



**NATIONAL  
AIDS  
COMMISSION**

**Republic of Indonesia**

# Country report on the Follow up to the Declaration of Commitment On HIV/AIDS

(UNGASS)  
Reporting Period 2006-2007

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## List of Abbreviations

AIDS:	Acquired Immune-Deficiency Syndrome
APBD (Ind.):	Regional Budget
APBN (Ind.):	State Budget
ART:	Anti Retroviral Therapy
ARV:	Anti Retroviral Drugs
ASA (Ind.):	Aksi Stop AIDS
Askesin (Ind.):	Poor health scheme
AusAID:	The Australian government's overseas aid program, formerly Australian
AID	Agency for International Development
BCI:	Behaviour Change Intervention
BKKBN (Ind):	Coordinating Board for National Family Planning
BNN:	National Narcotics Agency
BPS (Ind.):	Central Statistics Agency
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
ELISA:	Enzyme Linked Immuno Sorbent Assay
FHI:	Family Health International
FSW:	Female Sex Worker
GDP:	Gross Domestic Product
GFATM:	The Global Fund to fight AIDS, TB and Malaria
HBsAg:	Hepatitis B Surface Antigen
HCV:	Hepatitis C Virus
HDI:	Human Development Index
HIV:	Human Immunodeficiency Virus
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 Organisation
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
NIHRD:	National Institute of Health Research and Development
PKBI (Ind.):	Indonesia Family Planning Association
PLHIV:	People Living With HIV
PMI (Ind.):	Indonesian Red Cross
PMTCT:	Prevention of Mother to Child Transmission
Pokdisus AIDS (Ind.):	Study Group on AIDS
OI:	Opportunistic Infection
OVC:	Orphans and Vulnerable Children
SD (Ind.):	Primary school
SMP (Ind.):	Junior high school
SMU (Ind.):	Senior high school
STI:	Sexually Transmissible Infection (Ind.: PMS)
SW:	Sex Worker
TB:	Tuberculosis
TNI (Ind.):	Armed Forces
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



## Foreword

Over the past 20 years many strategic initiatives have been taken in response to the HIV epidemic in Indonesia.

This country report presents information specifically focused on achievements of the Government and civil society in Indonesia related to the Declaration of Commitment of UNGASS in the past two years, 2006-2007. We underscore and are proud that this report is a collaborative product reflecting perspectives of both the government and a wide range of civil society actors in this field.

For the period covered by this report, UNAIDS has stipulated 25 indicators to measure progress in the response to HIV and AIDS. The indicators fall into 4 categories i.e. national commitment and action, national program, knowledge and behavior, and impact. Indonesia can report what has been accomplished related to indicators relevant to concentrated epidemics. However, information related to some indicators is not available, as they refer to aspects of the epidemic not widely found in Indonesia.

Although the AIDS epidemic continues to grow, 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. During the period under review management of Indonesia's response has improved. Promulgation of Presidential Regulation number 75/2006 restructuring and strengthening the National AIDS Commission became the starting point for a more integrated, comprehensive, and systematic response to the epidemic. 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 great progress in the past two years and Indonesia honors the contribution of all actors -- government, private sector, NGO, domestic and international -- who have helped the country to address the challenge 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 & 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 us all. 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 to support our continuing decision making process in this field.

**Coordinating Minister for People's Welfare/  
Chairman, Indonesian National AIDS Commission**

A handwritten signature in black ink, appearing to read 'Aburizal Bakrie', is written over a horizontal line.

**Aburizal Bakrie**

# I. Status of Indonesia's HIV Response at a Glance

## A. *Glimpse of Indonesia*

With more than 17,000 islands, Indonesia is the largest archipelago in the world. Located between 2 oceans, the Indian and the Pacific, Indonesia is a Southeast Asian country home to more than 250 ethnic groups and thus has great cultural diversity. More than 245 million people inhabit the islands (July 2006 est.), making it the fourth most populous country in the world. Although one can find all major religions in the country, most of the inhabitants (88%) are Muslim and as such, Islamic views have a strong influence on state policy. (Crisovan, 1996).

Since the monetary crisis that hit the region in 1997, the country has been dealing with tremendous economic changes which led to political upheavals, namely a transition from 3 decades of authoritarianism to a democratically-elected government. The transition toward a more democratic country has taken place along with increasing poverty, a high unemployment rate, chronic cronyism and corruption. All these have significantly affected the quality of life of many low and middle income families living in Indonesia<sup>1</sup>.

According to the data on the progress toward the Millennium Development Goals (MDGs), it is estimated that 17.75% of the population was living below the poverty line in 2006, which was an increase from 15.97% in 2005. Life expectancy at birth is 66.2 years. The Central Bureau of Statistics estimated the infant mortality rate at 34.39 per 1000 live births in 2006. Maternal mortality, although in decline, remains the highest in Southeast, at 307 per 100,000 live births. Communicable diseases remain a large burden and even the prevalence from non-communicable diseases is climbing. Indonesia, for example, ranks third in the world for prevalence of tuberculosis (TB), at 262 per 100 000 (all cases), and TB mortality of 41 per 100,000 in 2005. Health spending per capita was estimated at USD 33 in 2004, representing 2.8% of the GDP.

The health sector has been acknowledged as a priority by the government of Indonesia, but this has not yet translated into a larger budget allocation. The majority of private spending on health is out-of-pocket. Recently an important step was taken by the government to ensure that the poor can access health facilities. With the implementation of a national social health insurance scheme for the poor, or Askeskin, from the beginning of 2005 the government will pay the premiums for 60 million poor. Some studies have shown that this scheme has significantly helped the poor, including with support for catastrophic illness such as haemodialysis, heart attack etc. Secondly, related to the HIV prevalence that is high among particular populations, since 2004 the government has guaranteed that antiretroviral medication

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<sup>1</sup> Indonesia's national socio economic survey. Jakarta, Central Bureau of Statistics, 2003.



can be accessed free of charge. Although there are some improvement required to enhance the system, this positive step has shown a commitment to dealing with HIV.

In 2001, Indonesia underwent a rapid process of decentralization, devolving budgetary and implementation authority for most health services to the municipality level. Previously it had been a vertical system, where the national level government set priorities and agendas, as well as determined funding. Now the authority rests with the 440 municipalities that are coordinated by 33 provinces across the country. While decentralization brings the opportunity for increased efficiency, flexibility and accountability, the ability of the central government to influence decisions about priority setting and funding is limited. The health system has been also affected by the challenges of intergovernmental relationships functioning in a decentralized system, with some functions such as disease surveillance becoming more difficult.

## ***B. About this report***

As indicated by its title, this report expresses not only the government's point of view but also presents opinions and information from all stakeholders in the AIDS response. Various partners have been actively engaged in producing data used herein.

On 3-4 September 2007 meetings were held to complete the National Composite Policy Index (NCPI) questionnaire. The first meeting was attended by representatives of civil society. The participants came from various backgrounds: NGOs, the Indonesian Red Cross, representatives of youth, PLHIV, the Association of Indonesian Family Planning, as well as ILO, UNICEF, UNAIDS and the NAC, who coordinated the report writing. This meeting was particularly important for capturing the voice of civil society organisations that have been working on this issue. The civil society agreed that a shadow report would not be produced, but rather that this report be enriched by an 'UNGASS community report' which aims to represent civil society's perspectives in a more qualitative manner. The comprehensive report on the NCPI is detailed in chapter 3.

The second NCPI meeting was held on 4 September 2007 and attended by representatives of the Ministry of Health, Ministry of National Education, Coordinating Ministry for Social Welfare, Ministry of Justice and Human Rights, Ministry of Social Affairs, Ministry of Manpower and Transmigration, as well as by WHO and the NAC.

During the workshop on most-at-risk populations (MARPs) held in Jakarta on 19-20 October 2007, participants shared the idea that difficulties in reaching these groups not only makes it difficult to obtain reliable data but also to provide proper prevention, care and support programs. The importance of data improvement and management was thus emphasized. Moreover, they agreed that to improve the monitoring and evaluation (M&E) system, the NAC should ensure data flow (reports) and a unified method of gathering data. The workshop was also attended by NAC's international partners such as FHI and IHPCP, which also shared their data and method for assessing the MARPs.

On 11 December 2007 a meeting was held by the M&E Working Group of the NAC, for related sectors such as the Ministry of Health, Ministry of Manpower and Transmigration, Ministry of Social Welfare, and Indonesian Red Cross, as well as other UN bodies like UNICEF and ILO, to share their data. This information and a narrative report contributed to the UNGASS indicators and analyses. In this meeting, the stakeholders' generally limited capacity to conduct monitoring and evaluation activities and to manage available data was recognized. Of note, many of the activities that had been conducted in the field were not covered by the UNGASS indicators and so it was decided that a narrative report should be prepared in order to share this additional information.

Following guidance from UNAIDS for the provision of a database in addition to this narrative report, training on the Country Response Information System was held on 2-3 January 2008. This was followed by data up-date meetings on January 9 and 16, 2008, which were attended by representatives of the sectors responsible for providing the data used in this report.

Data quality is still a challenge in Indonesia, and this is reflected in this report. The NAC and its strategic partners such as the Ministry of Health, the Ministry of National Education and the Ministry of Manpower and Transmigration have struggled to obtain reliable data. For several indicators, this report uses relevant data, however the survey methods need to be improved, for instance to avoid biased sampling. Due to time constraints, not all the data are weighted and represents the national situation. For example, the prevalence of HIV among MARPs is weighted and representative. However, data related to 15-49 year olds from Papua are not weighted and thus are not sufficiently representative to describe the national situation. TO take another example, while the Prevention of Mother to Child Transmission (PMTCT) and Orphan and Vulnerable Children (OVC) is a relevant in Indonesia, the data with which to report on these issues are hardly available as related programmes are still in being piloted and in their initial stages. It is expected that the data provided for future UNGASS reports will be better and more representative.

### **C. *The status of the epidemic***

Although the estimated annual number of new HIV infections decreased in South and South-East Asia from 450,000 (150,000-800,000) in 2001 to 340,000 (180,000-740,000) in 2007, in South-East Asia and particularly in Indonesia, the prevalence of HIV is growing. The increasing number of new HIV infections in Indonesia makes the epidemic one of the fastest growing in Asia, even though the aggregate national prevalence is as low as 0.16% (Review HIV/AIDS by MoH, 2007). Estimates are that currently there are 193,000 people living with HIV (PLHIV) in Indonesia.

The majority of HIV infections in this country are believed to occur through the use of contaminated injecting equipment, unprotected paid sex and, to a lesser extent, unprotected sex between men (Ministry of Health and Statistics Indonesia, 2006). Many injecting drug users also buy or sell sex (Ministry of Health Indonesia and Statistics Indonesia, 2006). In 2005, approximately one quarter of injecting drug users

in Bandung, Jakarta and Medan said they had had unprotected paid sex in the previous year (Ministry of Health Indonesia and Central Bureau Statistic, 2006).

The current percentage of MARPs that have received an HIV test and know their results doubled compared to in the previous reporting period (2004-2005). The breakdown of this result is: sex workers, from 14.8% to 30.97%; MSM from 15.4% to 31.01%; and injecting drug users from 18.1% to 35.90%.

In the near future HIV is predicted to be predominantly spread through sexual modes of infection. Thus, enhancing the STI clinics and promoting condom use will be necessary in this country. While many initiatives have been taken to encourage safer sex practices, the barriers to condom promotion remain. The main challenge is in persuading religious authorities to adopt public health perspectives in dealing with the epidemic.

An alarming situation has currently occurred in Papua and West Papua provinces (bordering Papua New Guinea) where the epidemic is more serious compared to other provinces. Although the epidemic in Indonesia is generally concentrated among high-risk populations, in 'Tanah Papua'<sup>2</sup> it has become a generalized epidemic. The main mode of transmission there is unprotected sex. In a province-wide, population-based survey conducted in 2006, adult HIV prevalence was estimated at 2.4%, and reached 3.2% in the remote highlands and 2.9% in less-accessible lowland areas. Among 15–24- year-olds, HIV prevalence was 3% (Ministry of Health Indonesia and Central Bureau Statistics, 2007).

#### ***D. Response to the epidemic***

The response to HIV in Indonesia started as early as 1985 with the establishment of a Study Group on AIDS (Pokdisus AIDS) at the School of Medicine of the University of Indonesia/Cipto Mangunkusumo Central Hospital, Jakarta. In the same year, the Ministry of Health (MOH) established a Working Group on AIDS based at the National Institute of Health Research and Development (NIHRD).

After the detection of the first confirmed case of AIDS in 1987, the MOH established a National AIDS Committee (NAC) under the chairmanship of the Director General of Communicable Disease Control and Environmental Health (CDC-EH). The first National AIDS Strategy was formulated in 1995 and the second National AIDS Strategy (2003-2007) was launched in 2003. According to the 2003 strategy, there are 21 agencies and ministries with roles and responsibilities in the HIV response. These agencies and ministries were reviewed in the Baseline Survey of 2004.

Based on Presidential Regulation No. 75/2006, the National AIDS Commission has recently been reorganized and expanded to encompass 5 non-government organizations in addition to the 21 government ministries and agencies. The new NAC has a full-time Secretary, Dr. Nafsiah Mboi, who is also a member of the

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<sup>2</sup> Term "Tanah Papua" used to refer to two provinces "Papua" and "West Papua" formerly the single province of Papua.

National AIDS Committee. With funding from the Indonesia Partnership Fund/DfID, a full-time Secretariat with over 30 personnel has been established.

A new National AIDS Strategy was launched in 2007. Roles and responsibilities were assigned to the various ministries, agencies and non-government organizations (NGOs), but the earlier roles and responsibilities of some ministries were removed. For example, the roles of the Ministry of Finance, Ministry of Defence, Ministry of Trade, Ministry of Agriculture and the Food & Drug Control Agency in the 2003 national strategy have changed or been omitted in the 2007 strategy. An Executive Team consisting of officials from the NAC's 26 member ministries, agencies and NGOs was formed in 2007 to represent the ministers and agency heads and to better coordinate the activities of the different sectors. The Executive Team is chaired by the Secretary of NAC and meets quarterly.

The NAC currently has 12 working groups that help formulate technical policies with each working group responsible for a specific aspect of the HIV response. These working groups are focused respectively on: Papua; Women; Children and Youth; Harm Reduction; Communications and Promotion; Care, Support and Treatment; Monitoring and Evaluation; Estimation and Surveillance; World of Work; Migrant Populations; Law and Human Rights; and Research and Operational Studies.

In addition to strengthening of the NAC as a leading entity to respond to the epidemic, there has been some progress made in national HIV programs such as an increased number of services provided to HIV beneficiaries. As of the end of 2007, there were 296 VCT clinics throughout Indonesia, plus 153 hospitals which provide free ART and 19 hospitals where PMTCT programs exist. In addition, there are already 20 referral networks for Integrated Management Adult Illnesses (CDC MoH, 2007).

While those numbers show sound achievement, the percentages of MARPs covered by the programmes are still low, ranging between 4 and 43%, and are thus still far from the targets established to reverse the course of epidemic. One of the most important factors is to encourage greater involvement of PLHIV and members of MARPs in prevention initiatives. Today there are 115 support groups that help 5000 PLHIV in 71 municipalities, as well as a growing number of community organizations that help reducing stigma and discrimination against PLHIV.

Up until now, the response to HIV in Indonesia is still heavily dependent on international support. Less than 30% of the HIV spending in Indonesian is contributed by the government. However, there is an increase in provincial budget allocated to the HIV response: in 23 provinces the HIV budget increased from Rp 8 billion in 2004 to Rp 57 billion in 2007. In the mean time, the municipalities' budgets have also increased from Rp 3.5 billion in 2005 (for 43 municipalities) to Rp 19 billion in 2007 (for 86 municipalities). Although this increase has not yet met the resource requirements, it signifies the commitment of the government to adequately address the epidemic.

## *Civil society*

Numerous NGOs and community-based organizations (CBOs) have been working on HIV in the field, particularly at the grass-roots level. They play a key role in implementing HIV prevention in Indonesia by reaching people of different groups that are often not easily reached by the government staff, most notably youth, faith-based groups, women, professionals, high-risk groups, and people living with HIV (PLHIV). The NGOs' activities include outreach, training, mentoring for PLHIV, giving support, and counseling. NGOs and CBOs also play an important role in motivating PLHIV to establish self-help groups to provide mutual support, and facilitating PLHIV to become more involved in HIV prevention.

However, a number of challenges are still faced by civil society groups in their response to HIV. Even with the important role that it plays at the grassroots level, civil society often lacks the political or financial support necessary for involvement in higher levels of decision-making. At times, it is even treated as a target group rather than as a stakeholder that is active in the nation's HIV response. This lack of involvement reflects challenges on several levels. In many cases, few members of civil society are familiar with commitments such as UNGASS-related the Declaration of Commitment on HIV/AIDS and are not aware of the requirements and opportunities to participate in related processes. This makes it difficult to meet demands for their involvement in the development of country reports, for example. In other cases, government agencies often perceive their systems as sufficient to collect all the data needed to get a clear picture of the HIV and AIDS situation within the country, which consequently hinders the involvement of civil society in compiling country reports.

Nevertheless, the progress made over the years should be acknowledged as significant changes have been made. The government of Indonesia has acknowledged that HIV is one of the important challenges in the health sector. Advocacy has led to the creation of policies that are favourable for HIV prevention and so far the results are quite positive. Support from international partners has also succeeded in developing the system to respond to HIV, including by raising awareness of the epidemic.

At the national level, progress is often reflected through the process of decision-making, policy design, development of the national AIDS programs, and other significant mechanisms. The National Composite Policy Index (NCPI) forum, the results of which are attached to this report, has facilitated greater involvement of civil society in the report-making process. This progress should be sustained so as to ensure equal partnerships between governments, multilateral & bilateral agencies, donors and civil society at the national, regional and international level.

## ***E. Policy and programmatic response***

Up to August 2007 there were a total of 31 HIV-related regulations and policies produced by the Indonesian government. The most important of these may be the Presidential Regulation no. 75/2006, regarding the re-formation of the National AIDS Commission. The aim of this is to accelerate HIV prevention and change the

course of the epidemic by intensifying programs which are holistic, unified, and well-coordinated. In general, the Indonesian government's commitment is to reduce the number of new infections to one million people by 2020, as well as to meet the targets as have been set in the MDGs and UNGASS.

The National HIV and AIDS Action Plan 2007-2010 is an important document which serves as a national guideline for HIV programs. It explains that AIDS program implementation in Indonesia takes into account 3 issues. First, the program is directed mainly at reaching the IDU and sex worker (SW) sub-populations, as well as two other sub-populations: partners of IDU and clients of sex workers. Second, the priority program components are preventing transmission through needles and syringes and preventing sexual transmission, in order to slow the rate of growth of new HIV infections. The program is comprehensive in certain areas, covering healthy lifestyle promotion, VCT, STI prevention, harm reduction, CST, universal precautions and safe blood transfusions. Third, the program prioritizes coverage in 19 provinces that contain 80% of the estimated total population of people most at risk throughout Indonesia. Among the provinces are 2 provinces in Tanah Papua that are experiencing a generalized epidemic and 2 will receive special attention.

Recognizing the enormity of the epidemic as well as its impacts upon the future of nation, the Indonesian government has committed to mobilizing resources not only to respond to the epidemic but also to lessen the stigma and discrimination associated with it. The government endorses family and community-based caring for PLHIV.

It is important to note that according to participants of the NCPI 2007 forum; in general there have been improvements in producing and implementing policies and the national AIDS strategy. Still, considering the rapid spread of the epidemic, Indonesia must continue to accelerate its response.

Following is an overview table of UNGASS indicators showing the situation in Indonesia and progress made in care and prevention.

