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

Indonesian National AIDS Commission, October 2011

COORDINATING MINISTER OF PEOPLE'S WELFARE
REPUBLIC OF INDONESIA

Remarks

Bismillahirrahmanirrahim
Assalamualaikum Warrahmatullahi Wabarakatuh,

Giving thanks to God the Almighty for his many gifts and great blessings, I welcome the hard work of the writing team in bringing together the data, program reports, and activities of the National AIDS Commission from 2006-2011 to prepare this comprehensive report, "Five Years Implementation of Presidential Regulation 75/2006 – Report on the Response to HIV and AIDS in Indonesia 2006 – 2011".

This report is an accounting by the National AIDS Commission to the President of Indonesia and head of government. It is also an open sharing of information with the people of Indonesia, international partners in the response and, most important of all, the community of people living with and affected by HIV and AIDS.

This report will be of benefit to readers, particularly members of the National AIDS Commission, the secretariat, civil society, international development partners as well as people infected and affected by HIV. It will be useful as a reference on progress of the Indonesian response to the epidemic.

There are various noteworthy accomplishment in the past five years. First, strengthening of the role of government ministries, members of the National AIDS Commission, as well as local government at provincial and district/ city level and the support and collaboration of civil society in the whole effort. Second, programs of the response have reached all the provinces of Indonesia, for example harm reduction, prevention of sexual transmission, voluntary counseling and testing, as well as care, support, and treatment for PLHIV. Thirdly, we see domestic resources increasing steadily.

I hope that as more is known and understood about progress in Indonesia's response to HIV and AIDS over the past five years, more people will value these efforts and participate in expansion of the coverage, strengthening of the quality, and assuring

the continuation of Indonesia's response to HIV and AIDS. I am confident that with effective cooperation and coordination we will be able to save the Indonesian people from the HIV epidemic.

I extend my thanks to all the members of the writing team who have completed their assignment satisfactorily.

May the blessing of God be with us all. Amin.

Thank you. Wassalamualaikum Warahmatullahi Wabarakatuh.

Coordinating Minister of People's Welfare
As Chairman of the National AIDS Commission

H.R. Agung Laksono

MINISTRY OF HEALTH
REPUBLIK OF INDONESIA

Remarks of the Minister of Health

In the past twenty years the response to HIV and AIDS in Indonesia has been steadily growing by both government and the community – work in prevention with counseling and testing primarily available in health service sites such as community health centers, hospitals and private clinics. This effort needs to be continued and both quality and coverage of service expanded still further.

I welcome publication of the "Report on the Response to HIV and AIDS in Indonesia 2006 – 2011: Report of Five Years Experience implementing Presidential Regulation75/2006." This report documents the progress which has been made in the response during this time. One of the important areas of development between 2006 and 2011 has been in the field of care, support, and treatment.

During this time the government has made free treatment with antiretrovirals available and increased both the number and capacity of specially trained health care providers – doctors, nurses, midwives, and counselor. Care, support and treatment now reach 77% of the people living with HIV (PLHIV) who are eligible for ARV based on the estimate in Presidential Instruction Number 3/2010.

Nonetheless, there are still things which need to be expanded, corrected or improved. Among others, there need to be improvements in general community understanding about HIV and AIDS; likewise we need to assure continuity in availability of antiretrovirals as well as distribution of health care staff trained for HIV and AIDS services. With that goal in mind, we need to strengthen community based health efforts and basic health services. Community Health Centers and Village Health Services need to become the front lines in provision of care, support and treatment for AIDS and these facilities need to provide the best possible service. Achieving this goal will require the participation of all levels of government and support of the whole community.

I am convinced that if we work hard and we work well, we can be effective in preventing the spread of HIV infection throughout the community and we can reach more people who are HIV+ and have AIDS with the care, support and treatment they need. I hope that this report will contribute to the success of Indonesia's response to HIV and AIDS and improvement in the general welfare of the people of Indonesia as a whole.

Minister of Health Republic of Indonesia
First Vice Chair, National AIDS Commission

Dr. Endang Rahayu Sedyaningsih, MPH, Dr.PH

MINISTRY OF HOME AFFAIRS
REPUBLIC OF INDONESIA

Remarks of the Minister of Home Affairs

Assalamualaikum Warrahmatullahi Wabarakatuh,
Blessings on us,

The response to HIV and AIDS is a joint responsibility of us all calling for cooperation of government, NGOs, the private sector, and the people. We must all join hands in the effort and not go our separate ways.

The government at all levels – provincial, district/ city, and village – has an important role in leading the response. Because of this, the Ministry of Home Affairs encourages local governments at all levels to fulfill this role and empower the community, as well.

In connection with this responsibility, I support and very much appreciate the publication of this Report which shows the synergy of all our efforts in the comprehensive response to AIDS – the leadership of government and the active role of the community working together to protect the people of Indonesia from HIV.

In supporting the secretariats of provincial, district, and city AIDS Commissions, the Ministry of Home Affairs has always endeavored to promote and strengthen a well coordinated response to the epidemic and will continue to do so.

In addition, the Ministry has given guidance to Senior Officials at the local level to provide adequate budgets for prevention and management of the comprehensive, synergistic, and sustainable response as a demonstration of their commitment to our responsibility for people's welfare.

As Vice Chair and member of the National AIDS Commission, I thank all those who have worked so hard to protect our people from the impact of HIV and AIDS in the 5 years since the Presidential Regulation 75/ 2006 and the Regulation of the Minister of Home Affairs 20/ 2007 went into effect and who will continue to do so in the future.

May God bless our efforts to protect the Indonesian people from the twin epidemics of HIV and drugs.

Minister of Home Affairs
As Vice Chair of the National AIDS Commission

Gamawan Fauzi

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.

This 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;
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 whole Indonesian family.

October 2011

Secretary, National AIDS Commission of Indonesia

Dr. Nafsiah Mboi, SpA, MPH.

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

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

* **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

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 and promote positive change for/ by them.

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 epi-

demic" to a "concentrated epidemic," an epidemic where typically infection reaches >5% among one or more key affected populations. (see **Table 1**)

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. (see **Annex 1**)

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 (see **Annex 2**). 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.

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 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] (see **Chart 1**)

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 3**) 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.

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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.*

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 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 in 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 Na-

* **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.

† 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.

tional 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 2011 the government of the United States joined the Partnership Fund with an annual commitment 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. (See **Table 10** and **Table 24**)

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 4**)

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] (see **Table 12**)

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 5 :** 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 (Rp 557.181.205.000) by the end of 2010.[17] (see **Table 13**)

11. The comprehensive response: The "comprehensive response to HIV and AIDS" in Indonesia includes provision of the necessary information, supplies, and services

* **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.

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 2**)

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 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

* 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.*

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 decree of 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 funding 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).

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] (See **Chart 10**)

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.

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

The final, critical component was close monitoring and evaluation by program managers from local to national level. (See **Box 3**)

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] (See **Chart 4** and **Table 11**)

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 distributed through 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 is 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."

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, 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. (See **Table 18**)

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.

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

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

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

to prevent transmission of infection from HIV+ women who are pregnant (PMTCT). Faced with high co-infection between TB and HIV a specific program response 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 6**). 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]

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

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

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] (see **Table 21** and **Table 22**).

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.

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] (See **Map 2**) 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/

* 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

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 -- 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 13,** Chapter 4)
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 that 350,550 people would be infected by 2015. (see **Chart 13**)
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 be reversed.

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 14**, 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. (see **Chart 14**)

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 7**: 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 outreach and strengthening of quality program promotion and support 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 - integrated with 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 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 socioeconomy 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 report, the "The Response to HIV and AIDS in Indonesia, 2006 – 2011 : Report on 5 Years Implementation of Presidential Regulation 75/ 2006" has been written with participation of relevant government departments, civil society, PLHIV, and the academic community. (see **Annex 8**: 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 writing team 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.

01

Background to Presidential Regulation 75/2006 and This Report

THE FIRST CONFIRMED CASE OF AIDS was identified in Indonesia in 1987, a foreign tourist in Bali. Shortly thereafter, HIV infection and cases of AIDS began to be found among Indonesians. Indonesia's response was modest, measured, and with a few exceptions focused within the health sector. By the early 1990s global understanding of the dynamics of infection and impact of AIDS had evolved making it clear to those concerned with the epidemic that to have an impact on infection and to support those already infected, a broad response was needed with attention to public policy, public values, social support, and community systems as well as the important technical health response.

Development of the epidemic in Indonesia, although apparently slow during these years was an issue of concern to a number of private practitioners who were treating patients and some public health advocates and activists concerned by Indonesia's narrow and exclusively health-focused response. They were concerned about the "iceberg phenomenon" and believed the epidemic to be spreading more widely and more quickly than reports indicated. This was a valid concern given the scarcity of testing in Indonesia, the high levels of stigma associated with both injecting drug use and HIV, the limited understanding of HIV and AIDS even in the world of health care professionals and because of competition with other, more visible health development issues.

Indonesia took a step forward in 1994. Following a high level study tour to Thailand to learn from Thai experience with HIV and AIDS (1993), a process of discussion, lobbying, drafting and re-drafting was undertaken in Indonesia which culminated in May of 1994 with appointment of Indonesia's First National AIDS Commission[1] and in June the first National Strategy.[2]

By 1999-2000 it became clear that HIV infection was found on a small scale in various places but was increasing rapidly in Indonesia's small but growing community of people who injected drugs (PWID). The Jakarta Drug Dependency Hospital reported 18% of injecting drug users were HIV+ in 1999. By 2001 that had jumped to 48%.[3] The total number of PWIDs was relatively small. Nonetheless, they were an important population for Indonesia. First, they were almost all in their late teens and early 20s, young Indonesians who should be looking forward to healthy, productive lives rather than faced with a lonely struggle with addiction, disease, and early death. Secondly, studies made clear that the overlap between the world of drug injection and the world of commercial sex was expanding the numbers of people infected. Likewise, infection was increasingly being found among the spouses of PWIDs, husbands and wives who were not, themselves, PWID.

A critical component in any effective response to HIV and AIDS is a well developed system for counseling and testing (VCT) -- counseling people to help them decide if they should be tested, preparing them for testing, giving them the results after testing, and discussing what the results mean in terms of future health and behavior. In order to build up capacity for VCT, Indonesia (Ministry of Health) applied for and received a grant from the AIDS component of the Global Fund to Fight AIDS, TB, and Malaria[4] (GF) to develop the necessary training program and to provide antiretrovirals free to people meeting the criteria for treatment. This grant (2003-2007) supported the launch of Indonesia's ARV treatment program.

The year 2004 was important in Indonesia's understanding of the epidemic and alternatives for mounting a more robust and effective response. The beginning of the year saw the launch of a new initiative to mobilize government attention on the epidemic in the 6 most affected provinces and stimulate action among several of the key government ministries.* The Sentani Commitment, signed 19 January 2004, called for condom use in all high risk sex, comprehensive harm reduction services related to injecting drug use, improved availability of ARV treatment, reduction in AIDS-related stigma and discrimination, establishment and/ or revitalization of AIDS Commissions at provincial and district/ city level, and promotion of enabling laws, policies, regulations, and budgets as needed for successful development and implementation of the activities agreed to. (see **Annex 1**)

On the other hand, the cumulative report on HIV and AIDS in Indonesia in 2004, ten years after the first AIDS Commission and Strategy had been put in place, dramatized for observers the urgency of Indonesia's reviewing its response to the epidemic and finding more effective ways to bring the accelerating epidemic under control, particularly among PWID. Between 2003 and 2004 total reported infection had increased nearly 4 times over and injecting drug use was recorded as the mode of infection in 68.95% of reported AIDS.[5]

Table 1: Cumulative reported HIV and AIDS. Year end 2003 and 2004

	HIV	AIDS	Total
2003	168	316	484
2004	649	1,195	1,844

Source: Ministry of Health. The Situation of HIV and AIDS in Indonesia. Year end Reports for 2003 and 2004.

* The signatories were Governors and Ministers or their representatives. Provinces : Papua, Bali, East Java, West Java, DKI Jakarta, and Riau, which by the end of the year had split giving birth to the new province the Riau Islands. Government Departments/ Bodies : Coordinating Minister of People's Welfare/ Chair, AIDS Commission, Minister of Health, Minister of Social Welfare, Minister of Religion, Minister of National Education, Minister of Home Affairs, Head of the National Family Planning Coordinating Board.

Evaluation of experience in the provinces of the Sentani Commitment demonstrated that the approach was effective and should be considered for wider application[6] - more pro active, broader in focus, and promoting multi-sectoral government engagement and responsibility, as well as cooperation between civil society and government.

In December of 2005, the newly appointed Coordinating Minister for People's Welfare/ Chair of the National AIDS Commission, Mr. Aburizal Bakrie asked to be briefed on the HIV epidemic and Indonesia's response by the secretariat of the National AIDS Commission and by Dr. Nafsiah Mboi, vice chair and officer in charge of follow-up and operationalizing of the 2004 Sentani Commitment.

Reviewing data on the epidemic and the information provided to him, the Minister quickly came to the conclusion that urgent action was needed to broaden, accelerate, systematize, and professionalize Indonesia's efforts to control the epidemic. The pace of infection was too high and the potential disruption to overall development as well as the cost in Indonesian lives, particularly among the younger generation were unacceptable.[7] He immediately took steps which culminated in the issuance of Presidential Regulation 75/ 2006 on the National AIDS Commission. (13 July 2006)

In article 1 of the Presidential Regulation, the new National AIDS Commission (NAC) was given the overall assignment of promoting a "more intensive, holistic, integrated, and coordinated prevention and management of the response to AIDS".[8] This reflected the conclusion at the highest level of government that a change was needed if the spread of HIV infection was to be halted and people already infected were to have an appropriate part in the response, and be adequately served.

Information dissemination at events, such as the World AIDS Day, mobilizing young people

The patchwork of uncoordinated activities which had grown up during the 19 years after AIDS was first diagnosed in Indonesia was the product of dedicated work by a combination of civil society AIDS activists working on a localized basis with interested individual health care providers from both government and in private practice. It was supported almost exclusively with funding from international sources. Nonetheless, it was clear that a more urgent, comprehensive, systematic approach was needed.

Presidential Regulation 75/ 2006 strengthened the position and responsibility of the AIDS Commission. Membership was diversified and the door opened to professionalization of staff and the work of the Commission. Specifically, Article 2 placed the AIDS Commission "under and responsible to the President". Membership of the Commission continued to include relevant government departments but was broadened with the addition of military, the national police, and the national narcotics board as well as representatives of civil society, professional health care organizations such as the Indonesian Doctor's Association (Ikatan Dokter Indonesia) and the Indonesian Public Health Association, as well as people living with HIV (PLHIV) and the private sector. (see **Annex 2** : membership of National AIDS Commission).

The President's intention to move the secretariat of the AIDS Commission towards greater professionalization was clear in Presidential Regulation 75/ 2006. Breaking with tradition, a member of the Commission, Dr. Nafsiah Mboi, a senior doctor and former Department Director at the Headquarters of the World Health Organization in Geneva was designated as the first, full time secretary of the Commission. Furthermore, she was designated to chair the multi-sectoral executing team. Subsequently, she was also charged by the Coordinating Minister/ Chair of the National AIDS Commission with responsibility for restructuring of the Commission's secretariat and leading it thereafter.[9]

It is five years since the National AIDS Commission was charged with this assignment. It is the purpose of this report to provide an up-date on the status of the epidemic in Indonesia and our response to it. Based on this information we will conclude with some projections and recommendations. In reviewing the situation of the past five years one finds there is some good news and some which is not so good. There are also some serious challenges at hand that call for improvements. It is hoped that this report can provide a good basis for analysis, advocacy, as well as strategizing, and moving forward for the next 5 years.

Throughout the years covered in this report three underlying concerns have informed the work of the National AIDS Commission in analysis, planning, monitoring, and evaluation of the national response --

- **Coverage :** Epidemiologically it is known that to control the epidemic at least 80% of those most at risk should be reached with information, supplies, as well as prevention and treatment services. National estimates of most at risk population in 2006 showed that coverage was still very low : 7% of PWID, 24% of direct female sex workers, 16% of indirect female sex workers, 43% of transgenders, only 2% of MSM, 5% of prisoners, and 8% of high risk men. The commitment to reach 80% of the vulnerable population in Indonesian meant that fast scaling up would be needed, not easily done given Indonesia's size and topography, and the very limited financial and human resources available at the time to control the HIV epidemic. (see **Chart 4**)

- **Effectiveness :** Surveys showed that prevention and treatment programs were not yet effective in 2006. Condom use was still low (approximately 10%), sharing of injecting equipment among PWID was common. Access to treatment was very limited, people came late (in the development of AIDS), adherence to medication was low with the result that mortality from AIDS-related illness was high. Addressing this set of issues called for creativity and innovation to improve effectiveness of programs, learning from successes and failures both in Indonesia and elsewhere and accompanied by a good system of monitoring and evaluation.

