Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS

(UNGASS)

Reporting Period 2004 – 2005

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List of Abbreviations

AIDS : Acquired Immunodeficiency Syndrome
ARV : Anti Retroviral
ART : Anti Retroviral Therapy
ASA : Aksi Stop AIDS
ASEAN : Association of South East Asian Nations
AusAID : Australian Agency for International Development
BKKBN : Badan Koordinasi Keluarga Berencana Nasional
(National Family Planning Coordinating Board)
BPS : Badan Pusat Statistik (Central Bureau of Statistics)
BSS : Behaviour Surveillance Survey
CBO : Community-Based Organization
CBS : Central Bureau of Statistics
CDC-EH : Communicable Disease Control-Environmental Health
CIMSA : Centre for Indonesia Medical Students' Activities
CRIS : Country Response Information System
CSW : Commercial Sex Worker
DOC : Declaration of Commitment
FHI : Family Health International
FSW : Female Sex Worker
GFATM : Global Fund to Fight AIDS, TB and Malaria
GoI : Government of Indonesia
HAPP : HIV/AIDS Prevention Program
HIV : Human Immunodeficiency Virus
IDU : Injecting Drug User
IHPCP : Indonesia HIV/AIDS Prevention and Care Project
ILO : International Labour Organization
IPPA : Indonesia Planned Parenthood Association
KfW : Kreditanstalt fur Wiederaufbau
KPA : Komisi Penanggulangan AIDS (National AIDS Commission)
LSE : Life Skills Education
M&E : Monitoring and Evaluation

MoH	: Ministry of Health
MoNE	: Ministry of National Education
MSM	: Men who have Sex with Men
NAC	: National AIDS Commission
NAP	: National AIDS Programme
NASA	: National AIDS Spending Assessment
NGO	: Non Governmental Organization
PLWHA	: Person Living with HIV/AIDS
PRT	: Project/Resource Tracking
STI	: Sexually Transmitted Infection
UNAIDS	: United Nations Joint Programme on HIV/AIDS
UNGASS	: UN General Assembly Special Session on HIV/AIDS
UNICEF	: United Nations Children's Fund
USAID	: United States Agency for International Development
WHO	: World Health Organization
YPI	: Yayasan Pelita Ilmu (Private Foundation)
YPKN	: Yayasan Pelangi Kasih Nusantara

Foreword

This progress report is prepared according to the UNAIDS Guidelines for Monitoring the UNGASS Declaration of Commitment on HIV/AIDS and covers the period 2004–2005. The guidelines emphasize the need to involve civil society in tracking the progress towards UNGASS targets, and indeed they have made a significant contribution to this edition of the report.

During the period 2004–2005, the Government of Indonesia included HIV/AIDS in its medium-term national development plan (2004-2009). The National AIDS Commission endorsed a range of technical strategies and foci consistent with the UNGASS Declaration of Commitment. The Sentani Commitment (a 2004 commitment to joint action on HIV/AIDS by government at national and local level initially in 6, later 14 priority provinces) has been a useful tool mobilizing attention and resources, promoting evaluation of local efforts, facilitating problem identification and problem solving as well as stimulating useful information sharing.

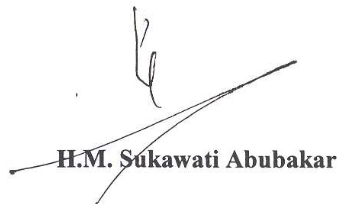
The National AIDS Commission, meanwhile, plans to accelerate the response and broaden the coverage of the HIV/AIDS Program in 100 districts/municipalities in 21 provinces, including the 14 Sentani Commitment provinces, and implementation is starting in early 2006.

To fulfil the Declaration of Commitment (DoC) on HIV/AIDS, the Ministry of Health and various agencies have various monitoring and evaluation mechanisms and procedures distributed nationwide—that is, sentinel surveillance, behaviour surveillance and program monitoring

A Monitoring & Evaluation Workshop was held in September 2005 and among the important outcomes were an agreed M&E framework for the HIV/AIDS Program in Indonesia and an M&E Working Group. It is expected that, the clear monitoring model and evaluation framework, will provide better corrective measures for the national response to HIV/AIDS which, in turn will result in more effective and efficient programmes.

We would like to thank the representatives of the government ministries and departments, UN agencies (coordinated by UNAIDS), bilateral donors, NGOs and PLWHAs who provided data and reviewed the draft report.

Jakarta, January 2006



Secretary of National AIDS Commission

Summary

In most of Indonesia, HIV/AIDS is concentrated within high-risk populations, but within those groups—particularly among IDUs and sex workers—infection rates are increasing rapidly. In Tanah Papua[*], the epidemic has already spread into the general population. This report is intended to describe Indonesia's progress in combating HIV/AIDS over 2004-2005 period.

Overall, the National Composite Policy Index has increased from 65 percent in 2003, to 75 percent in 2005. Indonesia is stepping up the response to the epidemic. In 2004, the government allocated US$13 million, a 106% increase over the HIV/AIDS budget for 2003. The National Composite Policy Index also increased from 65% in 2003 to 75% in 2005. The National AIDS Commission was reorganized and strengthened. Twelve ministries and local governments have translated the National Strategy into strategic plans and annual work plans.

The Ministry of Health is taking steps to revive the national sentinel surveillance programme which had not functioned properly since administrative decentralization was introduced in 2001. Most high prevalence provinces now also have reliable estimates of the number of people at high risk who are living with HIV/AIDS. A unified monitoring system, AIDS info (the HIV/AIDS Joint Database), was launched in October 2005. The information within AIDS Info will eventually cover all HIV/AIDS Programs in Indonesia as well as HIV/AIDS data that is updated on a monthly basis, HIV estimates, HIV prevalence and behavioural surveillance data.

However, there are not enough people at risk being reached by prevention programs (less than 10%), and too few have access to VCT (18% of IDU and 14% of sex workers). Among vulnerable groups, knowledge about HIV/AIDS is improving, but it is still inadequate: just 43% of men who have sex with men and 24% of female sex workers could correctly identify ways of preventing

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[*] Term "Tanah Papua" used to refer to two provinces "Papua" and "Irian Jaya Barat" formerly the single province of Papua

sexual transmission of HIV. Risky behaviour is still widespread: only just over 50% of female sex workers and men who have sex with men are reporting consistent condom use, while less than 20% of IDUs both avoid sharing needles and use condoms. Injecting drug use also interconnects profoundly with the sex industry, increasing the risk of a spread into the general population (BSS, 2004-2005).

Efforts are being made to increase awareness of young people about HIV/AIDS and equip them with the skills to protect themselves. More than 500 schools in 20 provinces are providing life skills-based HIV education, delivered by trained teachers. In Tanah Papua, a combination of culturally appropriate life skills education and peer education has been piloted in 123 schools and has already reached more than 40,000 junior secondary students.

In the world of work, the government, employers' associations and unions signed a tripartite Declaration of Commitment to take action on HIV/AIDS in the workplace, and in 2004 a Ministerial Decree was issued, putting in place anti-discrimination measures and requirements for HIV/AIDS prevention programs and policies. A total of 35 companies have HIV/AIDS workplace policies, 110 companies have participated in AIDS education programmes and 550,000 employees were reached with education.

Formidable challenges remain. Actions needed to overcome them include the following:

- Strengthening the capacity of national and local AIDS commissions
- Completing a costed-national action plan for implementation of the National AIDS Strategy
- Improving coordinating mechanisms in line with the *Three Ones* principle
- Developing national and local legislation to protect the rights of PLWHAs and promote HIV prevention
- Building capacity of health personnel, NGOs and CBOs

- Increasing availability and utilization of clean needles and condoms for people with high risk behavior
- Scaling up life skills education for youngsters in school and outside
- Strengthening the role of the private sector in HIV/ AIDS programming, especially for workplace-based HIV prevention programmes
- Rapid expansion of VCT facilities and improving access to a full range of treatment, including ARV and PMTCT
- Completing the development and beginning implementation of a comprehensive M&E system in line with the "Three Ones"[1] principle

[1] Three Ones principles for the coordination of national HIV/AIDS responses are:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One national HIV/AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- One agreed HIV/AIDS country-level Monitoring and Evaluation System.

Introduction

The purpose of this report is to report to UN Secretary General regarding Indonesia's progress in the fight against AIDS over the period of 2004–2005, by reporting on 9 specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators.

The 9 indicators related to national commitment and action are :

1. Amount of national funds disbursed by governments.
2. National Composite Policy Index.
3. Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the result.
4. Percentage (most-at-risk populations) reached by prevention programmes.
5. Percentage (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
6. Percentage of female and male sex workers reporting the use of a condom with their most recent client.
7. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.
8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last 12 months.
9. Percentage of (most-at-risk populations) who are HIV infected.

The Declaration of Commitment includes a set of indicators on which the Government of Indonesia has agreed to report to UNAIDS on a periodic basis. All UNGASS indicators have been included in the log frame for the national HIV/AIDS M&E system. This will ensure that the data collection and analysis for the UNGASS indicators are integrated into the national M&E system.

Several methods were used to prepare the report i.e desk review, special survey, and program monitoring.

