaires of NCPI Part A and B 91
Annex 2: National AIDS Spending Assessment (NASA) Matrix 134
References 143

List of Tables

Table 1: Overview of the 2010 report on UNGASS Indicators
Table 2: Overview of UNGASS 2010 Additional Indicators
Table 3: Total HIV and AIDS Spending 2008
Table 4: HIV and AIDS Spending by Ministries 2008
Table 5: HIV and AIDS Expenditure by Source in Papua Province and Selected Districts, 2006-2008
Table 6: Households Source of Fund to Seek Inpatient Care in Papua 2009
Table 7: Results of NCPI Part A
Table 8: Results of NCPI Part B

List of Figures

Figure 1: Map of HIV Epidemic in Indonesia
Figure 2: Projection of UA Achievements with Different Scenarios
Figure 3: Programme Coverage against UA Targets
Figure 4: Proportion of HIV and AIDS Spending by Category, 2008
Figure 5: Adults and Children with Advanced HIV Infection Receiving ART
Figure 6: Adults and children with advanced HIV infection receiving ART, by sex
Figure 7: Adults and children with advanced HIV infection receiving ART, by age
Figure 8: HIV Infected Pregnant Women Receiving ART to Prevent of Mother to Child Transmission, 2006-2009
Figure 9: MARPs who have received an HIV test in the last 12 months and know the results, by sex
Figure 10: MARPs who Have Received an HIV test in the Last 12 Months and Who Know the Results, by age
Figure 11: HIV Testing in Men Who Have Sex With Men by Age, 2007
Figure 12: MARPs Reached by HIV Prevention Programs, by Sex
Figure 13: MARPs Reached by HIV Prevention Programs, by Age
Figure 14: Percentage of Current School Attendace Rate of Orphans Aged 10-14
Figure 15: Percentage of Women and Men Aged 15-24 Who Both Correctly Identify Ways of Preventing the Sexual Transmissin of HIV and Who Reject Major Misconceptions about HIV Transmission
Figure 16: MARPs Who Both Correctly Identify Ways of Preventing the Sexual Transmission Of HIV and Reject Major Misconceptions about HIV Transmission, by Sex
Figure 17: MARPs Who Both Correctly Identify Ways of Preventing the Sexual Transmission Of HIV and Reject Major Misconceptions about HIV Transmission, by Age
Figure 18: MARPs Reporting the Use of a Condom with Their Most Recent Client (Sex Workers) or with Their Male Partners (MSM) or When They had Sexual Intercourse, by Sex

Figure 19: MARPs Reporting the Use of a Condom with Their Most Recent Client (Sex Workers) or with Their Male Partners (MSM) or When They had Sexual Intercourse, by Age
Figure 20: Injecting Drug Users Reporting the Use of Sterile Injecting Equipment the Last Time They Injected, by Sex
Figure 21: Injecting Drug Users Reporting the Use of Sterile Injecting Equipment the Last Time They Injected, by Age
Figure 22: Percentage of MARPs who are HIV-positive, by Age Group
Figure 23: Percentage of MARPs who are HIV-positive, by Sex
Figure 24: Percentage of Health Facilities that Offer ART 2007-2008
Figure 25: Percentage of Never Married Young Women and Men Aged 15-24 Who Have Never Had Sex
Figure 26: Percentage of Women and Men Aged 15-49 Expressing Accepting Attitudes Towards People Living with HIV
Figure 27: Percentage of children Under the Age of 15 Who are Orphans

List of Abbreviations

AIDS:	Acquired Immune-Deficiency Syndrome
ART:	Anti Retroviral Therapy
ARV:	Anti Retroviral Drugs
AusAID:	The Australian government's overseas aid program, formerly Australian
AID	Agency for International Development
BCI:	Behaviour Change Intervention
BSS:	Behaviour Surveillance Survey
CBO:	Community-based Organization
CBS:	Central Bureau of Statistics
CDC:	Directorate General of / Centre for Communicable Disease Control
CST:	Care, Support and Treatment
DC&EH:	Directorate General of Disease Control and Environmental Health
DFID:	United Kingdom Department for International Development
DHS:	Demographic Health Survey
FHI:	Family Health International
FSW:	Female Sex Worker
GFATM:	The Global Fund to fight AIDS, TB and Malaria
HIV:	Human Immunodeficiency Virus
HSTV	HIV sexual transmission prevention program
IEC:	Information, Education and Communication
IDU:	Injecting Drug Use
IBBS:	Integrated Bio-Behavioural Surveillance
IHPCP:	Indonesia HIV/AIDS Prevention and Care Project
ILO:	International Labour Organization
LSE:	Life Skilled-based HIV Education
MARPs:	Most-at-risk Population
MDG:	Millennium Development Goals
M&E:	Monitoring and Evaluation
MMT:	Methadone Maintenance Treatment
MoE:	Ministry of Education
MoH:	Ministry of Health
MSM:	Men who have Sex with Men
MSW:	Male Sex Worker
NAC:	National AIDS Commission
NASA:	National AIDS Spending Assessment
NCPI:	National Composite Policy Index
NGO:	Non-Governmental Organization
PLHIV:	People Living With HIV
PMI (Ind.):	Indonesian Red Cross
PMTCT:	Prevention of Mother to Child Transmission
OI:	Opportunistic Infection
OVC:	Orphans and Vulnerable Children

STI:	Sexually Transmissible Infection (Ind.: PMS)
FSW:	Female Sex Worker
TB:	Tuberculosis
UA:	Universal Access
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UNDP:	United Nations Development Program
UNESCO:	UN Educational, Scientific and Cultural Organization
UNFPA:	UN Fund for Population Activities
UNICEF:	United Nations Children's Fund
UNGASS:	United Nations General Assembly Special Session
USAID:	United States Agency for International Development
VCT:	Voluntary Counseling and Testing
Waria (Ind.):	Transgendered people/Transvestites
WHO:	World Health Organization

KOMISI PENANGGULANGAN AIDS

Foreword

This country report presents information specifically focused on achievements of the Government and civil society including people living with and affected by AIDS in Indonesia related to the Declaration of Commitment of UNGASS. The report covers work in the past two years, 2008-2009 and is a collaborative product reflecting the perspectives of partners in its preparation.

For the period covered by this report, UNAIDS has stipulated 25 indicators to measure progress in response to the epidemic. Indonesia can report fully on what has been accomplished related to indicators relevant to concentrated epidemics. However, data has not been collected on a national basis for some indicators which refer to aspects of generalised epidemics that are not widely found in Indonesia except in the provinces of Papua and West Papua.

The Government of Indonesia has shown strong commitment to mounting and sustaining an effective response and it endorses a broad range of activities run by many stakeholders and needed by people vulnerable to, living with and affected by HIV and AIDS. During the period under review, management of Indonesia's response has improved. Based on Presidential Regulation no. 75/2006 restructuring and strengthening the national response, the National AIDS Commission led development of a more integrated, comprehensive, and systematic response to the epidemic than in earlier years. A new National AIDS Strategy and Action Plan has been developed as part of Indonesia's overall National Five Year Development Plan 2010-2014. As recorded in this report, many national and international partners have taken part in this process.

Although much remains to be done, there has been encouraging progress in the past two years and Indonesia honors the contribution of all actors from government, the private sector, and non governmental organisations of Indonesia as well as a range of bi-lateral, UN and international civil society partners who have helped the country to address the challenges presented by the twin epidemics of HIV and injecting drug use across Indonesia.

To all those who have supported and taken part in the process of preparing this report: members of the Monitoring and Evaluation Working Group and the Executive Committee of the National AIDS Commission, representatives of civil society, UN and international agencies, donor agencies, and especially to all who have generated and helped analyze data related to our response, I would like to express my deepest gratitude. Preparing this report has been a useful exercise for all of us. We are pleased to be part of this global process. We hope its publication and circulation will not only fulfill an obligation to the UN but will lead to improvements in our national monitoring and evaluation system as well as providing good evidence and data to support our continuing efforts to bring the AIDS epidemic under control.

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Executive Summary

The Indonesian government has significantly increased its allocation of domestic resources for AIDS in recent years. From 2006 to 2009 the budget allocated for AIDS rose 7 times, from US$ 11 million to US$ 73 million. During the same period, provincial and district budgets increased around 3.5 times from Rp 20 billion to Rp 74 billion. While this increase is encouraging, still more resources will be needed to reach 100 per cent of Universal Access and UNGASS targets.

The HIV epidemic in Indonesia is among the fastest growing in Asia. At the end of 2009, it was estimated that there were 333,200 people living with HIV (PLHIV) in Indonesia. The cumulative number of reported AIDS cases has risen sharply from 2,682 cases in 2004 to 19,973 by December 2009. Among the cases 25% are women. The AIDS epidemic now affects almost all parts of Indonesia, as can been seen from the latest MoH report. In 2004 only 16 out of 33 provinces had reported HIV. However, by the end of 2009, AIDS cases were reported in 32 provinces of Indonesia's 33 provinces. These increases reflect both the spread of infection as well as better reporting as a result of growing availability and utilization of counseling and testing.

During the period coverd by this report (2008-2009), the National AIDS Commission, its members and a wide range of partners in the national response to HIV and AIDS have carried out numerous interventions as well as investing considerable time and energy in resource mobilization to address this situation. The results of these efforts can be seen in the expanded coverage of prevention, testing, and treatment programs for most at risk population and people living with and affected by HIV as well as the steadily growing resources available.

Injecting drug use and sexual transmission remain the main modes of HIV transmission in Indonesia. In 2009, data from Asia Epidemic Modeling (AEM) pointed to the need to give attention to various issues such as the increasing numbers of AIDS-related deaths; rising numbers of children with HIV; growing need for ART needs and the associated increase in national spending for treatment.

While the priority of the national response remains focused on efforts to work for and with key populations such as IDUs, sex workers, transgenders (*waria)*, and MSM, in order to prevent HIV from spreading to the general population, prevention efforts also need to be broadened to reach other people such as HIV positive pregnant women, women who are intimate partners of men with high risk behavior; migrant workers; and young people at risk.

In the provinces of Papua and West Papua (in the extreme east of Indonesia, bordering Papua New Guinea) the current HIV situation is extremely serious having already spread to the general population. It is driven almost exclusively by unsafe sexual intercourse. The epidemic there is a low-level, generalized epidemic with HIV prevalence of 2.4% among 15-49 year olds in the general population (IBBS 2007). While more resources have been made available and the number of condom outlets is steadily increasing, many challenges remain to ensure availability of a reliable supply of condoms, consistent condom use especially among indirect sex workers, and

accessible and well utilized information, services and support for the growing numbers of people living with and affected by AIDS. All the issues of logistics, outreach and availability of services are particularly challenging across the two provinces of Papua and West Papua which are sparsely populated and transportation and communication are limited. Recognizing the distinctive nature of the epidemic in these two provinces, attention efforts are underway to continue and expand integration of HIV prevention education in the education system.

The main goals of the Indonesian response to HIV and AIDS is to reduce number of new HIV infections; to improve the quality of life of PLHIV, and to provide programs to mitigate the impact of the epidemic both on those directly affected and the community at large. In 2008 and 2009, the National AIDS Commission advocated for increasing resources from the Government to provide support to people living with HIV and community based organizations to assist PLHIV in accessing quality care, support, and treatment.

The commitment of the government to respond effectively to the epidemic and to reach national and international HIV targets has strengthened steadily during the reporting period. In the opening ceremony of the 9th International Congress on AIDS in Asia and the Pacific (ICAAP IX) in Bali, August 2009, Indonesia's President, Susilo Bambang Yudhoyono, underlined four critical points to achieve a successful response: 1) strong national leadership, 2) community involvement, 3) regional and international cooperation, and 4) sustained and greater investment in the efforts to find an effective vaccine or cure.

During the reporting period, the system of AIDS Commissions in Indonesia has also grown in skill and importance from national to local level. Under the leadership of the National AIDS Commission they have worked to promote a more intensive, comprehensive, integrated and coordinated response. By the end of 2009 AIDS Commissions were fully functional at the National level as well as in 33 provinces and 172 priority districts and cities, an increase from 100 priority districts in 2007.

Harm reduction programs were initiated by the Indonesian government on a small scale already in 2003 in order to reduce the risk of contracting infection or spreading it further. Harm reduction services were available in 120 locations. A fully functioning Harm Reduction Program includes access to accurate information, distribution of syringes and condoms, access to primary health care and access to voluntary counseling and testing. By the end of 2008 there were approximately 49,000 IDU who had utilized the services of needle syringe programs through the 281 sites available by 2009. By the end of 2009, IDUs who needed methadone maintenance therapy (MMT) could receive service in 46 MMT units available in some health centers, hospitals and prisons. IDUs in Indonesia not only have they received condoms, but they also know where they can go for an HIV test (59%) if they wish and they have been given sterile needles and syringes (88%). This is an achievement in Indonesia’s prevention programs and without doubt makes a significant contribution to the country's efforts to bring HIV and AIDS under control.

Early work to prevent sexually transmitted HIV infection focused primarily on condom promotion and provision of STI services. By 2008 there were 245 STI service units to be found in community health centers, private clinics, and company clinics. Condom

promotion has been carried out in numerous sites and, over time, reached about 27,180 female sex workers, 403,030 of clients of sex workers, 27,810 transgender people (*waria*), 63,980 MSM and 50,420 IDUs (Program Coverage Data, NAC 2009). As of 2008, DKT reported 15,000 condom outlets across Indonesia and that there had been 20 million condom distributed (DKT, 2008).

Voluntary Counseling and Testing (VCT). Availability of ART. The Ministry of Health has issued several regulations related to counseling and testing. Many initiatives have also been taken by both government and civil society to increase the numbers of trained counselors to provide service and to encourage people to seek HIV testing. Serious attention has been given in both regulations and in training of counselors to assure the confidentiality of clients and access to referral hospitals when necessary. The number of VCT sites and their distribution had increased dramatically from only 25 in 2004 to 547 by mid 2009. The government plans to have 234 health facilities providing ART by the end of 2010.

Universal Access. In 2007 the government had introduced the National Action Plan for the period 2007-2010 with the target of making available to 80% of MARPs access to effective prevention, care, support and treatment as well as impact mitigation. However, monitoring indicated that only 51% of sex workers had been reached by mid 2009, and the figures were smaller still for IDUs (29%) and MSM (9%). Likewise, it was found that ART services reached only 45% of those estimated to need antiretroviral drugs. Clearly, more hard work is needed to reach the universal access targets. Notwithstanding all the short comings, it was encouraging to note that the mortality rate among PLHIV had decreased significantly from 46% in 2006 to 17% by the end of 2008.

Data as of December 2009 showed that 19,973 people had AIDS. Of that total, 6,653 people (36.8%) are currently receiving antiretroviral therapy (ART) in accordance with the nationally-approved treatment protocol. At the same time there were an estimated 5,170 pregnant women who were HIV positive in Indonesia. Of that number only 196 received ARV to reduce the risk of MTCT (3.8%) showing how very limited PMTC services are across Indonesia, thus far.

While this report provides data showing progress in some areas such as harm reduction in prison, strengthening of local leadership and commitment to increase condom use among sex workers and their partners; strengthening of AIDS Commissions; much improved systems for national M&E and growing success in resource mobilization, nonetheless, numerous challenges remain. In order to achieve UNGASS targets and reach Universal Access for prevention, care, support and treatment, building on its experience, and under the leadership of the National AIDS Commission and AIDS Commissions at provincial, district and city levels, Indonesia must continue to select, prioritize, and scale-up effective interventions while promoting and strengthening local, national, and international networking and partnerships.

I. Status at a Glance

1.1. Participation of stakeholders in the report writing process

A range of partners have been actively engaged in producing the data and analysis used in this report. Data collection and analysis was done in coordination with the Monitoring and Evaluation Working Group of the National AIDS Commission that was composed of representatives of government departments, donors and civil society. The leading governmental sectors for data collection and analysis were the Ministry of Health and the National AIDS Commission. Data was also gathered from several other ministries and departments: the Ministry of National Education, the Ministry of Manpower, the Ministry of Law and Human Rights, the Ministry of Social Welfare, BPS-Statistics Indonesia, the Indonesian Red Cross, the Indonesian Armed Forces, as well as from several local and international NGOs including Pelita Ilmu Foundation, Spiritia Foundation, HIV Cooperation Program in Indonesia, AIDS Study Groups at Cipto Mangunkusumo Hospital in Jakarta, and Family Health International. Support for data gathering came from various development partners including UNAIDS, WHO and UNICEF. Data collection and analysis on national AIDS spending was done jointly by the National AIDS Commission and a team from the University of Indonesia. The analysis of indicators and data reported were discussed and agreed to in a series of consultation meetings with the Monitoring and Evaluation Working Group beginning in January 2010. Civil society was actively involved in preparation of this report as was the case in the previous rounds of UNGASS reporting including in discussion forums related to the National Composite Policy Index. In 2009, consultations were held in July and November; thereafter, in December groups representing both government and civil society met to finalize the findings. The comprehensive report on the National Composite Policy Index is reported in chapter 3.

Currently there are civil society groups in Indonesia who represent people living with and affected by HIV, people more vulnerable to infections. In addition to critically analysing programs on HIV and sexual and reproductive health, civil society groups also monitor national progress in achieving UNGASS indicators.

Representatives of civil society plan to submit their own own report in March 2010. The report will be a parallel document to this report and contain qualitative review against the UNGASS indicators.

1.2. The status of the epidemic

According to the Global AIDS Report 2008 the AIDS epidemic in Indonesia is "among the fastest growing in Asia". A projection based on 2006 estimation concluded that there were 314.500 people aged 15-49 people living with HIV in 2009. Without an acceleration of prevention, it is estimated that by 2014 541,700 people will be HIV positive (CDC MoH, 2008). In recent years the cumulative number of reported AIDS cases has risen sharply from 2,682 cases in 2004 to 19,973 in December of 2009. Three thousand eight-hundred forty-six people of that total have died. Women make up 25% of all reported AIDS cases.

Asian Epidemic Modeling projects HIV prevalence among Indonesians aged 15-49 to increase from 0.22% in 2008 to 0.37% in 2014. Until that time (2014), both injecting drug use and sexual transmission will continue to be the main modes of transmission. The AEM projects that new infection among IDU will decrease from 40% in 2008 to 28% in 2014 and sexual transmission will rise from 43% to 58%.

According to several studies, some men who have sex with men have multiple sex partners, both male and female, and significant numbers of them also buy and sell sex. Data from the Integrated Behavior Biological Survey in 2007 found that one-third of men who have sex with men reported having a regular male partner, 16% also had a regular female partner, and 22% reported that their regular partners also had other partners. These complex sexual networks increase the risk of transmission among men who have sex with men and their sexual partners. Moreover, the sexual networks put a significant number of women at risk of HIV infection although they would often be perceived and described as 'low-risk' because they have sex only with their respective husbands or long-term partners. Details of the epidemic among men who have sex with men will be discussed in the next section.

Although in most parts of Indonesia the AIDS epidemic is generally concentrated among high-risk populations with an estimated national adult prevalence of 0.22% in 2008, two provinces in Tanah Papua (Papua and West Papua) are experiencing a low level generalized epidemic with prevalence of 2.4% among the general population age 15 – 49 (IBBS, CDC MoH 2006). Comparing the reported AIDS case rate (number of confirmed AIDS cases per 100,000 population), as of December 2009 the case rate in the province of Papua at 133.07 was just over 15 times the national rate of 8.66. These various figures make clear the relative seriousness of the epidemic in that area. Further details of the epidemic in Tanah Papua will be described in the next chapter.

According to data from the 2007 Integrated Behavior Biological Survey among Most at Risk Populations , between 6% to 16% of direct female sex workers (those who work in brothels and street-based sex workers), and 2% to 9% of indirect female sex workers (women working in karaoke bars, maasage parlours, etc) were infected with HIV, depending upon the province. The proportion of female sex workers infected in their first six months of selling sex is high, indicating that they get infected very quickly after initiating sex work. The prevalence of sexually transmitted infections which elevates the risk of acquiring and transmitting HIV infection was very high among brothel based female sex workers and moderately high among non brothel based female sex workers.

Some issues identified in the Asian Epidemic Model study needing serious attention are increase of AIDS-related death, an increase in the number of children with HIV, an increased need for ART and consequent rise in national spending on treatment. Cumulatively the number of AIDS-related deaths is projected to reach 185,700 by 2014 or approximately 23,000 deaths annually during the period 2009-2014 (CDC MoH, 2008). Estimates and projections of new infections among children show an increase from 1,070 in 2008 to 1,590 in 2014, with the total number of children with HIV projected to rise from 2,470 in 2008 to 6,240 in 2014.

Without effective prevention, the need for ARV therapy among the 15-49 age group is projected to increase three fold from 30,100 in 2008 to 86,800 in 2014. The number of children needing ART will also increase from 930 in 2008 to 2,660 in 2014.

1.3. Policy and Programmatic Response 2008-2009

There are three main goals to be achieved by HIV and AIDS control in Indonesia: to reduce the number of new infections; to improve the quality of life of PLHIV including reductions in morbidity and mortality; and impact mitigation. PLHIV in Indonesia should have high quality of life, as well as equitable and continuous access to care, support, and treatment including laboratory tests as needed to monitor their health.

The commitment of the government to reach these targets has increased steadily over the past several years. The speech of President Susilo Bambang Yudhoyono at the opening ceremony of the 9th International Congress on AIDS in Asia and the Pacific in Bali in August 2009 underlined four critical points to a successful response: strong national leadership, community involvement, regional and international cooperation, and sustained and greater investment in the efforts to find an effective vaccine or cure. On that occasion the President also noted that the actual number of AIDS cases in the country could be significantly higher than what has been reported. The attendance of the President at this meeting and the involvement of the Indonesian First Lady as AIDS ambassador indicated the commitment of the Indonesian government to keep AIDS high on the national agenda.

The role of the AIDS Commissions has also been strengthened from national to local level. The enactment of Presidential Regulation 75/2006 intensified the national programmatic response to AIDS in the country. As an independent body responsible to the President of Indonesia, the National AIDS Commission was restructured and strengthened to promote a more intensive, comprehensive, integrated and coordinated response. By the end of 2009 AIDS Commissions were functioning at national level, in 33 provinces and in 172 priority districts and cities, an increase from 100 districts in 2007. A number of policies and regulations have been issued by government ministries to strengthen the response to HIV such as the National HIV and AIDS Policy to Reduce Harm Arising from Injection of Narcotic, Psychotropic and Addictive Substances (2009). Under this new policy, drug users are to be sent to rehabilitation centers while criminal cases are being filed against them (High Court Decree no. 7/2009).

Harm reduction program. As a country that deals with a dual epidemic—AIDS and drug abuse—Indonesia has carried out serious efforts to reduce HIV transmission among injecting drug users. To reduce the risk of contracting and transmitting disease the Indonesian government initiated a Harm Reduction Strategy in 2003. The strategy aimed to avoid violation of the law while at the same time taking action to safeguard public and individual health. This pragmatic approach to break the chain of HIV transmission both among injecting drug users and from them to the general public, has been undertaken in 14 provinces in Indonesia.

The harm reduction programming is now available in 120 sites, including community health centres, correctional institutions, and nongovernmental organisations where

staff have carried out some or all of the twelve key components of harm reduction. For instance, methadone maintenance therapy services is implemented at the Jakarta Drug Dependence Hospital, Sanglah Hospital (Denpasar), Tanjung Priok Public Health Centre, Kerobokan Penitentiary (Denpasar), Hasan Sadikin Hospital (Bandung), Soetomo Hospital (Surabaya), and the Jakarta Narcotics Penitentiary. These methadone programs are being conducted cooperatively with partnership among the Department of Health, the World Health Organization, the National AIDS Commission, the Indonesia HIV Cooperation Program, Family Health International, Directorate General of Corrections, local governments, and regional hospitals, and with support from various NGOs and the community.

Several programs aimed at individuals vulnerable to drug dependence have been put in place: access to accurate information, comprehensive distribution and recovery of needles, coordinated methadone maintenance programs, behavior change communications, condom promotion, and access to primary health care. The number of sites which provide needle exchange programs has increased significantly, from 17 sites in 2005 to 281 by the end of 2009. During this same period, methadone maintenance therapy has been made available in 46 sites across the country a significant increase from only three sites in 2005 (NAC, 2009).

Sexual transmission. Prevention of HIV through sexual transmission has been carried out through condom promotion and STI services. By the year of 2008 there have been 245 STI services units provided by community health centers, private clinics, and company clinics. Condom promotion program has also been done in numerous sites and reached about 27,180 female sex workers, 403,030 of their clients, 27,810 transgender (*waria*), 63,980 MSM and 50,420 IDU (Program Coverage Data, NAC 2009). Until 2008, as many as 15,000 outlets and 20 millions of condoms had been distributed (DKT, 2008). Moreover, the National AIDS Commission took initiative to develop comprehensive program of HIV prevention through structural intervention in 12 priority cities/districts in 2008. This initiative will be scaled up in 36 sites by 2014 with the support from GFATM round 8.

The most important challenge currently is to increase condom use among MARPs. According to IBBS 2007, currently consistent condom use among FSW is at 35%; *waria* 40%; and MSM 15%. Consistent condom use among IDU has increased significantly from 17% in 2004 to 30% by the end of 2007.

VCT. The number of VCT sites has increased considerably in Indonesia from only 25 in 2004 to 547 by mid-2009. In order to meet the target of reaching 50% of people who are at risk of HIV infection, each VCT site needs to at least 1500 people per year. However, of the VCT sites known to be providing service, only about 200 sites submit reports on a regular basis. The number of referral hospitals in Indonesia has also increased from 25 in 2004 to 180 in June 2009 (data *Universal Access 2008*). The government plans to have 234 health facilities providing ART by 2010.

The Ministry of Health has issued several regulations related to counseling and testing. Nationally, the number of at-risk people who know their HIV status is still very low with the result that the number of people utilizing treatment programs is even lower. Many initiatives are underway to encourage more people, particularly those at elevated risk of HIV infection, to undergo counseling and HIV testing,

including assurance of confidentiality for clients and access to referral hospitals when necessary.

Universal Access. By the end of 2009, 51% of sex workers, 29% of injecting drug users, and 9% of men who have sex with men had been reached by prevention programmes. Forty-five percent of the total estimated number of people needing antiretroviral drugs were receiving treatment. On the other hand the annual mortality rate among people living with HIV has declined significantly from 46% in 2006 to 17% by the end of 2008. In short, results are mixed with some falling short of what is needed and others showing encouraging progress. Overall, it is clear that continued major effort will be needed to reach agreed upon universal access targets.

As mentioned earlier, various achievements have been made by the Indonesian national response to curb further acceleration and spread of the epidemic. In collaboration, government, civil society and a number of development partners, have supported, facilitated, and carried out many programmes to reach most-at-risk populations in many parts of the country and slow the progress of the epidemic. In 2007 the government introduced the National Action Plan 2007-2010 that had a target to reach 80% of the most at risk populations and assure availability of appropriate care, support and treatment as well as impact mitigation activity. Support for NGOs and various civil society organizations totalling US$ 216, 998 came through the National AIDS Commision. NAC also facilitated the establishment of various civil society mutual support groups for gay men, MSM, sex workers, and positive women.

Further discussion of most at risk populations will be provided in the next section on epidemic overview.

Sustainability. The Indonesian government has significantly increased its domestic resources for AIDS-related work. From 2006 to 2009 the budget allocated for AIDS rose 7 fold from $ 11 million to $ 73 million. The provincial and district budgets also increased over three fold from 20 billion to 74 billion Indonesian Rupiah during the same period. This amount is still far from what is required in order to respond adequately to the epidemic but shows progrss. An important challenge for the national response is how to increase domestic support for Indonesia's response to the epidemic. Strong political will is required to reduce dependency on overseas financial assistance to combat HIV and AIDS.

1.4. UNGASS indicator data in an overview table

Table 1. Overview of The 2010 Report on UNGASS Indicators

Indicators	Numbers				Data Sources
NATIONAL COMMITMENT AND ACTION					
1. Expenditures	Total : USD 50, 831, 105 39. 03% (USD 19,841,442) was financed by the domestic/public sector and 60,97% (USD 30,989,683) by international source.				National AIDS Spending Assessment 2010, Indonesia National AIDS Commission,
2. National Composite Policy Index	Please see chapter 3				Indonesia National AIDS Commission, 2010
NATIONAL PROGRAMMES					
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%				Programme report, Indonesia Red Cross and MoH 2010
4. Percentage of adults and children with advanced HIV infection receiving ART	Adults & children		35.24%		CDC MoH, 2009
	Males		32.03%		
	Females		49.25%		
	<15		-		
	15+		-		
5. Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of MTCT	3.79%				CDC MoH, 2009
6. Percentage of estimated HIV-positive incident TB cases who received treatment for TB and HIV	All	2.58%			CDC MoH, 2009
	Males	2.66%			
	Females	2.37%			
	<15	-			
	15+	-			
7. Percentage of women and men aged 15-49 who received an HIV test in the 12 months and who know their results	National data is not available				
8. Percentage of most-at-risk population who have received an HIV test in the last 12 months and who		**Sex Workers**	**MSM**	**IDUs**	Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
		%	**%**	**%**	
	Males	57.22	-	43.48	

know their results	Females	27.80	-	61.11	
	All	32.56	33.70	44.16	
	<25	27.31	31.39	36.61	
	25+	35.18	35.11	47.57	
	All	32.56	33.70	44.16	
9. Percentage of most-at-risk population reached with HIV prevention programmes		**Sex Workers**	**MSM**	**IDUs**	IBBS 2007, CDC MoH
		%	**%**	**%**	
	Males	55.22	-	43.04	
	Females	23.94	-	51.85	
	All	29.01	43.99	43.38	
	<25	25.74	37.59	36.84	
	25+	30.64	47.89	46.33	
	All	29.01	43.99	43.38	
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	12.99%				OVC Survey 2007, UNICEF
11. Percentage of schools that provided life skills-based HIV education in the last academic year	National data is not available.				
KNOWLEDGE AND BEHAVIOUR					
12. Current school attendance among orphans and among non-orphans aged 10-14		**Orphans**	**Non-orphans**		Indonesia Demographic Health Survey (IDHS) 2007, Statistic Indonesia
		%	**%**		
	All	87.20	92.60		
	Males	83.82	91.76		
	Females	91.23	93.50		
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	**Age**	**Males**	**Females**	**All**	Indonesia Youth Adolescent Reproductive Health Survey (IYARHSS) 2007, Statistics Indonesia
		%	%		
	15-19	11.66	12.93	-	
	20-24	16.72	20.08	-	
	All	13.66	15.12	14.30	
14. Percentage of most-at-risk populations who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission		**Sex Workers**	**MSM**	**IDUs**	Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
		%	**%**		
	Males	36.70	-	58.22	
	Females	25.24	-	68.52	
	All	27.10	43.85	58.62	
	<25	25.32	40.33	52.17	

	25+	27.98	46.00	61.53	
	All	27.10	43.85	58.62	
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		**Males**	**Females**	**All**	Indonesia Youth Adolescent Reproductive Health Survey (IYARHSS) 2007, Statistics Indonesia
		%	**%**		
	15-19	0.38	0.29		
	20-24	0.26	0.04		
	All	0.33	0.21	0.28	
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than 1 partner in the last 12 months		Males	Females		IDHS 2007, Statistics Indonesia
		%	**%**		
	All	0.33	-		
	15-19	-	-		
	20-24	0.23	-		
	25-49	0.34	-		
17. Percentage of women and men aged 15-49 who have had more than one partner in the last 12 months reporting the use of a condom during their last sexual-intercourse		**Males**	**Females**		IDHS 2007, Statistics Indonesia
		%	**%**		
	All	60.00	-		
	15-19	-	-		
	20-24	100.00	-		
	25-49	58.33	-		
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client		**%**			Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
	All	67.80			
	Males	79.12			
	Females	65.98			
	<25	63.56			
	25+	69.95			
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		**%**			Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
	All	57.25			
	<25	55.66			
	25+	58.22			
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse		**%**			Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
	All	35.77			
	Males	35.80			
	Females	35.14			
	<25	34.50			
	25+	36.25			
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time		**%**			Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
	All	88.03			
	Males	87.78			
	Females	86.96			

they injected	<25	88.52			
	25+	81.74			
IMPACT					
22. Percentage of young women and men aged 15-24 who are HIV infected	National data is not available				ANC sentinel surveillance
23. Percentage of most-at-risk population who are HIV infected		**Sex Workers**	**MSM**	**IDUs**	Integrated Bio Behavior Survey (IBBS) 2007, CDC MoH
	Males	24.40	-	52.14	
	Females	7.78	-	57.14	
	All	10.18	5.23	52.35	
	<25	10.39	4.17	41.47	
	25+	10.07	5.99	57.97	
	All	10.18	5.23	52.35	
24.Percentage of adults and children with HIV known to be on treatment 12 month after initiation of ART	64.92%				CDC MoH, 2009
25. Percentage of infants born to HIV-infected mothers who are infected	National data is not available				

Table 2. Overview of UNGASS 2010 Additional Indicators

Indicators	Numbers	Data Sources
1. Percentage of health facilities with post-exposure prophylaxis available	Data is not available	CDC MoH, 2009
2. Percentage of health facilities that offer ART	Data is not available	CDC MoH, 2009
3. Percentage of health facilities dispensing ARV that experienced a stock-out of at least one required ARV in the last 12 months	**%** All 5 Public - Private -	CDC MoH, 2009
4. Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral	**%** All 100 Public - Private -	CDC MoH, 2009
5. Percentage of sexually active young women and men aged 15-24 who received an HIV test in the last 12 months and who know their results	Data are not available	
6. Percentage of TB patients who had an HIV test result recorded in the TB register	Data are not available	
7. Percentage of pregnant women who were tested for HIV and who know their results	National data is not available	
8. Percentage of infants born to HIV-infected women who received an HIV test within 12 months	Data are not available	CDC MoH, 2009
9. Percentage of infants	Data are not available	CDC MoH, 2009

born to HIV-infected women who are started on cotrimoxazole prophylaxis within two months of birth		
10. Total number of male and female condoms available for distribution nationwide during the last 12 months per person aged 15-49	Data are not available	NAC, 2009
11. Percentage of young women and men aged 15-24 who report they could get condoms on their own	**%** 15-19 10.95 20-24 15.32 All 12.51 Male 22.07 Female 0.29 All 12.51	IYARHS 2007, Statistics Indonesia
12. Percentage of never married young women and men aged 15-24 who have never had sex	**%** 15-19 96.67 20-24 92.62 All 95.23 Male 93.08 Female 97.97 All 95.23	IYARHS 2007, Statistics Indonesia
13. Percentage of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid sexual intercourse	% 15-19 62,75 20-24 56,08 25-49 50,27 All 51,33 Truck drivers 65,65 Migrant workers - Other 46,91 Unformed services - All 51,33	IBBS 2007, CDC MoH
14. Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV	**%** 15-19 3.66 20-24 9.21 25-29 9.06 All 8.96 None 1.77 Primary 4.91 Secondary or higher 18.00	IDHS 2007, Statistics Indonesia

	All	8.96	
	Male	11.94	
	Female	8.27	
	All	8.96	
15. Percentage of children under the age of 18 who are orphans		**%**	IDHS 2007, Statistics Indonesia
	0-4	1.90	
	5-9	3.68	
	10-14	6.77	
	15-17	-	
	All	4.12	
	Male	4.18	
	Female	4.06	
	All	4.12	
	Maternal	2.57	
	Paternal	0.96	
	Double	0.59	
	All	4.12	

II. Overview of the AIDS Epidemic

Recently, the epidemic in Indonesia has been declared among the "fastest growing in Asia". The epidemic is largely concentrated among key populations such as IDUs, sex workers, their clients, men who have sex with men, *waria* and intimate partners, mostly female of key populations. The cumulative number of reported AIDS cases increased sharply from 2,682 cases in 2004 to 19,973 by the close of 2009. Of this total 3,846 people had by December 2009. As in other parts of the region, the AIDS epidemic in Indonesia is fuelled by unprotected sexual intercourse with an HIV infected partner and sharing of contaminated needles and syringes among IDUs.

It was estimated in 2006 that there were 193,000 adults living with HIV in Indonesia, 21% of whom were women. By 2009, the estimate of PLHIV had risen to 333,200 people, 25% of whom were women. These figures show a feminization of the epidemic in Indonesia.

Based on age groups, AIDS cases are reported mostly among people of productive age (15 - 49 years). According to Ministry of Heath quarterly report on the status of HIV and AIDS in Indonesia, as of December 2009, 18,192 of 19,973 cases of AIDS fell in the 15-49 age range. This situation has not changed much since the onset of the epidemic.

