Executive Summary

The Response to HIV and AIDS In Indonesia 2006 - 2011:

Report on 5 Years Implementation of Presidential Regulation No. 75/2006 on the National AIDS Commission

National AIDS Commission
Indonesia, October 2011

Foreword:
Secretary, National AIDS Commission

Five years ago, concerned at the rapid increase of HIV infection and its distribution across Indonesia, President Susilo Bambang Yudhoyono issued Regulation 75/ 2006 on the National AIDS Commission calling for a more "holistic, integrated, and coordinated prevention and management of the response to AIDS." The National AIDS Commission was called upon to lead, manage, and coordinate the multi-sectoral, multi-partner comprehensive response, the Indonesian "total football approach." The secretariat of the National AIDS Commission had the responsibility of mobilizing and coordinating efforts to carry out the President's instructions.

The present report is an accounting to the President of Indonesia by the National AIDS Commission of this effort and a transparent sharing of information with the general public including, in particular, people living with and affected by HIV. This is the Executive Summary of the full report which provides an overview of the wide ranging and diverse efforts of many people and institutions, both Indonesian and international in this field.

During the past five years fundamental changes have taken place both directly related to bringing the epidemic under control as well as the building and strengthening of systems within government and the community to sustain the response as needed in the future.

As Secretary of the National AIDS Commission, I take this occasion both to say thanks and pay tribute to the collaborative efforts related to program, finance, public policy, community action which have brought positive change for people infected and affected by HIV and AIDS and for the national family as a whole. We see great progress and take pride in the joint effort which has brought us this far.

At the same time we acknowledge that the road ahead is long and there remain many challenges to overcome. There are still too many Indonesians – men, women, and children -- who are not reached with the information, services, support, and supplies they

need. We need the active involvement of many partners in our efforts to reach them all and bring the HIV epidemic under control.

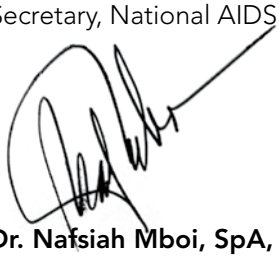
The full report consists of an Executive Summary and four chapters as follows:

Chapter 1 Background to the Presidential Regulation 75/ 2006 and this report;
Chapter 2 The epidemic and the response : changes between 2006 and 2011;
Chapter 3 Managing the change: building the systems and putting them to work; and,
Chapter 4 Looking ahead

We, in the AIDS Commissions at the national level and across the country, take up the challenge of the next five years with enthusiasm and commitment. We believe that if we continue and strengthen existing partnership with all actors in the response – civil society, people who are infected and affected by the virus, government at all levels, faith based communities, the media, research institutions and the academic world, the private sector, and the community of professional health care providers – with God's help Indonesia will be able to bring HIV and AIDS under control across our beloved country.

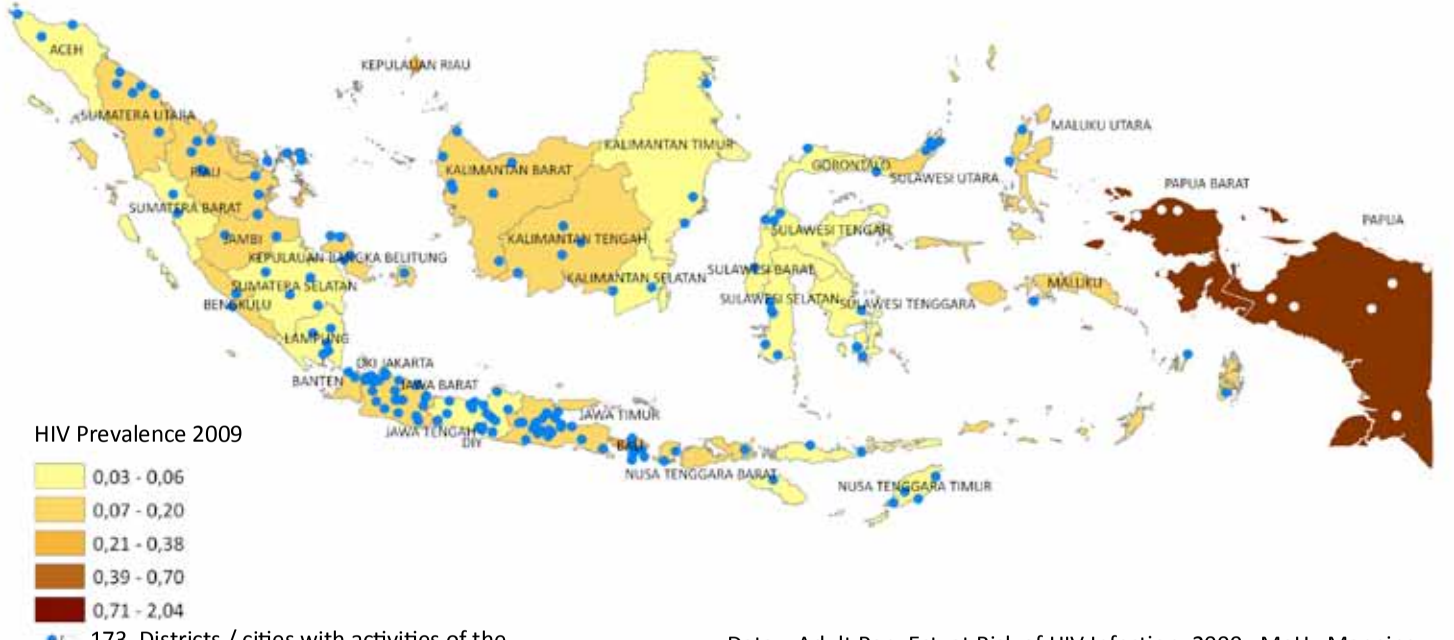
God Bless our efforts, the community of people living with HIV, and the whole Indonesian family.

October 2011
Secretary, National AIDS Commission of Indonesia



Dr. Nafsiah Mboi, SpA, MPH.

Map of HIV and AIDS Epidemic and Response in Indonesia, 2011



Data : Adult Pop .Est. at Risk of HIV Infection, 2009, MoH Mapping by National AIDS Commission, 2010 in 33 provinces and 440 districts/ cities.

Note to the Reader

Data:

Years: where available, data is used through at least June 2011. Otherwise data goes to December 2010 or the most recent available.

Information on civil society: Because of the scope of this report, information on the contribution of civil society to the national response is limited in detail. Because the role of civil society in the response to HIV and AIDS during the period 2006 – 2011 is of great importance separate work is being done to examine thoroughly what they have given and what they have received as participants/ contributors in implementation of Presidential Regulation 75/ 2006.

Sources: all listed. Where available, Indonesian government sources are used.

Re costs and funding: Information is provided related to both budgets and expenditures, the one reflecting a commitment the other an action. Every effort has been made in the text to be clear which is which. Information on expenditures is taken from the *Indonesian National* AIDS Spending Assessment (NASA) prepared by the Indonesian National AIDS Commission in accordance with global guidelines. The NASA reports for 2006-2008 are complete and have been published. The report for 2009 - 2010 is in preparation. Preliminary data is included in this report. The final report is expected later in 2011.

In general, budgets and expenditures are reported in US$ or Rupiah in line with the actual amount reported. In cases where, for clarity sake, an equivalent is given, the exchange rate used has been Rp. 8,500 = US$ 1.

Epidemiological data: Most of the data used in this report is taken from the Ministry of Health (MoH) quarterly reports : *The Situation of HIV and AIDS in Indonesia* or

other reports such as estimates of adults vulnerable to HIV infection carried out in 2006 and 2009, periodic surveillance etc. Some data is also drawn from the *Rapid Surveillance of Behavior* carried out by the National AIDS Commission in 2010.

Limitations on data: In preparation of this report every effort has been made to gather as much current, relevant information as possible from multiple sources. Notwithstanding that effort, there are surely activities at provincial, district/city*, and community level which are not included here because the National AIDS Commission does not have full data on such events. This is in no way a reflection on the value of such activities.

There are also important kinds of data which were not/ not yet available during preparation of this report: (1) Integrated Bio Behavioral Surveillance (IBBS) 2011, (2) the 2011 estimate of adults vulnerable to HIV infection, (3) the *National AIDS Spending Assessment* covering the two years 2009-2010, and (4) data of reported new HIV infection disaggregated by sex, mode of infection, and age.

* In Indonesia the district and cities fulfilling certain criteria are considered the same level of government. Throughout this report, therefore, the term "district/ cities" will be used to refer to this level of government.

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Abbreviations and Acronyms*

AIDS	Acquired Immuno Deficiency Syndrome
APBD	Local (provincial or district) budget. *Anggaran Pendapatan dan Belanja Daerah*
APBN	National Budget. *Anggaran Pendapatan dan Belanja Negara*
ART	Antiretroviral Therapy
ARV	Antiretroviral. Medication which when taken consistently, as prescribed, suppresses the HIV virus and stops the progression of HIV related disease.
ASA	*Aksi Stop AIDS*. USAID-supported HIV and AIDS program in Indonesia. ASA was active during part of the period covered by this report 2005 – 2008.
AusAID	Australian Agency for International Development
BAPPENAS	National Development Planning Board (Indonesia). *Badan Perencanaan dan Pembangunan Nasional*
BKKBN	National Family Planning Board. *Badan Koordinasi Keluarga Berencana Nasional*
BNN	National Narcotics Board. *Badan Narkotika Nasional*
BPK	National Audit Board. *Badan Pemeriksaan Keuangan.* Indonesian government board auditing utilization of national budget funds (APBN).
BPKP	An Indonesian Government Board responsible for auditing management of all government funds (regardless of source). *Badan Pengawasan Keuangan dan Pembangunan.*
BPPT	Government Agency for Assessment and Application of Technology *Badan Pengkajian dan Penerapan Teknologi*
BPS	Central Bureau of Statistics. *Biro Pusat Statistik*
Concentrated epidemic	See terminology, below

* **Source: NAC.** *Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS 2010-2014. Mid Term Review (2010).* **UNAIDS.** *Terminology Guidelines (January 2011).* **WHO.** Website. **MoH RI.** Terminology

CST Care, Support, and Treatment

CUP 100% Condom Use Programs

DFID Department for International Development. The United Kingdom's government agency responsible for international development assistance

DKT Condom Social Marketing Agency active in Indonesia. Named for Darmendra Kumar Tiagi

DPR RI Indonesian House of People's Representatives. *Dewan Perwakilan Rakyat*

EU European Union. Made up of 27 member states in the greater European region

FHI Family Health International - expatriate contractor funded by USAID working in the field of HIV in Indonesia. US headquarters.

FSW Female sex worker

Generalized epidemic See terminology, below

GFATM Global Fund to Fight AIDS, TB, and Malaria

GOI Government of Indonesia

GWL-INA Abbreviation for the National Network of Gay, Transgender, and Men who have Sex with Men - Indonesia

HACT Harmonized Approach to Cash Transfer. A risk assessment mechanism used by the UN to evaluate financial management of organizations which will receive UN funding advance.

HCPI HIV Cooperation Program in Indonesia. Australian supported HIV and AIDS program in Indonesia (2008 – the present). Successor to IHPCP, see below

HIV Human Immunodeficiency Virus

IBBS Integrated Bio Behavioral Survey

IBCA Indonesian Business Coalition on AIDS

ICAAP International Congress on AIDS in Asia and the Pacific. Holds regional meeting every two years. Indonesia hosted ICAAP 9 in 2009 in Bali.

IDU Injecting drug user - term replaced by People Who Inject Drugs (PWID)

IEC Information, Education, and Communication

IHPCP Indonesian HIV/ AIDS Prevention and Care Project (2006-2008). Australian supported HIV program in Indonesia

IMS Sexually transmitted infection. *Infeksi Menular Seksual*

IO Opportunistik Infection. *Infeksi Oportunistik*

IPF Indonesian Partnership Fund. Indonesian name is *Dana Kemitraan Indonesia untuk HIV dan AIDS,* abbreviated DKIA

IPPI Network of HIV Positive Women of Indonesia. *Ikatan Perempuan Positif Indonesia*

JOTHI Indonesian Network of Positive People. *Jaringan Orang Terinfeksi HIV Indonesia*

KDS Peer support group of HIV positive people. *Kelompok Dukungan Sebaya*

KPAK DIstrict/City AIDS Commission. *Komisi Penanggulangan AIDS Kabupaten dan Kota*

KPAN National AIDS Commission. *Komisi Penanggulangan AIDS Nasional*

KPAP Provincial AIDS Commission. *Komisi Penanggulangan AIDS Provinsi*

KPA AIDS Commission (any level). *Komisi Penanggulangan AIDS*

Lapas/ Rutan Prison and detention Centers. *Lembaga Pemasyarakatan/ Rumah Tahanan.*

Low level epidemic See terminology, below

MARA Most at Risk Adolescents (age 15 – 19)

MARY Most at Risk Youth (age 20 – 24)

MDG Millennium Development Goals adopted at UN summit in 2000 with goals and targets for achievement by 2015. Goal 6 is focused on HIV and AIDS.

MenKoKesra Coordinating Minister for People's Welfare/ Chair of National AIDS Commission. *Menteri Koordinator Kesejahteraan Rakyat*

MMT Methadone Maintenance Therapy. Effective for treatment of injecting drug use through provision of daily dose of methadone for oral consumption.

MoH Ministry of Health

MSM Men who have sex with men

MSW Male sex worker

NAC National AIDS Commission

NAPZA Narcotics, psychotropics, and other addictive substances. *Narkotika, Psikotropika dan Zat Adiktif*

NASA *National AIDS Spending Assessment.* Report on AIDS-related expenditures prepared following a global guideline/ format from UNAIDS. Indonesia took part in development and testing of global guidelines. Indonesia reports 2006 – 2008 are in the public record. 2009-2010 expected late 2011.

NGO Non-governmental organization

OST Oral Substitution Therapy

PICT Provider Initiated Counseling and Testing.

PKBI Indonesian Planned Parenthood Association (NGO). *Perkumpulan Keluarga Berencana Indonesia.* A Principle Recipients of Global Fund support 2009 – 2014.

PLHIV People Living with HIV

Positive People	People infected with HIV. Sometimes written "people who are HIV+"
PR	Global Fund term. Principle Recipient. Term for primary/ first level recipient of support from Global Fund.
PWID	People Who Inject Drugs
SRAN	Indonesian acronym for National Strategy and Action Plan 2010-2014
SSF	Global Fund term. Single Stream Financing – a management system used when two approved grants (in Indonesia's case, GF Round 8 and GF Round 9) are brought together and run as one program
STHP	Integrated Bio-Behavioral Surveillance. *Surveilans Terpadu HIV dan Perilaku*
STI	Sexually Transmitted Infection. *Infeksi Menular Seksual*
Surveillance	Periodic collection of data on specific populations to detect trends over time in behavior and/ or distribution of disease
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNODC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS (2001)
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VCT	Voluntary Counseling and Testing
Waria	Indonesian language term for transgender person
WBP	Prisoner. *Warga Binaan Pemasyarakatan*
WHO	World Health Organization

Terminology

Antiretroviral therapy: ARV is treatment for people who are HIV+. ARV is taken in the form of tablets and when correctly administered and consistently taken slows/ stops the progression of infection from HIV to AIDS by hindering replication of the virus in a person's body. Recent findings (2011) have demonstrated conclusively that early treatment with ARV will reduce the viral load in a person's blood, thereby reducing infectiousness. ARV does not eliminate the virus from the blood and if a person who is HIV+ stops ARV treatment the virus will again work to destroy the body's immune system. The person will become sick and ultimately die.