Because of limitations in the available data, information is not complete for some indicators; for example, estimation data is used to present data for the percentage (most-at-risk populations) reached by prevention programmes. However, the report still has compelling and significant data that are relevant to the standard UNGASS indicators. Compared to the previous report, more intensive preparation was done for this report, it more extensive.

Status at a Glance

Indonesia is in the early phase of the HIV/AIDS epidemic. Although for now the disease remains largely concentrated in a few high-risk populations, the level of infection among some of those groups is over 40% and there are several factors that could quickly propel HIV into the general population. In Tanah Papua, comprising Indonesia's two eastern-most province, this has already happened.

The following table shows data about budget, policy and infection trends in some high-risk populations that are particularly disturbing:

Indicators and available/related data	Data Source
National Commitment and Action	
Expenditures	
1. In 2003, national funds disbursed by the government for HIV/AIDS amounted to US$ 6.3 million and in 2004 US$ 9.3 million.	Baseline Survey of National Response to HIV/AIDS in 2003 – 2004 (IHPCP-NAC)
In 2005 this increased to US$ 13.0 million (11.4 million by the central government and 1.6 million by local government). This is an increase of 40 percent over the amount disbursed in 2004.	National AIDS Spending Assessment of GoI 2005 (NAC)
Policy Development and Implementation Status	
2. National Composite Policy Index Overall, 65 percent in 2003, increasing to 75 percent in 2005.	NCPI workshop with GoI's multisector and Civil Society
National Programmes: HIV testing and prevention programmes for most-at-risk populations	
3. Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the result: IDU: 18.1 percent MSM: 15.4 percent Sex workers: 14.8 percent Clients of sex workers: 3.3 percent	BSS, 2004-2005

Indicators and available/related data	Data Source
4. Percentage of most-at-risk populations reached by prevention programmes Reports by Indonesia HIV/AIDS Prevention and Care Project (IHPCP) and ASA/FHI Project revealed that the percentages reached by prevention programmes in 2004 are: • IDUs : 5.6 percent (denominator: 160,000) • FSW : 18.3 percent (denominator: 250,000) • Transvestites : 20 percent (denominator: 12,000) • Gay/MSM : 1.9 percent (denominator: 1 million) • Clients of FSW : 6.7 percent (denominator: 6 million)	Program Monitoring, 2004-2005
Knowledge and Behaviour	
5. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Data from 2004 show that MSM have better knowledge about ways of preventing sexual transmission of HIV compared to other groups. The data is as follows: • MSM : 43.3 percent • IDU : 6.7 percent • Sex workers : 23.8 percent, and • Clients of sex workers: 23.7 percent	BSS, 2004-2005
6. Percentage of female and male sex workers reporting the use of a condom with their most recent client: In both 2002 and 2004, condom use by sex workers at the last commercial sex was relatively high (48.4 percent and 54.7 percent respectively). In addition, data from the 2004 survey show that the percentage of FSW using condoms at the last commercial sex was in fact higher than MSW (56.2 percent and 47.5 percent).	BSS 2002 – 2003 BSS 2004 - 2005

7. Percentage of men reporting the use of a condom during the last anal sex with a male partner: 56.4 percent of respondents reported that they used a condom the last time they had anal sex with a male partner. Higher percentages were found in 25-plus age group, at 57.7 percent, compared to 54 percent for the under-25 age group.	BSS 2004-2005
8.Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid using non-sterile injection equipment and use condoms, in the last 12 months: Overall, the percentage of IDU who adopted behaviours that reduce transmission of HIV is still very low (18.5 percent); respondents from the under-25 age group were more likely to adopt such behaviour than the 25-plus age group (23 percent and 13.9 percent).	BSS 2004-2005
Impact	
9. Percentage of most at risk populations who are HIV infected: • HIV prevalence among IDUs in some sentinel sites in West Java in 2003 is 42.9% • HIV prevalence among IDUs in some sentinel sites in Jakarta in 2001 who were infected with HIV is 47.9%. • HIV prevalence among male sex workers in some sentinel sites in Jakarta in 2002 is 2.7 percent and 3.8% in 2004. • HIV prevalence among CSW in some sentinel sites in Jakarta in 2003 is 6.37 percent. • HIV prevalence among transvestites in some sentinel sites in Jakarta is 22.8% in 2002 and 25.7% in 2004.	Surveillance Report, MoH, 2002-2004. Sentinel Surveillance report, MoH, FKUI, YPKN, FHI, 2004.

Overview of the AIDS Epidemic

Impact indicators

Most-at-risk populations: HIV prevalence

Indonesia is dealing with a dual epidemic: HIV and injecting drug use. The IDU epidemic has caused an explosive increase in the number of HIV/AIDS cases since 1999 in Jakarta, West Java and Bali, and infections are spreading from IDUs to their non-injecting sex partners, including sex workers. In other parts of the country the epidemic is being driven chiefly by heterosexual transmission between sex workers and their clients—many of whom are married. Infection trends in some high-risk populations are particularly disturbing:

Table 1: HIV prevalence

Risk population	Prevalence by year	
Injection drug users in some sentinel sites in Jakarta	1999: 15%	2001: 47.9%
Injection drug users in some sentinel sites in West Java	--	2003: 42.9%
Female sex workers in some sentinel sites in Jakarta	1999: 0.25%	2003: 6.2%
Female sex workers in some sentinel sites in Tanah Papua	1999: 6.7%	2002: 16.7%
Prisoners in some sentinel sites in Jakarta	1999: 1.7%	2003:19.7%
Male sex workers in some sentinel sites in Jakarta	2002: 2.7%	2004:3.8%
Transvestites in some sentinel sites in Jakarta	2002: 22.8%	2004:25.7%

Source: Sentinel Surveillance report, MOH, Sept 1999-2004

It could be seen from table 1 that the data represented only the period 1999-2004. It is difficult to obtain updated Sero Surveillance data for Jakarta. Since the early 1990s, sentinel surveillance has been undertaken by the National Ministry of Health (MoH) but since the process of decentralization began in 2001, sentinel surveillance efforts suffered a setback because local health services were not prepared to implement the activities which historically had been the responsibility of the central government. The MoH has taken steps to

revitalize the Sentinel Surveillance Programme by training local staff and providing reagents for testing in all provinces.

In 2002, the Ministry of Health, with support from international experts, created a national estimation method for HIV infection in Indonesia. The method bases estimates on available sentinel surveillance and behavioural surveillance data. The estimates focus on high risk populations—that is, those most likely to be exposed to the virus, and on their total population sizes in each province. This process resulted in an estimate of between 90,000 and 130,000 people living with HIV/AIDS in Indonesia.

In 2004 the estimation process was carried out at the provincial level using more province-specific data and personnel. A total of seven provinces have prepared their estimations. The results, however, have not been released as figures are still being checked for accuracy, given the importance of local level ownership. The NAC has formed a technical working group to review these data and the Tanah Papua estimates for 2005.

The province of Tanah Papua, with a population of 2.5 million people, has entered the generalized stage of the HIV/AIDS epidemic, the only province yet to do so. As of September 2005, Tanah Papua had reported 932 cases of AIDS, which is a reported case rate of 40 per 100,000 individuals, or 20 times the national average of 2 per 100,000.

From 1998 to 2004, prevalence of HIV in commercial sex workers increased from about 1 or 2 percent to 16 percent in Sorong, 15 percent in Merauke, 14 percent in Nabire, 9 percent in Timika and 5 percent in Jayapura. The high rates of sexually transmitted infections among commercial sex workers in Tanah Papua (around 62 percent) also influence transmission of HIV. (District Health Office, 1998-2004)

Injecting drug use is not yet widespread in Tanah Papua and therefore is not a mode of transmission. Reasons for the rising HIV prevalence in Tanah Papua include considerable purchasing of sex as well as high levels of unprotected

sex before marriage, high personal mobility (seeking employment, education, and recreation), and problems of alcohol abuse. For example, 10 to 15 percent of young men (aged 15–24) have bought sex and 50 percent have had sex before marriage. Premarital sex among young women (aged 15–19) is also high: 6 percent in Merauke, 90 percent in the Jayawijaya highlands, 30 percent in Biak and 20 percent in Jayapura. (BSS, 2002-2003).

The official estimated number of HIV infections in Tanah Papua is between 8,000 and 14,000, or about 0.6 to 1 percent of the total adult population. Surveys of pregnant women in some areas of Tanah Papua (Mimika and Merauke) indicated a prevalence rate of over 1 percent. (National estimation, 2002).