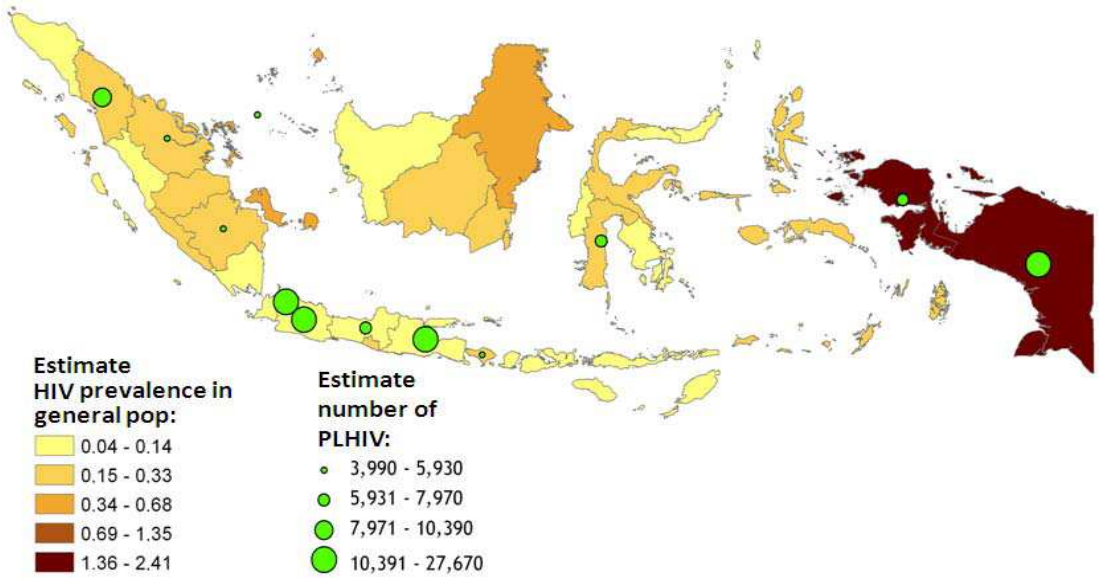
The AIDS epidemic now affects almost all parts of Indonesia, as can been seen from the latest MoH report. In 2004 only 16 out of 33 provinces reported HIV infection, however by the end of 2009 AIDS cases were being reported in all 33 provinces.

Indonesia has had a concentrated level epidemic since 2000, with HIV prevalence consistently over 5% in several sub-populations such as IDUs, sex workers, transgenders (*waria)*, and MSM in almost all provinces where data was available. According to the Integrated Bio-Behavioral Surveillance on HIV (IBBS) carried out in 2007 among most at risk populations, the prevalence of HIV was found to be as follows: Direct Sex Workers 10.4%; Indirect Sex Workers 4.6%; *Waria* 24.4 %. MSM 5.2%; Injecting Drug Users 52.4%. Surveillance among clients of sex workers found that overall prevalence of HIV stood at 0.8%. This figure came from surveillance conducted in 6 cities, among clients of sex workers (men with high risk behavior) including truck drivers, sailors, longshoremen, and taxi drivers which yielded prevalences ranging from 0.2% to 1.8%.

Although the national response to the epidemic currently focuses on these key populations, prevention efforts need to be broadened to prevent the spread of HIV and AIDS into the general population.

In the two provinces of Papua and West Papua in the extreme east of Indonesia, the epidemic is driven almost completely by unsafe sexual intercourse. The epidemic in those two provinces, with a prevalence of 2.4% among the general population aged 15-49, is categorized as a low level generalized epidemic (IBBS Tanah Papua 2007).

Figure 1. Map of HIV Epidemic in Indonesia

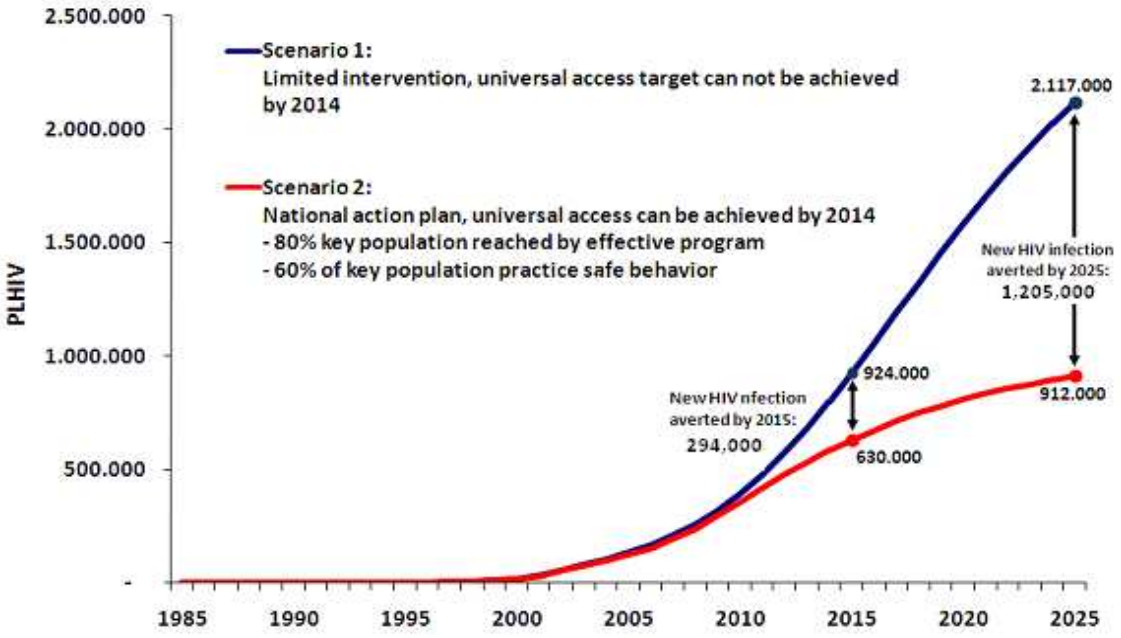


AIDS is a serious threat for the country unless prevention is accelerated and treatment made widely available. Based on trend analysis and projections from mathematical modeling, using current demographic, behavioral, and epidemiological data the following can be expected to occur**:**

- HIV prevalence among people 15-49 years old will increase from 0.22% in 2008 to 0.37% in 2014.
- There will be an increase in the number of new HIV infections among women, which may well lead to an increase in the number of new HIV infections among children.
- There will be a significant increase of new HIV cases among MSM.
- There is high potential for an increase in the number of new HIV infections among intimate partners of key populations.
- The number of PLHIV will increase from 371,800 in 2010 to 541,700 in 2014.
- The number of people needing ART will rise from50.400 people this year (2010) to 86,800 in 2014 (Source: Mathematic Model of HIV Epidemic in Indonesia, 2008-2014, Ministry of Health). The number of PLHIV needing ART will rise still further with the change in criteria for treatment (recommended CD4 count for treatment rising from CD4 count of 200 to CD4 count of 350).

Without appropriate, adequate, and effective intervention, the course of epidemic could be truly alarming. The graphic below depicts 2 possible scenarios for the response between 2010 and 2025: scenario 1 with limited interventions results in 2,117,000 cumulative infections by 2025; scenario 2 with effective work to achieve universal access by 2014 and to reach 80% of all key populations with effective programmes leading 60% of key populations to consistent practice of safe behavior.

Figure 2. Projection of UA Achievements with Different Scenarios



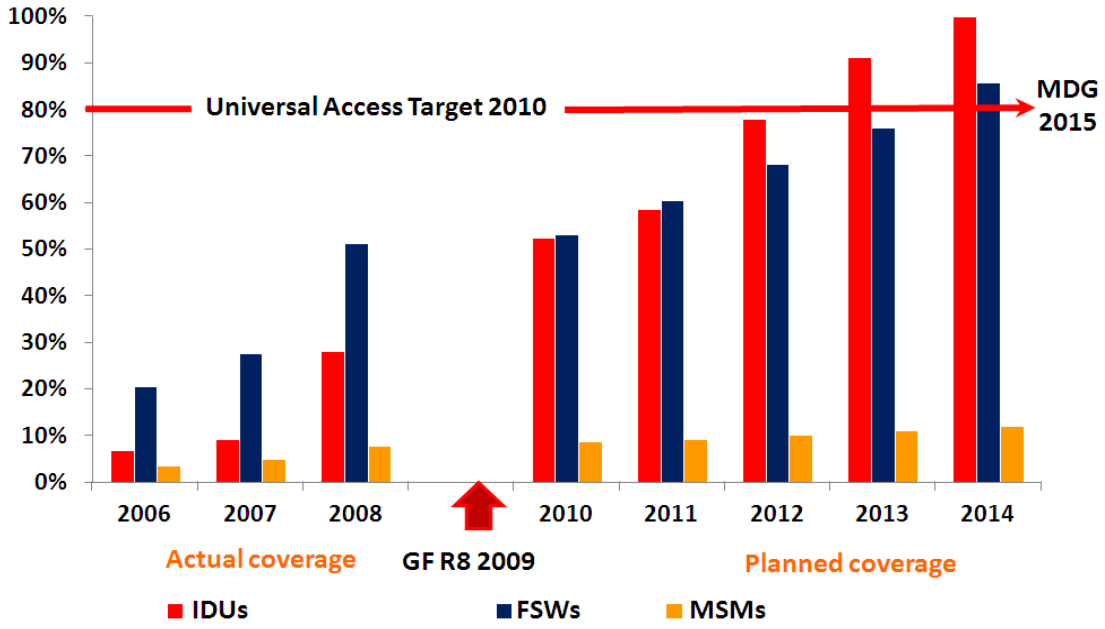
If the National Action Plan is implemented well, it is estimated that 294,000 new HIV infections can be prevented by the end of 2015. If this continues, by the year 2025 1,205,000 new HIV infections will have been averted. (*National HIV and AIDS Action and Strategy Plan 2010-2014*).

The National AIDS Strategy and Action Plan 2010 – 2014 indicates the main goal of the response to HIV and AIDS is to ensure that at least 80% of key populations have access to prevention, care, support, and treatment services. Furthermore, a more aggressive strategy should be in place soon to increase their knowledge and skill in preventing HIV transmission, assessing their own risk, obtaining and using condoms and clean needles, seeking out and utilizing VCT, STI and care, support and treatment services. Improvements are also needed in delivery of ARV -related services, and treatment for opportunistic infections, as well as other care and support. It is hoped that this combination of activities, information, and service will lead at least 60% of key populations to consistent practice of safe behavior.

As of November 2009 there were 538 centers for Voluntary Counseling and HIV Testing, 234 referral hospitals across 33 provinces providing Antiretroviral (ARV) services, 20 Community Health Centers (PUSKESMAS) providing IMAI services (Integrated Management of Adult Illness), and 37 referral centers for Preventing Mother to Child Transmission (PMTCT) in 24 provinces. An additional, 10 hospitals were designated as rehabilitation centers for intravenous drug users. In the districts and municipalities with HIV prevalence of 5% or more, collaborative efforts are on going between HIV programmes and those focused on eradication of tuberculosis. (MoH, 2009). The government is also fully subsidizing the cost of Anti Retroviral medication, anti-tuberculosis drugs, and HIV tests, as well as diagnosis and treatment through referral hospitals.

However, improvement and acceleration of work is needed because Indonesia has not yet reached the universal access targets. Although program coverage has increased since 2006, there is still a big gap between progress made thus far and full achievement of universal access.

Figure 3: Programme Coverage against UA Targets



Despite the target of reaching 80% of key populations, achievement has, fallen short of that target. As of the end of 2009 only 51% of sex workers, 29% of IDUs and 9% of MSM had been reached by programs. (NAC, 2009).

According to the National AIDS Strategy and Action Plan (2010-2014), the response to HIV and AIDS in Indonesia includes 4 major areas of concern 1) prevention, including improving the quality and availability of reproductive health services and understanding reproductive rights; 2) provision of medication and comprehensive care, support, and treatment for people living with HIV and affected by AIDS; 3) Impact mitigation to reduce the negative of sosio-economic impact of HIV and AIDS on PLHIV and their families; and 4) conducive environment to strengthen management and institutional capacity.

Below are some key findings from IBBS 2007 related to key populations, as well as other high-risk groups and sites in Indonesia.

2.1. AIDS amongst Most-at-Risk Populations

2.1.1. Injecting Drug Users

Transmission of HIV through sharing of contaminated injecting equipment persists as the primary mode of infection in Indonesia. The five provinces most affected by injecting drug use are the Greater (DKI) Jakarta area, East Java, West Java, North Sumatra and South Sulawesi. According to MOH data, in 2006, there were 219,200 people injecting drugs and 43% to 56% of them were infected with HIV. The prevalence of HIV among IDU was 55%-56% in three of the four cities in which

biological data were collected (Jakarta, Medan and Surabaya) but somewhat lower in Bandung (43%). This homogeneity is not accounted for by mobility of IDU between cities, as few IDU reported having traveled between provinces to inject (IBBS, MoH 2007).

According to IBBS findings, HIV prevalence among those who injected drugs for two years or less was substantially lower than among those who had injected drugs for more than two years. This finding suggests that many HIV infections among IDUs can be prevented if IDUs are effectively reached with appropriate information and action early in their injecting life. In Jakarta and Semarang, about a quarter of the IDUs have been injecting for less than a year, whereas in Malang only 4% are new IDUs. This variation should be considered in designing harm reduction programs.

The proportion of IDUs receiving clean needles and syringes from a Needle Exchange Program (NEP) in the past week, (an indicator of effective NEP coverage and programming), ranged from 98% in Medan to 33% in Surabaya. The cities that have achieved high coverage of IDUs through NEP tend to have a lower proportions of IDUs who report having shared a needle in the past week. Distribution of clean needles through NEP has risen dramatically in Indonesia since 2004. Substantial reductions in sharing needles have occurred over the same period except in Jakarta. However, the number of needles being distributed appears to be insufficient. A significant number of IDUs are being reached by methadone substitutions programs, but many of them also continue to inject. This may reflect irregular supply of methadone at distribution sites, inadequate dosage, or both.

Although fewer than 30% of all IDUs in six cities were tested for HIV in the year prior to the 2007 IBBS survey, the number of IDUs reached by prevention program already exceeded the 2007 target (40% were covered while the target was 15%). However, the percentage of IDUs reporting the use of condoms is the lowest of all key populations. Only 33.9% of IDUs reported the use of a condom the last time they had sexual intercourse, compared to 68.6% of sex workers and 39.3% of MSM. Clearly, the contribution of IDUs to the continuing growth of the AIDS epidemic in the country is considerable.

2.1.2. Sex Workers

Unsafe sexual practice between sex workers and their clients have long been the second most common route of HIV transmission in Indonesia. It is estimated that the total number of direct female sex workers (those who work in brothels and street-based sex workers) ranges between 95,000 – 157,000 while the number of indirect sex workers (sex workers employed in karaoke bars, massage parlors, etc. who occasionally, and generally off the premises, engage in sex work to add to their income) is estimated to be between 85,000 – 107,000.

Among direct FSWs, the highest prevalences of HIV were recorded in Tanah Papua and Bali, whereas the highest prevalences among indirect FSWs were found in Batam and Jakarta. Among both direct and indirect FSWs, the prevalence of HIV among those new to sex work was almost as high as the prevalence among FSWs with longer experience of sex work, indicating that FSWs get infected very quickly after becoming involved with the selling of sex. According to survey findings, the

proportion of FSW infected in their first six months after entering the business is alarmingly high. Among the direct FSWs the prevalence was between 6-16%, while among indirect FSWs the prevalence was between 2-9%.

The condom is the most important means to prevent HIV transmission among people who are professionally put at high risk of infection. However, the survey mentioned above found that consistent condom use in commercial sex in 2007 was low and there was no sign of condom use having increased during 2002-2007 period. The reported frequency of condom breakage is also very high. This data corresponds well with related findings on STIs : that there is little evidence of declining STI prevalence among FSW over the past five years. Chlamydia and syphilis are the two most prevalent STIs found among the two groups of FSW. As is well known, presence of an STI is among the most important preconditions for transmission of HIV infection. Moreover, despite the national campaign on condom use, it appears that still too few sex workers practice condom use consistently to protect them from HIV infection and other STI.

Injecting drug use among FSW is reported low. However, the use of methamphetamines is quite high. Thirty-two percent (32%) of indirect FSWs in Batam and 19% in Jakarta report having used this substance. While the immediate danger of HIV infection is less than if a person is injecting drugs, nonetheless use of methamphetamines by a FSWs can lower her attention and ability to negotiate condom use with her client. This data makes clear the need for a new strategy for promotion of condom use in order to accelerate work to meet 100% condom use targets in known hotspot.

2.1.3. MSM

Although HIV transmission among men who have sex with men is low compared to transmission among IDUs and FSWs and their clients, the increasing number of HIV infections among MSM is alarming. It is estimated that in 2006 there were between 384,320 – 1,149,270 MSM in Indonesia. The 2007 IBBS collected behavioral data from MSM in six cities – Medan, Batam, Jakarta, Bandung, Surabaya and Malang – and biological data in three cities, i.e. Jakarta, Bandung and Surabaya.

The first important finding related to the very high STI rates among MSM in Jakarta, Bandung and Surabaya, especially those engaging in commercial sex. Between 29% and 34% of MSM in those three cities were infected with one or more rectal STIs, with chlamydia being slightly more prevalent than gonorrhea. The high prevalence of rectal STIs is an indication of high prevalence of unprotected anal sex. This information matched the reported low levels of consistent condom use among MSM.

Despite the high prevalence of STIs among MSM, only a moderate proportion of MSM utilize available STI diagnostic and treatment services. The proportion of MSM who had visited an STI clinic in the three months prior to the IBBS ranged between a low of 18% and high of 30% in five cities, but reached 68% in Malang. Fifty-seven percent of MSM in Malang had ever been tested for HIV versus between 23% and 41% in the other five cities. Most MSM who had been tested for HIV had been tested in the year prior to the 2007 IBBS. This reflects improvements in the availability and

utilization of HIV counseling and testing services as well as increasing acceptance of the need for and utility of HIV counseling and testing among MSM, or both.

Sexual networks among MSM and their partners are both complicated and worrisome. MSM tend to have multiple sex partners, both male and female, and significant numbers of them also buy and sell sex. Almost 87% of MSM report having casual sex with a male partner and 40% with a female partner in the year prior to the IBBS survey. Buying and selling sex with male partners was also common: 20% reported buying sex from and 47% selling sex to a male partner in the past year. The corresponding figures for buying and selling sex with female partners were 10% (buying) and 14% (selling) respectively. One-third of MSM also reported having a regular male partner and 16% a regular female partner. Twenty-two percent (22%) also reported that their regular partners also had other partners.

As was true among FSWs, only a small proportion of MSM inject drugs. However, use of methamphetamines and similar drugs is quite common among MSM in some cities carrying with it the danger that these substances can impair the user's attention and ability to use condom during high risk sex (IBBS, 2007).

2.1.4. *Waria* (transgender)

Waria is the Indonesian term for transgender people, men who assume a female identity. Prior surveillance data shows that *waria* tend to engage in risky sexual behaviors by selling sex and that they have high HIV prevalence. Official estimates in 2006 placed the number of *waria* in Indonesia between 20,960 and 35,300.

The most striking finding of IBBS 2007 related to *waria* was the extremely high prevalence of HIV. Results of surveys in three cities where biological data was gathered (Jakarta, Bandung and Surabaya) showed HIV prevalence that ranged from 14% in Bandung to 34% in Jakarta. Prevalence of either rectal gonorrhea or chlamydia stood at 42% in Jakarta and 55% in Bandung. Syphilis prevalence ranged between 25% (Jakarta and Bandung) and 30% in Surabaya. The prevalence of syphilis is noteworthy as being among the highest recorded in Asia in recent years.

A large majority of *waria* sell sex to male customers. In addition to that, many *waria* also have regular, noncommercial male sexual partners. Most of the *waria* have been in commercial sex work from 9 to 13 years. The median number of clients in the last week ranged from 1 to 4 in the five cities (Semarang and Malang, in addition to that three cities). More than 90% of *waria* reported having both anal and oral sex with clients during the last year, while consistent condom use is only moderate at best (use in receptive anal sex with clients ranged from 13% in Jakarta to 48% in Bandung).

Findings are that *waria* are placed at risk by high levels of risky sexual behavior, including low levels of consistent condom use during anal sex. Consistent condom use with casual partners was even lower than with clients in all five cities. Fortunately, the proportion of *waria* who recently utilized STI services and received HIV counseling and testing is substantial. A good proportion of *waria* (more than 90%) had ever been tested for HIV during the last year perhaps reflecting expansion of service availability, increasing acceptance of VCT among *waria*, or both. However,

while the knowledge of preventive measures is quite satisfactory, their knowledge of HIV and STI tended to be superficial and behavior of many *waria* continues to place them at much elevated risk of HIV infection.

In the remaineder of this report, *waria* will be categorized under the male sex workers group.

2.1.5. High Risk Men (HRM)

In regard to HIV transmission, high risk men (men who are frequent clients of FSWs) are considered an important bridge between key populations and the general population. In the 2007 IBBS, men were selected from four occupational categories to represent the category "high risk men": truck drivers (in Deli Serdang and Batang), seafarers (in Batam, Medan, Semarang, and Surabaya), dock workers (in Jakarta, Merauke, and Sorong) and moto-taxi drivers (in Medan, Banyuwangi, and Jayapura).

Some results from the survey among high risk men confirmed that the HIV epidemic in Tanah Papua is mainly fuelled by unprotected sex between sex workers and their clients and with casual partners, contacts found to be more than double the levels in other provinces. Size estimation of key population (MoH, 2006) indicates that the number of clients of FSW is around 5% out of male adult population for Indonesia in general, while in Tanah Papua the figure is at 9%.

Around 30% of moto-taxi drivers and 25% of dock workers in Tanah Papua reported having had sex with a casual partner in the past year. Truck drivers and seafarers were the HRM outside of Papua who reported the highest percentages of sex with FSW in the past year, truck drivers at 60% and seafarers at 46% respectively. In Tanah Papua, sex with FSW was quite common among both moto taxi drivers (34%) and dock workers (43%).

The 2007 IBBS did not detect any HIV infection among moto-taxi drivers outside Papua. However, 0.2% of truck drivers and 0.5% of seafarers were infected with HIV. In Tanah Papua, the prevalence of HIV was much higher, with 1% of the moto-taxi drivers and 3% of the dock workers being infected with HIV. Among High Risk Men, chlamydia is a more frequent STI than gonorrhea. The prevalences of both chlamydia and gonorrhea are extremely high in Tanah Papua. Among the moto-taxi drivers in Tanah Papua, the prevalence of chlamydia and gonorrhea is similar, (7%), while the prevalence of syphilis reaches 9.3% among moto-taxi drivers and 4.5% among dock workers. The prevalence of syphilis is alarmingly high in all groups and geographic areas. This situation justifies extension of screening and treatment interventions to the general population in Tanah Papua.

Across Indonesia only a small number of high risk men use condoms consistently with either FSW or causal partners. Consistent condom use with FSW in the past 3 months ranged from 7% to 21% among the different occupational groups outside of Tanah Papua and from 37% to 46% in Tanah Papua. In general, across Indonesia, truck drivers, the occupational group with the highest frequency of sex with FSW, are also the least likely to use condoms. Likewise, knowledge that condoms can protect against sexual transmission of HIV was low, ranging from 36% to 55% among truck drivers.

Although very few high risk men reported having injected drugs in the past year, 7% of both truck drivers and seafarers reported using methamphetamines in the past three months, while in Tanah Papua, 8% of moto-taxi drivers had used methamphetamines in the past three months. As indicated by available scientific evidence, use of methamphetamines can lead to risky behavior.

Under this category (high-risk men), it is also important to take note of data from an Integrated Bio-Behavioral Survey conducted by the Indonesian Army among their men in 2007. Indonesian Army personnel are considered high-risk due to their mobility which often contributes to the practice by many of risky sexual behavior. Nonetheless, HIV prevalence among military personnel is relatively low compared to other sub-groups of high-risk men, i.e. 0.1-1.2%. This figure is consistent in several provinces. It is noteworthy that prevalence among unmarried personnel is four times higher than married personnel (0.63% compared to 0.15%).

Although most of the respondents in the military IBBS (>90%) have heard about HIV, comprehensive knowledge about HIV was low, ranging between 2.5% and 7.21%. A willingness to buy sex was acknowledged by many respondents regardless their marital status, but the percentages were different. Among the unmarried respondents, more than 40% said that they had bought sex from sex workers. The percentage was lower among widowers (18%), and married personnel (3.8%). The survey also indicated that on average, personnel assigned to a new post could abstain from sex only about two months before getting services from sex workers or looking for a new spouse. Reported condom use during the last sexual intercourse ranged between 27.8-66%. Condom use was lower during sexual activity with girlfriends and wives (34.8%).

2.2. HIV in Prisons

Prisons are settings with high concentrations of MARP and multiple risk factors are present and often meet. A high proportion of prisoners are people convicted for drug possession and use. Contaminated needles are used for both injecting and tattooing in prision. Furthermore, unsafe sex is often practiced among inmates. All of these conditions exist in a situation where there is often severe overcrowding.

In October 2007 there were 127,238 prisoners in 363 prisons across Indonesia with a capacity of 80,298 prisoners. A total of 25,238 people, nearly one quarter of the prison population, had been arrested on drug related offences. Of these drug offenders 73% were drug users (40% of them injecting drug users), 25% were drug dealers and 2% were involved in the manufacture of drugs. Indonesia drug laws are strict and stringently applied with the result that many people involved in the drug business are repeat offenders who may be incarcerated more than once and for varying periods of time during their drug-related career.

In 2009, there were 13 prisons in Indonesia specifically designated for drug offenders where 1,341 prisoners are serving a sentence. However, there are also large numbers of narcotic offenders spread throughout the prison system as a whole. Moreover, there are likely to be many more people in prisons who have used drugs or who are currently using but who have been convicted on non-drug related offences.

Data on HIV prevalence in prisons and detention centers in Indonesia is at present patchy and unsystematic, though improving. Sentinel surveillance among prisoners in 2005 showed HIV prevalence of 17.8% in Jakarta, 13.1% in West Java, 35.5% in Banten, 28% in Lampung and 4.5% in Bali (CDC MoH, 2006).

Results of VCT in Jakarta's narcotics prison showed that 200 of 250 prisoners tested positive for HIV. In another narcotics prison in West Java (Bandung Narcotics Prison) 40 of 63 prisoners tested were infected with HIV. Data from a women's and boys prison in Jakarta found that of 252 prisoners tested, 10.3% were HIV positive. Mortality figures for four prisons in Jakarta show an alarming situation: 90% of the inmates who died in prisons were drug users. (Ministry of Law and Human Rights, 2009).

The first national strategy to address HIV and AIDS and drug use in prisons was launched in June 2005 and covered the period 2005-2009. Prevention programs in prisons are now coordinated by the NAC's Working Group on Prisons, while the Directorate General of Correctional Institutions in the Department of Law and Human Rights is the leading sector. For the period 2007-2010 96 prisons in 24 provinces have been identified as priorities for capacity building in HIV prevention and care programs.

Priorities for a comprehensive national response throughout the prison system are as follows: high level government endorsement of the strategic plan and budgetary allocation for prison programs; development and coordination of a truly national response among all stakeholders; an increase in support of the Ministry of Health for strengthening of prison health services; substantial investment in human resource development; development of prison-based drug treatment facilities; and reliable allocation of adequate funding for the response.

Between 2007 and 2009 several policies were issued to respond to the presence of HIV in the prison system and the impact of the epidemic among inmates, i.e. National Strategy to Respond to HIV and AIDS and Drug Abuse in Prison and Detention Centers; Master Plan for System Strengthening and Provision of Clinical Services Related to HIV and AIDS in Prisons and Detention Centers; Technical Guidelines for Prison-Based HIV and AIDS Care, Support and Treatment; SOP for Methadone Service in Prisons and Detention Centers; Circular Letter from Directorate General of Prisons on Monitoring and Evaluation of the Response to HIV and AIDS in Prisons and Detention Centers (*National HIV and AIDS Action and Strategy Plan 2010-2014*).

As of July 2009, 4,285 inmates had utilized VCT services available in 15 prisons, in addition to other prevention and treatment programs. Four prisons have methadone services available. By the end of 2008 the services were being used by 1,079 inmates. Fifty-three prisons are currently collaborating with referral hospitals to provide ART, TB, and OI services for inmates. Funding of GF Round 8 will help to expand programs in 82 prisons which are located in 12 provinces. Prison based programs are implemented in collaboration with NGOs. There are currently 26 NGOs that implement prison based programs, including outreach activities for inmates (*National HIV and AIDS Action and Strategy Plan 2010-2014*).

The key implementing partners for the prisons programs are, among others, FHI-ASA (supporting capacity building in BCC, risk reduction program, and improvement of clinical services) and IHPCP (supporting BCC and harm reduction interventions). Funds of Global Fund are being used to provide simple laboratory equipment for 50 prisons, for capacity building in counseling and laboratory analysis for medical officers in prisons, and development of VCT centers in selected hospitals. Other key partners providing technical support to the prison programs are the National Narcotics Board, WHO, UNODC, as well as other government and development partners.

2.3. HIV in Tanah Papua

While most provinces in Indonesia still have concentrated HIV epidemics, the two provinces of Tanah Papua, Papua and West Papua, are already experiencing a generalized epidemic. Unlike other provinces, the HIV epidemic in Tanah Papua was caused and continues to be fueled almost exclusively by unsafe sexual practices. At the end of 2009 the AIDS case rate (number of reported AIDS patients per 100,000) for the province of Papua is 15 times higher than the national case rate standing at 133.07 for the province of Papua and 8.66 for Indonesia as a whole. The case rate for West Papua is twice the national rate. According to findings of IBBS among the general population of Papua and West Papua (data collected 2006, publication 2007), HIV prevalence across the two provices was 2.4% among the general population aged 15–49.

The Directorate General of CDC & EH, Ministry of Health, reports that Papua and West Papua identified 127 new AIDS cases during the last quarter of 2009 (October – December). With the total population of 2.5 million, AIDS had reached 6,245 people (4,745 in Papua, and 1,500 in West Papua) by December 2009. It is noteworthy also that two cities in the Province of Papua are among the five cities with highest number of reported cases of HIV infection in Indonesia, Timika, number 4 and Nabire number 5.

In 2004 Papua[1] had both Indonesia's fourth highest GRDP per capita (over Rp. 11 million per capita) and the highest incidence of poverty nationally, with 41.8% of people in living on less than USD 1 per day. Economic development has been largely concentrated in certain locations and certain sectors of the economy but has not translated into corresponding levels of human development. At the time data was collected for the 2004 Indonesian Human Development Index the incidence of poverty was more than double the national average of 18.2% (Indonesia Human Development Index Report, 2004).

For many non-economic indicators of poverty, including those measured by the MDGs, the people of the two provinces of Tanah Papua have long lagged behind most other provinces. According to the HDI 2004, Papua ranked lowest in Indonesia. It stood out as one of the few regions which HDI was actually declining.

Endowed with abundant forest, water, and mineral resources, the sparsely populated land, of Tanah Papua has attracted some investors and sustains high rates

[1] The two provinces of Papua and West Papua were still one province known as Papua in 2004.

of in-migration, people looking for work who settle primarily in a few rapidly growing costal locations. Some people feel that new values brought by outside migrants as well as the introduction of cash economy have transformed some traditional values and practices of the people of Papua. These changes have had mixed impact. Some observe that the social and economic change have had a negative influence on sexual behavior lowering the age of sexual debut and increasing the practice of extra-marital sex (Butt et al, 2002) increasing vulnerability to HIV infection.

Several studies show that sexual behavior patterns in Tanah Papua are of particular relevance to HIV transmission. Average sexual debut occurs at 19.5 years old for males and 18.8 for females *('Risk Behavior and HIV Prevalence in Tanah Papua: Results of the IBBS in Tanah Papua 2006',* collaboration between the Indonesian Central Bureau of Statistics and the Ministry of Health*)*. However, among younger people in Papua (14-24 years of age) the number who experience sexual debut before 15 years of age is significantly higher than is found amongst people who are older (25-39 years of age and 40-49 years of age). This downward trend of sexual debut is more predominant amongst females than males. The relatively early age of sexual debut is often accompanied by insufficient knowledge of reproductive health, including sexually transmitted infections and HIV for girls to understand the risks to which they are exposed and the options available to protect themselves. This lack of information increases their vulnerability to infection. At the same time, studies and contemporary discussions emphasize the lack of efficacy of women and girls in many fields, in particular, in sexual decision making. Improvements to reduce high risk behavior and increase the abilitity of young people, particularly girls, to protect themselves from HIV infection, will require intensive, gender appropriate programmes directed at both boys and girls, men and women.

Risky sexual behavior. In ideal terms, traditional Papuans have codes of appropriate behavior, including sexual behavior, that are embedded in cultural and religious teaching and values. In practice, however, these norms often unevenly applied or altogether set aside.

As often happens, along with the expansion of the mining, oil, and timber industries, as well as the arrival of large numbers of security forces, the selling and trading of sex has been commercialized and organized in new ways in urban areas and in isolated areas undergoing rapid economic development. This has also contributed to high personal mobility among the people of Tanah Papua as they feel increasing pressure of the money economy and move to take advantage of new employment opportunities. The number of HIV infections is expected to continue to increase as sex work (by both people of Papua and contract sex workers imported from other parts of Indonesia) continues to expand and the availability and consistent use of condoms remain low. In general, however, what is clear and undisputed in Tanah Papua is that risky sexual behavior (unprotected sex and frequently changing of partners) is responsible for over 90% of HIV transmission in Papua both in urban and more isolated rural areas (Papua Needs Assessment: An Overview of Findings and Implications for the Programming of Development Assistance'. UNDP, 2005).

Estimates suggest that of the population aged 16-29 who were surveyed (IBBS, MoH, 2006) 20%-25% were more likely than their age peers to be mobile, to drink, to have

sex at a young age, to have several sex partners, and to have sex with friends or acquaintances in an casual or "opportunistic" manner. According to Butt et al (2002) in the areas studied this “opportunistic sex” was characterized as follows:

1. It was clandestine and happened most often at social events like dances or parties
2. It frequently required the use of “brokers”
3. It tended to occur between Papuan partners (as contrasted with partnering between a Papuan and non-Papuan)
4. It was associated with gifts of money or goods
5. It was characterized by a high degree of mobility
6. It frequently took place outside of the partners regular cultural boundaries
7. It appeared to be associated with the increasing role of money in sexual relations.

In addition to early sexual debut, high risk sexual practices in Papua are also by found in extra-marital sex, partnering with multiple sex partners, and active sex life. Butt et al also recorded another risky practice they named “sequential sex” (*seks antri*) in which one girl has sex successively with several men. In urban centers it appears to be strongly associated with money and alcohol or drugs. Men who do not have enough money to purchase the services of a commercial sex worker or to meet the expectations of a potential girlfriend, group together to make up the fee to purchase time with a sex worker. They then negotiate a fee with the girl to have sex successively with each man in the group. (Butt et al, 2002).

Condoms are generally difficult to obtain in Papua. According to the result of IBBS Papua 2006, only 17% of respondents reported that it was easy to get condoms. Pharmacies and clinics are the main sources of condoms but many areas of Tanah Papua are still far from clinics or pharmacies. The very low level of condom use is linked, at least in part, to availability of condoms.

2.4. HIV among Women and Children

An estimated 50 million women in Asia are at risk of becoming infected with HIV from their intimate partners. Evidence from many Asian countries indicates that these women are either married or in long-term relationships with men who engage in high-risk sexual behaviors. Globally, by the end of 2008 women comprise 50% of the total 40 millions of people living with HIV and AIDS. At the end of 2009, women made up 25.8% of AIDS cases in Indonesia, (MoH, year end report on status of HIV and AIDS in Indonesia. 31 Dec 2009, p 2).

In addition to female sex workers and small proportion of female IDU, spouses of high risk men must be included in calculations of "most-at-risk population" in Indonesia which, last year, reached a total of more than 6 million people. Women are vulnerable to HIV infection not only as a result of biological factors but also because of a range of gender inequities including various forms of gender-based violence. In 2006, data showed that 221,000 women were working in the sex industry across Indonesia and served an estimated 4 millions clients per year. Many of the FSW entered commercial sex work reluctantly as a way to earn income to help

support their family or they were sold or traded into sex work by parents or boyfriends.

As part of the 9th ICAAP meeting hosted by Indonesia and held in Bali (August 2009), the first "South-East Asia Court of Women on HIV and Human Trafficking" was held. The Court provided a safe venue for testimonies of courage, and resilience in dealing with the harrowing situation of trafficking, violence, and exploitation. Twenty two women who were HIV positive talked of their experience. The testimonies broke the silence surrounding this field and brought forward a strong message that hundreds of thousands of women are still suffering serious violations of their rights not only in Indonesia but also in many parts of Asian region.

A multi-pronged national strategy has been formulated to guide the response to a range of HIV and AIDS issues related to women. There are 5 main elements:

1. Improving availability and quality of services for prevention, care, support, treatment and impact mitigation for women vulnerable to or infected by HIV.
2. Protecting the rights of women.
3. Creating an enabling and conducive environment within family and community to protect women from infection with STIs including HIV, thus reducing women's risk of becoming AIDS patients.
4. Conducting gender-informed operational research related to STI, HIV and AIDS to identify new approaches to respond to the epidemic which will increase acceptability and effectiveness in addressing the specific problems of women at risk or infected with STIs and HIV.
5. Involving men in the response to HIV and AIDS and specifically in the search for more gender-appropriate approaches for women and men.

Although data on prevalence of mother to child HIV transmission is still limited, the number of HIV positive pregnant women is increasing. It is projected that the number of HIV positive women needing PMTCT services will increase from 5,730 people in 2010 to 8,170 people in 2014 (*National HIV and AIDS Strategy and Action Plan 2010-2014*).