- **Sustainability :** Observation of program work underway in 2006 found that activity run by NGOs was seldom sustainable because of the dependence on external funding. When the funding stopped programs also generally stopped although the need for service continued.Another issue related to sustainability became apparent when the response went through a crisis as a result of a nine month freeze of support for Indonesia by the Global Fund in 2007 in connection with misuse of funds. During that time there were stock outs in many locations where ARV had previously been routinely available.

  Specifically, as far as funding was concerned, by mid 2007 Indonesia had taken the commitment to cover at least 70% of the total cost of the AIDS response by 2015. However, sustainability is not only related to financial or programmatic concerns. It is also related to building the knowledge and skill of all so that each person knows how to protect her/ himself from infection not waiting for or depending on the action of others. In this way program sustainability will be achieved when each person is motivated and able to achieve and maintain their own good health.

Coverage, effectiveness, and sustainability, then are crucial issues of on-going concern and indicators of performance to be monitored. They act synergistically and together

they provide the foundation for Indonesia's multi faceted, multi-sectoral, developmental, flexible response to HIV and AIDS.

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 working for

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

The progress presented in this report builds on the work of AIDS activists in the years before Presidential Regulation 75/ 2006 and reflects the efforts of many people and institutions across the country since then. All partners to the response are now working within the framework of Indonesia's comprehensive National AIDS Strategy and Action plan (2010-2014) for prevention and management of HIV and AIDS, the second since the Presidential Regulation.[10] Principal actors include civil society (networks of Key Affected Populations and people living with HIV (PLHIV) as well as AIDS service and advocacy groups, faith based activists, government departments, AIDS Commissions at all levels, university and hospital teams, public health services from Sabang to Merauke -- and increasingly the private sector.

The work reported also reflects the technical and financial support of international development partners including faithful bilateral partners[11] as well as various multi-lateral groups including the UN family, the Global Fund, and international NGOs from many parts of the world. Many of these actors contributed to the field of HIV and AIDS in Indonesia before Presidential Regulation 75/ 2006 came into effect, but the scope and integration of their work, thus their effectiveness, has grown as the national response, itself, has matured, becoming more comprehensive and clearly defined.

The response to the epidemic is now so wide ranging across the country, multi faceted and multi sectoral in its concerns and partnerships that no single individual or institution could possibly capture the full scope of what has been accomplished nor be cognizant of all the details, good and bad, in implementation of the response. Nonetheless, the National AIDS Commission secretariat in the course of carrying out its assigned responsibilities of leadership, coordination, monitoring and reporting on the response has a more complete picture than others. It is highlights of this more comprehensive picture that are shared in this report.

02

The Epidemic and The Response : Some Changes 2006 and 2011

THE CHALLENGES LYING AHEAD for the next several years are significant. Nonetheless, there is cause for cautious optimism about Indonesia's increasingly well established systems and growing commitment to bring the epidemic under control if the focus, collaboration, and momentum of the past five years can be maintained and strategically increased. A snap shot of the situation in 2006 and 2011 highlights both progress and some of the challenges ahead.

A. HIV infection, AIDS, and their treatment

Between 2006 and 2011 the Ministry of Health (MoH) published two estimates of the number of adults in Indonesia aged 15 – 49 at high risk of infection, their sexual partners, and the number of people already HIV+. One estimate was done in 2006, the second in 2009.[12] A new estimate was completed in 2011 and is eagerly awaited. As of August 2011 results had not yet been released. These estimates serve as critical points of reference in discussion of the status of the epidemic, planning the response, and measuring progress being made. In 2006 6,503,520 people were estimated at high risk and 193,030 were estimated to be HIV+. In 2009 6,396,187 were estimated at high risk with 186,257 estimated to be HIV+. (see **Annex 3**)

Data of the Ministry of Health during this period show reported new and cumulative HIV infections and new and cumulative AIDS cases climbing significantly from a combined total of 16,248 in 2006 to a combined total of 93,176 in 2011 (30 June 2011) indicating a total of 76,928 new PLHIV during the 5 year period.

Table 2: Reported New and Cumulative **HIV and AIDS, 2006 - 2011**

	HIV		AIDS	
	New	Cumulative	New	Cumulative
2006	7,195	8,054	2,873	8,194
2007	6,048	14,102	2,947	11,141
2008	10,362	24,464	4,969	16,110
2009	9,793	34,257	3,863	19,973
2010	21,591	55,848	4,158	24,131
2011 (June)	10,845	66,693	2,352	26,483

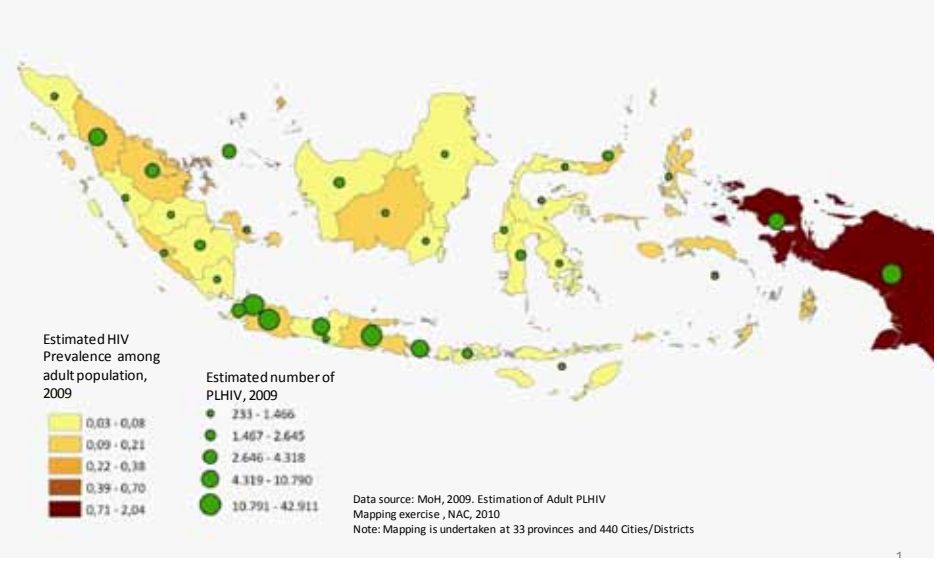
Source: MoH. Report on Situation of HIV and AIDS. Second quarter (June) 2011. New HIV Infection provided by MoH.

Reports of MoH indicate significant increase of HIV infection and AIDS cases since 2006. Nonetheless, a number of indicators suggest progress is being made toward bringing the epidemic under control – since 2010 both reported new HIV infection and

AIDS cases appear to have been stabilizing. The rapid rise in reported HIV infection reflects, among other things increase in availability and utilization of counseling and testing (VCT and PCIT), an important step forward in the national response. Choosing to be tested, is an activity with high importance in efforts to reduce new infection and to improve the quality of life of PLHIV. It is good news, therefore, if more people are being reached particularly among key affected populations, and successfully motivated to seek counseling and testing. It also suggests that stigma and discrimination in relation to HIV and AIDS may be declining compared with earlier times in the epidemic, a point worth investigating further.

Reports on infection come through the health system and are province- and district/ city- specific so we can observe intensity of the epidemic. Mapping reports on the epidemic shows HIV and AIDS are unevenly distributed across the country (see **map 1**, below). They have been reported in 300 districts in 32 provinces.*

Map 1: Distribution of HIV and AIDS across Indonesia based on 2009 estimate
Estimated number of PLHIV 2009: 186,257



Source: Data MoH, Mapping NAC

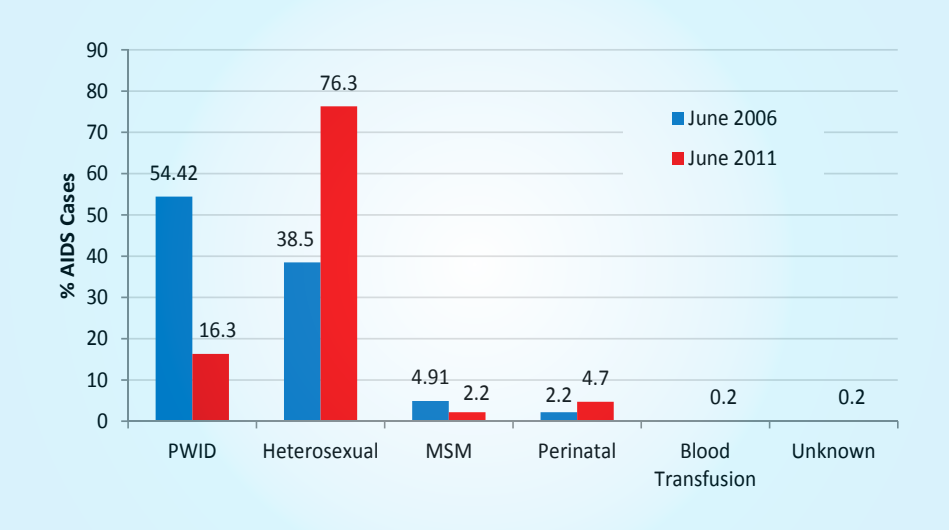
1. **New infection stable or slowing?** While reports on new HIV infection climbed rapidly during 2009, 2010 and into early 2011, it should be mentioned that during the same period the number of facilities for counseling and testing more than doubled from 156 in 27 provinces in 2009[13] to 388 reporting VCT sites in 33 provinces in 2011.[14]

* At time of writing Indonesia has 33 provinces and according to information from Ministry of Home Affairs 524 districts/ cities. The number of districts/ cities has been changing in recent years, for example at the time the National AIDS Action Plan 2007-2010 was being prepared there were 440.

Information, then is coming from new areas, an indication that the national response is, indeed, broadening its reach throughout the country. It is noteworthy also, that new reported cases of AIDS have been relatively stable during the past three years suggesting more people are getting earlier diagnosis and treatment. With improved counseling more positive people may change their lifestyle to reduce or eliminate risky behavior, delay progression of infection to AIDS (thus reducing medical costs as well), raise the quality of life of the PLHIV involved and, God willing, promote "positive prevention" (action on the part of positive people to assure that they do not infect others.)

2. **Change in mode of transmission:** In the five years since Presidential Regulation 75/2006 came into effect there has been a noticeable shift in the predominant mode of infection among reported AIDS cases (cumulative). Reduction of infection among PWID is making progress. Unsafe injecting is no longer the dominant mode of infection. While in June of 2006 slightly over fifty percent (54.4%) of new reported AIDS were drug related and only 38.5% were the result of heterosexual transmission by June of 2011 that situation was very different. Only 16.3% of total new reported AIDS cases were associated with injecting drug use, while 76.3% were the result of heterosexual infection.[15] Perinatal infection more than doubled from 2.0% to 4.7% during this same period, the logical outcome of the increase in infection among women.

Chart 1: Percent of new AIDS cases by mode of infection.
June 2006 and June 2011



Source: MoH. Report on Situation of HIV and AIDS in Indonesia. June 2006 and June 2011.

Accumulating evidence of the rise in sexual transmission of infection led the secretariat of the National AIDS Commission to formulate and promote adjustment in the strategy of Indonesia's response to the epidemic since 2010 to increase coverage and diversify approaches, to reach more people involved in high risk sex

with a comprehensive approach to prevention of sexual transmission – in Bahasa Indonesia *Pencegahan Infeksi HIV Melalui Transmisi Seksual*, referred to as PMTS. Specifically two new priority audiences are

a) **High Risk Men (HRM):** the large numbers of mobile men, mostly young men, with money working in the often isolated and super-macho environments of mining, the transportation industry, estate agriculture, forestry, fishing, heavy construction and similar fields (Estimated 3,241,244 million[16], an estimate that given the reality in the field is thought by many people to be too low). They tend to engage in high risk sex some for recreation and some in response to "unsatisfied natural drives."

Millions of men in the mobile workforce are at risk of HIV infection.

Working with government departments, leaders in the private sector, local government, AIDS Commissions of all level, the health sector, civil society, networks of key affected populations, and local community members intensive prevention efforts are carried out – general AIDS education, religious education, workplace efforts to integrate information about AIDS in existing programs on workplace health and safety (referred to as K3, *Keselamatan dan Kesehatan Kerja* in Bahasa Indonesia), development of healthy recreation opportunities to fill the workers time off duty. These activities are integrated with PMTS in "hotspots" patronized by HRM with the aim of reducing infection with sexually transmitted infections including HIV. This program for High Risk Men is important and strategic in its contribution to efforts to bring the epidemic under control because "zero new infections for men will mean zero new infections for women (including wives) and zero new infections among babies."

b) **Young people (age 15 - 24)** in work or adopting life styles that place them at high risk of infection, particularly young men and women in sex work or already part of the world of injecting drug use. As seen in **Table 3**, below, recent disaggregation and analysis of existing surveillance data found 9% of PWID were in the 15 - 19 age bracket and another 29% were between 20 and 24. The situation among female sex workers was not dramatically different 8% were 15 - 19 years of age, while 26% were 20-24. Among MSM 13% were 15 - 19 and 19% 20 - 24. Finally, the analysis found 10% of transgender people were between 15 and 19 years of age with another 19% in the 20 - 24 age bracket [17]

Table 3: Percent of Key Affected Populations aged 15 – 24 years

	15 - 19 years	20 – 24 years	Total 15 – 24 years
PWID	9%	29%	38%
Female sex workers	8%	26%	34%
Men who have sex with Men (MSM)	13%	19%	32%
Transgender	10%	19%	29%

Source: NAC and UNICEF. Laporan Analisis Lanjutan Data Survei dan Penelitian Berdasarkan Kelompok Umur. 2011.

As explained earlier, the percentages above are derived from various surveys and surveillance exercises using, one hopes, sampling techniques appropriate to represent the respective cities and provinces included in the analysis. The data is combined from these various sources and if disaggregated by city the outcome could be different for each. To reach an estimate of the number of young people most at risk in Indonesia the above percentages have been applied to the official estimate of total adult population at risk (the 2009 estimate) and suggest that something in the neighborhood of 345,000 young people fall in the category of "young people most at risk.

Table 4: Approximate numbers of young people among key affected populations

	15 - 19 years	20 – 24 years	Total 15 – 24 years
PWID	9.521	30.677	40.198
Female sex workers	17.124	55.654	72.778
Men who have sex with Men (MSM)	90.353	132.055	222.408
Transgender	3.207	6.092	9.299
	120.205	**224.478**	**344.683**

Source: Based on percentages from NAC and UNICEF study relative to the 2009 MoH national estimate of adults at risk of HIV infection.

Street work starts early exposing young people to many hazards including drug use and infection with HIV

The big challenge is how to help our young people avoid becoming caught up in high risk behavior and how to help those already involved stay free of HIV or other infection. In short : How can Indonesia make significant improvements in education about reproductive health, use and abuse of narcotics, and healthy living combined in effective life skill education enabling our young people to choose and to maintain healthy, productive life styles.

3. **Increase in proportion of women among those infected** : Another trend which has become clear during the reporting period : Whereas in June of 2006 the Ministry of Health reported only 16.90% of new reported AIDS were women, by June 2011 that had risen to 35.13%

Table 5: Changing proportion of men and women among new reported AIDS. June 2006 and June 2011

	Jun 2006		Jun 2011	
Men	422	82,9%	1.298	64,87%
Women	86	16,9%	703	35,13%
Unknown	1	0,2%	0	0,00%
Total	**509**	**100%**	**2.001**	**100%**

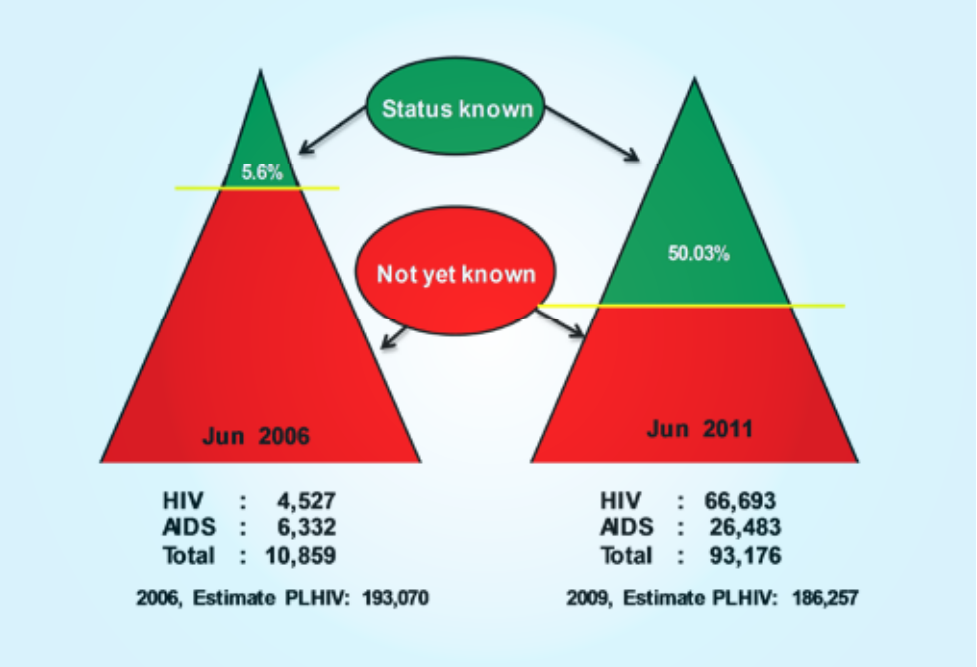
Source: MoH, Report on Situation of HIV and AIDS in Indonesia, June 2006 and 2011

This fact is important both because of the women involved but also because an HIV positive woman has the potential to transmit infection to her baby during pregnancy, during childbirth, or through breast feeding. Preventive treatment known as Prevention of Mother to Child Transmission (PMTCT) in available in Indonesia but these services are only available in a few locations in Indonesia (79 sites in 22 provinces).[18] Seeing the steady rise in numbers of women who are AIDS (most of whom are infected by their own husbands) it is clear that continuing work is called for among men and women to address norms and customs tolerating or perpetuating gender stereotypes and norms exposing women to high risk of infection at the same time limiting their options to protect themselves. At the same time, it should be noted that there are often violations of women human rights in various forms – including sexual violence and violation of a woman's right to live a healthy life, free of HIV and related illness.