Most-at-risk populations: HIV testing

Figure 1: Percentage of most-at-risk populations who received HIV tests in the last 12 months and who know the result

Source: BSS (CDC-EH/MoH, CBS 2004-2005)

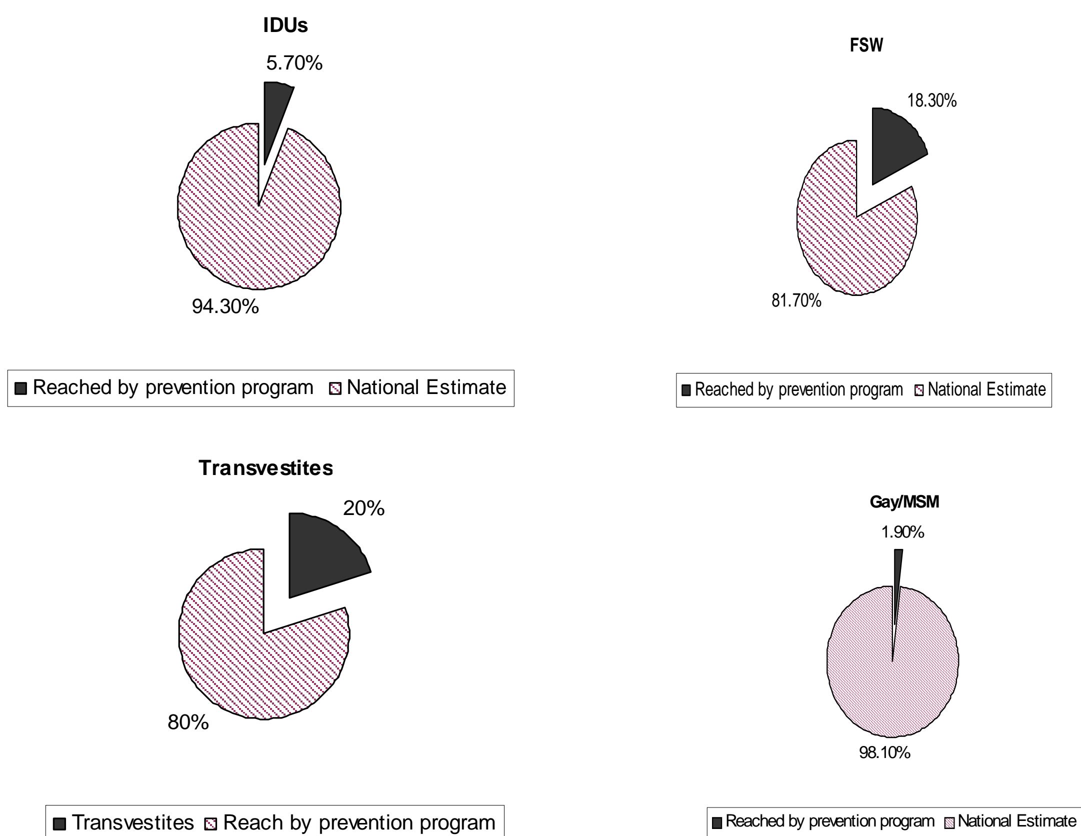
In order to protect themselves and to avoid infecting others, it is important for members of the most-at-risk populations to know their HIV status.

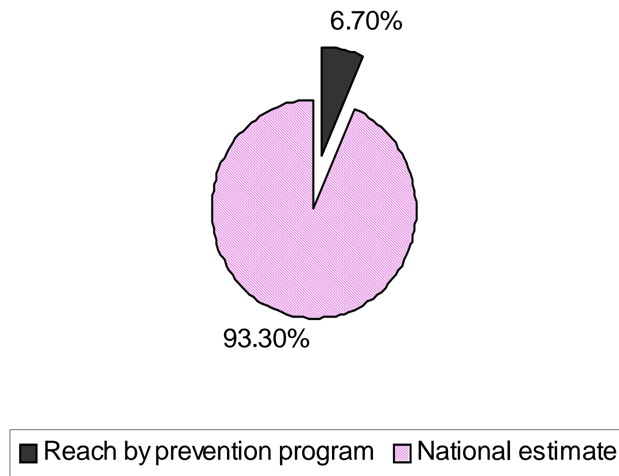
Figure 1 shows that the percentages across subgroups are very low. Sex worker clients had the lowest percentage of testing (3.3 percent): this is probably due to the lack of information and education among the clients of sex workers about how to prevent HIV/AIDS and their limited access to VCT.

Most-at-risk populations: reached by prevention programmes

The figures below were taken from program data on the target populations reached by the three largest donor funded projects; IHPCP/ AusAID, FHI/ USAID and the GFATM. The numerator is the number of people reached and the denominator is the population estimate.

Figure 2: Percentage of most-at-risk populations reached by prevention programs in 2005





Source: Program report, IHPCP/AusAID, FHI/USAID and GFATM, 2004-2005

In general the coverage of prevention programs has increased since the previous reporting period. For instance, the percentage of IDUs reached has increased from 1.5% in 2003 to 5.7% in 2004. The program needs to be scaled up to obtain wider coverage among high risk population.

Despite having the highest estimated number of HIV infections, the gay/MSM population was the least likely to be reached by prevention programs (1.9 percent). This is probably due to the fact that the gay/MSM community is relatively closed - a consequence of legal and social repression - and therefore these men are harder to identify and reach with prevention services.

AIDS patients receiving combination ART

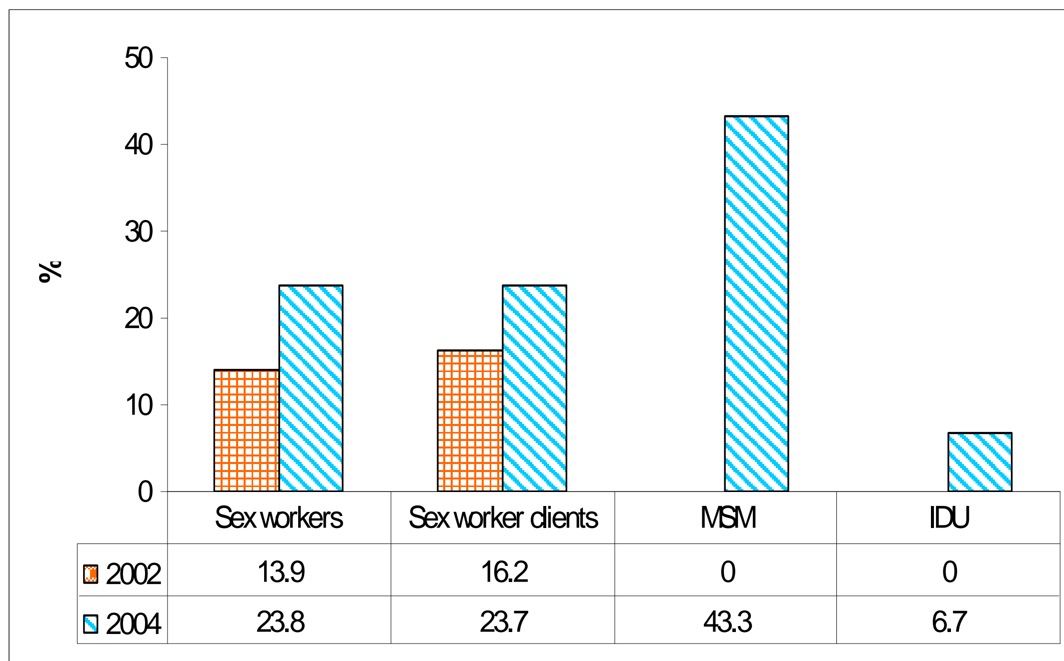
The number of men and women with advanced HIV infection is estimated at around 10,000 in 2002, approximately 10% of the estimated number of people living with HIV/AIDS. The government has subsidized the cost of ARV since 2004 and appointed 25 hospitals to provide ART in 2004 and increased into 50 hospitals in 2005 . Guidelines for ART have been prepared and personnel from the 25 hospitals had been given additional training. The number of

patients receiving ART increased from approximately 350 (3.5 percent) in 2003 to 2500 (25 percent) in 2004 and 5000 (50 percent) in 2005. (CDC&EH, MoH 2005).

Knowledge and behaviour indicators

Most-at-risk populations: knowledge about HIV prevention

Figure 3: Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission



Source: BSS (CDC-EH/MoH, CBS 2004-2005)

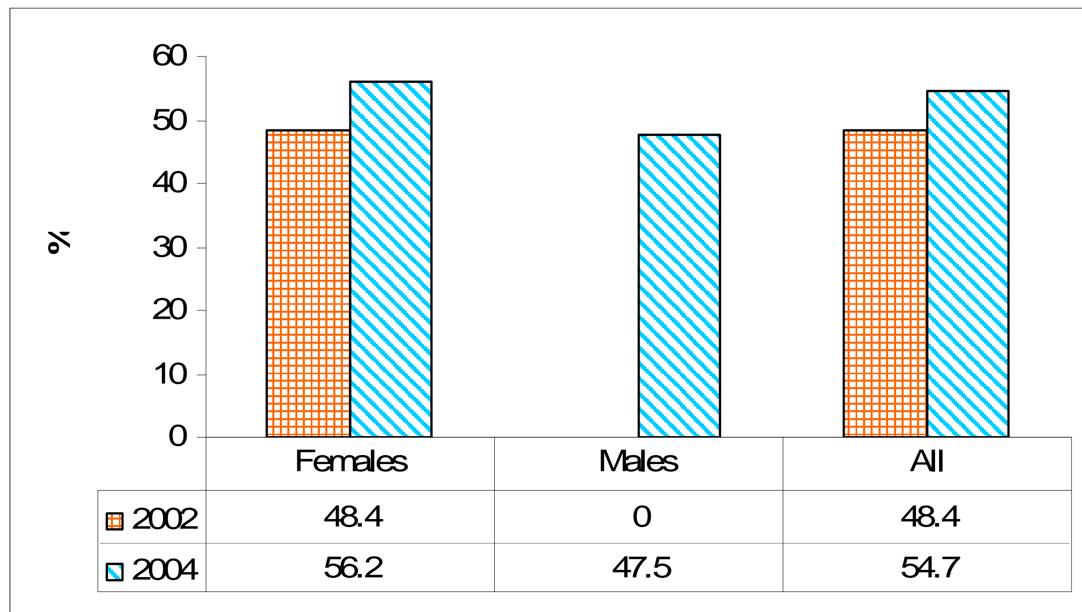
Figure 3 shows responses to the key question about HIV/AIDS information: can respondents both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. There were no data available for MSM and IDU population in 2002.