Since 2007, PMTCT programs have been available on a limited scale, particularly in areas with high HIV prevalence. By 2008, 30 PMTCT service units were in place, integrated in Antenatal Care units. Of 5,167 pregnant women tested for HIV in those centers 1,306 (25%) were found to be HIV positive. However, only 165 (12.6%) are known to have received ARV prophylaxis from the 30 service units. Several community organizations are also conducting outreach activities to improve utilization of PMTCT services (*National HIV and AIDS Strategy and Action Plan 2010-2014*).

III. National Response to the AIDS Epidemic

Since the onset of the HIV epidemic, the Indonesian government has taken essential steps to tackle the challenge. In 1987 a National AIDS Committee was established under the Directorate General of Communicable Diseases Control and Environmental Health in the Ministry of Health. A multisectoral approach was initiated in 1994 under the leadership of Coordinating Ministry of People's Welfare, to ensure that the epidemic would have a response from the national to the district level while involving all relevant sectors. The first National Strategy covering 1994-1998 was launched, involving international development partners and NGOs who had concern about the huge potential impact of the HIV epidemic.

Less than a decade after the first HIV infection in Indonesia was identified, it became clear that the country was challenged by twin epidemics - HIV and injecting drug use - as use of non sterile injecting equipment then became the most important mode of HIV transmission in the country. In 2003, a Memorandum of Understanding was signed together by the Coordinating Minister for People's Welfare as the Chair of the NAC, and the Chief of Indonesian Police Force as the Chair of National Narcotics Board. This Memorandum aimed to lay the groundwork for a constructive response to widespread HIV transmission among injecting drug users.

In order to enhance the national response, several actions have been taken over the past decade. One of the most important initiatives was the signing of the Sentani Commitment in 2004 by several ministers and governors and representatives of the 6 provinces most seriously affected by HIV. Further, different ministries began to take important initiatives within their respective areas of competence to halt the spread of HIV and abolish the stigma and discrimination that people living with HIV continued to experience. For example, in 2004, the Department of Manpower and Transmigration issued a decree to define and promote implementation of HIV and AIDS programs in the workplace. Also in that year the government started its free ARV program.

Since 2006 the response to AIDS has been intensified. The Presidential Decree No. 75/2006 to restructure National AIDS Commission was aimed not only to expand the participation of all government sectors and civil society in combating AIDS, but also to strengthen national leadership in this field. Following the decree, a number of important policies and guidelines were issued, for example Regulation No 2/2007 on harm reduction among injecting drug users issued by the Coordinating Minister for People's Welfare and the Ministry of Justice and Human Rights issued a policy on the response to HIV and AIDS in prisons.

Limited funding and availability of competent human resources in HIV and AIDS are still among the most important challenges. The funding needed to carry out the National Action Plan for 2010-2014 is estimated to be at Rp. 10.2 trillion, or US$ 1.1 billion. The funds would be used to implement work in four main areas: (1) prevention (57%); (2) care, support and treatment (28%); (3) impact mitigation (2%); (4) establishment of conducive environments (13%). Activities during this period are

to be focused on effective program implementation in 137 districts/ cities across Indonesia where 80% of the key populations live.

Despite the serious challenges, much progress is being made in some areas which will be reflected in the following report as will areas where progress is slower. The following report on UNGASS indicators will describe the current situation of the national response to HIV and AIDS. Wherever available, data on progress toward achievement of universal access will also be discussed under relevant indicators.

3.1. National Commitment and Action

Expenditures

Indicator 1: Domestic and international HIV and AIDS spending by categories and financing sources

This report covers expenditure data for the year 2008 from international and domestic/ public sources. Public expenditures include those from central government as well as those of selected provincial and district government. Only three provinces have been included in this analysis: Papua, Bali and East Nusa Tenggara. Private sources at national level were not included in the analysis as such data are not available, but an analysis at subnational level has been done to determine out-of-pocket spending and the contribution of some private companies for HIV and AIDS programs.

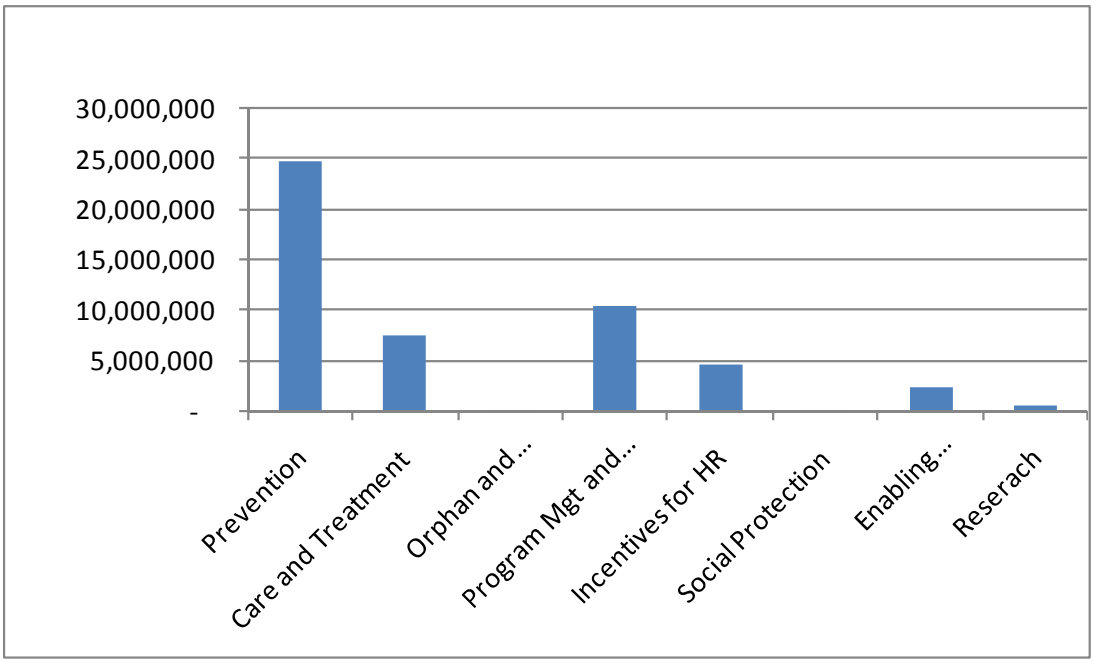
In 2008, the total HIV and AIDS expenditure was USD 49,563,284 of which 59.96% (USD 29,718,017) was financed by international sources and 40.04% (USD 19,845,267) was covered by the domestic/ public sector (central and local government) funds. In general, as compared to previous years the expenditures are declining. Total expenditure in 2007 was USD 58,671,397, of which 73.73% (USD 43,258,120) was financed by international sources and 26.27% (USD 15,413,277) by the public sector (central and local government). Despite the main source of fund is still external sources, government funds have shown an increasing trend.

Table 3. Total HIV and AIDS Spending in 2008

	Financing Sources							
	TOTAL (USD)	*Public Sources*			*International Sources*			
AIDS Spending Categories		Public Sub-Total	Central/National	Sub-National	International (Sub Total)	Multilateral	Bilateral	Other International
Total (USD)	**49,563,284**	**19,845,267**	**17,025,872**	**2,819,395**	**29,718,017**	**9,564,721**	**19,592,557**	**560,739**
I. Prevention	24,703,080	9,578,387	8,096,620	1,481,767	15,124,693	3,527,167	11,036,787	560,739
2. Care and Treatment	7,324,721	5,657,437	5,302,334	355,103	1,667,284	467,492	1,199,792	-
3. Orphans and Vulnerable Children	31,574	12,955	-	12,955	18,619	18,619	-	-
4. Program Management and Administration Strengthening	10,306,896	3,127,934	2,418,924	709,010	7,178,962	2,543,287	4,635,675	-
5. Incentive for Human Resources	4,461,580	232,853	61,165	171,688	4,228,727	2,019,327	2,209,400	-
6. Social Protection and Social Services excluding OPC	18,300		-		18,300	18,300	-	-
7. Enabling Environment and Community Development	2,360,528	1,210,536	1,146,829	63,707	1,149,992	651,410	498,582	-
8. Research excluding operations research	356,604	25,164	-	25,164	331,440	319,118	12,322	-

Table 3 shows that domestic/ public and international partner contributions are mostly used for prevention and program management as well as care and treatment. As reflected in Table 3, almost half of the HIV and AIDS expenditures was committed for prevention (49.84%), while care and treatment spending reached 14.78% and program management spending totalled 20.80%. Harm reduction was a priority program in responding to increasing number of HIV related to IDU. Two programs, OVC and social protection, consumed very low proportion of the fund.

Figure 4. Proportion of HIV and AIDS Spending by Category, 2008



NAC reported that program work in 2008 focused primarily on prevention of HIV infection by sexual transmission as well as continuing serious attention to a range of issues related to injecting drug use (see figure 4). Activities included improving the capacity of VCT, treatment of STIs and strengthening capacity for effective action among stakeholders working on sexual transmission.

Expenditure by Source of Fund

1) International Sources

In 2008, of the total international expenditures on HIV and AIDS in Indonesia, bilateral funds accounted for 65.93% (USD 19,592,557) of the total and multilateral partners contributed the remaining 32.18% (USD 9,564,721). Bilateral partnerships included three major countries that have been participated in HIV and AIDS program for several years. They are the government of the United States (USA), Australia, and United Kingdom (UK). There has also been technical support from the Government of Netherlands. Multilateral donors included United Nations, the Global Fund, European Union (IMPACT), the World Vision, the World Bank and Ford Foundation.

Bilateral Contribution

In 2008, of the bilateral commitments to the HIV response in Indonesia, significant contributions were provided by the governments of USA (USAID), UK (DFID), and Australia (AusAID). USAID (USA) expended USD 7,710,100. DFID (United Kingdom) expended approximately USD 5,880,900. The AusAID (Australia) HIV program contributed around USD 5,706,267. The Netherlands contribution totalled USD 295,290.

Multilateral Contribution

The Global Fund was the largest multilateral source of funding in Indonesia during 2008, providing USD 5,818,972 or 71.72% of the total multilateral contributions. While, UN agencies provided USD 2,241,962 or 27.63% of the total multilateral funding. The remaining funds were provided by the World Bank, the European Union, and World Vision, an international NGO. The GFATM budget in 2008 was less than previous years. According to Monev findings, the lower funding from GFATM reflected the fact that GFATM round 4 support had been completed and preparations were under way round 8 funding in 2009.

2) Public Sources

Central Government Spending

There was a slightly increase in government budget for HIV and AIDS compared to previous years. The combined total of all central government departments/ institutions was USD 17,025,871. Table 4 shows that MOH had spent USD 7,164,519 or 42.08% of total spending on HIV and AIDS from public sources. These funds supported prevention and program management. In addition the Health Department allocated USD 3,723,404 to support Indonesia Red Cross blood supply program. National Family Planning Coordinating Board, in which was primarily to support PMTCT, spent approximately USD 3,410,983 during 2008. The remaining was support from other central government agencies. The Table 4, below, shows national spending during 2008 on HIV and AIDS through central government budget.

Table 4. HIV and AIDS Spending By Ministries, 2008

MINISTRIES	TOTAL (USD)	%
Ministry Of Health	7,164,519	42.08
Indonesia Red Cross (MOH)	3,723,404	21.87
National Family Planning Coordinating Board	3,410,983	20,03
Coordinating Ministry Of People's Welfare	1,538,852	9.04
Ministry Of National Education	555,851	3.26
Ministry Of Social Affairs	280,128	1.65
Ministry Of Transportation	189,541	1.11
Ministry Of Home Affairs	78,956	0.46
Ministry Of Defense	47,872	028
Office of State Minister for Empowermen of Women	22,909	0.13
Ministry Of Labor and Transmigration	12,766	0.07
Indonesia Army	989	0.01
TOTAL	**17.025.871**	**100.00**

Sub National Spending

For the subnational spending, this report includes data from only three selected provinces: Bali, Papua and East Nusa Tenggara. Discussion of spending at subnational level examines only local government funds since other government funds will have been included in national level calculations. In general, subnational spending increased in 2008. The Province of Papua, a case in point shown a significant increase in their provincial budget from USD 260,758 in 2007 to USD 2,095,165 in 2008. HIV and AIDS expenditures in East Nusa Tenggara and Bali (provincial and district governments) reached USD 442,602 and USD 124,686 respectively in 2008. Consistent with overall picture, prevention programs consumed the highest proportion of the expenditure (more than 50%), except in Papua where CST consumes the highest proportion of expenditures.

A more comprehensive picture of HIV and AIDS spending at subnational level was developed recently based on a study supported by the World Bank in Papua province and three districts: Jayapura district, Jayapura municipality and Jayawijaya district. There were three types of funds included in the analysis: government, private (including private company) and international partner. In addition to data in table 5 on funding totals and sources, a household survey was carried out to describe the burden carried by the household in seeking care. Household survey results are shown in table 6. It is obvious that existing health subsidies (Jamkesmas and Jamkesda) for the poor have been very helful to protect PLHIV from being forced into catastrophic spending .

Table 5. HIV and AIDS Expenditure by Source in Papua Province and Selected Districts, 2006-2008

	Spending by Source (USD)			
	Sources	**2006**	**2007**	**2008**
Papua Province	Public	NA	NA	2,738,109
	Private Funds	NA	NA	321
	International	NA	NA	4,656,440
	Total	**NA**	**NA**	**7,715,841**
Jayapura District	Public	74,566	135,952	128,226
	Private Funds	NA	NA	17,615
	International	165,858	156,160	300,742
	Total	**240,424**	**292,112**	**446,584**
Jayawijaya District	Public	106,789	167,008	211,885
	Private Funds	NA	NA	25,295
	International	135,215	192,105	496,891
	Total	**242,004**	**359,114**	**734,071**
Jayapura Municipality	Public	127,293	196,356	241,804
	Private Funds	NA	NA	7,567
	International	280,500	150,205	220,822
	Total	**407,794**	**346,561**	**470,193**

Note:

- Data for 2006 and 2007 only covers three selected districts.
- Data on private funding was collected for year 2008 only.

Figures in table 5 show that international budget expenditure tend to be higher those of local authorities (province or district). However, public funding shows a steadily increasing trend from 2006 – 2008.

Table 6 depicted source of fund for household to seek inpatient care for PLWHA.

Table 6. Household Source of Fund to Seek Inpatient Care in Papua, 2009

Type of Payment	Spending for AIDS treatment (USD)		
	Jayapura Municipality	Jayapura District	Jayawijaya
Out of Pocket	21,131	48,670	5,560
Insurance	821	347	40
Subsidy for the Poor Scheme	10,429	14,085	1,611
Subsidy through MOH	27,145	29,814	3,208
Other sources	136	-	126
Total	**59,662**	**92,916**	**10,545**

Recommendations

The findings incates that in 2008 international sources played the major role in financing for HIV and AIDS program activities. Despite the analysis to determine household spending and private contribution that has been done in the Province of Papua, the results cannot be generalized for the country as a whole because of both the limited sample size and the distinctive social, cultural, economic environment.

Based on this, the following recommendations are made:

1. **Sustainability.** The government of Indonesia should continue to work to increase domestic resources and reduce reliance on external sources of funding for priority program interventions. Efforts to achieve self-reliance should include strengthening local capacity for resource mobilization, continued work in partnership with stakeholders and learning from the past.
2. **Data collection and analysis.** To improve data collection and analysis, it is recommended that the NAC and MOH track expenditure from more provinces, looking at both source of funds and spending categories. Analysis should highlight disparities among provinces with high and low prevalence and examine implications for resource mobilization. It is proposed that NAC institutionalize a process of tracking expenditures using NASA classification. Success stories in conducting cost-effective interventions need to be highlighted in order to improve effectiveness and efficiency of program interventions.
3. It is also recommended that the NAC replicate the Papua Study to collate data on expenditure from the private sources to obtain a more comprehensive picture of the origin of funds used in the response to HIV and AIDS. This would include data collection from service providers, private companies and completion of household surveys, especially in provinces with high prevalence such as DKI Jakarta and Bali.

Policy Development and Implementation Status

Indicator 2: National Composite Policy Index 2007

The purpose of the National Composite Policy Index (NCPI) is not only to measure major achievements within the last two years, but also to involve all stakeholders in evaluating progress, and evaluating the implementation of regulations, laws, policies as well as the national HIV strategic plan. As an integral part of the core UNGASS report, NCPI questionnaires have to be completed and reported along with the country progress report.

As mentioned earlier, prior to the report writing process, two workshops were held to complete the NCPI questionnaires. Two critical features about completion of the NCPI are as follows:

1. Similar to the previous rounds of NCPI, different participants from previous rounds were invited to NCPI discussions this time. Therefore it is difficult to develop a trend analysis of the NCPI results. During the consultation meeting with the Monitoring and Evaluation Working Group in January 2010, it was agreed that the results of NCPI evaluation are independent, not related to the previous ones. In addition to that, the NCPI result is influenced by the national issues that were raised during the discussions, for example issues on HIV policy implementation.
2. Although the questionnaires seem to be formulated in a clear and uncomplicated manner, differing perceptions and interpretations about the questions occurred during the discussions. There were times when participants debated over points of wording in the questionnaires. Clear facilitator guidelines would be helpful in order to focus discussion and minimize bias.

The NCPI process basically emphasizes the role of all stakeholders—government bodies, civil society organizations and development partners—in the HIV initiatives as well as in the reporting process. Based on experience gained through several rounds of NCPI discussions, it is recommended that the role of civil society should be clarified and perhaps expanded, even including in the process of vetting data. At the end of what may be a heated debate during the NCPI development process, the UNGASS report will benefit civil society and enrich the analysis of the current situation and the national HIV response.

Table 7. Results of NCPI Part A (Government Officials), compared to year 2007 (Scale 1 – 10)

No.	Topic	2007	2009
1	Strategic plan	7	8
2	Political support	7	7
3	Prevention - Policy - Implementation	 7 7	 8 7

4	Care, Support and Treatment	7	7
5	Monitoring and Evaluation	8	8

Compared to the NCPI 2007 results, participants indicated that improvements were achieved in the strategic plan and policy administered by the government.

Table 8. Results of NCPI Part B (Representatives of NGOs, bilateral organizations and UN agencies), compared to year 2007 (Scale 1 – 10)

No.	Topic	2007	2009
1	Human Rights - Policies, laws and regulations in place - Efforts to enforce existing policies, laws and regulations	 5 6	 4 3
2	Civil Society Participation	7	5
3	Policy Implementation	6	5
4	Care, Support and Treatment	6	6

Compared to the governmental scores, the values given by the civil society tended to be lower. Both government sectors and civil society representatives perceived that there was no significant improvement in the field of care, support and treatment.

Following are several conclusions resulting from the NCPI process:

1. Civil society participation

Strategic action formulated by the government of Indonesia has involved civil society from the planning stage to the monitoring and evaluation process. This involvement of civil society, endorsed by Presidential regulation (No. 75/2006), was part of the formulation stage of the National Strategy and National Action Plan 2007-2010 and National Strategy and Action Plan (SRAN) 2010-2014. While appreciating their involvement in development of the national strategic plan, civil society representatives criticized their involvement as being merely symbolic and called for greater participation in discussion of funding and budgeting. Furthermore, both government and civil society agreed that community participation needs to be increased in monitoring and evaluation processes, especially at the grassroots level.

Civil society's contribution is apparent, especially in prevention programs among youth and most-at-risk populations (female sex workers, waria, men who have sex with men, and injecting drug users), community-based care and support, and care for orphaned and vulnerable children.[3] Furthermore, participants at the NCPI

[3] As discussed in the following section, work with OVC is not yet a formal part of the national response to HIV and AIDS because in most parts of Indonesia .the epidemic is a concentrated epidemic. In general it is assumed that in this case not many children are left orphaned or specially vulnerable

discussion agreed that civil society has played a significant role in reducing stigma and discrimination and in development and staffing of voluntary counseling and testing programmes in many areas.

The participation of civil society in the UNGASS reporting process has been channeled through some organizations such as Forum UNGASS Indonesia, established in 2007 and various working groups established under the auspices of the National AIDS Commission. Other civil society organizations that were also actively involved in initiating HIV programs are academicians, a wide range of religious communities, professionals in various fields and the private sector. Among the most vocal civil society representatives there is a strong feeling that government does not give sufficient trust/ have sufficient confidence to civil society. This may discourage the capacity building that is necessary to increase people's participation in responding to the epidemic.

2. Laws and Regulations

In addition to a specific law to protect women against violence (Law no.7/1984 on the elimination of violence against women), Indonesia has a number of other laws and government regulations to protect vulnerable people such as youth, injecting drug users, prisoners, and migrant populations (Anti-trafficking Law no 21/2007), from any discriminatory acts. In addition to this antidiscrimination law, there are several regulations to ensure their implementation, i.e:

- Regulation No 2/2007 on harm reduction among injecting drug users issued by the Coordinating Minister for People's Welfare
- Chief of National Police Regulation No 8/2009 on human rights approach in carrying out National Police tasks. Article no. 20 in this regulation particularly emphasizes the special approach to women
- Government Regulation no.9/1999 on gender mainstreaming.

Unfortunately, not many people are familiar with these regulations. The National AIDS Strategy 2007-2010 raised the issue of participation of key populations which is important to reduce stigma and discrimination against PLHIV. Efforts should be made by civil society to document discrimination experienced by PLHIV and other vulnerable groups. This documentation will provide a good basis for advocacy and action to ensure the effective application of the regulations and laws.

Despite the intention to protect vulnerable groups of people, civil society deemed several laws and regulations to be counter-productive. Some examples were cited, such as mandatory HIV testing at the time of recruitment of military personnel, mandatory reporting of IDUs (Narcotics Law No 22/1997), and criminalization of sex between men and sex work in some provinces. To put it differently, in some areas, addressing the risk of HIV transmission is being done through legal approaches rather than enhancing health services or educating people at risk. Repressive

because of AIDS. In fact, in Tanah Papua where the epidemic is generalized and, increasingly in other areas, there are children affected by HIV and AIDS. In response to this situation, civil society -- some religious groups and some NGOs have been working with the Department of Social Welfare on impact mitigation programmes which can benefit many segments of society including OVC.

methods were seen as more common than protecting the rights of people who are at risk. The new Narcotics Law, in effect since last year, has declared that people who use illegal substances have to be sent to drug rehabilitation centers prior to being sentenced. More advocacy and better dissemination of information are needed in order to minimize violations of human rights.

In discussion of NCPI ratings, in some cases civil society representatives criticized the government's performance sharply, while government participants gave high scores to the national strategy and planning in response to the epidemic, especially during the year 2009. Among the achievements noted by the government representatives were: reduced transmission through contaminated injecting equipment; increased participation of key populations in HIV initiatives; better monitoring and evaluation systems; and an increase in government budget allocation for HIV. There are also several legal provisions which aimed to promote the rights of PLHIV, women, children and youth—especially those who are at higher risk of contracting the disease. In general, civil society representatives felt that prejudice persists against most at risk populations and is entrenched in laws, regulations, policies and operational guidelines of law enforcement agencies. Conflicting policies, lack of coordination amongst government bodies, and weak enforcement of the laws and regulation hamper programme implementation and promotion of human rights.

3. Universal Access and Political Support

Indonesia has been working to make universal access a reality and aims to achieve that goal by 2014. Despite the prolonged economic crisis that has hit the country, the government has successfully provided free antiretroviral therapy for those who are eligible and, to a lesser extent, methadone therapy and condoms, especially in hotspot areas. During discussions some participants criticized the uncertainty of ARV stock, noted that administration fees were being charged, and commented on the costs of laboratory tests which are considered expensive for most people living with HIV. The limited stock of condoms and difficulties in obtaining new syringes and needles were also criticised.

Despite the feminization of the AIDS epidemic across Asia participants of NCPI discussions noted the absence of regulations that ensure equal access for women to various programs of prevention, care, support and treatment. The absence of data on several UNGASS indicators, such as PMTCT and support to orphaned and vulnerable children, may suggest that the needs of all segments of the community have not yet been given equitable consideration and access to treatment and support. More on this issue will be discussed in the next section.

In addition to achievements in care and treatment, specific efforts have also been made to increase awareness and promote reproductive health rights, services and knowledge among youth. The integration of reproductive health information into the national curricula is in its initial stages as is are efforts to increase the capacity of school teachers to teach the new curriculum effectively. The main targets of sexuality and reproductive health education are: 1) so that young people are more knowledgeable about reproductive health and safe sex, 2) to promote and facilitate a change of attitude among young people, including to increase respect for the rights of others, and 3) to provide young people the knowledge, skill, and motivation to

behave in a safe manner relative to their reproductive health. Collaboration between the Ministry of National Education and some development partners is currently underway and aimed to broaden the focus among student populations, for instance to include students with special needs and those of younger ages. This initiative will be taken without neglecting programs which are reach and service key populations, i.e., education on HIV, alleviation of stigma and discrimination, condom promotion, HIV testing and counseling, as well as prevention and treatment of sexually transmitted infections.

Issues related to care and treatment have always been a cause of debate between government and civil society groups. It is interesting to note that although the NCPI score has stayed the same, both groups agreed that access to treatment, care and support have expanded in Indonesia and that supply chain management of ARV still needs improvement. The increase in local budgets for HIV programs received positive feedback from all participants. It was surprising to some that the prospect for Indonesia to produce generic ARV was not discussed during the meetings despite the capacity of the country to produce ARV that has improved over the past few years.

In his remarks during the opening ceremony of the 9th International Congress on AIDS in Asia and the Pacific in Bali in August 2009, the President of Indonesia emphasized the importance of strong leadership to prevent and reverse the spread of AIDS. In most countries, according to the President, national leadership spells the difference between the slowing down and the acceleration of the spread of the epidemic. Political support for AIDS initiatives has been increasing especially after strengthening, diversifying, and professionalizing the National AIDS Commissions in 2006. However, integrated efforts are still needed to maximize the impact of various programs and to improve coordination amongst government, civil society and development partners.

3.2. National Program Indicators

Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner.

There was an increase in the number of blood units being screened, from 1,556,819 bags in 2006 to 1,690,134 bags in 2007. From the total number of bags screened in 2007, 1,097 (0.07%) were identified as HIV positive. The latest data from 2008 indicated that 1,718,478 bags of donated blood were screened and 736 bags (0.06 percent) were identified as HIV positive.

Throughout Indonesia there are currently 211 blood transfusion units managed by the Indonesia Red Cross, a national independent body whose main task is providing safe blood for transfusion. Under the Ministry of Health, there are also 46 blood banks in districts hospitals. In general, all blood donated to either the Indonesian Red Cross or government blood banks in hospitals is screened not only for HIV but also for hepatitis B and C viruses and syphilis. However, not all blood donations in Indonesia flow through these institutions, thus there is no record available on whether all donated blood is screened adequately.

Incomplete records from existing blood transfusion units have been another challenge. Currently the Indonesian Red Cross is improving its monitoring and evaluation system and within 1 or 2 years more valid data will be available on a regular basis. Considering the vast archipelagic area of Indonesia (17,000+ islands), providing enough safe blood for transfusion to meet the national need is not an easy task. Furthermore natural disasters are frequent in the country and increase the need for safe, quick supplies of blood. More blood transfusion units and blood banks with qualified screening mechanisms are needed. Ideally, blood transfusion units should be available in every district and for that purpose more budget should be allocated for the provision of blood transfusion services.

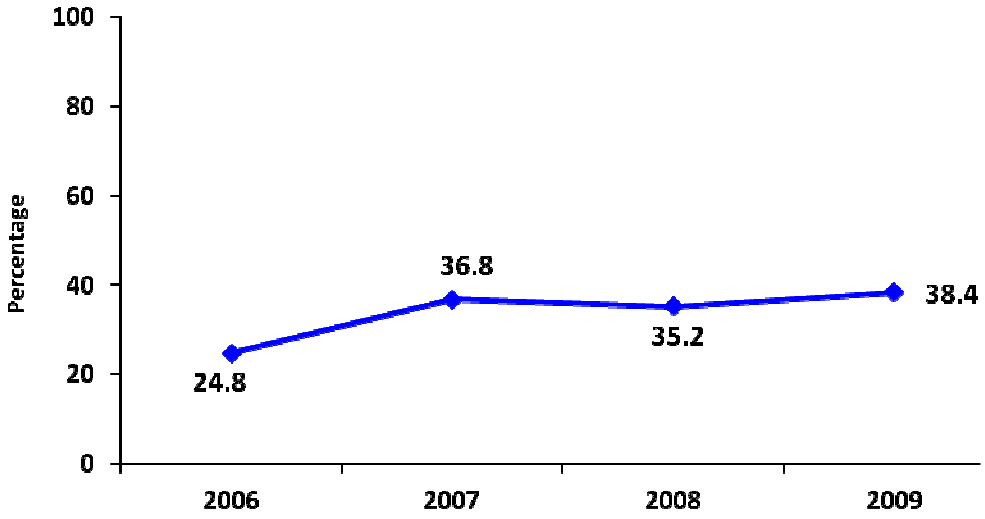
Although institutionally the Indonesian Red Cross is an independent body, it is still heavily dependent on the Ministry of Health to supply reagents needed for blood screening. The reagents being used are imported. The Government of Indonesia considers local production of reagents in order to increase the accessibility of safe blood nationally. Secondly, national guidelines for blood transfusion would periodically be revised following the publication of new evidence. These guidelines should then be made available to all health workers providing ART. For instance, not all people living with HIV with anemia need blood transfusion. Changing of ARV regimens can often avoid anemia for people living with HIV. However, not all health workers in Indonesia, particularly those living in more remote areas, are confident and familiar with such information.

Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.

By the end of 2008, 10,606 people—both adults and children—were receiving antiretroviral therapy (ART). This total was approximately one third of infected people who were eligible to receive this therapy. This is a significant increase from 2006 when only 5,100 people were receiving ARV treatment. Despite this progress, estimates suggest that more than 24,000 PLHIV who are also eligible for treatment are still not yet receiving it, making it absolutely critical to accelerate service delivery to reach universal access goals.

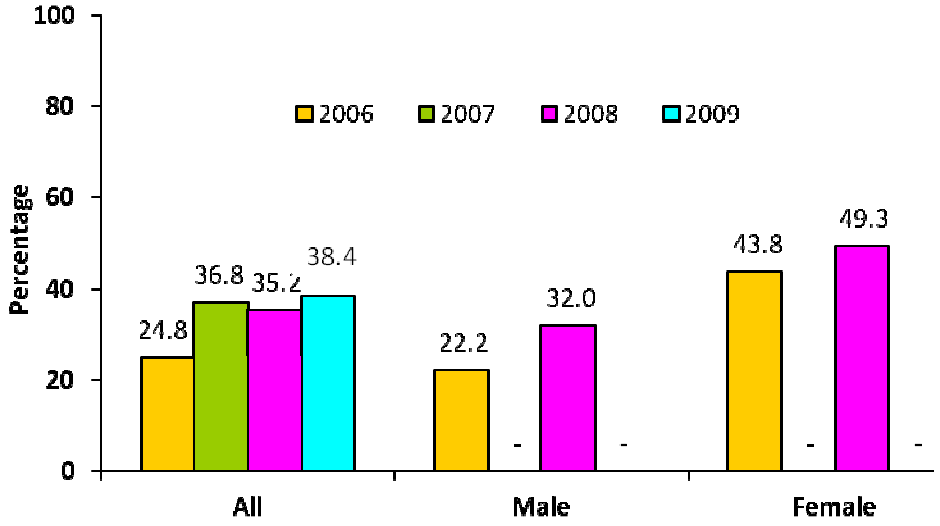
This situation parallels the huge difference between reported cases and estimated numbers of people living with the virus. In addition to accelerating increased availability of treatment programmes, improvement is needed in surveillance, outreach, and case finding systems. Recently there have been debates over the implementation of provider-initiated testing and counseling to strengthen the ability of health care providers to identify and serve people not yet receiving adequate information and/ or treatment.

Figure 5: Adults and Children with Advanced HIV Infection Receiving ART (ART Monitoring, CDC MoH, 2006-2009)



The above graph shows an upward trend of people living with HIV receiving ART during years 2006-2009, indicating improvement in the health care delivery system in Indonesia. The improvement can also be seen from the decline in AIDS-related death which fell dramatically from 46% in 2006 to 17% in 2008 (see indicator 24).

Figure 6: Adults and Children with Advanced HIV Infection Receiving ART, by Sex (ART Monitoring, CDC MoH, 2006-2009)



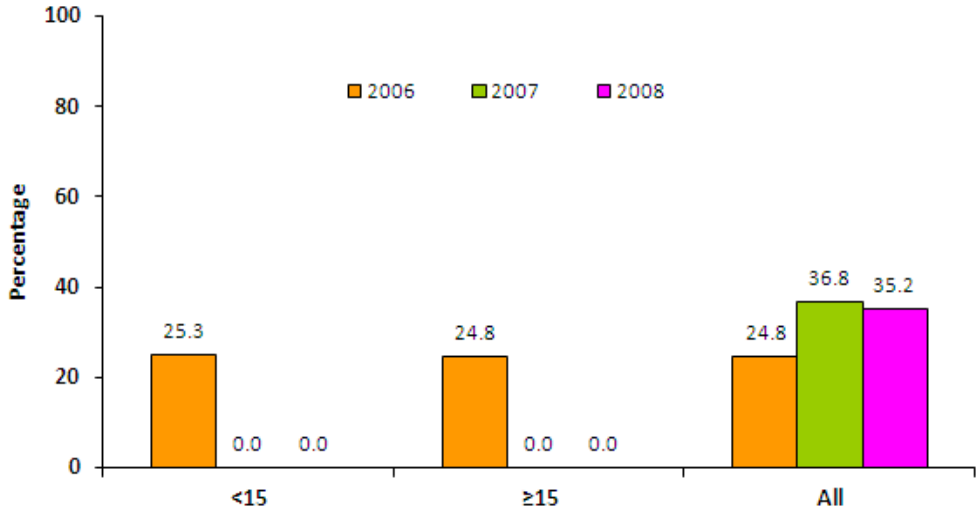
Data disaggregated by sex shows that females, both adults and children, had a slight advantage compared with adult men in receiving antiretroviral therapy during the period 2006-2009. While service delivery figures indicate that far more men were receiving ARV therapy than women and children, nonetheless a higher percentage of positive women were treated. In 2006, 4,138 of 18,651 (22.2%) male PLHIV received ARV treatment. While the total number of women receiving ARV (414) was only 1/10

of the number of men, nonetheless the percentage of women receiving treatment was almost twice that of the men with 414 of 1,926 female PLHIV (43.85%) being treated. In 2008, these figures increased both in absolute numbers and in % of people being served. Seven thousand eight hundred forty-eight of 24,500 male PLHIV (32%) received ARV treatment in 2008, more than three times higher than the number treated among females (2,758 of 5,600 or 49.3%) though again a higher per cent of women were served.

The number of PLHIV who received ARV therapy increased significantly last year. Reports from 163 hospitals across Indonesia up to 30 November 2009, indicated a cumulative total of 50,510 PLHIV who had received HIV care. Of that number, 66% (33,175) were eligible for ARV treatment. However, only 25,384 actually received treatment. Currently there are 15,442 people still taking ARV drugs. Among the balance 5,009 died, 15,442 were lost to follow up, 1,272 moved to other services, and 932 simply dropped out.

Among those who are taking ARV drugs, 80% (12,358 people) are still on original first line regimens, 17.7% (2,734 people) have changed one of their medication to another first line regimen. Only 2.3% (350 people) have changed to second line drugs (*Report on ARV Treatment 2004-2009, MoH*).

Figure 7: Adults and Children with Advanced HIV Infection Receiving ART, by Age (ART Monitoring, CDC MoH, 2006-2008)



As discussed during the M&E Working Group meeting on UNGASS, the biggest problem was related to the still limited (inadequate) number of people who know their HIV status. More aggressive campaigns are needed to increase people's awareness of the benefits of knowing their status and their willingness to be tested.

Jakarta is still the first choice in terms of ARV treatment. Free ARV has been available since 2006. Problems related to the limited supply of ARV, including continuity and availability of stock however, have been major obstacles to effective implementation of the free-of-charge policy in the provision of ARV. Additionally, the limited number

of health workers certified and with sound skills to administer ART has contributed to the unmet need for this therapy.

The challenges are thus to improve program performance of district health care providers, broadening access, and developing better supply chain management for ARV so that PLHIV in other provinces and districts are able to get reliable services. Furthermore, clinical monitoring of ARV efficacy and side effects should be prioritized. Changes in WHO guidelines last year recommending that ART be started when CD4 level reaches ≤ 350 rather than waiting until it is only 200 should be taken as a challenge rather than an impediment to achievement of Universal Access targets. By starting treatment earlier, the life expectancy of PLHIV will increase and the risk of transmission may decrease.

Problems may also arise due to change in another WHO guidelines suggesting phase out of stavudine due to its serious side effects, especially neuropathy and lipoatrophy. WHO recommends another drug, tenofovir, which is more expensive than stavudine. A panel of experts is currently studying what the impact on the national HIV budget and planning would be if stavudine were phased out. Presently about 5,000 PLHIV in Indonesia are using stavudine.

Data from 2009 indicated that every month there were about 450 new patients who were eligible for ARV treatment. Last year the government had to allocate 63 billion IDR (roughly equivalent to USD 7 million) only for ARV. From the total amount, 68% or 43 billion IDR came from the national budget, while 32% (20 billion IDR) was from the Global Fund.

ARV Providers. As had been discussed previously, access to treatment is still a problem in Indonesia. As a big archipelago, distribution of health services is challenging and budget and human resources are still limited, making it difficult to expand ART services. Over the past few years the government, through the Ministry of Health and National AIDS Commission, has done its best to gradually increase both the quality and availability of ART services.