**Table 1: Overview of UNGASS Indicators**

<b>Indicators</b>	<b>Numbers</b>	<b>Data Sources</b>
<b>NATIONAL COMMITMENT AND ACTION</b>		
1. Expenditures	Total AIDS expenditure: USD 56.6 m Public sectors (central and local government): USD 41.5 m (24%) International sources: USD 15 m (76%)	National AIDS Spending Assessment, NAC 2007
2. National Composite Policy Index	Please see annex A	NCPI workshop with GoI's multi-sector and civil society
<b>NATIONAL PROGRAMMES</b>		
3. Percentage of donated	Indicator is relevant to the country, but the	Indonesian Red

<b>Indicators</b>	<b>Numbers</b>				<b>Data Sources</b>
blood units screened for HIV in a quality assured manner	available data do not represent Indonesia. Detailed information available in chapter 3.				Cross Annual Report, 2007 and CDC MoH 2007
4. Percentage of adults and children with advanced HIV infection receiving ART	Adults & children: 24.8% Males: 22.2% Females: 43.8% Under 15: 25.3% Above 15: 24.8%				ART Monitoring, CDC MoH, 2007
5. Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of MTCT	3.5%				ART Monitoring, CDC MoH, 2007
6. Percentage of estimated HIV-positive incident TB cases who received treatment for TB and HIV	Indicator is relevant to the country, but data are not available				CDC MoH, 2007
7. Percentage of women and men aged 15-49 who received an HIV test in the 12 months and who knows their results	Indicator is not relevant to our country, data are not available.  Note: DHS 2007 has included this indicator, but the data are not ready.				DHS, Central Bureau Statistics, 2007
8. Percentage of most-at-risk population that have received an HIV test in the last 12 months and who know their results.		Sex Workers (%)	MSM (%)	IDUs (%)	IBBS MARPs, CDC MoH, 2007
	Males	52.2		35.7	
	Females	25.1		41.5	
	All	30.8		35.9	
	< 25	27.1	30.3	32.7	
	≥ 25	32.6	33.0	37.3	
	All	30.8	31.9	35.9	
9. Percentage of most-at-risk population reached with HIV prevention programmes (covering 2006)		Sex Workers (%)	MSM (%)	IDUs (%)	IBBS MARPs, CDC MoH, 2007
	Males	59.9			
	Females	34.3			
	All	39.6			
	< 25	36.8	35.8	38.9	
	≥ 25	41.0	43.2	47.3	
	All	39.6	40.1	44.7	
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in	Indicator is not relevant to country, data are not available				

<b>Indicators</b>	<b>Numbers</b>	<b>Data Sources</b>																												
caring for the child																														
11. Percentage of schools that provided life skills-based HIV education in the last academic year	10%	LSE Survey , UNICEF & MoE, 2006																												
<b>KNOWLEDGE AND BEHAVIOUR</b>																														
12. Current school attendance among orphans and among non-orphans aged 10-14	Indicator is not relevant to country, data are not available																													
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 misconception about HIV transmission	Indicator is relevant to country, data are not available	DHS, 2007 Central Bureau Statistics																												
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	<table border="1"> <thead> <tr> <th></th> <th>Sex Workers (%)</th> <th>MSM (%)</th> <th>IDUs (%)</th> </tr> </thead> <tbody> <tr> <td>Males</td> <td>37.1</td> <td></td> <td></td> </tr> <tr> <td>Females</td> <td>26.2</td> <td></td> <td></td> </tr> <tr> <td>All</td> <td>28.5</td> <td></td> <td></td> </tr> <tr> <td>&lt; 25</td> <td>27.5</td> <td>35.8</td> <td>51.4</td> </tr> <tr> <td>≥ 25</td> <td>29.0</td> <td>45.8</td> <td>61.4</td> </tr> <tr> <td>All</td> <td>28.5</td> <td>41.6</td> <td>58.3</td> </tr> </tbody> </table>		Sex Workers (%)	MSM (%)	IDUs (%)	Males	37.1			Females	26.2			All	28.5			< 25	27.5	35.8	51.4	≥ 25	29.0	45.8	61.4	All	28.5	41.6	58.3	IBBS MARPs, FHI & CDC MoH 2007
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16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than 1 partner in the last 12 months	Indicator is not relevant to country, data are not available	DHS 2007, Central Bureau Statistics																												
17. Percentage of women and men aged 15-49 who had more than one partner in the last 12 months reporting the use of a condom during their last sexual-intercourse	Indicator is not relevant to country, data are not available	DHS 2007, Central Bureau Statistics																												



<b>Indicators</b>	<b>Numbers</b>				<b>Data Sources</b>
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Males	72.0			IBBS MARPs, FHI & CDC MoH, 2007
	Females	67.7			
	All	68.6			
	< 25	65.3			
	≥ 25	70.2			
	All	68.6			
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	< 25	41.9			IBBS MARPs, FHI & CDC MoH 2007
	≥ 25	37.3			
	All	39.3			
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Female	34.0			IBBS MARPs, FHI & CDC MoH, 2007
	Males	30.2			
	All	33.9			
	< 25	29.1			
	≥ 25	36.1			
	All	33.9			
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Males	81.7			IBBS MARPs, FHI & CDC MoH, 2007
	Females	88.7			
	All	82.0			
	< 25	82.5			
	≥ 25	81.7			
	All	82.0			
<b>IMPACT</b>					
22. Percentage of young women and men aged 15-24 who are HIV infected	Indicator is not relevant to country, data are not available				
23. Percentage of most-at-risk population who are HIV infected		Sex Workers (%)	MSM (%)	IDUs (%)	IBBS MARPs, FHI & CDC MoH, 2007
	Males	20.3		52.2	
	Females	7.1		56.1	
	All	9.5		52.4	
	< 25	8.4	1.6	41.7	
	≥ 25	10.0	3.6	57.9	
	All	9.4	5.2	52.4	
24. Percentage of adults and children with HIV known to be on treatment 12 month after initiation of ART	Indicator is relevant to our country. Data is not available.				ART Monitoring, WHO & CDC MoH, 2007
25. Percentage of infants born to HIV-infected mothers who are infected	Country is not required to submit this indicator. This indicator will be modelled at UNAIDS Headquarters, using data submitted in Country Progress Reports for the coverage of services to prevent mother-to-child-transmission indicator				Report on Mathematic Modeling in Epidemic Trend on HIV-AIDS Indonesia until 2020,

<b>Indicators</b>	<b>Numbers</b>	<b>Data Sources</b>
		Pandu Riono, CDC MOH, NAC 2007

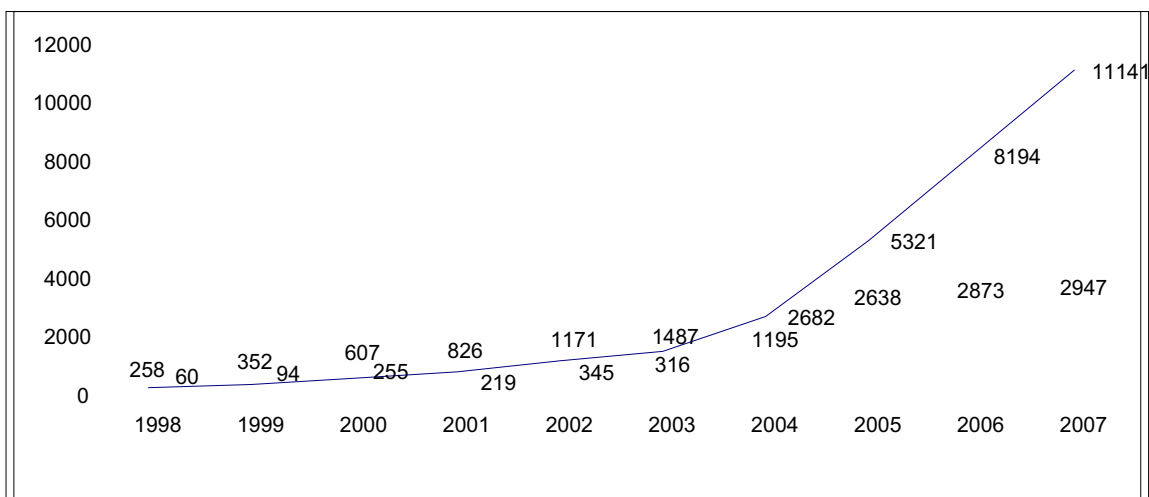
More comprehensive analysis of each indicator, when available, is provided in chapter 3 of this report.

## II. Overview of the AIDS Epidemic

The first known case of HIV in Indonesia was in a foreign tourist in Bali in 1987. In the 20 years since, the epidemic has grown from a low level, concentrated epidemic fuelled largely by sharing of injecting equipment, to an estimated 190,000 HIV infections increasingly transmitted through unsafe sex. Despite efforts to prevent increases in new infections, the number of new cases per year continues to rise. Transmission remains largely through the sharing of contaminated injecting equipment among drug users. Injecting drug use appears to be a growing phenomenon in urban Indonesia and is also increasingly recorded in non-urban areas. HIV prevalence among injecting drug users has been recorded as very high in Jakarta, West Java, East Java and Bali. This sub-population is thought to be the most severely affected by the HIV epidemic in Indonesia. Significant increases in transmission via unprotected sex are also being recorded, signifying a shift towards sexual transmission in the epidemics.

Besides the persistent challenges of injecting drug use and unprotected sex, the spread of HIV in the country is further exacerbated by several factors, including a widespread commercial sex industry, high prevalence rates of STIs and insufficient STI clinical services, as well as very low levels of condom use (discussed further in Chapter 3) ('Situasi Epidemi dan Kebijakan PMS, HIV - AIDS di Indonesia'. CDC MoH, 2007).

Figure 1: Trend in of Total AIDS Cases over 10 years (as of 31 December 2007)



Source: Ministry of Health, 2007

## **A. Most-at-Risk Populations (MARPs)**

The most recent data on the status of the HIV epidemic in Indonesia is from the report, 'Estimates of Adult Populations at Risk of HIV Infection in 2006', based on research conducted by the Ministry of Health and the NAC. This report estimates that 4 to 8 million people in the country are at high risk of contracting HIV, most of who belong to two sub-populations: clients of sex workers (3.1 million), and the partners of clients of sex workers (1.8 million). Among the estimated number of people living with HIV (PLHIV) in Indonesia, 46% are IDUs and 14% are clients of sex workers. Vulnerability is further complicated among IDUs, many of whom also buy and sell sex.

It is estimated that by 2010, some 400,000 people will be living with HIV, and 100,000 will have already died of AIDS. In 2015, there will be 1 million PLHIV and 350,000 HIV-related deaths in Indonesia. The risk of HIV transmission is not limited to people who engage in high risk behaviour; HIV can also be transmitted to partners or wives of those with high risk behavior, and in Indonesia, transmission from mothers to children is also increasing. It is estimated that by the end of 2015, HIV will have been transmitted to more than 38,500 children through their HIV- positive mothers. The majority of these mothers will have contracted HIV from their husbands.

It has also been predicted that the epidemic will continue to expand if coverage of programs remain at their current levels. Surveillance shows that the epidemic remains at a low level in the general population with prevalence at 0.2%. However, there are high prevalence rates in vulnerable subpopulations, including 48% of injecting drug users in East Java, 22% of sex workers in Papua, and 25% of prisoners in Jakarta (Epidemiology Update. UNAIDS, 2007).

Since the year 2000, the HIV epidemic in Indonesia has been concentrated in 4 particularly vulnerable sub-populations (with prevalence > 5%): injecting drug users (IDU) and sex workers (including female and male sex workers), MSM who sell sex, and waria<sup>3</sup> who sell sex. The Ministry of Health (MoH) has reported consistent HIV prevalence at above 5% in a number of high risk sub-populations since 2000. In 2006, data from various sentinel sites indicated that HIV prevalence was in the range of 21% - 52% among IDU, 1% - 22% among FSW, and 3% -17% among waria. From 2007 IBBS among MARPs, the prevalence of HIV are as follows: 20.3% among MSW, 7.1% among FSW (or 9.5% among all sex workers); 5.2% among MSM; and 52.2% among male IDUs, 56.1% among female IDUs (or 52.4% among all IDUs).

The Ministry of Health also reported that the rate of increase in new AIDS cases rose over the last 3 years. The number of new AIDS cases in 2006 totalled 2,873, which was more than double the number of cases reported in the first 17 years of the

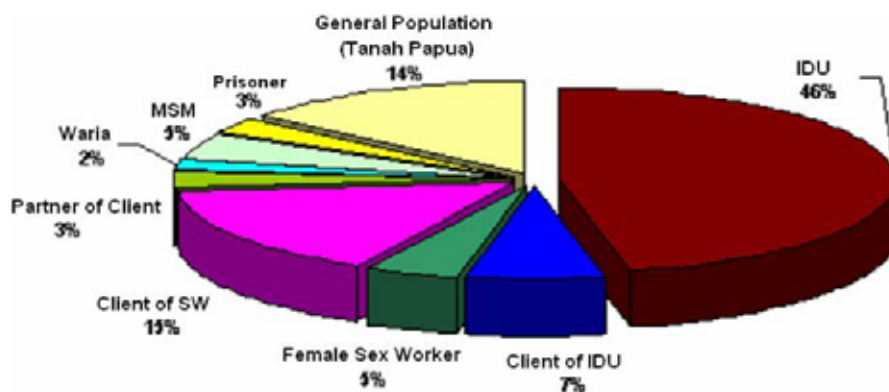
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<sup>3</sup> Waria is derived from the words female (wanita) and male (pria) and can describe a range of identities, including transgendered, those who identify as male but present as female, those who identify closely as female but are biologically male, and those that imitate women in dress and mannerism but identify as male, and those that neither identify as male or female.

epidemic. Of these new cases, 82% occurred in males and 74% in people under the age of 30.

The number of regions reporting AIDS cases has also increased. At the end of 2000, there were only 16 provinces reporting AIDS cases; however by the end of 2003 cases were reported in 25 provinces. This number increased sharply in 2006, with 32 of the 33 provinces in Indonesia reporting cases of AIDS.

**Figure 2: Estimated Proportions of People with HIV in Indonesia in 2006**



Source: Report on the Estimates of Populations at Risk of HIV Infection in 2006, Ministry of Health

### *Injecting Drug Use*

Heroin use took hold in Indonesia in the late 1990s, coinciding with the shock of the Asian financial crisis and the social and political upheavals associated with the fall of President Suharto's authoritarian regime. In Indonesia heroine is readily available and easy to buy.

Transmission through sharing contaminated injecting equipment is currently the primary mode of HIV infection in Indonesia. According to Estimates of Adult Populations at Risk of HIV Infection in 2006, the NAC reported that at the end of 2006 there were 219,200 people injecting drugs and 50% of them were infected with HIV. The 5 provinces most affected by injecting drug use are the Greater (DKI) Jakarta, East Java, West Java, North Sumatra and South Sulawesi.

According to a sentinel survey, half of all injecting drug users (IDUs) in Jakarta are HIV-positive, and modeling suggests that by the end of the decade they will account for over 100,000 infections in Jakarta alone. IDUs sharing needles rapidly spreads HIV, which can then potentially be transmitted into the wider population via unprotected sex. Even where the numbers of people injecting drugs are relatively small, their contribution to the overall HIV epidemic in a country can be considerable.

In 2007 the Coordinating Minister for People's Welfare issued a new regulation (no2/Per/Menko/Kesra/I/2007) on the National HIV and AIDS Policy for

Reducing Harm Arising from Injection of Narcotic, Psychotropic & Other Addictive Substances. Some leaders believe it has taken political bravery for the government to embrace the new drug policy; local communities generally regard addicts as street criminals and conservative politicians complain that the strategy encourages drug use, which has exploded over the past decade. However, the reality is that even with the recent changes, the authorities may be responding too late and too haphazardly.

## ***B. Report on the 'Tanah Papua' epidemic***

The region known as Papua consists of 2 provinces with special government autonomy within Indonesia. With 42.2 million hectares of land, it represents 22% of Indonesia's total land area. As a percentage of the total population, however, Papua is small, with the Bureau of Statistics reporting a total population of less than 3 million people in 2005. This makes the region geographically sparsely populated, with approximately 28 % of the population living in urban areas and the rest in rural, sometimes very isolated areas. Life expectancy is 65.2 years of age.

Papua is endowed with abundant forest, water and mineral resources, which, combined with its many vibrant cultures, gives it a unique identity. Although Papua enjoys Indonesia's fourth highest level of GRDP per capita (over Rp.11 million), economic development has not been shared by most Papuans and has not translated into corresponding levels of human development. Papua has the highest incidence of poverty nationally, with 41.8% of Papuans living on less than USD1 per day. This is 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 Papua provinces lag behind most other provinces. According to the HDI 2004, Papua ranks lowest in Indonesia. It stands out as one of the few 'declining' regions, actually suffering deterioration in HDI status, which is mostly attributed to declines in education coverage and income levels.

The government's 'Demographic Health Survey in Papua' (1997) showed an infant mortality rate at 65 per 1000 live births, and child mortality at approximately 30 per 1000. Barely half of all births are assisted by trained medical personnel in Papua (Provincial Health Service, 2005). The Bureau of Statistics census of 2000 indicated that only 82% of children in Papua attend primary school (SD), 47% attend junior secondary school (SLTP), and 19% attend senior secondary school (SMU). These figures place Papua far below national levels and paint a much more serious development situation than the GRDP data above ('Papua Needs Assessment: An Overview of Findings and Implications for the Programming of Development Assistance'. UNDP, 2005).

While most provinces in Indonesia still have concentrated HIV epidemics, the 2 provinces of Papua are experiencing a generalized epidemic. In Papua province the AIDS case rate (number of reported AIDS patients per 100,000) is 15 times higher

than the national average; and it is twice the national rate in West Papua<sup>4</sup>. A first population-based, integrated bio-behavioural surveillance study (IBBS) conducted there in late 2006 found an HIV prevalence rate of 2.4% among the general population aged 15–49.

Several studies show that sexual behaviour patterns in Papua are of particular relevance to HIV transmission. Average sexual debut begins at 19.5 years old for males and 18.8 for females ('Risk Behaviour 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 youth in Papua (14-24 years of age) the number with a sexual debut before 15 years of age is significantly higher than amongst people in older age groups (25-39 and 40-49). This trend is more predominant amongst females than males. The relatively early age of sexual debut is not accompanied by sufficient knowledge of reproductive health, including sexually transmitted infections and HIV. This lack of information increases their vulnerability to infection.

The IBBS study found that 48% percent of the population had never heard of HIV or AIDS. Population groups with low levels of education (never attended school or did not complete primary education) had much lower levels of knowledge, with 74% never having heard about HIV or AIDS, compared to 20% of those who have graduated from senior high school or university ('Risk Behaviour and HIV Prevalence in Tanah Papua: Results of the IBBS in Tanah Papua 2006').

HIV prevalence among the ethnic Papuans is higher (2.8 %) compared to non-ethnic Papuans (1.5 %). However this difference does not reflect vulnerability based on ethnicity, but rather reflects differences in knowledge levels, particularly related to prevention and risk behaviour.

According to a study completed by the Government Health Service in Papua (2003), 68% of HIV infected people in Papua are indigenous, 22% are non-Papuan and 10% are in high risk groups, such as sex workers and their customers. With the expansion of the mining, oil and timber industries, as well as the arrival of security forces in large numbers, many isolated areas in Papua have developed an accompanying sex work. The number of HIV infections are expected to continue to increase as the sex work continues to expand and the availability and consistent use of condoms remain low. In general, however, risky sexual behaviour (such unprotected sex and frequently changing partners) and is responsible for over 90% of HIV transmission in Papua (Papua Needs Assessment: An Overview of Findings and Implications for the Programming of Development Assistance'. UNDP, 2005).

The main sources of information about HIV for people in Papua are radio and television. Both media are cited by 52% of the population as their primary source of information. These respondents were also the group with the highest education levels. Only a small portion of the population had ever attended a meeting about HIV: just 8% of those with a low level of education and 26% of those with the

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<sup>4</sup> Ministry of Health. Quarterly report on the epidemic. 30 September 2007

highest level of education had attended meetings or information sessions ('Risk Behaviour and HIV Prevalence in Tanah Papua: Results of the IBBS in Tanah Papua 2006').

The attitudes of people in Papua who personally know someone living with HIV were highly diverse. The highest percentage (34.3%) kept their distance from PLHIV. PLHIV were shunned by a higher percentage of males than females (36.7% compared to 31.4%), and by those with lower levels of education (57.3% of residents who had not attended school/completed primary school, compared to 43.2% of those educated to primary and junior high school and 21.8% who those graduated from senior high school and above). The second highest percentage (28.3%) treated PLHIV just like any other people. Females are less likely to stigmatize PLHIV compared to males, as are people with higher education levels compared to those with lower education levels.

### *Sexual behaviour*

Most people in Papua (over 50%) reported in the IBBS that their first sexual experience was with their spouse or permanent partner, 40% with a friend and 1.6% with a sex worker. More of those in the youngest age group, both males and females, had had more than one partner compared to those belonging to older groups. In general, more than 20% of male residents and 8% of female residents had had more than one sex partner in the last 12 months. Approximately 16% of the population had had sex with a non-permanent partner in the last year. For more than half, some sort of payment was involved.

Condoms are difficult to access in Papua. Only 17% of the Papua population reported that it is easy to get condoms. Pharmacies and clinics are the main sources of condoms. The very low level of condom use is linked to availability of condoms.

HIV prevalence is higher among men who have not been circumcised, at 5.6%, compared to 1.0% among men who are circumcised. Only around 5% of ethnic Papua are circumcised, compared to 70% of non-Papuan. More in-depth research is needed to determine whether lower HIV infection rates are related to circumcision status.