The level of knowledge among sex workers and their clients increased from 16% in 2002 to 24% in 2004. MSM were considerably better informed; IDU, on the other hand, were not with only 6 percent responding correctly. These

trends indicate that behaviour change intervention programs have shown some impact, and consequently, the programs could be scaled up.

Female and male sex workers: condom use

Figure 4: Percentage of female and male sex workers reporting the use of a condom with their most recent client



	Females	Males	All
2002	48.4	0	48.4
2004	56.2	47.5	54.7

Source: BSS (CDC-EH/MoH, CBS 2004-2005)

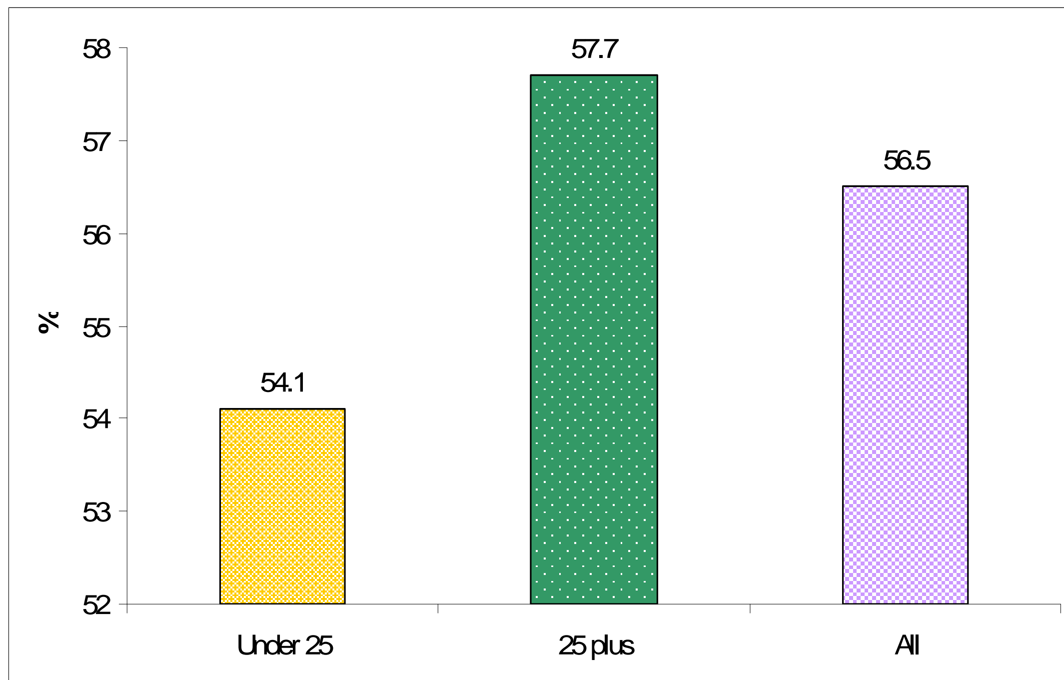
Sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use. The trend in condom use in the most recent sexual transaction will generally reflect the trend in consistent condom use. There were no data on male sex workers in 2002.

The BSS survey revealed that condom use by FSW at the last commercial sex in both years was relatively high, and there was an increase between 2002 and 2004 (48.37 percent and 56.16 percent respectively). The figure also shows that in 2004, the percentage of FSW who used condoms at the

last commercial sex was in fact higher than MSW. These data indicate that prevention programmes and mass media efforts are starting to succeed.

Men who have sex with men: condom use

Figure 5: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner by age group



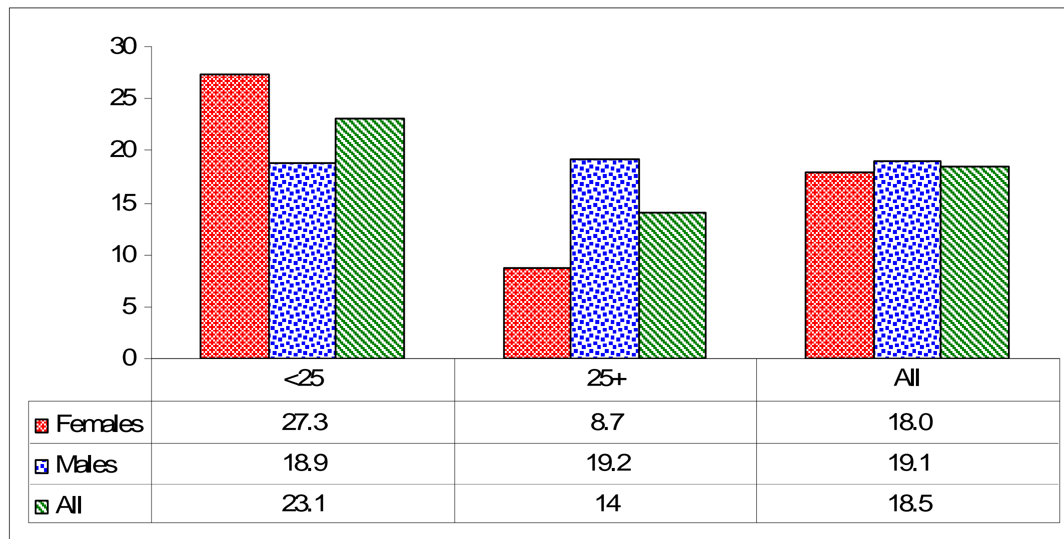
Source: BSS (CDC-EH/MoH, CBS 2004-2005)

In varying degrees, male-to-male transmission of HIV infection is a factor in all HIV epidemics. It has been the predominant mode of transmission of HIV in most high-income countries. Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have sex with men are a diverse population; many also have sex with women, and, as a result, the epidemic is steadily reaching their female partners.

More than half of the respondents (56.5 percent) reported that they used a condom the last time they had anal sex with a male partner. Higher percentages were found in 25-plus age group, at 57.7 percent, compared to 54.1 percent for the under-25 age group.

Injecting drug users: safe injecting and sexual practices

Figure 6: Percentage of IDUs who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid sharing injecting equipment and use condoms by 2004-2005



	<25	25+	All
Females	27.3	8.7	18.0
Males	18.9	19.2	19.1
All	23.1	14	18.5

Source: BSS (CDC-EH/MoH, CBS 2004-2005)

Injecting drug-related HIV epidemics do not remain limited to injecting drug users. Most injecting drug users are young, male and sexually active. They are likely to acquire or transmit the HIV virus not only by sharing injecting equipment but also through sexual intercourse with regular or casual partners. Injecting drug use also overlaps with the sex industry, with users often buying sex, or selling sex to finance their drug dependencies. Therefore, safer injecting and sexual practices among injecting drug users are essential to bringing the epidemic under control.

The BSS results show a difference between under 25 and over 25 age groups (23.1 percent and 14 percent respectively) in terms of adopting safe behaviours that reduce transmission of HIV. It is interesting to see that females under-25 were more likely to adopt safe behaviour than females over 25 (27.3 percent and 8.7 percent); on the contrary, the males under-25 were less likely to do so than males over 25 (18.9 percent and 19.2 percent). The low percentage values may suggest that the hidden IDU population is hard to reach by intervention program.

Overall, approximately only one in five female and male respondents were equally likely to adopt safe behaviour (18.1 percent and 19.1 percent).

Additional indicators

Access to ART

Indicator: Percentage of men and women with advanced HIV infection receiving antiretroviral combination therapy.

The government has subsidized the cost of ART since 2004 and the number of patients receiving ART increased from 350 (3.5 percent) in 2003 to 2500 in 2004 (25 percent) and 5000 (50 percent) in 2005 (CDC& EH, MoH, 2003-2005)

Life skills-based HIV/AIDS education in schools

Indicator: The percentage of schools with teachers who have been trained in life skills-based HIV/AIDS education and who taught it during the last academic year.

A total of 553 high schools in 20 provinces in Indonesia provided life skills-based HIV/AIDS education for their students. Each school has two trained teachers who taught the subject during the last academic year, and there are an additional 3,318 peer educators spread among the 553 schools. Since

there are a total of 8,036 high schools nationwide, this means that 7 percent of them are providing life skills education (MoNE, 2004).

Between January and July 2004, UNICEF, in collaboration with the Ministry of National Education (MoNE), trained master trainers, teachers and peer educators for LSE and peer education in Tanah Papua. Teaching and learning materials in the form of teachers' manuals, student booklets, flipcharts and two set of posters on LSE for HIV/AIDS were printed and distributed to 123 schools in Biak, Jayapura, Manokwari and Sorong districts in the area. The culturally appropriate education materials, (using imagery appropriate to Tanah Papua and bright colours), to which young people in Tanah Papua were exposed throughout the project were appreciated by both teachers and students. The Ministry of National Education (MoNE) also found the materials very useful and worked with UNICEF to re-design the module on LSE for HIV/AIDS (UNICEF, 2004).