Epidemic levels :

- **Low Level:** an epidemic where HIV prevalence has not consistently exceeded 1% in the general population nationally, nor 5% in any subpopulation.
- **Concentrated level:** an epidemic where HIV has spread rapidly in one or more populations but is not well established in the general population. Typically, the prevalence is over 5% in specific subpopulations while remaining under 1% in the general population.
- **Generalized:** an epidemic which is self-sustaining through heterosexual transmission. In a generalized epidemic, HIV prevalence usually exceeds 1% among pregnant women attending antenatal clinics.

Estimates: In connection with planning and monitoring the HIV epidemic in Indonesia during this five year period there have been two official estimates of key affective populations at risk of infection and estimates of people living with HIV (PLHIV) in Indonesia - 2006 and 2009. Such estimates are carried out periodically by the Ministry of Health in cooperation with the National AIDS Commission and their respective counter parts in 33 provinces. The estimate for 2006 was 193,070 people living with HIV. The estimate for 2009 was 186,257. Throughout this report the estimate of 2006 will be used as the basis for any calculations from 2006 through 2009. The estimate of 2009, which became available only in 2010, is used as the basis for calculations only related to 2010.

Harm Reduction: Program components in harm reduction have changed over time. Following global practice, up to 2009 comprehensive harm reduction in Indonesia

included 12 components listed in Ministerial regulation Per MenKo 02/2007 as follows : (1) outreach and support; (2) communication, information and education; (3) peer education; (4) behavior change communication; (5) VCT; (6) bleaching (sterilization) program; (7) needle-syringe program; (8) safe disposal of used equipment; (9) addiction treatment; (10) methadone maintenance therapy (MMT); (11) CST; (12) basic health care. In 2009, WHO, UNODC, and UNAIDS issued new global guidelines reducing basic components of comprehensive harm reduction to 9, as follows : (1) needle and syringe program; (2) opioid substitution therapy (OST) and other drug dependence treatment; (3) HIV testing and counseling; (4) antiretroviral Therapy; (5) prevention and treatment of sexually transmitted infections (STIs); (6) condom programs for PWIDs and their sexual partners; (7) targeted information, education and communication (IEC) for PWIDs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; (9) prevention, diagnosis and treatment of tuberculosis.

High risk men: In this report the term "high risk men" refers to the millions of men, primarily men in the mobile workforce, who are isolated from their family and familiar community settings having travelled to distant locations for employment in such the rapidly growing fields as mining, commercial agriculture, fishing, construction (roads, bridges, harbors, airports), forestry, and long distance transportation, particularly sea and land.

Iceberg phenomenon: An iceberg floats in the water with a portion visible above the surface of the water but more out of sight below the water's surface. The term "iceberg theory" applied to the field of HIV and AIDS refers to the fact that often the known cases of HIV infection and AIDS are like the visible tip of an iceberg, smaller than the invisible/ unknown number.

Key affected population: Those people in the population who determine the success or failure of the response to HIV and AIDS. Their active participation in the response, is therefore crucial. Key affected populations include a) people at risk of infection either because of unprotected sex or sharing of needles when injecting drugs; 2) those who are at risk because of their work or life style like migrant workers, displaced persons, high risk young people; (3) people living with HIV (PLHIV).

Structural intervention / structural approaches: Structural interventions are those that work to influence existing systems/ institutions/ policies/ structures (social, occupational, governmental) as well as working with individuals to alter the environment in which people are found to promote positive change for/ by them.


Stop AIDS
Take the Lead

Executive Summary

1987 - 2005: The Developing Epidemic and Response

1. The beginning of the epidemic in Indonesia (1987): The first confirmed case of AIDS was identified in Indonesia 24 years ago (1987). Between 1987 and 1997 infection appeared to increase slowly. The response was modest and focused primarily in the health sector. In 1994 Indonesia's first National AIDS Commission was appointed by the President (May)[1] and first National Strategy issued shortly thereafter (June).[2]

2. Development of the epidemic and the response (1994 - 2004): By the mid 1990s injecting drug use which historically had been low in Indonesia began to increase sharply. The social and legal environment which criminalized drug users led to almost universal sharing of needles and syringes among people who injected drugs (PWID) with disastrous impact on the people involved and the spread of HIV infection. While in 1993 there had been only one person known to be injecting drugs and HIV positive (in Jakarta) by March 2002 there were 116 reported AIDS cases in 6 provinces. By the end of 2004 the Ministry of Health reported a cumulative total of 2,682 people from 25 provinces with AIDS including 1,844 new PLHIV : 649 still HIV and 1,195 newly reported AIDS. Eight hundred twenty four of the people with AIDS, 68.95%,[3] reported injecting drug use as the cause of infection.

During this same time, surveillance among other people at increased risk of infection either because of life style or employment -- male, female, and transgender sex workers, men who have sex with men, and partners of them all -- showed significant levels

of infection. By 2003-2004 overall the epidemic appeared to be accelerating with reported new HIV infection and AIDS cases having increased nearly 4 times over (3.81 times) between 2003 and 2004 possibly in part reflecting improvements in availability of testing particularly in Java and Bali and in a few other locations as well. The epidemic in Indonesia moved, during these years, from one classed as a "low level epidemic" to a "concentrated epidemic," an epidemic where typically infection reaches >5% among one or more key affected populations.

The spread of HIV infection in the province of Papua[4] presented a different pattern from other parts of the country. Making up only one percent of the total population of Indonesia, in December 2004 reported new HIV infection in Papua amounted to 19.1% of reported new HIV in Indonesia.[5] In addition, while injecting drug use was the dominant source of infection in most of the country, unprotected heterosexual sex was responsible for more than 90% in Papua. The biggest challenges in addressing the epidemic across Papua were the daunting problems of communication and transportation, as well as seriously limited health and community infrastructure.

3. A new effort, the Sentani Commitment (2004): On the 19th of January 2004, the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission, Mr. Yusuf Kalla, led a consultation meeting in Sentani, Papua with governors of the six most seriously affected provinces,* ministers of six government departments,[6] lead members of the National AIDS Commission, and Chair of Commission VII of the National Parliament to examine the situation realistically and sign a commitment, the Sentani Commitment, to strengthen the response to HIV and AIDS in the six provinces with a comprehensive approach, specific targets, and a schedule for monitoring, information sharing and evaluation of the new approach every three months.

The Sentani Commitment was an effort to accelerate the response to HIV and AIDS with "total football", a multi-sectoral approach to address the spread of infection by reducing sexual and drug-related transmission of infection; strengthening of health services, and AIDS Commissions at all levels, as well as working with legal infrastructure to create environments more supportive of the response; and mobilization of local resources. Evaluation a year later (February 2005) found significant benefits in most of the provinces which were party to the Commitment.[7] The approach to the epidemic employed by the provinces including cooperation between government sectors and the community had merit. Nonetheless, it was clear that no matter how effective work was in the Sentani provinces, the reach was too limited to bring the epidemic under control.

* Provinces of Papua, Bali, East Java, West Java, DKI Jakarta, and Riau (which before the end of the year had split, giving birth to the new province of the Riau Islands).

2006 - 2010: Toward A National Response under Presidential Regulation 75/2006

4. Presidential Regulation 75 of 2006 - a new chapter in the response:

In December 2005, based on briefings by the vice chair of the Sentani Commitment working group and officers of the secretariat of the National AIDS Commission, the newly appointed Coordinating Minister for People's Welfare/ Chair of the National AIDS Commission, Mr. Aburizal Bakrie, concluded that AIDS was a serious threat to overall development in Indonesia, that it was not a localized concern, but a nation-wide threat, and that continuation of the uncoordinated and scattered response which had developed thus far would not be adequate to control the epidemic. Based on this analysis he concluded that a change was needed in status, membership, and the mechanisms of work of the AIDS Commissions throughout Indonesia.[8]

Six months later (13 July 2006) Presidential Regulation 75/ 2006 on the National AIDS Commission (NAC) was issued. The new National AIDS Commission was charged with responsibility to "promote more intensive, holistic, integrated and coordinated prevention and management of the response to AIDS" (article 1). Article 2 placed the AIDS Commission under and responsible to the President of Indonesia, strengthening its position as part of Indonesia's national development apparatus and raising the bar of accountability. It became more inclusive than formerly with addition of people living with HIV (PLHIV), representatives of the AIDS NGO community, professional health care providers, and the private sector along with relevant government sectors. A member of the Commission, Dr. Nafsiah Mboi, was designated full-time secretary and chair of the executing team. The secretary also headed the NAC secretariat. In line with decree 5/2007 of the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission, the term of secretary was set at five years from 2006 – 2011 and could be extended for only one term thereafter (see **Annex 1 :** members of the National AIDS Commission as stipulated in Presidential Regulation 75/2006).

5. Underlying concerns in the national response: From the day Presidential Regulation 75/2006 was issued, the underlying concerns of the National AIDS Commission have been to (a) achieve the widest possible **coverage** of HIV-related information, supplies and services for the key affected populations (PWID, sex workers – female, male, and transgender – men who have sex with men, PLHIV and intimate partners of them all); (b) assure **effectiveness** of activity in reducing new infection and improving the quality of life for those already infected; and (c) build toward **sustainability** of the response individually, within groups, and nationally across the country.

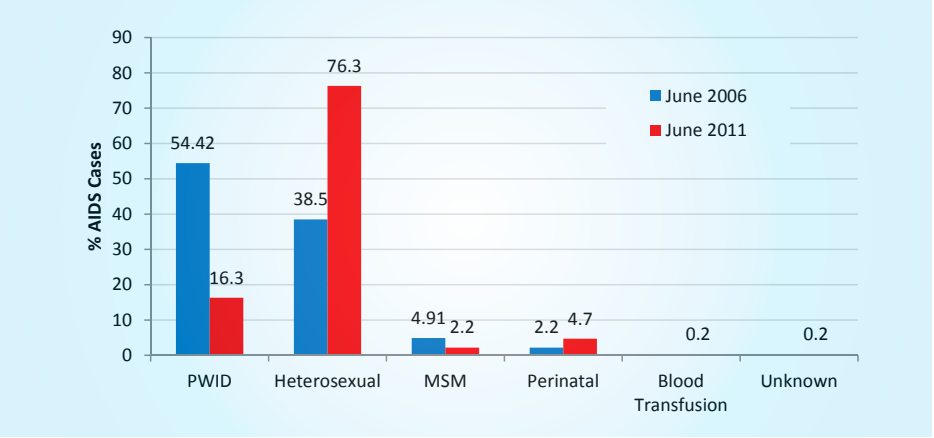
At the same time, the spirit of the national response, its implementation and evaluation were to be guided by basic principles of human rights as the foundation for creation of an inclusive, ethical and humane response to the epidemic:

- elimination of stigma, discrimination and the limitations of gender stereotypes and inequities
- promotion of environments, systems, and practices supportive of the actors and essential work of the national response.

6. Diversity in the HIV epidemic in Indonesia. Diversity in the response:

Results of studies, surveillance, and epidemiological data on HIV and AIDS in Indonesia over time all make clear the varied and changing nature of the epidemic -- who is at risk of infection, and the response of different actors to their options, their opportunities, and their responsibilities. This in turn calls for a diverse response. Variation in intensity of the epidemic was already clear by 2006 exemplified by the contrast between the overall situation in Indonesia as a whole and the distinctive situation in Tanah Papua. The changing nature is observed in various ways, among others in mode of infection : at the end of the second quarter of 2006 (June) 54.4% of new reported AIDS cases were attributed to unsafe injecting drug use while by June 2011 that figure had dropped to 16.3%. On the other hand, during the same period the importance of heterosexual transmission rose from 38.5% of new reported AIDS, to 76.3% by the end of June 2011. Another example of the changing nature of the epidemic : there has been a steady increase in the per cent of women among new AIDS cases. In 2006 women made up only 16.9% of reported new AIDS while by June 2011 they accounted for 35.1%. We have also seen an increase from 2.16% to 4.7% in reported perinatal AIDS in the same period of time.[9]

Chart 1: New AIDS June 2006 and June 2011, by mode of infection



Source : Data from MoH. *Report on Situation of HIV and AIDS in Indonesia.* 30 June 2006 & 2011

This situation has called for a flexible, responsive, evidence-based, decentralized approach to programming supported by on-going collection, analysis, and monitoring of evidence to be sure that the national response is on track in epidemiological terms. Likewise partnership and in-put were needed from people infected and affected as well as those most at risk in different settings - key affected populations across the country: young people, migrant workers, high risk men, the general population in Tanah Papua (particularly those who were more isolated and underserved) - to assure acceptability, and utilization of service.

Successive *National Strategies and Action Plans* (2007-2010 and 2010-2014) provided a common framework, goals, and objectives for the comprehensive response while leaving latitude for local identification of priority components in province- and district/city- specific plans, used as the basis for resource mobilization. Indonesia embraced a broad and comprehensive approach -- "total football" -- including partnership, policies, and programs needed by the broad range of key affected populations (prevention, care, support, treatment, and mitigation of social and economic impact). This would be the key to breaking the cycle of infection and changing the direction of the epidemic.

At the same time, work with the general population was important: introducing basic information about HIV and AIDS, modes of transmission and alternatives to avoid infection, non discrimination and principles of human rights in the context of the epidemic as well as practical messages of mutual fidelity between husband and wife and reinforcement of religious values.

Finally, in work with people living with HIV (PLHIV), as with key affected populations, emphasis was given to promoting the knowledge, skills, and activity to support self reliance, personal responsibility -- avoiding transmission of infection to others and adherence to medication -- while living a full and fulfilling life. Each range of concerns -- the key affected populations, the general population, and the community of PLHIV -- had a place in the "total football" of Indonesia's national response.

7. Start up: Start-up of the new AIDS Commission (in 2006) involved three initial steps -- (1) organization of a professionally qualified, full time secretariat selected through an open recruitment process, (2) preparation of a new national strategy, and based on that, development of Indonesia's first costed action plan with clear goals and targets, (SRAN, the acronym for the National Strategy and Action Plan) (3) mobilization of resources. SRAN laid out a comprehensive, national scheme based on a) the 2006 estimate of numbers and distribution of key affected populations and patterns of infection (see **Annex 2:** estimate of adults at risk of infection 2006 and 2009) and b) program approaches proven effective globally and in Indonesia. It established the framework for collaboration among all partners to the response -- the Indonesian government,

civil society (including key affected populations, NGO education, service and advocacy organizations, and faith based groups), the media, professional organizations of health care providers, and the private sector as well as multiple actors in the international community, among others the United Kingdom, Australia, the USA, the UN family of agencies, other multilateral bodies and international NGOs

Emphasis was to be given to prevention and care, support, and treatment for both drug-related and sexual transmission as well as strengthening of health and community systems to serve the needs of PLHIV. Equally important, in line with Presidential Regulation 75/ 2006, was regulation 20/2007 of the Minister of Home Affairs laying out general guidelines for formation of local AIDS Commissions and empowerment of the community for the response to HIV and AIDS*. This was the important and practical basis for growth of the system of AIDS Commissions at all levels to lead, manage, and coordinate the response.

8. The challenge of resources to support the national response: To carry out this ambitious plan, mobilization of significantly increased resources -- financial, technical, and human -- was a principle concern of the secretariat of the National AIDS Commission. Up to 2006, Indonesia's financial investment in the response to HIV and AIDS had been extremely modest at both national and local levels (provincial, district/ city). Furthermore, it had been almost completely concentrated in the health sector.