Alcohol use has long been acknowledged as a social problem in Papua. However, the IBBS in Papua did not establish a correlation between alcohol consumption and HIV vulnerability or transmission, or a relationship between alcohol and sexual behaviour.

To summarise, generally Indonesia is in concentrated level of epidemic among the high-risk populations, but a low level generalised epidemic has begun in Papua. The response focusing on MARPs needs to be intensified and special approaches need to be developed to address the challenges of the HIV response in Papua.



### III. National Response to the AIDS Epidemic

Since 2000, the AIDS epidemic in Indonesia has largely remained concentrated in 4 particularly vulnerable populations: Sex workers, IDUs, MSM, and waria. In the National Action Plan, there are 19 priority provinces<sup>5</sup> for the implementation of Indonesia's HIV program. By focusing the program in those provinces, it is estimated that 80% of MARPs will be reached and the number of new HIV infection can be reduced. Moreover, although Indonesia is experiencing a concentrated epidemic throughout most of the country, as was mentioned in the previous chapter, the Papua region is already experiencing a low-level, generalized epidemic with an HIV prevalence of 2.4%.

Transmission of HIV through sharing contaminated injecting equipment was identified as the cause of acceleration in the number of infections nationally in the last 5 years. However, it is predicted that in 2008 unsafe sexual behaviors will begin to dominate transmission. This prediction has been true in the Papua region, where HIV transmission through unsafe sex is the primary mode of transmission. Understanding these trends in the epidemic is crucial for strategic planning.

The government of Indonesia has committed to a comprehensive, coordinated and strengthened response to HIV. National policy and strategy reflect Indonesia's international commitment to respond to the epidemic, mobilize resources to fight the epidemic and to eliminate stigma and discrimination against PLHIV. Indonesia formulated an updated National HIV/AIDS Strategy 2007-2010, which aims: (1) To prevent and reduce the number of new HIV infections; (2) to increase the quality of life of those who are HIV positive; and (3) to reduce social and economic impacts for those with HIV and AIDS, their families and communities.

There are 8 key targets to be met by 2010:

1. 80% of most-at-risk populations (MARPs)<sup>6</sup> have access to a comprehensive prevention program.
2. 60% of MARPs reached with behavior change interventions.
3. 80% of those who are eligible can access ARV and CST as needed.
4. Enabling environment established, in which civil society can play a significant role, and stigma and discrimination are eliminated or at least minimised.

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<sup>5</sup> These provinces are: North Sumatra, Riau, South Sumatra, Lampung, Riau Islands, DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Banten, Bali, West Kalimantan, East Kalimantan, South Sulawesi, North Sulawesi, Maluku, West Papua and Papua.

<sup>6</sup> Sub-populations which have already been identified as MARPs in Indonesia are injecting drug users, MSM, sex workers and their clients, migrant workers, refugees, prisoners as well as those who are 15 years of age and above in Papua and West Papua provinces.

5. Funding and other resources (both from domestic and international sources) can meet needs in 2008.
6. 60% pregnant women who are HIV positive can get ARV prophylaxis.
7. Orphaned and vulnerable children (OVC) can access proper support.
8. 50% reduction in new infections, or 35,000 new infections instead of the 70,000 new infections projected in 2010 if program coverage remains at current levels.

To achieve these targets, programs must be guided by the following strategies:

1. Focusing programs to move towards achieving Universal Access, i.e. to achieve the 8 key targets mentioned above.
2. Establishing evidence-based priorities and targets.
3. Providing a comprehensive-services approach to those who are in need.
4. Building partnership between national and local government, and with support from international funding agencies.
5. Allocating funding from the national and provincial government budgets.
6. Improving human resource capability and technical assistance.
7. Conducting policy and intervention-oriented research.
8. Strengthening the monitoring and evaluation system.

Scaling-up the implementation of a prevention programs continues to be a focus of the national strategy. A large gap remains between the national estimates of the number of PLHIV (193,000 as of September 2007) and the number of reported cases (10,382 as reported by the CDC and NAC). This gap indicates weakness in national surveillance and outreach to MARPs. Data indicates that every year 3000 to 5000 people die of AIDS in Indonesia - almost 10 people per day - and it is expected that most of these deaths are preventable if there is earlier diagnosis and earlier commencement of appropriate treatment.

The NAC launched the 'Acceleration Program' in 100 districts in April 2006. This program aims to provide MARPs in 100 districts in Indonesia with comprehensive services, including: Behaviour change interventions; 100% condom use in at-risk areas; STI clinical services with a public health design; VCT services; harm reduction services for IDUs; CST services; PMTCT services; and Public Service Announcements.

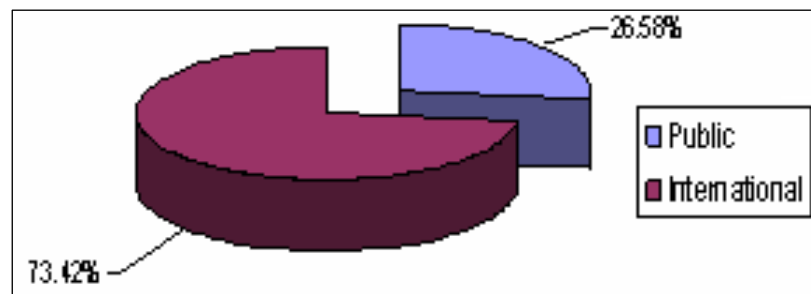
## ***A. National Commitment and Action***

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

This report covers expenditure data from 2006 from both international and public sources.

In 2006, total AIDS expenditure was USD 56,576,587, of which 73.42% (USD 41,538,103) was financed by international sources and 26.58% (USD 15,038,484) by the public sector (central and local government). Private sources were not included in the analysis since such data are not available.

**Figure 3: Proportions of AIDS Spending by Source of Funds in 2006**

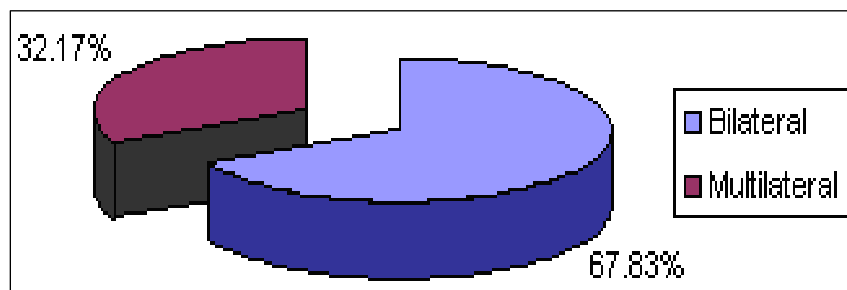


### **Expenditure by Source of Fund**

#### **1) International Sources**

In 2006, of the total international expenditure on AIDS in Indonesia, bilateral funds contributed 67.83% (USD 28,175,558) and multilateral partners contributed 32.17% (USD 13,362,545). Bilateral partnerships included the government of the United States (US), Australia, United Kingdom (UK), Japan and the Netherlands, while multilateral donors included United Nations programs, as well as the Global Fund and a number of other international partners such as International Red Cross. Figure 4 below shows the breakdown of total international expenditure on AIDS in Indonesia.

**Figure 4: Proportions of AIDS Spending by International Partners in 2006**



## Bilateral Contribution

Of all bilateral commitments to the HIV response in Indonesia, significant contributions were provided by the governments of UK (DFID), USA (USAID) and Australia (AusAID). The Indonesian Partnership Fund for HIV/AIDS, funded by DFID, consisted of 52.74% of total bilateral commitment for AIDS. The proportion of the bilateral funds from USAID was 25.15% (mostly implemented by FHI/ASA) and AusAID 21.34% (mostly implemented by IHPCP). The remaining bilateral support (less than 1%) was provided by other partners.

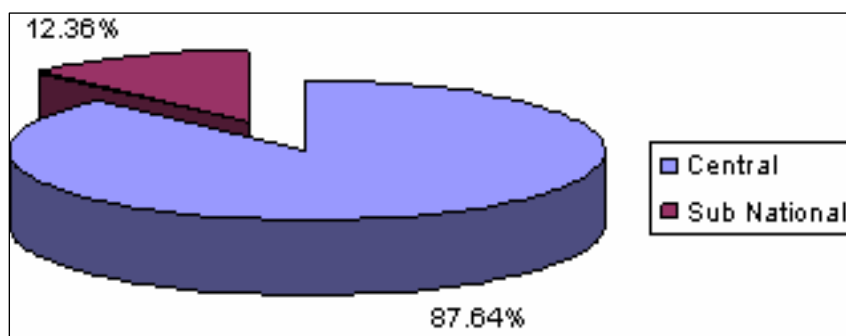
## Multilateral Contribution

The Global Fund was the largest sources of funding from multilateral source in Indonesia, providing USD 10,464,961 or 78.32% of the total multilateral contributions. While, UN development partners, funds and programs provided USD 2,897,137 or 21.68% of the total multilateral funding, and the remaining funds were provided by other international source.

### 2) Public Sources

Figure 5 shows that 87.64% of public spending on AIDS in 2006 was contributed by the national government. In analyzing the sub-national level contributions from public sources, 3 provinces with the highest prevalence were sampled: DKI Jakarta, Bali and Papua.

Figure 5: Proportions of AIDS Spending by Public Source in 2006



### Central Level Contribution

Contributions from the national level come predominantly through the Ministry of Health (MOH), the primary implementer of HIV programs in Indonesia.

Table 2 outlines spending by sector. The MOH spent USD 12,543,092 in 2006, or 95.17% of national government spending on AIDS.

**Table 2: Central Level Public Spending by Ministries, 2006**

No	Ministry	Expenditure (USD)	%
1	MINISTRY OF HEALTH	12,543,092	95.17
2	MINISTRY OF MANPOWER	17,793	0.14
3	MINISTRY OF WOMEN'S EMPOWERMENT	19,651	0.15
4	ARMED FORCES (TNI)	48,478	0.37
5	MINISTRY OF EDUCATION	116,206	0.88
6	NATIONAL FAMILY PLANNING BOARD	23,033	0.17
7	MINISTRY OF SOCIAL WELFARE	188,490	1.43
8	MINISTRY OF INTERNAL AFFAIR	25,992	0.20
9	MINISTRY OF TRANSPORTATION	24,457	0.19
10	MINISTRY OF LAW AND HUMAN RIGHT	9,626	0.07
11	MINISTRY OF DEFENSE	162,645	1.23
	Total	13,179,462	100.00

### Sub-National Expenditure

In 2006, total AIDS expenditures at the sub-national level (3 provinces) amounted to USD 1,859,021 or 12.36% of total public spending. Among the 3 provinces sampled, DKI Jakarta is the province with highest HIV and AIDS expenditure within the year (USD1,195,652), followed by Papua (USD 545,464) and Bali (USD 117,905). Other provinces' contributions were not included in the analysis since information on spending category is not available.

### AIDS Spending Categories

Total AIDS expenditure from international and public sources is further broken down in Table 3. The majority of funding was used in prevention programs (40.97%), followed by care and treatment (24.88%), and program management (21.50%).

**Table 3: AIDS Spending: Total expenditure from international and public sources**

No	Program	Expenditure (USD)	%
1	Prevention	23,179,628	40.97
2	Care and Treatment	14,073,523	24.88
3	Orphan and vulnerable children	45,850	0.08
4	Program Management and Administration Strengthening	12,161,368	21.50
5	Incentives for Human Resources	4,562,592	8.06
6	Social Protection and Social Services	27,174	0.05

No	Program	Expenditure (USD)	%
	excluding Orphans and Vulnerable Children		
7	Enabling Environment and Community Development	2,413,421	4.27
8	Research excluding operations research	113,031	0.20
	Total	56,576,587	100.00

Harm reduction programs were the government's major area of expenditure in the national HIV response in Indonesia. Most of the care and treatment spending was for providing treatment of opportunistic infection (OI). The MOH reported that Round IV of GFATM is focused on providing care and treatment. GFATM support for care and treatment was higher than any other sources of funding and accounted for about 67% of total resources to fund care and treatment programs. Social Protection and Social Services was the lowest funded category in AIDS spending in 2006.

Analysis of AIDS Spending in 2006 indicates that the majority of funding continues to come from international sources. While data available from the public sector are limited, there is almost no known funding from the private sector. In this context, the government of Indonesia should prioritize HIV programs by increasing their budget allocations. The government of Indonesia should begin to phase out the international support for programs such as care and treatment (which is currently supported mostly by GFATM), or prevention, and gradually take over the role in the future. The government should increasingly fund these programs, depending less on external sources in the future, and eventually should take the role as the main source of funding for all program areas.

To improve data collection and analyses, it is recommended that the NAC and MOH track expenditure from other than the 3 mentioned provinces, both by source and by spending category, and highlight disparities between provinces with high and low prevalence and resource implications. Additionally, the National AIDS Spending Assessment (NASA) provides a set of spending categories which can be used for monitoring and evaluation purposes. It is proposed that NAC institutionalize a process of tracking expenditures using NASA tools, not only for future UNGASS reporting but also for resource mobilization and advocacy purposes.

It is also recommended that the NAC collate data on expenditure from private sources. This could be done through data collection from providers, private companies and a household survey, especially in provinces with high prevalence.

## **Indicator 2: National Composite Policy Index 2007**

The purpose of the National Composite Policy Index (NCPI) is not only to measure achievements within the last 2 years, but also to involve all stakeholders in the reporting process. As mentioned in Chapter 1, prior to the report writing process, 2 workshops were held to complete the NCPI questionnaire. Two critical aspects about that process are: (1) that there were different participants from previous NCPI

processes invited to the meeting; and, (2) that the 2007 NCPI participants re-evaluated the appraisal of some topics completed by previous NCPI participants (see the NCPI Result table below).

## Responses in the National Composite Policy Index (NCPI) 2007

### Part A: Administered by government officials

Table 4: Results of NCPI Part A 2003 and 2005, compared to year 2007

No	Topic	Rate out of 10			
		2003	2005	Re-valuation of 2005's score by 2007 respondents	2007
1.	Strategic plan	6	7	6	7
2.	Political support	6	6	-	7
3.	Prevention	6	7	6	7
4.	Care and support	6	7	6	7
5.	Monitoring and Evaluation	5	6	7	8

Based on the re-valuation of 2005 scores, the NCPI 2007 participants indicated that improvements were achieved in the strategic plan, political support, prevention, care and support, as well as in monitoring and evaluation systems administered by the government.

### Part B: Administered by representatives of NGOs, bilateral organizations and UN

Table 5: NCPI results Part B 2003 and 2005, compared to year 2007

No	Topic	Rate out of 10			
		2003	2005	Re-valuation of 2005's score by 2007 respondents	2007
1.	Human Rights Policies, laws and regulations in place	3	4	-	5
	Efforts to enforce existing policies, laws and regulations	5	6	-	6
3.	Civil society participation	6	7	5	7
4.	Prevention program	6	7	5	6
5.	Care and support	6	8	5	6

*Note: The 2007 NCPI participants were different to those of 2005, and this meant there were different results for some topics.*

Based on the re-valuation of NCPI 2005 scores, the participants agreed that there were improvements regarding the accomplishment in human rights, civil society

participation, prevention, care and support. However, on a scale of 0-10 the scores that participants gave and agreed upon reflect the challenges that still need to be overcome, especially in care and support. Compared to 2003, for instance, it is evident that participants believe no significant improvements have been made in several areas.

The participants indicated that although the number of referral hospitals providing HIV services to patients has increased (including antiretroviral therapy and harm reduction programs in Jakarta and West Java province), other problems are still far from being properly addressed. The co-infection of HIV with tuberculosis, increasing number of HIV patients suffering from opportunistic infection, as well as the number of paediatric cases are among the reasons for this re-valuation score.

The critical challenges highlighted by the participants in 2007 were as follows:

1. Inadequate program management
2. Low levels of knowledge of STI and HIV;
3. Low levels of condom use, especially triggered by controversy over condom promotion and effective regulations for condom promotion not yet developed;
4. The generalized epidemic in Papua;
5. Lack of commitment of local AIDS commissions;
6. Limited role of AIDS commissions, both at the national and local level;
7. Lack of internal coordination in National AIDS Commission;
8. Sectoral regulations that do not support HIV prevention;
9. Inequitable distribution of funding within provinces; and
10. Not all donor blood can be screened due to lack of facilities at the district level.

### **Indonesia's Policy Response**

National policy aims at creating an enabling environment for successful program implementation. Important policies and documents formulated by the government that support implementation of HIV programs are:

Presidential Decree No. 36/1994 regarding the Establishment of the National AIDS Commission (NAC) and Regional AIDS Commissions as the government institution that will coordinate the fight against AIDS. This was followed by the first National AIDS Strategy (1995-1999 Strategic Plan), the 2003-2007 Strategic Plan, and most recently the 2007-2010 Strategic Plan.

The adoption of the commitment at the United Nation General Assembly Special Session on HIV and AIDS (UNGASS) in 2001, as a working framework for an expanded response to AIDS.



The signing of the Sentani Commitment in 2004 by 6 provinces with the most serious HIV epidemics, as a joint movement to combat AIDS; and

The Memorandum of Understanding (MoU) between the National Narcotics Agency and the NAC, which was followed by the Decision of the Coordinating Minister for Peoples Welfare Number 2/2007 regarding the Reduction of Harm Caused by Drug Use (National Action Plan, 2007-2010).

In addition to these important documents, several efforts have been taken to strengthen leadership and commitment. Special cabinet sessions on AIDS were held in 2002 and 2003 and were followed by the announcement of the National AIDS Movement. Also, to address the institutional strengthening of the NAC at the central level and in the regions, Presidential Regulation No. 75/2006 was issued to restructure the NAC in order to promote a more intensive, comprehensive, integrated and coordinated response.

The government has committed to mobilizing the necessary resources - in accordance with the country's economic capacity and circumstances - needed to control AIDS and to reduce stigma and discrimination. The government has also encouraged families and communities to take more responsibility in caring for PLHIV. On the other hand, efforts to make PLHIV themselves more responsible for safeguarding their families and communities against infection also need to be increased. Given that the HIV epidemic is a problem of global proportions, the government of Indonesia has made commitments to various international agreements to respond to AIDS, promote multilateral and bilateral cooperation, and to expand cooperation with neighboring countries in AIDS programs.

To improve coordination and participation of the community in the AIDS response, the following efforts have been made: (1) Accelerated programs in 100 districts and municipalities in provinces with a concentrated HIV epidemic; (2) Strengthened role of civil society in the AIDS response, which is realized, for example, through policy development and program implementation; and (3) Coordination of government sector planning.

## ***B. National Programme Indicators***

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

Based on Indonesian Red Cross (PMI) data, in 2006 there were 1,556,819 bags of blood screened (100%), and of that number as many as 1,097 (0.07%) were identified as HIV positive.

In Indonesia, there are 188 blood transfusion units which are managed by the PMI and where all blood units donated (100%) are screened in a quality assured manner. Based on the government regulation No. 82/2006, the PMI is an independent body responsible for blood management in the whole country. PMI has succeeded in providing safe blood for transfusion, but it is still dependent on the Ministry of Health for the reagents needed for HIV screening.

In addition to the 188 blood transfusion units which are operated by PMI, there are currently 46 blood banks established in hospitals and managed by the Ministry of Health. These blood banks are located in 185 of the total 447 districts. One quarter of these services are located in hospitals. The PMI's blood transfusion services are partly subsidized by the government.

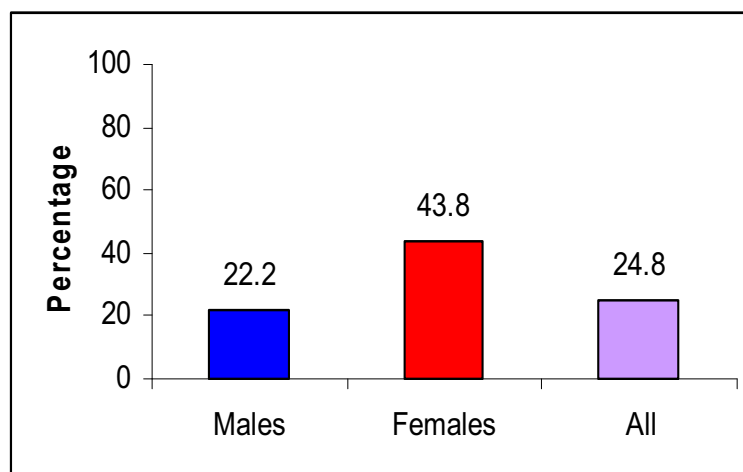
Testing of blood is supported through various means. In 2006, the Directorate General of DC & EH provided 1,500,000 routine reagents and ELISA HIV test kits, 220,000 tests for Hepatitis C Virus (HCV), 1,000,000 VDRL tests, and a small quantity of Hepatitis B (HBsAg) test kits. WHO supported 8% of the estimated requirement for HCV tests in 2006 and 2007 ('Review of the Health Sector Response to HIV-AIDS in Indonesia 2007'). The remaining reagents required for ensuring blood safety are meant to be provided directly by the blood transfusion service of the PMI, with the support of local government budgets.