By the end of 2009, the government aimed to have 234 health facilities in 33 providing ART. So far 189 facilities in 31 provinces have been trained. One hundred sixty-three (163) of these submit reports on a regular basis. The number of facilities that provide ART has increased steadily from 117 in 2006 to 136 in 2007. All of the facilities that provide ART are also able to deliver post-exposure prophylaxis (PEP). However, this is still far below the number of service sites needed. Authorities have also taken necessary steps to equip these facilities with capacity for CD4 monitoring which is in line with national guidelines. This monitoring is now done either on-site or through referral to locations with CD4 monitoring capability.

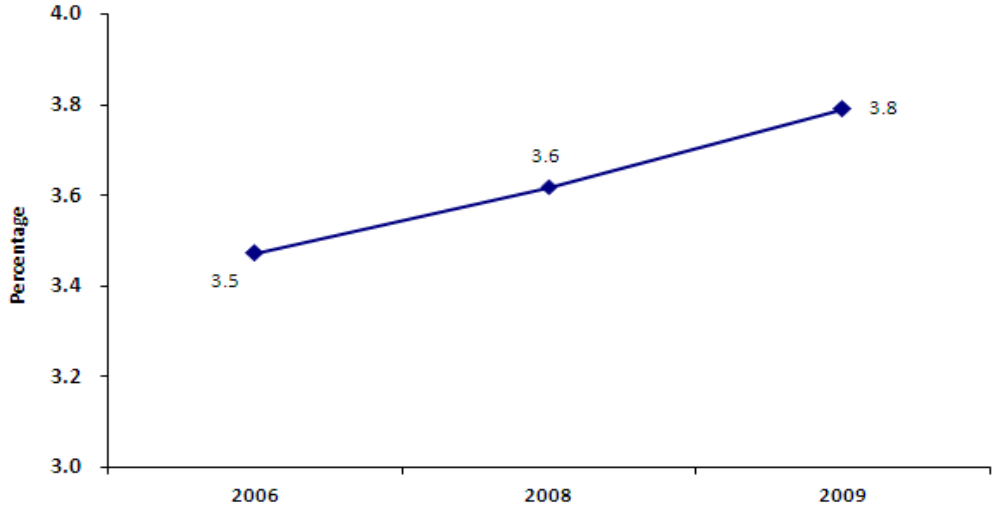
Efforts have also been made to ensure availability of a continuous supply of medication and reduce the incidence of ARV stock-out. In 2008, of 150 health facilities that provide ART, only two facilities (1.33%) experienced a stock-out within the immediate 12 month period. This percentage was lower than 2007, when three facilities out of 136 (2.21%) experienced stock-out.

Since the middle of 2009, children with HIV can receive a fixed-dose combination (FDC) of ARV. Previously they were given ground ARV pills. Staff in 20 hospitals in 12 provinces have now been trained to deliver FDC for infants and children.

Indicator 5: Percentage of HIV-positive women who received ART to reduce the risk of Mother To Child Transmission

Based on the universal access report, as of 2009 the 3.8% of pregnant women living with HIV received medication to prevent the transmission of the virus to their babies, a slightly increase from 3.5% in 2006. Although there was a moderate improvement, the coverage in antenatal settings has remained far from the global average which is 45% for low and middle income countries. On the other hand, the number of new HIV infections among children appears to be climbing only slowly.

Figure 8: HIV Infected Pregnant Women Receiving ART to Prevent of Mother to Child Transmission, 2006-2009
(UNGASS 2008, UA 2009, dan UA 2010)



In 2009, it was estimated that there were 5,170 HIV-infected women, of whom 196 were receiving ARV prophylaxis. This figure was a slight increase over 2008 when it was estimated that there were 4,560 HIV-positive women 165 of whom were receiving prophylaxis ARV. Both the estimate and number of positive women who received prophylaxis ARV in 2008 have doubled since to 2006, when it was estimated there were 2,563 HIV positive women, 89 of whom received the treatment. Although the number of new HIV infections among children appears to be climbing only slowly, nonetheless prevention of mother to child transmission is beginning to receive more attention from the relevant sectors and there is agreement that expanding availability of PMTCT services in Indonesia needs to be accelerateds on a strategic basis.

Studies have proved that prophylaxis ARV for HIV-positive women who are pregnant can reduce morbidity and mortality among babies. Findings from a prospective hospital-based cohort study held for one year, from January 2004 until December 2004 — or before the provision of free ART—showed that transmission was confirmed in 6 of 17 infants (Nia Kurniati, et al, 2006). However, by the end of 2009,

the same hospital where the study took place (RSCM, Jakarta) found transmission of infection in only one case among 150 infants born of mothers with positive HIV status.

At the end of 2009 there were 37 PMTCT service centers available in 24 provinces. However, comprehensive services (including of testing and counseling for pregnant women, delivery by cesarean section, provision of formula for infants, PCR testing for the infants) were available in only 9 provinces. Problems also occurred because of inconsistent reporting which make sound evaluation difficult.

Indicator 6: Percentage of HIV-positive TB cases who receive treatment for TB and HIV

Among various communicable diseases that cause disease burden in Indonesia, tuberculosis ranks first as the cause of death (Riskesdas, 2007). Despite the fact that people living with HIV now live longer, have lower morbidity, and access to free ART in Indonesia, nonetheless, TB remains a leading cause of death among HIV positive people. Non-adherence to treatment — triggered mainly by the side effects of the TB drug—and drop-out are the biggest challenges in TB management.

The percentage of HIV-positive incident TB cases who received treatment for TB and HIV is estimated 2.58% among all male and female cases. Although the percentage is small, important steps to combine HIV and TB treatment have been taken in some provinces where the HIV prevalence among MARP is higher than 5%.

Accurate diagnosis and cure of TB will not only increase life expectancy of PLHIV but will also ease the TB-related disease burden on society. The risk of PLHIV developing active TB is ten times higher than people free of HIV infection. In the early stages of HIV infection, 30% of PLHIV have a risk of developing TB, slightly lower than those with advanced HIV-infection who have a 50% risk of developing the disease (Djoerban et al, 2008). TB infection also affects the progress of HIV infection as PLHIV who develop TB tend also to have higher viral loads.

TB drugs can be obtained in most community health centers, while ARV must be received in hospitals. Only a small number of health centers are entitled to provide ARV and TB treatment simultaneously. One-roof programmes that would enable people to obtain ARV and TB treatments in one site are not yet in place. Furthermore, not all HIV patients are required to check their sputum and undergo X-ray test.

Prevalence of TB-HIV co-infection is not known in Indonesia. In 2003, Corbett et al estimated that the HIV prevalence was around 0.2% among all TB cases in the country (Djoerban, 2008). This figure should be interpreted carefully since Indonesia does not have a policy to screen TB patients with HIV serology.

A descriptive cross-sectional study conducted by Djoerban et al (2008) in one private hospital in Jakarta found that the prevalence of TB among male PLHIV reached 80% while among female PLHIV it was 20%. These figures were similar to epidemiological data published in Universal Access Report by WHO in 2006 which showed that TB infection was found among 82% of male PLHIV and 18% of female PLHIV.

To sum up, TB has long been a major health problem among the general population in Indonesia and has increased alarmingly with the progress of the HIV epidemic. TB-HIV program management still needs major improvement. National TB-HIV guidelines should be disseminated to all levels of health care providers. More importantly, case finding systems should be strengthened by encouraging a policy of TB screening among HIV patients and vice versa.

Indicator 7: Percentage of women and men aged 15-49 who received HIV test in the last 12 months and know their results

Information on this particular indicator is not available for Indonesia except for Tanah Papua province. MoH and BPS-Statistics Indonesia (data collection 2006, publication of report 2007) noted that HIV transmission in Tanah Papua was caused mainly by unprotected sex, either with regular partners, casual partners, or sex workers. Adult HIV prevalence among the general population aged 15 - 49 was 2.4%: 2.9% among men and 1.9% among women. According to the same source, 24.2% of adult population in two provinces of Papua aged 15-49 had received HIV test and knew their results.

HIV testing is often referred to as the first step to treatment and care services, and needs to be linked to care to increase the coverage of services for HIV. Low uptake of HIV testing is one of the reasons for a delayed start on antiretroviral therapy for people in need. Delay in receiving ART also can cause high mortality within months after treatment is initiated. The availability of care and treatment services can play an important role in encouraging HIV testing.

The reported number of health facilities providing HIV testing and counseling services in Indonesia increased from 290 in 2007 to 547 in 2008. However, the gap in reporting on VCT is huge. Only 212 VCT sites are known to be regular in submitting reports on their activities. Data seems to indicate that the number of adults served per testing and counseling facility between 2007 and 2008 decreased. This could be as a result of greater availability of HIV testing facilities. In terms of total numbers of people tested, it is noteworthy that there has been a doubling of those tested between 2007 and 2008 : in 2007 53,929 people aged 15 and above received HIV counseling and were tested while in 2008 that number rose to 109,544 people.

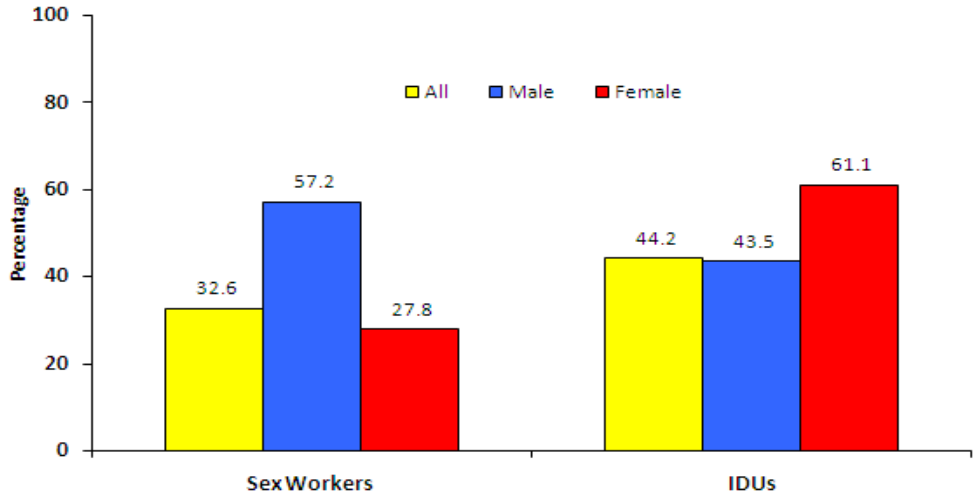
Several problems occur in delivering better VCT services with the result that although the number of VCT sites has increased, their utilization and impact is still far below target. This has contributed to the continuing large gap between the number of HIV cases estimated and reported. Secondly, counselors for adherence are not yet widely available while at the same time the budget to increase skills and capacity of existing counselors is very limited. As a consequence, many VCT sites are not yet able to deliver comprehensive services needed by the people they serve.

Indicator 8: Percentage of most at risk population that have received an HIV test in the last 12 months and know their results

HIV infection among female sex workers and their clients has long played an important role in the heterosexual transmission of HIV in Indonesia. While that is true, it is important to note that the female sex worker population is not

homogenous. The environments in the sites where they work can vary considerably from one place to another and their mobility may have an important effect on HIV transmission. Although various programs have been implemented by many NGOs to limit the spread of HIV among FSW and their clients, only one third of sex workers had an HIV test and knew the result in 2007. Figure 9 showed that the percentage of FSW received an HIV test in the last 12 months and know their result was 32.6% , while the IDUs were 44.2%, indicating that existing interventions related to this issue need fundamental reevaluation and possible redirection either in approach or in targets.

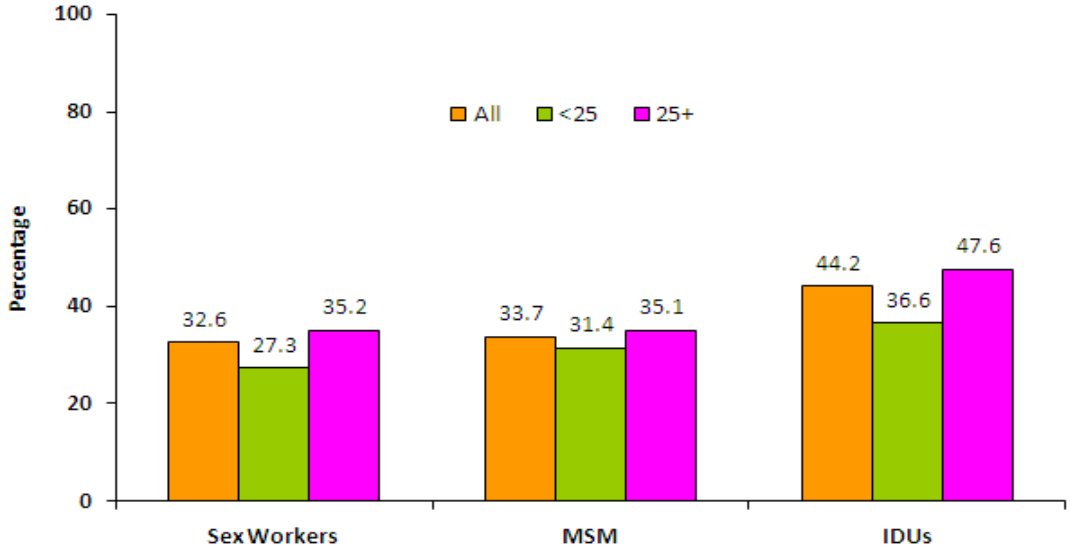
Figure 9: MARPs Who Have Received an HIV Test in The Last 12 Month and Know The Results, by Sex (IBBS MARPs, CDC MoH, 2007)



Data disaggregated by sex showed that female sex workers are less likely to undergo HIV testing and receive the result than male sex workers. One out of two male sex workers had an HIV test and know their results, while less than one third of female sex workers do so. Lack of gender-sensitive services might be one of the explanations. Male sex workers often live near where they work and can get treatment. Female sex workers often live far from work and, in any event, wouldn't dream of telling people at home that they have HIV. So have they have little incentive to be tested.

The result of IBBS among most at risk populations (2007) showed that the HIV prevalence among FSW from 9 provinces where the survey took place ranged between 6% and 16% among direct FSW. For indirect FSW, the range of HIV prevalenece was 2% to 9% . This situation is made worse by the very high prevalence of sexually transmitted diseases—which increase the risk of acquiring and transmitting HIV infection—among FSW. Active syphilis is very high in some big cities like Jakarta and Medan, while the prevalence of chlamydia and gonorrhea are among the highest in Asia. This situation suggests that STI control among FSW has been ineffective and immediate action is needed to improve the situation.

Figure 10: MARPs Who Have Received an HIV Test in The Last 12 Month and Who Know The Results, by Age (IBBS MARPs, CDC MoH, 2007)

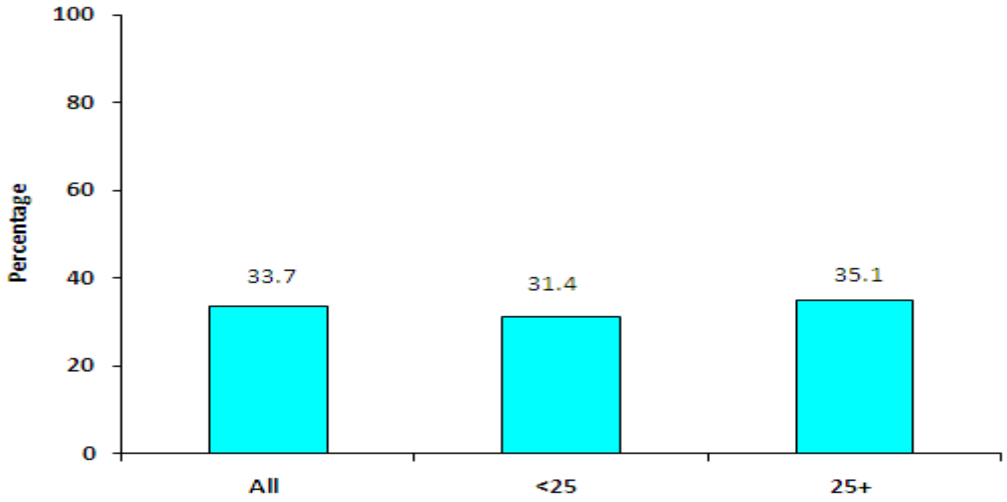


There was a consistent pattern of HIV testing among MARPs by age. The older age tends to receive more HIV testing that the younger one. The disaggregated percentage by age showed that all younger groups of key populations have less knowledge on their HIV status, so that they have higher risk to contract and transmit the disease in comparison to the older groups.

Sharing contaminated injecting equipment among IDUs continues to be the main route of new HIV infection. Data available showed that the percentage of both male and female IDUs who had an HIV test in the last 12 months and who know the result held steady during years 2007-2009. The percentage of female injectors who underwent HIV testing in the last 12 months and obtained the result was higher than among male injectors.

The percentage of MSM who underwent HIV testing during the previous 12 months and received the results remained stable. Out of every three MSM only one person had an HIV test and received his result. Moreover the percentage of MSM aged 25 above who received an HIV test in the last 12 months and knew their result was higher than young MSM aged below 25.

Figure 11: HIV Testing in Men Who Have Sex With Men, by Age (IBBS MARPs, CDC MoH, 2007)



Prevention Program

Indicator 9: Percentage of most-at-risk population reached with HIV prevention program

The main focus of the HIV response in Indonesia is the prevention of new HIV infections focusing mainly on people among most-at-risk populations or key populations, that is female sex workers, men who have sex with men, drug user, transgender people, and high risk male populations. The HIV prevention program also aims to reduce the vulnerability of the general population by preventing transmission from the MARPs. The success of this approach depends on the intensity, coverage, and effectiveness of the interventions. However, in the case of Tanah Papua where the epidemic has moved into the general population and become a low-level generalized epidemic, this strategy needs to be complimented by work with young people, harbor workers, street children, mobile men and others.
This indicator is composed of three questions: (1) whether the respondent has been given condoms in the past 12 months, (2) whether the respondent knows where they can go for an HIV test, and (3) whether the respondent has been given sterile needles and syringes in the past 12 months.

The IBBS MARPs 2007 showed that coverage of prevention programme for MARPs was still below the Universal Access target. Figure 12 showing figures of female sex workers at 23.9% and IDUs at 43.4%. To meet this challenge, responses have been intensified with support from the GFATM round 8 to scale up prevention work among the MARPs in 12 priority provinces. With the support from the GFATM, the 80% target of Universal Access will be reached in 2012 for IDUs, and 2013 for FSW.

Twenty-nine per cent of female sex workers know where they can go if they wish to receive an HIV test and have been given condoms in the last 12 months as a part of HIV prevention program.

Figure 12: MARPs Reached by HIV Prevention Programs, by Sex (IBBS MARPs, CDC MoH, 2007)

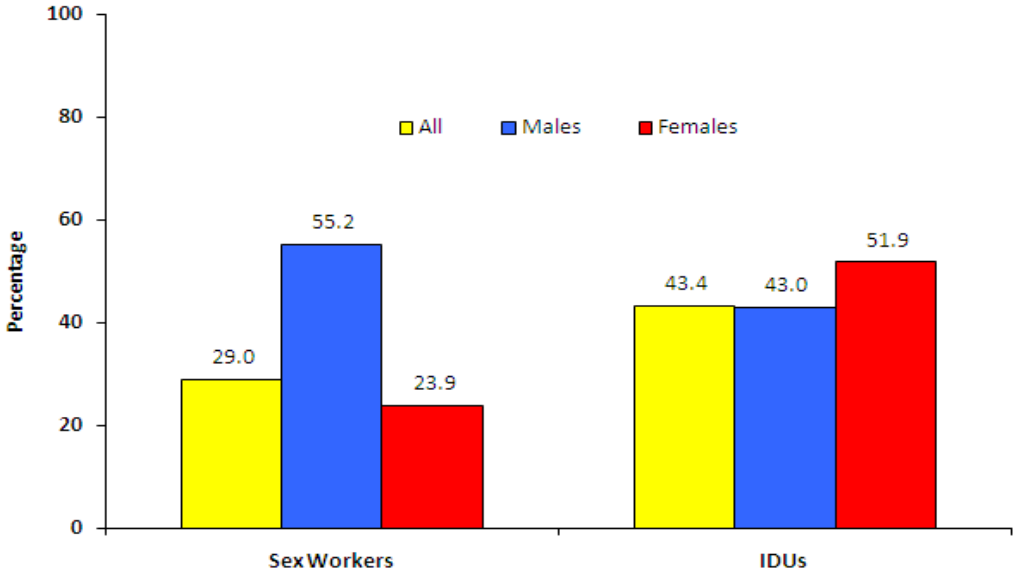
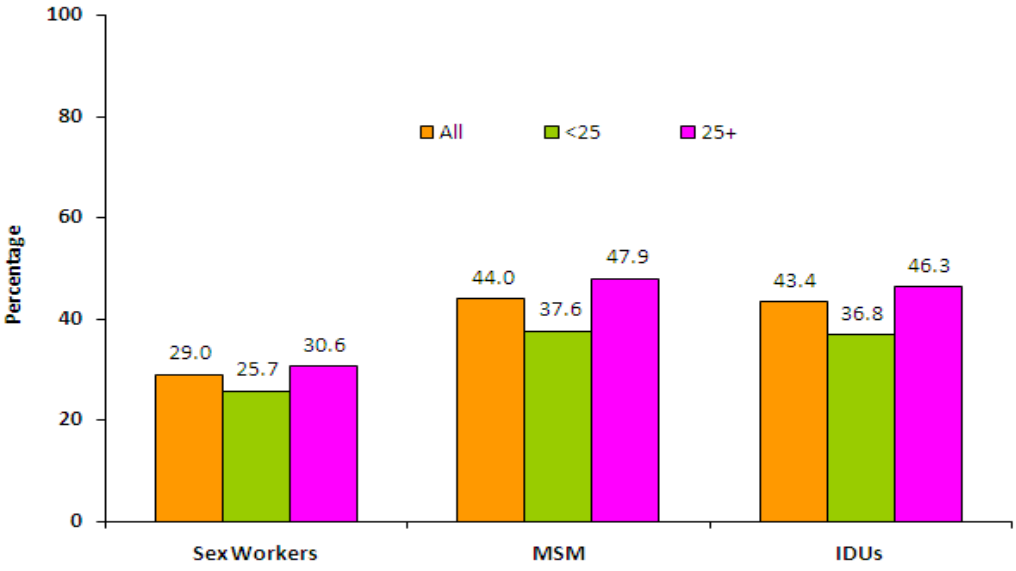


Figure 13: MARPs Reached by HIV Prevention Programs, by Age (IBBS MARPs, CDC MoH, 2007)



Question number 3 is only related to injecting drug users. Eighty three percent of IDUs said that they had received sterile needles and syringes in the last 12 months. The main sources reported for this sterile injecting equipment were outreach workers, peer educators or a needle exchange programmes. Although the percentage of female IDUs who received sterile injecting equipment is higher than their male counterpart (79.6 percent compared to 75.3 %), the number of male IDUs reached by these program was much greater than female IDUs reflecting the larger

number of male IDUs. During the survey 1,165 out of 1,404 male IDU noted that they received sterile needles while only 54 female IDU were surveyed, of whom 43 got the service.

The presence of female injecting drug users is a hidden problem that needs a special approach. Sharing contaminated injecting equipment and the possibility of being involved in risky sex makes them vulnerable to acquiring and transmitting the virus. Family, outreach workers, and counselors need to understand their psychological situation to be able to encourage female IDUs to seek and take advantage of the best treatment available to them.

Indicator 10: Percentage of orphaned and vulnerable children aged 0-17 whose household received free basic external support in caring for the child

The AIDS epidemic will cause an increasing number of orphaned and vulnerable children. Although at the present time the number of children known to be OVC is relatively small, their existence cannot be ignored. While precise data is not available in any systematic way there is increasing discussion of such children in the two provinces of Tanah Papua where the epidemic has already spread into the general public and, there is no doubt that in the future, as numbers of OVC will increase both in Tanah Papua and ellsewhere. Indonesia will soon need to begin to deal with the special challenges faced by these children, their relatives and communities.

Even although provision of ART is free, nonetheless, HIV infection almost always leads to a catastrophic situation, especially when the one who falls ill is an incoming earning member of the household or family head. Loss of income, arranging for prevention of vertical transmission of infection from mother to child, and expensive treatment for various opportunistic infections are among the consequences that are may be faced by Indonesian families as a result of HIV infection.

A survey conducted by the Indonesian Central Bureau of Statistics showed that HIV in the household influences the quality of life of the children. Loss of income and an increase in expenditures - particularly for medical expenses - have been experienced by three quarters of Indonesia's PLHIV families. This led, in turn, to a decline in savings, borrowing from relatives, withdrawal of children from school, and accelerated entry of children to the workforce. In the meantime, support from governments is almost unavailable (Executive Summary "Impact of HIV on the Household Socio-Economy"). The Ministry of Social Welfare has recently begun a pilot program of family support for AIDS affected families in Bandung, West Java.

Some non-governmental organizations, for example the Spiritia Foundation, have long been concerned with a range of issues related to impact mitigation for PLHIV. They have recently increased attention to OVC issues and have provided various services to ease the burden on their households. Out of 590 PLWHA households that ever received assistance, nineteen out of twenty got it from non-governmental organizations. Other support also came from workplace and neighbors although at a much smaller scale. The aid provided takes various forms: medical support, food, and cash.

Indicator 11: Percentage of schools that provided life skills based HIV education in the last academic year

In Indonesia sexuality education is generally taught in school as early as primary level. The focus, however, is merely on the biology of reproduction. In the higher level or secondary schools, students learn about family planning and various contraceptive methods along with the advantages and disadvantages of each method for users. They also learn about HIV and other sexually transmitted infections.

While delivered using a science-based approach, issues related to sex and sexuality are also taught with moral values in classes on religion and social subjects. Messages would emphasize values and norms allowing sexual activity only between husband and wife and extramarital sex as illicit and strongly discouraged. In Indonesia sexuality education in the school setting is strongly influenced by widely held social norms. While in some parts of the world, education about sex and reproductive health includes attention to promoting understanding and practice of safe sex by students, in Indonesia, where religion is still dominant, the focus is on delay of sexual debut and promotion of fidelity within marriage. Sexuality is then approached as a science and moral subject while the social context and issues of gender equity in every day life, including related to sexual practices is either left out altogether or is given very minor attention in some schools.

Since the 1980s, the Indonesian Government has implemented the Population Education curricula which also addressed reproductive health issues. The curricula emphasized the internalization of the principle of the "Small, Happy and Prosperous Family Norm" (*Norma Keluarga Kecil Sejahtera dan Bahagia*) – the slogan of the important and successful national family planning programme – and was focused more on family planning in the national and family context than on reproductive health.

In 1997, due to growing concern about the spread of AIDS, the Ministry of National Education initiated school-based HIV and AIDS curricula : Life Skills-based HIV Education (LSE) which was developed and utilized on a limited basis. Unfortunately LSE is not yet been incorporated into the national education agenda. In addition to students of regular schools, other school-aged children such as those with disabilities, children with special needs, children in detention centers and children out of school also need the information but for the most part are not yet reached by reproductive health programs.

Limited data is available on schools that have already implemented the LSE programme in Indonesia, except from the two provinces of Tanah Papua. During 2008-2009, 256 of 315 junior high schools in Tanah Papua (81%) implemented the LSE approach. This figure is higher than previously reported data in 2007 which reported that among 110 schools surveyed in the two provinces, only 41% of secondary schools and less than 3% of primary schools were using the LSE in their curriculum.

Life skills education has been on-going primarily at the junior high school level in selected districts since 2004 in Tanah Papua and it has been the subject of considerable monitoring and evaluation. Based on concern about the challenges of meeting the generalized epidemic and the evaluations and experience with Life Skills Education thus far, the Education Departments of the two provinces have decided to proceed with full integration of HIV education in the education system. This will involve development of materials, appropriate training of all educators -- class room teachers, sports coaches, special activity teachers, tutors in out of school programmes. It is hoped that the programme being developed and carried out in cooperation with parent groups, civil society, the National AIDS Commission and local AIDS Commissions, the National Education Department, and UNICEF, will provide useful lessons which may be drawn on for wider adaptation in other parts of Indonesia.

While the 2001 decentralization policy provided opportunity for greater autonomy for local authorities to prioritize their educational needs, it also led to discontinuity of national and sub-national reporting linkages and subsequently less commitment (technical and financial resources) from national level. Lack of adequate resources and other support such as teacher training, development and distribution of educational materials, are the main obstacle to rapid scale-up of these efforts to achieve national coverage. Nonetheless, the Ministry of National Education is addressing this issue and taking steps to promote and provide better educational programs in reproductive health and life-skills education.

3.3. Knowledge and Behavior Indicators

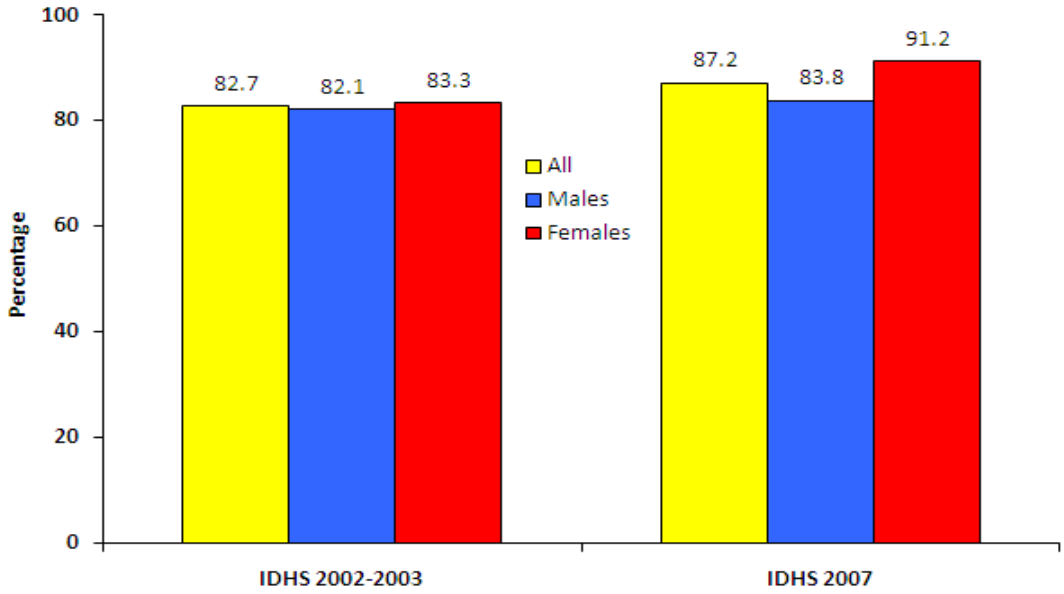
Indicator 12: Current school attendance among orphans and among non-orphans aged 10-14.

According to IDHS 2007, 4.12% of children under 18 years of age are orphans, an increase from 3.36% reported during the IDHS 2002-2003. Data from the 2007 Indonesia Young Adult Reproductive Health Surveys (IYARHS) indicates that the school attendance rate among orphans is 87.2%. School attendance of female orphans is higher than males, at 91.2% for females and 83.8% for males. School attendance among children age 10-14 whose both parents are alive but living with only one parent is higher at 92.6%. Again, the figure for female children (93.5%) is higher than for male children (91.8%).

In other words, the difference between orphaned and non-orphaned children in terms of school attendance is not significant although the presence of parents seems to be advantageous for better education.

In general, school attendance of orphans aged 10-14 in 2007 has improved over the situation in 2002-2003 for both males and females. The increase from 2002-2003 to 2007 of school attendance for females orphans is very significant, almost 8 percent. Although, there was an improvement in school attendance for non-orphans from 2002-2003 to 2007, the increase was lower than the school attendance of the orphans.

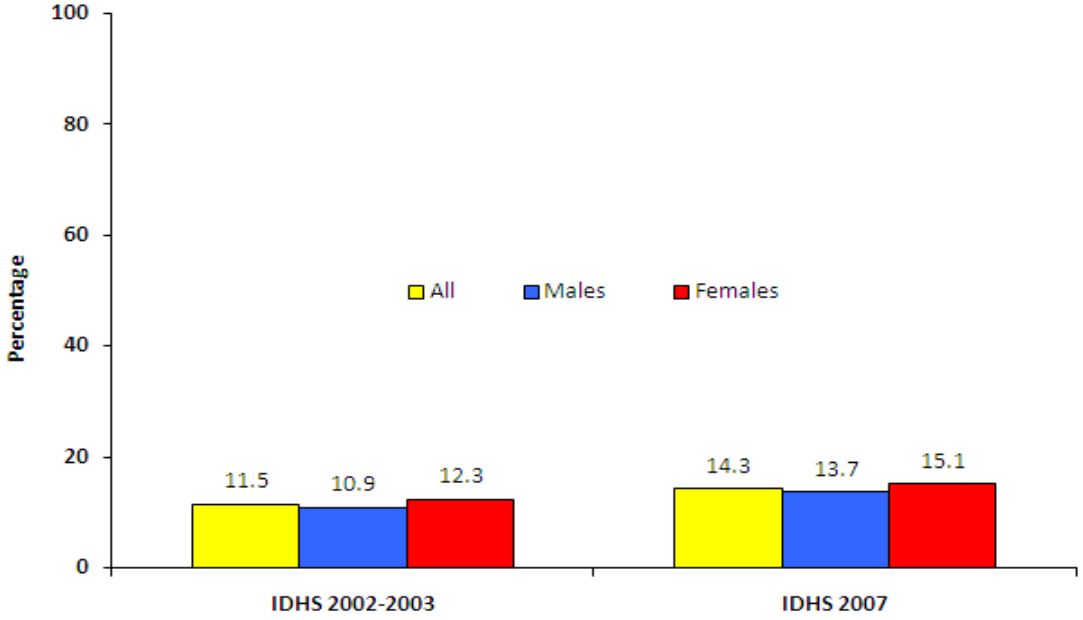
Figure 14: Percentage of Current School Attendance Rate of Orphans Aged 10-14 (IDHS 2002-2003, IDHS 2007)



Indicator 13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission.

HIV is a real threat for young people. Those aged 20-29 have the highest risk of contracting the disease compared to other age groups. Numerous programs and strategies have been implemented on a national scale to raise awareness of HIV and AIDS. However, data from 2007 IYARHS report shows that only 14.3% of young people aged 15 - 24 have comprehensive knowledge about HIV and AIDS. While this is an increase from 11.5 percent in 2002-2003 it is still far too low. The percentage among young female is almost 3.5 percent higher than the figure for males (20.1% compared to 16.7%).

Figure 15: Percentage of Women and Men Aged 15-24 Who Both Correctly Identify Ways of Preventing the Sexual Transmission of HIV and Who Reject Major Misconceptions about HIV Transmission (IYARHS 2002-2003, IYARHS 2007)



By sex, female respondents have better understanding about HIV than male respondents. Examining knowledge by age, both males and females aged 20-24 have better knowledge than those aged 15-19. Unfortunately, there is not yet any agreed indicator to measure the coverage or impact of such knowledge. Likewise disaggregation by setting -- rural and urban -- is not available and could be expected to show differences.

Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconception about HIV transmission.

The data from IBBS among most at risk populations conducted in 2007 covered sex workers, MSM and IDU populations. A sample of female sex workers was drawn from 14 cities. The sample of male sex workers was drawn through sampling men who have sex with men who sell sex in 4 cities, including *waria* who sell sex in 5 cities. The IDU sample was drawn from 4 big cities.

The questions asked were the same as questions for indicator 13. That is:

1. Knowledge of HIV prevention by limiting sexual intercourse to one uninfected partner
2. Knowledge of HIV prevention by using condom
3. Knowledge of whether a healthy-looking person can have HIV
4. Rejecting the misconception that HIV can be transmitted by mosquito bites
5. Rejecting the misconception that HIV can be transmitted by sharing food with a person who has HIV or AIDS.