4. **How many people know their status ?** : Knowledge of one's HIV status is important both to the person concerned and to the larger effort to bring the epidemic under control. If an individual knows his/ hers status while still HIV, with good counseling they can build the motivation to adopt a safe, healthy life style thus delaying the onset of declining health and development of AIDS. In addition, people who know themselves to be HIV+ tend to behave responsibly and take care not to infect other people. If an individual is already AIDS, early treatment can stop the progress of the disease becoming worse. New studies (2011) have found that early and consistent use of ARV by PLHIV can reduce transmission of infection by as much as 96%.[19]

   In June 2006 only 5.6% of the total number of people estimated to be living with HIV (PLHIV)[20] knew their status. By June of 2011 that number had risen 10 times over. Fifty percent (50%) of the estimated PLHIV[21] knew that they were HIV+. The more people who know their HIV status the more people can benefit from services intended for their care, support, and treatment in public, private and community-based facilities including peer support groups (kelompok dukungan sebaya-KDS) found in 27 provinces. Across Indonesia today many people who are HIV+ become informed advocates and activists educating others about HIV and AIDS, how to avoid infection, and how to live a full life even if HIV positive.

Chart 2: Percent of people knowing their HIV status, 2006 and 2011 (30 June)



Source: Data from MoH 2nd quarter report (June) 2006 and 2011 on Situation of HIV and AIDS in Indonesia.

5. **Expansion of VCT Services** : There is only one way to know if a person has been infected with HIV : a blood test with pre- and post- test counseling (VCT) to understand how the test will be carried out and what the results mean - the sequence being referred to as VCT, short for Voluntary, Counseling, and Testing. In 2005 it was estimated that there were 51 VCT sites providing service in seven provinces.[22] In June of 2011 the Ministry of Health reported 388 active VCT sites located in 142 districts/ cities across Indonesia[23] including 14 in facilities of the Corrections Division of the Ministry of Justice and Human Rights across the country.

   It is hoped that Provider Initiated Counseling and Testing (PICT) which is already underway and scheduled for expansion will help increase access to this important service. (See point 6, below, on expansion of ARV treatment).

   Physical access, of course, is not the only challenge in scaling up provision and utilization of VCT and other services. While small studies of quality of service make clear that with adequate training, supervision, and motivation, facilities can provide consistently acceptable service.[24] it is also true that achieving and maintaining high quality service in the large, decentralized public health service is a challenge.

Providing information about HIV and AIDS at a community health center

6. **Anti retroviral treatment (ARV treatment)** : In the early years of the epidemic there was no known treatment and once a person was infected with HIV it was expected that she/ he would not have more than a few years to live. That is no longer true. ARV treatment, first made widely known in 1996[25] was quickly approved by the Department of Health for use in Indonesia (1997). However, approving its use was only the first step in an evolving process.

   Around the world a significant obstacle to availability of this life extending treatment has been cost. Indonesia was no exception. ARV treatment was out of reach of most patients particularly since once initiated, it must continue for life. In 2000, Indonesia began to import generic ARV medication from India and in 2003 Kimia Farma (Indonesia) began assembling ARVs from imported materials.[26] In 2004 the Minister of Health designated 25 hospitals as ARV treatment sites in 14 provinces* and, using resources from Global Fund to purchase the drugs, provided ARV treatment free of charge[27] in those locations (see **Annex 9** : for hospitals included). By 2010, the costs for ARV in Indonesia were covered jointly by APBN (70%) and Global Fund (30%),[28] an important step toward sustainability of service.

   The network of hospitals providing service had grown to a total of 148 in 2007,[29] and by June 2011 totaled 218 hospitals with 68 associated satellite public health centers.[30] (see **Annex 6** : locations listed by Ministry of Health, July 2011). The to-

* *SK MenKes 781/ MENKES/ SK/ VII/ 2004*. Sumatera Utara, Sumatera Selatan, Riau, Kepulauan Riau, DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Bali, West Kalimantan, South Sulawesi, North Sulawesi, Papua. [note: locations designated for Papua 2004 included one in what is now province of West Papua.]

tal number of patients receiving regular ARV had reached 21,347 by 30 June 2011, 55.7% of those who have ever received ARV,[31] a vast improvement over the days when only a few private patients were being treated. However, that number still falls far short of the total whose lives could be improved and extended by regular consumption of ARV. Furthermore adherence -- continuation with treatment -- has fluctuated since it began, never rising higher than 2009 when 60.8% of those who had started treatment were still taking ARV at the end of the year. The regular MoH quarterly report on the "Situation of HIV and AIDS" in Indonesia indicates that in other years continuation of treatment fell below 60%.[32]

Issues of logistics (transportation, stock, storage, reporting), diagnosis, prescription and accessibility remain to be solved on the "delivery" side. Issues of understanding, access to regular supply, support and adherence to prescription remain to be solved on the "demand side". These are concerns addressed in community and health system strengthening presently underway and planned by the Health Sector for continued expansion with Global Fund support.

7. **Services related to harm reduction** : Through a combination of policy change, achieved through intensive advocacy, and phased program development, Indonesia has increased availability of both needle-syringe programs (NSP) and Methadone Maintenance Treatment (MMT) making it possible to manage drug-related addiction and reduce HIV and other infections resulting from the use of non-sterile injecting equipment by PWIDs. Where in 2000-2002 there were no public services available and HIV infection among injecting drug users was found to be as high as 50% in some settings,[33] by 2011 there were nearly 200 (194) needle syringe programs located in public health centers and NGO facilities in 23 provinces across the country.

   MMT services also had increased from only 3 sites (2005) to a total of 65 sites in prison and public health centers. Availability of funds from AusAID and the Indonesian Partnership Fund made initial rapid scale-up possible with the Australian-supported AIDS program (IHPCP) and the USAID-supported work of FHI providing technical support.[34] Work continues presently with funding from multiple sources - Indonesian national budget (APBN), local budgets (APBD), the current Australian program (HIV Cooperation Program in Indonesia, HCPI) and Global Fund.

Table 6 : Increase in availability of Needle Syringe Program (NSP) and Methadone Maintenance Treatment (MMT). 2005 - 2011

	2005	2006	2011
Needle Syringe Program - Public Health Centers	10	65	160
Needle Syringe Program - NGO based	7	55	34
Needle Syringe Program - Total	17	120	194
Methadone Maintenance Therapy - Prison, hospital and Public Health Centers	3	11	65

Source: National AIDS Commission Monitoring through Jun 2011

Over time, Indonesia became a destination for study visits, Malaysia and Myanmar in 2008 and a pair of visits from Afghanistan (Oct 2010 and Jan 2011) coming to learn about management and implementation of harm reduction in an Islamic setting. In the course of the two Afghan visits a broad range of people-- government officials from the Ministry to Counter Narcotics, the Ministries of Public Works, Justice, and Women's Affairs, a number a medical doctors, a specialist in development of IEC material and several religious leaders -- were exposed to Indonesian work. Their visit included consultation with AIDS Commissions at National and local level, Ministry of Health, Provincial health departments, NGO service points, PWIDs, and public health officials.

8. **Services for Prevention of Sexual Transmission.** Sexual transmission has always had an important role in the growing epidemic in Indonesia. Even as injecting drug use grew to be the dominant source of new infection, sexual transmission continued to be important. Various approaches to condom promotion were used with only minor benefit. Evidence provided by IBBS 2007 (MoH and BPS), and NAC's 2009 mid term review of implementation of the National AIDS Strategy and Action Plan 2007-2010 confirmed that condom use was hardly changing and sexually transmitted infection continued high particularly among female sex workers and the transgender community. The decision was taken to develop another approach. Discussion culminated in development of a structural intervention for prevention of sexual transmission (PMTS). Built around 4 principle components, PMTS was tested, found promising, and is now one of the principle strategic programs in the national scale-up of the comprehensive response to HIV and AIDS being carried out with Global Fund Support.

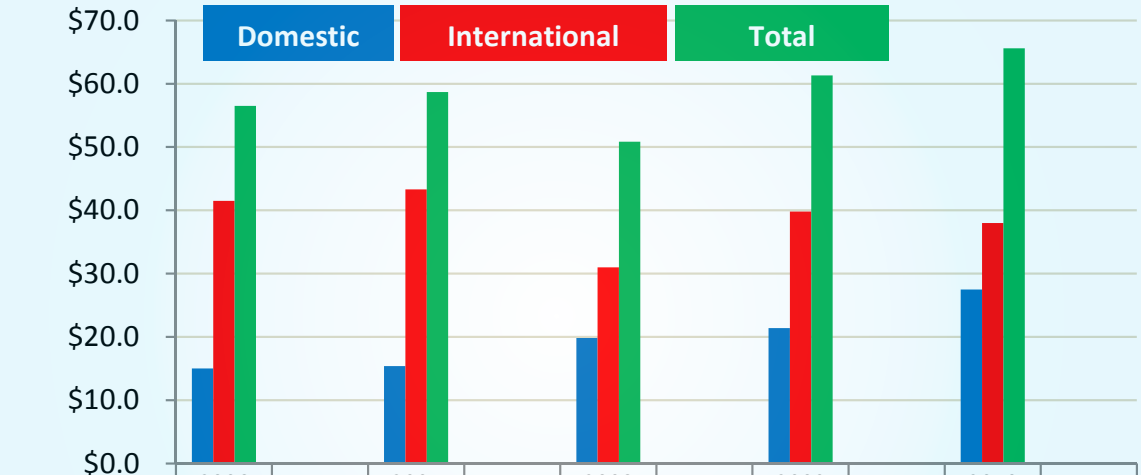
   As of July 2011 more than 13 million male condoms and nearly 550 thousand female condoms were distributed through 4,066 condom outlet. More than 600 sex workers have been trained in pilot testing of a training module which will ultimately

be used with 10,000 sex workers across the country. Already launched in 72 locations, PMTS will be operational in 159 locations before 2015.

B. Funding of the response

Indonesia's progress toward self reliance in funding of the national response to HIV and AIDS has increased steadily over the years since 2006 when only 26.58% of the total expenditures came from national, provincial, or district/ city resources.[35] By 2010, the total budget had grown overall from US$ 56,576,587 to US$ 65.6 million and Indonesian resources were covering 48.95% of the total,[36] including funds from 33 provinces and 166 districts/ cities.

Chart 3: AIDS Expenditures, domestic & international (2006 – 2010)
(in millions of US$, by source)



	2006		2007		2008		2009		2010	
Domestic	$15.0	26.58%	$15.4	26.27%	$19.8	39.03%	$21.4	35.00%	$27.5	42.00%
International	$41.5	73.42%	$43.3	73.73%	$31.0	60.97%	$39.8	65.00%	$38.0	58.00%
Total	$56.5		$58.7		$50.8		$61.3		$65.6	

Source: NAC, NASA reports 2006 - 2008. NASA Preliminary report (unpublished) for 2009 and 2010.

In terms of budget there is also significant progress at the national level. While in 2006 confirmed budget of 11 sectors reached Rp. 118.6 billion by 2011 19 sectors had AIDS budgets totaling Rp. 856.281 billion.

Table 7: Increase in participation of provinces and districts/ cities in the funding of HIV and AIDS expenditures

	2006 (1)	2010 (2)
Provinces allocating budget for AIDS	19	33
Districts/ cities allocating budget for AIDS	73	166

Source: (1) NAC, National Spending Assessment, 2006-2007, published. (2) Preliminary draft for 2010.

Particularly noteworthy related to finance was the fact that, in line with Presidential Regulation 75/ 2006 (art. 15) and article 13 of decree 20/2007 of the Minister of Home Affairs, by 2011 the full costs of the secretariats of the AIDS Commission of 63 districts and 9 cities in 24 provinces* which had heretofore been paid for by the Indonesian Partnership Fund were covered 100% from their own resources (APBD). (see **Annex 5** for secretariats of 72 district and city AIDS Commissions paid for 100% from local resources). Given the intense competition for funds from local resources this would appear to be an indisputable indication of the growing recognition at least in some areas of the importance of addressing HIV and AIDS. It is also important for our national self respect as acknowledgement of the fact that the welfare of the Indonesian people is our own responsibility and we should not be dependent on external support to meet our obligations.

C. Management of the response

At the time of the Sentani Commitment (2004) only a limited number of Provincial AIDS Commissions were active beyond those of the 6 provinces that had signed the Commitment. By 2007 there were 23[37] provinces with functioning AIDS Commissions. By 2011 all 33 provinces had active AIDS Commissions managing funds from various sources including national budget (APBN), local budgets (APBD), Global Fund and AusAID. The relative size, experience, and effectiveness of the AIDS Commissions varied greatly. Some were only just getting organized, learning about HIV and AIDS and becoming acquainted with their tasks. Others, for example Bali, DKI Jakarta, and West Java have been planning, coordinating, and managing the response in their respective areas, facilitating the development and monitoring of innovative work since at least 2004. They have earned credibility in the eyes of many partners for their program and management skill and expertise. Although domestic resources for the AIDS Commission system were severely limited at all levels, with the support of the

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

Indonesian Partnership Fund, particularly during the period 2006 to 2008, development of the network of AIDS Commissions at the district/ city level was able to proceed. (see **Table 24** for information on IPF support to strengthening of the AIDS Commission system). In 2006 there were 73 AIDS district and city AIDS Commissions active in 19 provinces.[38] At the close of 2010 there were 166 and by July 2011 there were 173 spread across 33 Prov.[39]

Table 8: Expansion of AIDS Commission network 2006 to 2011

	2006	2007	2008	2009	2010	2011
Districts/Cities	105	105	170	170	166	173
Prov	19	22	33	33	33	33

Source: National AIDS Commission monitoring and IPF reports 2006-2011

D. Actors in the national response

The number of people and institutions active in the response has grown in quantity, diversity, skill, and expertise. Equally important positive activism related to HIV and AIDS has become increasingly widely distributed across the country during the five years since Presidential Regulation 75/2006 went into effect.

During this period, five national networks of organizations of the key affected populations have been established (see **Table 9**) at the national level. They are developing branches, their planning and management skills, and activity at provincial level as advocates, participants in policy making, and AIDS educators.

Organizations of people who are HIV+ in peer support groups of various sorts started at the local level in many areas already in the 1990s. Some groups started in association with the national NGO, Spiritia (founded in 1995), others on their own. These groups are crucially important mechanisms for education and support of positive people where ever they are found. Likewise, as members of AIDS Commissions, issue-focused working groups, and participants in organization of pubic events such as commemoration of World AIDS Day (1 December each year), the Candlelight Memorial (May each year) and other public events they play an important role in AIDS education. By September 2011 Spiritia reported the network of support groups working with them had grown to 200 groups in 121 districts/ cities across 21 provinces. Cumulatively they have served more than 23,500 group members directly[41] and indirectly, many times over that number as family and intimate friends of PLHIV took part in their activities.