Although it is believed that these blood banks conduct screening, reporting is still a challenge in many areas of activity, including blood donation and screening. Of the blood transfusion units under the PMI, only 83% report on a regular basis. Additionally, budget limitations only allow the Ministry of Health to monitor the implementation of External Quality Assessment in 10 blood transfusion units each year. Another problem acknowledged is the varying capacity to conduct screening from one unit to another.

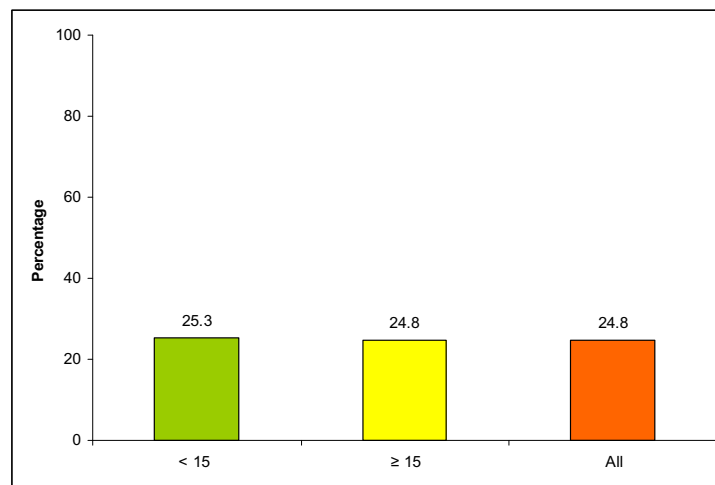
### Antiretroviral Therapy

#### Indicator 4: Percentage of adults and children with advanced HIV infection receiving ART

Figure 6: Adults and children with advanced HIV infection receiving ART, by sex (ART monitoring, CDC MoH, 2006)



**Figure 7: Adults and children with advanced HIV infection receiving ART, by age (ART monitoring, CDC MoH, 2006)**



Data as of December 2006 showed that an estimated 20,577 people had advanced HIV infection. Of those, as many as 5100 people (24.78%) are currently receiving antiretroviral therapy (ART) in accordance with the nationally-approved treatment protocol. This percentage indicates that the ART system in Indonesia is already run well, although scaling up is urgently needed to catch up with the increase of new HIV infections that has occurred. Only a minority of PLHIV who need ARVs are receiving this treatments. Most PLHIV on ART live in big cities such as Jakarta. In Papua, where there is a generalized epidemic, only 3% of PLHIV have ever received ARV treatment. Among the IDU population it is estimated that 50% of the drug users are HIV positive, but the percentage of those on ART is as low as 3%.

Distribution of antiretroviral drugs (ARV) is still a problem. While ART can be accessed free of charge since 2004, drugs are available only in hospitals in big cities. By the end of 2007, there were 296 VCT clinics throughout Indonesia, plus 153 hospitals which provide free ART, and 19 hospitals with Prevention of Mother to Child Transmission (PMTCT) programs. In addition, there are already 20 referral networks for Integrated Management Adult Illnesses (CDC MoH, 2007).

One challenge in treatment is the late diagnosis of HIV status in patients. In some public hospitals in Jakarta, many patients who consult doctors already have a very low CD4 count. For example, one patient's test results for CD4 were only 1/mm<sup>3</sup>. Many patients present to hospitals with symptoms such as fever, wasting syndrome, diarrhoea, tuberculosis, or even toxoplasmosis. This can be a serious impediment to treatment, particularly when treatment protocol recommends starting antiretroviral therapy when CD4 count is more than 200/mm<sup>3</sup>.

Several problems persist related to ARV: (1) In addition to delays in diagnosing HIV status, laboratory tests and OI medications are expensive. Most HIV patients have to pay these costs themselves as insurance companies do not reimburse such tests and medications; (2) the prevalence of HIV among IDUs, as well as the number of IDUs, is increasing. Among this population the problem is not limited to HIV, but also Hepatitis C and B, pneumonia and endocarditic infections that often impede

treatment success; (3) Capacity in each health service location varies. Among the VCT clinics, there are some staff with extensive experience and that are better in delivering services delivery, while others have only recently started providing services; and (4) Collaboration between NGOs and health providers, especially in relevant units, is still far from optimal.

Another serious obstacle in treating those in need is a lack of trained medical doctors and nurses who are able to treat PLHIV. Moreover, ART monitoring (including CD4 counts) is limited to quantitative data with a limited number of indicators. Laboratory monitoring or data collection on side effects are still limited or nonexistent.

#### **Indicator 5: Percentage of HIV-positive pregnant women who received ARV to reduce the risk of MTCT**

As of December 2006, there were an estimated 2563 HIV-positive pregnant mothers in Indonesia. Of that number, 89 received ARV to reduce the risk of MTCT (3.5%). This shows that PMTCT programs are not yet well established in the country. The number of HIV-positive pregnant women who received prophylaxis was much lower than the estimated number of HIV-positive pregnant women. PMTCT is not yet available in health care settings in districts with high HIV prevalence.

Efforts to scale up PMTCT are underway. A working group on PMTCT coordinated by the Directorate of Maternal and Child Health in the Ministry of Health has been formed. National level guidelines exist and have been adopted in most districts. Implementation, however, is inconsistent. In some districts, all pregnant women are offered testing and counseling with high levels of acceptance. In other districts, testing and counseling seems to be selectively offered, and acceptance is much lower ('Review of the Health Sector Response to HIV-AIDS in Indonesia 2007').

The focus in PMTCT programs is largely on the provision of ARVs to HIV-positive pregnant women. The prevention of unintended pregnancies among women living with HIV is not yet a prominent feature, and neither is primary prevention of HIV transmission among women generally. Different antiretroviral regimens are used in different places, and infant feeding support varies depending on the existence of external funding. Where services are in place, the number of infected pregnant women detected and provided ARV remains very low. In the future, the PMTCT program will be emphasized in areas with a generalized epidemic and with spouses and partners of IDUs.

In a rapid assessment of PMTCT, many constraints were identified and which need to be addressed immediately. The provision of basic information on HIV is not yet well understood by health service personnel. Similarly, the national strategy for PMTCT is not yet widely known. There is a lack of facilities for PMTCT and sexual health is not generally discussed by health personnel with their clients. Another important challenge in assisting HIV-positive pregnant women is the stigma and discrimination often faced when accessing health care services in hospitals, clinics and other health centres ('Indonesian UNGASS Community Report 2006-2007').

**Indicator 6: Percentage of estimated HIV-positive TB cases who received treatment for TB and HIV**

Although this indicator is relevant to Indonesia, no data are available. A study by Amir Fauzan showed that almost 50% of HIV-positive people sampled suffered from tuberculosis (TB). TB, in other words, is the most common OI in Indonesia (Amir Fauzan, 'Effectiveness of ARV Treatment and Influenced Factors among HIV Patients', Department of Internal Medicine, School of Medicine, University of Indonesia, Jakarta, 2005). Unfortunately, patients are not routinely screened for TB prior to ART initiation. TB patients are also not routinely offered HIV testing and counseling.

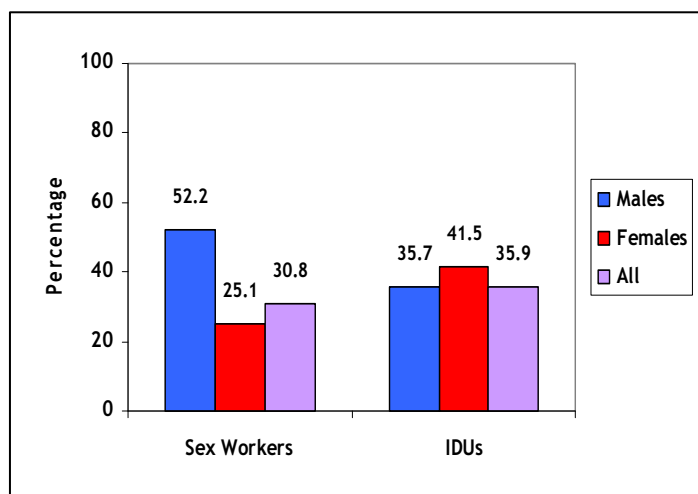
Ideally, HIV and TB treatment would be integrated under one roof so that HIV patients can access ARV for free and simultaneously can get free TB medication. Links between TB and HIV treatment clinics have generally not been strong, although there are examples where links between VCT and TB DOTS service have been well-coordinated, such as in Sanglah Hospital in Bali. In the future prevention, diagnosis and treatment of OIs will be improved to reduce mortality.

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

This indicator is not relevant to Indonesia where the epidemic is still concentrated among high risk populations. However, the provinces in Papua are experiencing a generalized epidemic, and this indicator is relevant there. Results of the 'Integrated Bio-Behavioural Surveillance' (IBBS) in Papua provinces in 2006 found a correlation between age and risk behaviour and this is related to higher exposure to HIV infection. In Papua provinces, HIV prevalence among residents aged 40-49 years is 3.4%, higher than in the 15-24 age population (3.0%) and in the 25-39 age population (2.0%). The results from the 2007 Papua IBBS revealed that 24.2% of adults received an HIV test in the last 12 months and know their results.

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

**Figure 8: MARPs who have received an HIV test in the last 12 months and know the results, by sex (IBBS MARPs, FHI and CDC MoH, 2007)**



**Figure 9: MARPs who have received an HIV test in the last 12 months and who know the results, by age (< 25, ≥ 25, All) (IBBS MARPs, FHI and CDC MoH, 2007)**



Compared to the previous report (2004-2005 period), the percentage of MARPs who have received an HIV test in the last 12 months and know their results has doubled. The percentage for sex workers increased from 14.8% to 30.8%; MSM from 15.4% to 31.9%; and injecting drug users from 18.1% to 35.9%. Yet, a careful reading is needed here because of the different methodology applied during the survey for these results. In the 2004-2005 BBS, the behaviour data were not linked with biological data. Not only was the sample size bigger, but the sites where samples taken were also greater in number. This survey was conducted in areas where HIV intervention projects took place and thus a certain level of bias cannot be avoided. In the future, the method of survey should be improved in order to obtain more reliable data.

Another interesting feature of the data relates to the IDU population. More IDUs have had an HIV test in the last 12 months and know the result is consistently higher

than the other 2 at-risk populations. This may be related to the fact that usually drug users are better organized than other at-risk populations, such as female sex workers, for example. Their network is also stronger and wider. This creates a kind of peer population pressure that motivates each member to undergo a test. More or less the same situation is also found among sex workers. Another explanation could be that HIV rates appear higher among IDUs now that testing is becoming more common.

The percentage of male sex workers (MSW) who had received an HIV test by the time the survey conducted was twice as high as for female sex workers (FSW), or 53.55% compared to 25.14%. This may relate to the fact that STI—a predisposing factor for HIV transmission—symptoms among men are more observable than among women. This will lead to higher frequency of visit to STI clinics where they tend to have good information about VCT services. Moreover, males are less likely to be stigmatized when they visit STI clinic than females.

The percentage of MARPs who received a test and know the result is slightly higher for youth (<25 years old) than older group ( $\geq 25$  years old). This may be related to more frequent exposure to HIV prevention programmes of the younger groups compared to the older age groups.

## **Prevention Programmes**

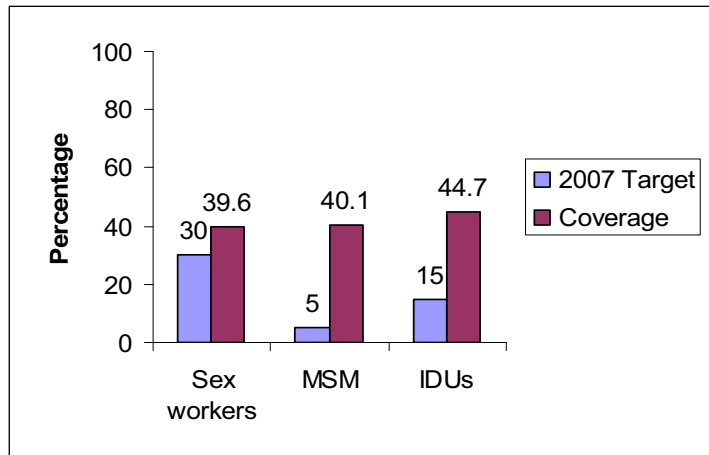
### **Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programmes (during 2006)**

HIV prevention has been the primary priority area of the HIV response in Indonesia, as outlined in National Strategic Plan for the Prevention of HIV/AIDS in Indonesia (2003-2007) through to the National HIV/AIDS Strategy 2007-2010 and to the National HIV and AIDS Action Plan 2007-2010 prepared by the National AIDS Commission. The HIV prevention programme aims to reduce the vulnerability of the general population by preventing transmission from the most affected populations. Its success will depend on the intensity and coverage of the interventions chosen. In areas where the epidemic has generalized, as it has done in Tanah Papua, this approach is still crucial. Other interventions must also be scaled up for the general population, including for young people in and out of school, harbour workers and other mobile men, street children and other vulnerable populations.

This indicator consists of three questions: (1) whether the respondent has been given condoms in the last 12 months, and (2) whether the respondent know where they can go for an HIV test, and (3) especially for IDU, whether the respondent has been given sterile needles and syringes in the last 12 months.

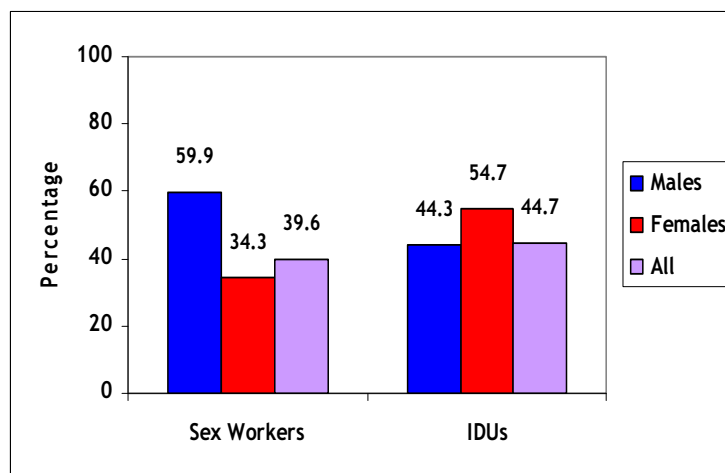
Available data shows that the prevention programmes have exceeded the 2007 targets stated in the National HIV and AIDS Action Plan.

**Figure 10: MARPs reached by HIV prevention program versus 2007 targets (IBBS MARPs, FHI and CDC MoH, 2007)**



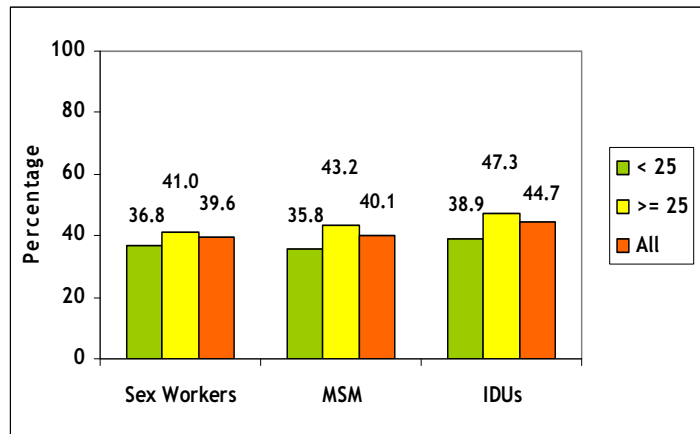
As well as exceeding targets for MARPs, the prevention programmes are achieving national targets overall. Among FSW, approximately 39.6 % were exposed to prevention programmes, whereas the target in the National Action Plan by 2007 is 30%. National targets for MSM and IDU were also exceeded (40.1 %, compared to target 5%; 44.7% compared to target 15%, respectively). Coverage already achieved is near the national targets for 2008 (50% for FSW, 10% for MSM, and 40% for IDU) (National HIV and AIDS Action Plan 2007-2010).

**Figure 11: MARPs reached by HIV prevention programs, by sex (IBBS MARPs, FHI and CDC MoH, 2007)**





**Figure 12: MARPs reached by HIV prevention programs, by age (IBBS MARPs, FHI and CDC MoH, 2007)**



Almost all of the MARPs have received condoms through an outreach service, drop-in centre or sexual health clinic. Among these populations, sex workers have the highest percentage compared to MSM and IDU (93.03% compared to 50.56% and 52.92%). Condom programmes are more focused on sex workers than other populations, even though the risk of HIV through sexual transmission is still significant in the MSM and IDU sub-populations. Estimates by some experts are that 50% of injecting drug users have paid for sex. Furthermore, much smaller numbers of SW and MSM populations know where to go if they wish to have an HIV test (41.97% among the SW and 25.64% among MSM).

Consistent with the previous indicator, IDU in Indonesia tend to be more knowledgeable and reached by prevention programmes. Not only have they received condoms, but they also know where to go to have an HIV test (77.71%) and have been given sterile needles and syringes (82.98%). This is an achievement in Indonesia's prevention programs, especially in harm reduction.

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

(Indicator not relevant to Indonesia)

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

Data for this indicator came from a monitoring survey conducted by UNICEF in Papua and from program monitoring by the Ministry of Education. The aim of the survey was to assess the effectiveness of life skill-based HIV education provided in primary and secondary schools in Indonesia. The survey included 110 junior high schools and discovered that only 10% of schools implement Life Skills Education (LSE).

The data from program monitoring by the Ministry of Education showed that of the 10% of schools in Indonesia providing LSE at schools, 2.3% were primary schools and 41% were secondary schools. Qualitative assessments of LSE programs indicate that there are some positive results from life skills-based HIV education offered in schools. For instance, students are more able to express their opinions, more responsive to teachers' instruction, more responsible and cooperative, and more dynamic in class. Moreover, the survey results indicated that conflict between parents and teachers lessened, although there were some parents who objected to 'sex education' being given to primary school students.

In Papua, according to the survey findings, there were no students who got pregnant after LSE was implemented. The survey team also found that more students have condoms. This means the students became more knowledgeable about preventing unwanted pregnancy and perhaps about avoiding sexually transmitted infections.

Despite the positive results of such programs and demands to replicate it in more schools, there is not adequate financial and programmatic support from schools or higher authorities. Also, the survey report indicated a lack of coordination between teachers and school principals. In the future, both the monitoring system and political support need to be enhanced to strengthen prevention efforts through the education system.

### **C. *Knowledge and Behaviour Indicators***

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

This indicator is not relevant to Indonesia.

#### **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 misconception about HIV transmission**

National data are not available and data for Papua are not available.

#### **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**

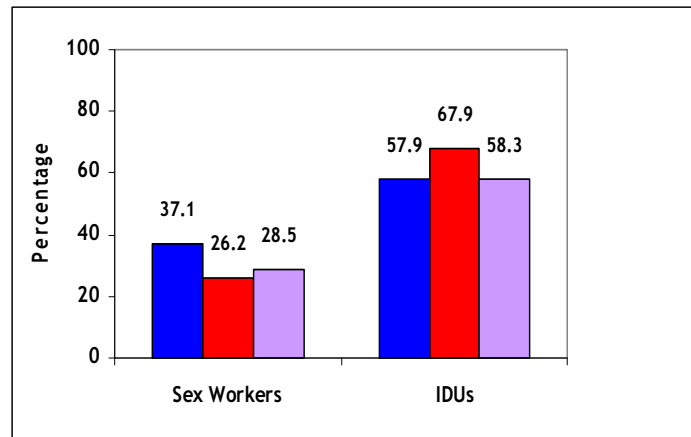
The data provided here covers sex workers, MSM and IDU populations (with a FSW sample from 14 cities, and MSW being calculated based on data of MSM who sell sex from 4 cities and waria who sell sex from 5 cities). Both MSM and IDU samples are from 4 big cities.

For a country with a concentrated epidemic like Indonesia, it is important for the most at risk populations to know modes of HIV transmission. It is also important to measure perceived risk as it will be an indicator of how well the general population understands that they have engaged in risky behaviour.