Figure 16: MARPs Who Both Correctly Identify Ways of Preventing The Sexual Transmission of HIV and Reject Major Misconceptions about HIV Transmission, by Sex (IBBS MARPs, CDC MoH, 2007)

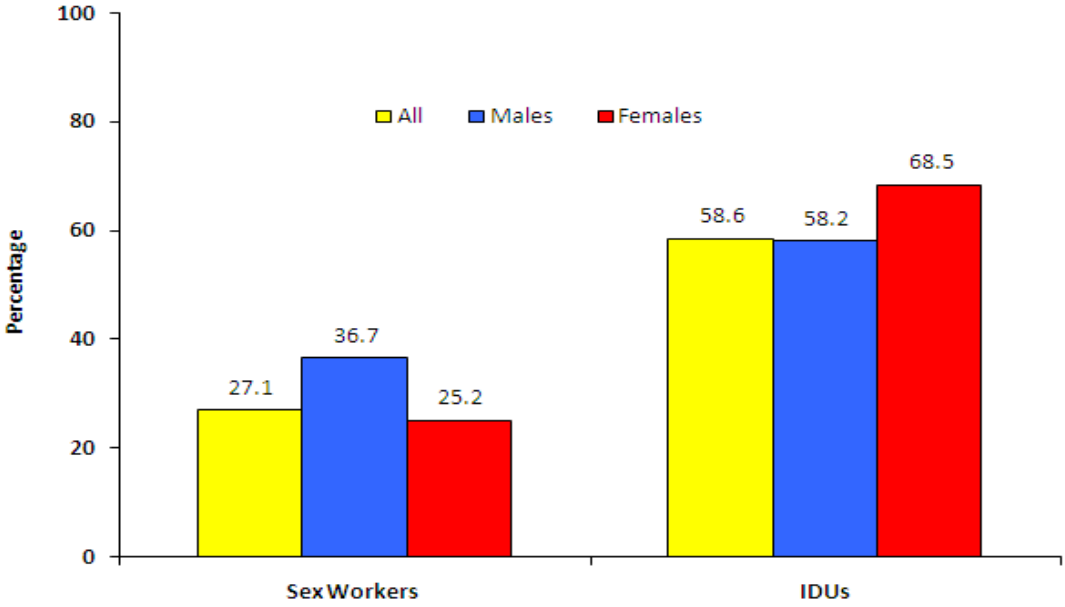
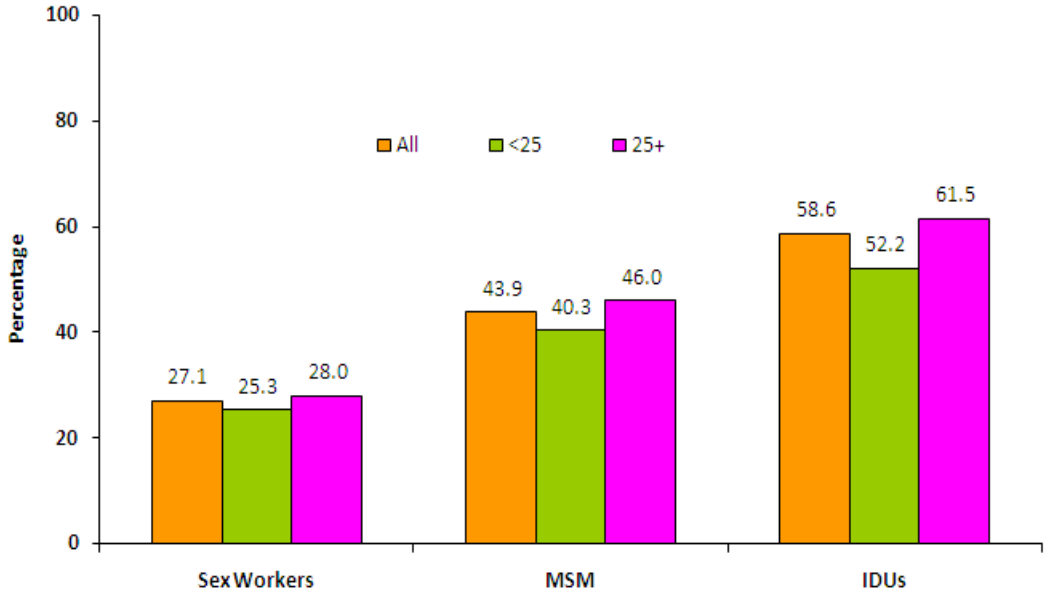


Figure 17: MARPs Who Both Correctly Identify Ways of Preventing The Sexual Transmission of HIV and Reject Major Misconceptions about HIV Transmission, by Age (IBBS MARPs, CDC MoH, 2007)



Twenty seven percent of sex workers had comprehensive knowledge about HIV prevention. Knowledge of sex workers about HIV prevention was highest related to the question "by using condom can reduce the risk of HIV" (81.4 percent), while the lowest knowledge was related to the question "whether a person can get HIV from mosquito bites". By gender, male sex workers have better understanding about HIV

prevention than female sex workers. Those aged 25 and over have better knowledge than those under 25 years of age.

Thirty-four and a half per cent of MSM had comprehensive knowledge of HIV prevention. Knowledge of MSM about HIV prevention was highest related to the question "by using condom can reduce the risk of HIV" (78.9 percent), while the lowest knowledge was related to the question "whether a person can get HIV from sharing food with someone who is infected".

Comprehensive knowledge about HIV prevention among IDUs was higher (58.3 %) than the sex workers and MSM. As opposed to IDUs and sex workers, the highest knowledge about HIV prevention for IDUs was related to the question on knowledge "whether a healthy-looking person can have HIV" (82.9%). By gender, female IDUs have better understanding about the HIV prevention. Those aged 25 and over have better knowledge than those below 25 years of age.

Several conclusions can be drawn from the data above.

1. Most members of key populations have only partial knowledge about HIV. This means more should be done in behavior change communication (BCC) and Education and Communication (IEC). The basic information which needs to be communicated to key populations is clear. Further research -- both operational research and social marketing research --is needed to fine-tune messages, know what kind of messages and media are needed by each audience. For example, whether they need a single, direct message or multiple comprehensive messages at one time.

2. In general, IDUs are more knowledgeable than sex workers and MSM populations. This is presumably due to the demographic characteristic of IDUs who generally live in big cities where the survey was conducted, have higher levels of education, and better exposure to media. As has been mentioned before, IDUs tend to have more networks and are better organized. Peer groups can be a good source of information. At the same time, there are more programmes for IDUs than other key populations. In short, IDUs can be expected to have more exposure to HIV education messages. Nevertheless, drug education among young people and expansion of HIV-related education and skill training should have priority as primary prevention.

Indicator 15: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

Sex before marriage is not a common practice or accepted norm in Indonesian society, though the rising numbers of adolescent pregnancy outside of marriage (discussed below) would seem to indicate this norm is under increasing pressure.

Findings of the 2007 IYARHS showed consistently that the percentage of young women and men aged 15-24 who have had sexual intercourse before the age 15 is very small (0. 28 percent). The percentage for males is higher than females. However, the percentage of both males and females who have had sexual intercourse before the age of 15 is much higher for the younger age group (15-19). This would seem to indicate earlier sexual debut among the younger age group. Sex at an early age is very likely to occur in the absence of adequate knowledge of

reproductive health and safe sex, thus the risk of HIV othely"r STI infection must be assumed to be high, particularly among young girls

Inadequate knowledge of reproductive health and safe sex could lead to unwanted pregnancy which is increasingly common among adolescents. Unwanted pregnancy can lead to unsafe abortion that contributes to maternal death. Based on IDHS 2007, 8.5% of pregnancies are among adolescents with the highest proportion among older adolescents who are 18 and 19 years of age. In urban areas, the prevalence of adolescent pregnancy is about 4%, while in the rural it rises to 12.7%. Some studies show that women under 20 years old have a higher risk of experiencing complications during delivery and a higher rate of mortality.

Findings from Young Adult Reproductive Health Survey in 2007 also showed that that the initiation of dating is more likely to occur at a younger age among women than men. Twenty-four percent of women say that they started dating before reaching age 15, compared with 19% of men. Despite the Marriage Law no 1/1974 which declares that minimum legal age at marriage is 16 for women and 19 for men, under-age marriage is still occurs in some parts of Indonesia, especially in rural areas. Data from National Family Planning Coordinating Board/BKKBN (2004) indicated that in 25% of all marriages at least one partner was an adolescent below 16 years of age.

Studies have found that sexual and reproductive health education can delay sexual debut and thus decreasing the exposure to HIV and other STIs. As such, a national and integrated sexual and reproductive health program needs to be developed rapidly. Various ministries have carried out their own sexual and reproductive health programmes with different focuses and targets, yet there is not yet a national plan that can provide direction to develop a sound curriculum on sexual and reproductive health education that meets the needs of different target groups.

Indicator 16: Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.

Data for this indicator comes from the 2007 Indonesia Demographic and Health Survey (IDHS). The question was only asked to married men aged 15-54. Female respondents were not asked this question. Overall, 0.33 % of respondents acknowledged that they had had sexual intercourse with more than one partner in the last 12 months. This was an increase compared to 2002-2003 IDHS when 0.16% acknowledged having had sex with more than partner in the previous 12 months. However, none of the younger married men aged 15-19 said that they had been involved with sex partners other than their wives. Married men who acknowledged having had sex with someone other their wife were 20 years of age. They were more mature, and are more likely to have had more money, thus could afford paid sex (see chapter 2 for more detailed discussion of high risk men).

Indicator 17: Percentage of women and men aged 15-49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse.

This indicator is related to Indicator 16. Among married men who were respondents aged 15-49 and have had more than one sexual partner in the last 12 months, 60%

reported having used a condom the last time they had sex. In the age group 20 - 24 years, reported condom use rose to 100%. In age group 25-49 58.3% reported condom use in their last sexual activity.

These percentages have to be interpreted carefully, because the actual number of respondents in each group was extremely small. Among 7,604 respondents (male, married, and 15 - 49 years of age) only 25 acknowledged having had sexual intercourse with more than one partner during the last twelve months and only 15 of those 25 men said they used a condom during the last sexual intercourse. In the 20-24 year old group, only one person reported having more than one sexual partner and he used a condom during his last sexual intercourse. In the older group, 25-49 years of age, 14 of 24 men with more than one sexual partner reported using a condom during the last sexual intercourse. These figures are far too small to be counted as nationally representative.

Data from IBBS Tanah Papua (collected late 2006, published mid 2007) also indicated that the level of consistent condom use during sex is very low. Only 3.8% reported using a condom every time they had sex with a non-regular partner. Among females, consistent condom use was relatively high at 8.4%; while among males it was only 2.5% percent.

Meanwhile a total of 17.9% of the residents of Tanah Papua used a condom during sex with a non regular partner in the last month. Compared to the percentage of condom use with a permanent partner (8.4%), the level of condom use during sex with a non-regular partner was relatively high though still far from adequate in the context of a generalized epidemic.

As was discussed earlier in chapter 2, another relevant data source on many of these issues was a special IBBS conducted among military personnel in 2007. Many respondents acknowledged buying sex regardless of their marital status, although the percentages were different. Among the unmarried respondents, more than 40% said that they bought sex from sex workers. The percentage was lower among the widowers (18%) and lowest among those who were married (3.8%). Moreover, the survey also found that on average, personnel sent to a new post would abstain from sex for only two months before buying services from sex workers or looking for a new spouse.

Data on reported condom use among military personnel was widely varied ranging from 27.8% to 66% reporting use. Condoms were used less during sexual activity with girlfriends and wives (34.8% nationally). The most important reason for not using a condom, reported by more than 50% of respondents, was because they were sure their sexual partners—be it their spouses or sex workers—were “clean”.

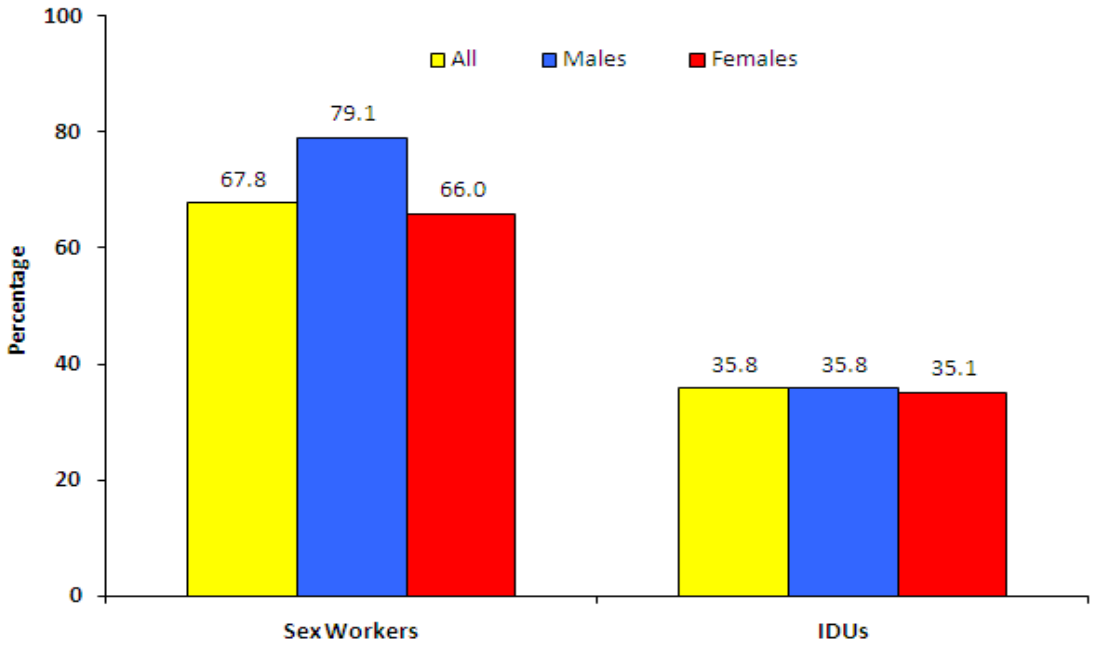
Another important issue that needs to be seriously addressed is condom availability and use among prisoners. It has long been known that inmates are involved in risky sexual behavior, including same-sex intercourse. Education on HIV, STIs, drug use and ways to stay healthy including condom use all need to be regularly and easily available to prison inmates along with condoms. In the future, condom provision efforts should be based primarily on inmates’ needs.

Indicator 18: Percentage of sex workers reporting the use of condoms with their most recent client

Condom use among sex worker is quite high. Approximately 70% of sex workers reported using condoms with their most recent client. The explanation may lie in aggressive campaigns promoting condom use among sex workers and also the provision of condoms in areas identified as "hot spots". In other words, sex workers are educated in condom use and in general condoms are available to them. Male sex workers are more likely to report condom use with their most recent client than female sex workers. Also, younger sex workers are more likely to use condoms than those who are older.

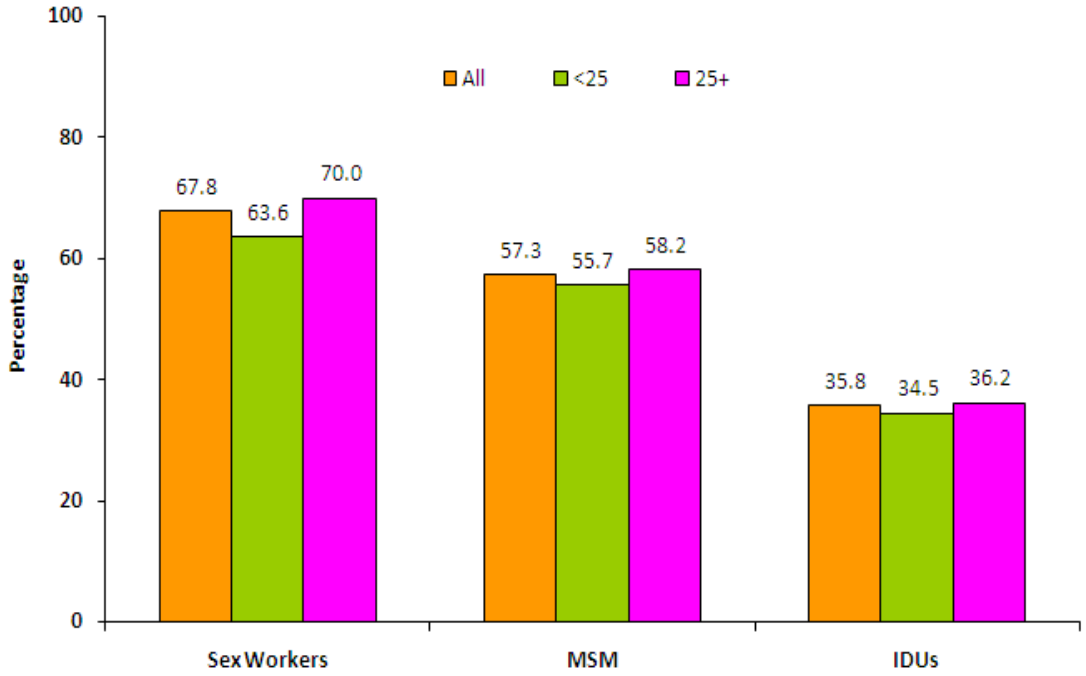
The percentage of sex workers who used a condom with their most recent client is double the percentage of IDUs who used a condom on last sex. However, as had been discussed before, only when used consistently are condoms effective to reverse the course of the epidemic.

Figure 18: MARPs Reporting The use of a Condom with Their Most Recent Client (Sex Workers) or with Their Male Partners (MSM) or When They Had Sexual Intercourse, by Sex (IBBS MARPs, CDC MoH, 2007)



Meanwhile, in Healthy Indonesia 2010, the stated target for condom use is 80%. Clearly, much hard work remains to be done to reach Indonesia's national target in this area.

Figure 19: MARPs Reporting The use of a Condom with Their Most Recent Client (Sex Workers) or with Their Male Partners (MSM) or When They Had Sexual Intercourse, by Age (IBBS MARPs, CDC MoH, 2007)



Indicator 19: percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner

Compared to the previous report, the percentage of MSM now reporting the use of a condom the last time they had anal sex with a male partner has increased significantly. The most recent data showed that 57.3% reported using condom during risky sexual activities, a significant increase from the 39.3% previously reported. However this figure is lower than that of sex workers (figure 21). The percentage for condom use is roughly similar for different age groups. Despite the sampling bias that might influence analysis, such achievement may be due to the perception of risk among MSM as compared to the perception of risk among people of other key populations.

Indicator 20: percentage of IDUs reporting the use of a condom the last time they had sexual intercourse

Only 35.8% of IDUs reported using a condom the last time they had sexual intercourse. This is the lowest report among key populations in Indonesia. It can be concluded that the situation has not improved for several years, as previously the percentage reported was 33.9%.

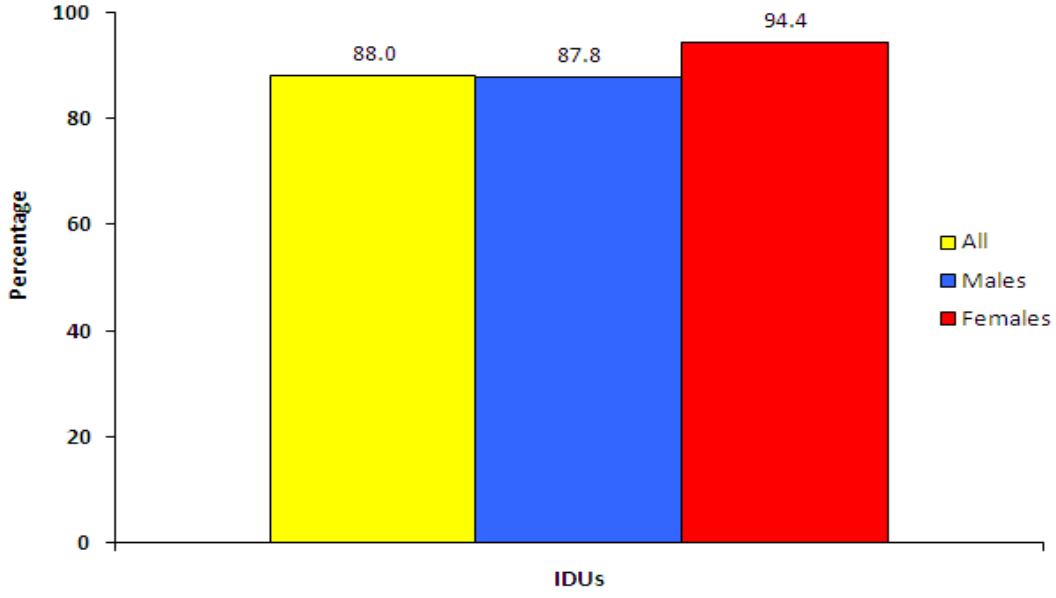
Condom promotion still faces constraints in Indonesia, the most important of which is the lack of strong political support for the implementation of condom programs.

Even when a condom promotion program is supported by local legislation and regulations, enforcement of the legislation is either weak or non existent. The situation is quite different from what has happened elsewhere in Asia with 100% condom programs The difference may be due primarily to continuing conservative, religious perspectives in some areas which hamper effective implementation of 100% condom use programmes. Many policymakers also do not want to be unpopular, which they fear may happen if they are seen as encouraging condom programs.

In Indonesia, 100% condom use programs are usually limited to distribution of condoms in recognized hotspot and localized brothel areas. This approach may be an effective way to increase condom use or at least motivation for condom use among sex workers but for other risk groups condom distribution should also be accompanied by well designed, and distributed IEC, well targeted BCC campaigns and persistent, well distributed condom social marketing.

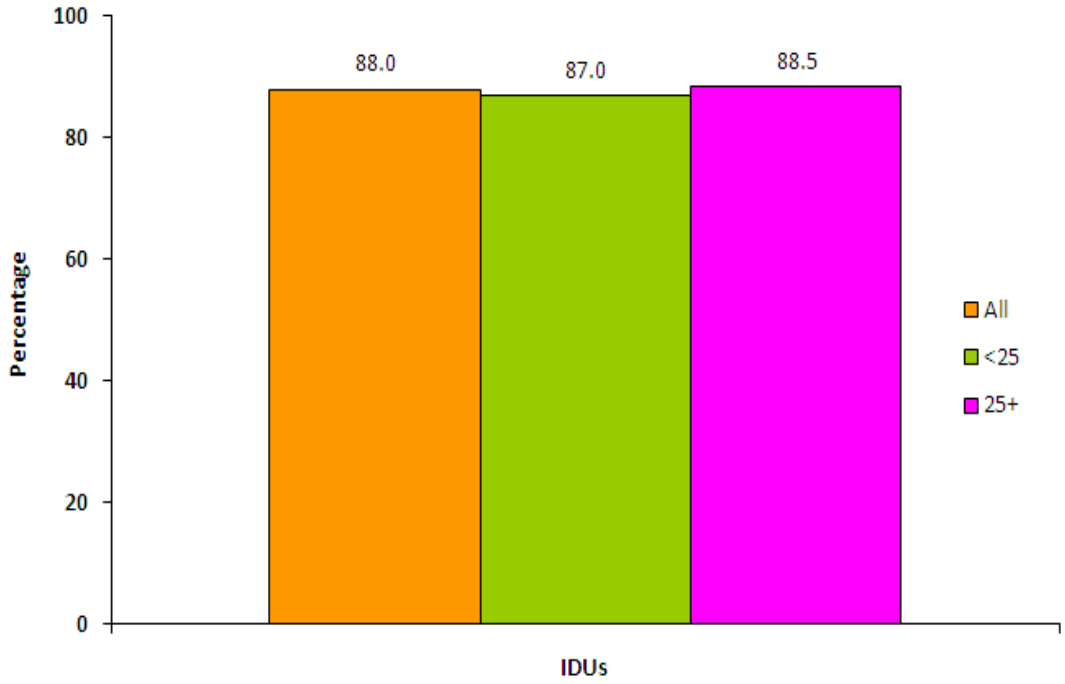
Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.

Figure 20: Injecting Drug Users Reporting The Use of Sterile Injecting Equipment The Last Time They Injected, by Sex (IBBS MARPs, CDC MoH, 2007)



The percentage of IDUs using sterile injecting equipment the last time they injected drugs is quite high at 88%. The percentage among female IDUs at 94.4%, is higher than among male IDUs, at 87.8 %. There are no significant differences according to age group. These data are from the IBBS conducted in 2007. The number of sites which provide needle exchange programs has increased significantly, from 17 sites in 2005 to 281 by the end of 2009. The challenge now is to increase the consistent use of sterile injecting equipment. The scaling up of this prevention program is currently underway in 10 priority provinces with support from GFTAM round 8.

Figure 21: Injecting Drug Users Reporting The Use of Sterile Injecting Equipment The Last Time They Injected, by Age (IBBS MARPs, CDC MoH, 2007)



3.4. Impact Indicators

Indicator 22: Percentage of young women and men aged 15-24 who are HIV infected

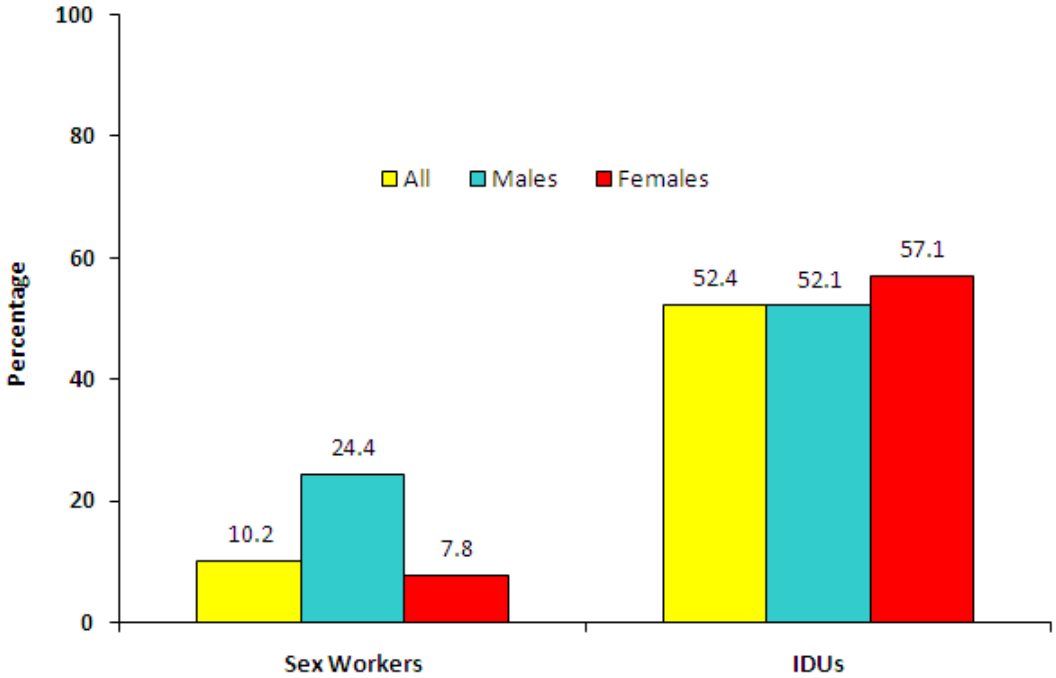
National data is not available

Indicator 23: Percentage of MARP who are HIV-positive

The prevalence of HIV among sex workers stands at 10.2%. If we define sex workers according to their types, then the prevalence among direct sex workers is between 6% and 16%, while among indirect sex workers the prevalence is between 2% and 9%. For male sex workers (including *waria* in this case) the prevalence is three times higher than the prevalence for female sex workers (24.4% for *waria* compared to 7.8% for female sex workers). Ten point one percent (10.1)of sex workers aged 25 and over are infected with HIV, while the prevalence for sex workers younger than 25 years is 10.4%.

Figure 22: Percentage of MARPs Who are HIV-positive, by Age Group (IBBS MARPs, CDC MoH, 2007)

Figure 23: Percentage of MARPs Who are HIV-positive, by Sex (IBBS MARPs, CDC MoH, 2007)



The prevalence of HIV among MSM is 5.2%. Among those aged 25 and over, HIV prevalence is twice that of those younger than 25 (6.64 % among those above 25, 3.3% among those younger than25).

HIV prevalence among IDUs has been reported as the highest among MARPs in Indonesia. Transmission of infection among IDUs is mostly due to sharing contaminated injection equipment. The IBBS result found that the HIV prevalence among the IDUs is 52.4%. HIV prevalence among female IDU is higher than among their male counterparts, 57.1% for female IDUs compared to 52.1% among male IDUs. This data also should be interpreted carefully since not all IDUs are easily reached for surveillance. Although there is a constant increase in the number of female IDUs, male IDUs still outnumber female IDUs.

Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART

Data on ARV monitoring up to March 2009 showed that the reduction of mortality among PLHIV has declined significantly from 46% in 2006, to 21% in 2007, 17% in 2008 to 11% in March 2009. In other words, Indonesia's ARV policy and its implementation has dramatically improved the life prospects of those who are infected.

Data for 2008 on progress toward achievement of Universal Access targets showed that of the total number of all adults and children who initiated ART during the twelve months prior to the beginning of the reporting period (including those who have died, those who have stopped ART, and those lost to follow-up), almost 65% are known still to be on treatment. The document noted that of 801 people with AIDS who started ART 12 months earlier, 520 of them still continue their medication.

Once started on antiretroviral, the medication must be continued for the rest of one's life. This longer life expectancy, the steady addition of new people going on treatment, and the need for ARV stock for post-exposure prophylaxis, will combine to creat major increases in the need for ARV supplies and funding for their purchase and safe, effective delivery. As of September 2009 almost 14,000 people have received ARV treatment or approximately 450 new cases eligible for treatment every month. This number will increase with the implementation of new ARV guidelines from WHO that recommending that ARV treatment be started at the CD4 level of 350 rather than 200.

To meet all these challenges, Indonesia would do well to produce local, high quality ARV. Although the initial investment would be high, in the long run it will ensure the availability and affordability of the medication as it is needed in Indonesia. Kimia Farma, a local parastatal, pharmaceutical company has started to develop its capacity to producing ARV drug. However, strong political support and advocacy will be needed, particularly to seek and obtain prequalification from WHO.

Moreover, equal provision of ARVs throughout the country will require persistent, serious consideration and innovative solutions to address a range of interrelated challenges of logistics, geography, and health care skills.

To ensure the continuous supply of ARV to remote areas of Indonesia, the government is currently improving planning and analysis of ARV needs and inventory management, reducing the complexity in the distribution and storage system, and

building capacity of local staff for effective monitoring and evaluation of the implementation of ARV supply chain management.

Indicator 25: Percentage of infant born to HIV-infected mothers who infected

Another important mode of HIV transmission is from mother to child. Viral transmission can occur during pregnancy, delivery, and breastfeeding. According to the MoH current projection there has been a decreasing percentage of infant born to HIV-infected mothers who are infected, from 23 percent in 2008 to 20.7 percent in 2009. The decrease might be due to growing availability of PMTCT services in some areas.

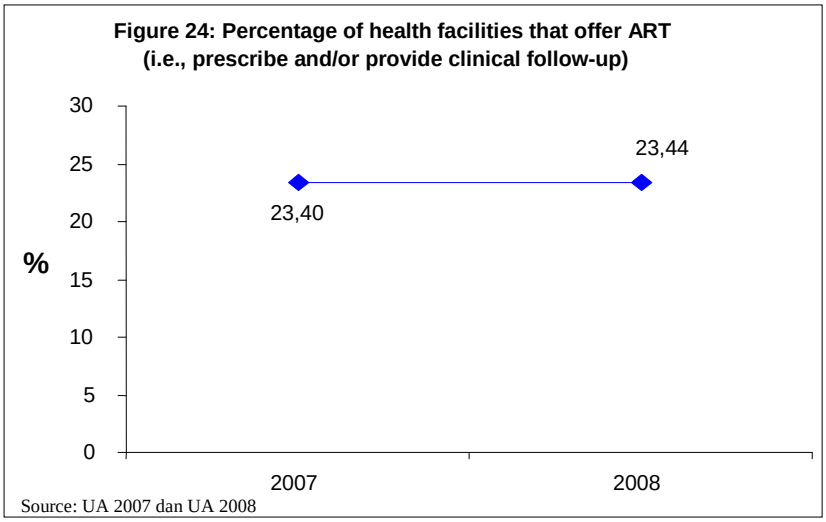
Additional Indicators

Indicator 1: Percentage of health facilities with post-exposure prophylaxis available by exposure.

Data is no longer relevant. All health facilities that offer ART will automatically offer PEP service.

Indicator 2: Percentage of health facilities that offer ART

Overall, the number of health facilities has increased almost 30 percent from 2007 to 2008. The percentage of total health facilities that offer ART during the period 2007 to 2008 slightly increased from 23.40 to 23.44 percent. However the availability of this specific health facility does not meet the need of all PLHIV who are eligible to ART.



Indicator 3: Percentage of health facilities dispensing ARV that experienced a-stock out at least one required ARV in the last 12 months.

As mentioned above ART is a combination of at least three antiretroviral dugs to maximally suppress the HIV virus and stop the progress of HIV disease. Some health facilities in Indonesia had experienced a stock out, where at least one of the ARV drugs have run out of stock of in the last 12 months. As the country is trying to scale-up ART services, it is important to ensure that ARV are made available and accessible to those who need them.

The data shows that was a decrease in the percentage of health facilities dispensing ARV that experienced a stock-out in the last 12 months. In 2007, the percentage was 2.21 while in 2008 it was 1.33 percent. This indicates an improvement in the provision of ART medicines and efficiency in supply management. However, in 2009, there were 9 out of 180 sites (5%) which experienced stock-out, indicating the supply management of ARV remains to be the challenge.

Indicator 4: Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral.

WHO recommends CD4 monitoring for better and accurate clinical decision making. This indicator may also be used as a proxy measure of the quality of ART services provided in a country. CD4 is a primary receptor used by HIV-1 to gain entry into host T cells. CD4 test measure the number of T cells containing the CD4 receptor. CD4 has a function to fight any kind of infection. The decrease of CD4 in human body indicates the decrease of lymphocytes which have a role in fighting infection.

By the end of 2008 all health facilities providing ART has followed the standard of ARV service provision.

Indicator 5: Percentage of sexually active young women and men aged 15-24 who received an HIV test in the last 12 months and who know the their results.

Data are not available.

Indicator 6: Percentage of TB patients who had an HIV test result recorded in the TB register.

Data are not available.

Indicator 7: Percentage of pregnant women who were tested for HIV and who know their results.

So far only less than 3 percent of pregnant women were tested for HIV. This number is quite small considering the number of women at risk of infection.

Mother-to-child transmission of HIV can occur during pregnancy, delivery, or during breastfeeding. The risk of MTCT can be reduced by range of interventions, such as provision of antiretroviral prophylaxis given to positive women during pregnancy and delivery and also to their infants in the first week after they were born.

HIV testing for pregnant women as early as possible in their pregnancy will enable HIV-positive pregnant women to benefit from HIV services and reduce the risk of HIV transmission to their infants. Unfortunately the number of pregnant women who underwent testing for HIV is still limited. This is in contrast to blood testing for pregnancy and delivery purposes such as the hemoglobin, glucose, and blood type. HIV test services so far are only available in big cities. It is unfortunate that the cost for HIV testing is still relatively expensive and unaffordable for most underprivileged people.

Indicator 8: Percentage of infants born to HIV-infected women who received an HIV test within 12 months by type of testing (virological testing within 2 months, virological testing between 2 and 12 months or antibody testing between 9 and 12 months).

Data are not available.

Indicator 9: Percentage of infants born to HIV-infected women who are started on cotrimoxazole prophylaxis within two months of births.

Data are not available.

Indicator 10: Total number of male and female condoms available for distribution nationwide during the last 12 months per person aged 15-49.

The role of National Family Planning Coordinating Board in distributing condoms nationwide is very important. As a family planning methods, condoms have been one of the least popular methods among men and women aged 15-49. Based on IDHS result, current users of condom among women is only 1.3 percent. Among the reasons are that condoms are uncomfortable to use, easy to break, and can disturb the concentration.

Only male condoms are distributed by the National Planning Board. Female condom is not yet familiar in Indonesia. The stock for female condom is so far limited for advocacy purposes. Therefore it is unsurprising that the data available is only for male condoms. Condom stock for distribution nationwide in 2009 is more than six times higher than the stock in 2008 (19.54 million condoms compared to only 3.07 million condoms).

Promotion of condom as a mean to prevent HIV transmission should be improved and involving other public sectors.

Indicator 11: Percentage of young women and men aged 15-24 who report they could get condoms on their own.

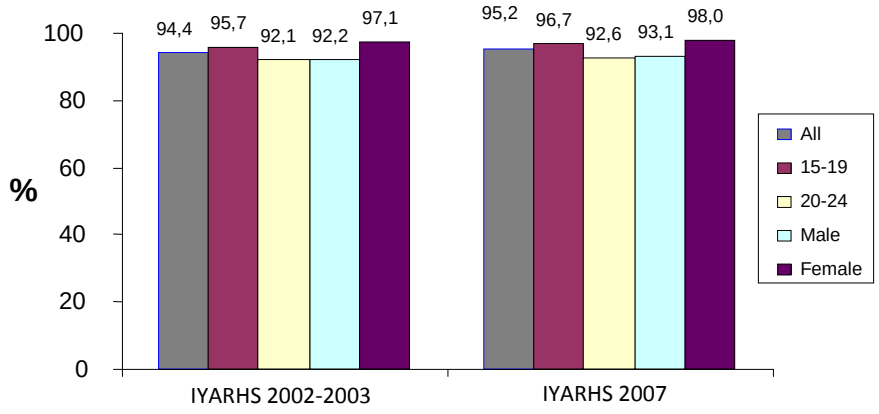
Data for indicator 11 only reported women and men aged 15-24 who know a place where they can get condoms. However, if they know a place to get condoms it is assumed that they could get condoms on their own. In Indonesia condoms are easy to buy. They are available in pharmacies, drug stores, supermarkets, and even in small retail stores. This means that it is easy to practise safe sex by using condoms, because it is easy to get and available anywhere. However, this situation only occurs in big cities, not in small towns or other rural areas.

Based on IYARHS 2007, the percentage of young women and men aged 15-24 who reported that they could get condom on their own is 12.5 percent. This number is lower than the reported figure in 2002-2003 IYARHS which was 15.4 percent. This discrepancy might be caused by the different coverage area in the two surveys. The 2007 IYARHS covered 33 provinces, where as the 2002-2003 IYARHS only covered not more than half provinces. The percentage of young adult aged 20-24 who reported they could get condoms on their own is higher than in the younger age group 15-19. This pattern looks the same in 2007 IYARHS and 2002-2003 IYARHS. The difference in young adults between males and females who reported they could get condoms on their own is very significant (22.1 compared to 0.3 percent). Young women may be ashamed to buy condoms by themselves, or they do not want to report that they do when they asked by the survey team members.