Table 9 : National networks of key affected people

Organization	Found-ing	Provinces	Principle Program concerns
Network of HIV Positive Women of Indonesia. Ikatan Perempuan Positif Indonesia. (IPPI)	2006	22 Prov	That women who are HIV+ and those affected by HIV to have quality of life equal to other Indonesian women in particular related to health, social status, education, and economic participation and well being.
National Network of Gay-Transgender-and Lesbians. Gaya Warna Lentera Indonesia. (GWL-Ina)	2007	19 Prov with 37 members organizations in the network	That individuals and the community of GWL-INA prevent transmission of sexually transmitted infection including HIV and have the care, support and treatment they need based on the principle that sexual and reproductive health are human rights.
National Network of People Infected by HIV. Jaringan Orang Terinfeksi HIV Indonesia. (JOTHI)	2007	25 Prov	That the rights of positive people are defended through policy development and monitoring implementation of policy.
National Network of Victims of narcotics, psychotropic drugs and other addictive substances. Persaudaraan Korban Napza Indonesia. (PKNI)	2007	12 Prov	That PWID have same rights as others and contribute to realization of social justice.
National Network of Sex Workers. Organisasi Perubahan Sosial Indonesia (OPSI)	2009	23 Prov, 15 of which have had prov congress[40]	To contribute to empowerment of sex workers and to realization of a country where the rights of sex workers are respected, protected, and fulfilled.

Source : Information provided by respective organizations answering questionnaire of NAC, May 2011.

First National Meeting of Waria in January 2009, Bogor. Pictured together with Dr. Nafsiah Mboi, Secretary of National AIDS Commission

Civil society organizations (NGOs, faith based, academic) focused on HIV advocacy, rights, education, and service or including these activities in on-going programs are multiplying across the country and play increasingly important roles as partners in the response at national and sub-national levels working with AIDS Commissions and government, with communities of key affected people, with PLHIV, and a broad range of other activists in the community.

A small group of long-standing NGOs were among the early pioneers particularly in Jakarta, Bali, Surabaya and Medan before there were organized government response on any scale. They led in early work related to care and treatment, development of peer support groups, work with the full range of key affected populations, and initiated programs of AIDS education in the workplace. They have continued their service, shared experience, and continued as important partners as the broader national program has evolved.

The importance of the NGO community, its contribution to the field of HIV and AIDS, its activism, and its wide distribution across the country has been demonstrated also in

their response to "calls for proposals" opened by Indonesian Partnership Fund (IPF) managed by the National AIDS Commission secretariat. One component in the IPF work program is a small grant program. Since 2008, the IPF has issued 3 successive calls for proposals[42] from NGOs active in the field of HIV and AIDS. In 2008 one hundred nineteen (119) NGOs serving 18 provinces from Aceh to Papua submitted proposals. Nine were supported with total funding of Rp. 8.872.062.000 for activity reaching 18 provinces. The following year the IPF received 89 proposals 7 of which were supported with activity in 13 provinces for a similar opportunity. In early 2011 a call for proposals went out, specifically seeking to support NGO work focused on reducing sexual transmission in Java using the approach of "structural intervention" (PMTS).[43] Even then, there were 33 proposals 13 of which were selected to receive support.

Table 10 : IPF Small grants program. Awards 2008 - 2011(*)

Year	Rp. Grant	US$ equivalent	Proposals received	Activities supported	Number of Provinces with active.
IPF - 2008	Rp 8.872.062.000	$ 1,043,772	119	9	18
IPF - 2009	Rp 5.087.235.400	$ 598,498	89	7	13
IPF - 2011	Rp 4.676.381.400	$ 550,163	33	13	5

Source : Regular IPF reports 2008 - 2011

(*) Call for proposal in 2011 focused on proposals to contribute to expansion of PMTS coverage in Java

Civil society organizations are also full partners in the national scale-up of the comprehensive response to HIV and AIDS which is presently underway with financial support from Global Fund. As mentioned above, during the period 2009 - 2015 Global Fund will provide support to Indonesia through 4 principle recipients including 2 civil society organizations, the Indonesian Planned Parenthood Association and Nahdlatul Ulama (NU).

Turning to government actors in the response, the executing team (tim pelaksana) stipulated in Presidential Regulation 75/ 2006 (Chapter 2, part 2, Article 5), has been the key to dialogue, consultation, and collaboration which has mobilized steadily increasing government commitment and multi sectoral action related to the epidemic since Presidential Regulation 75/ 2006 came into effect. Chaired by the Secretary of the National AIDS Commission, the executing team consists of representatives of institutional members of the National AIDS Commission both from government and outside. The team meets regularly 4 times a year (January, April, July and October) with members hosting meetings in rotation at their respective offices/ headquarters. Meetings have focused on sharing activity reports, discussion of planning and organizational issues related to the response, as well as a regular update on the epidemic and

Indonesia's response. As appropriate and in harmony with the government national planning cycle, discussions also may focus on issues of sectoral program development and budgeting as well as synchronization and complementarity of national programs and international support for AIDS-related work.

Candlelight Memorial to honor the memory of those who have died from AIDS-related causes.

During assessment of implementation of the Sentani Commitment (late 2004 and early 2005) the multi-sectoral evaluation team[44] came "reluctantly to the conclusion that in general little progress had been made in mobilizing wide reaching, synergistic, effective sectoral and multisectoral work related to prevention of HIV infection or support for the ever growing numbers of people and communities living with AIDS in Indonesia."[45] Little seemed to have changed between that situation and a year later when the Presidential Regulation 75/ 2006 was issued. In 2006 - 2007 still only a few government departments/ institutions had their own active AIDS working groups or sectoral AIDS budgets of any size.

Since then there has been significant change. By 2010-2011 nineteen governmental members of the National AIDS Commission had confirmed program budgets for education of their own staff and for work within the framework of their own technical field of work (see **Table 12**). Many also had functioning AIDS Working Groups, and several had sectoral AIDS work plans.

In 2010 two more major steps forward were taken toward full integration of the response into Indonesia's overall development efforts, and thus progress toward more assured sustainability of the work. In January Presidential Regulation 05/ 2010 was issued and came into effect[46] laying out Indonesia's mid-term development program and including discussion of the importance of the sustained and multi sectoral response to the HIV epidemic. In April the President issued instruction 03/2010 for

development with justice[47] including, among other things a call for intensification of Indonesia's efforts to achieve the Millennium Development Goals (MDGs) including Goal Six focused on HIV and detailed with specific AIDS related indicators. These two actions gave the response to HIV an undisputed place in the national development agenda, a strong platform for continuing advocacy and action to broaden the scope of AIDS partnership across government at all levels.

As will be discussed below in chapter 3, a number of Indonesia's international development partners have played a longstanding role supporting development of the response to HIV and AIDS contributing both funds and technical support. Since Presidential Regulation 75/ 2006 the national response to the epidemic has matured and become more clearly defined as well as more decisively and professionally managed. Work with international development partners likewise has matured becoming more consultative. In line with the Paris Declaration on AID Effectiveness (1995) bilateral, multilateral, as well as international NGO work has become progressively better integrated in the overall national effort as set forth in successive National Action Plans than was previously possible.

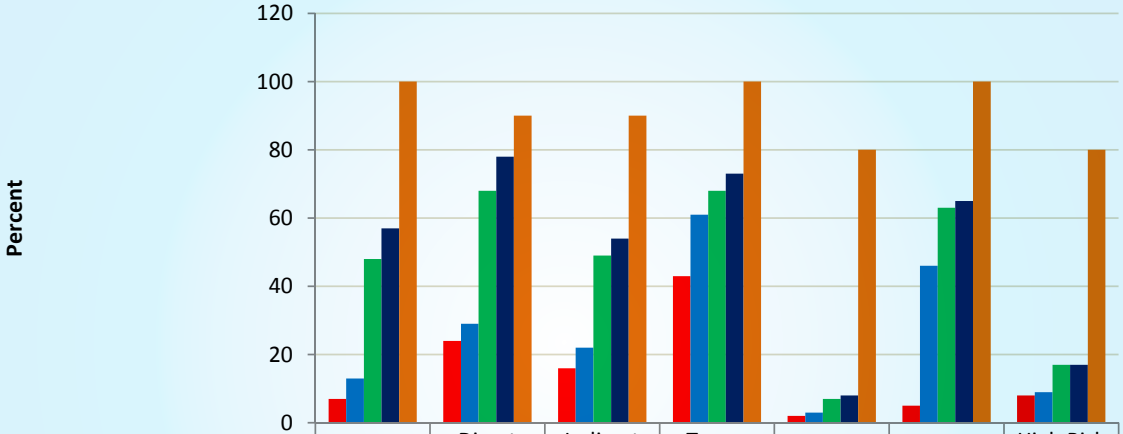
E. Coverage and Effectiveness

In successive National AIDS Action Plans of the NAC[48] two fundamental targets (related to Indonesia's efforts to control the epidemic) have been 1) to achieve coverage of 80% of key affected populations (PWID, sex workers -- male, female, and transgender --, men who have sex with men, high risk men, and prisoners) as well as general population in Tanah Papua and PLHIV and 2) the practice of safe behavior by at least 60% of them. If those targets are reached, growth of the HIV epidemic in Indonesia will begin to slow and thereafter begin to decline. Likewise sexual partners of all will be at reduced risk of new infection contributing, again, to overall reductions in new infections.

Monitoring of progress between 2006 and 2011 (see **Chart 4** below) found coverage improving steadily. The most modest increase, only 6% points (from 2% - 8%) occurred among men who have sex with men. The largest increase, 60% was in the prison population reflecting the policy decision by the Directorate General of Corrections to develop and progressively integrate a comprehensive response to HIV (including harm reduction and sexual transmission) and related health problems within the prison system. Overall, from 2006 to 2011 one sees a dramatic improvement in coverage going from just over 339,245 people to slightly over 900,000 people (917,000) in 2011.

Initial priority was given to bringing down the high levels of new infection among PWID, an effort which has had some success (see below). With Harm Reduction well launched, attention was given to strengthening effectiveness of sexual transmission with (2008-2009) organization, testing, and starting in 2009, scale-up of prevention of sexual transmission (PMTS) using the new, more effective structural intervention. As of 30 June 2011 PMTS is incorporated in the comprehensive response being phased in 159 districts/ cities (137 with full support of Global Fund; 22 district/ cities with joint funding of APBN, GF, and IPF). It is anticipated that this will produce a significant increase in coverage of most key affected populations. Complementing this effort is the new (2011) strategy with and for high risk men, a public private partnership with financing from government and private sector. Similarly, the 2011 program of capacity building and action research was developed to increase understanding of the needs, challenges, and interests of the community of MSM and how better to partner and serve them.

Chart 4 : Percent coverage of key affected populations from 2006 to 2010 and target for 2014



	PWID	Direct FSW	Indirect FSW	Trans-gender	MSM	Prisoners	High Risk Men
2006 (Baseline)	7	24	16	43	2	5	8
2009 (against est. 2006)	13	29	22	61	3	46	9
2010 (against est. 2009)	48	68	49	68	7	63	17
Jun 2011 (against est. 2009)	57	78	54	73	8	65	17
NASAP Target 2014	100	90	90	100	80	100	80

Sources : 2006, IBBS MoH and BPS estimate[49]; 2009 and 2010, NAC Monitoring

Converted from percentages to people reached, the figures would be as follows :

Table 11 : Reported outreach contact with Key Affected Populations 2006, 2009, 2010 and Jun 2011(*)

	2006	2009	2010	Jun 2011
PWID	15,340	29,575	50,669	60,227
Female Sex workers - Direct	25,644	40,029	72,435	82,384
Female Sex Workers - Indirect	14,875	21,895	53,266	58,244
Transgender	11,252	18,518	21,855	23,269
MSM	15,336	21,358	47,590	54,836
Prisoners	3,845	45,865	88,392	91,948
High Risk Men	252,953	288,577	524,089	546,796
	339,245	**465,817**	**858,296**	**917,604**

Source : National AIDS Commission monitoring Verified.
(*) no comparable data available for 2007 and 2008

While it is encouraging to have increased coverage 3 times over, nonetheless major challenges remain to reach targets set for 2014.

And what do we know about effectiveness?

PWID : Comparing the data on reported new AIDS for the second quarter of 2006 (30 June) and the second quarter of 2011 we see a major drop in contribution of injectinG drug use as the cause of infection. At the end of June (2006) 54.4% of reported new AIDS was attributed to injecting drug use. By the end of June 2011 only 16.3% of new AIDS identified injecting drug use as the mode of infection.

A number of factors working together have contributed to this outcome :

- Sharing of needles and syringes (which exposes the user to extremely high risk of HIV infection if another user is HIV+) was still common in 2005-2006. As programs to reach PWID increased both their coverage and effectiveness, PWID came to understand the dynamics of infection, increased their use of MMT and NSP programs as they became more widely available through the public health system. Results of both IBBS in 2007 and the Rapid Behavior Survey of 2010 show those "not sharing needles in the past week" having risen above the critical SRAN target of 60%. It is noteworthy also that the Rapid Behavior Survey

also indicated 61% of PWID reported not having shared needles "in the past month", again, above the critical 60% target of SRAN. (see **Chart 5** and **Chart 6**).

- Coverage of PWID increased significantly from 7% in 2006 to 57% by June 2011. They are getting more information.

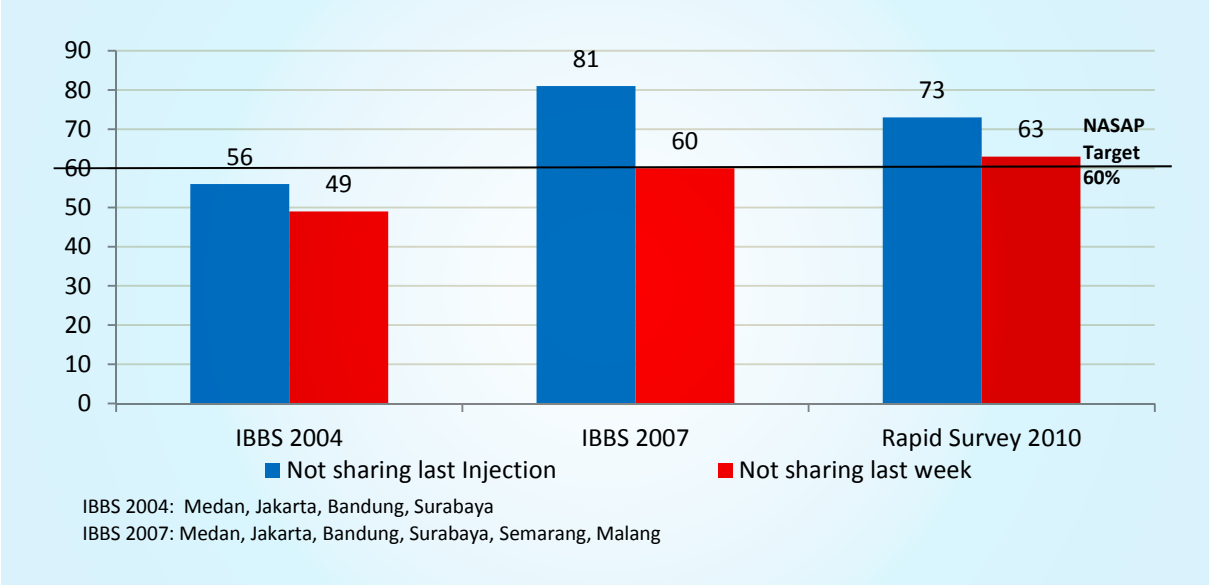
Example of information about HIV and AIDS for different audiences in different parts of Indonesia

- Positive changes occurred in the policy environment permitting accelerated expansion of appropriate service programs integrated in existing service systems. (see **Box 2** in chapter 3 showing evolution of the legal and regulatory environment)

- Flowing from improvement in the policy environment, access to NSP and oral substitution facilities increased rapidly both in number and geographic distribution (see **Table 6** and **Chart 10** for year by year data) between 2006 and 2010

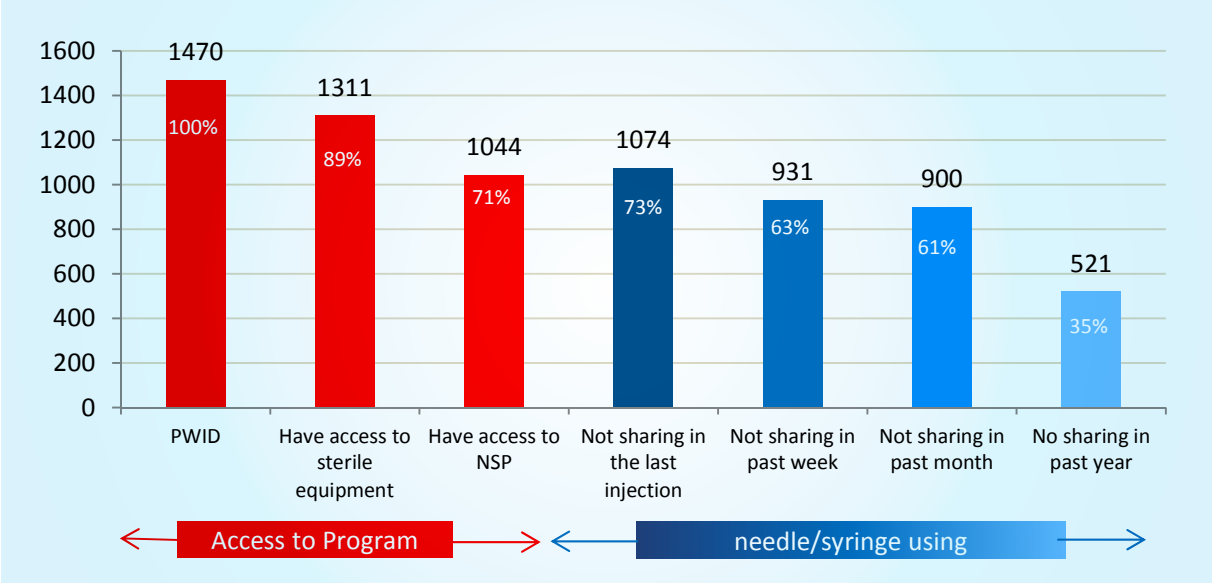
- The Rapid Behavior Survey (2010), **Chart 6**, below, further showed that already 89% of PWID indicated they had access to sterile equipment, while somewhat fewer (73%) had access to NSP. While full interpretation of this result will need further confirmation, it suggests that by this time some PWID were taking more responsibility for their own health by buying and using their own equipment.