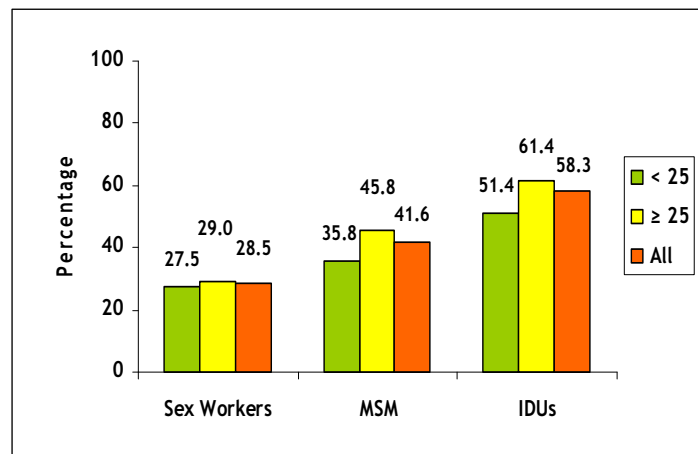
Five (5) questions about risky behaviour and HIV prevention were asked to respondents during a survey : (1) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners; (2) Can a person reduce the risk of getting HIV by using a condom every time they have sex; (3) Can a healthy-looking person have HIV?; (4) Can a person get HIV from mosquito bites?; (5) Can a person get HIV by sharing food with someone who is infected?

There were high percentages of responses for each individual question, but low numbers for all 5 questions for all sub-populations. While the percentage of respondents who could answer every single question was relatively high, the percentage of those who gave correct answers to all 5 questions was lower: 28.5% for SW, 41.6% for MSM and 58.3% for IDU.

**Figure 13: MARPs who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission, by sex (IBBS MARPs, FHI and CDC MoH, 2007)**



**Figure 14: MARPs who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission, by age (IBBS MARPs, FHI and CDC MoH, 2007)**



Several conclusions can be drawn from the data. First, while almost all of the respondents (MARPs) have good knowledge about condom; most of them have only partial knowledge about HIV. This means more should be done in behaviour change communication (BCC) and Information, Education and Communication (IEC). Further research is required to know what kind of messages are needed by these populations, for example, whether they need a single, direct message or comprehensive messages at one time.

Secondly, in general IDUs are more knowledgeable compared to sex workers and MSM populations. This is presumably due to the social characteristic of IDUs who generally live in big cities (where the survey was conducted), have higher levels of education, and better exposure to media. However, as is discussed further below, this population ranks the lowest in using condoms. Moreover, 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 targetted to the IDUs compare to other vulnerable populations. It makes IDUs are better exposed to HIV messages.

The third conclusion is that primary prevention of drug use among young people, and expansion of life skills education (formal and non-formal) should be a priority.

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

As for other population-based indicators, national data on the percentage of youth who have had sexual intercourse before the age of 15 are not available. However data for Tanah Papua are available. For discussion related to knowledge on HIV transmission among Papua residents, please refer to Chapter 2: 'Overview of the AIDS Epidemic'.

**Indicator 16: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last two months**

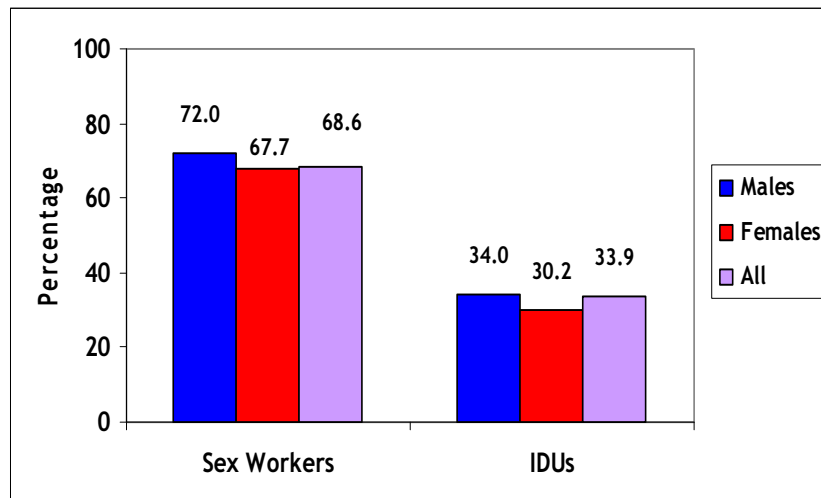
No national data are available currently. Related data are available from the IBBS among the general population in Tanah Papua only (see chapter 2).

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

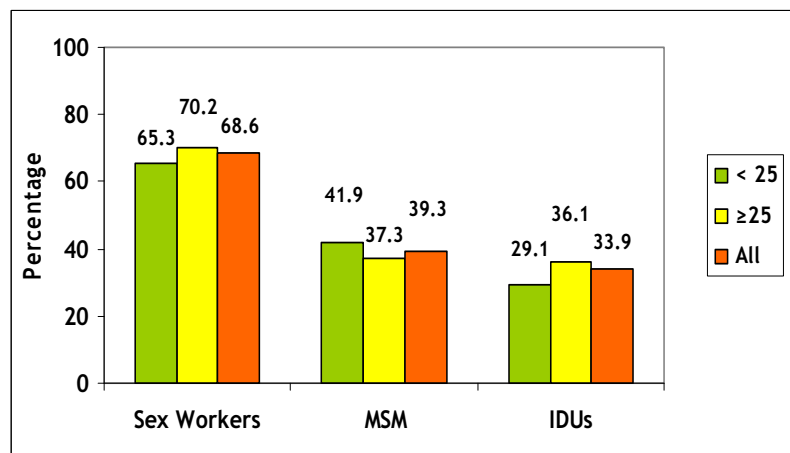
No national data are available currently. Related data are available from IBBS among the general population in Tanah Papua only (see chapter 2).

**Indicator 18, 19, 20: Percentage of 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 (IDUs)**

**Figure 15: 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, FHI and CDC MoH, 2007)**



**Figure 16: 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, FHI and CDC MoH 2007)**



Despite religious groups and the authorities' strong resistance to condom promotion, data shows that condom use among sex workers is quite high. Approximately 70% of sex workers reported using condoms with their most recent clients. This number is slightly lower than government 2010 targets of 80%. However, the survey was conducted in project sites, where respondents tend to provide predictable answers to questions on program implementation. Due to the potential bias in sampling, further research involving a more representative sample is needed to get a better understanding of condom use among sex workers.

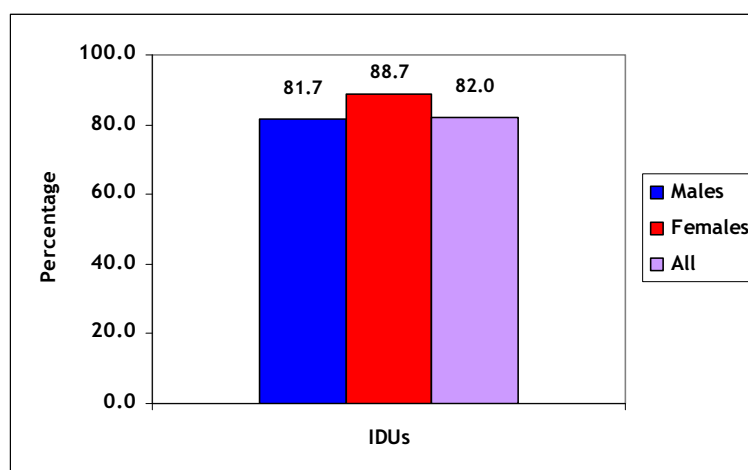
About 39.3% of MSM respondents reported using a condom the last time they had anal sex with a male partner. Like condom use among sex workers, this result or percentage among MSM is relatively high. Despite the sampling bias that might influence analysis, such achievement may be due to the perception of risk among MSM population that is higher compared to other sub-populations.

As mentioned above, the percentage of IDUs reporting the use of condoms is the lowest compared to other at-risk 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. 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. Although a condom promotion program is supported by local legislation and regulations, there is no enforcement of the legislation. The situation is quite different to what has happened elsewhere in Asia with 100% condom programs and the difference is mostly due to a conservative, religious perspective that hampers implementing and achieving a 100% condom program. Many policymakers also do not want to be unpopular, which they fear may happen if they are pro-condom programs.

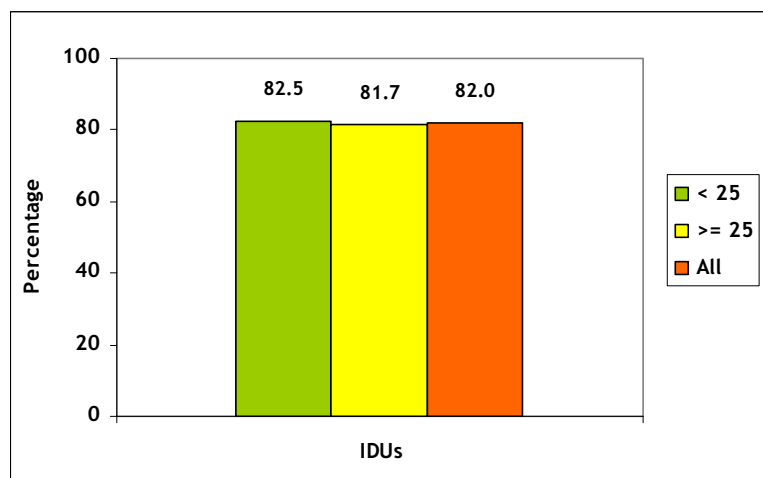
The 100% condom program is usually limited to distribution of condoms in hotspot areas and localized brothel areas. This approach might be an effective way to increase condom use among sex workers but for other risk groups, condom distribution should be accompanied by other means such as IEC, BCC and condom social marketing.

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

**Figure 17: Injecting drug users reporting the use of sterile injecting equipment the last time they injected, by sex (IBBS MARPs, FHI, CDC MoH, 2007)**



**Figure 18: Injecting drug users reporting the use of sterile injecting equipment the last time they injected, by age (IBBS MARPs, FHI, CDC, MoH 2007)**



Eighty-two percent (82%) of injecting drug users surveyed reported the use of sterile injecting equipment the last time they injected. Although the data obtained contain a certain level of bias (because the survey areas were project intervention areas), there are at least 2 explanations why the use of sterile injecting equipment is high. First, sterile needles are easier (sharper) and more pleasant to use compared to old needles. The effect of the drug is faster than when injected with an old needle. Secondly, according to Ministry of Social Welfare Regulation No. 2/2007, unlike an old needle and syringe, a new needle cannot be used as evidence of drug use before the courts.

One potential risk for continued prevention efforts is that the supply of sterile injecting equipment depends on continued funding from GFATM. The government has not yet made plans to ensure a continued supply of injecting equipment.

### **Impact Indicators**

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

As for other population-based indicators, national data on percentages of young women and men aged 15-24 who are HIV-positive are not available. However, data for Papua are available. For discussion related to knowledge on HIV transmission among the youth of Tanah Papua, please refer to Chapter 2: 'Overview of the AIDS Epidemic'.

### Indicator 23: Percentage of MARPs who are HIV-positive

Figure 19: MARPs who are HIV-positive, by sex  
(IBBS MARPs, FHI and CDC MoH, 2007)

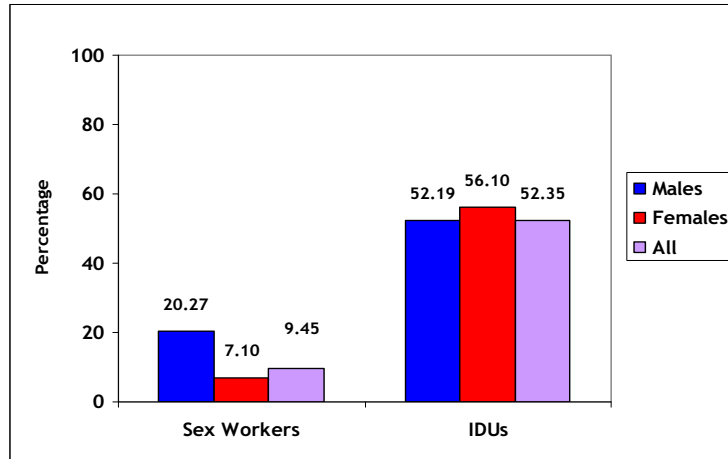
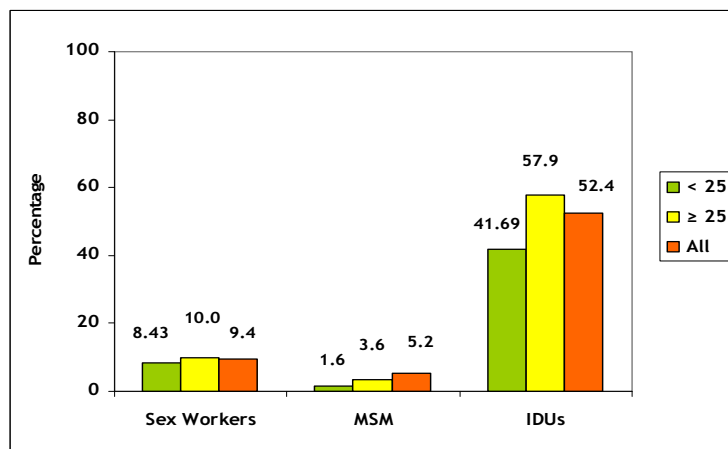


Figure 20: MARPs who are HIV-positive, by age group  
(IBBS MARPs, FHI and CDC MoH, 2007)



Data on prevalence of MARPs are more valid for this indicator than it has been in previous country reports. Different sampling methods, however, make the 2 data sets incomparable.

The prevalence of HIV among IDUs is very high. A total of 52.35% of IDUs (males and females) are HIV-positive. HIV prevalence among female IDUs is slightly higher than amongst male IDUs (56.1% compared to 52.2%). This is important for program purposes and points to a need for future interventions to focus on the feminization of the epidemic. Infection of partners and spouses of IDUs should also be a major focus.



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

This indicator is relevant; however no national data are available currently.

**Indicator 25: Percentage of infants born to HIV-positive mothers who are infected**

The country is not required to report on indicator as it will be calculated the Head Quarter office in Geneva, using indicator no.5 regarding PMTCT.

**HIV in the Workplace**

Workers and the workplace have been integrated into the national HIV response. It is estimated that in Indonesia there are between 200,000 and 300,000 sex workers and approximately 7 to 9 million male workers considered to be potential sex buyers. Adding to the fact that about 85% of PLHIV are of productive age, one can conclude that male workers are vulnerable to HIV infection.

Presently in Indonesia there are approximately 176,000 companies with 95 million workers. The Ministry of Manpower and Transmigration has formulated a National Strategy for HIV. Several important national policies also support workplace HIV programs, including Ministerial Decree No. 68/2004 and Directorate General Decree No. 20/2005. These reinforce policies on mobile populations and conflict/disaster areas, and on the coordination of HIV program for workers and migrants.

In November and December 2007 a survey on HIV prevention in the workplace was carried out by the Directorate for Work Safety and Health Norms in the Ministry of Manpower and Transmigration in 5 provinces: DKI Jakarta; East Java; Papua; Riau; and East Kalimantan. This survey involved national companies with more than 100 workers and trans-national companies. Sampling bias affects data analysis because companies surveyed have interventions funded by GFATM and other donors. Of the 150 companies that received the questionnaire, 127 responded. Seventy-one (71) respondents (or 56%) had policies related to HIV in the workplace. The policies were partly integrated to existing Work Safety and Health Norms policies.

Among those companies with HIV policies, awareness within the company of the HIV policies was high in the provinces surveyed. The company HIV policy was disseminated in most of the 71 companies that have such HIV workplace policies. There were 39 companies that reported having a person in charge of HIV programs and providing free condoms and VCT services.

In future, the Directorate for Work Safety and Health Norms in the Ministry of Manpower and Transmigration plans to conduct similar surveys in non-intervention areas.

## IV. Best Practices

### **Comprehensive Harm Reduction Programme at Community Level in West Java Province**

HIV infection has been increasing rapidly in the Indonesian province of West Java. It is a large province, with 26 districts and more than 41 million inhabitants. By the end of September 2007, it was estimated that about 80% of HIV infections in the province were caused by the sharing of contaminated injecting equipments. Another 20% of infection cases were transmitted via unsafe sex. IDUs are mostly concentrated in urban-industrial areas such as Bandung and its satellite regions, while sexual transmission is more common in areas where child and women trafficking are prevalent.,

The increasing transmission of HIV through sharing contaminated injecting equipment has encouraged the local government to expand the coverage of prevention programmes in some hot spots, including prisons.

#### *Developing Local Response*

To respond to this urgent situation, the provincial government developed a joint policy commitment on HIV prevention among IDUs with other local government partners. These partners include the provincial Governor, mayor of the largest city (Bandung), and the provincial House of Representatives. This policy eventually developed into the West Java Provincial HIV/AIDS Strategic Plan, which focused on harm reduction among IDUs and the prevention of sexual transmission of HIV. The local harm reduction policy and programme was based on a ministerial regulation no. /2007 on national policy on harm reduction. The regulation was issued by the Indonesian Coordinating Ministry of People's Welfare as Chairperson of the National AIDS Commission.

Important steps were taken to coordinate and implement the harm reduction policy at local level. First, assessing efforts that had been taken in responding the HIV epidemic. The assessment was done by mapping out the existed responses. Aims of this effort include identifying HIV and AIDS services available in each municipality and its coverage, and also identifying local HIV stakeholders.

After the mapping out had been done, the next step was formulating a scaling-up plan on implementation and monitoring of comprehensive harm reduction programmes.

The scaling up also took into account the functioning of community health centres (puskesmas) in providing, treatment, care and support programmes in addition to prevention programmes.



The West Java programme focuses on a comprehensive package of harm reduction services in line with the national policy, including: (1) coverage and advocacy, (2) information, communication and education (IEC), (3) peer education, (4) behaviour change counselling, (5) voluntary counselling and testing for HIV (VCT), (6) bleaching programme, (7) sterile needle and syringe service (SNSS), (8) used needle eradication, (9) drugs addiction recovering therapy service, (10) Methadone maintenance therapy (MMT), (11) care, support and treatment service (CST) and basic health service.

A number of local working groups on harm reduction have been established. The working groups consisted of several organizations that have concern to the problems triggered by flourishing of the epidemic, e.g. the Hasan Sadikin Hospital, Law and Human Rights District Office, Banceuy State Prison, the Faculty of Law of the Padjadjaran University, Daarut Tauhid Moslem Boarding School, etc. These working groups assisted the Local AIDS Commission and District Health Office in developing policy, advocacy, information dissemination, capacity development, and monitoring and evaluation.

### *Achievements and Challenges*

By the end of 2007, significant achievements were made. In regard to policy, the HR working groups are currently drafting local Guideline on the Right of Discretion on HIV/AIDS. This guideline aims to encourage the police to treat drug use more as a health issue rather than crime, and to help referring drug users to nearby health facilities. Secondly, the working group had developed a Harm Reduction Guidance Book for Community Health Centres (Puskesmas).

The Provincial Harm Reduction Working Group has succeeded in scaling up the programmes in 15 out of the 26 districts in the province. By the end of 2007, 42 community health centres (Puskesmas) in 15 districts were able to provide harm reduction services to 27,000 IDUs. This programme included the work of nine community health centres in Bandung city, funded by the local government.

There are other achievements being made in harm reduction, including:

- **Sterile Needle and Syringe Service (SNSS):** increasing numbers of IDUs are accessing the service from community health services and NGOs. By June 2007, 2,079 IDUs were reached by SNSS activities. The total number of IDUs accessing SNSS has been increasing on a regular basis. This programme was initially planned in 33 Puskesmas in 15 municipalities, but then the number escalated to 42 by the end of 2007.
- **Voluntary counselling and testing services:** the number of people accessing the VCT service is also increasing, and reach nearly 4,000 by the end of 2007.
- **Referrals for Methadone Maintenance Therapy Programme (MMT) and ARV** from October 2006 – June 2007 shows an increase. This also shows that community health centres and referral Hospital has given easier access toward patients calling for therapy. The MMT programme now can be accessed in 5

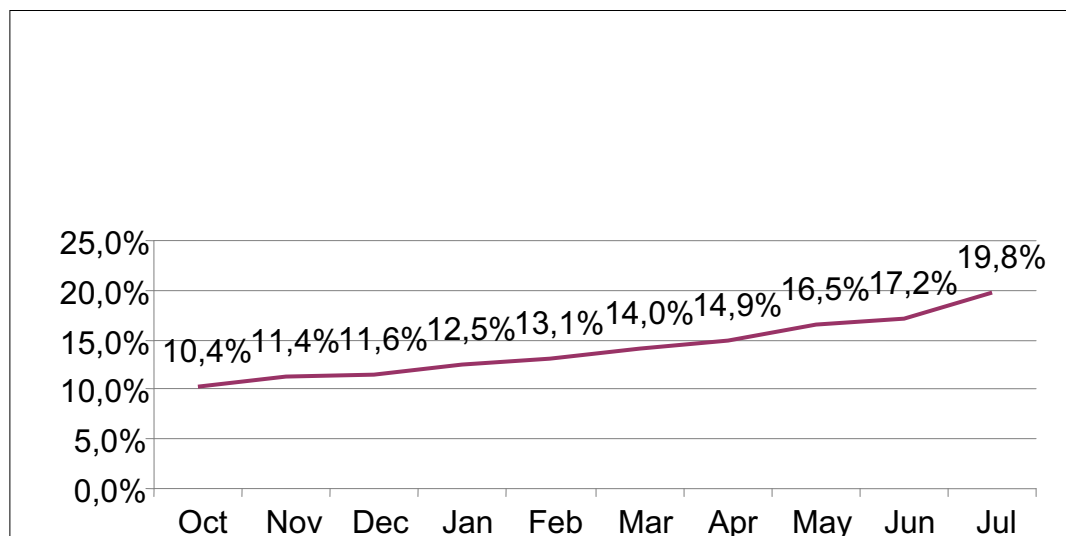
satellite clinics in Tasikmalaya, Cirebon, Bogor, Bekasi and Sukabumi districts.