Peer education in Tanah Papua is a replication of peer education delivered by the Jakarta-based Center for Indonesia Medical Student Activities (CIMSA) at Cendrawasih University in Jayapura, Tanah Papua. Specific achievements of the programme include the following:

- 40,880 junior secondary students in 123 schools were reached with information and education about LSE for HIV/AIDS
- 369 people (113 females, 256 males) from these schools were trained as facilitators at the district level
- 25 peer educators (10 females, 15 males) from Cendrawasih University in Jayapura were trained.

Radio is an important means of communication in Tanah Papua. A radio talk show involving provincial HIV/AIDS experts was broadcast as another part of the peer education outreach. Facilitated by the Indonesia Planned Parenthood Association (IPPA), the show focused on youth and HIV/AIDS, with topics including "Let's talk about HIV/AIDS", dating, and youth psychological and

reproductive health. The talk show reached more than 100,000 people in the five districts in Tanah Papua. (UNICEF, 2004).

HIV/AIDS in the workplace

In the world of work, the Indonesian government, employers' associations and unions have signed a tripartite Declaration of Commitment to take action on HIV/AIDS in the workplace. In 2004 a Ministerial Decree was issued, putting in place anti-discrimination measures and requirements for HIV/AIDS prevention programs and policies. A total of 35 companies have HIV/AIDS workplace policies, 110 companies have participated in AIDS education programmes and 550,000 employees have been reached with education.

In 2005, the Ministry of Manpower and Transmigration was awarded funding from GFATM to support the implementation of HIV/AIDS Prevention in the Workplace in 4 provinces (Riau, East Kalimantan, East Java and Papua)and at the national level. The funding was to mobilize the three parties (government, employers and trade unions) to implement Ministerial Decree 68/2004 on HIV/AIDS Prevention in the Workplace. To facilitate implementation of the Ministerial Decree 68/2004, a Technical Guideline on the implementation of Ministerial Decree 68/2004 was issued by the Ministry of Manpower and Transmigration (June 2005).

GFATM support for HIV/AIDS Prevention in the Workplace led to several workshops. There were 123 senior managers and 650 tripartite members at the National level and 4 provinces. The GFATM HIV/AIDS Prevention in the Workplace also conducted several training of trainers that consisted of 200 labour inspectors, 125 trade union members and 125 employer associations members.

ILO, complementing the GFATM supported activity is piloting behavior change communication strategies to reduce risk behavior among targeted workers and also to reduce discrimination in the workplace. The piloting is taking place

in 4 sectors: manufacturing, shipyard, heavy industry and the informal sector (dockworkers). The pilots are taking place in two highly industrialized provinces of Indonesia -- Batam, East Java -- and 2 urban locations in Tanah Papua -- the cities of Sorong and Jayapura. Under these activities 35,456 workers will benefit directly.

Using funding from UNAIDS' Project Acceleration Fund (PAF), ILO has initiated a process to improve the pre departure preparation of Indonesian overseas migrant worker to enable them to receive information on HIV/AIDS. The objective of the initiative is to assist those involved in work with Indonesian overseas migrant worker to disseminate information on HIV/ AIDS during the pre departure process. With funding from the Indonesian Partnership Fund for HIV/ AIDS, ILO plans to scale up this initiative and also address the issue of mandatory testing of Indonesian overseas migrant workers through establishment of VCT protocols for Indonesian overseas migrant workers. The intention is to reduce the damage of mandatory testing. ILO will also scale up work introducing HIV/ AIDS training in the pre-departure orientation of Indonesian migrant workers so that it will cover more districts and cities where migrant workers are concentrated.

Major Challenges Faced and Action Needed to address them Achieve the Goals

The development and launch of the Second National AIDS Strategy on May 9, 2003, was a significant step towards encouraging a multi-sectoral response. Since then, a total of 21 government institutions -- national ministries/ government agencies and local governments -- have translated the National Strategy into strategic plans and annual action plans. Twelve ministries/ government agencies had action plans and budgets in place since 2004.

Understanding and utilization of the three ones framework is important at all levels to assure harmonization and coordination of implementation of this multi-sectoral response, the many other activities generated by the National AIDS Strategy, as well as utilization of the substantial external resources (among others GFATM, USAID, AusAID and DfID) supporting Indonesia's national response to HIV/ AIDS.

The main challenges of implementation relate to the need for high levels of leadership and institutional capacity to assure effective management of all partners in the national response, in particular government at all levels and a wide range of NGOs/ CBOs.

In late 2005, through the Indonesian Partnership Fund for HIV/AIDS the National AIDS Commission was strengthened with full-time staff for the Secretariat and acquired additional office space. The NAC secretariat now has staff of more than 20 people. The work of NAC in organized in five divisions: (i) policy, programme and interagency relations; (ii) data and information; (iii) strengthening of local AIDS commissions; (iv) general affairs; and (v) supervision.

There are number of special issues that pose formidable challenges to design and implementation of a successful national AIDS programme in Indonesia. Among others:

- Limited outreach to high-risk behaviour groups (injecting drug users, men who have sex with men, sex workers and their clients, and partners of people in these groups)
- The lack of costed national and local level action plans which hampers accurate costing of the national response and development of the necessary annual estimates
- Calculation of the cost of the national response
- Low levels of condom use and resistance both from many men and from some religious groups to condom promotion
- High levels of needle sharing among IDUs
- Stigma and discrimination against PLWHAs
- Limited availability of testing and counselling related to HIV, and facilities for ARV treatment
- Limited facilities for STI management
- Legal issues which constrain implementation of a full harm reduction strategy among IDUs
- Limited capacity of health personnel and distribution of competent health care facilities
- Limited government funding
- Lack of consensus on clear overall direction and priorities for action

The actions needed to overcome those challenges include:

- Strengthening the capacity of AIDS Commissions at national, provincial, district, and city level, with particular attention to the situation of provinces with concentrated epidemics like Jakarta, Riau, the Riau Islands, West Java, East Java and Bali and more generalized epidemic areas like Tanah Papua.
- Complete a costed national action plan
- Strengthening management and programme implementation capacity of NGOs/CBOs

- Improving coordinating mechanisms at all levels in line with Three Ones principle
- Increasing availability and utilization of clean needles and condoms for those in high risk populations
- Scaling up life skills education for young people both in and out of school
- Increasing the role of the private sector, especially wide spread implementation of workplace-based HIV prevention programmes
- Rapid expansion of voluntary counselling and testing facilities and improving access to a full range of treatment, including ARV
- Development and adoption of laws and implementing regulations at national and local levels to protect the rights of PLWHAs and promote HIV prevention
- Strengthening of the health system -- both govenrmental and non governmental -- including training for health personnel, improvements in quality of service, and availability of necessary supplies
- Completing development and beginning implementation of a comprehensive M&E system

Support Needs of Civil Society

In December 2005, a workshop was held to build the capacity of civil society in tracking progress towards the UNGASS targets. Civil society was represented by local NGOs, universities and PLWHA support groups from different regions in Indonesia. The results of the group discussions constitute feedback from civil society to the Government of Indonesia and donors regarding the support needed to fight HIV/AIDS in Indonesia. The key points are summarized below:

Government support:

- Recognition that HIV/AIDS is a significant problem which must be addressed as a priority
- Promotion of legislation to support efforts to prevent HIV and reduce the impact of HIV/AIDS on society
- Serious attention to the challenges of sustainability faced by NGOs implementing programmes so that when funding support ends, their programmes can continue
- Greater acknowledgment of the role and functions of civil society in combating HIV/AIDS
- Increased government involvement in both inter-sectoral coordination and coordination at the implementing level of both government and non-government institutions
- Capacity building for program implementers to develop HIV/AIDS prevention programs
- More transparent and equitable management of funding and other resources

Donor support:

- Support to increasing NGO capacity, both institutional and human resources
- Support to increasing NGO capacity, both institutional and human resources
- More transparent decision-making—with the involvement of civil society—on funding
- Stronger feedback mechanisms in the monitoring and evaluation systems.
- More harmonized donor procedures and adherence to the "Three Ones" principles.

The country requires around US $ 100 million a year to accelerate and scale up the response to achieve universal access to prevention, treatment and care interventions by 2010. In 2005 only US $ 13 million can be provided by the central and local government budgets, while around US $ 50 million was provided by international donors. The government budgets for HIV/AIDS is growing at around 25% per year since 2003, but as the country has not fully recovered from the economic, social and political crisis of 1998, it is expected that the Global Fund, bilateral and multilateral donors will be able to support the Indonesian HIV/AIDS program but around US $ 75 million a year in the next five years. (NAC M&E unit, 2005).

Monitoring and Evaluation Environment

The National AIDS Strategy 2003–2007 highlights the importance of monitoring and evaluation in order to monitor progress, take appropriate corrective measures, and maximize programme effectiveness and efficiency. Policies and guidelines for monitoring and evaluation are being formulated.

The Ministry of Health made AIDS a reportable disease in 1989 and now implements a sentinel surveillance programme in most provinces. HIV surveillance is undertaken by the MoH. Behavioural surveillance is conducted by the MoH and NAC, with the assistance of FHI/USAID (HAPP & ASA projects), the AusAID HIV/AIDS Prevention & Care Project and Central Bureau Statistics in 1996, 1998, 2000, 2002, and 2004.