Chart 5 : Percent of people who inject drugs NOT sharing needles 2004, 2007, and 2010



Sources : MoH and BPS. IBBS 2004 and 2007. NAC. Rapid Behavior Survey 2010.

Chart 6 : Program access and Injecting behavior among People Who Inject Drugs



Source : Rapid Behavior Survey, National AIDS Commission, 2010.

There remain many challenges for continued expansion and support of the well distributed Harm Reduction programs of the public health service, prison, and community systems, between 2006 and 2011. On the other hand, the results achieved thus far appear to provide a strong, Indonesian demonstration of the benefits of comprehen-

sive, well targeted action on multiple fronts related to policy and program, working in a collaborative manner (PWID, government policy makers, service providers, outreach workers and community/ family support networks).

Sexual transmission : Effectiveness of work to bring sexual transmission under control depends on behavior change : 1) reduction or elimination of risk behaviors and 2) consistent and correct use of condoms. Here is where Indonesia's "total football" becomes important -- some basic information and messages for everyone, some tailored to different audiences and different levels of risk and vulnerability to HIV infection. For example,

- Everyone at risk needs to have accurate understanding about HIV, modes of infection, alternatives to avoid infection, and how PLHIV can live full, responsible lives.
- Everyone, general public, key affected populations, policy makers and service providers need education about causes and symptoms of stigma and discrimination and the fact that they are unacceptable.

Beyond that,

- For some people, further discussion and action focused on strengthening of religious values and family resilience is important along with special efforts for empowerment of young people with knowledge and skills to stay free of high risk behavior.
- For other people, who because of their work or life style, are at high risk of infection, information and services to promote pro-active, safe behavior and availability of services are crucial -- access to condoms and lubricants, training in their use, creation of environments encouraging condom use, access to treatment of sexually transmitted infection as well as counseling and testing.

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

Historically condom use in Indonesia has been low. In spite of considerable effort in the early years of HIV and AIDS to increase condom use the persistence of low use severely hampered efforts to reduce sexual transmission of HIV. In more recent years evidence from Indonesia and abroad has shown that comprehensive work with people and institution in "hot spot" areas can increase condom use with corresponding reduction in sexually transmitted infection including HIV.[50] Building on this limited experience, expanding and intensifying empowerment of sex workers (male, female, and transgender; direct and indirect) involvement and responsibility of a wide range of local stakeholders, and partnership with health services Indonesia has developed and with initial financial support of Global Fund and IPF in scaling up implementation in strategically targeted locations -- 159 districts/ cites in 33 provinces this "structural intervention" package for prevention of sexual transmission of HIV (PMTS). This whole effort is accompanied by significant increase in outlets for sale/purchase of condoms and lubricants convenient to sex workers (direct and indirect, male, female, and transgender) and their clients.

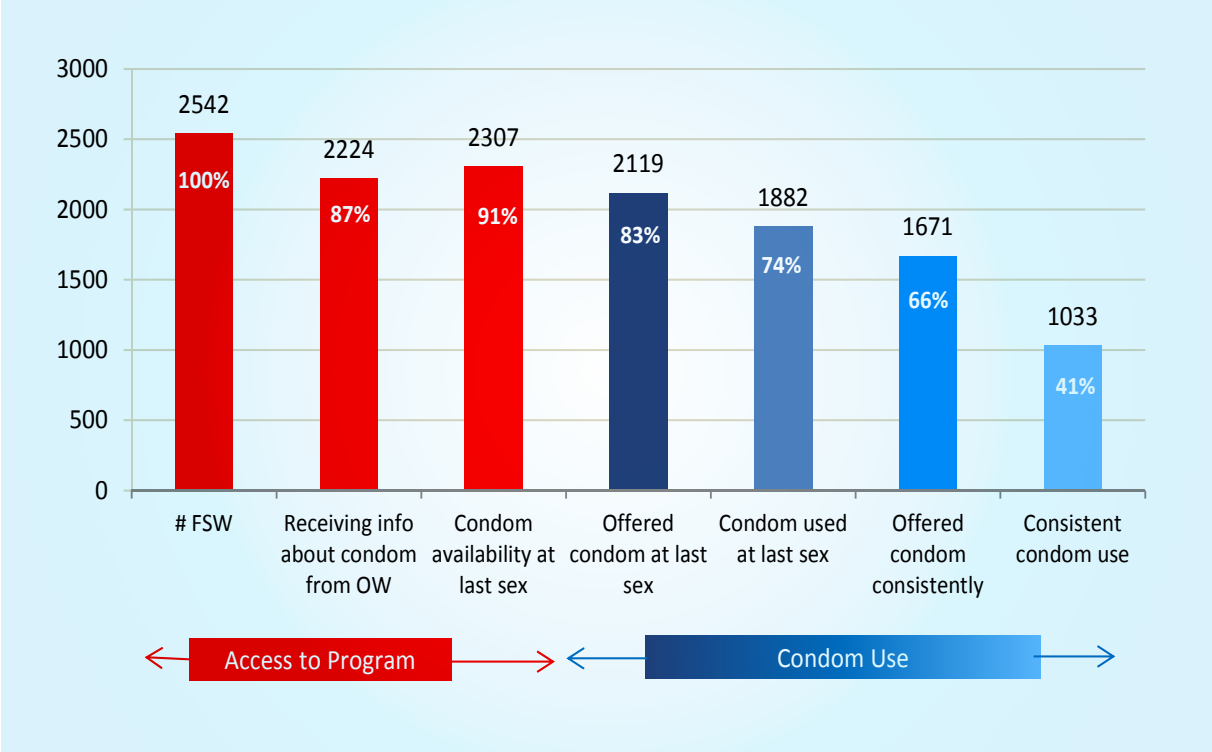
Although launched only in mid 2009, nonetheless preliminary reports are promising in terms of numbers of condom/ lubricant outlets as well as condom distribution and condom use. By June 2011 3,466 distribution outlets for male condoms, 1,762 outlets for lubricants, and 600 outlets for female condoms were operational. Between July 2009 and July 2011 distribution was as follows :[51]

- nearly 14 million (13,830,854) male condoms
- 1,069,387 lubricant packets, and
- 548,000 female condoms

These condoms were provided free to lower paid sex workers while promotion of condom use also incorporates the message of self reliance, advocating purchase and consistent use of condoms as a sensible action to protect one's own health. Commercial marketing of condoms continued during this period and rose in annual sales from a total of 69,587,608 pieces in 2006 to 116,701,048 pieces in 2010.[52] It has been suggested that the increase of 23,140,424 between annual sales of 2009 and 2010 may reflect positive impact of experience with free condoms leading more men to be willing to purchase their own condoms – in short, it may be that the free condoms are contributing to "demand creation" for commercial sale of condoms.

Findings of the mid term evaluation of progress on the national response (2009) also confirm increasing access to information and services by sex workers as well as encouraging levels of condom use in some cases -- 74% in last sex for female sex workers.

Chart 7 : Condom use reported by female sex workers, 2010



Source : Rapid Behavior Survey, National AIDS Commission, 2010

What happened between 2006 and 2010 to make the changes we have reviewed possible? How well established are the systems to address the challenges ahead? The remainder of this report examines those issues and closes with projections for the future and recommendations.

03

Managing the Change: Building the Systems and Putting Them to Work

THE TRANSITION FROM A RESPONSE BASED ON EXTERNAL FUNDING, carried out in scattered locations, without overall national coordination or management to a comprehensive, national response based on analysis of the epidemic, the subject of regular monitoring and progressively integrated into Indonesian government and community systems reflected a conscious change in strategy and policy adopted shortly after induction of the secretary of the newly designated AIDS Commission. Throughout the five years since, policy, planning, and program development, mobilization and strengthening of human and financial resources, as well as nurture of diverse partnerships have all been focused on a systematic, phased process toward the establishment of that national system.

The start up : Simultaneous early priorities for the new AIDS Commission were (1) restructuring of its secretariat to lead the planning, coordination, and monitoring of the comprehensive national response called for in Presidential Regulation 75/2006 as well as to provide direction to the AIDS Commissions at the Provincial and District/ City level, (2) staffing of the newly conceived secretariat through a process of open recruitment to find, train, mentor, and supervise appropriately qualified professionals,[53] and (3) preparation of a new national AIDS strategy, followed by development of Indonesia's first, costed National AIDS action plan.

With no or very limited domestic funding yet allocated to support AIDS Commissions or the information, supplies, and services needed, Indonesia was fortunate to have received a major, multi-year grant, GB £ 25 (US$ 47 million) starting late in 2005 through 2008 from the United Kingdom (UK) The primary purposes of the funds were to support scale-up of locally appropriate activity with and for key affected populations and to support Indonesia's evolving, comprehensive and multi-sectoral response[54].

From 2007 on the Coordinating Minister of People's Welfare (Chair of the NAC) chaired a Steering Committee of the Indonesian Partnership Fund which served as the senior oversight body for the IPF. Representatives of the Indonesian government, international development partners active in the national response, as well as civil society and PLHIV all had seats on the Steering Committee. Flowing from the collaborative system through which IPF resources were managed, the Fund also stimulated dialogue and participation among partners to the national response contributing to increased harmonization among programs supported by different partners in the national response.

IPF funds were already in place as the secretariat of the new AIDS Commission was designed and taking shape (2006-2007).[55] In the absence of national budget, IPF provided the National AIDS Commission secretariat the necessary resources to do three things :

1. start work immediately -- staff recruitment, a succession of phased planning, training, and management development activities for AIDS Commissions across Indonesia, and at the same time
2. continue support for expansion of activity with and for key affected populations.*
3. develop a new National AIDS Strategy and Costed Action Plan based on strategic information on the epidemiology of the epidemic which became available during 2006 – new estimates of a) the numbers and distribution of key affected populations and b) PLHIV as well as c) the integrated bio-behavior surveillance (behavior and HIV) among the general population aged 15 – 49 in Tanah Papua.

At the time IPF was starting up (late 2005-early 2006) the major action programs related to HIV and AIDS were led by Australian- and US- supported teams working primarily on a localized basis with Indonesian NGOs, some AIDS Commissions and some government technical departments.[56] Accordingly, working agreements were made for IPF funds to support the expansion of these on-going programs in 11 provinces.†

Early in 2007, the Coordinating Minister for People's Welfare/ Chair of the National AIDS Commission issued a series of regulations establishing structure, division of labor, and guidelines on monitoring and evaluation for the National AIDS Commission and AIDS Commissions across the country.[57] By February newly recruited senior and mid level professionals were in place and revision of the new National Strategy was completed. On 12 March 2007 the Strategy was released[58] with 7 substantive priority areas

- Prevention of HIV and AIDS and STIs (sexually transmitted infections),
- Care support and treatment for PLHIV,
- Surveillance of HIV and AIDS as well as sexually transmitted infection,
- Research especially operational research
- Promotion of environments conducive to the comprehensive, integrated, inclusive response
- Coordination and harmonization among partners
- Mobilization of domestic resources for sustainability of the response

Immediately thereafter the Secretary of the National AIDS Commission called for development of Indonesia's first costed action plan to guide development of a coher-

* By 2008, the end of the Partnership Fund's first phase of work, 75% of the funds had been used for scale-up of essential activity, 18% for support of the newly constituted secretariat of the National AIDS Commission and secretariats of AIDS Commissions across the country, and 7%, an administrative fee paid to the UNDP for services as Fund Manager.

† North Sumatera, The Riau Islands, Riau, DKI Jakarta, West Java, Central Java, East Java, Bali, NTT, Sulawesi Selatan, West Papua, Papua.

ent national response moving toward the coverage and effectiveness needed to have epidemiological impact. Based on a variety of local and national data related to the epidemic -- its intensity, distribution, and populations most at risk of infection[59] -- the plan would serve as the basis for dialogue and advocacy with domestic and international partners, thereby promoting a more focused and integrated response. It also provided the starting point for development of a national monitoring and evaluation system.

The geographic focus for the plan was based on results of the careful 2006 estimation of size and distribution of key affected populations including PLHIV across Indonesia which had been carried out by the Ministry of Health and the National AIDS Commission consultation with provincial authorities. This process pointed to 19 provinces, home to 80% of Indonesia's key affected populations,* to be given priority in development and implementation of action during the period 2007-2010.

As stated in the introduction to the Action Plan, initial program efforts focused on the use of interventions already proven effective in reducing the pace of infection both in Indonesia and globally.[60] However, the multiple program components of prevention, counseling, testing, care, support, treatment, and mitigation of impact were conceived of not as separate programs but as part of a comprehensive, integrated approach -- "total football" -- to defeat the virus. Establishment and strengthening of management systems including monitoring and evaluation at national and local level had a crucial role in the 2007 - 2010 action plan, as well.

In the longer run, the national response would be expanded as quickly as possible in terms of both finance and management capacity. In fact, within less than a year (early 2008) strategic data collection and planning were already underway for Indonesia to apply for major new funding from the Global Fund to support continuation of the planned, selectively targeted, scale-up of the national response. The emphasis was always on prevention but also included the full continuum of care, support, and treatment as well as building of the systems -- health, community, and management -- needed to sustain and expand action.

The commitment to start with methods proven effective was not the end of program design and development for Indonesia. It was, in fact, the beginning. As new challenges in managing the epidemic were identified, solutions were developed. As new, more effective approaches to provision of information, supplies, and service evolved, they were tested, adapted, and promptly scaled up. In some cases, new approaches

* National AIDS Action Plan (2007-2010), North Sumatera, Riau, South Sumatera, Lampung, the Riau Islands, DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Banten, Bali, West Kalimantan, East Kalimantan, South Sulawesi, North Sulawesi, Maluku, West Papua, and Papua.

supplemented and strengthened activity already underway.
During this start-up period after Presidential Regulation 75/ 2006, Indonesia was moving systematically to clarify and systematize the three mechanisms identified in global experience as the pillars for effective management of a national AIDS response -- one agreed action framework, one coordination authority, one agreed monitoring and evaluation system - often referred to as "the three ones."

Once the basic steps were taken to launch the new system, completing the process called for attention to issues of

- **Mobilization of Resources :** (1) collaborative review of current program agreements with bi- and multi-lateral partners in the national response to determine appropriateness of continuation or need for program adjustment to come in closer conformity with Indonesian priorities; (2) identification of potential new sources of support and development of appropriate proposals;

- **Program :** (1) prioritizing people to be served, program needs to be met, and locations based on systematic analysis of experience, challenges, available resources, and potential for impact on the epidemic; (2) assuring development of policy, standards, and guidelines for scaling up of activity proven acceptable to the people concerned and cost effective;

- **Management :** building a national management system to plan and monitor the rapidly growing national response; mobilize and account for resources in a timely and transparent manner; to advocate and promote standards and the practice of non discrimination throughout all facets of the national response; to stimulate and province technical support for development of a comprehensive positive "enabling environment" (policy, law, guidelines, and training to promote their understanding and full implementation)

- **Partnership :** developing with domestic and international partners both large and small dialogue and working systems to assure full understanding of Indonesia's national approach to the epidemic and synergistic collaboration among partners in line with their respective roles, responsibilities, and expertise under the overall framework of successive, existing National AIDS Strategies and Action Plan

In relation to overall development and evaluation of the national response, as mentioned earlier, there is on-going attention to coverage, effectiveness, and sustainability. In addition, in substantive terms the issues of stigma, discrimination, and the overall environment (particularly regulatory and public opinion) have been subjects of constant concern in program design, training, monitoring, and evaluation. From the first

days of the system of AIDS Commissions launched by Presidential Regulation 75/ 2006 these issues have been considered in connection with delivery of service, in advocacy and outreach to the general public, in work with and for key affected populations, with government officials, and legislators at all levels.