In the mean time, the coverage harm reduction programmes in prisons is also increasing Besides the political and financial endorsement of the local government, the success in scaling up comprehensive HR programme in West Java province was also facilitated by support of an international agency, i.e, IHPCP. Moreover, the success was also determined by the choice to strengthening existed institutions such as Puskesmas and hospitals instead of establishing new harm reduction centres.

However, as was recognized by local authorities, there were a number of challenges still on the way. First, there are another 10 districts not yet reached by the programme in addition to vary capacity of each Puskesmas providing comprehensive HR programmes.

Secondly, there are still a number of influential people and groups who need to be convinced of the importance of harm reduction. For example, so far some local prison officers, district health offices and police do not support harm reduction even though the effort had been established in most areas of West Java province.

**Figure 21: Coverage of IDUs reached by NSP in West Java  
October 2006 – July 2007**



### *Papua Province: Bringing Health Services Closer to the People*

The health system in Indonesia is a decentralized service, under the responsibility of the Provincial Health Services. Comprehensive primary health care is provided by the Community Health Centre, the Puskesmas.

Efforts to strengthen the health system response to HIV are focusing on strengthening six components of the existing health system: (1) service delivery; (2)

human resource capacity building; (3) financial resources and management; (4) management, (5) community mobilization and outreach; and (6) the logistics of health service delivery. If the existing health system can be strengthened, it would be unnecessary to develop a new system.

Health care system strengthening also aims to empower health care workers by integrating hospital and Puskesmas in one a network, which can provide quality VCT, CST and ARV services to the local population. The Puskesmas can undertake blood test, STI and OI treatment, and make referrals for more complex treatment. Hospitals will provide more complex medical services, and act as mentors and technical support for Puskesmas.

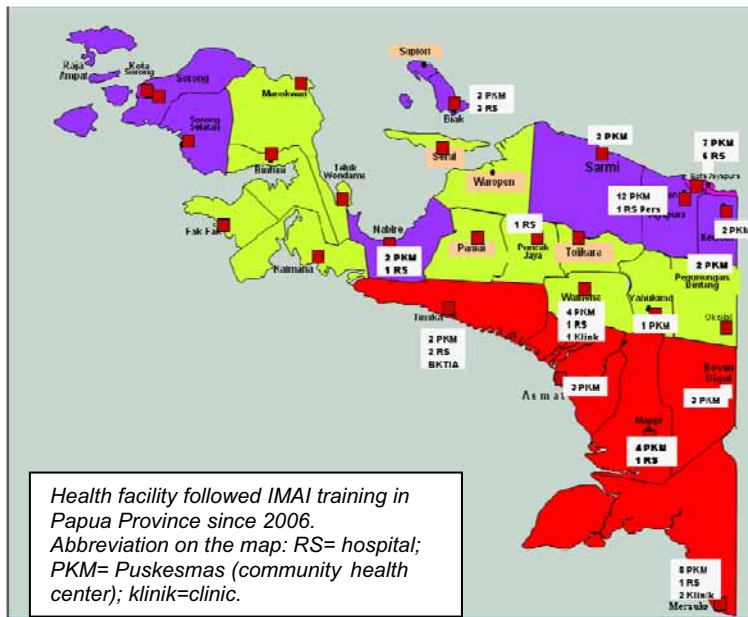
With this concept, a total service package can be provided to local populations, and the HIV epidemic will be better controlled. With better HIV prevention, treatment, care and support, the social and economic condition of local communities will be improved.

### *Applying the New Health System Approach to Papua Province*

Papua province has one of the highest HIV prevalence in Indonesia, with over 2% of the adult population aged 15-49 already infected with HIV. The HIV prevalence rate is 15 times that of the rest of Indonesia. Papua Provinces also have serious development challenges, including comparatively poorer education and health services, and infrastructure.

This pilot programme to strengthen the health system in Papua Province, focused initially on improving health service facilities. Efforts were also made to build the capacity of health care providers at hospital and Puskesmas levels, following the national policy and standard operating procedures of the Ministry of Health. The programme also built a networking of local supporting organizations such as AIDS Commission, related sectors, local level policy makers, health service provider technical teams and international partners.

This pilot of integrated HIV services was started in four Puskesmas in Jayapura (the capital of Papua Province) in early 2006. The pilot was expanded in stages, to eventually reach 16 districts in two years, by the end of 2007. A total of 55 Puskesmas, 17 hospitals and 5 clinics participated in the pilot, which included training and mentoring in the IMAI, VCT, Case Management, and laboratory support (see map below).



Healthcare provider capacity building was carried out through training on HIV and AIDS for all Puskesmas staff, counsellors and case managers, and laboratory technicians. On going mentoring support was also provided.

The Papua Provincial Health Office had systematically coordinated this health system strengthening programme. From early 2006 to end 2007, a total of 231 men and 358 women had participated in project activities including orientation, consultation meetings, training, apprenticeships, meetings on external quality assurance, and HIV/AIDS case management SOP.

The hospital and Puskesmas have agreed to implement a sustainable logistic supply chain, to include HIV reagents, OI drugs, and ARVs. Regular coordination meetings have been held between hospitals, puskesmas, NGOs, Provincial and district AIDS Commissions, province and district Social Service and Health Service Offices.

Regular health service system monitoring and mentoring were undertaken throughout the past two years, in coordination with the provincial care, support and treatment working group.

*Outcomes and Accomplishment Facts*

**Table 6: Community Health Centres in Jayapura City and District, Papua Province: Data from three pilot Puskesmas**

NO	DATA	Puskesmas A (by 3 July 2007)	Puskesmas B (by April 2007)	Puskesmas C (by April 2007)
1.	Number of patients visiting VCT clinic	219 people	166 people	90 people
2.	The number of patients who participated in pre-test counselling	219 people	136 people	71 people
3.	The number of patients who participated in post-test counselling	194 people	87 people	68 people
4.	The number of patients having reactive reagent status (HIV +)	9 people ( 4.1 % )	4 people ( 3 % )	1 people ( 1.4 % )
5.	The number of patients having indeterminate status	3 people	4 people	4 people

By bringing VCT services closer to the community, more people can be tested, and more positive individuals can be assisted. As part of this health system strengthening project, VCT and PMTCT services were established in six Puskesmas in Jayapura city and district. During 2007, 890 pregnant women underwent VCT, and 19 of them tested HIV+. Prevention on Mother to Child Transmission (PMTCT) services were provided to these women. The children born to these women all underwent PCR 2, and all were HIV.

Two Puskesmas in the city provided service for adolescents through education and information to 6 Junior High Schools, and outreach to 400 street children.

This project has achieved significant strengthening of the health system response to HIV in Papua province in 2006- 2007. Specifically, health services, STI, OI and ARV treatment was strengthened, along with VCT and PMTCT services. Outreach to sex workers, pregnant women, adolescents and street children was also strengthened.



However, most of these efforts were undertaken in urban areas in Papua Province. There is an urgent need to expand efforts to rural areas, where the majority of the population live.



## V. Major Challenges and Remedial Actions

A lot of efforts have been made and a great amount of money has been invested in Indonesia's HIV response over the past 20 years. The government of Indonesia has also shown political commitment. In a cabinet meeting on July 18, 2007, the President declared HIV and AIDS as a threat to the nation's development, and considered one of the country's priorities that needed urgent response. Yet, the challenge remains huge. Overall programme coverage of vulnerable populations is still too low while the number of new infections is still increasing very fast.

In 2006, with the enactment of a new Presidential Regulation, the government has strengthened the National AIDS Commission (NAC) as an independent body responsible to the President of Indonesia. The NAC provides leadership and overall management of the HIV and AIDS response in the country. The NAC restructuring aims to promote a more intensive, comprehensive integrated and coordinated response. A number of policies and regulations have been published by ministries to strengthen the response to HIV. Important regulation is on National HIV and AIDS Policy to Reduce Harm Arising from Injection of Narcotic, Psychotropic and Other Addictive Substances issued by the Coordinating Minister for People's Welfare<sup>7</sup>,

At the end of 2006, a new national strategy and action plan for 2007-2010 was launched, following extensive national consultations led by the NAC. This action plan now serves as the reference for Indonesia's annual plan for comprehensive HIV prevention, care, support and treatment and which includes targets, a monitoring and evaluation (M&E) framework, unit costs of intervention and sectoral responsibilities.

There are a number of special issues that pose huge challenges to the design and implementation of a successful national AIDS programme in Indonesia. These include, among others, the following:

1. Communication and resource distribution are very difficult challenges in HIV responses due to the fact that Indonesia is the largest archipelagic country, (over 17000 islands) with a population of over 220 million people, with very diverse cultural background
2. 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)
3. Low levels of condom use and resistance from men and as some religious groups to condom promotion
4. High levels of needle sharing among IDUs
5. Widespread stigma and discrimination against PLWHAs

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<sup>7</sup> This Minister is also the chairman of the NAC.

6. Limited availability of testing and counselling related to HIV, and facilities for ARV treatment
7. Limited facilities for STI management
8. Legal issues which constrain the implementation of a full harm reduction strategy among IDUs
9. Limited capacity of health personnel and distribution of appropriate health care facilities
10. Limited government funding and high dependence on foreign donors.

The actions planned and partially implemented during 2006 & 2007 to address these challenges include:

### **Prevention**

1. Developing a national communication strategy
2. Strengthening policy, the VCT services and delivery system and capacity, especially for the MARP
3. Strengthening STI services
4. Strengthening harm reduction programmes including ensuring the quality of services and access
5. Strengthening civil society and NGO capacity to outreach to MARP clients
6. Improving the capacity of health personnel
7. Scaling up PMTCT services, especially to most-at-risk population's spouses
8. Strengthening the capacity of related sectors to provide qualified LSE
9. Enhancing capacity to ensure the quality of blood screening
10. Enhancing 100% condom policy, including use of female condoms

### **Care, Support and Treatment**

1. Improving the availability and distribution of drugs and reagents
2. Enhancing CST programmes to be more accessible, especially for MARP
3. Improving quality of life of PLHIV

### **AIDS surveillance and research**

1. Conducting HIV and behaviour surveillance among sub-populations with different levels of vulnerability to HIV, both in terms of coverage area and quality
2. Expanding the surveillance of STI
3. Expanding surveillance of HIV among pregnant women
4. Increasing the number and quality of HIV laboratories
5. Conducting research on ARV drug resistance and operational research on various prevention efforts
6. Conducting research on social, economic and cultural impacts of HIV and AIDS in order to collect material for advocacy purposes and to design culturally-sensitive programmes
7. Conducting epidemiological and behavioural research for the purpose of learning more about the epidemic and influencing factors
8. Completing development, and beginning implementation, of a comprehensive M&E system
9. Institutionalization of NASA into M&E system.

### **Sustainability**

1. 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
2. Increasing central and local government funding for HIV (as stipulated in the National HIV and AIDS Action Plan 2007-2010)
3. Strengthening management and programme implementation capacity of NGOs/CBOs
4. Improving coordination mechanisms at all levels in line with Three Ones principle
5. Increasing the role of the private sector, especially widespread implementation of workplace-based HIV prevention programmes
6. Development and adoption of laws and implementing regulations at national and local levels to protect the rights of PLHIV and promote HIV prevention.

As a nation, Indonesia acknowledges there is still much work to be done to reverse the course of the epidemic. This awareness will encourage the government and other HIV stakeholders to continue their hard work.

## **VI. Support from the Country's Development Partners**

As had been mentioned earlier, in the last few years there was significant increase in the Government of Indonesia's commitment to mobilizing the necessary resources needed to control HIV transmission and to reduce stigma and discrimination. Due to the nature of HIV as a global epidemic, the Government has also made commitments to various international agreements to respond to AIDS, as well as to promote multilateral and bilateral cooperation.

Over the years, Indonesia has received many types of support, including technical assistance, from a range of development partners responding to the HIV epidemic. Bilateral and multilateral agencies have long been major sponsor for prevention efforts, CST, and creating conducive atmosphere for HIV responses.

Funding from donor agencies is indeed a major component of the support to the HIV response in Indonesia. As discussed in Chapter 3, more than 70% of HIV/AIDS funding in Indonesia is from international development partners. Four biggest external donors are the Indonesian Partnership Fund (IPF)/DFID, The Global Fund (GFATM), USAID, and AusAID. The IPF with a generous contribution from DFID (USD 47 million, during 2005-2008 period) has provided flexible funding which has made supported scaling-up of prevention, care, support and treatment activities in areas of concentrated epidemics as well as supporting the "three ones": strengthening of AIDS Commissions at all levels to provide the leadership and management of the national response, one national action framework and one monitoring evaluation system.

The Global Fund R4 supported CST activities in 17 provinces. In this regard, GF has donated more than 40 million USD to Indonesia. USAID, through the FHI/ASA project, focuses among others on STI, HIV transmission through commercial sex, MSM and harm reduction in 8 provinces and uniformed services. USAID also supported a number of surveillance studies, including the IBBS in Tanah Papua. AusAID places more stress on harm reduction, including in prisons, on STI prevention and on CST. USAID and AusAID respectively had allocated about USD 26.2 million (2005-2008) and 37 million Australian dollar (2005-2008) for those activities - yes, please. Also GFATM in 2006 and 2007.

The Global Fund temporarily froze the funding from May-November 2007, but it was resumed after improvements were made in the management of funds. Although programmes have begun to recover, this situation highlighted issues of dependency on foreign aid. Self-reliance can be achieved through mobilizing domestic resources both in state budget (APBN) or regional (province and municipality) budget (APBD). The Government has committed to increase the mobilization of domestic resources in the coming years.

UNAIDS has played an important role in the HIV responses in Indonesia. UNAIDS has supported the development of national Monitoring and Evaluation system,

partnership with the media, and the strengthening of the NAC and other government institutions and work with the GFATM.

UN development partners such as UNICEF and ILO gave support for developing various education programs in and out of schools. The programs targeted students, workers, and at-risk populations. Target audiences were not only taught about reproductive health and HIV/AIDS but were also given more general Life Skills Education (LSE). UNICEF, for instance, has helped to develop a LSE module about adolescent reproductive health and HIV/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 gave technical assistance and financial support to the MoH for the development of national guideline for PMTCT.

WHO has long been a major provider of technical assistance in STI prevention and care services and laboratory capacity strengthening. The agency has supported Indonesia to improve safety of blood supply and blood products. WHO 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.

In the National HIV/AIDS Strategy 2007-2010 and Costed AIDS Plan, the international aid will be targeted to help reducing new infections among MARPs. Poverty alleviation and education must also be emphasized in prevention programs. Interventions need to be based on reliable data and therefore surveillance and research on HIV and AIDS must be enhanced. In the CST realm, strengthening the health facilities and laboratories is essential. A strong health system will not only improve the quality of life of PLHIV, but also help in reducing stigma and discrimination. Last but not least, a strong national monitoring and evaluation system has been built both at the central and local levels to ensure the deliverables of each programme are achieved.

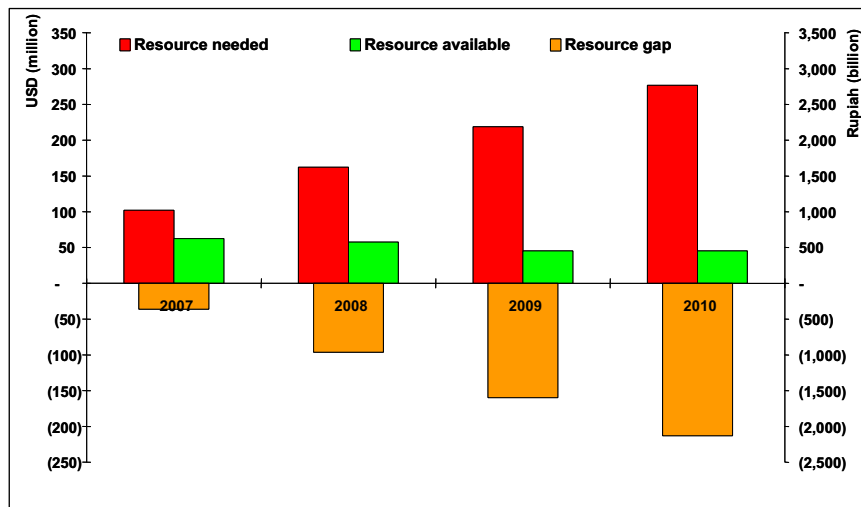
The total estimated funds needed for the National Action Plan 2007-2010 are as follows:

- Prevention program - USD 459,950,169;
- Care, support and treatment - USD 119,311,638;
- Management - USD 173,678,022; and
- Mitigation - USD 6,760,828, or total USD 759,700,657

The government budget for HIV and AIDS has been growing at around 20% per year since 2003. But because Indonesia is committed to scale up the activities so as to reverse the course of the epidemic, the resource need is increasing faster than is the available budget, Therefore, although support from the Indonesian Partnership Fund, the Global Fund, as well as bilateral and multilateral donors, are expected to continue, there will still be an increasing resource gap to support the Indonesian HIV

and AIDS programs in the coming years (National HIV and AIDS Action Plan 2007-2010).

**Table 7: Total Gap Analysis 2007-2010**



## VII. Monitoring and Evaluation

All partners involved in Indonesia's national HIV response have embraced the principle of a unified monitoring and evaluation (M&E) system at the all levels such as the UN and the international organizations and GFATM and bilateral donors such as USAID and AusAID. Local NGOs monitor program coverage regularly, assisted by the projects of these and other international agencies.

National M&E guidelines have been used in 100 districts to monitor and evaluate the 'Acceleration of Comprehensive Programs in 100 Priority Districts' program since April 2006, under the coordination of the national AIDS Commission (NAC). The M&E guidelines include a common set of national indicators, data flow, reporting format and responsibilities of HIV program managers and other key stakeholders. Ninety-four (94) districts in 22 provinces report regularly to the NAC regarding program coverage from line ministries and local NGOs. Local AIDS commissions also report regularly on indicators for institutional strengthening and local budget.

An M&E Working Group was actively involved in providing technical input during the development and implementation of the national M&E guidelines. The M&E working group includes members from line ministries, national NGOs, international agencies and donors. The group has clear terms of reference and was formalized by ministerial decree.

Indonesia has developed the National Strategy and National AIDS Action Plan for 2007–2010 with clear national targets to measure progress towards Universal Access. Costed M&E guidelines with national targets will be developed to accommodate the focus areas to be monitored within the National Action Plan.

Indonesia has implemented second generation surveillance. The surveillance system includes mandatory AIDS case reporting and systematic sero-surveillance among sex workers and IDUs in 16 sentinel sites. Routine STI surveillance was previously non-existent. Sex workers included in HIV surveillance are also tested for syphilis, but the infections that more reliably reflect recent risk behaviour, such as gonorrhoea, Chlamydia and to a lesser extent trichomonas, are not included in sentinel surveillance. The health system requires government health services to report common STIs. The provincial level HIV surveillance tasks include planning surveillance activities, supporting district surveillance teams in data collection, and ensuring reporting of results to the centre. Districts are responsible for data collection.

Indonesia is undergoing a complex and rapid process of decentralization, roles laid out on paper are not always matched by finances, personnel or skills and has been challenged in implementing national surveillance guideline at local level.

The existing Behaviour Surveillance Systems follows standardized methodologies, constructing sample frames from a thorough mapping of populations, and using standardized pre-coded questionnaires administered by trained interviewers (Family

Health International, 2000) . By early 2005, Indonesia had 2 years of behavioural data for sex workers and clients in 10 sites, data for 6 years in three sites, and data for 9 years in a further 3 sites. In 2006, large amounts of data became available, adding to the understanding of the size of various sub-populations at risk for HIV, of levels of HIV infection in those various sub-populations, and of risk behaviours linking different risk population. Since 2006, the Ministry of Health and National AIDS Commission have worked to improved estimates of HIV prevalence in Indonesia, including collaboration with more stakeholders.