The Ministry of Health and the Central Bureau of Statistics (CBS) carried out a second round of behaviour surveillance surveys in 13 provinces in 2003 and 2004. The National AIDS Commission and UNAIDS Secretariat conducted a national workshop on the Country Response Information System and M&E of AIDS programmes in mid 2005. Agreement was reached on a set of relevant indicators and the methods of data collection at the workshop.

The major international organizations supporting Indonesia's response to HIV/AIDS, Tuberculosis and Malaria (the United Nations system, the Global Fund to Fight AIDS, TB and Malaria, and the major bilateral donors—USAID, AusAID, KFW (Germany) and DfID (British)) have all embraced the principle of unified monitoring and evaluation systems at the national level. In an effort to move towards such a system, a Working Group on M&E has begun to discuss development of a joint database that meets the needs of all stakeholders and is in line with the "Three Ones" principle.

The NAC secretariat has established a Monitoring and Evaluation Unit and in November 2004, the UNAIDS secretariat in Indonesia recruited a full time Monitoring and Evaluation (M&E) adviser who is working with her team on development and maintenance of the NAC M&E system.

AIDS Info — a HIV/AIDS M&E Joint Database — was launched in October 2005. AIDS Info is a web-based (www.aidsinfo.or.id), integrated database initiated by the NAC M&E Working Group and is being used by the three largest major donors (AusAID, USAID, and GFATM) working in the field of HIV/AIDS at national level. Initially, the idea was to have all NGOs working under the three major donors enter data on agreed indicators on a regular basis to allow program progress to be observed and any gaps rapidly identified.

After the try-out of the joint database in December 2005, input was given to improve the database so that it would be able to meet the needs of government sectors, as well. The National AIDS Commission, for example, required modification of the joint database so that local AIDS commissions and health offices could access and enter HIV/AIDS-related data.

Key national program indicators and some information within AIDS Info is accessible to public and covers data on HIV/AIDS programs in Indonesia as well as HIV/AIDS data that is updated on a monthly basis, HIV estimates, HIV prevalence and behavioural surveillance data. These data will be extremely useful at the local and national levels for planning, decision making and advocacy purposes. The last sentinel surveillance data available is for the year 2002.

Annex 1: Consultation/Preparation Process for the National Report

In preparing this report, the National AIDS Commission, in close collaboration with UNAIDS, and other stakeholders conducted the following activities:

Table 2: NAC Activities for UNGASS Report Preparation

No	Activities	Results
1	M&E adviser of NAC/UNAIDS and a statistician from National Statistic Office attended Country Response Information System Training (hands-on training) in Bangkok.	CRIS is used to store and analyze data related to the UNGASS indicator as well as producing charts and graphics for UNGASS reporting needs.
2	Training for National AIDS Spending Assessment (NASA), November 2005	The training enables tracking and standardization of AIDS expenditure categories at national level, making it internationally comparable (by disbursement). Expenditure by the Government for 2004 has now been calculated at national level and tried out in Tanah Papua and Bali
3	National Composite Policy Index Review and Discussions, September & October 2006	The National Composite Policy Index questionnaire was completed by civil society and government sector and it is attached to the UNGASS 2006 Report.
4	Consultation meeting with M&E working group to review UNGASS report.	M&E working group members provided input to the UNGASS report and the report was revised based on the input.

Annex 2: National and International Funding for HIV/AIDS

Table 3 (below) shows that the government budget increased US $ 2 million from 2003 to 2004 and US $ 5 million from 2004 to 2005. The information in the tables below was collated initially from a field trial of the UNAIDS Country Response Information System Project/Resource Tracking (PRT) module in May 2004, with new data being added as it became available. The table in its present form shows data as of 2004. The data on UN agency expenditure was taken from the 2004 report on the UN Joint Action Programme on HIV/AIDS in Indonesia.

UN agencies are gradually increasing their HIV/AIDS allocations, their budget also includes bilateral contributions, as in the case of UNICEF.

Table 3: Estimated HIV/AIDS Funding 2003-2005 (in US$)

Agency	2003	2004	2005
Total Government	6,315,000	8,767,000	13,000,000
DFID	-	-	18,000,000
USAID	9,600,000	8,800,000	9,000,000
AUSAID	4,760,000	4,760,000	4,760,000
GFATM	1,000,000	1,000,000	12,000,000
DKT/KFW	1,000,000	3,000,000	3,500,000
UNICEF	800,000	1,000,000	1,500,000
UNFPA	665,555	638,032	654,250
UNDP	146,518	746,518	555,000
WHO	-	400,125	233,375
ILO	-	200,000	150,000
UNESCO	-	12,000	4,000
UNV	-	216,000	309,000
World Bank	-	50,000	75,000
UNHCR	-	65,000	-
UNAIDS	329,000	588,000	685,000
MSF Belgium	-	150,000	150,000
Cordaid	239,835	206,657	75,000
Church World Service	-	-	100,000
Save the Children US	35,000	35,000	35,000
Save the Children UK*	-	-	100,000
Total (US $)	**24,890,908**	**30,407,332**	**64,885,625**

The breakdown of the budget by sector/agency can be seen in **Table 4** on the next page.

Table 4: Indonesian Government Sectoral HIV/AIDS Budgets 2003 – 2004 (in US$)

Ministry/agency	2003	2004
1. Ministry of Health	4,951,538	7,479,062.4
2. Ministry of National Education	827,777	800,000
3. Coordinating Minister for People's Welfare	110,979	109,064.7
4. Ministry of Religious Affairs	111,045	99,422.5
5. National Narcotics Board	100,000	90,000
6. Ministry of Social Affairs	49,399	71,600
7. National Family Planning Board	47,019	47,604
8. Ministry of Defense	75,182	13,120.5
9. Ministry of Home Affairs	21,380	13,417.7
10. Ministry of Women's Empowerment	8,333	21,800
11. Ministry of Transport	8,333	9,402.1
12. Ministry of Manpower & Transmigration	4,444	12,495
Total	**6,315,433**	**8,766,988.9**

It should be noted that governments at the local, provincial, district, and municipal levels increased both financial and organizational support for HIV/AIDS activities. In 2005, local government allocated around US $1.6 million (National AIDS Spending Assessment report, 2005). This is an increase of 100 percent compared to the US $ 0.8 million allocated in 2004.

The proportion of the use of the 2004 government budget (according to NASA functions) is as follows:

1. Prevention Programs : 41.7 percent
2. Treatment and Care : 12.5 percent
3. Program Development & Coordination : 44.6 percent
4. Incentives for Human Resources : 0.1 percent
5. Vulnerability Reduction (women) : 0.3 percent

Total : 100 percent

Annex 3: National Composite Policy Index Questionnaire

Government HIV/AIDS policies

Questionnaires were completed during the course of two meetings through group discussion. The chair of group discussion was Dr. Suriadi Gunawan who represented National AIDS Commission. The discussion worked to find consensus among the participating organizations.

The participating organizations were:

Questionnaire Part A:

1. National AIDS Commission
2. Ministry of Social Affairs
3. UNFPA
4. UNICEF
5. Faculty of Medicine, University of Indonesia
6. UNAIDS Secretariat

Questionnaire Part B:

1. Pelita Ilmu Foundation (NGO)
2. Indonesian Family Planning Association (NGO)
3. The Jabotabek NGO Forum
4. Indonesian Harm Reduction Network (JANGKAR) (NGO)
5. PITA Foundation (NGO)
6. National Commission on Women

The results are as follows:

Table 5: Results of NCPI Part A

Topic	Rate	
	2003	2005
Strategic plan	6	7
Political support	6	6
Prevention	6	7
Care and support	6	7
Monitoring & evaluation	5	6

Table 5 shows that the overall scores for Part A of the questionnaire raised by one point, with the exception of 'political support'.

Table 6: Results of NCPI Part B

Topic	Rate	
	2003	2005
Human rights • Policies, laws & regulations in place • Efforts to enforce existing policies, laws & regulations	 3 5	 4 6
Civil society participation	6	7
Prevention program	6	7
Care and support	6	8

The scores for human rights are relatively low, while the score for Care and Support rose by 2 points, and for the other two topics, by one point each. Scores are on a scale of 0–10.

(See complete questionnaire attached.)

Annex 3: National Composite Policy Index Questionnaire Part A

I. Strategic plan

1. Has your country developed a national multisectoral strategy/action framework to combat HIV/AIDS?

(Multisectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below.)

Yes √	No	Not Applicable (N/A)	Period covered:

1.1 *IF YES*, which sectors are included?

Sectors included	Strategy/Action framework		Focal point/Responsible	
Health	Yes √	No	Yes √	No
Education	Yes √	No	Yes √	No
Labour	Yes √	No	Yes √	No
Transportation	Yes	No	Yes √	No
Military	Yes √	No	Yes √	No
Women	Yes √	No	Yes √	No
Youth	Yes	No	Yes	No
Others to specify	Yes √	No	Yes √	No

Comments: *A second national strategy was launched in 2003. Other sectors that have developed strategies and action frameworks include religious affairs, social affairs, interior affairs, family planning board*.