Globally and in Indonesia stigma and discrimination are documented obstacles to effective responses to HIV and AIDS. They can reduce availability of information and service. They can reduce the quality of service. At the same time, the experience of discrimination and fear of stigma can cause people who are at risk of infection or already HIV+ to shun available information and services for fear that they will be treated as "second class citizens" or worse. The whole society looses out when this happens.

A. Mobilization of resources

The systematic planning which had been done during start-up made clear that Indonesia needed an increase in the total pool of resources to support rapid expansion and intensification of the response. Without expansion of the resource base there would be little possibility of moving broadly enough and quickly enough to slow the spread of HIV infection and ultimately change the direction of the epidemic. Indonesia would pay a high price economically, socially, and, many individuals and families would pay in very personal terms. However, at the same time, it was urgent that such an expansion not come solely from external sources.

In 2006 the response to HIV and AIDS was funded only 26.58% from domestic resources and 73.42% from external grants.[61] As discussed earlier, sustainability was one of three fundamental concerns in building the response to HIV and AIDS. While the Partnership Fund and other AIDS-related agreements[62] were invaluable in supporting initial efforts to address the epidemic, a priority management concern was working toward the agreed goal of greater national financial self-reliance of the response. To this end, mobilization of domestic resources was given high priority.

Different strategies were employed to address the distinct but interrelated challenges of mobilizing resources.

1. Increase in domestic resources - toward sustainability: As clearly stipulated in Presidential Regulation 75/ 2006, article 15, it was a fundamental principle of AIDS Commissions that Indonesia would fund the national AIDS response including the work of the AIDS Commission system at all levels primarily from state budgets (provincial/ district/city budget)

Box 1 : Presidential Regulation 75/ 2006 : On funding of the response to HIV and AIDS.

Chapter V
FUNDING
Article 15

(1) All of the costs required for carrying out the work of the National AIDS Commission shall be borne by the State Budget and other non-binding funding sources in accordance with existing laws and legislation.
(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.

Source : Presidential Regulation 75/ 2006

Among the first steps taken in an effort to assure allocation of Indonesian resources in the response to HIV and AIDS was consultation by the Secretary of the new National AIDS Commission with the Commission's Vice-Chair, the Minister of Home Affairs on appropriate instructions to Provinces and Districts/ Cities on their responsibility under the Presidential Regulation for management of the response to HIV and AIDS.

In April 2007 the Minister issued regulation 20/ 2007, providing to Provincial and District/ City governments "Guidance on Formation of AIDS Commissions and Community Empowerment in Relation to the Response to HIV and AIDS".[63] Under this regulation every province, district, and city should establish (or reorient, as necessary) a multi-sectoral AIDS Commission including representation of NGOs and PLHIV and allocate budget for the secretariat and work of the AIDS Commission. Later in the year (October) the Minister issued a subsequent regulation related to financing of the work of the AIDS Commissions in local budgets (APBD).[64] Each year since then the appropriate regulation has been issued by the Department of Home Affairs to ensure funding for AIDS Commissions at Provincial, District, and City level.

As seen in **Chart 8** (below) by 2008 all 33 province had allocated some funds for HIV and AIDS. Since then growth in total annual expenditures of local funds at provincial level has also grown steadily. Preliminary data for 2010 suggests a jump in total AIDS expenditure between 2009 Rp. 38.3 billion (US$ 4,505,882) and 2010 Rp. 81.4 billion

(US$ 9,576,471). Success at the level of district/ city has been somewhat uneven, climbing steadily from 2005 to 2009 but declining slightly in 2010. This perhaps reflected the fact that the number of district/ cities reporting expenditures also declined from 173 in 2009 to 166 in 2010.[65] While the number of active AIDS Commissions at that level has increased again somewhat in 2011 reaching a total of 173, monitoring of overall expenditures will be interesting once accounts for 2011 are complete and available.

Efforts by the National AIDS Commission and secretariat staff to stimulate increases in HIV and AIDS budgets proceeded on twin tracks one focusing on potential at the national level, the other working with individuals and institutions at the provincial, district/ city level. This effort began shortly after Presidential Regulation 75/ 2006 came into effect and continues today including intensive advocacy, program analysis and information sharing about the epidemic, training and technical support for AIDS-related planning and capacity building with special attention to development of provincial and district action plans, financial and management reporting as the basis for informed and effective advocacy.

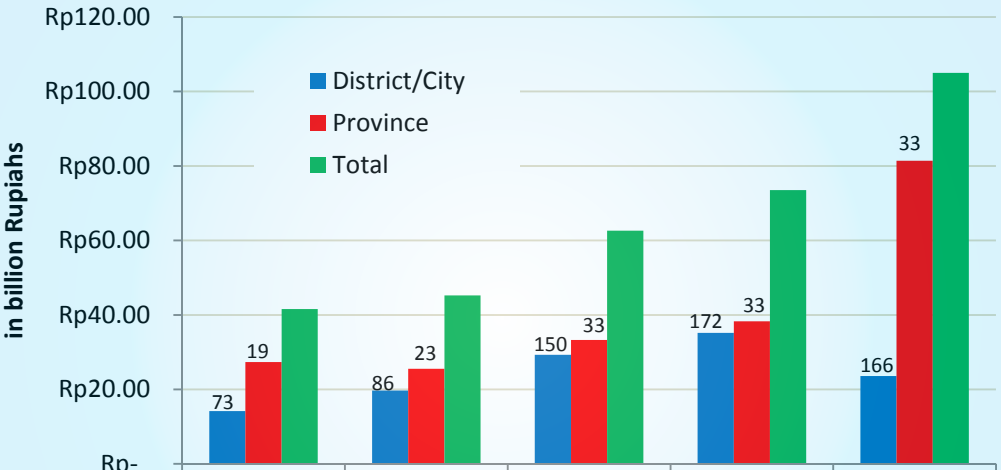
As a matter of policy, governors, vice governors, and other senior officials at the provincial level have been kept well informed about development of the epidemic and response both overall and in their respective provinces. In 2008, 2009, and 2011 gubernatorial meetings were organized led personally by the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission, the two vice chairs of the NAC, Minister of Home Affairs and Minister of Health, the Secretary of the AIDS Commission and other senior officials. In addition, there have also been face to face courtesy calls, advocacy, and program discussion by the Secretary of the National AIDS Commission whenever travelling on provincial visits, among others with governors

- In NAC region 1 Aceh, Sumatera Utara, Riau, The Riau Islands, Sumatera Selatan and Bangka Belitung;
- In NAC region 2 West Java, East Java, Jakarta, Yogyakarta, Central Java and Banten;
- In NAC region 3 North Sulawesi, South Sulawesi, Central Sulawesi, East Kalimantan, West Kalimantan;
- In NAC region 4 Papua, West Papua, Nusa Tenggara Timur, Nusa Tenggara Barat; Maluku

Staff of provincial, district, and city AIDS Commissions and their civil society and NGO partners have also been subject to intensive advocacy, as well as training, and technical support in planning, costing, budgeting and reporting from staff, partners, and consultants of the National AIDS Commission.

As seen in **Chart 8**, below, there is progress. Budgets have been rising in recent years. In fact, starting from 2010 the secretariat of some district/ city AIDS Commissions began to be paid for out of local funding. By 2011 a total of 63 districts and 9 cities in 24 provinces were financed 100% from local resources. (see **Annex 5**)

Chart 8 : Growth in AIDS expenditures at provincial, district/ city level. (2006-2010) (Billion Rupah)



	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 : 2005 - 2008 NAC, National AIDS Spending Assessment (NASA)
2009-2010. NAC preliminary NASA findings.

At the national level, efforts of the AIDS Commission secretariat have likewise been intensive, diverse and non-stop including regular discussions, consultation, and planning with members of the AIDS Commission Executing Team as a group and in connection with sector specific (or multi-sector) program work -- for example harm reduction, care, support, and treatment, mitigation of the social and economic impact of AIDS at the family level, development of the comprehensive package of AIDS-related services in the prison system and so forth. In all these cases attention has been given to both technical program concerns and finance. And always, with an eye to the three issues of coverage, effectiveness, and sustainability.

Indications are that the effort has been effective. The response has also been growing steadily as indicated by expanding budgets; increases in AIDS related sectoral activity; and formalization of sector policy, structure, and mechanisms for AIDS work.

In 2006 the allocation for sectoral work related to HIV and AIDS was Rp. 118.6 billion (US$ 13,952,941) for 11 departments.[66] That total had risen to Rp. 643.098 billion (US$ 75,658,588) in 2010 and Rp. 856.281 billion (US$ 100,738,941) in 2011 respectively with 19 national government departments/ bodies having activity planned (see **Table 12**, for departments/ bodies and amounts; see **Box 6** for examples of diverse sectoral policy development).

Table 12 : 2006 and 2011 AIDS budgets of national government ministries and institutions, members of National AIDS Commission (million Rupiah)

	Ministry/ Institution	2006 Budget	2011 Budget
1	Ministry of Health	Rp 113	Rp 801.172
2	Office of Coordinating Minister of People's Welfare (Secretariat KPA N)	---	Rp 25.000
3	Ministry of Social Affairs	Rp 1.7	Rp 4.367
4	Agency for Assessment and Application of Technology	---	Rp 547
5	Ministry of Justice and Human Rights	Rp 0.09	Rp 5.000
6	Ministry of Communication and Information	---	Rp 3.745
7	Ministry of National Education	Rp 1.05	Rp 1.458
8	National Family Planning Coordinating Board	Rp 0.20	Rp 3.017
9	Ministry of Home Affairs	Rp 0.23	Rp 3.463
10	Office of State Minister of Sport	---	Rp 300
11	Ministry of Defense	Rp 1.50	Rp 360
12	National Narcotics Board	---	Rp 2.1
13	Ministry of Transportation	Rp 0.22	Rp 1.800
14	Ministry of Religion	---	Rp 365.9
15	Ministry of Culture and Tourism		Rp 3.592
16	Office of State Minister for Empowerment of Women and Protection of Children	Rp 0.17	Rp 133.9
17	Armed Forces of Indonesia	Rp 0.44	Rp 400
18	Ministry of Labor and Transmigration	Rp 0.16	Rp 958
19	Ministry of Public Works	---	Rp 600
	TOTAL	**Rp 118.6**	**Rp 856.281**

Source : Confirmation meetings of National AIDS Commission Executing Team, April and May 2011.

A long-term objective of the work of the secretariat of the National AIDS Commission related to mobilization of domestic resources was the integration of HIV and AIDS budgets into Indonesian's overall development effort. To this end, consultation, collaboration, and partnership with BAPPENAS was crucial both as a member of the Executing Team of the National AIDS Commission and in its leadership role in development and structure of national development plans. They engaged immediately in this effort and by 2010 there were strong indications that major progress had been achieved. As mentioned earlier, on 20 January 2010 President Susilo Bambang Yudhoyono issued regulation no 05/2010 on Indonesia's National Midterm Development Program (2010-2014)[67] including action on HIV and AIDS. Only a few months later, April 20, the President issued an instruction[68] (Inpres 3/2010) for a program to advance efforts for equitable development including specifically acceleration toward achievement of the mid-term development goals (MDGs) including goal 6 focused on HIV.

Overall during this period (2006-2010) in both absolute and relative terms domestic expenditures for HIV and AIDS increased. Total expenditures rose from US$ 56,576,587 (Rp. 480.9 billion) in 2006 to a total of US$ 65,550,730 (Rp. 557.2 billion) in 2010. Indonesia's total investment in AIDS increased every year. The proportion of the total, likewise grew from 27% in 2006 to 42% in 2010.

Table 13 : Annual AIDS expenditures 2006 - 2010 and source (domestic or international)

	2006	2007	2008	2009	2010
Domestic	$ 15,038,057	$ 15,412,976	$ 19,839,380	$ 21,318,854	$ 27,779,280
International	$ 41,538,530	$ 43,258,421	$ 30,991,725	$ 39,957,601	$ 37,771,450
TOTAL	**$ 56,576,587**	**$ 58,671,397**	**$ 50,831,105**	**$ 61,276,455**	**$ 65,550,730**

Source : National AIDS Commission, NASA reports 2006-2010

2. International Resources

Support from a range of international development partners, both bilateral and multilateral has been crucial to Indonesia's scale-up of the response to HIV and AIDS during the past five years. When Indonesia's own AIDS budget was still very limited they supported the development of some of the social, management, technical, and financial systems needed for an effective, accountable, sustainable, comprehensive national response. Funding from the Indonesian Partnership Fund provided support to the proposal development process leading to new multi year grants for Indonesia

from the Global Fund for the period 2009-2015, a profoundly important step towards implementation of a truly national response as contrasted with a scattering of local responses planned individually.

During the first three years under Presidential Regulation 75/ 2006 three bilateral donors -- the UK, USAID, and Australia -- provided the most substantial financial support for the national response, US$ 35.3 million, US$ 24.4 million, and US$ 20.9 million respectively. Support of the Global Fund (US$ 19.9 million), the fourth major contributor, during the same period became more important in the years thereafter. (see **Table 14**, below)

The bi-lateral support of the United Kingdom was invaluable direct support to the government of Indonesia and gave birth to the Indonesian Partnership Fund managed by the secretariat of the National AIDS Commission with UNDP hired as Fund Manager until such time as the NAC secretariat was ready to assume that responsibility. The bilateral support of both Australia and the United States was directed to work carried out primarily by Indonesian NGOs in 11 provinces but also included some work with local government, AIDS Commissions of all levels, and national and local Health Departments. While the scope of the programs was not sufficient to have the impact needed on the epidemic, important lessons were learned, local organizations and capacity were strengthened all of which have contributed to building of the national response.

International support has been diverse -- provided to individual projects, to research and studies, to capacity building within Indonesia and abroad, to development and strengthening of the overall AIDS management system and many other kinds of activities. It has taken different forms at different times -- sometimes designated project funding for activity designed by a donor's own design team, sometimes provision of supplies or services. At times, international donors provide full funding for activity at other times they join with Indonesia or others for co-financing of activity. Increasingly, as international partners seek maximum impact for their investment in the national response they consult with the National AIDS Commission at the national level and local AIDS Commissions at provincial, district, and city levels regardless of the form of support they are offering or the nature of the activity to be supported.

The principle change in international participation in HIV and AIDS work in Indonesia before and after Presidential Regulation 75/ 2006 has been the introduction of 1) the role of National AIDS Commission secretariat leading overall coordination and management of the response as well as 2) the existence of the comprehensive framework for action provided by the two successive National Strategies and Action Plans (2007-2010 and 2010-2014).

Table 14 : International funding to support Indonesia's national response to HIV and AIDS. 2006 - 2008 (in US$)

	2006	2007	2008	2009	2010	Total
UK (DFID)	$ 14,859,921	$ 14,542,239	$ 5,880,900	$ --	$ --	**$ 35,283,060**
US (USAID)	$ 7,084,881	$ 9,639,336	$ 7,710,100	$ 7,795,576	$ 3,962,570	**$ 36,192,463**
Australia (AusAID)	$ 6,013,785	$ 9,234,395	$ 5,706,267	$ 6,959,074	$ 8,829,372	**$ 36,742,893**
Global Fund	$ 10,464,951	$ 3,656,642	$ 5,818,972	$ 20,199,097	$ 19,992,709	**$ 60,132,371**
UN Agencies	$ 2,897,137	$ 5,400,313	$ 2,368,333	$ 4,674,854	$ 4,412,998	**$ 19,753,653**
World Vision Int.			$ 578,700			**$ 578,700**
Netherlands	$ 167,499	$ 92,906	$ 295,290	$ 140,272	$ 381,800	**$ 1,077,767**
World Bank		$ 310,000	$ 52,500	$ 188,728	$ 192,000	**$ 743,228**
European Union (IMPACT)		$ 313,129	$ 872,588			**$ 1,185,717**
Japan	$ 49,472	$ 65,514				**$ 114,986**
Other	$ 457	$ 3,628	$ 1,708,075			**$ 1,712,160**
TOTAL	**$ 41,538,103**	**$ 43,258,120**	**$ 30,991,725**	**$ 39,957,601**	**$ 37,771,449**	**$ 193,516,998**

Sources : National AIDS Commission. NASA 2006-2010

Furthermore, the National AIDS Commission secretariat has had an inclusive and proactive approach towards the work of international partners calling for both harmonization of work under the umbrella of the national response (as set forth in the action plans) and for conformity with Indonesian standards, guidelines, and practices. In addition, the secretariat of the National AIDS Commission often involved international partners in technical discussions or teams assembled for operational program development, field evaluation, mentoring and monitoring etc. The combination of these actions has made this five years a period of much increased synergy, focus, and effectiveness in work with and by international partners.

Beyond coordination of existing activity, the National AIDS Commission secretariat led a participatory process conceptualizing and formulating of overall national plans. Additional work has included design and development of supplementary activity to assure successful implementation of the national plans, and redesign for scale-up of work to address particular issues within the response.