Indicator 12: Percentage of never married young women and men aged 15-24 who have never had sex.

A high percentage of young women and men who have never had sex will indicate themay lead to a small proportion of young adults who can acquire HIV through sex. The IYARHS reported that 95 percent of young women and men aged 15-24 have never had sex. This means there are 5% of this unmarried young women and men aged 15-24 have had sex and need attention whether they involve in risky sexual behaviour. This percentage is high and relevant to Indonesia, where the society is still holding on to a norm of restricting sex before marriage. Religion plays an important role in preventing sex before marriage, which is considered sinful according to all major religions in Indonesia.

Figure 25: Percentage of never married young women and men aged 15-24 who have never had sex



Source: IYARHS 2002-2003 & IYARHS 2007

Younger age cohort tends to delay sexual activity before marriage. As age increased, the percentage of young adult who have never had sex tends to decrease (96.7 percent for the age group 15-19 and 92.6 percent for the age group 20-24). More females did not report sex than males (98.0 percent compared to 93.1 percent). Delay in sexual debut means a smaller risk of acquiring HIV. Information on HIV prevention can be given at school, university, neighborhood youth association, mosque youth groups and church youth groups.

The percentage of never married people who never had sex in 2007 has increased slightly from 2002-2003 (from 94.4 to 95.2 percent). The percentage in 2007 among 15-19 and 20-24 age groups, both males and females, who never had sex are similar to the percentage in 2002-2003.

Indicator 13: Percentage of men aged 15-49 reporting sex with a sex worker in the last 12 months who used condom during last paid sexual intercourse by age and population group.

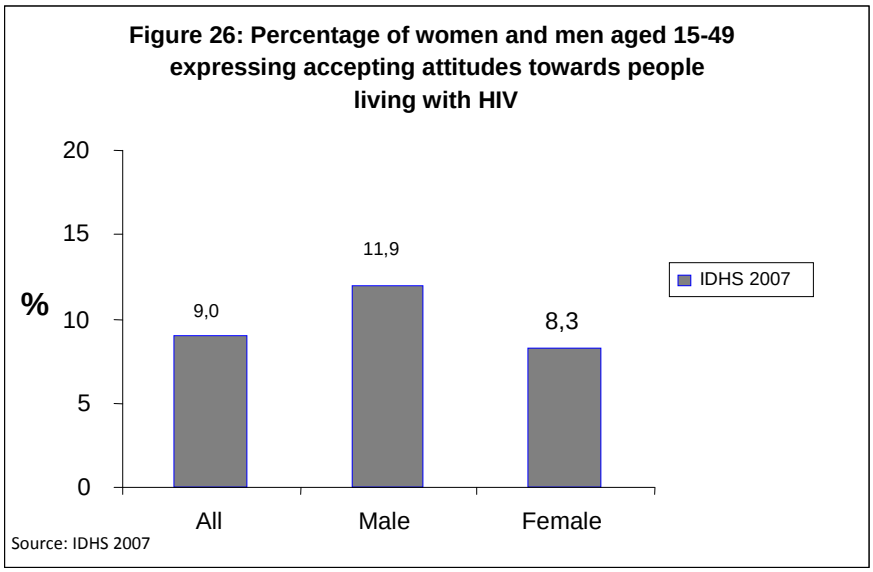
This indicator measures self-reported condom use among male clients of sex workers. The male clients include truck drivers and others, such as, migrant workers, uniformed services/military, motorcycle drivers, taxi drivers, loading and discharging

workers. More than 50 percent of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid sexual intercourse. As age increases, the percentage of male clients reporting sex with a sex worker in the last 12 months who used a condom during last paid sexual intercourse tend to low. This seems that younger clients are more aware in practicing save sex activities. By activity, two third of trucks drivers reporting sex with a sex worker in the last 12 months who used a condom during last paid sexual intercourse, where as less than half of male clients in other activities did it. The explanation behind this, is maybe the truck drivers are more frequent in having sexual activities with sex workers than others, so they always use condom every time they have sex. The information of condom used among male clients of sex workers does not consider whether the clients always use condom, sometimes, or never during paid sex. So, this indicator may not be quite relevant for intervention strategies to increase condom use.

Indicator 14: Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV

In Indonesia, people living with HIV are still neglected in terms of care. The support of the family to people with HIV is still far below what is needed. People with HIV might be ostracized from family or community. Most of them got discriminative treatment in society. Widespread stigmatization and discrimination in a population in turn affects both people's willingness to undergo testing and perhaps adherence to antiretroviral therapy. Reduction of stigma and discrimination has become an important indicator of the success of program for HIV prevention.

To assess the level of stigma, respondents who had heard of AIDS were asked if would be willing to care for a relative who has AIDS in their own household, if they would be willing to buy fresh vegetables from shopkeeper who has AIDS, if they would allow a female teacher with AIDS who is not sick to continue teaching, and if they would not want to keep secret that a family member got infected AIDS. The percentage of male and female respondent expressing acceptance attitudes on those four indicators is almost 9 percent. Male respondents express more acceptance than females (11.9 percent compared to 8.3 percent).



The comparison by age group shows that respondents aged 20-24 tend to express more acceptance than those in the age group 25-49 and 15-19. Education has a positive relationship with the expression on acceptance attitudes. Higher education has higher percentage of the expression on acceptance attitudes on those four indicators. Respondents with secondary or higher education reached 18 percent. This can be understood because their knowledge on the HIV/AIDS is much better than those with lower education.

To challenge the stigma and discrimination against people with HIV a better advocacy strategy is needed to allow people to obtain correct knowledge on HIV and AIDS. Information access is essential to increasing people's knowledge and awareness of what is taking place around them that may eventually affect their perceptions and behavior.

Indicator 15: percentage of children under age 15 who are orphans.

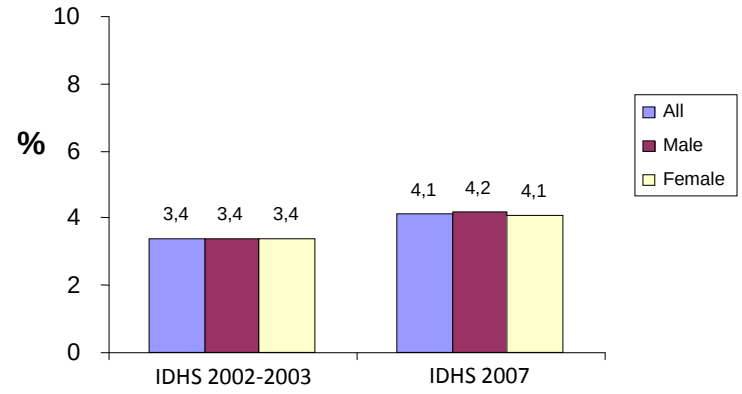
The definition of orphanhood used refers to all children under age 15 who have lost either one or both parents. Data provided here came from 2007 Indonesia Demographic Health Survey. Data on orphanhood in the demographic analysis is also used to calculate mortality and fertility using the indirect estimation. Data on orphanhood is important in term of children's care. Some adult mortality is related to deaths because of HIV infection. The deaths of parents leave behind orphans who must be cared for, generally by other relatives or members of the community.

Data on an increase in orphanhood can be a very powerful indication of the impact of the AIDS epidemic. Moreover, this data can be used for tracking the impact of AIDS deaths in the communities, and can also be used as advocacy purposes. In the case of Indonesia, the number of parent deaths because of HIV/AIDS may not be significant. The number might be very small, or even no data is available. It is still a problem to produce mortality data which relate to the cause of death.

The percentage of orphans in 2007 is 4.1 percent, which most of them were aged 10-14 years old. There was an increase of 0.7 percent compared to the figure in 2002-

2003. By this age, children are still need attention and support from their parents. Some evidence points to the finding that many of them have dropped out from schooling because they cannot afford the school fees. Nowadays, there is a 9 year compulsory education program promoted by the Ministry of Education which is free. This program may help orphans to continue their education.

Figure 27: Percentage of children under the age of 15 who are orphans



Source: IDHS 2002-2003 & IDHS 2007

There were more male orphans than female orphans. Orphans who lost their mothers were three times higher than those who lost their fathers. The percentage of orphans who lost both parents has increased twofold from 2002-2003 to 2007.

IV. Best Practices

4.1. Bringing art to life in Kerobokan Prison, Bali[1]

The Situation in Kerobokan Prison

"It seems unlikely that HIV control has something to do with 'kentongan' (a traditional bamboo xylophone). But in Kerobokan prison in Bali, this traditional instrument has played an important role in therapy."

Data collected by the General Directorate of Corrections shows that there are 137,144 inmates in state prison in Indonesia, well in excess of the capacity for 88,599. Thirty per cent or 38,126 of these inmates are there because of drug crimes. Over-crowned prisons increase the risk of both tuberculosis and HIV.

Ministry of Health surveillance data shows that in 2006 HIV prevalence in prisons was 5.4% prevalence which likely was an increase from 2004. In Kerobokan prison HIV prevalence was 3.45% in 2006. This figure encouraged prison management to make a commitment to intensify HIV activities.

Harm Reduction in Kerobokan Prison

In Indonesia the harm reduction package consists of twelve activities as a strategic approach to HIV prevention among injecting drug users. In Kerobokan prison ten of the twelve activities in the national package have been adopted. Only sterile syringe supply and safe disposal are excluded. These ten activities combined in a unique and creative manner and combined with methadone maintenance therapy.

Figure 1. Methadone consumption program

The methadone program began after a study tour to Australia and Iran in 2003. Prison medical staffs were told about the study tour. The program was supported by the Ministry of Health, the Indonesia HIV and AIDS Prevention and Care Project (now the HIV Cooperation Programme for Indonesia), the World Health Organization, and Family Health International's "Stop AIDS Action". The Bali Provincial Police Department has been involved since the beginning. By the end of December 2004 the methadone clinic in Kerobokan prison was officially announced by prison authorities.

Methadone patients were first recruited in August 2005. At that time, the procedure was involved registration, counseling, laboratory tests and methadone treatment. Information on newly registered inmates was collected through screening and counseling at patient orientation.

[1] Contributed by Endar Tri A

The number of inmates using methadone has increased every year so that in September 2008 there were 39 active methadone patients in the prison. This number is likely to increase since new inmates with drug dependence who have never received counseling continue to arrive at the prison.

Art Therapy

Apart from counseling and methadone, the prison methadone team has also arranged for innovative supplementary programs such as art therapy and yoga therapy. Kerobokan prison is the only institution with these therapies associated with a methadone program.

Figure 2: Yoga training for MMT patients and other inmates

Dancing and playing bamboo xylophones are not simple activities for drug dependent inmates. Memorizing things was difficult for them because of their addiction. For some it was even difficult to hold the instruments. Playing in harmony, collaborating with other players and performing before audiences was even more complicated. They sucessfully proved that they were perfectly confident and played concerts well. They have been in various performances including one for World Tuberculosis Day in March 2008.

Figure 3. Kentongan in Action, played by MMT patients in International Tuberculosis Day.

Art therapy is an inexpensive means of HIV prevention which also decreases the number of prisoners who uses heroin. PLWHIV in the prison are better monitored on daily basis and most importantly are able to live their normal life. This in turn maintains prison safety and order which further help to monitor the use of the therapy. Antiretroviral therapy is easily initiated after receiving methadone therapy.

As of October 2008, 45 patients out of 142 begun on methadone and were released from methadone consumption following proper treatment for over one year.

Forty-one of them were dropped out of the program due to the side effects, intolerance or being released from prison. Nine of them were reported to have died from HIV-related causes, five dropped out for unknown reasons and the remaining three were transferred to other prison.

Gaining Support to Achieve Optimum Results

The harm reduction program in Kerobokan prison can be sustainable as it has gained valuable support from many stakeholders. They are Sanglah Hospital as the referral hospital, the HIV Cooperation Program for Indonesia (HCPI) which provides resources and technical assistance, the two local community health centres as referral health centres and antiretroviral treatment points, the Bali Health Foundation that provides drug rehabilitation program, the Bali Plus Foundation that provides support services for people living with HIV, the Kerti Praja Foundation that provides laboratory support, OI drugs and ARV, the Mata Hati Foundation which takes an active role in pre-release programs and the Bali Hati Kita Foundation which focuses on Narcotics Anonymous and peer educator program.

Internal Challenges

During program implementation, lack of funds has been a challenge in achieving the goals of the program. The Head of Prison and prison staff had committed themselves to the program and were capable of overcoming these constraints by optimal use of resources.

Of greater hindrance was the envy and negative viewpoints among inmates who were not in the program which led to discrimination against those in the program. A negative myth that methadone presages death among inmates was also problemmatic. It was the duty of prison staff and peer support groups to improve communication, information and education. A prison radio transmission is an innovative idea to successfully dissiminate information. The Prison Working Group planned to implement prison radio this plan in 2009 by creating a partnership with Bali Province AIDS Commission and the Indonesian bilaterally-funded HCPI.

Experience

Harm reduction programs do not immediately cure inmates of drug dependence. HIV transmission can be reduced among people with healthier lives. Once inmates return to the community, they are expected to be independent and responsible community members. Many of them showed that they are met this expectation.

Partnership was also of importance. Advocacy to encourage planning and budgeting of programs will ensure independent future program implementation. Harm reduction and a healthy life among inmates leads to a healthy community. This is the meaning of the saying ”healthy prison - healthy community.”

4.2. Local Commitment toward Program Strengthening[2]

Banyuwangi and the HIV Epidemic

"Building mutual understanding in HIV prevention is not a simple task. But, Banyuwangi District has shown that it can be done. Through leadership and collective support, a mutual understanding can be achieved to prevent the spread of HIV."

HIV transmission is high in Banyuwangi District in East Java province. Data collected through surveys of the HIV situation in 2008 showed that 69% of cases occurred from sexual transmission and 23% from use of non-sterile injecting equipment. It is highly suspected that the high percentage of reported transmission through sexual was related to high risk sexual transaction in this area where there are 14 brothels within which there were 525 female sex workers, plus other forty-nine places where sex are sold in bars, karaokes, cafes, massage parlours and others.

From the same source of data, it was estimated that the number of clients of female sex workers in that year were about 22,600. Some of them were fisherman, shipping crew members, bus or truck drivers, motor rickshaw and motorcycle taxi drivers and others. It is important to be noted that in this district there are other key populations i.e. injecting drug users, transgender, and men who have sex with men.

Some of the well-known NGOs currently working in prevention programs are the Bina Sehat Working Group, the Pelita Hati Husada Working Group and the HIV and AIDS Control Unit of the Indonesian Red Cross. Three of them are located under one roof office with Banyuwangi District AIDS Commission, that allows easier coordination among them.

In performing its duties the Banyuwangi District AIDS Commission is supported by monitoring and evaluation officers and four working groups, namely Organizational Development Unit, Medical Service and Assistance Unit, Education and Community Empowerment Unit and Research and Epidemiology Unit.

The Awakening of the Banyuwangi District AIDS Commission

HIV and AIDS information dissemination and education has been carried out through programs with various sectors and community groups ever since the commission was established in 1999. The programs are as follow:

Figure 4: Example IEC media for the community

1. **Events,** in the form of education sessions in schools and on university campuses, to Java-Bali ferry passengers, through talk shows on local radio stations, and demonstration walks.
2. **Information and Education Communication (IEC)**, by designing and publishing IEC material such as posters using local vernacular (native Banyuwangi dialect) so that information on HIV and AIDS will be easily accepted by local people.

[2] Contributed by Jumadi

3. **Advocacy to various comunity and religious leaders,** for example those in Indonesian Ulama Council, religious preachers and other community figures. This advocacy activities is aimed to raise their awareness on the HIV epidemic which if increased would enable more support to HIV program implementation.

4. **Condom Campaign targeting Clients of Female Sex Worker using various media.** A man figure named *BungKus* was created to represent a responsible clients. Using various media, such as condom package, and other IEC materials. Literally, BungKus can also be intrepreted as ”covering” which is associated with condom function to ”wrap something” in order to prevent from STIs/HIV infection. An event as one means of campaign held on 8 May was 2008 attended by the Mayor of Banyuwangi .

Figure 3 & 4: TMMC event socializing HIV/AIDS and condom promotion honourably attended by the Mayor of Banyuwangi Mrs. Ratna Ari Lestari, SE. MM.

Figure 3

Figure 4

5. **Media Relations** were carried out by holding an event for local media such as Newspaper (Radar Banyuwangi, Koran Sindo, and Koran PKB) and fifteen private radio stations in Banyuwangi.

Local Agreement, the milestone promoting HIV/AIDS control

On 6th of July 2004, Banyuwangi local government endorsed the Blambangan Agreement to battle against drug use and HIV. The agreement was then signed by the Banyuwangi Mayor in a letter dated 23 February 2007 regarding the encouragement of 100% condom use by key populations.

The agreement was set out to guide the work of several local NGOs concentrating on HIV prevention in early 2004. They were incorporated as Banyuwangi District AIDS Commission working groups funded by international donors such as Family Health International and the Global Fund. Program implementation covers outreach and advocacy for key populations, regular STI and HIV tests, care, support and treatment for people living with HIV, harm reduction, peer education and condom distribution.

With its well-trained field workers, the working group members provide education on STIs and HIV and AIDS for both individuals and groups. They also conduct monthly STI test at each brothel area and HIV tests every three months. This program is in cooperation with Health Office of Banyuwangi District.

In order to support the implementation of Blambangan Agreement, one NGO, KKBS organized representatives from nine brothel areas to act as a commission. It involves local stakeholders such as district administration, police officer, military, village head and community head. This program is aimed to promote regular check-up and the consistent use of condom among female sex workers.

Agreement and Code of Conducts
in Padang Pasir Localization Karangbendo Village
Rogojampi District Banyuwangi Regency

Code of conducts

1. New sex workers (moving from other place/region) must possess origin KTP (ID Card) or transmittance letter. Within 1 x 24 hours, procures must report them to the administrator or RT and the new worker must undergo test at the available clinic prior performing their job.
2. All procures are prohibited to accept new worker who is under 20 years old unless once married.
3. All workers must undergo regular test once in every month at the available clinic and encourage 100% condom use during each sexual transaction.
4. Any sound system including tape recorder, VCD and other sound systems must be turned off before 24.00.
5. During ramadhan month, any cafe and houses must stop total operation.
6. Any visitor are prohibited to bring any weapon or explosives in to localization.
7. Every person must keep everything safe and in order.
8. Other issue beyond what is written herein will be proposed hereafter depending on further condition.

Penalties:

1. Upon violating code of conducts number 3 there above, anyone will be given strong warning and fined with two sacks of cement.
2. Upon violating code of conducts number 2, 4, 5 and 6 there above, anyone will be penalized under government statutes.

Banyuwangi, 5 April 2007

Head of Karangbendo Village | Head of Community/RT

Approving,

Head of Rogojampi District Police | Head of Rogojampi District | Head of Rogojampi Regional Military Unit

Easy access to condoms is also promoted in the program to support the agreement. In 2006, condom vending machine in several localization were found to be ineffective. However, the devices were out of order after one month of use. Therefore, KKBS, one NGO working in this area, supports each representative from brothel areas to cooperate with the condom distributor of a social marketing program so that female sex workers can get condom at an affordable price. Condoms are then available in sex workers' rooms or given free to sex worker clients in the parking lots of the brothel areas. The condom price is included in the parking fee.

Another NGO involved in HIV/AIDS control program was the Indonesian Red Cross which works with high risk men groups such as groups of fishermen, transportation workers, snack sellers, and street entertainers.

Success Indicators

Based on data gathered by KKBS, it was reported that there was a significant decrease of cases of sexually transmitted diseases after beginning the intervention in 2004 and after local agreements was applied at several brothel areas covered by the NGOs.

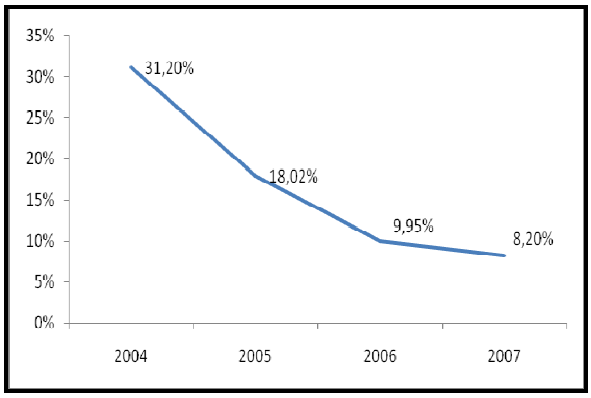


Chart 1: Cervicitis rate decrease on FSW in 2004 – 2007

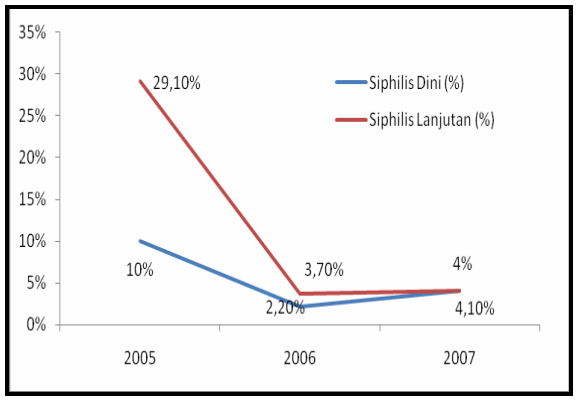


Chart 2: Siphilis rate decrease on FSW in 2005 – 2007

After making local agreements, twenty-three condom outlets were established before June 2008 within all nine brothel areas. Besides distribution through outlets, condoms were also directly distributed to female sex workers by field workers.

Constraints and Solutions

A decrease in reported sexually transmitted infections has not been followed by a decrease in HIV case decrease in Banyuwangi District. There has been an increase in HIV reporting each year. HIV case reporting, however, can be influenced by a change in behaviour, a change in the number of people undergoing HIV testing, and the number of service facilities.

HIV prevention programs in Banyuwangi District since 2004 were implemented by many NGOs and funded by an international fund (USAID). Therefore, in order to ensure the program sustainability, Nurul Islam, the secretary of Banyuwangi AIDS Commission, said that she will facilitate the establishment of a Technical Team to develop HIV program which is supported by local government fund based. This is in line with the suggestion from Ministry of Sport and Youth letter. This team will involve government as well as NGOs.

One constraint is the understanding of female sex workes and their clients. This requires repetitive and continuous education. Sexually transmitted infections continue to be transmitted due to inconsistent condom use among the men clients of female sex workers. Brothel administrators are encouraged to make a punishment and reward system for female sex workers as stated in the Blambangan Agreement.

The Banyuwangi AIDS Commission and the working groups expect effective monitoring and evaluation from the Provincial and National AIDS Commissions.

V. Major Challenges and Remedial Actions

Some progresses are made on key challenges reported in the 2007 UNGASS Country Progress report. As mentioned in 2007 report that communication and resource distribution are one of the main challenges that impaired the even responses throughout Indonesia. To date, all 33 provinces in Indonesia and 172 districts out of 450 districts in Indonesia already have Provincial/District AIDS Commission Secretariat as local authorities equipped with full time officers. This condition has enabled a routine communication between national and sub-national AIDS Commission using monthly reports which include programmatic and financial report. However, close mentoring and supervisions are still strongly required.

In relation to limited outreach to high-risk behavior groups as mentioned in 2007 UNGASS, as of 2009, the level of coverage to Female and *waria* Sex Workers – and their clients, Injecting Drug Users as well as prisoners are increasing. However, outreach to men who have sex with men did not show much progress. Despite the increasing trend in coverage, the quality of outreach remains in question.

As the UNGASS 2007 brought up the low coverage of condom use and resistance from men as well as religious leader as one of the main challenges, to date there is no new recent national data on condom use. However, intensive review, policy dialog and some successful pilot program had been carried out that resulted in new approach to prevention of sexual transmission which focuses on structural intervention. This approach has been adopted into the National AIDS Strategic and Action Plan 2010-2014.

On area of prevention through contaminated syringe/needle, even a greater progress is achieved with the enactment of Regulation No. 35/2009 about Narcotics. Potentially the harm reduction program will be more acceptable in program so-called the medical and social rehabilitation, which are issued by the Supreme Court Decree No.7/2009. Based on this regulation Government of Indonesia is now developing regulation which put emphasize on human rights in the guideline.

Those three of 10 main challenges pointed out in 2007 UNGASS report exemplified how serious Indonesia has taken actions in improving the program implementation which includes policy, management and technical issues. One of significant progresses occurred in the period of 2008-2009 are the issuance of the 2008 Minister of Home Affair Regulation about guideline for local government to access planning and budgeting process at local level in order to respond to HIV and AIDS. Progress in implementation includes scaling up of prevention, care, support and treatment services as well as providing enabling environment for delivery of such services.

A new national strategy and action plan for 2010-2014 was launched, following extensive national consultations led by the NAC Secretariat. This document was

developed in accordance with the National Mid-Term Development Plan 2010-2014, and now serves as the main reference for all government sectors at all level, international development partners and other government/non government institutions to develop strategic/annual plan for comprehensive HIV prevention, care, support and treatment. Targets, a monitoring and evaluation (M&E) framework, unit costs of intervention and sectoral responsibilities are also comprised in this document.

Despite any progresses achieved to date, most of the areas still need to be improved in terms of coverage, program effectiveness as well as program sustainability. Below are identified issues that potentially challenge the implementation of abovementioned National AIDS Strategy and Action Plan that Indonesia should continuously monitor their status.

The challenges:

1. Inadequate coverage compared to Universal Access targets, especially prevention coverage among key populations (MSM, *waria*, injecting drug users, clients of female sex workers, migrant workers, and their respective intimate partners). Special attention must be paid to prevention of mother to child transmission as well as care, support, and treatment for PLHIV in needs for services, and also for impact mitigation.

2. The lack of resources to ensure program effectiveness which focus on behavioral change. This intervention requires, both human and financial resources, to meet program standards.

3. The barrier to scale up prevention program of sexual transmission, more specifically, at the commercial sex transaction sites due to local specific characteristics to deal with. Although new approach has been decided, lots of work needs to be done to increase conducive environment to support consistent condom use program.

4. Program sustainability. Resources, both human and financial, are not yet sufficiently secured at national, provincial, and district level. Support from international fund is available but limited. Compared to international fund, the domestic fund makes up around one third of the total fund available.

5. Weak health service systems and uneven capacity in health care and community systems. These include weak capacity in prevention, diagnosis, care and treatment, blood safety and universal precautions. There is also the need to strengthen the community systems in which NGOs and other civil society are accounted for their active participation in response to HIV and AIDS especially in working with key population and people living with HIV.

6. The need to improve good governance practices including effective coordination among stakeholders, policy harmonization, effective and accountable

management, sharing and utilization of strategic information, as well as more transparent program implementation, monitoring and evaluation.

7. The need to build more positive, enabling environments to support implementation of the comprehensive programs involving both government and civil society which is aimed to eliminate stigma and discrimination as well as violation of basic human rights, and to achieve gender equities.

8. The need to improve the program implementation at the field level:
   a) District AIDS Commission leadership to support program implementation
   b) Financial management
   c) Logistic management, particularly ARV and methadone, as well as STI drugs and other prevention commodities such as condom and syringe
   d) Coordination and partnerships among local stakeholders
   e) Involvement of key population, including positive prevention
   f) M&E

The strategies:

1. Scaling-up coverage of prevention
   a. Prevention of HIV infection transmitted through use of contaminated needle/ syringe
   b. Prevention of HIV through unsafe sexual contact
   c. Development of comprehensive program for MSM
   d. Prevention of Mother to Child Transmission

2. Increase and expand care, support and treatment services
3. Reducing the negative impact of the epidemic, by improving access to and utilization of programs for impact mitigation
4. Strengthening partnerships, health systems and community systems
5. Increase coordination among stakeholders and resource mobilization at all levels
6. Structural interventions
7. Evidence-Informed Planning, Prioritizing, and Program Implementation

Action plans for remedial actions:

In regards with the Indonesia's epidemic situation, the response to AIDS focuses on prevention programs for the populations which are most at risk. In parallel to prevention the strengthening of care, support and treatment services for people living with HIV (PLHIV) is also promoted. The response has been developed with the aim to achieve maximum effectiveness and high impact at low cost.

The main populations to be reached and served in prevention programs are: injecting drug users, sex workers and their clients, and men who have sex with men (MSM). Intimate partners of each key population group are also stated as one important to reach.

As we acknowledge through projections that a significant increase in new HIV infections will occurred among MSM in the near future, it is very important to

increase the program coverage timely so that the rising trend of AIDS epidemic can be reversed. This action will prevent not only MSM but also their intimate partners.

Next are focus areas of remedial actions needed to achieve Universal Access targets with quality program:

1. Resource mobilization:
   a. Continue leveraging of central government and local government budget.
   b. Cover the financial gap until 2014/15 by using GFATM budget for Round 8 starting mid 2009 and using round 9 budget starting mid 2010. It is expected that the domestic financial source will be higher than external source in 2014.
2. Policy development:
   a. Increase resources: financial and human resources
   b. Strengthening institution capacity
   c. Increase quality of services of prevention and control program, treatment and impact mitigation
   d. Reduce stigma and discrimination
3. Prevention: increase and extend prevention coverage, to reach 80% coverage for each key population and 60% of the key populations practicing safe behavior in 2014.
   a. Prevention through contaminated injecting equipments
   b. Prevention of sexual transmission
   c. Development of comprehensive prevention program for MSM
   d. Prevention of Maternal Child Transmission
   e. Prevention among the sex workers' clients in the work place (30% of the clients)
   f. Prevention among the migrant and mobile workers (20% of the clients)
   g. Prevention among high risk youth (aged 15-24 years old) to have healthy behavior through formal education or community approach.
4. Care, support, and treatment: To be provided for all PLHIV including ARV treatment for those meeting the agreed upon criteria including CD4 count and basic health condition
5. Social impact mitigation:
   Improve data collection and provision of social and economic support for PLHIV and those affected by HIV, as needed.
6. Establishment of a enabling environment: Attention will be given to reducing stigma and discrimination, increasing government commitment reflected in allocation of appropriate budgets as well as establishment of policies that support the response to HIV and AIDS.

Despite the hard work needs to be done, compared to 2007 situation, government commitment to work towards achieving MDGs goals, specifically, goal number 6 are now significantly stronger. A more coordinated action is performed among government sectors as well as civil society, including academia, professional organizations, PLHIV, and private sectors. Recently, civil society members have been added to the National AIDS Commission structure: the National Network of PLHIV,

National Network of Positive Women, National Network of Gay, Transgender and Men who have Sex with Men, and National Network of Sex Worker.

Implications

The success of the program seems to be determined by the support from the local authority which provides a leadership. While program were initiated by NGOs the community gradually takes a significant role to organize the program. Once the community are actively support the program implementation the ownership of the program can be moved to the community itself while the government takes the responsibility.

VI. Support from the Country's Development Partners

Key support received from international development partners

Indonesia continues to receive technical and financial support from international development partners in scaling up the AIDS response. Support covers all areas of increasing prevention, care, support and treatment program coverage, ensuring effectiveness of interventions and support to build sustainability and creating conducive environment for addressing HIV and AIDS.

Bilateral partners

The largest contribution from a single external donor was from DfID, UK for the Indonesian Partnership Fund for AIDS (IPF) with amount of US$ 58.5 million for period 2005 to 2010. Subsequently, AusAID joined and contributed US$ 2.5 million to the IPF for period 2008 to 2010. Due to its flexibility, this funding mechanism has proven extremely valuable to the National AIDS Commission as the IPF has enabled the scaling-up of prevention, care, support and treatment programs; improved management of the AIDS response and achieved the "Three Ones" principle with strengthened AIDS Commissions at all levels coordinating the AIDS response, providing one national action framework and one national monitoring and evaluation system. Most importantly the IPF has also been utilized to fill in critical gaps in the national budget allocation for AIDS and the National AIDS Commission was able to provide significant funding support to people living with HIV, networks and community-based organizations.

The US and Australian governments are long time supporters of Indonesia's AIDS response. From 2005 to 2008, USAID contributed US$ 26.2 million and AusAID contributed Aus$ 37 million. Through Family Health International and the Australia-Indonesia partnership program HCPI, the bilateral support focuses on interventions for controlling sexual transmission of HIV as well as harm reduction programs for drug users and inmates in prisons and detention centres in the provinces of Java, Bali and Papua and West Papua.

The Global Fund to fight AIDS, TB and Malaria

From 2001 to 2008, Indonesia received three grants for AIDS from Global Fund in Round 1 (US$ 5.4 million disbursed), Round 4 (US$ 43.4 million disbursed), and Round 8 (US$ 125 million requested and approved). In 2009, Indonesia was also awarded Round 9 (US$ 87 million requested and approved). For Round 1 and Round 4, the Ministry of Health was the sole Principal Recipient and the grants mainly focused on Voluntary Counseling and Testing and scaling up of antiretroviral and opportunistic infection treatment for people living with HIV in 19 provinces. In 2008, Round 8 was divided into three grants with National AIDS Commission, Ministry of Health and the Indonesian Planned Parenthood Association as the Principal Recipients. The Round 8 dual-track grant (government and civil society) focuses on

comprehensive and partnership approach to scale up interventions for prevention, care, support and treatment in 12 most affected provinces. The Round 9 grant compliments Round 8 and expands program for the remaining 21 provinces. The civil society Principal Recipient for Round 9 is Nahdatul Ulama (NU), the largest Islamic network organization in Indonesia.

United Nations system organization and UNAIDS

The UNAIDS Country Office provided technical support in developing the national M&E system, strengthening the National AIDS Commission and other key government and civil society partners and technical support in strategic planning for the National AIDS Strategic Plan and proposal development for the Global Fund.

UNAIDS also coordinates the effort of the UN system organizations in contributing to the AIDS response in Indonesia. Organizations such as UNDP, WHO, UNICEF, UNFPA and ILO work with their national counterparts in various development areas such as governance, health, education, gender, workplace, and young people. Besides financial contribution, UN organizations provides technical and policy advice as requested by the national stakeholders.

UNICEF and ILO provided technical support for developing various education programs (in- and out-of-school). UNICEF supported the development of a Life Skills Education module on adolescent reproductive health and AIDS. Ongoing implementation of the module in government schools in Papua and in Islamic schools in East Java has seen the program reach tens of thousands of high school students and hundreds of junior high school. UNICEF also provided technical assistance and financial support to the Ministry of Health for the development of a national guideline for the prevention of mother to child transmission of HIV.

WHO has long been a key provider of technical assistance in STI prevention; care services; and health systems. The agency has supported Indonesia to improve safety of blood supply and blood products. WHO and UNODC has also provided technical support for the development of policies and guidelines for IDU harm reduction services, including methadone substitution.

UNFPA has provided assistance to the National Family Planning Board among others in promoting higher condom use. UNFPA has also supported Indonesia to promote youth friendly sexual and other health services.

Actions that need to taken by development partners to ensure achievement of the UNGASS targets

Although Indonesia is progressing consistently towards achieving the UNGASS targets, key challenges remain that require assistance from Indonesia's development partners, these include:

- Increasing program coverage and reaching most at risk populations

The Mid-Term review of the National HIV/AIDS Strategy 2007-2010 shows the average percentage of most at risk population (sex workers, MSM, and IDUs)

reached with HIV prevention programmes at 38%. For sex workers the percentage is 29%, still not high enough to achieve desired impact to reduce sexual transmission of the AIDS epidemic. Support from development partners to provide advocacy, technical guidance and prioritized interventions to scale-up activities and programs for most at risk populations continue to be required.

- Increasing domestic resources and achieving sustainability

While Indonesian domestic resources for AIDS has been increasing at around 20% per year since 2003, it is still far from adequate to respond to the commitment to reverse the course of the epidemic. Resource needs remain high and contributions from all partners domestic as well as external remain necessary. Support from development partners is needed to develop a resource mobilization strategy to increase domestic resource allocation and tap into innovative financing channels to maintain a sustainable AIDS response.

- Improving M&E and reporting at provincial and district level

Ensuring data and information is managed effectively and strategic information is used to inform program planning and implementation is an essential part of the national effort to achieve UNGASS targets. While there is progress in the national M&E system and reporting mechanism, gaps remain in ensuring that provincial and district level M&E run as smoothly and effectively as at national level. In order to ensure consistency in data management and timely reporting across 440 districts and 33 provinces, technical and financial resource needs are required. Development partners need to provide technical guidance in improving data management and reporting system among AIDS programs, implemented by government, civil society and international development partners.

- Improving health systems

Health systems strengthening programs in Indonesia still require significant technical and financial support. Quality of public health sector services is not yet optimal with patient demands outweighing available health services and personnel. In order to expedite achievement of UNGASS targets for care, support and treatment and increase number of people receiving ARV, OI and TB treatment, more investment and effort must be provided to health systems strengthening for higher quality, non-discriminatory health services for poor people, people living with HIV and most at risk population.

- Ensuring effectiveness of interventions

One of the priority areas in the 2010-2014 National AIDS Strategic Plan is ensuring that all interventions for prevention, care, support and treatment are effective and produces the desired outcome as set out in program targets. Program reviews must be routinely carried out to check that program interventions are effective reducing risk taking actions among most at risk population and young people who are vulnerable to HIV infection particularly in using condoms for high risk sexual interactions and injecting drugs or sharing injecting equipment. Development partners are requested to provide technical support in program reviews and policy guidance and information on up-to-date technology and interventions to inform program implementation in Indonesia.