In the early years of the epidemic, up to 2003, there had been technical support and collaboration with a variety of international organizations related to the epidemic. Work in specific locations in eleven provinces† was supported through bilateral agreements with the governments of Australia (funded through AusAID) and the United States (funded through USAID). Their work was useful focusing at the operational level primarily on provision of technical training and financial support to service programs of NGOs working with people at high risk, as well as those infected and affected. While neither program was limited exclusively to work with NGOs nonetheless, their contributions in that area were significant. Between 2005 and 2011 AusAID provided cumulative support to NGOs totaling US$ 9,918,190 (Rp. 84.3 billion). During the same period, USAID support to NGOs totaled US$ 10,899,258 million (Rp. 92.6 billion).[10]

Beyond this work, the Australian program supported long term capacity building of the AIDS Commission system working in close collaboration with the National AIDS

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* *Peraturan Menteri Dalam Negeri Nomor 20 Tahun 2007 tentang pedoman umum pembentukan Komisi Penanggulangan AIDS dan pemberdayaan masyarakat dalam rangka penanggulangan HIV dan AIDS di daerah.*

† **Both AusAID and USAID :** DKI Jakarta , West Java, Central Java, East Java, Papua, West Papua. **AusAID alone :** DI Yogyakarta, Banten, Bali. **USAID alone :** The Riau Islands, North Sumatera.

Commission secretariat providing technical support for training, materials development, external, and self evaluation. Family Health International (USAID supported) on the other hand, worked closely with the Ministry of Health supporting development of technical, operational, and training guidelines for risk reduction among PLHIV, risk reduction among PWID, and development of clinical services. Both bilateral partners also supported a range of research and study projects intended to contribute to understanding of the epidemic and response as well as in-put to support policy and program development.

In 2003, Global Fund Round 1 support began in five provinces* followed by support of Round 4 (2005-2010) in 19 provinces.† Global Fund Round 1 and 4 supported the Ministry of Health developing counseling, testing, and treatment services.

In 2006 neither these resources nor Indonesia's domestic resources were adequate to support the rapid scale-up of activity called for to achieve the targets of the 2007-2010 National Action Plan. From 2006 onward, therefore, mobilization of domestic and international resources has been a crucial element in the work of the secretariat of the National AIDS Commission to assure adequate funding was available for the work needed to bring the epidemic under control as called for in Presidential Regulation 75/2006.

9. The Indonesian Partnership Fund (IPF) - support for transition to the comprehensive national program and mobilization of other resources: Late in 2005 the Coordinating Minister for People's Welfare acting as chair of the National AIDS Commission signed a multi-year grant- agreement between the government of the United Kingdom and the Government of Indonesia which led to the Government of Indonesia's establishment of the Indonesian Partnership Fund (IPF/DKIA)[11] with the GB £ 25 million (US$ 47 million) provided to support scale-up of Indonesia's AIDS response[12] for three years (2005-2008). In line with the National Strategy and Action Plan (2003-2007) and working agreement between the two governments, the National AIDS Commission secretariat was charged with responsibility for utilization of these funds on behalf of the government and from 2008 the Secretary of the National AIDS Commission was designated National Director (IPD). The UNDP was initially appointed to act as Fund Manager until such time as the NAC secretariat was ready and able to take on that work. During 2008-2010 grant support was continued by the United Kingdom (US$ 4.6 million). At the same time, the Australian government joined the Partnership Fund with a commitment of Aus$ 3 million (US$ 2.6 million) for 3 years. In

* Riau, the Riau Islands, DKI Jakarta, Bali, Papua.

† North Sumatera, Riau, South Sumatera, Lampung, the Riau Islands, DKI Jakarta, West Java, Central Java, DY Yogyakarta, East Java, Banten, Bali, West Kalimantan, East Kalimantan, South Sulawesi, North Sulawesi, Maluku, West Papua, Papua.

2011 the government of the United States joined the Partnership Fund with an annual commitments of US$ 1 million a year for three years.

While in the first years of IPF/DKIA (2005-2008) most of the funds (75%) would be used for expanding coverage and strengthening quality of service programs, a portion (ultimately totaling 18% from late 2005 to mid 2008) was used for strengthening the management system of the response.[13] In 2006 – 2007 on the management side alone, IPF/DKIA provided support for staff and operational expenses of the National AIDS Commission plus AIDS Commissions of 105 districts/cities in 22 provinces. In 2008 that was increased to include AIDS Commissions in all 33 provinces and 170 districts/ cities. The support for full time staff and operational expenses demonstrated the need and benefit to be had from effective AIDS Commissions and made possible gradual leveraging of growing funds from national, provincial, and district/city governments. During the period covered, contributions of IPF/DKIA to civil society organizations and their work totaled Rp. 59.904.041.000 (US$ 7,047,534),[14] as well.

Funds of the IPF/DKIA were also used to support outside resource mobilization, for example Indonesia's **proposal development process** (2008 and 2009) for applications to the Global Fund to Fight AIDS, TB and Malaria (GF) – Global Fund Round 8 and Round 9. Two successive, successful applications gained a commitment from Global Fund for a total of US$ 212 million beginning 1 July 2009 and running to 30 June 2015. These funds have been used to support phased launch of the comprehensive response to HIV and AIDS in selected locations in all 33 provinces. On 1 July 2009 work began in twelve (12) provinces (68 districts/cities). In July 2010 11 provinces were added bringing the number of districts/ cities included to 103). Beginning in July of 2011 additional locations were added and work was underway in all 33 provinces and the 137 districts/ cities as planned. The four Principle Recipients designated responsible for management of Global Fund resources included the Ministry of Health, the secretariat of the National AIDS Commission and two civil society organizations, the Indonesian Planned Parenthood Association (2009 - 2014 - *Perkumpulan Keluarga Berencana Indonesia)* and *Nahdlatul Ulama* (2010 - 2015). (see **Annex 3 :** overview of Global Fund support to Indonesia's response to HIV and AIDS and locations.)

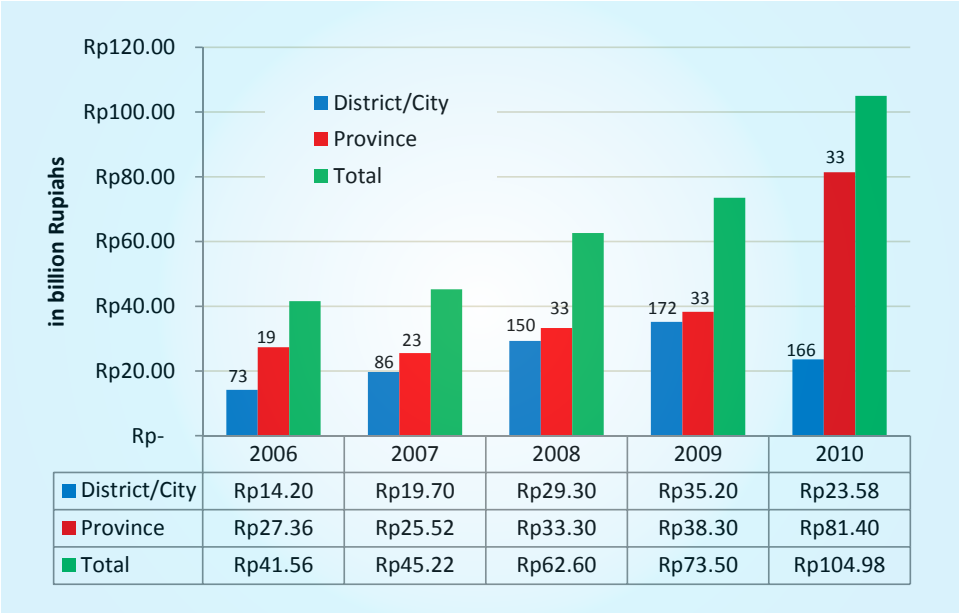
10. Domestic resource mobilization: During this same five year period there has also been major progress in mobilization of Indonesian resources at national level (APBN), as well as provincial, and district/city level (APBD). While the APBN allocation for sectoral work related to HIV and AIDS in 2006 was Rp. 118.6 billion (US$ 13,952,941) for 11 departments[15] that total had risen to Rp. 856,281,000,000 in 2011 (US$ 100,738,941) with budgets allocated for 19 national government departments/ bodies.[16]

Strengthening of the response is also clear at provincial and district/city level. Where in 2006 monitoring of the National AIDS Commission found only 19 provinces and 73

districts/ cities with designated HIV and AIDS budgets by 2010 all 33 provinces and 166 districts/ cities had some AIDS budget. Furthermore, by 2011 AIDS Commission secretariats in 63 districts and 9 cities across 24 provinces* were completely funded from local budget (APBD). (see **Annex 4 :** for districts/ cities funding their AIDS Commission secretariats 100% from local resources).

An additional indicator of progress related to domestic support of the national response is found in the shifting balance between domestic and international sources. In 2006 27% of AIDS expenditures were covered by Indonesia (US$ 15,038,057 = Rp127.823.484.500). By 2010 42% was covered from Indonesian resources (US$ 27.5 million = Rp 234,016,106,100) with the remaining 58% from outside. Overall, HIV and AIDS-related expenditures totaled US$ 56.6 million in 2006 (Rp 481.100.000.000) and had reached US$ 65.6 million (Rp557,181,205,000) by the end of 2010.[17]

Chart 2 : Growth in local budgets (APBD Province, District/ City) for HIV and AIDS
(in billions of Rupiah)



	2006	2007	2008	2009	2010
District/City	Rp14.20	Rp19.70	Rp29.30	Rp35.20	Rp23.58
Province	Rp27.36	Rp25.52	Rp33.30	Rp38.30	Rp81.40
Total	Rp41.56	Rp45.22	Rp62.60	Rp73.50	Rp104.98

Source : National AIDS Commission.

Note : Height of column indicates size of budget. Number atop column Indicates number of provinces and districts/ cities allocating budget.

* **2010 :** North Sumatera, West Sumatera, South Sumatera, the Riau Islands, Lampung, Banten, West Java, Central Java, DI Yogyakarta, East Java, Bali, NTT, South Sulawesi, North Sulawesi, West Sulawesi, West Kalimantan, Central Kalimantan, East Kalimantan. **2011 :** NAD, Riau, Bangka Belitung, South Kalimantan, Central Sulawesi, Gorontolo.

11. The comprehensive response: The "comprehensive response to HIV and AIDS" in Indonesia includes provision of the necessary information, supplies, and services for comprehensive counseling and testing for HIV, along with well distributed systems to provide care, support, and treatment including reliable ARV treatment for those needing it. It implies, as well, the on going capacity development and system building necessary to sustain, modify, and continue the response in the future. For example, in program terms, the comprehensive response includes on-going AIDS education for health care providers, capacity development for HIV-related social and behavioral research, broad efforts at general public education about HIV and AIDS through the media, extra curricular activity in school settings, targeted activity for out of school young people in the community and so forth. It also calls for strengthening of logistics and management systems. Development and diverse capacity building within the network of AIDS Commissions from national to provincial and district/ city level (among others advocacy, planning, financial and program management) has both contributed to and benefited from the comprehensive response. Activities of these sorts are now widespread across the country. (see map)

Success of the comprehensive response, however, does not depend just on the number of HIV-related activities that take place. It depends also on the synergy, the complementarity, the appropriateness of the activities to the nature of the epidemic on a local basis. Managing, focusing, and leading these efforts is the responsibility of the AIDS Commissions at district/city, and provincial level working with multiple partners. In short, in Indonesia, the comprehensive response includes consideration not only of what needs to be done but also how to do it and by whom, all working under the overall framework of the National Strategy and Action Plan.

12. First priority to prevention: In 2006 Indonesia took the strategic decision to prioritize prevention in its response to HIV and AIDS. This priority has been reflected in program selection, design, advocacy, and training.

Prevention takes many forms and overtime there has been some variation in the mix of activity included in prevention as the epidemic has changed. For example, in the early years noting the high levels of infection among PWID, prevention efforts were particularly directed to develop, strengthen, and expand coverage of harm reduction related to injecting drug use. However, based on results of the NAC mid-term review (2009) and discussion of field experience, prevention of sexual transmission has grown in importance and the approach has consolidated around an Indonesian structural intervention known as PMTS (*Pencegahan (HIV) Melalui Transmisi Seksual)*, now being scaled up to achieve national coverage. (more discussion of PMTS point 14 below).

Another case in point : in the two provinces of Papua and West Papua, a major initiative to address growing infection in the general population has been development of comprehensive integration of HIV and AIDS education throughout the work of the Department of Education, Youth and Sports both in school and out. This approach developed individually with the technical support of UNICEF and financial support of the Dutch government, in each province is being introduced based on their own policy guidelines, graded curriculum, and accompanying materials, planned training of educators (including class room teachers, extra curricular tutors and trainers of sports, music, the arts, drama and other supplementary fields).

13. Harm reduction - prevention of HIV infection among people who inject drugs (PWID): In 2006 the primary source of new HIV infection in Indonesia was injecting drug use. The potential negative impacts of drug injection are multiple including a) death from overdose; b) infection with HIV, hepatitis C and B or any one of several blood borne infections; c) long term personal and social dysfunction possibly including criminal behavior resulting from uncontrolled addiction and the drive for its satisfaction. Learning from limited Indonesian experience with local harm reduction activists -- NGOs, the hospital for addiction services (RSKO - *Rumah Sakit Ketergantungan Obat)*, the Australian and US supported AIDS Programs, the World Health Organization, AIDS Commissions in some provinces, the Ministry of Health, the Division of Corrections in the Ministry of Law and Human Rights -- it was clear already by the time of the Sentani Commitment in 2004 that comprehensive harm reduction could be effective in Indonesia. Nonetheless, there were major social, legal, and service delivery obstacles which stood in the way of the scale-up which was needed to protect the young people of Indonesia from the impact of unsafe injecting drug use and to stop it from being the leading cause of HIV infection in the country.

The first step taken by the Secretary of the National AIDS Commission to reduce those obstacles was consultation with partners in the fields of law and health in various government sectors/ institutions such as the police, Ministry of Health, National Narcotics Board, Ministry of Social Affairs, Ministry of National Education, and others to prepare a legal/ regulatory environment more conducive to advancing harm reduction in Indonesia. This process culminated in a new regulation by the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission (No. 02/Per/Menko/Kesra/i/2007) setting out National Policy on the Response to HIV and AIDS through Reduction of Harm caused by Injecting Drug Use.* Harm reduction followed the principles of public

* Peraturan Menteri Koordinator bidang Kesejahteraan Rakyat selaku Ketua Komisi Penanggulangan AIDS Nasional No. 2/PER/MENKO/KESRA/I/2007 tentang *Kebijakan Nasional Penanggulangan HIV dan AIDS melalui Pengurangan Dampak Buruk Penggunaan Narkotka Psikotropika dan Zat Adiktif Suntik.*

health and aimed to prevent spread of HIV infection among drug users and their partners as well as to the general public.