Among international partners, the United Kingdom (funds managed through the Department for International Development, DFID) was the largest contributor to the national response "inherited" by the National AIDS Commission designated by Presidential Regulation 75/2006 with the grant agreement having been signed in 2005.

For mobilization of new resources two critical factors were (1) development of logical, fully developed proposals and open; and (2) responsible management of funds demonstrated by full, accurate, timely, accounting and reporting. For this reason the secretariat of the National AIDS Commission gave high priority to management of its own finances and capacity building of AIDS Commissions at provincial and district/ city level in this field.

The Global Fund, which had provided support to Indonesia since 2003, announced new opportunity for applications for funds in 2007. The new AIDS Commission as a member of the Country Coordinating Mechanism (CCM) managing Indonesia's work supported by Global Fund urged development of a proposal to start the scale-up of a coordinated, multi sectoral, comprehensive national response. The idea was accepted and the Secretary of the national AIDS Commission was asked to chair the Technical Working Group to prepare the proposal in line with the National Strategy and Action Plan 2007-2010. The proposal, in final form, was subsequently put forward for consideration in Global Fund Round 8 and approved for the period 2009-2014.

Table 15 : Global Fund support to phased development of Indonesian national response

Province	GF Round	Years	Grant Support	Launching Date	Pgm Focus
5 Prov	GF 1	2003-2007	US$ 12 million		Focus prevention
19 Prov	GF 4	2005-2010	US$ 65 million		Focus care, support and treatment
12 Prov	GF 8	2009-2014	US$ 130 million	launch Jul 2009	Focus comprehensive
23 Prov	SSF th 1	2010-2015	US$ 87 million	launch Jul 2010	Focus comprehensive
33 Prov	SSF th 2	2011-2015	xxxxxxxx	launch Jul 2011	Focus comprehensive

Source : National AIDS Commission

(see **Annex 4** for overview of Global Fund support to Indonesia including provinces receiving support)

Shortly thereafter, the Technical Working Group still chaired by the Secretary of the National AIDS Commission continued work and proceeded to develop a proposal for Global Fund Round 9. Given the wide distribution of reported infection, high mobil-

ity of Indonesia's population, the increasingly well documented fact that there were in all 33 provinces districts/ cities ("hot spots") priority areas needing attention in the response as well as Indonesia's increasingly integrated transportation networks -- land, sea, and air -- the decision was taken to opt for national coverage of strategically selected locations in all provinces.

At the same time the Global Fund proposals were in preparation, the secretariat of the National AIDS Commission continued work with partners, in particular USAID and AusAID, to consolidate and focus their respective activities to assure synergy and harmonization of the multiple in-puts to the national response particularly in areas of geographic overlap. In the end USAID, their contractors, and partners gave particular attention to activity related to sexual transmission while AusAID focused on a full range of issues related to injecting drug use in community settings and prison as well as support for institutional strengthening in 14 provinces.

Mobilization of resources was only step one of what needed to be done to build a comprehensive, national response. Resources made action possible. They provided no guarantee of effectiveness. Program and financial management capacity and systems needed to be grown, nurtured, and systematized if Indonesia's response was to be effective and sustainable in the long run.

B. Program

Bringing the epidemic under control depends on prevention of infection being successful. This fact has been central to the thinking behind Indonesia's strategy and planning for action.

In some countries prevention can concentrate heavily on one mode of transmission of infection. Because in Indonesia both unsafe drug use and sexual transmission are major contributors to new infection it has been necessary to mount and maintain effective responses to both modes of transmission. Within the overall framework of Indonesia's "total football" approach to addressing the epidemic initial priority was given to acceleration of work to reduce new infection among PWID and improve the services needed to help address problems of addiction and infection. At the same time, noting, the steadily increasing numbers of women found to be HIV+ it was clear that attention was also needed to gender disparities and improvement of women's knowledge, skill, and efficacy in protecting themselves from infection. By 30 June of 2011 7,255 women were among the cumulative reported AIDS cases and they comprised 26.4% of the total. The situation as reported for the first six months of the year alone, however, (Jan - Jun 2011) was more striking, still. Of the 2,001 new cases of AIDS reported during that period, 35.1% were women![69]

1. Harm reduction : Program components in harm reduction have changed over time. Already by 2006 the package of services and activities commonly referred to as "Harm Reduction" for addressing the issue of injecting drug use and HIV was well known and had been proven successful around the world. 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) adiction treatment; (10) methadone maintenance therapy (MMT); (11) CST; (12) basic health care.*

Notwithstanding positive global experience with harm reduction, for Indonesia there were multiple challenges to speedy and full adoption and implementation of harm reduction on a scale sufficient to have an impact on the epidemic. In particular, the regulatory environment was hostile and the views of many people in government and community were uninformed about drugs and unsympathetic about PWID. Likewise they did not yet understand the many options available for working with people who injected drugs (PWID) and the potential benefits to society at large from constructive work with and for PWID to reduce HIV and other infection and improve the quality and productivity of their lives.

Daily methadone treatment delivered through the public health services

* In 2009 WHO, UNODC, and UNAUDS issued new global guidelines reducing basic components of harm reduction to 9, as follows : (1) needle and syringe program; (2) opioid substitution therapy (OST) and other drug dependence tr4eatment; (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) vacination, diagnosis and treatment of viral hepatitis; (9) prevention, diagnosis and treatment of tuberculosis.

Staff of the new NAC secretariat worked in multiple ways with multiple partners -- strategically situated allies in government, a few local AIDS Commissions, the community of PWID, social and public health activists who had practical experience with the positive impact of harm reduction, international development partners from Australia, the US, and the UN community -- and followed multiple approaches. Together and individually they advocated, educated, and demonstrated the importance and effectiveness of harm reduction for Indonesia. As it became possible, the NAC secretariat quickly turned to mobilization of additional financial resources to start a strategic, scale-up of the comprehensive program.

The harm reduction package was familiar. The approach was new. It was

- **structural,** working to create the legal environment necessary for the program and to integrate within existing systems particularly the public health system and systems of law and public security the legal framework and services needed to facilitate implementation of harm reduction in Indonesia. The principle partners were in the National Narcotics Board (BNN), the police, the legislature, Ministry of Health, the Ministry of Justice and Human Rights, (particularly Department of Corrections), and Ministry of Social Affairs.
- **inclusive,** giving prominent attention to empowerment of PWID as part of the team to develop and advance harm reduction in Indonesia; concerned with PWIDs both in the community and in prison settings; and
- **comprehensive,** with activity designed to address prevention, care, support, and treatment including for addiction, infection (sexually transmitted infections including HIV, hepatitis B and C and others) as well as TB.

Because of the social and legal obstacles, earlier efforts (pre 2006) to launch harm reduction had been limited to pilot projects and largely in the hands of NGOs with support from outside funding sources (Australia) and with technical support also from outside (Burnett, FHI, some UN agencies). From 2006 to 2008 it became possible to broaden activity with additional funding from the Indonesian Partnership Fund especially through IHPCP, and FHI working with local NGOs.

As policy and the regulatory environment improved (see **Box 2** showing evolution of policy related to drug use and PWID) and the effectiveness and benefits of harm reduction were better understood, wider scale-up became possible with new resources from the Australian supported HIV Cooperation Program in Indonesia (HCPI) and Global Fund.

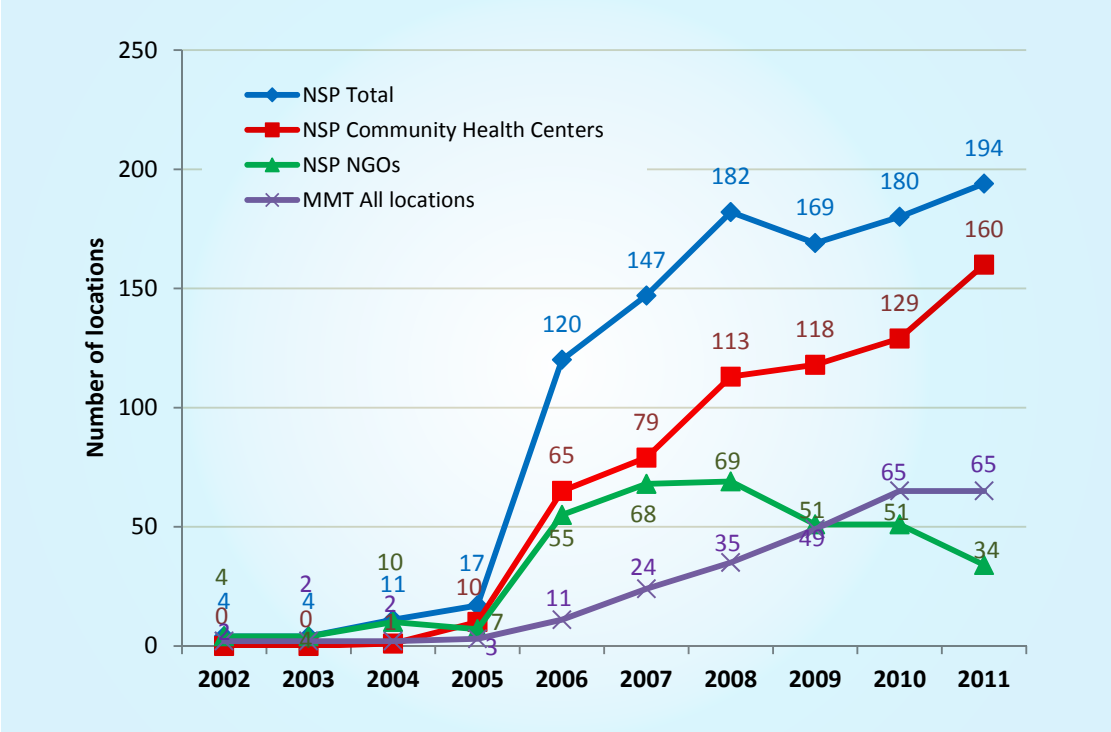
Box 2 : Creation of supportive environment for Harm Reduction (1997-2010)

- 1997 Law on drugs and psychotropic substances. (Criminalized PWID)
- 2006 MoH endorses WHO guidelines for prevention and cure among drug users
- 2006 Decree of Minister of Health : KepMenKes 567/ Menkes/ SK/VIII / 2006 on guidelines for implementation of harm reduction for narcotics, psikotropika and other addictive substances
- 2007 Regulation of the Coordinating Minister on People's Welfare number 02 on Harm Reduction
- 2008 Regulation of the Minister of Health 350/Menkes/SK/IV/2008 designating hospitals and satellites for Methadone Maintenance Therapy and Guidelines
- 2009 National Law no 35 on narcotic drugs. (User recognized as victim entitled to treatment)
- 2010 Circular letter of the Court Mahkamah Agung no 4/ 2010. (Drug users/ addicts to be referred to treatment)
- 2010 Regulation of Minister of Justice and Human Rights number HH 01.PH.02.05/2010 on the National Action Plan for control of HIV and AIDS and Drug Abuse in Correctional Institutions 2010-2014

Notwithstanding the fact that it was not until 2009 that drug use was decriminalized (National Law 35 on narcotic drugs) work in the field proceeded earlier than that. As seen in **Chart 9** and **Chart 10**, below, between 2005 and 2010 availability of needle syringe programs (a key component in harm reduction) jumped from 17 locations to 194 while methadone maintenance treatment (another critical component) rose from 3 to 64 locations. This reflected the strategic decision subsequently followed by policy and program that to assure availability of the essential comprehensive services needed by PWID and long term sustainability, harm reduction had to be integrated into the existing public health system -- hospital, public health clinics, health services in the prison system.

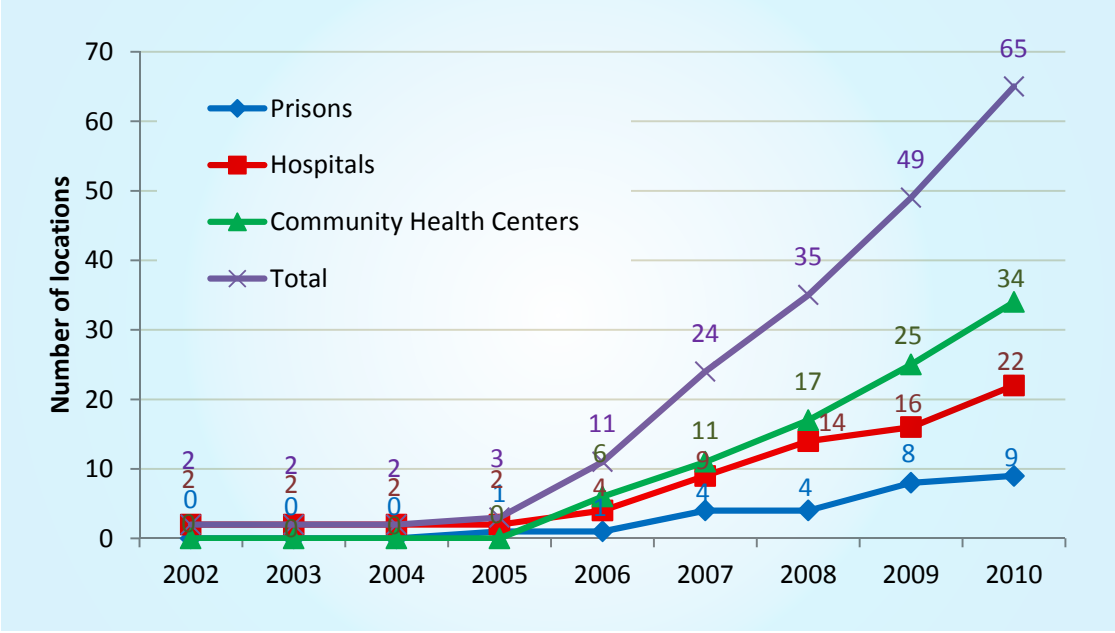
It was observed during this period that NGO harm reduction services declined in number as people were able to get service in "regular" public health facilities. While this was true, the importance of the civil society contribution in managing the response to drug-related HIV infection and associated personal, social, and community problems was no way diminished in importance. The NGO Community (both PWID and other activists) continues to be of great importance providing the essential outreach, education, and referrals needed for PWIDs and their partners.

Chart 9 : Growth of harm reduction services in Indonesia. 2002 - 2011



Source : National AIDS Commission, monitoring data

Chart 10 : Increasing availability of methadone maintenance services (MMT)

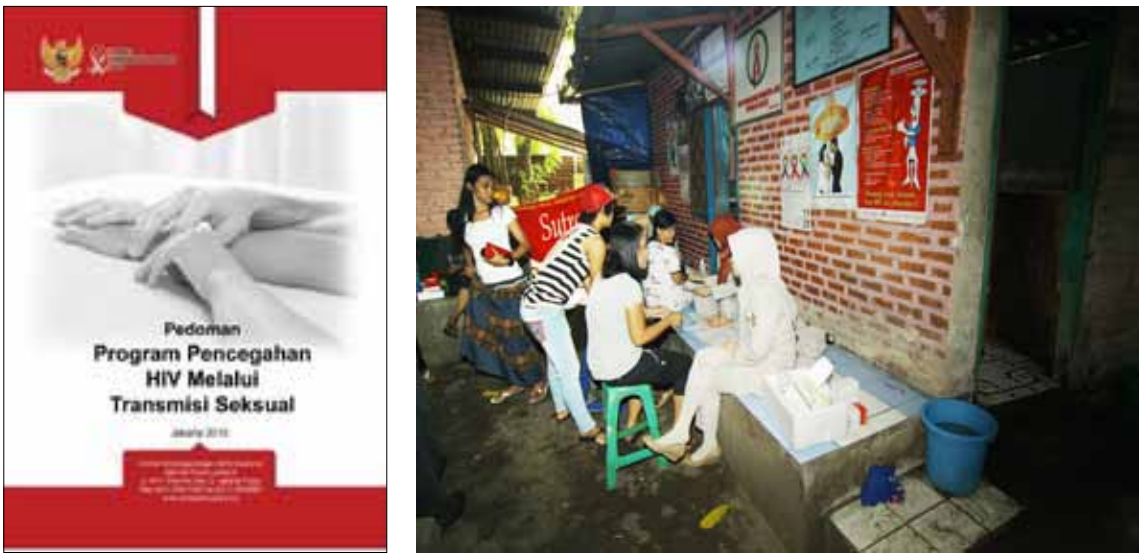


Source : National AIDS Commission, monitoring data

As we record here, much progress has been made. However, much work remains to be done. This is discussed further in Chapter 4 on challenges and recommendations.

2. Prevention of sexual transmission : Sexual transmission of HIV infection can take place through heterosexual and homosexual sex. It takes place in the context of commercial sexual transactions, in mutually consensual, casual situations, and within the confines of formal marriage. In all of those situations there is the potential for transmission of sexually transmitted infection including HIV between partners if one of the two is infected. Even where regular treatment of sexually transmitted infection is available there is no guarantee of complete success as many STIs are now resistant to available treatments.