- Coordinating and managing technical support

Although more resources are being made available for scaling-up AIDS programs across 33 provinces and 137 districts, it is notable that money alone is not adequate to ensure successful response to AIDS. All the challenges listed above require effort and technical support. As program scale-up intensifies, various providers and recipients of technical support negotiate technical support programs from donors and program implementers. The National AIDS Commission is coordinating a National Technical Support Plan to manage technical support programs for all program implementers regardless of funding source. Development partners are invited and encouraged to participate in developing and implementing the National Technical Support Plan.

VII. Monitoring and Evaluation Environment

National HIV and AIDS program is equipped with the national M&E system. The system is being implemented by all implementers at national and local level after they have all been exposed to the M&E guideline as national reference. The guideline consists of a common set of national indicators, data flow, reporting format and responsibilities of HIV program managers and other key stakeholders. Currently there are 33 provinces and 172 districts use the guideline as reference and report the national indicators regularly to NAC regarding program coverage from line ministries and local NGOs.

Several indicators being monitored regularly are feeding the main national indicators and some of it would be withdrawn for UNGASS input indicators, Universal Access indicators and Millennium Development Goals indicators.

Monitoring of the indicators is conducted by NAC M&E team. There are 6 full time professional M&E staff working for NAC, meanwhile there are 33 program staff at province and 172 staff at district who also have responsibility for working on M&E related tasks.

The team is monitoring the input, process, output, outcome and impact indicators of AIDS national program. Input indicators are dealing with institutional capacity situation at national and sub national AIDS Commission, proportion of AIDS program funding and spending, the issue and implementation of HIV and AIDS policies. Recent institutional capacity situation is known by annual monitoring of AIDS Commission plan for its organizational improvement and provision of technical assistance for improvement, monitoring of the program funding is conducted through biannual National AIDS Spending Assessment

Process indicators cover the program and service data which mainly come from the Ministry of Health. Output indicators are providing data and information on program coverage for key populations. The outcome and impact indicators mostly traced by MoH through surveys such as integrated bio behavioral surveys. In addition the NAC is also conducting rapid survey on HIV prevention through sexual transmission that will complement the national data for the outcome and impact indicators.

Mechanism of data sharing is through routine M&E working group meetings. The working group comprises of member of NAC including government sectors, civil society and international partners. Each meeting will discuss different topic on M&E as well as data sharing or update among members. Some critical issues to improve Monev system implementation is also discussed. Other mechanism of dissemination is through executive meeting, displaying M&E results in the website, printed versions and fact sheet.

Reporting flow of data and information starts from district to province and finally to national level. At district and province level, regular meeting is ongoing to validate

and verify data before sending it to the national. This is to ensure the quality of data being collected. Analysis and data use is done at each level and this increase sense of belonging of the M&E results.

The use of M&E results is increasing from time to time. At national level, it is has been used for program improvement, basis of developing the new AIDS strategy and action plan, decision making, resources mobilization, etc. For the last 2 years, key line ministries have realized the importance of using these data. Most of them use these for input on AIDS program within their institution and for taking more significant participation in the national AIDS response. At local level, the M&E results become valuable information for local authority to better response to the AIDS situation in their respective area. Similar thing happen to international partners which really need the M&E results for the development of plan on AIDS-related assistance to the country.

The changing future in monitoring and evaluating the AIDS program has stimulated the M&E staff to improve their knowledge, skill and attitude for managing and executing the tasks. For the last 2 years, there was an intensive capacity building for M&E national staff, such as participating in estimation workshop, resources needs workshop, HIV and AIDS management short course, data management training and HIV and AIDS program monitoring and evaluation training. The national M&E team and other M&E staff from national implementing partners are now become national trainers on M&E on HIV and AIDS and this is a great asset for the country.

Development of trainers on M&E was started by inviting 9 state universities from 9 provinces to send 2 representatives plus 1 member of provincial AIDS Commission assistance team to attend M&E Training of Trainers. Currently, there are 27 provincial trainers who can be invited to train other people in or out of their province. This also becomes local asset for capacity development human resources. Participating universities is now become center of study for M&E on HIV and AIDS program.

At local level, there was a series of trainings for provincial AIDS program manager and M&E staff on M&E topics such as key populations mapping, health mapper, data analysis using pivot table, etc. Long term and sustainability capacity building plan is developed with respect to the needs.

List of Annexes

Annex 1: Completed Questionnaires of National Composite Policy Index (NCPI) Part A and B
Annex 2: National AIDS Spending Assessment (NASA) Matrix

Annex 1: Completed Questionnaires of NCPI Part A and B

NCPI Respondents

Structure of the Questionnaire
The NCPI is divided into two parts:

PART A to be administered to government officials covers five areas:

1. Strategic plan
2. Political Support
3. Prevention
4. Treatment, Care and Support
5. Monitoring and Evaluation

Part B to be administered to civil society organizations, bilateral agencies, and UN organizations covers four areas:

1. Human Rights
2. Civil Society involvement
3. Prevention
4. Treatment, Care and Support

Respondens
NCPI –PART A

Organization	Names/Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Ministry of Religious affair	Hamim	√	√			
Ministry of Tourism	Yabez Tasih (Kasubdit)	√	√			
Ministry of Health	Rita Djupuri (Dirjen P2PL)	√	√	√	√	√
Ministry of Sport and Youth Affairs	Purwanto (Kasubdit)	√	√			
Indonesian Police	dr. harianto (Kasubdit Kesum)			√	√	√
Ministry of Reseatch and Technology	Fitri Yunita (Bidang Kedokteran Dasar)			√	√	√
Ministry of Defence	Cholid AR (KSD Minkes Dikes)			√	√	√
Ministry of Law and Human Right	Enjang Sudarya, SH (Bagian Pengembangan)	√	√			

Family Planning Coordination Board	Suminto (Kasi Prom ODHA)	√	√			
Ministry of People's Welfare	Silvanie Tompodung (Kasubdit P2M)	√	√			
Central Health for Indonesia Armed Forces	Ghufron Sholihin (Kasubdit kesprov)			√	√	√
Ministry of Social Welfare	Desmawati Dahlan (Penyuluh Sosial)	√	√			
Directorate General of Detaining Centre	A Zaenal Fikri (Kasi Ket Usada)			√	√	√
National AIDS Commission (NAC)	Dr. Kemal Siregar (Deputy)	√	√	√	√	√
National AIDS Commission (NAC)	Dr. Suriadi (Senior Advisor)	√	√	√	√	√
National AIDS Commission (NAC)	Ali Zazri (Reporting Coordinator)	√	√	√	√	√
UNAIDS	Lely Wahyuniar (M&E Officer)	√	√	√	√	√

NCPI - PART B

Organization	Names/Position	Respondents to Part B [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
UNGASS Forum Indonesia	Aditya Wardhana	√	√	√	√	
Jayapura Support Group	Robert sihombing	√	√			
Yayasan Gaya Nusantara	Ko Budiyanto	√	√			
Hotline Surabaya	Esthi susanti	√	√			
Solidaritas Perempuan	Thaufik Zulbahary	√	√			
Ikon Bali	I G N Wahyunda	√	√			
JOTHI	Abdullah Denovan	√	√			
IPPI	Chyntia	√	√			
LP3Y	Slamet Riyadi	√	√			
Yayasan Kusuma Buana	Adi sasongko	√	√			
FHI	Cipta sari			√	√	
STIGMA	M.sugi	√	√	√	√	
UNGASS Forum	Belinda	√	√	√	√	
FHI	Kiki Syafitri	√	√			
JOTHI NAD	M.Rizal	√	√			
AIDS Research Centre Atmajaya	Octavery Kamil	√	√	√	√	
Yayasan Gerbang	Andika			√	√	
YPI	Husein habsyi			√	√	

GWL INA	Harry P			√	√	
OPSI	Aldo			√	√	
Y.Tegak Tegar	Sika			√	√	
Y.laras Kalimantan timur	Suhendro sugiharto			√	√	
Y.Kipas Bengkulu	Merly Yuanda			√	√	
Kios Informasi Atmajaya	Arman Arya			√	√	
Yayasan rempah	Hidayatul Fitri			√	√	
PKBI DKI	Heri Susanto	√	√			
JANGKAR	Irawan Afrianto	√	√			
Our Voice	Hartoyo	√	√	√	√	
Tegak Tegar	Adhi	√	√			
FHI	Rizky I Shafitri	√	√			

National Composite Policy Index (NCPI) questionnaire

Part A
[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV? (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes √	No	Not Applicable (N/A)

Period covered: 2007-2010 (Third National AIDS Strategy)

IF NO or NOT APPLICABLE, briefly explain why:

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: 15 years since the First National AIDS Strategy of 1994

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	**Included in Strategy**		**Earmarked budget**	
Health	Yes √	No	Yes √	No
Education	Yes √	No	Yes √	No
Labour	Yes √	No	Yes √	No
Transportation	Yes √	No	Yes √	No
Military/Police	Yes √	No	Yes √	No
Women	Yes √	No	Yes √	No
Young people	Yes √	No	Yes √	No
Other*: Nat.Family Planning Board, Social Affairs, Home Affairs, Religious Affairs, Justice/Prisons, Nat. Narcotics Board	Yes √	No	Yes √	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities? *Most the sectors used government fund for implementing the activities*

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	Yes **√**	No
b. Young women/young men	Yes **√**	No
c. Injecting Drug Users	Yes **√**	No
d. Men who have sex with men	Yes **√**	No
e. Sex workers	Yes **√**	No
f. Orphans and other vulnerable children	Yes **√**	No
g. Other specific vulnerable sub-populations[15]	**--**	No **√**
Settings		
h. Workplace	Yes **√**	No
i. Schools	Yes **√**	No
j. Prisons	Yes **√**	No
Cross-cutting issues		
k. HIV and poverty	Yes **√**	No
l. Human rights protection	Yes **√**	No
m. Involvement of PLHIV	Yes **√**	No
n. Addressing stigma and discrimination	Yes **√**	No
o. Gender empowerment and/or gender equality	Yes **√**	No

1.4 Were target populations identified through a needs assessment?

Yes **√**	No

IF YES, when was this needs assessment conducted?

Year: in 2007 through IBBS (key populations, incl. military) and in 2009 through mapping/special surveys of key populations (IDUs, sex workers, MSM, PLHIV, etc)

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

Injecting drug users, sex workers, trangenders, clients of sex workers, prisoners, people living with HIV

1.6 Does the multisectoral strategy include an operational plan?

Yes **√**	No

[15] Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identifi ed as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

1.7 Does the multisectoral strategy or operational plan include:

a.	Formal programme goals?	Yes **√**	No
b.	Clear targets or milestones?	Yes **√**	No
c.	Detailed costs for each programmatic area?	Yes **√**	No
d.	An indications of funding sources to support programme implementation?	Yes **√**	No
e.	A monitoring and evaluation framework?	Yes **√**	No

1.8 Has the country ensured "full involvement and participation" of civil society[16] in the development of the multisectoral strategy?

Active involvement **√**	Moderate involvement	No involvement

IF active involvement, briefly explain how this was organized: *The National AIDS Commission and its Executive Team has representatives from civil society/networks of key populations.* *Technical working groups established by NAC, including the Team to prepare the National Strategy & Action Plan for 2010-2014 also have representatives of civil society.* *Civil society is also represented in the CCM for the Global Fund and be Principal Recipients of GF funds.* *The NAC actively supports the establishment and operation of networks of key populations, e.g. in providing office space and sponsoring their national consultations.*

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes **√**	No

1.10 Have external Development Partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners **√**	Yes, some partners	No

IF SOME or NO, briefly explain for which areas there is no alignment/harmonization and why

[16] Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

2. Has the country integrated HIV into its general development plans such as in: a) National Development Plan, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy, d) sector-wide approach?

Yes **√**	No	N/A

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes **√**	No	N/A
b. Common Country Assessment/ UN Development Assistance Framework	Yes **√**	No	N/A
c. Poverty Reduction Strategy	Yes **√**	No	N/A
d. Sector-wide approach	Yes **√**	No	N/A
e. Other: *[write in]*	Yes	No **√**	N/A

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related areas included in development plan(s)		
HIV Prevention	Yes **√**	No
Treatment for opportunistic infections	Yes **√**	No
Antiretroviral therapy	Yes **√**	No
Treatment for opportunistic infections	Yes **√**	No
Care and support (including social security or other schemes)	Yes **√**	No
HIV impact alleviation	Yes **√**	No
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and/or support	Yes **√**	No
Reduction of **income** inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes **√**	No
Reduction of stigma and discrimination	Yes **√**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes **√**	No
Other: [write in]	Yes	No **√**

3. Has the country evaluated the impact of HIV on its socio-economic development for planning purposes?

Yes	No **√**	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low				**High**	
0	**1**	**2**	**3**	**4**	**5**

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc.)?

Yes **√**	No

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes **√**	No
Condom provision	Yes **√**	No
HIV testing and counseling	Yes **√**	No
STI services	Yes **√**	No
Antiretroviral Treatment	Yes **√**	No
Care and support	Yes **√**	No
Others: *[write in]*	Yes	No **√**

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

In principle, VCT is provided for uniformed services.
Mandatory testing is practiced for screening military recruits (volunteers) and for pre and post deployment (e.g. military operations or international peace keeping operations)

5. Does the country have non-descrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes **√**	No

5.1 ***IF YES,*** for which subpopulations?

a. Women	Yes **√**	No
b. Young people	Yes **√**	No
c. Injecting drug users	Yes **√**	No
d. Men who have sex with men	Yes	No **√**
e. Sex workers	Yes	No **√**
f. Prison inmates	Yes **√**	No
g. Migrants/mobile populations	Yes **√**	No
Others: *[write in]*	Yes	No **√**

IF YES, briefl y explain what mechanisms are in place to ensure these laws are implemented:

For non-discrimination of women there is Law No.7/1984 against all discrimination of women and Government Regulation No.9/1999 on gender mainstreaming. There is also Law No21/2007 against human trafficking. A National Commission for the Protection of Women has also been established.

Indonesia has also Law No.39/1999 on Basic Human Rights and established a National Commission on Human Rights.

Briefly comment on the degree to which these laws are currently implemented:

These laws are being gradually implemented. Socialization and coordination among the implementers/stakeholders like the police, military, law enforcement agencies and local governments still has to be improved.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes **√**	No

5.1 ***IF YES,*** for which subpopulations?

a. Women	Yes	No **√**
b. Young people	Yes	No **√**
c. Injecting drug users	Yes **√**	No
d. Men who have sex with men	Yes	No **√**
e. Sex workers	Yes **√**	No
f. Prison inmates	Yes	No **√**
g. Migrants/mobile populations	Yes	No **√**
Others: *[write in]*	Yes	No **√**

IF YES, briefly describe the content of these laws, regulations or policies:

The Law on Narcotics still prohibits all forms of narcotics use and require all addicts/users to undergo rehabilitation.

Several Local Government Bylaws prohibits prostitution/commercial sex and require the closure of red light areas (localization).

Briefly comment on how they pose barriers:

The Law on Narcotics does not support harm reduction services such as needle/syringe exchange. Special arrangements and negotiations with the local police are needed to enable needle/syringe exhange services to be provided.

The local government bylaws closing prostitution complexes resulted in the spread of street prostitution and make it difficult for local health departments to provide services for sexually transmitted disease control/condom promotion.

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes **√**	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes **√**	No

7.2 Have the estimates of the size of the main target population been updated?

Yes **√**	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs **√**	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes **√**	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes **√**	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes **√**	No

IF YES, which population groups?

Key populations like IDUs, sex workers, transgenders, clients of sex workers

Briefly explain how this information is used:

This is used for evaluation and planning of programmes

(c) ***IF YES***, is coverage monitored by geographical area?

Yes **√**	No

IF YES, at which geographical levels (provincial, district, other)?

Province/district/city

Briefly explain how this information is used

Evaluation and planning of programmes:

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes **√**	No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?											
2009	Very Poor										Excellent
	0	1	2	3	4	5	6	7	**8 √**	9	10

Since 2007, what have been key achievements in this area:

Coverage of HR services (methadone substitution an needled/syringe exchange has increased
Participation of sectors (outside health) has increased
The national budget (central and local government) devoted to AIDS has increased
Participation of civil society/key populations have increased
Monitoring & evaluations Surveillance have improved

What are remaining challenges in this area:

Better control HIV transmission through commercial sex and among MSM
The resistance against condom use have to be overcome
The Narcotics Law and other legislation/local bylaws which present obstacles to HIV prevention have to be amended
Stigma and discrimination remain a challenge
Health system should be further strengthened
Community knowledge and awareness on AIDS need to be improved

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support the HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes **√**	No
Other high officials	Yes **√**	No
Other officials in regions and/or districts	Yes **√**	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body? (i.e., a National AIDS Council or equivalent)?

Yes **√**	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 ***IF YES***, when was it created?

Year:1987 (established by the Minister of Health) and in 1994 it was reorganized and established by the President. In 2006 it was reorganized based on Presidential Regulation No 75/2006.

[write in]

2.2 ***IF YES***, who is the Chair?

Name : Dr Agung Leksono
Position/Title:Coordinating Minister for People's Wellafare

[write in]

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes **√**	No
have active Government leadership and participation?	Yes **√**	No
have a defined membership? *IF YES, how many members? 30*	Yes **√**	No
include civil society representatives? ***IF YES***, how many? *5*	Yes **√**	No
include people living with HIV? *IF YES, how many?5*	Yes **√**	No
include the private sector?	Yes **√**	No
have an action plan?	Yes **√**	No
have a functional Secretariat?	Yes **√**	No
meet at least quarterly? (the Exeecutive Team)	Yes **√**	No
review actions on policy decisions regularly?	Yes **√**	No
actively promote policy decisions?	Yes **√**	No
provide opportunity for civil society to influence decision-making?	Yes **√**	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes **√**	No

3. Does the country have a mechanism to promote interaction between government, civil society organization, and the private sector for implementing HIV strategies/programmes?

Yes **√**	No	N/A

IF YES, briefly describe the main achievements:

Representatives of civil society and the private sector played active roles in ExecutiveTeam of NAC. A Business AIDS Coalition and Networks of Key populations (drug users, sex workers, PLHIV, gays & transgenders) have been formed

Briefly describe the main challenges:

Government officials (members of NAC and its Executive Team) have limited time, but need to give more time and attention to HIV/AIDS.

The private sector and civil society networks still need strengthening and expand their memberships.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

   Percentage: Less than 10%, but funding from international organizations (e.g. USAID, AusAID, Global Fund) are channeled to civil society organizations

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes **√**	No
Technical guidance	Yes **√**	No
Procurement and distribution of drugs or other supplies	Yes **√**	No
Coordination with other implementing partners	Yes **√**	No
Capacity building	Yes **√**	No
Other:		

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes **√**	No

   6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes **√**	No

IF YES, name and describe how the policies / laws were amended:

Laws are made by Parliament. The NAC attended a hearing with Parliament and lobbied members of Parliament when the new Law on Narcotics was being prepared.
The Law still prohibits the use of narcotics, but allows drug users to stay out of jail if they report to a health facility and undergo rehabilitation. The use of methadone as substitution is allowed by the law.

Regulation No. 2/2007 of the Coordinating Minister for People's Welfare/Chair of the NAC on the National Strategy of HIV/AIDS Control through Harm Reduction of the Use of Narcotics, Psychotropic's and Addictive Substances is used a a basis for providing HT services to IDUs. Negotiations and agreements with local police are needed to ensure collaboration and support from the local police.

Local government bylaws (issued by local parliaments) which are based on Syariah (Islamic law) are being studied by the Ministry of Interior/Ministry of Law & Human Rights and will be amended if found to contradict the Constitution.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies: *The Law on Narcotics still does not completely support harm reduction.* *Several local government bylaws on the closure of commercial sex localization areas interfere with efforts to control sexually transmitted diseases and condom promotion.*

Overall, how would you rate the *political support* for the HIV programmes in 2009?										
2009	Very Poor									Excellent
	0	1	2	3	4	5	6	**7 √**	8	9	10

Since 2007, what have been key achievements in this area:

1. *The establishment of the National Planning Forum for HIV/AIDS by the National Planning Board.*
2. *Several local governments have issued bylaws on HIV/AIDS prevention & control*
3. *Regulation No.2/2007 of the Coordinating Minister for People's Welfare on Harm Reduction*
4. *Regulation No. 20/2007 of the Minister of Home Affairs on the Formation of Local AIDS Commissions and the Empowerment of Communities for HIV Prevention and Control*
5. *Speech of the President at the Opening of ICAAP9 in Bali on August 2009*

What are remaining challenges in this area:

The challenge is to put the good policies into practice by strengthening the capacity of AIDS Commissions at national, provincial and district/city levels and the community/civil society

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes **√**	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?
√ Check for key message explicitly promoted

a. Be sexually abstinent	**√**
b. Delay sexual debut	**√**
c. Be faithful	**√**
d. Reduce the number of sexual partners	**√**
e. Use condoms consistently	**√**
f. Engage in safe(r) sex	**√**
g. Avoid commercial sex	**√**
h. Abstain from injecting drugs	**√**
i. Use clean needles and syringes	**√**

j. Fight against violence against women	√
k.Greater acceptance and involvement of people living with HIV	√
l. Greater involvement of men in reproductive health programmes	√
m. Males to get circumcised under medical supervision	√
n. Know your HIV status	√
o. Prevent mother-to-child transmission of HIV	√
Other: support for PLHIV *[write in]*	√

In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes √	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes √	No	N/A

2.1 Is HIV education part of the curriculum in:

primary schools?	Yes	No √
secondary schools?	Yes √	No
teacher training?	Yes √	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes √	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes √	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for *most-at-risk or other vulnerable sub-populations*?

Yes √	No

IF NO, briefly explain:

3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?

√ Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM **	Sex Workers	Clients of sex workers	Prison inmates	Other populations* *Migrant workers*
Targeted information on risk reduction and HIV education	√	√	√	√	√	√
Stigma & discrimination reduction	√	√	√	√	√	√
Condom promotion	√	√	√	√	√	√
HIV testing & counselling	√	√	√	√	√	√
Reproductive health, including STI prevention & treatment	√	√	√	√	√	√
Vulnerability reduction (e.g.income generation)	N/A	N/A	√	N/A	N/A	
Drug substitution therapy	√	N/A	N/A	N/A	√	
Needle and syringe exchange	√	N/A	N/A	N/A	N/A	

Overall, how would you rate *policy efforts* in support of HIV prevention in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 **8 √** 9 10

Since 2007, what have been key achievements in this area:

- *The adoption of harm reduction as national policy*
- *The Circular of the Supreme Court stating that drug users/addicts should be rehabilitated rather than put in jail (the limited number of rehabilitation centres, however, is an obstacle)*
- *Guidelines on community based addiction treatment usede in pilot projects*
- *New guidelines on prevention of sexual transmission put into practice in commercial sex localization areas in 12 cities*

What are remaining challenges in this area:

To put the policies and guidelines into practice still requires a lot of efforts: socialization of the policies, better coordination, formulation of,operational & technical guidelines

4. Has the country identified specific needs for HIV prevention programmes?

Yes √	No

IF YES, how were these specific needs determined?

Specific needs are determined after a careful analysis of existing data / situational analysis, policy analysis and cost analysis

IF NO, how are HIV prevention programmes being scaled-up?:

* IDU = Injecting Drug Users

** MSM = men who have sex with men

4.1. To what extent has HIV prevention been implemented?

HIV prevention components	The majority of people in need have access		
Blood safety	Agree **√**	Don't agree	N/A
Universal precautions in health care settings	Agree **√**	Don't agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't agree **√**	N/A
IEC* on risk reduction	Agree **√**	Don't agree	N/A
IEC* on stigma and discrimination reduction	Agree **√**	Don't agree	N/A
Condom promotion	Agree **√**	Don't agree	N/A
HIV testing & counseling	Agree	Don't agree **√**	N/A
Harm reduction for injecting drugs users	Agree **√**	Don't agree	N/A
Risk reduction for men who have sex with men	Agree	Don't agree **√**	N/A
Risk reduction for sex workers	Agree **√**	Don't agree	N/A
Reproductive health services including STI prevention & treatment	Agree **√**	Don't agree	N/A
School-based HIV education for young people	Agree	Don't agree **√**	N/A
HIV prevention for out-of-school young people	Agree	Don't agree **√**	N/A
HIV prevention in the workplace	Agree	Don't agree **√**	N/A
Other [*write in*] - HIV Prevention in National Army - HIV Prevention in Police Republic of Indonesia	Agree **√**	Don't agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?											
2009 Very Poor											Excellent
	0	1	2	3	4	5	6	**7 √**	8	9	10
Since 2007, what have been key achievements in this area: *Increased coverage pf HR for IDUs* *Incraesed coverage of services for female sex workers* What are remaining challenges in this area: *The limited coverage of PMTCT and services for MSM*											

* IEC = information, education, communication

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but it is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

Yes **√**	No

1.1 ***IF YES***, does it address barriers for women?

Yes **√**	No

1.2 *IF YES*, does it address barriers for most- at-risk populations?

Yes **√**	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes **√**	No

IF YES, how were these determined?

Based on the standards of care/recommendations of of the Technical Working Group on CST

IF NO, how are HIV treatment, care and support services being scaled up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support services	The majority of people in need have acces		
Antiretroviral theraphy	Agree **√**	Don't Agree	N/A
Nutritional care	Agree	Don't Agree **√**	N/A
Paediatric AIDS treatment	Agree	Don't Agree **√**	N/A
Sexually transmitted infection management	Agree	Don't Agree **√**	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree **√**	N/A
Home-based care	Agree	Don't Agree **√**	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree **√**	N/A
HIV testing and counseling for TB patients	Agree **√**	Don't Agree	N/A
TB screening for HIV-infected people	Agree **√**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree **√**	Don't Agree	N/A

TB infection control in HIV treatment and care facilities	Agree **√**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV infected people	Agree **√**	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree **√**	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree **√**	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree **√**	N/A
Other: *[write in]*			

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes **√**	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes **√**	No

4.1 ***IF YES***, for which commodities?: *[write in]*

ARV, condoms and substitution drugs

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?										
2009 Very Poor										Excellent
0	1	2	3	4	5	6	**7 √**	8	9	10

Since 2007, what have been key achievements in this area:

The increase in hospitals and health centres capable of providing VCT, CST, ART

What are remaining challenges in this area:

- *Limitation in the coverage of health insurance for the poor*
- *Improvement of logistic management of ARV*

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children (OVC)?

Yes **√**	No	N/A

5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children (OVC) in the country?

Yes **√**	No

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes **√**	No

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes	No **√**

IF YES, what percentage of OVC is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
2009 Very Poor										Excellent
0	1	2	3	**4 √**	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- *The existence of a National Strategy for Children and Youth*
- *Mitigation of the impact of HIV/AIDS on OVC has been included in the National Strategic Action Plan 2010-2014*

What are remaining challenges in this area:

To collect better data on OVC

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes **√**	In progress	No

IF NO, briefly describe the challenges:

1.1 IF YES, years covered? Since 2005
[write in]

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes **√**	No

1.3. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes **√**	No

1.4. ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners **√**	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes **√**	No
IF YES, does it address:		
routine programme monitoring	Yes **√**	No
behavioural surveys	Yes **√**	No
HIV surveillance	Yes **√**	No
Evaluation / research studies	Yes **√**	No
a well-defined standardized set of indicators	Yes **√**	No
guidelines on tools for data collection	Yes **√**	No
a strategy for assessing data (i.e., validity, reliability)	Yes **√**	No
a data analysis strategy	Yes **√**	No
a data dissemination and use strategy	Yes **√**	No

3. Is there a budget for implementation of the M&E plan?

Yes **√**	In progress	No

3.1 ***IF YES,*** what percentage of the total HIV programme funding is budgeted for M&E activities? *10%* *[write in]*

3.2. ***IF YES***, has full funding been secured?

Yes **√**	No

IF NO, briefly describe the challenges:

3.3. ***IF YES,*** are M&E expenditures being monitored?

Yes **√**	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes **√**	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves: *Once a year. It involves data management, capacity building, reporting mechanisms and the national strategy*

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes **√**	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit?

5.1 ***IF YES***, is the M&E Unit based

In the NAC (or equivalent)?	Yes **√**	No
In the Ministry of Health?	Yes **√**	No
Elsewhere? [*write in*] *Others sector*	Yes **√**	No

5.2 ***IF YES***, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position: [write in] Coordinator	**Full time**	Since **2006**
Technical assistant (sectoral activities)	**Full time**	Since **2006**
[Add as many as needed]		
Technical assistant (provincial/district activities)	**Full time**	Since **2007**
Technical assistant (Global fund activities)]	**Full time**	Since **2008**
Technical assistant (report writing)	**Full time**	Since **2008**

4.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes **√**	No

IF YES, briefly describe the data sharing mechanisms:
District/city AIDS Commissions report monthly to Provincial AIDS Commissions(with a copy to NAC).
Sectoral M&E units sent quarterly reports to NAC.
NAC Secreatary reports quarterly to Coordinating Minister for People's Welfare/Chair of NAC (copies to all members of NAC) Chair of NAC reports semi-annually to the President (copies to all members of NAC). Routine M&E Working group is also scheduled minimum o 4 times a year. This become mechanism of data sharing and discussion on M&E related issues.

What are the major challenges?

- *Limited capacity of M&E staff at provincial/district/city levels*
- *Limited utilization of data for improvement of programmes at local level*
- *Limited capacity to provide feedback*

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly **√**

6.1 Does it include representation from civil society?

Yes **√**	No

IF YES, describe who the representatives from civil society are and what their role is: *Representatives from civil society come from the Indoensian Family Planning Association, The Indoensian Red Cross,Spriritia Foundation and Pelita Imu Foundation*

7. Is there a central national database with HIV- related data?

Yes **√**	No

7.1 ***IF YES***, briefly describes the national database and who manages it? *[write in]*

The national data base include the profiles of sectoral AIDS working groups, provincial/district/city AIDS commissions, data from periodic reports from provincial/district/city AIDS commissions.
It is managed by the M&E Unit of the NAC Secretariat

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes **√**	No

7.3 Is there a functional* Health Information System?

At national level	Yes **√**	No
At sub-national level ***IF YES***, at what level(s)? [*write in*] *Provincial/district/city levels*	Yes **√**	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes **√**	No

9. To what extent are M&E data used?

9.1. in developing/revising the national AIDS strategy?:

Low				**High**	
0	1	2	3	**4 √**	5

Provide a specific example: *The coverage data of the different programmes for key populations have been*

used to formulate targets in the National Strategy & Action Plan 2010-2014 and modelling of the epidemic

What are the main challenges, if any?

To improve surveillance and reporting system

9.2. for resource allocation?:

Low				**High**	
0	1	2	**3 √**	4	5

Provide a specific example:

The data on coverage have been used to formulate targets of the National Strategic Action Plan 2010-2014 and calculate the cost to reach the targets

What are the main challenges, if any?

To collect more reliable data for costing

9.3. for programme improvement

Low				**High**	
0	1	2	**3 √**	4	5

Provide a specific example:
Sharing the data with implementers, including fata on the quality of prgrammes

What are the main challenges, if any?
The measurement of effectiviness and quality of prgrammes have to be improved

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:
    a. Yes, at all levels **√**
    b. Yes, but only addressing some levels : *[write in]*
    c. No

10.1 In the last year, was training in M&E conducted

At national level?	Yes **√**	No
IF YES, Number trained: 125		
At sub-national level?	Yes **√**	No
IF YES, Number trained: 390		
At service delivery level including civil society?	Yes **√**	No
IF YES, Number trained: 45		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes **√**	No

IF YES, describe what type of activities: *supervision and mentoring*
[write in]

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009										
2009	Very Poor									Excellent
	0	1	2	3	4	5	6	7	**8 √**	9	10

Since 2007, what have been key achievements in this area:

- *Ability to measure coverage and effectiveness of programmes*
- *The data have been utilized for planning and programme improvement*
- *The data have been used for advocacy to stakeholders: sectors, local governments and parliaments*

What are remaining challenges in this area:

To have better data on effectiveness and impacts of programmes through better second generation surveillance

Part B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.).

Yes	No **√**

1.1 ***IF YES***, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision: [*write in*]

Comment: *Participants have different response to this question. Some said the Human Rights Law is already meeting the needs. Some thought the question is asking whether it is Law or specific regulation. Final answer is: No.*

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk population and other vulnerable sub-populations?

Yes **√**	No

2.1 ***IF YES***, for which sub-populations?

a. Women	Yes **√**	No
b. Young people	Yes **√**	No
c. IDU	Yes **√**	No
d.MSM	Yes **√**	No
e. Sex Workers	Yes	No **√**
f. Prison inmates	Yes **√**	No
g. Migrants/mobile populations	Yes	No **√**
h. Other: [write in]	Yes	No**√**

Note: The above answer is based on discussion. Representative from civil society thought that there will be some policies that they do not know or do not understand the content. It shows importance of disseminating policies published by government.

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:

Regular Report from the government once every four years on the implementation status of item A through Ministry of Women Empowerment.

Briefly describe the content of these laws:
- *Domestic Violation Law.*
- *Narcotics Law.*

Note: Answer was given by asking some participants without explaining the las in detail.

Briefly comment on the degree to which they are currently implemented:

Narcotics Law No 22/1997 and then revised into Law No 35 / 2009 has provided explanation related to rehabilitation service for drugs users and narcotics addict. Until now, implementation of the law is not smooth due to the absence of Ministry Regulation as technical guideline.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk population and other vulnerable sub-populations?

Yes √	No

3.1 ***IF YES***, for which sub-populations?

a. Women	Yes √	No
b. Young people	Yes √	No
c. IDU	Yes √	No
d. MSM	Yes √	No
e. Sex Workers	Yes √	No
f. Prison inmates	Yes √	No
g. Migrants/mobile populations	Yes	No √
h. Other: [write in] Child Protection	Yes √	No

IF YES, briefly describe the content of these laws, regulations or policies:

- *Injecting drugs users: the new Narcotics Law is still a threat especially about the obligation to report. This implies to families providing support on HIV and AIDS prevention and control.*
- *MSM: article 4 para 1, "uncommon intercourse is homosexual and lesbi" Law No 44 year 2009 about Pornography. The article states that*

homosexual intercourse is something uncommon and breaking the rule. This implies to prevention effort.

- *People disseminating the information will be treated as people breaking the Pornography Law. This implies information dissemination for women, youth, MSM, sex workers (Article 1 Para 1).*
- *Youth: a regulation states that sex education is only for those who are married.*
- *Prisoners: difficulty in accessing condom and sterile needle and syringe for prisoners in prison.*

Briefly describe on how they pose barriers:

Civil society request for cancellation of implementation of local regulation on prostitution but the final decision will be made by the Supreme Court. .
There will be material testing to other law products for the cancellation of the regulations

Note: *Comprehensive and thorough review is necessary to be done to existing laws and regulations. The need is at national level (nationally bind Law or Regulation) and local regulation as well.*
Some reviews have been made but not in the context of synchronizing the Law with specific regulation, or regulation at local level.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes **√**	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The National Strategy 2007 – 2010 has not explicitly mentioned human rights protection for key populations and stakeholders taking participation in the AIDS Prevention and Control Program.

Note:
The National Strategy 2010-2014 draft accommodates this.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulation?

Yes	No **√**

IF YES, briefly describe this mechanism:

6. Has the Government, through political and financial support, involved people living with HIV, most at-risk populations and/or other vulnerable subpopulation in governmental HIV-policy design and programme implementation?

Yes **√**	No

IF YES, briefly describe some examples

Civil society is invited to take participation but only for formal purpose. More involvement is still far behind compare to what civil society is expecting.

Meaningful involvement is only at the last stage of policy development process, just asking for approval to the document drafted by the government.

In the future, NAC is expected to develop a mechanism for more meaningful involvement of civil society in terms of policy development and they also have chance to share their aspirations more significant.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes **√**	No
b. Anti-retroviral treatment	Yes **√**	No
c. HIV-related care and support interventions	Yes **√**	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

1. *Methadone is available but sometimes they have to pay for several related services. Needle and syringe for HR program is available for free. Condom stock is limited. In some places, people sell condom in order to make them more independent (item A).*
2. *ARV service facility provides free ARV. But it charges administration fee, and doctor fee. In several places and at certain time, ARV is not available.*
3. *Care and support intervention related to HIV is not provided for free, except in Papua.*

Support is still limited through community health insurance (jamkesmas), and local health insurance (jamkesda) and not accessible to all key populations. Service treatment is different when a patient uses his or her own money.

Note:
Outreach as one of HIV prevention activities is still fully funded by donor. Needle and condom are distributed for free.
ARV drugs is available for free. But for other supportive examinations, people

should pay (example: doctor consultation fee, CD4 test fee, lab fee: SGOT, SGPT, etc). Other HIV treatment fee is not free. *Health insurance is only for few people. This facility is accessible when there is support from AIDS NGO staff to help.*

8. Does the country have a policy to ensure equal access for women and men, to HIV prevention, treatment, care and support, for women outside the context of pregnancy and childbirth?

Yes	No **√**

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No **√**

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulation to HIV prevention, treatment, care and support?

Yes	No **√**

IF YES, briefly describe the content of this policy:

9.1 ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	No **√**

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes **√**	No

*)– This become internal department policy.