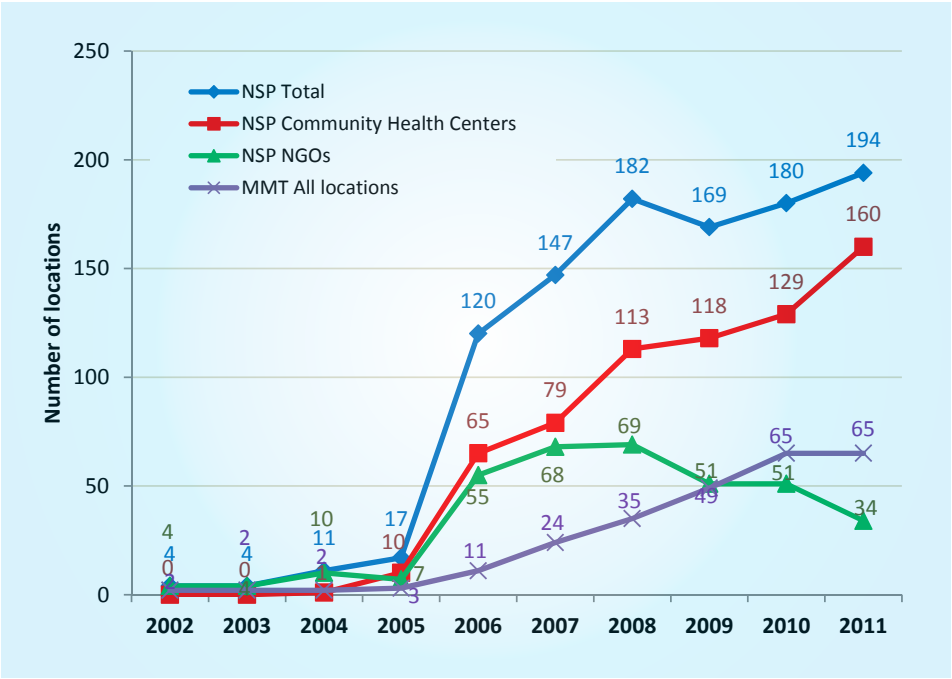
Continuing to work with a broad range of partners – PWID, law enforcement agencies including police, the Ministry of Health and the National Narcotics Board, Ministry of Social Affairs – the secretariat of the National AIDS Commission launched an intensive campaign of advocacy, training, as well as development of policy, manuals and preparation for integration of needle-syringe and methadone services in existing public health facilities (public health centers, clinics, and hospitals). Attention was also given to the human side of the field including the process of empowerment of PWID and other activists to give in-put to assure acceptable program design and to provide adequate outreach and education for other PWID to understand and utilize the information and services becoming increasingly available in the community and in the prison system.

The commitment to scale-up comprehensive harm reduction was clear in the National AIDS Strategy and subsequent costed Action Plan (2007-2010) and the Plan for 2010-2014. Initial work was started in line with the Coordinating Minister's decree 02/2007 on harm reduction and with funding from IPF/DKIA and AusAID. Longer term, more widely distributed work was included with the two successive Global Fund Proposals which provided support starting in 2009 and running through 2015.

Indications are that the phased build up of services for and with PWID is working. Where in 2005 there were only 17 needle-syringe programs (combination of NGO and Public Health Center based work), by June 2011 there were 194, most (160) already integrated into on-going public health facilities providing the assurance of longer term sustainability and access to integrated, more comprehensive care and treatment including service to meet basic health needs, treat infections like HIV, TB, hepatitis, and routine service such as ante natal care (ANC). (see **Chart 3**, below)

Daily methadone treatment delivered through the public health services

Chart 3 : Growth of Harm Reduction Services in Indonesia, 2002 - 2011



Source : National AIDS Commission

The role of the NGO community (both PWID and other AIDS activists) continues to be of great importance providing the essential outreach, education, and referrals needed for PWIDs and their partners. Oral substitution therapy (OST) including methadone and buprenorphine, for people with addiction problems, rose from only 3 programs (2005) to 65 (2011) -- 9 in prisons, 22 in hospitals, and 34 in public health clinics.[18]

An important component in Harm Reduction is treatment of drug addiction : A new program to expand comprehensive coverage of harm reduction to an even wider pool of PWID is Community-Based Drug Dependency Treatment (in Indonesia called *PABM,* the acronym for *Pemulihan Adiksi Berbasis Masyarakat).* PABM began to be available in Indonesia in 2009. By June 2011, 675 PWID had completed the 6 month PABM program (initial 1 to 2 months in-patient care providing intensive counseling, detox if needed, and psycho-social support, followed by a longer period of outpatient care and activity) carried out by 11 NGOs in 7 provinces.

Progress is being made in responding to the needs of PWID but new challenges related to drug use are appearing, among the most serious, rising use of ATS (amphetamine type stimulants) and other sex stimulants.

14. Prevention of sexual transmission of HIV infection: In 2006 efforts to prevent sexual transmission of infection were focused on promotion of an approach called "100% condom use" which had earned a good name for itself in Thailand. With encouragement from the World Health Organization and technical support from a variety of partners, serious efforts had been directed to launch a similar approach in Indonesia.

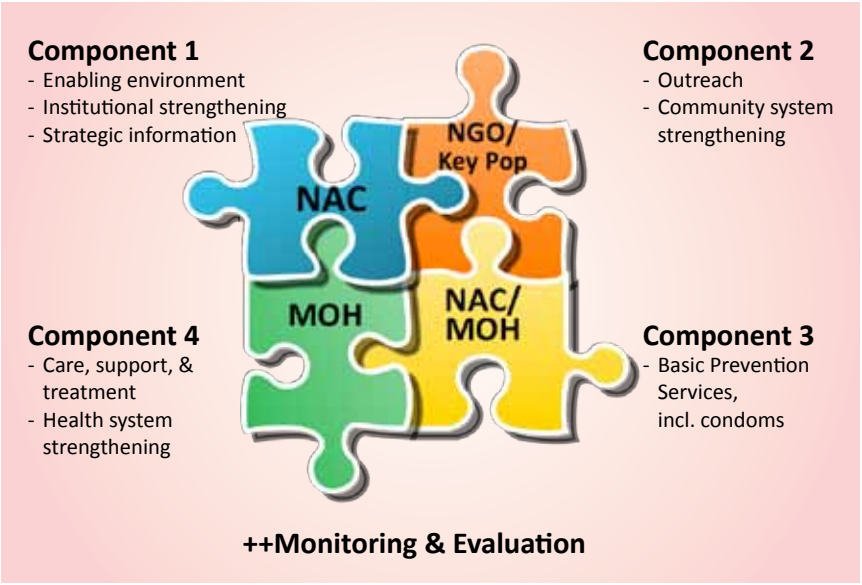
Results of IBBS 2002 and 2007 showed that 100% condom use had not been effective in Indonesia. Data indicated condom use continued low, sexually transmitted infections (STIs) including HIV continued high, in fact they were climbing among female sex workers and transgenders.[19] The failure was the result of various unresolved challenges: First, condom use among clients, even when easily available, remained stubbornly low; second, the mechanisms for distribution of condoms and lubricants continued to fall short of need; third, in general, public opinion and local leadership in many cases didn't support promotion of condoms and in some areas were explicitly hostile to discussion of the topic in the context of prostitution and sex work.

At the same time, sex workers who were less well organized than those working in brothel complexes -- street sex workers (female, male, and transgender), informal sex workers based in bars and massage parlors, men who had sex with men, and their clients – all continued to be deeply disadvantaged in their access to information, supplies, and service.

Fully aware that without a change in this field, the epidemic could not be brought under control the Secretary of the National AIDS Commission called a meeting of individuals and organizations -- male, female, and transgender sex workers, international development partners, Indonesian NGOs, relevant government actors -- to brainstorm development of a better approach for Indonesia. In April of 2009 a pilot program was begun in Jayapura (Province of Papua) and shortly thereafter in 5 other cities of Java and Sumatera. Drawing on results of those pilot locations and supplementary discussions during ICAAP 9* in Bali, experience was consolidated and became the program for prevention of sexual transmission of HIV, PMTS (*Pencegahan HIV Melalui Transmisi Seksual*). PMTS took a structural approach to prevention and was built around four mutually supportive components : (1) mobilization of a wide range of stakeholders in areas where sexual transactions took place; (2) behavior change communication with an emphasis on empowerment of sex workers with the knowledge, skills, and the motivation to protect their own right to good health and that of their clients/ sexual partners, as well; (3) increased availability of condoms and lubricants, through improved storage and distribution by much increased numbers of small, locally managed outlets and (4) comprehensive diagnosis and management of sexually transmitted infection. The final, critical component was close monitoring and evaluation by program managers from local to national level.

* International Congress on AIDS in Asia and the Pacific, hosted in 2009 by Indonesia.

Box 1 : Partnership in implementation of PMTS
(prevention of sexual transmission of HIV)



Source : National AIDS Commission

By July 2009 it was clear that this structural approach showed promise for addressing sexual transmission in its many settings in Indonesia -- both direct and indirect sex work and with male, female, and transgender sex workers. Scale up of the approach was supported with Global Fund resources. By June 2011, reports indicated that 82,384 direct female sex workers, (78% of total estimated population), 58,244 indirect female sex workers (54%), 23,269 transgender sex workers (73%) were being reached along with 54,836 MSM (8%)[20] Between March and June of 2011 three successive rounds of training for empowerment of sex workers were carried out reaching 1,222 sex workers in 22 provinces.[21]

One result of PMTS structural intervention – condom use is increasing. Between July 2009 and 2011 a cumulative total of 13,830,854 male condoms and 548,175 female condoms were supplied to the more than 4,000 condom outlets.[22] Commercial condom sales likewise continued to rise over the period from a total of 69,587,608 in 2006 to 116,701,048 in 2010.[23] Condom sales showed a particularly large increase between 2009 and 2010 suggesting possible "demand creation" as increasing numbers of men have positive experience with condoms. While this is encouraging it is nonetheless far below what is needed. To bring the epidemic under control wider and more effective coverage of programs and services as needed, as well as more consistent safe behavior.

Beginning in 2011 the effort to bring sexual transmission under control was strengthened and became more inclusive with addition of activity specifically focused on high risk men. PMTS focusing on "hotspots" has been expanded to include areas where high risk men are working -- young, male, migrant workers with high mobility and looking for a better future. For the most part, these men are isolated from their families and conventional community values and surrounded with strongly "macho" values including, among other things, encouragement of risk taking such as participation in recreational sex, excessive consumption of alcohol, drugs, sex stimulants and so forth. Effective work to protect these men from infection has the double value of also protecting any sex partners they have including their wives. In short, "zero infection among high risk men will mean zero infection among women (sex workers and other intimate partners), and children."

Migrant workers in many parts of Indonesia, for example in road construction, can be at high risk of HIV infections

As part of the comprehensive PMTS, special attention is also being given to strengthening both outreach and effectiveness of work with men who have sex with men, those who are gay and transgender people as well as those men who have sex with other men because of their circumstances – those in jail, sailors long at sea, those living in all male dormitories etc. A multi faceted special project was begun in 2010, piloted in 10 cities located in 10 provinces*. That basic work is presently being strengthened and diversified with research (among others focused on the norms and behavior of MSM, how MSM learn about sexual health etc.), mapping, development of a communication strategy and specific methods to reach this mostly hidden group of people among the key affected populations, develop preventive and health services which are MSM-friendly,

* North Sumatera, Riau, the Riau Islands, DKI Jakarta, West Java, East Java, Bali, East Kalimantan, West Kalimantan, and South Sulawesi.

supportive, and not stigmatizing. It is anticipated that results of this project will strengthen understanding of the special needs of MSM, their voice in discussion of national policy and programs as well as relevance, coverage, and effectiveness of HIV-related activity. 2011 will see steady scale up of this work to reach all 33 provinces in 2012.

15. Voluntary counseling and testing (VCT): VCT sites and facilities have been growing steadily in numbers and in their contribution to the national response. Mobilization of broad involvement in VCT is reflected in the training provided by national trainers of the health sector between 2004 and 2011. This training reached candidate counselors and case managers from 1,053 institutions including hospitals, public health clinics, lung clinics, civil society organizations, private sector firms and others.*

The Ministry of Health reports that while in 2006 there were 100 VCT sites, by June 2011 there were 388 VCT[24] sites in hospitals, public health clinics, and in the prison system providing regular reports. The system has been growing steadily in recent years and is on track for continued expansion.

Table 1 : Number of VCT sites, visits, HIV tests administered, people testing HIV+, and positivity rate. (2006 – March 2011)

	2006 (1)	2007 (1)	2008 (1)	2009 (2)	2010 (2)	Jun 2011 (2)
VCT Sites	100	120	135	156	388	388
Visits	71,179	129,731	248,813	415,943	669,137	827,172
Tests administered	56,926	105,061	192,712	333,100	535,943	658,401
People HIV Positive	8,054	14,102	24,464	34,257	55,848	66,693
Positivity rate	14.1%	13.4%	12.7%	10.8%	10.4%	10.1%

Sources : 1) MoH. 2006-2008 : information included in reports to Global Fund. 2) 2009 – 2011 : MoH. *Report on Situation of the Development of HIV and AIDS in Indonesia.* Year end report for 2009 and 2010. Second quarter report, June 2011.

Working to build a well distributed, self-reliant, sustainable response to the epidemic, priority attention has been given since 2006 to expansion,[25] strengthening,[26] and integration of HIV services including VCT in existing government and community systems -- among others health sector, social affairs, the Corrections Department of the Ministry of Law and Human Rights and others.

* 361 general hospitals, 15 mental hospitals, 389 public health clinics, 6 lung clinics, 26 prisons, 157 NGOs, 35 private sector firms, 64 private clinics.

16. Care, Support, and Treatment: An important part of Indonesia's comprehensive "total football" response to HIV and AIDS is played by the integration of HIV and AIDS-related medical care and services within the existing health system and appropriate capacity raising, as needed. The basic continuum of care includes a sequence of activity and services : Counseling and testing, diagnosis and treatment of STIs, treatment of opportunistic infection, cotrimoxasole prophylaxis for pneumonia, early diagnosis and early treatment of AIDS with appropriate antiretrovirals (ARVs). To reduce the likelihood of a child being born HIV+ special efforts were introduced for integration of services to prevent transmission of infection from HIV+ women who are pregnant (PMTCT). Faced with high co-infection between TB and HIV a specific program has been developed and is underway to assure mutually pro-active work in these two fields both in the community and in prisons. Likewise, co-infection of HIV with hepatitis B and C calls for on-going attention, particularly among PWID.

As of June 2011 two hundred eighteen (218) hospitals and sixty eight (68) satellite facilities (community health centers, hospitals, NGO and others) were reporting on provision of integrated care, support, and treatment in 32 provinces[27] (see **Annex 5 :** Hospitals and satellite facilities active in provision of care, support, and treatment. 2011). In an effort to accelerate testing and appropriate service, as needed, Provider Initiated Counseling and Testing (PICT) is now being integrated in progressively more HIV and AIDS service facilities – hospitals and community health centers – with requisite training and guidelines. PMTCT, the program for prevention of vertical transmission from a woman to her child, is another important component in provision of full and appropriate AIDS-related services. Already integrated in public health services in 79 locations, the Ministry of Health plans to scale-up both availability and quality of these services.[28]

Box 2: Development of Care, Support, and Treatment (CST) including ARV

CST

2004: 24 Hospitals		June 2011: 218 Hospitals + 68 Satellites
ARV	**2006**	**June 2011**
New Patients	2.171	2.203
Cumulative Patients	4.552	21.347
Financing	100% international	70% domestic

Source : Ministry of Health. Prepared for National AIDS Commission. June 2011.

ARV treatment for AIDS patients was launched in 2005, also with support from Global Fund, in 25 designated hospitals across the country. Data of MoH indicates that by the end of that first year 2,381 patients were receiving ARV. By June 2011 a cumulative total of 21,347 were receiving ART regularly and the medication was funded 70% from Indonesian resources (APBN). While that is a dramatic and important increase, it is also true that there are still too many people who do not start treatment early enough or who drop out thus placing themselves at risk of fatal resurgence of AIDS. According to the Ministry of Health, the 21,347 comprise only 55.7% of those who have at some point in the past received ARV, and should be continuing with treatment.[29]

17. Peer support groups of and for positive people: This points to the crucial importance of mechanisms of support for people who are HIV+ (both people who are asymptomatic with HIV infection and those already taking regular ARV medication). All need medical and social support to ensure adherence and healthy life-styles and to help avoid self-stigmatization but open their status with confidence. Various networks of positive people exist and work to promote high quality service, and self reliant full lives for their members. The largest network of independent support groups works in association with the national NGO Spiritia, founded in 1995, specifically to work with and for HIV+ people and their families. They focus on activities promoting self reliance, health, dignity, and "positive prevention"* among PLHIV. As of August 2011, Spiritia reported collaboration with 200 local support groups (KDS) in 121 districts/cities (21 Provinces).[30] Cumulatively they have provided support to 23,589 PLHIV. Anecdotal reports and a recent field study of peer support groups in 21 provinces† consistently emphasize the importance of these groups in helping PLHIV adjust to their positive status, sharing information about treatment and care issues, and often serving as a "community base" for more active participation in the community.[31]

Other networks of PLHIV include JOTHI, the national network of people infected with HIV, founded in 2007 and with branches and activity in 25 provinces and IPPI, the Indonesian Network of Positive Women founded in 2006 and with activity in 22 provinces.[32] Both organizations have broad agendas including encouragement for participation of members in support groups but also including advocacy and action related to policy development, human rights of PLHIV, and monitoring of the national response, in particular the availability of ARV.