1.2 *IF YES*, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (*Yes/ No*)

Programme a. Voluntary counselling and testing? b. Condom promotion and distribution? c. Sexually transmitted infection prevention and treatment? d. Blood safety? e. Prevention of mother-to-child transmission? f. Breastfeeding? g. Care and treatment? h. Migration? **Target populations** i. Women and girls? j. Youth?	a. Yes b. Yes c. Yes d. Yes e. Yes f. Yes g. Yes h. No i. Yes j. Yes
k. Most-at-risk populations? l. Orphans and other vulnerable children?	k. Yes l. No

Cross-cutting issues	
m. HIV/AIDS and poverty?	m. Yes
n. Human rights?	n. No
o. PLHA involvement?	o. No

1.3 *IF YES*, does it include an operational plan?

Yes √	**No**

1.4 *IF YES,* does the strategy/operational plan include:

Yes √	**No**

a. formal programme goals?	**Yes** √	**No**
b. detailed budget of costs?	**Yes** √	**No**
c. indications of funding sources?	**Yes** √	**No**

1.5 Has your country ensured "full involvement and participation" of civil society in the planning phase?

Yes	**No** √

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

Yes √	**No**

Comments: *The multisectoral national strategy of 2003 was formulated after one year of consultations with civil society, the private sector and local governments.*

2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)?

Yes √	No	N/A

2.1 *IF YES*, in which development plan? a) √ b) √ c) √ other

Covering which of the following aspects? (Yes/ No)

	a)	b)	c)
HIV Prevention	Yes	Yes	Yes
Care and support	Yes	Yes	Yes
HIV/AIDS impact alleviation	No	No	No
Reduction of gender inequalities as relates to HIV/AIDS prevention/care	Yes	Yes	Yes
Reduction of income inequalities as relates to HIV prevention/care	No	No	No
Others:			

3. Has your country evaluated the impact of HIV and AIDS on its economic development for planning purposes?

Yes √	No	N/A

3.1 *IF YES*, how much has it informed resource allocation decisions? (Low to High)

Low High

0	1	**2**	3	4	5	6	7	8	9	10

Comments: AusAID completed a study of social economic impact in Tanah Papua Province.

4. Does your country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police?

Yes √	No	N/A

4.1 IF YES, which of the following have been implemented?

HIV Prevention	Yes √	No
Care and support	Yes √	No
Voluntary HIV testing and counselling Mandatory HIV testing and counselling	Yes √ Yes	No No √
Others to specify:	Yes	No

Comments: In 2002 the Ministry of Defence established an AIDS committee and developed a policy/strategy to combat AIDS in the armed forces

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?
2005 Poor Good
0 1 2 3 4 5 6 **7** 8 9 10
2003 Poor Good
0 1 2 3 4 5 **6** 7 8 9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The Sentani Commitment to intensify responses to HIV/AIDS was signed by 6 ministries and 6 provinces in 2004. Another 8 provinces joined in 2005. The NAC is now preparing a work plan to intensify HIV/AIDS prevention and care in 100 districts/cities with highest prevalence.*

II. Political support

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

1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government	Yes √	No
Other high officials	Yes √	No

2. Does your country have a national multi-sectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)*

Yes √	No	N/A

2.1 *IF YES*, when was it created? Year: Presidential Decree No. 36/1994 on the National AIDS Commission

2.2 Does it include?

Terms of reference	Yes √	No
Defined membership Including civil society People living with HIV Private sector	Yes √ Yes Yes Yes	No No √ No √ No √
Action plan	Yes	No √
Functional Secretariat	Yes √	No
Date of last meeting of the Secretariat	Date: August 2005	

Comments: Efforts are underway to reorganize the NAC and give it a stronger legal basis.

3. Does your country have a national HIV and AIDS body that promote interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes?

Yes	No √	N/A

3.1 *IF YES*, does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Date of last meeting	Date:	

Comments: There are no representatives of civil society on the NAC but the NAC has formed working groups, e.g. on HIV in the workplace and HIV/AIDS and IDU, which include representatives from civil society/private sector.

4. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations?

Yes	No √	N/A

4.1 *IF YES*, does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Date of last meeting	Date:	

Comments: The National Strategy stated that the response to HIV/AIDS should be a partnership between the community (civil) society, the government and NGOs. Meetings/conferences to improve coordination with civil society and NGOs have been organized annually. The CCM of GATM was reorganized in 2005 to include equal membership of government and non government members.

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10

III. Prevention

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

Yes √	No	N/A

1.1 In the last year, did you implement an active programme to promote accurate HIV and AIDS reporting by the media?

Yes √	No

Comments: The Global Fund is funding a project to involve the media in promoting IEC on HIV/AIDS to the general population.

2. Does your country have a policy or strategy promoting HIV and AIDS-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

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

Yes √	No

Comments: The Minister of National Education has established an AIDS Task Force and developed a strategy for HIV/AIDS education in schools.

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

Yes √	No	N/A

3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including:	Yes	No	N/A
- Risk reduction information, education and counselling?	Yes √	No	N/A
- Needle and syringe programmes?	Yes √	No	N/A
- Treatment services?	Yes √	No	N/A
- If yes, drug substitution treatment?	Yes √	No	N/A
Men who have sex with men?	Yes √	No	N/A
Sex workers?	Yes √	No	N/A
Prison inmates?	Yes √	No	N/A
Cross-border migrants, mobile populations	Yes	No	N/A
Refugees and/or displaced populations?	Yes	No	N/A

Other most-at-risk populations? Please specify	Yes	No	N/A

Comments: The National Strategy stated that priority should be given to the most-at-risk populations. Several working groups have been established and guidelines have been prepared.

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)

Yes √	No	N/A

4.1 Do you have programmes in support of the policy or strategy?

A social-marketing programme for condoms?	Yes √	No
A blood-safety programme?	Yes √	No
A programme to ensure safe injections in health care settings?	Yes √	No
A programme on antenatal syphilis screening	Yes	No √
Other programmes? Please specify	Yes	No √

Comments:

- *DKT International has a Condom Social Marketing Programme*
- *Blood safety is implemented by the Indonesian Red Cross*
- *Universal precautions is a health sector policy, but implementation is weak due to inadequate supplies and weak supervision*
- *The program on antenatal syphilis screening has been discontinued*

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005 Poor										Good	
	0	1	2	3	4	5	6	**7**	8	9	10
2003 Poor										Good	
	0	1	2	3	4	5	**6**	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The adoption of the Harm Reduction Strategy by the NAC and the NNB (National Narcotics Board) is an important step.*											

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media	a. √	a. √
b. A social-marketing programme for condoms	b. √	b. √

c. School-based AIDS education for youth	c. --	c. √
d. Behaviour-change communications	d. √	d. √
e. Voluntary counselling and testing	e. √	e. √
f. Programmes for sex workers	f. √	f. √
g. Programmes for men who have sex with men	g. --	g. √
h. Programmes for injecting drug users, if applicable	h. √	h. √
i. Programmes for other most-at-risk populations	i. √	i. √
j. Blood safety	j. √	j. √
k. Programmes to prevent mother-to-child transmission of HIV	k. --	k. √
l. Programmes to ensure universal precautions in health care settings	l. √	l. √
m. Other: (please specify)	m. --	m. --

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The Sentani Commitment and the MoU between the NAC and the NNB.*											

IV. Care and support

1. **Does your country have a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counselling and testing, psychosocial care, access to medicines, and home and community-based care.)**

Yes √	No	N/A

2. **Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?**

	2003	2005
a. HIV screening of blood transfusion	a. √	a. √
b. Universal precautions	b. √	b. √
c. Treatment of opportunistic infection	c. √	c. √
d. Antiretroviral therapy (ART)	d. --	d. √
e. Nutritional care	e. √	e. √
f. Sexually transmitted infection care	f. √	f. √
g. Family planning services	g. √	g. √
h. Psychosocial support for people living with HIV and their families	h. √	h. √
i. Home-based care	i. -	i. √
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidacies and pulmonary TB (DOTS)	j. -	j. √
k. Cotrimoxazole prophylaxis among HIV-infected people	k. √	k. √
l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. -	l. √
m. Other: (please specify)	m. -	m. -

Comments:

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The production of ARV in-country and the appointment of 25 hospitals by the MoH as referral centres for CST*											

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

Yes	No √	N/A

3.1 *IF YES*, Is there an operational definition for orphans and other vulnerable children in the country?

Yes	No

IF YES, please provide definition: ____________________________

3.2 Which of the following activities have been implemented under orphan and vulnerable children programmes?

	2003	2005
School fees for orphans and vulnerable children Community programmes Other: (please specify)		

Comments: The needs of orphans and other vulnerable children will be given more attention in the next 2 years.

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

V. Monitoring and Evaluation

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

Yes	No	In Progress √	Years covered : 2005 - 2007

1.1 IF YES, was it endorsed by key partners in evaluation?

Yes √	No

Comments: A national workshop on M&E was held in September and recommended a draft national strategy (including indicators)

1.2 Was the Monitoring and Evaluation plan developed in consultation with civil society, people living with HIV?

Yes √	No

2. Does the Monitoring and Evaluation plan include?

A data collection and analysis strategy	Yes √	No
well defined standardized set of indicators	Yes √	No
guidelines on tools for data collection	Yes √	No
A strategy for assessing quality and accuracy of data	Yes √	No
A data dissemination and use strategy	Yes √	No

3. Is there a budget for the Monitoring and Evaluation plan?

Yes √	No	In Progress	Years covered : 2005 - 2006

3.1 IF YES, has funding been secured?

Yes √	No

4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes √	No	In Progress

IF YES,

Based in NAC or equivalent?	Yes √	No
Based in Ministry of Health?	Yes	No
Elsewhere? Please specify		

4.1 *If yes,* are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?