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes **√**	No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	No**√**

Note: *Policy does not state clearly the standard for AIDS research protocol. But it considers covering AIDS research*

IF YES, describe the approach and effectiveness of this review committee:
.
Ethical commission is identified from existing MOH regulation. In the implementation, no specific research that has undergone ethical review if it is related to PLHIV with all confidential issues around.

Note: Policy no 11 is not yet available for AIDS research protocol. MOH has protocol for research will be conducted within MOH environment.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No **√**

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	No **√**

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No **√**

IF YES, on any of the above questions, describe some examples:

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes	No **√**

14. Are the following legal support services available in the country?

– Legal aid systems for HIV casework

Yes **√**	No

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No **√**

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	No **√**

Note: *The program being managed by Spiritia; support from HIVOS*

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes **√**	No

IF YES, what types of programmes?

Media	Yes **√**	No
School education	Yes **√**	No
Personalities regularly speaking out	Yes **√**	No
Other: *[write in]*	Yes	No **√**

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009?											
2009	Very Poor										Excellent
	0	1	2	3	4 **√**	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

The products were:

- *HIV and AIDS Prevention and Control National Strategy 2007-2010*
- *Ministry of Home Affairs Regulatin No 20 year 2007*
- *Law No 11 year 2009 on Social Welfare Insurance (clearly mention PLHIV)*
    - *Regulation of Coordinating Ministry of People's Welfare Permenkokesra on Harm Reduction*
    - *National Strategy for Children and Youth*
    - *National Strategy for Women*

What are remaining challenges in this area:

- *Some policies are formalized (strongly believed it will be able to support national response on HIV and AIDS prevention) but it has not been understood well by those who need it. For example, Permenkokesra on Harm Reduction (2006), Minister of Health Decree on HR (2006) were not understood and supported by police and several local institutions response the same.*
- *The policy seems not to be used for sectoral plan development.*
- *Existing national policies do not have strong support from key sectors (example: Police, local government in response to HR program or National Strategy) therefore policy implementation is still weak.*

Overall, how would you rate the *efforts to enforce* the existing policies, laws and regulations in 2009?											
2009	Very Poor										Excellent
	0	1	2	3 **√**	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

In the last 2 years NAC has been actively approaching other sectors or institutions such as Indonesian Police or POLRI and Ministry of Law and Human Rights.

What are remaining challenges in this area:

Policies supporting national HIV and AIDS program has not yet socialized well either for related government institutions or civil society. No mechanism exist on how to disseminate and ensure every body is implementing it. For example: those who should support the implementation of HR program in the field do not know or understand the program, MoH decree on HR implementation is not well understood by different institutions at national or local level.

II. CIVIL SOCIETY[17] PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulation?

Low				High	
0	1	2	3	4 √	5

Comments and examples:
Intensive involvement of civil society is happened recently, specifically involvement of representatives from key population in NAC working groups.
In the future, civil society involvement is earlier in the process of developing policy. There should be enough time to ask their meaningful involvement, with systematic and well planned and supported by the government. There is also the need for maintaining and optimizing their role as well as capacity building.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low				High	
0	1 √	2	3	4	5

Comments and examples:
In budgeting the program, very limited involvement of civil society. Only ceremonial things they are invited, for example during policy socialization.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:
   a. the National AIDS Strategy ?

Low				High	
0	1	2	3 √	4	5

   b. in the national AIDS budget?

Low				High	
0 √	1	2	3	4	5

   c. National AIDS reports?

Low				High	
0	1	2	3	4 √	5

[17] Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Comments and examples:

National Strategy shown great need of fund for prevention but until now the fund for this is coming from donor (example: outreach and personal buddies).

When a donor funded project stop, NGOs do not get support on how to continue their contribution to the country since no fund allocated for them and or a mechanism developed for them to be able to access government fund.

Activities executed by civil society are only counted for national reports. Most of coverage data (outreach data) are from their work.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

   a. developing the national M&E plan?

Low				High	
0	1 √	2	3	4	5

   b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low				High	
0	1	2 √	3	4	5

   c. M&E efforts at local level?

Low				High	
0	1 √	2	3	4	5

Comments and examples:

Civil society involvement in M&E related activities is improved for the last 2 years although it is still symbolic.

Its involvement will be more significant if they have opportunity to improve their capacity in M&E. Hopefully, they are able to give meaningful contribution in the future.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organization (e.g., networks of PLWHIV, organization of sex workers, faith-based organization)?

Low				High	
0	1	2	3 √	4	5

Comments and examples:

Representatives from the national network of key populations at National AIDS Commission. In Indonesia, there are several key population networks (sex worker, women, gay, transgender, MSM, drugs users) and PLHIV network.

Currently looks like a distinction between key population network and NGO. This situation will lead to weaken the current response. NGO representatives as main contributor in prevention activities should receive full support so that their inputs and concerns are fully considered. In order to maintain program coverage and quality it is important to sponsor NGO involvement in program being implemented.

6. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities?

Low					High
0	**1**	**2**	**3 √**	**4**	**5**

b. adequate technical support to implement its HIV activities?

Low					High
0	**1**	**2**	**3 √**	**4**	**5**

Comments and examples:

Inequal access, unclear structure of support for organizations and key population network.

For activities funded by donor, civil society has access to it. It should be inserted in the national strategy on estimating program sustainability that have already started by the NGOs. Mainly for funding support issues. Whenever there is no plan for sustainability so resources that have already invested will not be useful anymore and will become waste.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for Youth	**< 25%**	25 – 50%	51 – 75%	> 75%
Prevention for most-at-risk-population				
- Injecting drud users	< 25%	25 – 50%	51 – 75%	**> 75%**
- Men who have sex with men	< 25%	25 – 50%	51 – 75%	**> 75%**
- Sex workers	< 25%	25 – 50%	**51 – 75%**	> 75%
Testing and Counselling	< 25%	**25 – 50%**	51 – 75%	> 75%
Reduction of Stigma and Discrimination	< 25%	**25 – 50%**	51 – 75%	> 75%
Clinical services (ART/OI)*	**< 25%**	25 – 50%	51 – 75%	> 75%
Home-based care	**< 25%**	25 – 50%	51 – 75%	> 75%
Programmes for OVC**	**< 25%**	25 – 50%	51 – 75%	> 75%

Overall, how would you rate the efforts *to increase civil society participation* in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 **√** 6 7 8 9 10

Since 2007, what have been key achievements in this area:

The intention for taking civil society to be actively involved in the national response is by creating the key populations networks, it was all led by NAC. Many of the networks become member of the NAC working groups (such as Research Working Group, HR Working Group, Sexual Transmission Working Group, Prison Working Group, PMTCT Working Group, etc.).

Other type of involvement that is considered as NAC success is the establishment of UNGASS Forum Indonesia. The new forum is coordinating all inputs from all civil society in the process of UNGASS report development, under NAC coordination.

What are remaining challenges in this area:

- *Participants felt that government is still reluctant to ask more involvement of the civil society.*
- *Civil society capacity in field experience and technical horizon become the biggest challenge. They need full back up from the government to optimize their role and contribution.*

* *ART = Antiretroviral Therapy; OI = Opportunistic Infection*
** *OVC = Orphans and other vulnerable children*

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes √	No

IF YES, how were these specific needs determined?

- *Indonesia has National Action Plan, it covers all national players in HIV and AIDS response. The government institutions are mentioned to have role but there is no target stipulated for each sector, therefore, it is difficult to measure progress of response from each of them. This situation does not happen to targets of key population to be reached or received interventions.*

- *Civil society has been asked to et involve in the process of identification of needs and targets. But it was only few people from civil society and no socialization to community regarding the whole process. This resulted in limited participation of them. In the future, there will be more transparent procedure. Beginning from initial phase of the process, then socialization to mass community, and collection of feedback adequately. Final decision should be known by public and let the public give their own assessment to this.*

- *Prevention policy seems protect only few people and it has not been socialized well. It requires commitment of decision makers and other parties to ensure all policy elements are available and support prevention activities and well function.*

IF NO, how are HIV prevention programmes being scaled-up?:

1.1. To what extent has HIV prevention been implemented?

HIV prevention components	**The majority of people in need have access**		
Blood safety	Agree √	Don't agree	N/A
Universal precautions in health care settings	Agree	Don't agree √	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't agree √	N/A
IEC* in risk reduction	Agree √	Don't agree	N/A
IEC* on stigma and discrimination reduction	Agree √	Don't agree	N/A
Condom promotion	Agree	Don't agree √	N/A

* IEC = information, education, communication

HIV testing & counseling	Agree **√**	Don't agree	N/A
Harm reduction for injecting drugs users	Agree **√**	Don't agree	N/A
Risk reduction for men who have sex with men	Agree	Don't agree **√**	N/A
Risk reduction for sex workers	Agree	Don't agree **√**	N/A
Reproductive health services including STI prevention & treatment	Agree	Don't agree **√**	N/A
School-based HIV education for young people	Agree	Don't agree **√**	N/A
HIV Prevention for out-of-school young people	Agree	Don't agree **√**	N/A
HIV prevention in the workplace	Agree	Don't agree **√**	N/A
Other: *[write in]* *Prison*	Agree **√**	Don't agree	N/A

Overall, how would you rate the efforts in *the implementation* of HIV prevention programmes in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5 **√**	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- *Blood safety, there are more blood transfusion unit or UTD performing blood screening. But it has big concern on the quality and its routine implementation, need to consider logistic issues (example shortage in reagent for blood testing).*
- *Most of people understand Universal Precaution but still weak in the implementation.*
- *PMTCT, since 2007 there was an effort to expand the program. but until now very few centers providing PMTCT service. Interpretation, needs, and PMTCT strategy only known by very few people from civil society to be promoted to PLHIV.*
- *IEC materials have reached wider scope, however its quality is still need to be improved. The current materials only cover regions with outreach program.*
- *There seems an increase of civil society institution taking active role in prevention program within sexual transmission subject, particularly targeted toward MSM. Meanwhile, prevention program with FSW as targeted population has improved its treatment quality and prevention effort. It has implemented in several regions.*
- *There has been various programs regarding condom promotion which mainly organized and conducted by NGO. Leadership from government component is required to provide real support toward whatsoever effort in inciting greater effect. Government with its greater authority is expected to follow up any knowledge gained from program implementation to subsequently achieve greater result.*
- *Harm Reduction Program shows highest accomplishment through IBBS and intervention program in the last 2 years. Planned scaling up program is fulfilled by the hard work of the civil society institution through outreach program. However, a challenge has emerged regarding the program continuity since foreign funding support to one of the program is soon to be over.*
- *In the last few years, the number of methadone maintenance therapy sites has been rapidly increased, including the development of several service points within*

prison and detention center. A resolution toward better methadone service quality is of the utmost important. Subsequent methadone related service shall acquire serious attention to improve the effectiveness of the given therapy (e.g.: need of quality HIV related service, addiction counseling service, life skill training etc.)

- *Prevention effort toward general population is reported to have been initiated. One of them is the school-based program. It has to be made sure that prevention effort in forms of education toward general population must cover the most of youth population.*

What are remaining challenges in this area:

- *It is important to ensure that Harm Reduction program plans and continuity shall be wisely maintained to preserve the current outreach and quality without which will decrease. Two major policies (KepMenkes and Permenko) must be socialized across the regions to be well implemented by HR worker. Protection and security guarantee for service provider and user shall be put at first priority. Drug treatment component must be developed concerning the limited type and number of service.*
- *For sexual transmission prevention, the greatest challenge is creating conducive climate to promote condom use. Government institution component is expected to take charge in overcoming such technical challenges. For instance in how to make 100% commitment of condom use in certain location, it will need support and direction from local government, Province/Regency/City AIDS Commission, Tourism Office, Social Office, Health Office and Police department.*
- *In the meantime, program implementation can only be carried out across targeted program areas of the foreign support funding. Outside which, it seems that we cannot do anything about it though in fact, there are many exclusive areas with high risk status. Therefore, it is expected that a pecific strategy will be produced to accommodate this particular situation.*
- *In terms of policy, there are two great challenges incessantly impeding the sake of the programs: First, commitment at national level has not been followed up by the perpetrator at local level. This is proven by many local statutes that are in fact contradictory against national commitment. Second, commitment drawn by National AIDS Commission as coordinative institution is not followed by similar commitment from the technical units.*
- *Currently, Indonesia receives fund and this increases allocation of fund for AIDS programs. However, it is incomprehensible whether or not the fund usage has met its priority point. For instance: whether or not prevention component actually receives bigger allocation in regards to the field requirements. Transparence toward AIDS program funding is hence highly required. By the increase of the fund absorbed in the AIDS program, the accountability of the fund usage and program maintenance becomes the main importance for civil society to pay attention to as one of society control mechanism.*
- *In regards to the program sustainability, a careful overview is imperative to figure out what committment will the local government be performed in preserving the existing programs.*

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes √	No

IF YES, how were these specific needs determined?

Care, Supprt and Treatment needs were identified. CST service is easier to observe but more technical issues involved. The weakness found on CST service is more to technical issues. In terms of prevention, the weaknesses are in fundamental issues such as policy and its implementation.

IF NO, how are HIV treatment, care and support services being scaled-up?:

1.1. To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support services	**The majority of people in need have access**		
Antiretroviral therapy	Agree √	Don't agree	N/A
Nutritional care	Agree	Don't agree √	N/A
Paediatric AIDS treatment	Agree	Don't agree √	N/A
Sexually transmitted infection management	Agree	Don't agree √	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't agree √	N/A
Home-based care	Agree	Don't agree √	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't agree √	N/A
HIV testing and counseling for TB patients	Agree	Don't agree √	N/A
TB screening for HIV-infected people	Agree	Don't agree √	N/A
TB preventive therapy for HIV-infected people	Agree	Don't agree √	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't agree √	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree √	Don't agree	N/A
Post-exposure prophylaxis	Agree	Don't agree √	N/A

(e.g. occupational exposures to HIV, rape)			
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't agree **√**	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't agree **√**	N/A
Other programmes: *[write in]*	Agree	Don't agree	N/A

Overall, how would you rate the efforts *in the implementation* of HIV treatment, care and support programmes in 2009?										
2009 Very Poor										Excellent
0	1	2	3	4	5	6 **√**	7	8	9	10

Since 2007, what have been key achievements in this area:

Growing number of referral hospitals for providing CST service throughout Indonesia, inclusing VCT and referral hospital for ARV.
In addition, it is known that there is an improved commitment from local stakeholders by provision of funding support originated from local budget in some districts/cities for buying ARV.

What are remaining challenges in this area:
More VCT sites, more trained counselors, and VCT mobile service is initiated. Result shown that there is an improved number of participants attending VCT service. Tone concern is about quality of counseling, for effective practice there should be adequate coordination between VCT service providers and civil society organizations for outreach activity.

Continuous ARV provision is still a big challenge. Monitoring of quality of ARV distribution and service has become a challenge too. There were some expired ARVs found to be distributed to patients. In the future, there is a reliable and transparent mechanism so that civil society could help monitoring the running of it.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children (OVC)?

Yes **√**	No	N/A

2.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	No **√**

2.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes	No **√**

2.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes	No **√**

IF YES, what percentage of OVC is being reached? % *[write in]*

Overall, how would you rate the efforts *to meet the HIV-related needs* of orphans and other vulnerable children in 2009?										
2009 Very Poor										Excellent
0	1 **√**	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Ministry of Social Affairs has social impact mitigation program by distributing nutrition packages and financial support for orphans, program coverage is very limited.

What are remaining challenges in this area:

Strong stigma and discrimination have made parents having HIV positive child (ren) feel shame accessing this support. Until now, mechanism for reporting child (ren) living with HIV and benefit of reporting is unclear.

Further notes, it is possible to collect data on children living with HIV and how their condition are by collaborating with civil society and coordinated and led by government institution. Program recipients have to know benefits of taking this program. There is a need for evaluation on activities conducted at first stage. Program effectiveness is also important in order to find solutions to problems being faced.

Annex 2: National AIDS Spending Assessment (NASA) Matrix

Cover Sheet Indicator No. 1: National Funding Matrix — 2007, 2008 & 2009

Country	**INDONESIA**	
Date of Data Entry	**31-Mar-10**	example: 20/08/2009

1) Which institutions/entities were responsible for filling out the indicator forms?

	NAC or equivalent	(NAC or equivalent, NAP or Others)
If Others, please specify:		

2) Who is the person responsible for submission of the report and for follow-up if there are questions regarding Indicator No. 1?

Name / title:	**Yanti Susanti**
Address:	**National AIDS Commission-Menara Eksekutif Floor 9, Jl. MH Thamrin Kav 9, Central Jakarta**
Email:	**yanti.susanti@aidsindonesia.or.id**
Telephone:	**62 21 390 1758**

3) Name of Local Currency:	**Indonesian Rupiah**	
4) Amounts reported in:	**2007:** **US Dollars**	(Local Currency or US Dollars)
	2008: **US Dollars**	(Local Currency or US Dollars)
	2009:	(Local Currency or US Dollars)
5) Amounts expresed in:	**2007:** **Units (x 1)**	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2008: **Units (x 1)**	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2009: **Units (x 1)**	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))

6) Average exchange rate with US dollars during the reporting cycle:

2007:	**10000.00**	Local Currency per 1 US Dollar
2008:	**10000.00**	Local Currency per 1 US Dollar
2009:		Local Currency per 1 US Dollar

7) Reporting cycle:	**2007:** Calendar Year	(Calendar Year or Fiscal Year)
	2008: Calendar Year	(Calendar Year or Fiscal Year)
	2009:	(Calendar Year or Fiscal Year)

8) Please indicate month and year (M/YYYY) of reporting cycle:

2007	Month	Year
From:	1	2007
To:	12	2007

2008	Month	Year
From:	1	2008
To:	12	2008

2009	Month	Year
From:		
To:		

9) Methodology used:

2007:	National AIDS Spending Assessment (NASA)	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2008:	National AIDS Spending Assessment (NASA)	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2009:		(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)

10) Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

11) Budget Support: Is general budget support from an international source reported under Public Sources of financing (e.g. a bilateral donor to Ministry of Finance)?

2007:	**No**	(Yes or No)
2008:	**No**	(Yes or No)
2009:		(Yes or No)

Country:		INDONESIA	
Reporting cycle:		Calendar Year	
Data Measurement Tool		National AIDS Spending Assessment (NASA)	
Amounts reported in:		US Dollars	
Please indicate month and year (M/YYYY)	From:	Month: 1	Year: 2007
	To:	12	2007
Name of Local Currency		Indonesian Rupiah	
Currency expressed in:		Units (x 1)	
Average Exchange Rate for the year (local currency to USD)		10000.000	

Financing Sources

2007 AIDS Spending Categories	TOTAL US Dollars	Public Sources						International Sources							Private Sources (optional for UNGASS reporting)			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multi lateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL **US Dollars**	**58,671,397**	**15,413,277**	**13,292,688**	**2,120,589**	**0**	**0**	**0**	**43,258,120**	**33,574,390**	**5,400,331**	**3,656,642**	**623,128**	**0**	**3,628**	**0**	**0**	**0**	**0**
1. Prevention (sub-total)	**24,369,081**	**2,940,759**	**2,508,890**	**431,869**	**0**	**0**	**0**	**21,428,322**	**17,956,865**	**2,738,283**	**709,718**	**23,234**	**0**	**221**	**0**	**0**	**0**	**0**
1.01 Communication for social and behavioural change	531,609	531,609	381,992	149,617				0							0			
1.02 Community mobilization	23,228	23,228		23,228				0							0			
1.03 Voluntary counselling and testing (VCT)	8,397	8,397		8,397				0							0			
1.04 Risk-reduction for vulnerable and accessible populations	0	0						0							0			
1.05. Prevention - Youth in school	65,597	65,597	4,894	60,703				0							0			
1.06 Prevention - Youth out-of-school	12,442	12,442		12,442				0							0			
1.07 Prevention of HIV transmission aimed at people living with HIV	7,963	7,963	7,883	80				0							0			
1.08 Prevention programmes for sex workers and their clients	0	0						0							0			
1.09 Programmes for men who have sex with men	0	0						0							0			
1.10 Harm-reduction programmes for injecting drug users	1,960,891	1,960,891	1,892,767	68,124				0							0			
1.11 Prevention programmes in the workplace	135,800	135,800	86,937	48,863				0							0			
1.12 Condom social marketing	0	0						0							0			
1.13 Public and commercial sector male condom provision	136,331	136,331	129,123	7,207				0							0			
1.14 Public and commercial sector female condom provision	0	0						0							0			
1.15 Microbicides	0	0						0							0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	23,210	23,210		23,210				0							0			
1.17 Prevention of mother-to-child transmission	16,899	16,899		16,899				0							0			
1.18 Male Circumsicion	5,294	5,294	5,294					0							0			
1.19 Blood safety	0	0						0							0			
1.20 Safe medical injections	0	0						0							0			
1.21 Universal precautions	0	0						0							0			
1.22 Post-exposure prophylaxis	0	0						0							0			
1.98 Prevention activities not disaggregated by intervention	0	0						0							0			
1.99 Prevention activities not elsewhere classified	13,100	13,100		13,100				0							0			
2. Care and Treatment (sub-total)	**9,269,525**	**782,071**	**83,362**	**698,709**	**0**	**0**	**0**	**8,487,454**	**5,133,402**	**398,739**	**2,946,924**	**8,363**	**0**	**25**	**0**	**0**	**0**	**0**
2.01 Outpatient care	782,071	782,071	**83,362**	**698,709**	**0**	**0**	**0**	0	**0**	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**
2.01.01 Provider- initiated testing and counselling	0	0						0							0			
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0						0							0			
2.01.03 Antiretroviral therapy	83,362	83,362	83,362					0							0			
2.01.04 Nutritional support associated to ARV therapy	1,048	1,048		1,048				0							0			
2.01.05 Specific HIV-related laboratory monitoring	0	0						0							0			
2.01.06 Dental programmes for PLHIV	0	0						0							0			
2.01.07 Psychological treatment and support services	0	0						0							0			
2.01.08 Outpatient palliative care	0	0						0							0			
2.01.09 Home-based care	0	0						0							0			
2.01.10 Traditional medicine and informal care and treatment services	0	0						0							0			
2.01.98 Outpatient care services not disaggregated by intervention	0	0						0							0			
2.01.99 Outpatient Care services not elsewhere classified	14,656	14,656		14,656				0							0			
2.02 In-patient care	0	0	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)	0	0						0							0			
2.02.02 Inpatient palliative care	0	0						0							0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0			
2.02.99 In-patient services not elsewhere classified	0	0						0							0			
2.03 Patient transport and emergency rescue	0	0						0							0			
2.98 Care and treatment services not disaggregated by intervention	0	0						0							0			
2.99 Care and treatment services not-elsewhere classified	0	0						0							0			

3. Orphans and Vulnerable Children (sub-total)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3.01 OVC Education	0	0						0							0			
3.02 OVC Basic health care	0	0						0							0			
3.03 OVC Family/home support	0	0						0							0			
3.04 OVC Community support	0	0						0							0			
3.05 OVC Social services and Administrative costs	0	0						0							0			
3.06 OVC Institutional Care	0	0						0							0			
3.98 OVC services not disaggregated by intervention	0	0						0							0			
3.99 OVC services not-elsewhere classified	0	0						0							0			
4. Program Management and Administration Strengthening (sub-total)	**20,191,409**	**10,693,258**	**10,126,113**	**567,144**	**0**	**0**	**0**	**9,498,151**	**8,009,008**	**1,355,888**	**0**	**129,957**	**0**	**3,298**	**0**	**0**	**0**	**0**
4.01 Planning, coordination and programme management	30,437	30,437		30,437				0							0			
4.02 Administration and transaction costs associated with managing and disbursing funds	16,697	16,697		16,697				0							0			
4.03 Monitoring and evaluation	55,772	55,772	28,710	27,061				0							0			
4.04 Operations research	0	0						0							0			
4.05 Serological-surveillance (Serosurveillance)	199,852	199,852	116,794	83,059				0							0			
4.06 HIV drug-resistance surveillance	0	0						0							0			
4.07 Drug supply systems	9,642,354	9,642,354	9,642,354					0							0			
4.08 Information technology	18,310	18,310	7,270	11,041				0							0			
4.09 Patient tracking	0	0						0							0			
4.10 Upgrading and construction of infrastructure	22,532	22,532		22,532				0							0			
4.11 Mandatory HIV testing (not VCT)	0	0						0							0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0						0							0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	707,304	707,304	330,986	376,318				0							0			
5. Human resources (sub-total)	**1,888,791**	**541,652**	**426,030**	**115,623**	**0**	**0**	**0**	**1,347,139**	**1,097,734**	**111,762**	**0**	**137,570**	**0**	**73**	**0**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	154,338	154,338	144,480	9,859				0							0			
5.02 Formative education to build-up an HIV workforce	0	0						0							0			
5.03 Training	368,227	368,227	281,550	86,677				0							0			
5.98 Incentives for Human Resources not specified by kind	0	0						0							0			
5.99 Incentives for Human Resources not elsewhere classified	19,086	19,086		19,086				0							0			
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**206,704**	**36,704**	**0**	**36,704**	**0**	**0**	**0**	**170,000**	**0**	**170,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6.01 Social protection through monetary benefits	0	0						0							0			
6.02 Social protection through in-kind benefits	0	0						0							0			
6.03 Social protection through provision of social services	0	0						0							0			
6.04 HIV-specific income generation projects	0	0						0							0			
6.98 Social protection services and social services not disaggregated by type	31,105	31,105		31,105				0							0			
6.99 Social protection services and social services not elsewhere classified	5,599	5,599		5,599				0							0			
7. Enabling Environment (sub-total)	**2,371,548**	**409,820**	**148,293**	**261,527**	**0**	**0**	**0**	**1,961,727**	**1,358,061**	**595,573**	**0**	**8,082**	**0**	**11**	**0**	**0**	**0**	**0**
7.01 Advocacy	212,784	212,784	98,489	114,294				0							0			
7.02 Human rights programmes	0	0						0							0			
7.03 AIDS-specific institutional development	0	0						0							0			
7.04 AIDS-specific programmes focused on women	49,804	49,804	49,804					0							0			
7.05 Programmes to reduce Gender Based Violence	0	0						0							0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0			
7.99 Enabling Environment and Community Development not elsewhere classified	147,233	147,233		147,233				0							0			
8. Research (sub-total)	**374,341**	**9,013**	**0**	**9,013**	**0**	**0**	**0**	**365,328**	**19,321**	**30,086**	**0**	**315,921**	**0**	**0**	**0**	**0**	**0**	**0**
8.01 Biomedical research	0	0						0							0			
8.02 Clinical research	0	0						0							0			
8.03 Epidemiological research	0	0						0							0			
8.04 Social science research	0	0						0							0			
8.05 Vaccine-related research	0	0						0							0			
8.98 Research not disaggregated by type	0	0						0							0			
8.99 Research not elsewhere classified	9,013	9,013		9,013				0							0			

Country:		INDONESIA	
Reporting cycle:		Calendar Year	
Data Measurement Tool		National AIDS Spending Assessment (NASA)	
Amounts reported in:		US Dollars	
Please indicate month and year (M/YYYY)	From:	Month: 1	Year: 2008
	To:	12	2008
Name of Local Currency		Indonesian Rupiah	
Currency expressed in:		Units (x 1)	
Average Exchange Rate for the year (local currency to USD)		10000.000	

Financing Sources

2008 AIDS Spending Categories	TOTAL US Dollars	Public Sources						International Sources							Private Sources (optional for UNGASS report			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL	**49,563,286**	**19,845,267**	**17,025,873**	**2,819,394**	**0**	**0**	**0**	**29,718,019**	**19,592,558**	**2,241,962**	**5,818,972**	**1,503,788**	**0**	**560,739**	**0**	**0**	**0**	**0**
1. Prevention (sub-total)	**24,703,080**	**9,578,387**	**8,096,620**	**1,481,767**	**0**	**0**	**0**	**15,124,693**	**11,036,787**	**704,313**	**2,488,955**	**333,899**	**0**	**560,739**	**0**	**0**	**0**	**0**
1.01 Communication for social and behavioural change	649,463	337,530	305,184	32,346				311,933	98,147	15,532	193,949	4,305			0			
1.02 Community mobilization	1,457,434	26,939		26,939				1,430,495	817,145		613,350				0			
1.03 Voluntary counselling and testing (VCT)	3,021,205	17,439		17,439				3,003,766	1,759,352	83,078	1,161,336				0			
1.04 Risk-reduction for vulnerable and accessible populations	645,478	58,533	55,272	3,261				586,945	294,000	292,945					0			
1.05. Prevention - Youth in school	592,689	569,016	555,851	13,165				23,673		23,673					0			
1.06 Prevention - Youth out-of-school	216,306	1,087		1,087				215,219		42,119		173,100			0			
1.07 Prevention of HIV transmission aimed at people living with HIV	790,121	102,183	80,907	21,276				687,938	587,938			100,000			0			
1.08 Prevention programmes for sex workers and their clients	1,978,265	102,063		102,063				1,876,202	1,876,202						0			
1.09 Programmes for men who have sex with men	1,300,577	0						1,300,577	1,300,577						0			
1.10 Harm-reduction programmes for injecting drug users	2,362,090	22,171		22,171				2,339,919	2,339,919						0			
1.11 Prevention programmes in the workplace	348,447	28,828	21,734	7,094				319,619	215,000	104,619					0			
1.12 Condom social marketing	169,265	101,702	101,022	680				67,563		802	66,761				0			
1.13 Public and commercial sector male condom provision	8,804	8,804		8,804				0							0			
1.14 Public and commercial sector female condom provision	5,362	5,362	5,362					0							0			
1.15 Microbicides	0	0						0							0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	1,707,570	2,135		2,135				1,705,435	1,360,000	77,522	267,913				0			
1.17 Prevention of mother-to-child transmission	2,598	2,598		2,598				0							0			
1.18 Male Circumsicion	10,543	10,543		10,543				0							0			
1.19 Blood safety	3,909,050	3,723,404	3,723,404					185,646			185,646				0			
1.20 Safe medical injections	0	0						0							0			
1.21 Universal precautions	3,247,884	3,247,884	3,247,884					0							0			
1.22 Post-exposure prophylaxis	0	0						0							0			
1.98 Prevention activities not disaggregated by intervention	0	0						0							0			
1.99 Prevention activities not elsewhere classified	2,279,929	1,210,166		1,210,166				1,069,763	388,507	64,023		56,494		560,739	0			
2. Care and Treatment (sub-total)	**7,324,722**	**5,657,437**	**5,302,334**	**355,103**	**0**	**0**	**0**	**1,667,285**	**1,199,792**	**36,096**	**404,745**	**26,652**	**0**	**0**	**0**	**0**	**0**	**0**
2.01 Outpatient care	7,324,722	5,657,437	**5,302,334**	**355,103**	**0**	**0**	**0**	1,667,285	**1,199,792**	**36,096**	**404,745**	**26,652**	**0**	**0**	0	**0**	**0**	**0**
2.01.01 Provider- initiated testing and counselling	56,933	296		296				56,637		35,654		20,983			0			
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0						0							0			
2.01.03 Antiretroviral therapy	5,504,110	5,302,334	5,302,334					201,776			201,776				0			
2.01.04 Nutritional support associated to ARV therapy	543	543		543				0							0			
2.01.05 Specific HIV-related laboratory monitoring	0	0						0							0			
2.01.06 Dental programmes for PLHIV	0	0						0							0			
2.01.07 Psychological treatment and support services	90,000	0						90,000	90,000						0			
2.01.08 Outpatient palliative care	144,000	0						144,000	144,000						0			
2.01.09 Home-based care	839	839		839				0							0			
2.01.10 Traditional medicine and informal care and treatment services	3,261	3,261		3,261				0							0			
2.01.98 Outpatient care services not disaggregated by intervention	0	0						0							0			
2.01.99 Outpatient Care services not elsewhere classified	1,465,036	350,164		350,164				1,114,872	905,792	442	202,969	5,669			0			
2.02 In-patient care	0	0	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)	0	0						0							0			
2.02.02 Inpatient palliative care	0	0						0							0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0			
2.02.99 In-patient services not elsewhere classified	0	0						0							0			
2.03 Patient transport and emergency rescue	0	0						0							0			
2.98 Care and treatment services not disaggregated by intervention	0	0						0							0			
2.99 Care and treatment services not-elsewhere classified	0	0						0							0			

3. Orphans and Vulnerable Children (sub-total)	**31,574**	**12,955**	**0**	**12,955**	**0**	**0**	**0**	**18,619**	**0**	**0**	**18,619**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3.01 OVC Education	0	0						0							0			
3.02 OVC Basic health care	5,129	5,129		5,129				0							0			
3.03 OVC Family/home support	0	0						0							0			
3.04 OVC Community support	0	0						0							0			
3.05 OVC Social services and Administrative costs	7,826	7,826		7,826				0							0			
3.06 OVC Institutional Care	0	0						0							0			
3.98 OVC services not disaggregated by intervention	0	0						0							0			
3.99 OVC services not-elsewhere classified	18,619	0						18,619			18,619				0			
4. Program Management and Administration Strengthening (sub-total)	**10,306,896**	**3,127,933**	**2,418,924**	**709,009**	**0**	**0**	**0**	**7,178,963**	**4,635,675**	**875,123**	**1,519,598**	**148,567**	**0**	**0**	**0**	**0**	**0**	**0**
4.01 Planning, coordination and programme management	3,527,586	125,359	83,058	42,301				3,402,227	1,835,181	588,205	956,917	21,924			0			
4.02 Administration and transaction costs associated with managing and disbursing funds	1,795,945	449,280	440,600	8,680				1,346,665	770,335	37,236	444,526	94,568			0			
4.03 Monitoring and evaluation	1,353,193	49,078	35,426	13,652				1,304,115	1,196,946	106,994		175			0			
4.04 Operations research	92,450	0						92,450	20,000		71,313	1,137			0			
4.05 Serological-surveillance (Serosurveillance)	94,643	65,246		65,246				29,397	29,397						0			
4.06 HIV drug-resistance surveillance	9,183	0						9,183		9,183					0			
4.07 Drug supply systems	1,765,294	1,748,138	1,748,138					17,156		17,156					0			
4.08 Information technology	244,811	0						244,811	223,639	2,282	9,416	9,474			0			
4.09 Patient tracking	270,000	0						270,000	270,000						0			
4.10 Upgrading and construction of infrastructure	263,348	111,702	111,702					151,646		99,438	37,426	14,782			0			
4.11 Mandatory HIV testing (not VCT)	0	0						0							0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0						0							0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	890,443	579,130		579,130				311,313	290,177	14,629		6,507			0			
5. Human resources (sub-total)	**4,461,580**	**232,854**	**61,165**	**171,689**	**0**	**0**	**0**	**4,228,726**	**2,209,400**	**427,722**	**1,152,922**	**438,682**	**0**	**0**	**0**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	268,731	0						268,731				268,731			0			
5.02 Formative education to build-up an HIV workforce	1,691,965	0						1,691,965	1,609,000			82,965			0			
5.03 Training	1,182,872	93,366	61,165	32,201				1,089,506	600,400	427,722		61,384			0			
5.98 Incentives for Human Resources not specified by kind	0	0						0							0			
5.99 Incentives for Human Resources not elsewhere classified	1,318,012	139,488		139,488				1,178,524			1,152,922	25,602			0			
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**18,300**	**0**	**0**	**0**	**0**	**0**	**0**	**18,300**	**0**	**18,300**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6.01 Social protection through monetary benefits	0	0						0							0			
6.02 Social protection through in-kind benefits	0	0						0							0			
6.03 Social protection through provision of social services	0	0						0							0			
6.04 HIV-specific income generation projects	0	0						0							0			
6.98 Social protection services and social services not disaggregated by type	0	0						0							0			
6.99 Social protection services and social services not elsewhere classified	0	0						0							0			
7. Enabling Environment (sub-total)	**2,360,529**	**1,210,537**	**1,146,830**	**63,707**	**0**	**0**	**0**	**1,149,992**	**498,582**	**165,408**	**234,133**	**251,869**	**0**	**0**	**0**	**0**	**0**	**0**
7.01 Advocacy	1,675,672	881,898	818,191	63,707				793,774	344,926	155,242	197,737	95,869			0			
7.02 Human rights programmes	49,050	0						49,050	49,050						0			
7.03 AIDS-specific institutional development	388,008	305,730	305,730					82,278	82,278						0			
7.04 AIDS-specific programmes focused on women	42,909	22,909	22,909					20,000	20,000						0			
7.05 Programmes to reduce Gender Based Violence	0	0						0							0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0			
7.99 Enabling Environment and Community Development not elsewhere classified	204,890	0						204,890	2,328	10,166	36,396	156,000			0			
8. Research (sub-total)	**356,605**	**25,164**	**0**	**25,164**	**0**	**0**	**0**	**331,441**	**12,322**	**15,000**	**0**	**304,119**	**0**	**0**	**0**	**0**	**0**	**0**
8.01 Biomedical research	172,687	0						172,687				172,687			0			
8.02 Clinical research	72,089	0						72,089				72,089			0			
8.03 Epidemiological research	22,500	0						22,500				22,500			0			
8.04 Social science research	35,500	0						35,500		15,000		20,500			0			
8.05 Vaccine-related research	6,343	0						6,343				6,343			0			
8.98 Research not disaggregated by type	10,000	0						10,000				10,000			0			
8.99 Research not elsewhere classified	37,486	25,164		25,164				12,322	12,322						0			

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