* Responsible behavior assuring that an infected person does not transmit infection to another person

† NAD, North Sumatera, West Sumatera, Riau, the Riau Islands, Lampung, Jambi, DKI Jakarta, Banten, West Java, Central Java, Di Yogyakarta, East Java, Bali, West Nusa Tenggara, East Nusa Tenggara, West Kalimantan, South Sulawesi North Sulawesi, Gorontalo, and West Papua

18. Managing the response in Indonesia: The national response has grown in a short space of time from the limited number of provinces and districts/ cities involved at the time of the Sentani Commitment in 2004 to reach 173 districts and cities across 33 provinces, a program conceptually united but operationally decentralized with planning and implementation in accordance with the local epidemiological situation.[33] Developing the necessary systems and capacity at all levels to assure local program effectiveness as well as compliance with national and international standards and accountability for the use of resources has been and continues to be a management challenge of daunting proportion. Local program effectiveness calls for considerable technical knowledge and local sensitivity for evidence-based planning, implementation, and monitoring of program work. At the same time, national and international accountability for resources call for a high level of financial and administrative know how.

The secretariat of National AIDS Commission, charged in Presidential Regulation 75/2006 with responsibility to provide direction to provincial and district/city AIDS Commissions, organized four regional support teams (3 people in each team, one each focusing on program, finance, and monitoring-evaluation). Using resources successively from IPF/DKIA and later Global Fund and APBN, the secretariat of the National AIDS Commission has organized extensive program and management training for provincial, and district/city teams including staff of local AIDS Commission as well as local partners. Some training was provided in annual regional meetings. Other trainings have been incidental and issue-focused. For example, in connection with the launch of the comprehensive response with support of Global Fund, APBN, and IPF/DKIA between July of 2009 and May 2011 a total of 2,000 people were given training (1,135 men, 804 women, and 61 transgender people). This capacity raising, 64% of which was carried out at provincial or district/city level, covered 22 different management and program related topics.[34]

Program indicators -- numbers of people entering VCT, reduction in needle-syringe sharing by PWID, rising coverage of key affected populations with information and services from year to year, the relatively stable number of new reported AIDS each year for the past 3 years -- all suggest progress on the program side. Evaluation in successive financial management audits since 2006 by both national and international organizations (Indonesia government, private Indonesian accountancy firms, UN agency management risk assessment, DFID (United Kingdom), AusAID, and USAID management audits) likewise indicate that management development is also proceeding effectively.

Training and capacity building have been undertaken both in-country and internationally at higher levels related to policy development, planning and program design. The result has been that the technology and skills for program analysis, modeling, projection, and mapping as well as AIDS related operations research can now almost all be

found within Indonesia (government, civil society, and universities) rather than needing to rely on external consultants as in the past.

19. Partnership - domestic and international: Partnership has been a critical key to building of Indonesia's national response. Since Presidential Regulation 75/ 2006 dialogue and collaboration in program development, implementation, monitoring and evaluation with key affected populations, PLHIV, civil society (including faith based organizations), government sectors and institutions, government of all levels, the private sector, the media, and international development partners (bi lateral and multilateral) have been enormously important to national progress in addressing the challenges of HIV and AIDS across the country. Each group has brought to the table their respective experience, resources, needs, and potential. In line with Presidential Regulation 75/ 2006, the challenge for the National AIDS Commission and its secretariat has been how to nurture and promote partnership so that rather than working individually all players were contributing to achievement of the objectives of the National AIDS Strategy and Action Plan initially of 2007-2010 and thereafter 2010-2014.

During the five years since Presidential Regulation 75/2006 the skills, trust, and mechanisms for collaboration have grown thus assuring that the contributions of all, strengthen Indonesia's response to HIV and AIDS.

20. Looking ahead - Challenges needing special attention to ensure sustainability of an effective national response: The progress which has been made in the past five years needs to be sustained, and improved upon in the next five year. Only in this way will it be possible to achieve MDG goal 6 and more important still, bring the HIV epidemic under control in Indonesia. What needs to be done is laid out in the National AIDS Strategy and Action plan, 2010-2014, with indicators, division of labor, the phasing of work and costs.

Concluding this overview of Indonesia's experience in responding to HIV and AIDS since Presidential Regulation 75/2006 it is appropriate to look at up-coming challenges and make recommendations to address them.

Based on existing data from monitoring development of the epidemic, impact made by the response thus far, and modeling of potential impact of successful implementation of Indonesia's current National AIDS Action Plan (2010-2014) two points stand out :

First, although results of the 2011 IBBS have not yet been released by MoH, it would appear there has been some slowing in the increase of the epidemic compared with some time ago. This is the result of the combined efforts of all partners in the national response.

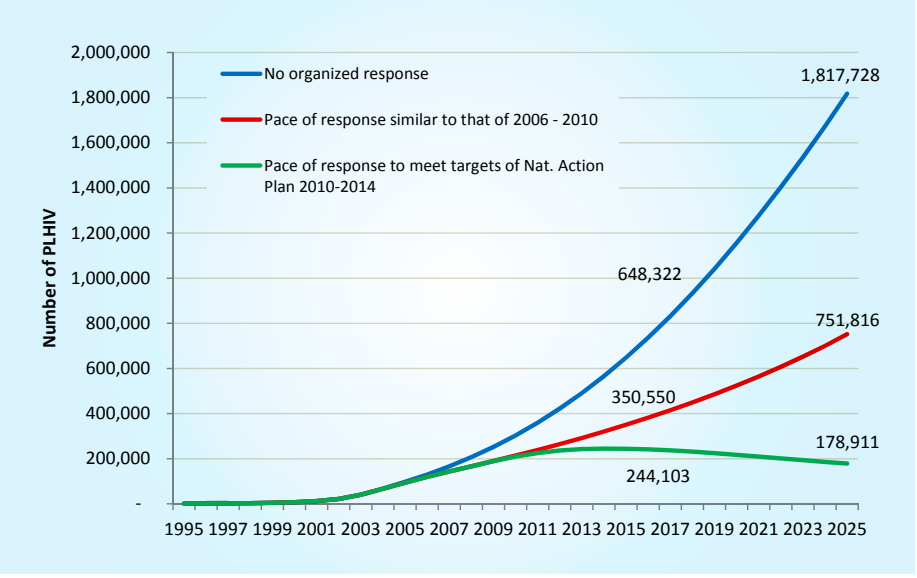
Second, using the Asian Epidemic Model to support analysis and understand what lies ahead, one sees

1) With **no organized action**, it is estimated that infection would follow the trajectory of the blue line, reaching 648,322 people by 2015. (See **Chart 4,** below)

2) With the scale-up and work of all partners of the past 5 years – government, civil society, the private sector, international development partners – the pace of infection has been slowed and the foundations laid for increased out-reach and effectiveness during the latter half of the current plan-period, 2010 – 2014. If work continues at the pace of 2006-2010 the infection will be slower than with no action. Nonetheless, still an estimated 350,550 people would be infected by 2015. (See **Chart 4,** below)

3) On the other hand, if all funds and forces, policies and programs, training and action are directed to accomplishment of the goals and targets set forth in the National AIDS Action Plan 2010 – 2014, 2015 could be the year when the direction of the epidemic begins to change for Indonesia and, although new infections will still occur, the trajectory of the epidemic will start to be reversed.

Chart 4 : Modeling the impact of 3 scenarios responding to the HIV epidemic in Indonesia

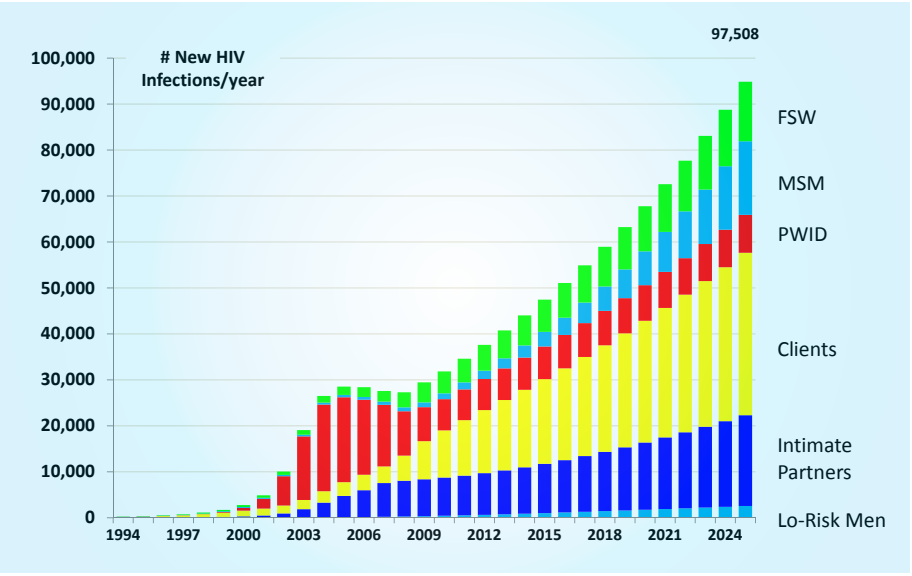


Source : National AIDS Commission

This does not, of course, mean that HIV and AIDS will be gone from Indonesia or that the work of the national response will be at an end. Only that the balance of action and attention will need on-going monitoring and adjustment in planning of program, services, and action for the community.

As is clearly seen in projection of who is impacted by HIV and AIDS in the years to come, action will continue to be needed among PWID, (red in Chart 5, below). Nonetheless, the most important message is that we need to continue with scale up of the comprehensive response to sexual transmission (comprehensive PMTS) because sexual transmission will remain important in the years to come. It will continue to impact men who buy sex and their sexual partners (sex workers as well as other sex partners), men who have sex with men (in the community, in prison or other all male settings) and the respective female partners of them all. We also need to continue attention to sexual transmission among PWID and their intimate partners.

Chart 5 : Projected impact of HIV and AIDS to 2025



Source : National AIDS Commission

Although the pace of increase will be slowing nonetheless, the total number of people (women, men, and children) living with HIV will grow and they still need information, treatment, services and support networks. Likewise, prevention programs -- assuring that people who are negative stay free of infection -- will continue to be an important concern.

Achieving that objective – bringing about a change in the direction of the epidemic -- will call for cooperation, continuing expansion of coverage, steady and improving program effectiveness including use of new technology, as well as work toward sustainability. With those things in mind, the following recommendations are offered:

- **Policy, resources and institutional structure to assure an effective and sustainable response:** In Presidential Regulation 75/2006 (art. 15) and Regulation of the Minister of Home Affairs 20/2007 (art 13) it is written that

  (1) all of the costs required for carrying out the work of the National AIDS Commission shall be borne by the State Budget.
  (2) all of the costs required for carrying out the work of the Provincial AIDS Commission shall be borne by the Provincial Budget.
  (3) all of the costs required for carrying out the work of the district/city AIDS Commission shall be borne by the district/city Budget.

  For the period 2010-2014 planning and budgeting of the national response is integrated in the National Mid-Term Development Plan (RPJMN-*Rencana Pembangungan Jangka Menengah Nasional 2010-2014*) as well as Presidential Instruction 3/2010 on Just Development. This will assure some measure of support from APBN through 2014. Nonetheless, the amount allocated is inadequate to meet the needs of the national response. On the other hand if external resources (GFATM, AusAID, USAID etc.) were to decline or stop altogether the current comprehensive work would be seriously threatened. In addition, although domestic budgets particularly APBD are increasing and in several areas planning and budgets for AIDS are integrated in RPJMD, nonetheless, sustainability of the response is not yet adequately guaranteed.

  At this time there are only 16 Provinces and 34 district/ cities with regulations on HIV and AIDS; this means, the AIDS budget depends mostly on the personal commitment of the governor, district head, mayor, and members of the legislature (DPRD). (see **Annex 6**: Provinces and Districts/Cities with local AIDS regulation - Perda).

  In other words, continuity and sustainability of the Indonesian response is not assured. Because of this, mobilization of resources and institutional strengthening are of great importance during the next five years and beyond.

  In addition, the government needs to give serious thought to the issue of the long-term leadership and institutional home for the response to HIV and AIDS. Is it to continue as now in a non-structural government institution (like the present AIDS Commission but with adequate assured funding) or is it to be integrated in to an existing ministry or other institution? This issue needs to be addressed and a decision made in the near future. It cannot wait until 2015.

- **Prevention:** Prevention needs to be continually strengthened during the five years to come in terms of coverage, effectiveness, and sustainability. As seen above, prevention among PWID has had considerable success, nonetheless the use of drugs will continue to need attention among other things in connection with outreach, and effectiveness of harm reduction, in particular needle-syringe and methadone services, treatment of addiction, as well as community based medical and social rehabilitation and treatment. Prevention and treatment for abuse of ATS will also need to be strengthened in cooperation with various partners such as the National Narcotics Board, Police, and Ministries of Health, Social Affairs, and others. This is a field of growing interest and activity by KPA.

  Comprehensive prevention of sexual transmission with structural intervention (PMTS): Prevention of sexual transmission needs strengthening of both outreach and quality of programs with expansion of the comprehensive PMTS, that is PMTS in "hotspots", locations known for sexual and other transactions, placing people at high risk of infection with STIs including HIV (ports, bus-train-truck terminals, brothel complexes etc) integrating PMTS in such locations and focused on high risk men in the workplace – migrant workers, sailors and other crew members, police and military with long term assignments away from their family, mining, construction, commercial estate agriculture, men who have sex with men. In short, prevention of sexual transmission of HIV is needed whether between husband and wife, casual heterosexual sex, homo- sex, or bi-sex. In an effort to understand and assure access to the widest possible range of options for prevention, the National AIDS Commission is committed to exploring new preventive technologies (for example tenofovir gels etc.) through research and information sharing with appropriate partners.

  Prevention of transmission of infection from parents (via the mother) to baby (PMTCT): There is wide agreement on the importance of expanding coverage and quality of PMTCT for the women and families involved and as part of the comprehensive response to HIV and AIDS as well as the contribution effective PMTCT will make to the overall effort to bring the epidemic under control. In line with this consensus, the Ministry of Health is planning integration of PMTCT services into basic Mother and Child services along with the necessary staff training.

- **Health system strengthening for care, support, and treatment of PLHIV:** During the past five years the Ministry of Health and health services at provincial and district/city level have been increasing the number and quality of sites for voluntary counseling and testing (VCT), provider initiated counseling and testing (PICT), skills for medical diagnosis, support and treatment for people who are HIV+. They have also developed the necessary regulations, guidelines, and manuals. In the five years to come, comprehensive health system strengthening will need to focus on strengthening the quality of service for key affected populations and PLHIV including service related to ARV and HIV-related illnesses. In addition, comprehensive

services for PWID including health promotion, prevention of infection, treatment and rehabilitation need to be provided within a health system free of stigma and discrimination, to a good professional standard and welcoming of people of the key affected populations.