USAID funded the implementation of Integrated Bio-behaviour Surveillance (IBBS) in the general population in Tanah Papua. The results included overall prevalence and distribution of HIV and the socio-behavioural basis of HIV infection in Papua. The survey was the general population surveillance in Papua. Experience in Africa strongly indicates that repeated surveys of this type are the preferred means of conducting general population HIV surveillance. Recently, USAID also funded IBBS among MARPs in its project areas.

The challenge for Indonesia is to build a surveillance system that captures this diversity and that focuses attention on the elements that are most likely to explain and predict shifts and trends in the epidemic. Perhaps the greatest challenge is to be able to use the data to guide policies and programs which are most likely to make a difference at the local as well as at the national level. Recommendations for improving the surveillance system in Indonesia secure financing, secure data for analyzing trends on HIV prevalence among MARPs and the general population for Tanah Papua region, and data on trends in knowledge and behaviour. Other recommendations are for improving the policy and training, improvement quality assurance, and better use of data for improving programmes. Other challenges include developing the M&E system at the service delivery level, i.e. VCT services, ART provision services and MMT services. Harmonization efforts have been initiated by CDC MoH and FHI and by an AusAID-funded project to standardize the reporting format, data flow and ensure better quality data at service delivery sites.

Capacity building in the M&E system is also needed to improve the capacity of staff at service delivery level, for staff of district, provincial and National AIDS Commissions, and M&E staff of line ministries. Technical capacity is needed to standardize the implementation of monitoring and evaluating programs. The existing national database needs to be improved to enhance the system to store and to analyze data, regarding program coverage, surveillance, finance and evaluation data. An M&E capacity-building plan for national and local counterparts needs to be developed to better address these needs. Technical assistance is also needed to develop an M&E capacity-building plan for M&E specialists at country level, to develop costed M&E plans and to utilize data using statistical software for planning, advocacy and program improvement. Furthermore, there is a need to strengthen civil society capacity in M&E knowledge and skills to better articulate evidence-based advocacy activities.



## Annex 1: National Composite Policy Index Questionnaire (NCPI)

### 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 representatives from nongovernmental organizations, bilateral agencies, and UN organizations covers four areas:**

1. Human rights
2. Civil society involvement
3. Prevention
4. Treatment, care and support

### Respondents

#### NCPI - PART A

Organization	Name/Position	Respondents to Part A				
		A.I	A.II	A.III	A.IV	A.V
Coordinating Minister for People's Welfare	Emil Agustiono	ALL RESPONDENTS ANSWERED ALL PARTS OF QUESTIONNAIRE				
Health Center of the Indonesia Armed Forces (Puskes TNI)	Sugiyono					
Center for Health Research University of Indonesia	Ede Surya Darmawan					
Ministry of Social Affairs	Enang Rochjana					
Correctional Directorate of Ministry of Justice and Human Rights	Harto					
National Family Planning Coordinating Board	Dja'far					
Ministry of Manpower and	Bing Wantoro					

Organization	Name/Position	Respondents to Part A				
		A.I	A.II	A.III	A.IV	A.V
Transmigration						
World Health Organization/Ministry of Health	Erfandi					
Ministry of Manpower and Transmigration	Erwin A. Ichsan					
Ministry of National Education	Purnomo Ananto					
National AIDS Commission	Kemal Siregar					
National AIDS Commission	Suriadi Gunawan					
National AIDS Commission	Roberta Taher					
National AIDS Commission	Yanti Susanti					
National AIDS Commission	Lely Wahyuniar					

#### NCPI - PART B

Organization	Name/Position	Respondents to Part A				
		B.I	B.II	B.III	B.IV	B.V
ILO	Early Dewi					
PKBI	Edi Sugiarto					
Forum LSM Peduli AIDS Jabodetabek	Imam Mulyadi					
IHPCP	Steve Leenhouts					
Indonesian Red Cross	Dewi Rahmadania					
STIGMA Foundation	Budi R.					
IPPNI	Sekar Wulan Sari					
UNGASS Community	Belinda					
Hotline Surabaya Foundation	Esthi Susanti H.					
UNGASS Community	Rico Gustav					
UNAIDS	Lely Wahyuniar					
Duta Remaja (Youth)	Loveria Sekarrini					
Indonesian Red Cross	Kristanti P.					
UNICEF	Remy Rohadian					
FHI	Sulami					
FKKM Jakarta Selatan	A. Rohili					

ALL RESPONDENTS ANSWERED ALL PARTS OF QUESTIONNAIRE

*Note: In the NCPI answers, N/A stands for "Not Applicable"*

## National Composite Policy Index questionnaire

### Part A

#### I. Strategic plan

1. Has the country developed a national multi-sectoral strategy/action framework to combat AIDS?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes <input checked="" type="checkbox"/>	Period covered: 2003-2007 and 2007-2010	Not Applicable (N/A)	No
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IF NO or N/A, briefly explain
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IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multi-sectoral strategy/action framework?

Number of Years: 5 years

1.2 Which sectors are included in the multi-sectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy/Action framework		Earmarked budget	
	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Health	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Education	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Labour	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Transportation	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Military/Police	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Women	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Young people	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Other*8: Ministry of Internal Affairs Ministry of Law and	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No

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

<sup>13</sup>Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

Sectors included	Strategy/Action framework		Earmarked budget	
Human Rights Ministry of Defence Ministry of Religious National Narcotics Board				

IF NO earmarked budget, how is the money allocated?

1.3 Does the multi-sectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	a. Yes ✓	No
b. Young women/young men	b. Yes ✓	No
c. Specific vulnerable sub- populations <sup>15</sup>	c. Yes ✓	No
d. Orphans and other vulnerable children	d. Yes	No ✓
Settings		
e. Workplace	e. Yes ✓	No
f. Schools	f. Yes ✓	No
g. Prisons	g. Yes ✓	No
Cross-cutting issues		
h. HIV, AIDS and poverty	h. Yes ✓	No
i. Human rights protection	i. Yes ✓	No
j. PLHIV involvement	j. Yes ✓	No
k. Addressing stigma and discrimination	k. Yes ✓	No
l. Gender empowerment and/or gender equality	l. Yes ✓	No

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes ✓	No
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IF YES, when was this needs assessment /analysis conducted? Year: 2002, 2004 and 2006

IF NO, how were target populations identified?

1.5 What are the target populations in the country? Most-at-risk populations: Injecting Drugs Users (IDUs), Female Sex Workers (FSW), Transgender (Waria), Man Sex with Men (MSM), Clients of Sex Workers, Prisoners, general population age above 15 years old.

1.6 Does the multi-sectoral strategy/action framework include an operational plan?

Yes ✓	No
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1.7 Does the multi-sectoral strategy/action framework or operational plan include:

a. Formal program goals?	Yes ✓	No
b. Clear targets and/or milestones?	Yes ✓	No

c.	Detailed budget of costs per programmatic area?	Yes√	No
d.	Indications of funding sources?	Yes√	No
e.	Monitoring and Evaluation framework?	Yes√	No

1.8 Has the country ensured “full involvement and participation” of civil society<sup>16</sup> in the development of the multi-sectoral strategy/action framework? Yes. Based on the National Strategy, Presidential Decree and Ministry of Health Regulation.

Active involvement√	Moderate involvement	No involvement
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<sup>16</sup> 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 MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately

IF active involvement, briefly explain how this was done:  
Explicitly, the role of civil society is explained in the National Strategy, Presidential Decree (civil society is in the National AIDS Commission Structure, as the Executive Board) and also stated in the Ministry of Internal Affairs Regulation.

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multi-sectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes√	No
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1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programs to the national multi-sectoral strategy/action framework?

Yes, all partners√	Yes, some partners	No
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IF SOME or NO, briefly explain

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

Yes, all partners√	Yes, some partners	No
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2.1 IF YES, in which development plans is policy support for HIV and AIDS integrated?

a) National Development Plans; b) Common Country Assessment/United National Development Assistance Framework; c) Poverty Reduction Strategy Papers; d) Sector Wide Approach e) other

2.2 IF YES, which policy areas below are included in these development plans?

√ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	√	√	√	√	√
Treatment for opportunistic infections	√				√
Antiretroviral therapy					√
Treatment for opportunistic infections	√				√
Care and support (including social security or other schemes)	√				√
AIDS impact alleviation	√		√		√
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	√				√
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	√				√
Reduction of stigma and discrimination Women's economic empowerment (e.g. access to credit, access to land, training)	√				
Other: [write in]					

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

Yes	No ✓	N/A
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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/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes ✓	No
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4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

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

\*What is the approach taken to HIV testing and counselling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:  
 For the Indonesian Armed Forces: VCT is a mandatory when the member would like to go or comes back from the area where he or she is posted (including outside Indonesia), VCT is provided. For those who are known to be HIV positive, they should not be posted out of the country but will be assigned to do other work that requires minimum physical effort and there must measures to reduce the possibility of transmission.

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

Yes ✓	No
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5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes ✓	No
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5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes ✓	No
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5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs ✓	Estimates only	No
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5.4 Is HIV and AIDS programme coverage being monitored?

Yes ✓	No
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IF YES, is coverage monitored by sex (male, female)?

Yes ✓	No
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IF YES, is coverage monitored by population sub-groups?

Yes ✓	No
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IF YES, which population sub-groups? Most-at-risk populations: Injecting Drugs Users (IDUs), Female Sex Workers (FSW), Transgender (Waria), Man Sex with Men (MSM), Clients of Sex Workers, Prisoners, general population aged above 15 years.

IF YES, is coverage monitored by geographical area?

Yes ✓	No
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IF YES, at which levels (provincial, district, other)? At district level

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

Yes ✓	No
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Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?												
2007	Poor											
	Good											
		0	1	2	3	4	5	6	7 ✓	8	9	10
2005	Poor											
	Good											
		0	1	2	3	4	5	6 ✓	7	8	9	10
Comments on progress made since 2005: In 2005, respondents answering the questionnaire were different therefore the reassessment occurred / was re-evaluated. Indonesia has revised the National Strategy 2003-2007 into the National Strategy 2007-2010 completed with the costed-National Action Plan.												

## 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 programs and effective use of government and civil society organizations and processes to support effective AIDS programs.

1. Do high officials speak publicly and favorably about AIDS efforts in major domestic for at least twice a year?

President/Head of government

Yes ✓	No
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Other high officials  
Other officials in regions and/or districts

Yes ✓	No
Yes ✓	No

2. Does the country have an officially recognized national multi-sectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes ✓	No
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IF NO, briefly explain:

2.1 IF YES, when was it created? Year: 1994

2.2 IF YES, who is the Chair?

Ir. Aburizal Bakrie (the Coordinating Minister of People's Welfare)

2.3 IF YES, does it:

have terms of reference?	Yes ✓	No
have active Government leadership and participation?	Yes ✓	No
have a defined membership?	Yes ✓	No
include civil society representatives? IF YES, what percentage? 20%	Yes ✓	No
include people living with HIV?	Yes ✓	No
include the private sector?	Yes ✓	No
have an action plan?	Yes ✓	No
have a functional Secretariat?	Yes ✓	No
meet at least quarterly?	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 national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?

Yes ✓	No
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3.1 IF YES, does it include?

Terms of reference	Yes ✓	No
Defined membership	Yes ✓	No
Action plan	Yes ✓	No
Functional Secretariat	Yes ✓	No
Regular meetings	Yes ✓	No
	Frequency of meetings: Once in three months	

IF YES, What are the main achievements?  
 PLHIV are now able to access ARV. This was one of the major achievements of civil society's dealing with the government. Other achievements are the harm reduction program and peer-support group.

IF YES, What are the main challenges for the work of this body?  
 Civil society has diverse background and they still need internal coordination, and MSM community needs better outreach and coordination at national level.

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

Percentage: 10%

What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes√	No
Technical guidance/materials	Yes√	No
Drugs/supplies procurement and distribution	Yes√	No
Coordination with other implementing partners	Yes√	No
Capacity building	Yes√	No
Other: [write in]		

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

Yes√  No

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

Yes√  No

6.2 IF YES, which policies and legislation were amended and when?

Policy/Law:  Regulation no 22/97 about drugs defined injecting drugs users as criminals who should be arrested and put in jail.  At the moment, the regulation is being amended by the Indonesian Forum Parliament for Population Development. The National AIDS Commission supports this process.	Year: 2005
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Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7√	8	9	10

2005	Poor											Good
	0	1	2	3	4	5	6√	7	8	9	10	
Comments on progress made since 2005: Indonesia has revised the National AIDS Strategy 2003-2007 into the National Strategy 2007-2010 completed with the costed-work plan												

### III. Prevention

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
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1.1 IF YES, what key messages are explicitly promoted?

√ Check for key message explicitly promoted

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	√
Use condoms consistently	√
Engage in safe(r) sex	√
Avoid commercial sex	√
Abstain from injecting drugs	√
Use clean needles and syringes	√
Fight against violence against women	√
Greater acceptance and involvement of people living with HIV	√
Greater involvement of men in reproductive health programmes	√
Other: [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
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2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes√	No
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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
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2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes√	No
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3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes√	No
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IF NO, briefly explain:
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3.1 IF YES, which sub-populations and what elements of HIV prevention do the policy/strategy address?

√ Check for policy/strategy included

	IDU	MS M	Sex Worker s	Clients of sex worker s	Prison inmat es	Other sub- population s* [write in]
Targeted information on risk reduction and HIV education	√	√	√	√	√	Workplace √
Stigma & discrimination reduction	√	√	√	√	√	
Condom promotion	√	√	√	√	√	
HIV testing & counseling	√	√	√	√	√	
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	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 2007 and in 2005?											
2007 Poor											Good
0	1	2	3	4	5	6	7√	8	9	10	
2005 Poor											
0	1	2	3	4	5	6√	7	8	9	10	
Comments on progress made since 2005: Respondents in 2005 was different with respondents in 2007 therefore re-assessment occurred. Prevention program for IDUs has made significant achievements through the issue of regulation of the Coordinating Minister for People's Welfare No.2/ 2007 about the											

national policy on the AIDS response and the harm reduction program. The regulation explained that IDUs are victims that should be in rehabilitation centers and not to be considered as criminals.  
 The prevention program for FSW in sex transaction places experienced obstacles from people in the local area and there were issues to do with a local regulation to close some commercial sex sites.

4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes√	No
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Notes:

The selection of the 100 priority districts out of 430 districts in Indonesia  
 Strengthen the Local AIDS Commission by providing technical assistance and limited operational cost  
 Train/set up the Assistance Team to help the district team to provide comprehensive services (VCT, BCI, CST)  
 Provide services covering 80% of most-at-risk populations

IF NO, how are HIV prevention programmes being scaled-up?:
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IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts\* in need?

√ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety	√		
Universal precautions in health care settings		√	
Prevention of mother-to-child transmission of HIV			√
IEC on risk reduction		√	
IEC on stigma and discrimination reduction		√	
Condom promotion		√	
HIV testing & counseling			√
Harm reduction for injecting drugs users			√
Risk reduction for men who have sex with men			√
Risk reduction for sex workers		√	
Programmes for other vulnerable sub-populations			√
Reproductive health services including STI prevention & treatment			√

HIV prevention programmes	The activity is available in		
	all districts* in need	most districts* in need	some districts* in need
School-based AIDS education for young people		√	
HIV prevention in the workplace			√
Other [write in]			

Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7√	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6√	7	8	9	10
<p>Comments on progress made since 2005:</p> <p>The Harm Reduction Program was mainly for the provision of sterile needle and syringe program and methadone maintenance therapy, and now these have been incorporated into a broader health service program.</p> <p>PMTCT has been started in some hospitals. The policy for PMTCT is now being composed.</p> <p>Femidom or female condoms are now being introduced.</p> <p>The HIV response in the workplace through prevention programs has been expanded.</p>											

#### 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
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IF YES, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes√	No
------	----

2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes√	No	N/A
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IF NO, how are HIV and AIDS treatment, care and support services being scaled up?
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IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?

153 hospitals are providing ARV and scattered in more than 105 districts throughout Indonesia, with VCT service, laboratory and other services. In collaboration with the NGOs, those who are on ART can be accompanied and fully assisted by the case manager to make sure they comply with the regime for taking ARV.

√ Check the relevant implementation level for each activity or indicate N/A if not applicable HIV treatment, care and support

HIV treatment, care and support services	The service is available in		
	All districts* in need	Most districts* in need	Some districts* in need
Antiretroviral therapy		√	
Nutritional care			√
Pediatric AIDS treatment			√
Sexually transmitted infection management		√	
Psychosocial support for people living with HIV and their families			√
Home-based care			√
Palliative care and treatment of common			√
HIV-related infections		√	
HIV testing and counseling for TB patients			√
TB screening for HIV-infected people			√
TB infection control in HIV treatment and care facilities			√
Cotrimoxazole prophylaxis in HIV infected people			√
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			√
HIV treatment services in the workplace or treatment referral systems through the workplace			√
HIV care and support in the workplace (including alternative working arrangements)			√
Other programmes: [write in]			

\*Districts or equivalent de-centralized governmental level in urban and rural areas

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

Yes√	No
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4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

Yes√	No
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4.1 IF YES, for which commodities?: Methadon, ART, condom

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

Yes	No√	N/A
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5.1 IF YES, is there an operational definition for OVC in the country?

Yes	No
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5.2 IF YES, does the country have a national action plan specifically for OVC?

Yes	No
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5.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?

Yes	No
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IF YES, what percentage of OVC is being reached?          % [write in]

Overall, how would you rate the efforts to meet the need of orphans and other vulnerable children?												
2007	Poor											Good
		0	1	2	3√	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2√	3	4	5	6	7	8	9	10
Comments on progress made since 2005:												
Although Indonesia does not have a policy or strategy for HIV and AIDS-related needs for orphans and vulnerable children, there are some NGOs that have been started to work on this issue.												



#### IV. Monitoring and evaluation

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

Yes✓	Years covered: 2005	In progress	No
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1.1 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes✓	No
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1.2. IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes✓	No
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1.3. 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
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2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes✓	No
behavioural surveillance	Yes✓	No
HIV surveillance	Yes✓	No
a 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 M&E plan?

Yes✓	Years covered: 2007-2010	In progress	No
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3.1 IF YES, has funding been secured?

Yes✓	No
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4. Is there a functional M&E Unit or Department?

Yes✓	In progress	No
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IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?
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4.1 IF YES, is the M&E Unit/Department based

In the NAC (or equivalent)?	Yes√	No
In the Ministry of Health?	Yes√	No
Elsewhere?		

4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:	8 persons	
Position: Deputy for Program Development	Full time	Since February 2007
Position: Monitoring and Evaluation Coordinator	Full time	Since December 2006
Position: Data Management Assistant 1 for internal/secretariat monitoring and evaluation	Full time	Since October 2006
Position: Data Management Assistant 2 for national program monitoring and evaluation	Full time	Since August 2006
Position: Data Management Assistant 3 for national program monitoring and evaluation	Full time	Since April 2007
Position: Coordinator for Reporting	Full time	Since February 2007
Position: Coordinator for Data and Information Center (including website and national information center)	Full time	Since July 2007
Position: Administration staff for Program Development Division	Full time	Since February 2007
Number of temporary staff:	None	

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/Department for review and consideration in the country's national reports?

Yes√	No
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IF YES, does this mechanism work? What are the major challenges?  The M & E mechanism has been implemented for a certain period of time. The main
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obstacle is in developing the data collection system from district level to national level, in terms of data quality, human resources, coordination with related sectors and the issue of under-reporting.

4.4 IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low							High	
0	1	2	3	4√	5			

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

No	Yes, but meets irregularly	Yes, meets regularly √
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IF YES, Date last meeting: 4 September 2007

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

Yes√	No
------	----

Notes: the working group has include civil society but not PLHIV

IF YES, describe the role of civil society representatives and people living with HIV in the working group? Civil society has input to the national and local monitoring and evaluation system improvement, NGOs are encouraged to report their activities to the AIDS Commission.

6. Does the M&E Unit/Department manage a central national database?

Yes√	No	N/A
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6.1 IF YES, what type is it? Country Response Information System

6.2. IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes√	No
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6.3 Is there a functional\* Health Information System?

National level	Yes√  Only 30% on function	No
Sub-national level IF YES, at what level(s)? [write in]	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)

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

Yes√	No
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7. To what extent is M&E data used in planning and implementation?

Low						High
0	1	2	3√	4	5	

What are examples of data use?

At the national level, various data from many resources were used for planning using the Asian Epidemic Model and Resource Needs Model. The results were used in the National Action Plan.

What are the main challenges to data use?