Yes	No √

Comments: The M & E unit was established at the NAC secretariat in August 2005. A joint database of HIV/AIDS data/activities was launched in October 2005. The three major implementing agencies (80% of national response) will be submitting data to the joint database.

4.2 Is there a full-time officer responsible for monitoring and evaluation activities of the national programme?

Yes full time √	Yes part-time	No Monitoring and Evaluation Officer

4.3 *IF YES*, since when? : Year 2005

5. Is there a committee or working group that meets regularly coordinating Monitoring and Evaluation activities?

Yes regular	Yes irregular √	No	Date last meeting: *October 2005*

5.1 Does it include representation from civil society, people living with HIV?

Yes √	No

6. Have individual agency programmes been reviewed to harmonize Monitoring and Evaluation indicators with those of your country?

Yes √	No	N/A

7. To what degree (Low to High) are UN, bi-laterals, other institutions sharing Monitoring and Evaluation results?

Low									**High**
1	2	3	4	5	**6**	7	8	9	10

Comments: The UN agencies are coordinated under the UN Joint Action Programme (UNJAP). Global Fund and two bilateral projects (USAID and AusAID) are sharing their data in the Joint Database.

8. Does the Monitoring and Evaluation Unit manage a central national database?

Yes √	No	N/A

8.1 *IF YES*, what type is it? *The Joint Database (Developed by the Central Bureau of Statistics) is a web-based database.*

9. Is there a functional* Health Information System?

National level	Yes	No √
Sub national*	Yes	No √

*(*reporting regularly data from health facilities aggregated at district level and sent to national level, analyzed, and used at different levels)*

Comments: Since the decentralization of health services in 2001, the information system managed by MoH has not been functioning well. The MoH is developing a revised health information system.

10. Is there a functional Education Information System?

National level	Yes	No √
Sub national*	Yes	No √

- *If yes, please specify the level, i.e., district*

11. Does your country publish at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports?

Yes √	No	N/A

12. To what extent strategic information is used in planning and implementation?

Comments: The results of the HIV/AIDS Surveillance Survey and Behaviour Surveillance Surveys are used in planning and implementation.

13. In the last year, was training in Monitoring and Evaluation Conducted?

At national level?	Yes √	No
At sub national level?	Yes	No √
Including civil society?	Yes	No √

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?
2005 Poor Good
0 1 2 3 4 5 **6** 7 8 9 10
2003 Poor Good
0 1 2 3 4 **5** 6 7 8 9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The establishment of an M & E unit and Joint Database*

National Composite Policy Index Questionnaire Part B

I. Human Rights

1. **Does your country have laws and regulations that protect people living with HIV and AIDS against discrimination previsions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?**

Yes √	No	N/A

Comments: The National Strategy states non discrimination as one of the principles of AIDS control. The Ministry of Health and the Ministry of Manpower issued policies on non discrimination in health facilities and workplaces.

2. **Does your country have non-discrimination laws or regulation which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e. groups such as injecting drugs users, men who have sex with men, sex workers, youth, mobile populations and prison inmates)?**

Yes	No √	N/A

IF YES, please list groups:

3. **Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?**

Yes √	No	N/A

IF YES, please list groups: IDUs and sex workers

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

Yes √	No	N/A

Comments: The National Strategy states that non discrimination and respect for human dignity should be key principles in the response to HIV/AIDS.

5. **Has the government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation?**

Yes √	No	N/A

IF YES, please list groups: PLWHAs and member of vulnerable populations have been members of NAC working groups, the GF CCM and the Project Steering Group of the Partnership Fund.

6. **Does your country have a policy to ensure equal access, between men and woman, to prevention and care?**

Yes √	No	N/A

Comments: This is also stated as one of the principles of the National Strategy.

7. **Does your country have a policy to ensure equal access to prevention and care for most-at-risk population?**

Yes √	No	N/A

Comments: This is stated in the National Strategy.

8. **Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?**

Yes √	No	N/A

9. **Does your country have a policy that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**

Yes √	No	N/A

9.1. IF YES, does the ethical review committee include civil society and people living with HIV?

Yes	No √	N/A

Comments: *The 25 ethical review committees in the country do not include PLWHAs, but 50% have representatives from civil society.*

10. **Does your country have the following monitoring and enforcement mechanisms?**

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and programme development reform.	Yes √	No
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV and AIDS related issues within their work.	Yes √	No
Established of local points within governmental health and other departments to monitor HIV related human rights abuses.	Yes	No √
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts.	Yes	No √

11. **Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?**

Yes	No √	N/A

12. Are the following legal support services available in your country?

Legal AIDS systems for HIV and AIDS casework	Yes	No √
State support to private sector laws firms or university based centres to provide free pro bono legal services to people living with and AIDS in areas such as discrimination	Yes	No √
Programmes to educate, raise awareness among people living with HIV and AIDS concerning their rights.	Yes √	No

13. Are there programmes designed to changed societal attitudes of discriminations and stigmatization associated with HIV and AIDS to understanding and acceptance? Yes

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?											
2005	Poor										Good
	0	1	2	3	**4**	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	**3**	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The Global Fund is funding the media campaign for IEC, especially to reduce stigma & discrimination in 2005.*											

Overall, how would you rate the effort to enforce the existing policies, laws and regulations?											
2005	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The 2004 Decree of the Minister of Manpower on HIV/AIDS Prevention and Control in the Workplace and the technical guidelines issued by the Director General of Manpower Protection in 2005.*											

II. Civil Society Participation

1. **To what extent civil society has made a signification contribution to strengthening the political of top leaders and national policy formulation?**

Low									High
1	2	3	4	5	6	7	**8**	9	10

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

Low									High
1	2	3	**4**	5	6	7	8	9	10

3. **To what extent the complimentary services provided by civil society to areas of prevention and care are included in the both National Strategic Plans and Reports?**

Low									High
1	2	3	4	5	6	**7**	8	9	10

4. **Has your country conducted a National Periodic Review of the Strategic Plan with the participation of the civil society in:**

Yes	No	N/A √

Month _______________ Year ________________

5. **To what extent does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people living with HIV and caregivers participate?**:

Low									High
1	2	3	4	**5**	6	7	8	9	10

Overall, how would you rate the effort to increase civil society participation?											
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *Several NAC working groups include representatives from civil society.*											

III. Prevention

1. **Which of the following activities have been implemented in 2003 and 2005 in support of the HIV – prevention policy / strategy?**
   (Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).

	2003	2005
a. A Programme to promote accurate HIV and AIDS reporting by the media	a. √	a. √
b. A social – marketing programme for condoms	b. √	b. √
c. School – based AIDS education for youth	c. √	c. √
d. Behaviour-change communications	d. √	d. √
e. Voluntary counselling and testing	e. √	e. √
f. Programmes for sex workers	f. √	f. √
g. Programmes for men who have sex with men	g. √	g. √
h. Programmes for injecting drug users, if applicable	h. √	h. √
i. Programmes for other most-at-risk populations	i. √	i. √
j. Blood safety	j. √	j. √
k. Programmes to prevent mother-to-child transmission of HIV	k. √	k. √
l. Programmes to ensure safe injections in health care settings	l. √	l. √
m. Other : (please specify) Workplace AIDS orphans (for the last 2 years)	m. √	m. √

Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The Sentani Commitment has boosted HIV prevention efforts, and the MoU between the NAC and the National Narcotics Board stimulated harm reduction.*											

IV. Care and Support

1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

		2003	2005
a.	HIV screening of blood transfusion	a. √	a. √
b.	Universal precautions	b. √	b. √
c.	Treatment of opportunistic infections (OI)	c. √	c. √
d.	Antiretroviral therapy (ART)	d. √	d. √
e.	Nutritional Care	e. __	e. √
f.	Sexually transmitted infection care	f. √	f. √
g.	Family planning services	g. √	g. √
h.	Psychological support for people living with HIV and their families	h. √	h. √
i.	Home-based care	i. √	i. √
j.	Palliative care and treatment of common HIV related infections: pneumonia, oral thrush, vaginal candidacies and pulmonary TB (DOTS)	j. √	j. √
k.	Cotrimoxazole prophylaxis among HIV – infected people	k. √	k. √
l.	Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. __	l. √
m.	Other: (please specify)	m. __	m. __

Overall, how would you rate the care and treatment effort of the HIV and AIDS programme?
2005 Poor … Good
0 1 2 3 4 5 6 7 **8** 9 10
2003 Poor … Good
0 1 2 3 4 5 **6** 7 8 9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: *The production of ARV in Indonesia and the 2004 Decree of Ministry of Health on the provision ARV fee of charge.*

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

Yes	No √	N/A

2.1. Which of the following activities have been implemented under the orphans and other vulnerable children programme?

	2003	2005
School fees for orphans and vulnerable children Community programmes Other: (please specify)		

Comments:

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