Strengthening of the public health system needs to be accompanied by strengthening of community based support systems for PLHIV whose numbers will climb in the next five years : Family support, peer support groups of PLHIV (*KDS – Kelompok Dukungan Sebaya),* organizations of people who are HIV+ and the community in general, income generating and other activities to mitigate the socioeconomic impact of the HIV epidemic.

- **Partnership of government and civil society:** The number of civil society organizations/ activists and importance of their role in the response to HIV and AIDS has grown significantly in the past five years –
  1) Some AIDS-related NGOs/ community groups are members of the National AIDS Commission and local AIDS Commission, although not yet in all provinces and district/ cities;
  2) Individuals have become members of AIDS Commission secretariat or working groups;
  3) Five national networks of key affected populations – IPPI, GWL-Ina, JOTHI, PKNI and OPSI – have been formed each of which has received support since founding for operational costs and activities from the secretariat of the National AIDS Commission;
  4) Since Presidential Regulation 75/2006 AIDS NGOs and the networks of key affected populations including PLHIV have been included in key activities of the National AIDS Commission such as mapping, planning, resource mobilization, monitoring and evaluation etc.
  5) NGOs/ civil society groups are members of the supervisory/ oversight body (*badan pengawas)* and advisory boards of various AIDS – related bodies such as the Country Coordinating Mechanism (CCM) for GFATM, the Indonesian Partnership Fund (IPF/DKIA);
  6) In the management structure of Indonesia's GFATM resources two civil society groups are Principle Recipients (PR) and many more are sub-recipients, sub-sub-recipients, and implementing partners;
  7) During the period 2005-2011 support reported to the secretariat of the National AIDS Commission for civil society/ NGOs came from 8 sources[35] and totaled Rp. 251.687.843.635 (US$ 29,610,335).

In short, civil society and government have been partners in the comprehensive response to HIV and AIDS from local to national level.

As health system strengthening is needed in the coming five years, so community system strengthening is also needed to strengthen the capacity for continuing effective and collaborative work at all levels to achieve the shared goals and targets related to HIV and AIDS laid out in Indonesia's National AIDS Strategy and Action Plan.

21. Conclusion: This document is the Executive Summary of the "The Response to HIV and AIDS in Indonesia, 2006 – 2011 : Report on 5 Years Implementation of Presidential Regulation 75/ 2006" which has been written with participation of relevant government departments, civil society, PLHIV, the academic community, and international development partners. (see **Annex 7**: Writing Team).

The drafting committee offers great thanks to all, individuals and institutions, who have supported the drafting of this report. Notwithstanding our efforts and the support received, there are surely shortcomings. We welcome suggestions and corrections. The drafting committee closes this Report with hope that this record of the progress made and the challenges ahead will contribute to the great national endeavor to bring the epidemic under control and assure to PLHIV the support and freedom to lead dignified, independent, and fulfilling lives.

References

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2 Decree of the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission number 9/KEP/MENKO/KESRA/VI/1994 of 16 June.

3 MoH. Year End Report. *Development of HIV and AIDS Situation in Indonesia*, 2004.

4 The organization of the province of Papua Barat was underway at the time but government, including the health services still ran under the unified services of Papua.

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10 Data analysed and confirmed by NAC, 2011.

11 Called *Dana Kemitraan Indonesia untuk HIV dan AIDS (DKIA) in indonesian.*

12 Intended to support (1) scale up of information, supplies, and service with and for key affected populations, and (2) strengthening of the multi-sectoral/ multi-partner approach. It was also hoped that during the life of the grant (2005-2008) the Partnership Fund could begin to attract contributions from other sources to continue the life of the Fund if and when support from DFID was phased out.

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18 Data from NAC monitoring.

19 IBBS 2007.

20 NAC monitoring. Data verified January 2011.

21 NAC. Training report 2011.

22 NAC monitoring of program reports for condoms and condom outlets - 3,466 male condom outlets, 600 female condom outlets.

23 DKT sales report.

24 Information June 2011 from MoH to NAC.

25 Wider geographic coverage.

26 Improved effectiveness.

27 MoH. *Situation of HIV and AIDS in Indonesia.* Second quarter report. Through June 2011.

28 MoH. Notes on health services related to HIV and AIDS in Indonesia. Provided by MoH to NAC in connection with preparation of 5 year report to President.

29 All data this paragraph is from MoH. *Report on situation of HIV and AIDS in Indonesia.* (June) 2011, table 2.8

30 Spiritia Foundation. Cumulative report including monthly reports for 2011.

31 Yayasan Spiritia, Universitas Hamka, and KPA Nasional. 2011. *Pengaruh Dukungan Sebaya Terhadap Mutu Hidup ODHA*. Jakarta.

32 Organizational data received from JOTHI and IPPI, May 2011.

33 137 districts/ cities are receiving support from Global Fund. Activity in 71 districts/ cities includes PMTS for sexual transmission, harm reduction, as well as strengthening of health and management systems for HIV and AIDS. In the remaining sixty-six districts/ cities issues of sexual transmission and health and management system strengthening are covered. During the planning phase in those areas, Harm Reduction was judged to be unnecessary at this time. Twenty two additional districts/ cities were added to scale up prevention of sexual transmission (PMTS) supported from multiple sources -- GF, IPF/DKIA, and local government budgets, (APBD).

34 NAC training reports.

35 APBN, AusAID, Global Fund, ICAAP, IPF, UNESCO, UNODC, USAID

Annexes

Annex 1

Regulation number 75/ 2006 of the President of the Republic of Indonesia

Chapter I ....

Chapter II

ORGANIZATION
Part 1, Membership

Article 4

(1) Membership of the National AIDS Commission shall consist of :

1. Chairperson, and member : Coordinating Minister for People's Welfare
2. Vice Chairperson I, and member : Minister of Health
3. Vice Chairperson II, and member : Minister of Home Affairs
4. Member :
   a. Minister of Religion;
   b. Minister of Social Affairs;
   c. Minister of Communictions and Informatics;
   d. Minister of Law and Human Rights
   e. Minister of Culture and Tourism
   f. Minister of National Education
   g. Minister of Manpower and Transmigration;
   h. Minister of Communication;
   i. State Minister of Youth and Sports ;
   j. State Minister for Empowerment of Women;
   k. State Minister for National Development/ Head of National Development Planning Board;
   l. State Minister of Research and Technology
   m. Cabinet Secretary
   n. Indonesian Armed Forces Chief;
   o. National Police Chief;
   p. Head of Agency for Assessment and Application of Technology;
   q. Head of the National Family Planning Coordination Board
   r. Chairperson of the National Narcotics Board
   s. Chairperson of the Executive Board of the Indonesian Doctors Assocation
   t. Chairperson of the Indonesian Public Health Specialist Association
   u. Chairperson of the Indonesian Red Cross
   v. Chairperson of the Chamter of Commerce and Industry
   w. Chairperson of the National Organization of People Living with AIDS
5. Secretary, and member : Dr. Nafsiah Ben Mboi

(2) Membership of the National AIDS Commission as mentioned in paragraph (1) may be increased by the Chairperson of the Commission as required.

(3) ....

Annex 2

Ministry of Health & National AIDS Commission
Estimate of Adults at Risk of HIV Infection, 2006

Ministry of Health
Estimate of Adults at Risk of HIV Infection, 2009

	2006	2009	Difference in Estimates 2006 & 2009
People Who Inject Drugs (PWID)	219,130	105,784	-113,346
Partners of PWID	93,350	28,805	-64,545
Female Sex Workers (FSW)- Direct	128,220	106,011	-22,209
FSW - Indirect	92,970	108,043	15,073
Total : FSW	221,190	214,054	-7,136
Clients of Direct FSW	2,479,860	2,285,996	-193,864
Clients of Indirect FSW	682,060	883,932	201,872
Total : Clients of FSW	3,161,920	3,169,928	8,008
Partners of Clients of FSW	1,833,660	1,938,650	104,990
Transgender	28,130	32,065	3,935
Clients of Transgender	83,130	71,316	-11,814
MSM	766,800	695,026	-71,774
Prisoners	96,210	140,559	44,349
PLHIV	193,030	186,257	-6,773

Total number of partners at risk	1,927,010	1,967,455	40,445
Total number of people at risk of infection (including partners but excluding PLHIV)	6,503,520	6,396,187	-107,333
Range (Estimated PLHIV)	169,230-216,820	132,089-287,357	

Annex 3

Overview of support for Indonesian response to AIDS by Global Fund to Fight AIDS, TB and Malaria 2003 - 2015

Data : from NAC and Global Fund Website

Round	Year	US$ (million)	Prov	Dist/City	Launch	Field
GF 1	2003 - 2007	$12	5			Prevention
GF 4	2005 - 2010	$65	19			CST
GF 8	2009 - 2014	$130	12	68	Jul-09	Comprehensive Prevention
SSF thn 1	2010 - 2015	$87	+11 = 23	+35 = 103	Jul-10	Comprehensive Prevention
SSF thn 2			+10 = 33	+34 = 137	Jul-11	Comprehensive Prevention

GF total $294

GF Round 1, 5 provinces, 2003-2007

1 The Riau Islands
2 Riau
3 DKI Jakarta
4 Papua
5 Bali

Note : Indonesia was granted a no-cost-extension for completion in 2008

GF Round 4, 19 provinces, 2005 - 2010

1 North Sumatera
2 South Sumateran
3 The Riau Islands
4 Riau
5 Banten
6 DKI Jakarta
7 West Java
8 Central Java
9 DI Yogyakarta
10 East Java
11 West Kalimantan
12 East Kalimantan
13 Bali
14 South Sulawesi
15 North Sulawesi
16 NTB
17 NTT
18 Papua
19 West Papua

Group A (2009-2014)	Group B (2010-2015)	Group C (2011-2015)
GF Round 8, 12 Provinces 1 North Sumatera 2 Riau 3 South Sumatera 4 The Riau Islands 5 DKI Jakarta 6 West Java 7 Central Java 8 East Java 9 Bali 10 South Sulawesi 11 Papua 12. West Papua	**GF SSF - Year 1 +**11 Provinces 1 West Sumatera 2 Lampung 3 DI Yogyakarta 4 Banten 5 NTB 6 NTT 7 West Kalimantan 8 South Kalimantan 9 East Kalimantan 10 North Sulawesi 11 Maluku	**GF SSF – Year 2** +10 Provinces 1 N Aceh Darussalam 2 Jambi 3 Bengkulu 4 The Bangka Blitung Is. 5 Central Kalimantan 6 Central Sulawesi 7 S E Sulawesi 8 Gorantolo 9 West Sulawesi 10 North Maluku

Annex 4

63 Districts and 9 cities funded from local resources (APBD) in 24 provinces 2010 & 2011

Note : "District" = Kab; "City" = Kota

2010

No	Provinces(18)	No	Dist (48) Cities (8)	
1	North Sumatera	1	Kab Serdang Bedagai	
		2	Kab Tj. Balai	
2	West Sumatera	1	Kab. Solok	
3	South Sumatera	1	Kota Lubuklinggau	1
		2	Kab. Ogan Komering Ulu	
4	The Riau Islands	1	Kab Bintan	
		2	Kab Natuna	
5	Lampung	1	Kota Metro	2
6	Banten	1	Kota Tangerang South	3
		2	Kota Serang	4
7	West Java	1	Kab Bandung	
		2	Kab Sumedang	
		3	Kab Subang	
		4	Kab Tasikmalaya	
		5	Kab Garut	
		6	Kota Sukabumi	5
		7	Kab Tasikmalaya	
		8	Kab Cimahi	
8	Central Java	1	Kota Salatiga	6
		2	Kab Temanggung	
		3	Kab Jepara	
		4	Kab Grobogan	
		5	Kab Sragen	
9	DI Yogyakarta	1	Kab Gunung Kidul	
		2	Kab Kulon Progo	
10	East Java	1	Kab Pasuruan	
		2	Kota Pasuruan	7
		3	Kab Tulung Agung	
		4	Kab Madiun	
		5	Kab Jombang	
		6	Kab Gresik	
		7	Kab Batu	
		8	Kab Nganjuk	
		9	Kota Madiun	8
11	Bali	1	Kab Klungkung	
		2	Kab Karang Asem	
		3	Kab Jembrana	
		4	Kab Bangli	
		5	Kab Gianyar	
12	NTT	1	Kab Flores East	
		2	Kab Ende	
		3	Kab Sumba West	
		4	Kab Timor East South	

13	West Kalimantan	1	Kab. Landak	
14	Central Kalimantan	1	Kab. Muara Teweh	
15	East Kalimantan	1	Kab. Nunukan	
		2	Kab. Bontang	
		3	Kutai East	
		4	Kutai Kartanegara	
16	North Sulawesi	1	Kab Minahasa	
		2	Kab Minahasa South	
17	South Sulawesi	1	Kab. Luwu East	
		2	Kab Bulukumba	
		3	Kab Wajo	
18	West Sulawesi	1	Kab Mamasa	
	18 Propinsi		48 Kabupaten	8 cities

2011

#	Province (6)	#	Dist (15) Cities (1)	
1	NAD	1	Kab. Aceh West	
		2	Kab. Aceh North	
2	Riau	1	Kab Siak	
		2	Kab Kepulauan Meranti	
3	Bangka Belitung	1	Kab Bangka South	
		2	Kab Belitung East	1
4	South Kalimantan	1	Kota Banjar Baru	
		2	Kab. Banjar	
		3	Kab. Balangan	
5	Central Sulawesi	1	Kab. Parigimoutong	
		2	Kab. Tojo Una Una	
		3	Kab. Luwuk	
		3	Kab. Bangkep	
6	Gorontalo	1	Kab. Bonebolango	
		2	Kab. Gorontalo	
		3	Kab. Pohuwato	
	6 Propinsi		15 Kabupaten	1 Cities

24 Propinsi	63 Kabupaten	**9 Cities**

Annex 5

June 2011. Active care, support, and treatment for HIV and AIDS
218 Hospitals and 68 satellites

Data source : Ministry of Health, June 2011

No.	Province	District/City	Hospital
1	N A D	Banda Aceh	RSU Dr. Zainoel Abidin
2	Sumatera Utara	Asahan	RSUD H. Abdul Manan Simatupang Kisaran
3	Sumatera Utara	Binjai	RSUD Dr.Djoelham
4	Sumatera Utara	Deli Serdang	RSU Lubuk Pakam Deli Serdang
5	Sumatera Utara	Medan	RS Bhayangkara Tk.II Sumut
6	Sumatera Utara	Medan	RS Haji Medan - VCT Bina Us Syifa
7	Sumatera Utara	Medan	RS Kesdam II Bukit Barisan
8	Sumatera Utara	Medan	RSU Dr. Pirngadi
9	Sumatera Utara	Medan	RSU H. Adam Malik
10	Sumatera Utara	Pematang Siantar	RSUD Djasemen Saragih
11	Sumatera Utara	Rantau Prapat	RSUD Rantau Prapat Labuhan Batu
12	Sumatera Utara	Serdang Bedagai	RSU Sultan Sulaiman - Serdang Bedagai
13	Sumatera Barat	Bukittinggi	RSU Dr. Achmad Mochtar
14	Sumatera Barat	Padang	RSU Dr. M. Djamil
15	Riau	Bagan Siapiapi	RS. Dr. RM Pratomo
16	Riau	Bengkalis	RSUD Bengkalis
17	Riau	Dumai	RSUD Dumai
18	Riau	Duri	RS PT Chevron Duri
19	Riau	Indragiri Hilir	RSU Puri Husada-Tembilahan
20	Riau	Kampar	RSUD Bangkinang-Kampar
21	Riau	Mandau	RSUD Mandau
22	Riau	Pangkalan Kerinci	RSUD Selasih
23	Riau	Pekanbaru	RS St. Maria
24	Riau	Pekanbaru	RSJ Tampan
25	Riau	Pekanbaru	RSUD Arifin Achmad
26	Kepulauan Riau	Batam	RS Budi Kemuliaan
27	Kepulauan Riau	Batam	RS. Saint Elizabeth
28	Kepulauan Riau	Batam	RSUD Batam
29	Kepulauan Riau	Karimun	RSUD Karimun
30	Kepulauan Riau	Bintan	RSUD Tanjung Uban
31	Kepulauan Riau	Tanjung Pinang	RSU Tanjung Pinang
32	Sumatera Selatan	Banyuasin	RSUD Banyuasin
33	Sumatera Selatan	Kayu agung	RSUD Kayuagung
34	Sumatera Selatan	Lubuk Linggau	RSUD Siti Aisyah
35	Sumatera Selatan	Muara Enim	RSU Prabumulih
36	Sumatera Selatan	Musi Rawas	RS. Dr. Sobirin Musi Rawas