Human resource capacity to analyze and use data for planning and advocacy needs to be improved.  
Data collection tools are quite complex and cannot be used when the data to be entered is incomplete data, such that the tool does not assist particularly for planning purpose.

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

At national level?	Yes√	No
International HIV/AIDS Monitoring and Evaluation Training Course, Bali, September 2006. IF YES, Number of individuals trained: 31 participants from National AIDS Commission, Local AIDS Commission, International Donors and Civil Society.		
Country Response Information System (CRIS) Training of Trainers, Jakarta, March 2006. 4 NAC staff attended the training but 2 of them are not longer working for NAC anymore.		
Development Assistance Database (DAD) for HIV and AIDS, Jakarta, December 2006. The training was attended by all staff from Information, Monitoring and Evaluation Division (previous name of the NAC M&E Unit)		
Resource Needs Model Training, Jakarta, December 2006. The training was		

attended by 32 representatives from departments and civil society with HIV and AIDS Program.		
At sub-national level?	Yes√	No
Monitoring and Evaluation training for District/City Project Officer (PO) and Administrative Officer (AO) of Local AIDS Commission in 4 Series of Regional Meetings, occurred from March up to May 2006. Each took place in Bandung, Jakarta, Surabaya and Jayapura.		
Including civil society?	Yes√	No
IF YES, number of individuals trained: 20 persons		

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8√	9	10
2005	Poor										
	0	1	2	3	4	5	6	7√	8	9	10
<p>Comments on progress made since 2005:</p> <p>In 2005, the National Monitoring and Evaluation Guideline has been developed, but it did not yet explain clear targets because there was not yet a National Action Plan. In 2007, the guideline is scheduled to be revised and adjusted with the national targets to reach the universal access.</p> <p>The Integrated Bio Behavioral Survey (IBBS) was conducted in 2006 in Tanah Papua. IBBS for most-at-risk population is being conducted in 7 provinces.</p> <p>The Monitoring and Evaluation Working Group has been revitalized and functioning. The monitoring and evaluation of activities from sectors/ members of NAC have started.</p>											

## Part B

### I. Human Rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as 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: Regulations about Human Rights are available but do not explicitly discuss HIV and AIDS issues, and should be improved. Discrimination and stigmatization are still a major problem. Therefore, civil society and government need to take action to explain this issue more completely and correctly. Discrimination at health facility is gradually reducing.

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	No√
-----	-----

Regulations regarding anti-discrimination are available (Regulation of CEDAW Ratification No 7 in 1984) but have never been used.

The policy is not gender sensitive and there are many obstacles in implementation, such as there being no reproductive health service for women living with HIV.

In terms of drugs use, there are 2 regulations, Regulation No. 22/1997 about Narcotics and Presidential Instruction No. 3/ 2002 about The Response to Narcotic, Psychotropics, Precursor and other Addictive Substance and their Distribution, which really hinder the prevention and control of HIV and AIDS. This situation has made government officers break Human Rights rules in dealing with drugs users. Nevertheless the government is trying to handle the situation by developing the National Strategy on the Response to HIV and AIDS 2007-2010 and The Coordinating Minister for People's Welfare issued a Decree called PERMENKO KESRA No. 2/2007 about The National Strategy on the Response to HIV and AIDS through Harm Reduction Program.

Policy and programs for youth are still discriminative and fragmented in some departments (Departments of Education, State Minister of Youth and Sports Affairs and Ministry of Health). Issues about youth sexuality are not yet clearly exposed and there is no youth-specific health service, even though many youth are now practicing risky behavior.

One so-called 'moral approach' has been proposed to deal with sex industry, emphasizing the closing of commercial sex work sites. Such actions will limit the opportunity to provide responses to treat STIs, HIV and AIDS in these areas and sub-populations.

2.1 IF YES, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: [write in]	Yes	No

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

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

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

Yes√	No
------	----

3.1 IF YES, for which sub-populations?

Women	Yes√	No
Young people	Yes√	No
IDU	Yes√	No
MSM	Yes√	No
Sex Workers	Yes√	No
Prison inmates	Yes√	No
Migrants/mobile populations	Yes√	No
Other: [write in]	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

In article 6 line 5 within PERMENKOKESRA No. 02/PER/MENKO/KESRA/I/2007 about National Policy on HIV Response and Community Empowerment stated that “.....The Indonesian Police/National Narcotics Board (NNB) is protected by law to conduct activities within health services for IDUs, and IDUs can be referred to health services.....”. This service cannot be provided because it is contradictive to another similar but higher order Regulation, No. 22/1997 about Narcotics which basically positions drug users as criminal. Therefore, it is hard for police and the NNB to function or carry out their tasks as stated in the Ministerial Decree (PERMENKO KESRA) because it is a lower order of regulation.

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

Yes√	No
------	----

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

Yes	No√
-----	-----

Note: Almost all NGOs have outreach programs and they try to encounter the problems in their own ways. Some of them record and document the discrimination experienced by PLHIV. Officially, the government does not record, document or discuss discrimination cases specifically.

IF YES, briefly describe this mechanism
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6. Has the Government, through political and financial support, involved most at-risk populations in governmental HIV-policy design and program implementation?

Yes√	No
------	----

<p>IF YES, briefly describe this mechanism</p> <p>Civil society is only involve in the implementation. At the decision making level, civil society is often invited as part of a policy making team but more often their inputs are not well-accomodated.</p> <p>Civil society is often the program implementer and invited to participate if they agree with the policy draft that has been developed by the government. Some groups of people act as representatives of civil society but there is no democratic system to convey the results of meetings back to other groups, therefore, genuine civil society representation is not very well-known.</p> <p>Experience from the DKI Jakarta area and other places is that the local government has been very actively working with civil society in the drafting stage , as well as in program implementation.</p>
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7. Does the country have a policy of free services for the following:

HIV prevention services	Yes√	No
Anti-retroviral treatment	Yes√	No
HIV-related care and support interventions	Yes√	No

<p>IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:</p> <p>The policy is being implemented and funded by the international partners, mainly for HIV prevention.</p> <p>ARV is not yet formulated for infants and children.</p>
---



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

Yes√	No
------	----

Note: Female has more obstacles for accessing many kinds of services as stated above because of the services system and structure.

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

Yes√	No
------	----

9.1 Are there differences in approaches for different most-at-risk populations?

Yes√	No
------	----

IF YES, briefly explain the differences:

Peer Education approaches apply for transgender (waria), FSW, MSM and IDUs. Indirect approaches apply for clients of sex workers, for example through HIV prevention programs in the workplace, which aim to reach workers that might be clients of sex workers. For prisoners, the system and the policy to respond to HIV and AIDS in prisons is still being developed.

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

Yes√	No
------	----

Note: The Indonesian workers are strongly required to do HIV testing because it is required the destination country. They should do it without counseling and signing an informed consent.

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 and people living with HIV?

Yes√	No
------	----

IF YES, describe the effectiveness of this review committee

The review committee is the so-called Ethics Committee and has non scientists as members but PLHIV are not involved as members.

The Ministry of Health develops national ethics guidelines for research and together with the Central Bureau of Statistics, they conduct the surveys and other research.

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√
-----	-----

reduction of HIV-related stigma and discrimination

Yes	No√
-----	-----

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

13. 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 and AIDS 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√
-----	-----

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

Yes√	No
------	----

15. Are there programs designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes√	No
------	----

IF YES, what types of programs?

Media	Yes√	No
School education	Yes√	No

Personalities regularly speaking out	Yes√	No
<p>Other:</p> <p>HIV and AIDS issues were discussed publicly at least in 2 public events</p> <p>HIV and AIDS education through formal school is still focused in big cities and selected schools</p> <p>NAC team provides HIV and AIDS information to communities</p>		

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5√	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4√	5	6	7	8	9	10
<p>Comments on progress made since 2005:</p> <p>Respondents answering the questionnaire in 2005 and 2007 were different, therefore, a re-assessment occurred. The recent respondents assess the progress based on:</p> <ul style="list-style-type: none"> <li>-Existence of PLHIV and MARPs (lesbian, gay, bisexual, and transgender) in the National Human Rights Committee.</li> <li>- PLHIV as staff of local AIDS Commission</li> <li>- Existence of PERMENKO KESRA no 02/PER/MENKO/KESRA/I/2007 about National Policy to Response to HIV and AIDS through Harm Reduction of the use of Narcotics, Psychotropic, and Injectable drugs.</li> </ul>											

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6√	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5√	6	7	8	9	10
<p>Comments on progress made since 2005:</p> <p>Respondents answering questionnaire in 2005 and 2007 were different, therefore, a re-assessment occurred. The law regarding drugs is being implemented on the ground but it still has a public health implementation perspective and tends to emphasize HIV/AIDS-related problems. For example, PLHIV in jail are hardly given access to ARV or are unable to continue their treatment.</p>											

II. Civil society17 participant

II. Civil society17 participation

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

Low High  
0 1 2 3 4√ 5

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

Low High  
0 1 2√ 3 4 5

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in both the National Strategic plans and national reports?

Low High  
0 1 2 3 4√ 5

b. in the national budget?

Low High  
0 1√ 2 3 4 5

4. Has the country included civil society in a National Review of the National Strategic Plan?

Yes	No√
-----	-----

Note: the National Review is still on the plan

IF YES, when was the Review conducted? Year: [write in]

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low High  
0 1 2√ 3 4 5

List the types of organizations representing civil society in HIV and AIDS efforts: PLHIV support group and NGOs, academics, professional organization (Indonesian Doctors Association, and Indonesian Public Health Expert Association), faith-based organization and journalists.

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 vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

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

Note: Financial support from government is very minimum. Donor financial support is available but it is much far from needed.

b. adequate technical support to implement its HIV activities?

Low						High
0	1	2√	3	4	5	

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7√	8	9	10
2005	Poor										
	0	1	2	3	4	5√	6	7	8	9	10
Comments on progress made since 2005: Respondents answering questionnaire in 2005 and 2007 were different, therefore a re-assessment occurred. There is a 2 point increase for the 2007 rate. Acceleration Program and Program Scaling Up have made significant and positive improvements.											

### III. Prevention

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programs?

Yes√	No
------	----

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

IF YES, to what extent have the following HIV prevention programs been implemented in identified districts in need?

Program Acceleration and Scaling Up have meant an expansion of response and program coverage.

√ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety		√	
Universal precautions in health care settings			√
Prevention of mother-to-child transmission of HIV			√
IEC in risk reduction		√	
IEC on stigma and discrimination reduction			√
Condom promotion		√	
HIV testing & counseling			√

Harm reduction for injecting drugs users			√
Risk reduction for men who have sex with men		√	
Risk reduction for sex workers		√	
Programmes for other most-at-risk populations			√
Reproductive health services including STI prevention & treatment			√
School-based AIDS education for young people			√
Programmes for out-of-school young people			√
HIV prevention in the workplace			√
Other programmes: Youth friendly clinic Migrant workers			√ √ √
HIV integration into trafficking program			

Districts or equivalent geographical/de-centralized levels in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?												
2007	Poor											Good
		0	1	2	3	4	5	6√	7	8	9	10
2005	Poor											
		0	1	2	3	4	5√	6	7	8	9	10
Comments on progress made since 2005:												
Respondents answering questionnaire in 2005 and 2007 were different, therefore a re-assessment occurred.												

#### IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes√	No
------	----

IF YES, how are HIV and AIDS treatment, care and support services being scaled-up?:  
In the beginning there were 25 Referral Hospitals and this has risen to 100 hospitals, and now there is a total of 153 hospitals. All districts/cities are expected to be able to access these hospitals.

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?

√ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
Antiretroviral therapy		√	
Nutritional care			√
Paediatric AIDS treatment			√
Sexually transmitted infection management		√	
Psychosocial support for people living with HIV and their families			√
Home-based care			√
Palliative care and treatment of common HIV-related infections			√
HIV testing and counseling for TB patients			√
TB screening for HIV-infected people			√
TB preventive therapy for HIV-infected people			√
TB infection control in HIV treatment and care facilities			√
Cotrimoxazole prophylaxis in HIV-infected people			√
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			√
HIV treatment services in the workplace or treatment referral systems through the workplace			√
HIV care and support in the workplace (including alternative working arrangements)			√
Other programmes: Comprehensive program with psychosocial and spiritual aspect for vulnerable populations.			√
Reintegration vulnerable stigmatized sub population			√
Social mitigation program			√

\*Districts or equivalent geographical de-centralized governmental levels in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6√	7	8	9	10
2005	Poor										
	0	1	2	3	4	5√	6	7	8	9	10
Comments on progress made since 2005: Respondents answering questionnaire in 2005 and 2007 were different, re assessment occurred.											
There is significant attention related to IO, TB, and pediatric care. The problem occurs in relation to health insurance for poor people, with a government program called ASKESKIN. HIV positive poor will face problems if they want to use ASKESKIN.											

2. What percentage of the following HIV programs or services is estimated to be provided by civil society?

Prevention for youth	<25%			
Prevention for vulnerable sub-populations				
-IDU	<25%			
-MSM	<25%			
-Sex workers		25-50%		
Counseling and Testing	<25%			
Clinical services (OI/ART)	<25%			
Home-based care	<25%			
Programs for OVC**	<25%			

\*OI Opportunistic infections;

\*\*OVC Orphans and other vulnerable children

3. Does the 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 OVC in the country?

Yes	No
-----	----

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

Yes	No
-----	----

3.3 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]



National Funding Matrix  
AIDS Spending Categories by Financing Sources

Jan - Dec 2007  
Calendar Year: Yes \_\_\_ V \_\_\_ No \_\_\_  
(Specify beginning/end)  
Average Exchange Rate for the year: \_\_\_ IDR 92000 \_\_\_

AIDS Spending Categories	FINANCING SOURCES																
	TOTAL	Public Sources				International Sources				Private Sources							
		Public Sub-Total	Central/National	Sub National*)	Dev. Bank Reim-bursable	All Other Public	International Sub-Total	Bilaterals	Multilateral (sub total)	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable	All Other International	Private Sub Total	Coorpo-rations	Consumer/ Out of-pocket	
<b>TOTAL (Local Currency)</b>																	
<b>1. Prevention (sub-total)</b>	23,179,628	5,029,743	4,377,906	651,837		18,149,885	15,881,136	2,568,749	1,477,949	1,080,521		279					
1.1 Mass media	3,764,739	3,764,739	3,515,924	248,815													
1.2 Community mobilization	192,001	192,001	142,001	50,000													
1.3 Voluntary counselling and testing	128,463	128,463	97,892	30,571													
1.4 Programs for vulnerable and special populations	36,957	36,957	-	36,957													
1.5 Youth in school	103,371	103,371	58,284	45,087													
1.6 Youth out of school	6,522	6,522	-	6,522													
1.7 Prevention program for PLHA	109,170	109,170	100,474	8,696													
1.8 Programs for sex workers and their clients	18,478	18,478	-	18,478													
1.9 Programs for MSM	-	-	-	-													
1.10 Harm reduction programs for IDUs	124,436	124,436	86,936	37,500													
1.11 Workplace activities	54,165	54,165	24,817	29,348													
1.12 Condom social marketing	254,891	254,891	239,130	15,761													
1.13 Public and commercial sector condom provision	5,000	5,000	-	5,000													
1.14 Female condom	-	-	-	-													
1.15 Microbicides	-	-	-	-													
1.16 Improving management of STIs	25,625	25,625	-	25,625													
1.17 Prevention of mother-to-child transmission	21,739	21,739	-	21,739													
1.18 Blood safety	29,283	29,283	29,283	-													
1.19 Post-exposure prophylaxis	-	-	-	-													
1.20 Safe medical injections	-	-	-	-													
1.21 Male circumcision	-	-	-	-													
1.22 Universal precautions	27,508	27,508	27,508	-													
1.99 Others / Not-elsewhere classified	127,397	127,397	55,659	71,739													
<b>2. Care and Treatment (sub-total)</b>	14,073,523	106,832	92,158	14,674		13,966,690	4,403,757	9,562,934	188,472	9,374,430		32					
2.1 Outpatient care	-	-	-	-													
2.2 Provider initiated testing	-	-	-	-													
2.3 Opportunistic Infection (OI) prophylaxis	-	-	-	-													
2.4 Antiretroviral therapy	92,158	92,158	92,158	-													
2.5 Nutritional support	1,087	1,087	-	1,087													
2.6 Specific HIV laboratory monitoring	-	-	-	-													
2.7 Dental care	-	-	-	-													
2.8 Psychological care	-	-	-	-													
2.9 Palliative care	-	-	-	-													
2.10 Home-based care	-	-	-	-													
2.11 Additional/informal providers	-	-	-	-													
2.12 In-patient care	-	-	-	-													
2.13 Opportunistic Infection (OI) treatment	-	-	-	-													
2.99 Others / Not-elsewhere classified	13,587	13,587	-	13,587													

AIDS Spending Categories		FINANCING SOURCES														
		TOTAL				Public Sources				International Sources				Private Sources		
		Public Sub-Total	Central/National	Sub National <sup>1)</sup>	Dev. Bank Reimbursable	All Other Public	International Sub-Total	Bilaterals	Multilateral (sub total)	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable	All Other International	Private Sub-Total	Cooperations	Consumer/Out-of-pocket
<b>3. Orphans and Vulnerable Children * (sub-total)</b>						45,850		45,850								
3.1	Education	-	-	-	-											
3.2	Basic health care	-	-	-	-											
3.3	Family support	-	-	-	-											
3.4	Community support	-	-	-	-											
3.5	Administrative costs	-	-	-	-											
3.99	Others / Not-elsewhere classified	-	-	-	-											
<b>4. Program Management and Administration Strengthening (sub-total)</b>		12,161,368	8,998,960	8,127,294	871,666	3,162,408	2,600,023	562,385	562,344		41					
4.1	Programme management	259,616	259,616	112,374	147,242											
4.2	Planning and coordination	681,573	681,573	215,217	466,356											
4.3	Monitoring and evaluation	203,675	203,675	184,973	18,702											
4.4	Operations research	435	435	-	435											
4.5	Sero-surveillance	156,537	156,537	78,602	77,935											
4.6	HIV drug-resistance surveillance	-	-	-	-											
4.7	Drug supply systems	2,059,125	2,059,125	2,059,125	-											
4.8	Information technology	-	-	-	-											
4.9	Supervision of personnel	-	-	-	-											
4.10	Upgrading laboratory infrastructure	5,443,207	5,443,207	5,443,207	-											
4.11	Construction of new health centres	-	-	-	-											
4.99	Others / Not-elsewhere classified	194,792	194,792	33,797	160,996											
<b>5. Incentives for Human Resources ** (sub-total)</b>		4,562,592	340,779	215,206	125,573	4,221,813	4,003,611	218,202	218,111		91					
5.1	Monetary incentive for physicians	-	-	-	-											
5.2	Monetary incentive for nurses	-	-	-	-											
5.3	Monetary incentive for other staff	95,522	95,522	-	95,522											
5.4	Formative education and build-up of an AIDS workforce	3,209	3,209	-	3,209											
5.5	Training	229,005	229,005	215,206	13,799											
5.99	Others / Not-elsewhere classified	13,043	13,043	-	13,043											
<b>6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)</b>		27,174	27,174	-	27,174	-	-	-	-	-	-	-	-	-		
6.1	Monetary benefits	-	-	-	-											
6.2	In-kind benefits	-	-	-	-											
6.3	Social services	27,174	27,174	-	27,174											
6.4	Income generation	-	-	-	-											
6.99	Others / Not-elsewhere classified	-	-	-	-											
<b>7. Enabling Environment and Community Development (sub-total)</b>		2,413,407	495,866	327,768	168,098	1,917,541	379,412	1,538,129	379,412		14					
7.1	Advocacy and strategic communication	410,781	410,781	263,063	147,717											
7.2	Human rights	6,793	6,793	-	6,793											
7.3	AIDS-specific institutional development	-	-	-	-											
7.4	AIDS-specific programs involving women	19,651	19,651	19,651	-											
7.99	Others / Not-elsewhere classified	58,641	58,641	45,054	13,587											
<b>8. Research excluding operations research which is included under (sub-total)</b>		113,031	39,129	39,129	-	73,902	25,000	48,902	25,000							
8.1	Biomedical research	-	-	-	-											
8.2	Clinical research	21,336	21,336	21,336	-											
8.3	Epidemiological research	-	-	-	-											
8.4	Social science research	-	-	-	-											
8.5	Behavioral research	-	-	-	-											
8.6	Research in economics	-	-	-	-											
8.7	Research capacity strengthening	-	-	-	-											
8.8	Vaccine-related research	-	-	-	-											
8.99	Others / Not-elsewhere classified	17,793	17,793	17,793	-											

<sup>1)</sup> subnational data is sampled from 3 provinces with high prevalence



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