No.	Province	District/City	Hospital
37	Sumatera Selatan	Ogan Komering Ulu	RSUD Dr. Ibnu Sutowo Baturaja
38	Sumatera Selatan	Palembang	RS Ernaldi Bahar
39	Sumatera Selatan	Palembang	RS Myria Palembang
40	Sumatera Selatan	Palembang	RS RK Charitas
41	Sumatera Selatan	Palembang	RSU Dr. M.Hoesin Palembang
42	Bengkulu	Bengkulu	RSU Dr. M. Yunus
43	Jambi	Jambi	RSU Raden Mattaher
44	Lampung	Bandar Lampung	RSU Dr. H. Abdoel Moeloek
45	Lampung	Lampung Selatan	RSUD Kalianda
46	Bangka Belitung	Bangka	RSU Sungai Liat
47	Bangka Belitung	Belitung	RSUD Tanjung Pandan - Pangkal Pinang
48	Bangka Belitung	Pangkal Pinang	RSUD Depati Hamzah - Pangkal Pinang
49	DKI Jakarta	Jakarta Barat	RS Kanker Dharmais
50	DKI Jakarta	Jakarta Barat	RS PELNI
51	DKI Jakarta	Jakarta Barat	RS Royal Taruma
52	DKI Jakarta	Jakarta Barat	RSAB Harapan Kita
53	DKI Jakarta	Jakarta Barat	RSUD Cengkareng
54	DKI Jakarta	Jakarta Pusat	RS Husada
55	DKI Jakarta	Jakarta Pusat	RS Kramat 128
56	DKI Jakarta	Jakarta Pusat	RS St. Carolous
57	DKI Jakarta	Jakarta Pusat	RSAL Dr. Mintoharjo
58	DKI Jakarta	Jakarta Pusat	RSPAD Gatoet Soebroto
59	DKI Jakarta	Jakarta Pusat	RSUD Tarakan
60	DKI Jakarta	Jakarta Pusat	RSUPN Dr. Cipto Mangunkusumo
61	DKI Jakarta	Jakarta Selatan	RS Jakarta
62	DKI Jakarta	Jakarta Selatan	RSU Fatmawati
63	DKI Jakarta	Jakarta Timur	RS Kepolisian Pusat Dr. Soekanto
64	DKI Jakarta	Jakarta Timur	RS Ketergantungan Obat
65	DKI Jakarta	Jakarta Timur	RS UKI
66	DKI Jakarta	Jakarta Timur	RSJ Duren Sawit
67	DKI Jakarta	Jakarta Timur	RSPAU Dr. Esnawan Antariksa
68	DKI Jakarta	Jakarta Timur	RSUD Budhi Asih
69	DKI Jakarta	Jakarta Timur	RSUP Persahabatan
70	DKI Jakarta	Jakarta Utara	RS Pluit
71	DKI Jakarta	Jakarta Utara	RSPI Prof. Dr. Sulianti Saroso
72	DKI Jakarta	Jakarta Utara	RSUD Koja
73	Jawa Barat	Bandung	RS Al Islam Bandung
74	Jawa Barat	Bandung	RS Bungsu
75	Jawa Barat	Bandung	RS Paru Dr. H.A. Rotinsulu
76	Jawa Barat	Bandung	RSUD Kota Bandung - Ujung Berung
77	Jawa Barat	Bandung	RSUP Dr. Hasan Sadikin
78	Jawa Barat	Bekasi	RS Ananda

No.	Province	District/City	Hospital
79	Jawa Barat	Bekasi	RSU Kota Bekasi
80	Jawa Barat	Bekasi	RSUD Kabupaten Bekasi
81	Jawa Barat	Bogor	RSJ Dr. H. Marzoeki Mahdi
82	Jawa Barat	Cirebon	RSUD Gunung Jati
83	Jawa Barat	Cirebon	RSUD Waled
84	Jawa Barat	Indramayu	RS Bhayangkara - Indramayu
85	Jawa Barat	Karawang	RSU Karawang
86	Jawa Barat	Tasikmalaya	RSU Tasikmalaya
87	Banten	Serang	RSU Serang
88	Banten	Tangerang	RS Qadr
89	Banten	Tangerang	RS Cilegon
90	Banten	Tangerang	RS Usada Insani
91	Banten	Tangerang	RSU Tangerang
92	Jawa Tengah	Banyumas	RSU Banyumas
93	Jawa Tengah	Batang	RSU Batang
94	Jawa Tengah	Brebes	RSUD Brebes
95	Jawa Tengah	Cilacap	RSU Cilacap
96	Jawa Tengah	Jepara	RSUD RA Kartini
97	Jawa Tengah	Kebumen	RSUD Kebumen
98	Jawa Tengah	Kendal	RSUD Dr. H. Soewondo Kendal
99	Jawa Tengah	Pati	RSUD RAA Soewondo - Pati
100	Jawa Tengah	Purwokerto	RSU Prof. Dr. Margono Soekarjo
101	Jawa Tengah	Salatiga	RS Paru Dr. Ario Wirawan Salatiga
102	Jawa Tengah	Salatiga	RSUD Salatiga
103	Jawa Tengah	Semarang	RSUP Dr. Kariadi
104	Jawa Tengah	Semarang	RS Tugurejo
105	Jawa Tengah	Semarang	RSU Ambarawa
106	Jawa Tengah	Semarang	RSU Pantiwilasa Citarum
107	Jawa Tengah	Slawi	RSU Dr. H.M. Suselo
108	Jawa Tengah	Surakarta	RS Dr. Oen
109	Jawa Tengah	Surakarta	RSU Dr. Moewardi
110	Jawa Tengah	Tegal	RSU Kardinah = RSU Tegal
111	Jawa Tengah	Temanggung	RSU Temanggung
112	D I Yogyakarta	Yogyakarta	RS Bethesda
113	D I Yogyakarta	Yogyakarta	RS PKU MUHAMMADIYAH
114	D I Yogyakarta	Yogyakarta	RSU Dr. Sardjito
115	D I Yogyakarta	Yogyakarta	RSU Panti Rapih
116	D I Yogyakarta	Bantul	RSUD Panembahan Senopati
117	Jawa Timur	Banyuwangi	RSU Blambangan
118	Jawa Timur	Banyuwangi	RSUD Genteng
119	Jawa Timur	Blitar	RSUD Ngudi Waluyo Wlingi
120	Jawa Timur	Gresik	RS Ibnu Sina Gresik

No.	Province	District/City	Hospital
121	Jawa Timur	Jember	RSUD Balung
122	Jawa Timur	Jember	RSU Dr. Soebandi
123	Jawa Timur	Jombang	RSU Jombang
124	Jawa Timur	Kediri	RSUD Gambiran
125	Jawa Timur	Kediri	RSU Pare
126	Jawa Timur	Lamongan	RSUD Dr Soegiri Lamongan
127	Jawa Timur	Madiun	RSUD Dr. Soedono Madiun
128	Jawa Timur	Malang	RS Islam Malang – UNISMA
129	Jawa Timur	Malang	RSU Dr. Syaiful Anwar
130	Jawa Timur	Malang	RSU Kepanjen
131	Jawa Timur	Mojokerto	RSU Dr. Wahidin Sudiro Husodo
132	Jawa Timur	Mojokerto	RSUD Prof. Dr. Soekandar
133	Jawa Timur	Nganjuk	RSU Nganjuk
134	Jawa Timur	Sampang	RSUD Sampang
135	Jawa Timur	Sidoarjo	RSU Sidoarjo
136	Jawa Timur	Surabaya	RS Bhayangkara Tk II. Jatim
137	Jawa Timur	Surabaya	RSUD Dr. M. Soewandhie
138	Jawa Timur	Surabaya	RS Khusus Paru Surabaya
139	Jawa Timur	Surabaya	RSAL Dr. Ramelan
140	Jawa Timur	Surabaya	RSJ Menur
141	Jawa Timur	Surabaya	RSUD Dr. Soetomo
142	Jawa Timur	Tulungagung	RSUD Dr. Iskak Tulungagung
143	Bali	Badung	RSUD Badung
144	Bali	Buleleng	RSU Singaraja
145	Bali	Denpasar	RSUP Sanglah
146	Bali	Gianyar	RSUD Sanjiwani
147	Bali	Tabanan	RSUD Tabanan
148	Bali	Wangaya	RSUD Wangaya
149	Kalimantan Barat	Ketapang	RSUD Agoesdjam
150	Kalimantan Barat	Mempawah	RSUD Dr. Rubini Mempawah
151	Kalimantan Barat	Pontianak	RS Khusus Prov. Kalimantan Barat
152	Kalimantan Barat	Pontianak	RSU Dr. Soedarso
153	Kalimantan Barat	Pontianak	RSU St. Antonius
154	Kalimantan Barat	Sambas	RSU Pemangkat
155	Kalimantan Barat	Sanggau	RSU Sanggau
156	Kalimantan Barat	Singkawang	RSU Dr. Abdul Aziz
157	Kalimantan Barat	Sintang	RS Ade M Djoen
158	Kalimantan Timur	Balikpapan	RS TNI Dr. R. Hardjanto
159	Kalimantan Timur	Balikpapan	RSU Dr. Kanudjoso Djatiwibowo
160	Kalimantan Timur	Malinau	RSUD Malinau
161	Kalimantan Timur	Nunukan	RSU Kab Nunukan
162	Kalimantan Timur	Samarinda	RS Dirgahayu

No.	Province	District/City	Hospital
163	Kalimantan Timur	Samarinda	RSU H. A. Wahab Sjahranie
164	Kalimantan Timur	Tarakan	RSUD Tarakan
165	Kalimantan Tengah	Palangkaraya	RSU Dr. Doris Sylvanus
166	Kalimantan Tengah	Kota Waringin Barat	RSUD Sultan Imanuddin Pangkalan Bun
167	Kalimantan Selatan	Banjarmasin	RS Ansari Saleh
168	Kalimantan Selatan	Banjarmasin	RSU Ulin Banjarmasin
169	N T B	Lombok Tengah	RSUD Praya
170	N T B	Lombok Timur	RSU Dr. R. Soedjono Selong
171	N T B	Mataram	RSJ Prov. NTB
172	N T B	Mataram	RSU Mataram
173	NTT	Belu	RSU Atambua
174	NTT	Ende	RSUD Ende
175	NTT	Flores Timur	RSUD Larantuka
176	NTT	Kupang	RS REM 161 Wirasakti
177	NTT	Kupang	RSUD Prof. Dr. W.Z. Johanes
178	NTT	Kupang	RSUD Umbu Rara Meha
179	NTT	Manggarai	RSUD RUTENG
180	NTT	Sikka	RSUD Dr. TC. Hillers
181	NTT	Sumba Daya Barat	RS Karitas
182	Sulawesi Utara	Bitung	RSU Bitung
183	Sulawesi Utara	Manado	RS Prof. Dr. V.L. Ratumbuysang
184	Sulawesi Utara	Manado	RSUP Prof. dr. R. D. Kandaou Manado
185	Sulawesi Utara	Teling	RSAD R.W. Mongisidi
186	Sulawesi Utara	Tomohon	RS Bethesda Tomohon
187	Sulawesi Tengah	Palu	RSU Undata Palu
188	Sulawesi Selatan	Bulukumba	RSUD Haji Andi Sultang Daeng Radja
189	Sulawesi Selatan	Makassar	RS Bhayangkara
190	Sulawesi Selatan	Makassar	RS Jiwa Dadi
191	Sulawesi Selatan	Makassar	RSUD Labuang Baji
192	Sulawesi Selatan	Makassar	RS Pelamonia
193	Sulawesi Selatan	Makassar	RSU Daya
194	Sulawesi Selatan	Makassar	RSUP Dr. Wahidin Sudirohusodo
195	Sulawesi Selatan	Palopo	RSU Sawerigading
196	Sulawesi Selatan	Pare-pare	RSU Andi Makassau
197	Sulawesi Selatan	Pinrang	RSU Lasinrang
198	Sulawesi Tenggara	Kendari	RSU Prop.SULAWESI TENGGARA- Kendari
199	Gorontalo	Gorontalo	RSUD Prof. Dr.H. Aloei Saboe
200	Maluku	Ambon	RSUD Dr. M. Haulussy
201	Maluku	Tual	RSUD Karel Sadsuitubun Langgur
202	Maluku Utara	Ternate	RSUD Dr. Chasan Boesoirie
203	Papua Barat	Fak Fak	RSU Fak-fak
204	Papua Barat	Manokwari	RSU Manokwari

No.	Province	District/City	Hospital
205	Papua Barat	Sorong	RSU Sorong
206	Papua Barat	Sorong	RSUD Sele Be Solu
207	Papua	Jayapura	RSUD Yowari
208	Papua	Abepura	RSUD Abepura
209	Papua	Biak	RSUD Biak
210	Papua	Jayapura	RS Dian Harapan
211	Papua	Jayapura	RSUD Jayapura
212	Papua	JayaWijaya	RSUD Wamena
213	Papua	Merauke	RSUD Merauke
214	Papua	Mimika	RS Mitra Masyarakat
215	Papua	Mimika	RS Tembagapura
216	Papua	Mimika	RSU Timika
217	Papua	Nabire	RSU Nabire
218	Papua	Paniai	RSUD Paniai

June 2011. Active care, support, and treatment
218 Hospitals, (above) and 68 Satellites, (below)

Note : Types of Satellites. RS = Hospital, Klinik = Clinic, Lapas = Prison, PKM = Community Health Center, Balai Negara = Lung Treatment Center, LSM = NGO,

No.	Province	District/City	Hospital/ Clinic	Type of Satellite
1	N A D	Aceh Barat	Rsu Cut Nyak Dien (satelit RS Zaenoel Abidin)	RS
2	N A D	Aceh Tamiang	Rsu Tamiang (satelit RS Zaenoel Abidin)	RS
3	N A D	Aceh Timur	RSU Langsa (satelit RS Zaenoel Abidin)	RS
4	N A D	Aceh Utara	Rsu Cut Meutia (satelit RS Zaenoel Abidin)	RS
5	N A D	Pidie	RSU Sigli (satelit RS Zaenoel Abidin)	RS
6	Sumatera Utara	Medan	Klinik Penyakit Tropik dan Infeksi: Dr Umar Zein (Satelit RS Pirngadi)	Klinik
7	Sumatera Utara	Balige	RS HKBP Tobasa (satelit RS Bhayangkara)	RS
8	Sumatera Utara	Karo	RS Kabanjahe (satelit RS Adam Malik)	RS
9	Sumatera Utara	Medan	RSU Bina Kasih (satelit RS Kesdam)	RS
10	Bangka Belitung	Belitong Timur	RSUD Manggar (satellit RSUD Tj Pandan)	RS
11	DKI Jakarta	Jakarta Pusat	LAPAS Salemba (satelit St Carolous)	Lapas
12	DKI Jakarta	Jakarta Timur	Lapas Pondok Bambu (satelit RSJ Duren Sawit?)	Lapas
13	DKI Jakarta	Jakarta Pusat	PPTI (Perhimpunan Penanggulangan Tuberculosisi Indonesia, satelit RSPI)	LSM
14	DKI Jakarta	Jakarta Pusat	YPI (satelit RSCM)	LSM
15	DKI Jakarta	Jakarta Barat	Puskesmas Kali Deres (satelit YPI-RSCM)	PKM
16	DKI Jakarta	Jakarta Pusat	Puskesmas Kecamatan Gambir (satelit RS Tarakan)	PKM
17	DKI Jakarta	Jakarta Selatan	Puskesmas Tebet (satelit YPI-RSCM)	PKM
18	Jawa Barat	Bandung	Lapas Kebon Waru (satelit RSHS)	Lapas
19	Jawa Barat	Bandung	Lapas Banceuy (Rutan Klas I, satelit RSHS)	Lapas

No.	Province	District/City	Hospital/ Clinic	Type of Satellite
20	Jawa Barat	Bandung	Lapas Suka Miskin (satelit RSHS)	Lapas
21	Jawa Barat	Bekasi	Lapas Bekasi (satelit RS Ananda)	Lapas
22	Jawa Barat	Cirebon	Lapas Gintung (satelit RS Gunung Jati)	Lapas
23	Jawa Barat	Bandung	Puskesmas Kopo (satelit RSHS)	PKM
24	Jawa Barat	Bandung	Puskesmas Salam (satelit RSHS)	PKM
25	Jawa Barat	Cirebon	Puskesmas Larangan (satelit RS Gunung Jati)	PKM
26	Jawa Barat	Bandung	RS Immanuel (satelit RSHS)	RS
27	Jawa Barat	Bandung	RS St. Borromeus (satelit RSHS)	RS
28	Jawa Barat	Cianjur	RSUD Cianjur(satelit RSHS)	RS
29	Jawa Barat	Indramayu	RSU Indramayu(satelit RSHS)	RS
30	Jawa Barat	Kuningan	RSU Kuningan(satelit RSHS)	RS
31	Jawa Barat	Purwakarta	RSUD Bayu Asih(satelit RSHS)	RS
32	Jawa Barat	Subang	RSUD Subang(satelit RSHS)	RS
33	Jawa Barat	Sukabumi	RS Assyifa (satelit RSHS)	RS
34	Jawa Barat	Sukabumi	RSUD R. Syamsudin SH (satelit RSHS)	RS
35	Jawa Tengah	Semarang	BKPM Semarang (Badan kes Paru Masy.) (satelit Kariadi)	Balai Negara
36	Jawa Tengah	Surakarta	BBKPM (Balai Besar Kes Paru Masy. Satelit Moewardi)	Balai Negara
37	Bali	Denpasar	Yayasan Kepti Praja (satelit Sanglah)	LSM
38	Bali	Buleleng	Puskesmas Grogak (satelit Buleleng)	PKM
39	Kalimantan Selatan	Tanah Bumbu	RS Amanah Husada (satelit RS Ansari Saleh)	RS
40	Sulawesi Selatan	Makassar	Klinik Prof. dr. Abd Halim (satelit RS Wahidin)	Klinik
41	Sulawesi Selatan	Makassar	Puskesmas Jumpandang Baru (satelit RS Wahidin)	PKM
42	Sulawesi Selatan	Makassar	Puskesmas Kasi-kasi (satelit RS Wahidin)	PKM
43	Papua	Jaya wijaya	Klinik Kalvari	Klinik
44	Papua	Merauke	Puskesmas Kuprik (satelit RSUD Merauke)	Klinik
45	Papua	Merauke	Puskesmas Mopah (RSUD Merauke)	Klinik
46	Papua	(induk: Abepura)	Puskesmas Depapre (satelit RS Abepura)	PKM
47	Papua	(induk: Abepura)	Puskesmas Dosai (satelit RS Abepura)	PKM
48	Papua	(induk: Abepura)	Puskesmas Harapan (satelit RS Abepura)	PKM
49	Papua	(induk: Abepura)	Puskesmas Jayapura Utara (satelit RS Abepura)	PKM
50	Papua	(induk: Abepura)	Puskesmas Kota Raja (satelit RS Abepura)	PKM
51	Papua	(induk: Abepura)	Puskesmas Koya Barat (satelit RS Abepura)	PKM
52	Papua	(induk: Abepura)	Puskesmas Sentani (satelit RS Abepura)	PKM
53	Papua	(induk: Abepura)	Puskesmas Waena(satelit RS Abepura)	PKM
54	Papua	Jaya wijaya	Puskesmas Wamena (sateli RS Wamena)	PKM
55	Papua	Mimika	Puskesmas Timika (satelit RS Mimika)	PKM
56	Papua	Mimika	Puskesmas Timika Jaya (satelit RS Mimika)	PKM
57	Papua	Mimika	Puskesmas Koamki (satelit RS Mitra Masy.)	PKM
58	Papua	(induk: Abepura)	RS Mulia Puncak Jaya (satelit RS Abepura)	RS
59	Papua	Baru	RSUD Asmat (satelit RS Merauke)	RS

No.	Province	District/City	Hospital/ Clinic	Type of Satellite
60	Papua	Bovendigul	RS Boven Digul (satelit RS Merauke)	RS
61	Papua	Kepi	RS Kepi (satelit RS Merauke)	RS
62	Papua	Tembaga Pura	RS Waa Banti- Tembaga Pura (satelit Tembaga Pura)	RS
63	Papua Barat	Kota Sorong	Klinik Santo Agustinus (satelit RSU Selebe Solu)	Klinik
64	Papua Barat	Fak Fak	Puskesmas Fak Fak Kota (satelit RSU Fak Fak)	PKM
65	Papua Barat	Kab. Sorong	Puskesmas Aimas (Satelit RSU Sorong)	PKM
66	Papua Barat	Kota Sorong	Puskesmas Malawe (satelit RSU Selebe Solu)	PKM
67	Papua Barat	Kota Sorong	Puskesmas Remu (satelit RSU Selebe Solu)	PKM
68	Papua Barat	Manokwari	Puskesmas Sanggeng (Satelit RSU Manokwari)	PKM

Annex 6

Local Regulations on HIV and AIDS : 16 Provinces & 34 Districts/Cities

Has local or Gubernatorial regulation

Has no provincial level regulation

AIDS Comm. (Prov)	District/City	AIDS regulation number
North Sumatera	1 Kab. Serdang Bedagai	Number 11 / 2006
	2 Kab. Tanjung Balai Asahan	Number 6 / 2009
1 Riau		Number 4 / 2006
South Sumatera	3 Kota Palembang	Number 16 / 2007
2 The Riau Islands		Number 15 / 2007
3 DKI Jakarta		Number 5 / 2008
4 West Java		Per Gub Number 78 / 2010
	4 Kota Cirebon	Number 1 / 2010
	5 Kab. Indramayu	Number 8 / 2009
	6 Kota Bekasi	Number 3 / 2009
	7 Kab. Tasikmalaya	Number 4 /2007
	8 Kota Tasikmalaya	Number 2 / 2008
5 Central Java		Number 5 / 2009
	9 Kab. Semarang	Number 3 / 2010
	10 Kab. Batang	Number unknown
6 DI Yogyakarta		Number 12 / 2010
7 East Java		Number 5 / 2004.
	11 Kab. Banyuwangi	Number 6 / 2007
	12 Kab Pasurun	Number 4 /2010
	13 Kab. Malang	Number 14 / 2008
	14 Kota Probolinggo	Number 9 / 2005
8 Banten		Number 6 / 2010
9 Bali		Number 3 / 2006
	15 Kab. Badung	Number 1 / 2008
	16 Kab. Buleleng	Number 5 / 2007
	17 Kab. Klungkung	Number 3 / 2007
	18 Kab. Gianyar	Number 15 / 2007
	19 Kab. Jembrana	Number 1 / 2008
	20 Kab. Bangli	Number 4 / 2010

AIDS Comm. (Prov)	District/City	AIDS Regulation
10 West Kalimantan		Number 2 / 2009
11 East Kalimantan		Number 5 / 2007
	21 Kota Samarinda	Number 23 / 2000
	22 Kota Tarakan	Number 6 / 2007
12 North Sulawesi		Number 1 / 2009
	23 Kota Bitung	Number 19 / 2006
13 South Sulawesi		Number 4 / 2010
	24 Kab. Bulukumba	Number 5 / 2008
	25 Kab. Luwu Timur	Number 7 / 2009
14 NTB		Number 11 / 2008
15 NTT		Number 3 / 2007
West Papua	26 Kab. Manokwari	Number 6 / 2006
	27 Kab. Teluk Bintuni	Number 21 / 2006
	28 Kota Sorong	Number 41 / 2006
16 Papua		Number 8 / 2010
	29 Kab. Jayapura	Number 20 / 2003
	30 Kota Jayapura	Number 7 / 2006
	31 Kab. Biak Numfor	Number 2 / 2006
	22 Kab. Nabire	Number 18 / 2003
	33 Kab. Merauke	Number 5 / 2003
	34 Kab. Mimika	Number 11 / 2007

Source : NAC (per September 2011)

Total local AIDS regulations at provincial level : 15
Total Gubernatorial regulations : 1
Total local AIDS at district/ city level : 34

Annex 7

KOMISI PENANGGULANGAN AIDS

KEPUTUSAN
SEKRETARIS KOMISI PENANGGULANGAN AIDS NASIONAL
Nomor: 2 /SKep/KPA/III/2011
TENTANG
TIM PENYUSUN LAPORAN KEPADA PRESIDEN REPUBLIK INDONESIA

SEKRETARIS KOMISI PENANGGULANGAN AIDS NASIONAL

MENIMBANG :

a. bahwa setelah dikeluarkannya Peraturan Presiden RI Nomor 75 tahun 2006 perlu disusun Laporan Pertanggung-jawaban Ketua Komisi Penanggulangan AIDS Nasional kepada Presiden Republik Indonesia sebagai pemberi mandat;
b. bahwa untuk penyusunan, penyempurnaan dan penyelesaian laporan tersebut perlu dibentuk suatu tim penyusun dan finalisasi yang ditetapkan dalam surat keputusan;
c. bahwa mereka yang disebut dalam keputusan ini dianggap memenuhi syarat dan mampu untuk diserahi tugas dan tanggung jawab sebagai anggota tim

MENGINGAT :

a. Peraturan Presiden RI Nomor 75 tahun 2006 tentang Komisi Penanggulangan AIDS Nasional
b. Peraturan Menteri Koordinator bidang Kesejahteraan Rakyat Nomor 5 tahun 2007

MEMUTUSKAN:

MENETAPKAN : Keputusan Sekretaris Komisi Penanggulangan AIDS Nasional tentang Tim Penyusun Laporan kepada Presiden Republik Indonesia

PERTAMA : Membentuk Tim Penyusun Laporan Kepada Presiden Republik Indonesia, Lima Tahun Setelah Peraturan Presiden Nomor 75 tahun 2006 tentang Komisi Penanggulangan AIDS Nasional dengan susunan keanggotan sebagaimana tersebut dalam Lampiran Surat Keputusan ini.

KEDUA : Tim bertanggungjawab membantu KPA Nasional menyusun Laporan Kepada Presiden RI, tentang pelaksanaan lima tahun Peraturan Presiden Nomor 75 tahun 2006..

KETIGA : Untuk keperluan pada butir kedua, Tim dapat bekerja sama dengan narasumber dan pihak lain yang diperlukan

KEEMPAT : Segala biaya yang diperlukan Tim untuk melakukan tugasnya dibebankan pada Anggaran Rutin KPA Nasional dan sumber lain yang tidak mengikat dan dapat dipertanggung jawabkan

KELIMA : Keputusan ini mulai berkalu sejak tanggal ditetapkan dengan ketentuan apabila di kemudian haru terdapat kekeliruan dalam keputusan ini akan diadakan pembetulan sebagaimana mestinya.

Ditetapkan di : Jakarta
Pada tanggal : 15 Maret 2011

SEKRETARIS KOMINSI PENANGGULANGAN AIDS NASIONAL

KOMISI PENANGGULANGAN AIDS

Dr. Nafsiah Mboi, SpA, MPH

Tembusan Yth:

1. Ketua Komisi Penanggulangan AIDS Nasional (sebagai Laporan)
2. Wakil Ketua I dan II Komisi Penanggulangan AIDS Nasional (sebagai Laporan)
3. Anggota Komisi Penanggulangan AIDS Nasional (sebagai Laporan)

Lampiran Surat Keputusan

Nomor : /SK/SET/KPA/V/2011

Tentang : Tim Penyusun Laporan kepada Presiden RI, lima tahun setelah Peraturan Presiden RI Nomor 75 tahun 2006

Susunan Tim Penyusun Laporan Kepada Presiden RI, lima tahun setelah Peraturan Presiden RI Nomor 75 tahun 2006

TIM PENGARAH

KETUA: Nafsiah Mboi, Sekretaris KPA Nasional

Wakil Ketua 1: Emil Agustiono, Deputi Bidang koordinasi Kesehatan, kependudukan dan Keluarga Berencana Kementerian Koordinator Bidang Kesejahteraan Rakyat

Wakil Ketua 2: Tjandra Yoga Aditama, Dirjen P2PL, Kementerian Kesehatan

Sekretaris: Kemal N. Siregar, Deputi bidang Pengembangan Program Sekretariat KPA Nasional

ANGGOTA:

1. Eppy Lugiarti, Direktorat Pemberdayaan Adat dan Sosial budaya masyarakat, Kemendagri
2. H. Tulus, Staf Ahli Menteri Bidang Hukum dan HAM, Kementerian Agama
3. Emma Purba, Pusat Kesejahteraan Rakyat, Badan Informasi Publik Kementerian Komunikasi dan Informasi
4. Muqowimul Aman, Direktur Jenderal Pemasyarakatan, KemKumHAM
5. Bakrie, Direktur Pemberdayaan Masyarakat, Direktorat Jenderal Pengembangan Destinasi Pariwisata
6. Sudi Astono, Sekretariat Jenderal Kementerian Tenaga Kerja dan Transmigrasi
7. Ella Yulaelawati, Direktur Pendidikan Masyarakat, Kemdiknas
8. Max. H. Tuapattimain, Direktur Rehabilitasi Penyalahgunaan Narkoba, Kemsos
9. A. M. Asnandar, Direktur Rehabilitasi Tuna Sosial, Kemsos
10. Medianto, mewakili Staf Ahli Bidang Lingkungan, Kementerian Perhubungan
11. Imam Gunawan, Sekretariat Menteri Pemuda dan Olah raga, Kementerian Pemuda dan Olahraga
12. Ida Suselo Wulan, Deputi Bidang PUG bidang Polsoskum, Kementerian PP dan PA

13. Hadiat, Direktur Kesehatan dan Gizi Masyarakat,, Bappenas
14. Heri Widyawati, Sekretariat Menteri Negara Riset dan teknologi, KNRT
15. Djoko Rahwidiarto, Kedeputian Sekretaris Kabinet Bidang Pemerintahan, Sekretaris Kabinet
16. Ghufron Sholihin, Pusat Kesehatan TNI
17. Rudatin, Perwakilan Pusdokkes POLRI
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