Halting transmission by sexual means can be done only by avoiding sex except with a known, uninfected partner or through consistent, correct use of a condom. Control of sexual transmission, therefore, is always tied to behavior -- either maintenance of safe behavior or changing of unsafe behavior to reduce or eliminate risk. Postponing the age of first sex, reducing the number of sex partners, use of a condom even if only intermittently all help lower the risk of infection … but they do not eliminate it. Avoiding risky sex and correct, consistent use of a condom are the only two ways to eliminate transmission of HIV.



Guideline Booklet and example of activities for prevention of sexual transmission

The importance of sexual transmission in the HIV epidemic in Indonesia is growing. In 2009 the Ministry of Health estimated a total of 6,396,187 people were at risk of infection -- PWID, female sex workers and their clients, transgenders and their clients, men who have sex with men, prisoners and the sex partners of all (including husbands and wives). An additional 186,257 people were estimated to be HIV+ (PLHIV).[70] (see **Annex 3**).

Furthermore, projections show sexual transmission becoming more important in the HIV epidemic as infection within the community of PWID declines.

In the early years of the national response, considerable effort was invested in work to reduce high risk sex and increase condom use with attention being given by the World Health Organization and others to the approach called "100% condom use" which had been successfully pioneered and implemented in some areas of Thailand. The principle aspects of the approach 1) sale of sexual services was limited to specific locations, 2) it was required that condoms be used in all risky sex, 3) sex workers were required to have regular check ups for sexually transmitted infections, 4) if a sex worker was regularly employed and found to be infected, the management of his/ her place of work was fined and responsible to pay for treatment. Furthermore, according to the law the place of business could be closed.

The approach of 100% condom use was included and promoted in the National AIDS Strategy of 2003 - 2007. As the secretariat of the newly designated National AIDS Commission settled in to their work (2007) they began a systematic review of the effectiveness of on-going activity as they were developing the new National Strategy and thereafter the costed action plan.

In 2007 the periodic national surveillance related to HIV was carried out.[71] During 2008, as results became available, they suggested that the campaign was having little impact on levels of infection. It was clear that if Indonesia was to make any progress in bringing the HIV epidemic under control more effective approaches would be needed to reduce sexual transmission.

Acting on these observations and in the context of preparing a major new proposal to seek funding from Global Fund, the Secretary of the National AIDS Commission called an urgent consultation meeting with partners, individuals and organizations experienced in the field of sexual transmission. Participants included representatives from the NGO community, some international development partners, representatives of relevant government departments that were members of the National AIDS Commission. Discussion and brain storming included analysis of obstacles to success in the approach of 100% condom use as well as experience internationally and in 4 locations in Java which had shown rising levels of condom use and declining rates of sexually transmitted infection.[72]

Follow-on work from that meeting led to a new, comprehensive approach to address the challenge of sexual transmission in Indonesia -- prevention of sexual transmission of HIV[73] (PMTS). Although many of the partners and specific program components were different from work on harm reduction, the fundamental principles of the program

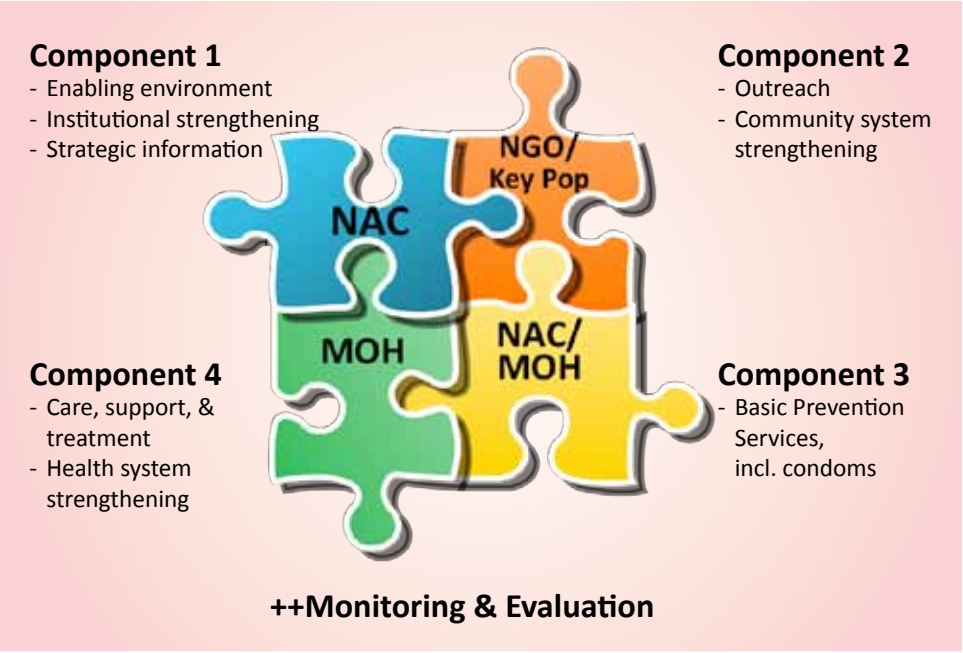
were similar : PMTS was a structural intervention (working to bring about change in the existing systems and the local environment), it was broadly inclusive (local authorities, the public health service, sex workers and others involved in the sex industry), and the policy/ program concerns and components made a comprehensive package.

PMTS is built around 4 basic components

1. Energizing and empowerment of those locally concerned -- community leaders, condom sales people, sex workers, local official -- to share concern and responsibility for creating the regulatory and social context to facilitate and promote condom use in the context of concern for community health
2. Behavior change communication to empower sex workers with concern for their own health as well as the knowledge and skill to increase their efficacy in promoting condom use and monitoring their own health
3. Improved management and availability of condoms and lubricants
4. Comprehensive management of sexually transmitted infections

PMTS is the product and a good example of the partnership approach to the national response with extensive partnerships being essential to the effective implementation and sustainability of PMTS. (see **Box 3** below). This particular Box portrays the partners and division of labor in the setting of Global Fund-supported PMTS. In another PMTS setting the partners might be different but the need for clear division of labor and mechanisms to promote collaboration among partners would be the same.

Box 3 : Partnership in scaling up prevention of sexual transmission, 2009 - 2015



Source : National AIDS Commission

Although initially scale-up was funded by Global Fund (2009 - 2015), some aspects of this program have benefitted from joint funding with additional resources coming from APBN, while some support in the form of condoms was received from BKKBN and Family Health International.

Table 16 : Partnership in support of PMTS operations. July 2009 - June 2011[74]

Distribution Jul 2009 - June 2011	Global Fund Support	Other Support	Outlets	No of prov.	No of Dist/ Cities
Lubricants (1)	1.067.866	1.521		33	137
Male condoms (2)	12.209.888	1.620.966	3.466	33	137
Female condoms (3)	None	548.175	600	33	137

Source: National AIDS Commission. (1) International NGO, FHI, (2) BKKBN, (3) APBN, UNFPA, FHI

After development of appropriate training modules, PMTS got off to a good start in April and July of 2011 : more than a thousand sex workers from 66 different locations in 23 provinces were trained (1,222).* Moving forward with the comprehensive and structural approach to prevention of sexual transmission training was carried out for 144 members of the local civil defense force (*SatPol PP*)† from 16 provinces. Most of the participants were district/ city level commanders. The purpose of the training was to introduce them to the new structural approach to prevention of sexual transmission of HIV and to seek their positive leadership in encouraging active participation by the men and women serving under their command in promotion of effective operationalization of PMTS where they were assigned.

3. HIV related technical health services - Counseling, Testing, Care, Support, and Treatment : Voluntary counseling and testing (VCT) is the critical point of contact between the world of the uninformed and entry into the world of HIV and AIDS information and technical services. When community systems and health systems are well linked counseling and testing provides the crucial link needed for a person newly informed that he/ she is HIV positive to a peer support group among whom many HIV+ people find information, renewal, and empowerment to understand their condition and how to build and live a fulfilling and responsible life. It is the entry point into the continuum of care needed by people at risk of infection or HIV+.

While standards, guidelines and basic training in these fields are set by the Ministry of Health, HIV and AIDS services are provided through both the public health system (government) and a variety of non governmental facilities and networks -- civil soci-

* NAC Training report.
† Serve at the community level but part of a national network.

ety based, faith based, and private sector. Coordination and collaboration between government and other service providers is needed and staff often receive training together. In fact, according to MoH, as of May 2011, 32 (15%) of 218 hospitals with CST services are private. At the same time, they provided ARV treatment for 4,440 patients (21%) of those receiving ARV while government hospitals provided treatment for 17,171 (79%) of those served.[75]

Service provided where it is needed ... on location

VCT : Starting in 2003, the MoH sub directorate for AIDS worked with WHO implementing VCT training using a curriculum accredited by the training division of the Ministry. Thereafter, counselors were trained from the 25 hospitals (14 provinces) that had been designated as the initial hospitals to provide HIV and AIDS care, support and treatment. During 2005-2006 training of counselors was carried out in 32 provinces in line with the guidelines on counseling and testing issued by the MoH.[76] VCT services were launched in the public health system initially in 5 provinces* with Round 1 support of Global Fund (2003-2007). Expansion of services has continued since then using a variety of funding sources (Indonesian national and local budgets (APBN and APBD) as well as Global Fund, AusAID, USAID). As of June 2011 388 VCT centers were reporting VCT results from 33 provinces.

HIV related counseling requires appropriate training. As of March 2011 there were forty-three (43) national trainers based in 7 provinces.† Between 2004 and 2010 train-

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

† DKI Jakarta, Papua, Sulawesi Selatan, Bali, Central Java, West Java, East Java.

ing was carried out for selected staff and volunteers (2,772 people) serving in 1,053 institutions including among others hospitals, private sector firms, prisons, and NGO, (**Table 17**).

Table 17 : Institutions receiving VCT training (2004 – 2010).

Institution	Hos-pital	Mental Hospt.	Public Clinic	Lung Clinics	Prisons	NGO	Private Sector	Clinic	TOTAL
People trained	361	15	389	6	26	157	35	64	1,053

Source : MoH Data. Cumulative to Dec 2010. Provided Jul 2011.

Among VCT counselors trained during this period, 1,609 were women (58%), 1,163 were (42%) were men.

The development of the VCT system proceeded slowly from 2006 to 2009 adding only 56 new locations to the 100 already available in 2006. During 2009 the number of VCT sites more than doubled going from 156 at the end of 2009 to 388 locations in 142 districts/ cities[77] by the end of 2010.

As seen below (**Table 18**) utilization of VCT has increased bringing significant growth in the number of people being tested. This reflects improvements in availability of service mentioned above. It also suggests improvements in coverage and effectiveness of outreach work. More people among the key affected populations appear to have been empowered with information about the benefits of early diagnosis and treatment and grown in confidence and willingness to take responsibility for their own health. Likewise, the rapidly growing up-take on VCT suggests that on-going training of health care providers to strengthen provision of non-stigmatizing, client-friendly, comprehensive service, free of discrimination, integrated in the existing public health system is beginning to have positive impact.

Tabel 18 : Number of VCT sites, visits, HIV tests administered, people testing HIV+, and positivity rate. (2006 – June 2011)

	2006	2007	2008	2009	2010	Jun 2011
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 Development of HIV and AIDS in Indonesia. Year end report for 2009 and 2010. Second quarter report for 2011.

Mobile testing : In an effort to bring VCT closer to those needing it but who have difficult access, some VCTs in hospitals and public health centers have now started mobile services, similar in principle to the mobile community health centers (*PusKesMas Keliling*) started long ago to take service overland or up river by boat to more isolated communities. Mobile VCT services work in collaboration with local community groups and volunteer outreach workers who help publicize the availability of VCT service and sometimes bring people for testing. Standards and procedures for testing follow the same national protocol whether testing is carried out in a hospital, clinic or mobile testing site. Testing is done using rapid tests so results are quickly available and follow up treatment and support can be provided promptly. Results of mobile unit tests are incorporated in the report of the hospital/ clinic managing the mobile service. Mobile service is severely limited at present but holds some promise as a method to improve availability and utilization of comprehensive HIV and AIDS information, counseling, testing, as well as access to condoms and needle-syringes (NSP).

PICT : Strong evidence has accumulated around the globe in recent years of the benefits of early diagnosis and early treatment of HIV infection. To this end, the role of health care providers -- doctors, nurses, midwives, and other technical staff -- is being strengthened to work toward earlier detection of HIV. In 2006 Indonesia adapted a WHO training module and guidelines for what is called "provider initiated counseling and testing" (PICT). Training and the use of PICT is now being scaled up. It is hoped this approach will contribute positively to continuation of recent rises in the numbers of people seeking counseling and being tested. In 2010 the scale-up of PICT made a modest beginning. Two hundred twenty (228) health care providers, a mix of professionals from seven provinces* were given PICT training.

Table 19 : Health care providers trained for PICT

	Doctor	Nurse	Midwives	Other	Total
Jakarta	21	20	4	12	**57**
West Sumatera	14	11	1	5	**31**
NAD	14	6	2	8	**30**
West Kalimantan	7	16	3	3	**29**
NTT	11	7	1	11	**30**
Central Java	13	9	0	8	**30**
East Java	4	13	1	3	**21**
TOTAL	**84**	**82**	**12**	**50**	**228**

Source : MoH. Provided to NAC 2011

* Aceh, Sumatera Barat, DKI Jakarta, Central Java, East Java, West Kalimantan, and NTT.

Care, support, and treatment : People who are HIV positive and meet criteria determined by MoH are offered and encouraged to take ARV treatment. Availability of treatment has been undergoing steady improvement since the launch of WHO's 2003 global campaign "3 by 5" which aimed to enroll 3 million people by 2005.

Table 20 : New patients receiving ARV in Indonesia, 2006 - 2011

	2006	2007	2008	2009	2010	Thru Jun 2011
Total	2,753	1,860	3,608	8,524	7,755	4969
Male	2,396	1,384	2,526	5,597	4,513	2,802
Female	320	405	930	2,620	2,930	1,999
Children < 14	37	71	152	307	312	168

Source : MoH. Information provided to NAC, Jul 2011

In 2006, as seen in **Table 20**, 2,753 new AIDS patients in Indonesia received ART with women accounting for about twelve percent (12%) of those being treated and children under the age of 14 one percent (1%). By the end of the first 6 months of 2011 there were 4,969 new patients receiving ARV with women, by that time making up 40% of those treated and children under the age of 14 making up four percent (4%) of the total. ART provided through the public health system was initially funded 100% from external resources (Global Fund). As a matter of policy, to ensure availability of ARV is not, in the long run, dependent on outside funding, stock is already now jointly funded with 70% covered by the Indonesian national budget (APBN), the remaining 30% is covered with Global Fund resources. National funding is scheduled to grow.

As of June 2011 there were a total of 286 service units (218 hospitals and 68 satellites, see **Annex 6** : for hospitals, satellites, and locations)[78] providing reports on the full range of HIV and AIDS-related services they provided, number of patients, as well as outcome of testing and other services. At that time 21,775 people were also regularly receiving ARV.[79]

Just over seventeen thousand (17,360) people were on 1st line ARV treatment. Three thousand five hundred eighty-six were still on first line treatment but on doctor's orders had substituted one first line medication for another, also first line.* Eight hundred twenty-nine (829) patients had been switched from first to second line ARV.† 2,777 peo-

ple had changed their location of treatment on referral (transferred out).* 1,641 had dropped their ARV therapy, and 8,005 people died after having initiated ART.[80]

Taken as prescribed, ARV reduces the viral load (reducing infectiousness), raises the quality of life, and extends life of PLHIV. It is, therefore, highly desireable to have all PLHIV who qualify taking ARV regularly. Although there have been improvements in the system over the years nonetheless utilization of ARV has fluctuated somewhat between 2008 and mid 2011. After a sharp drop in mortality [81]starting in 2006, it began to rise again from the low of 17% (2008) to 23.8% (at the end of June 2011) and at the same time, a sharp decline was reported in the percent of elegible PLHIV be receiving ARV -- 64% in 2009 and only 44% by mid year 2011.[82]

This points to two interrelated challenges which are on-going issues of concern and will need continuing attention in the future and which influence utilization of ARV : (1) quality of service and (2) strengthening support systems to increase motivation, and discipline for high levels of service utilization and disciplined adherence to the requirements of medication among people taking ARV. These are every-day challenges for those now on ARV but they are also longer term challenges for health and community systems and the national response as a whole.

For most people who are HIV positive, support is crucial for quality of life, to help with AIDS education, to strengthen discipline for consistent adherence to medication and condom use, to lift the spirits and help acquire the mind set and skills to live a full and satisfying life. Within the health system, AIDS-related training emphasizes the importance of linking PLHIV with local support networks either within the health service system (counselors and case managers attached to a hospital or community health center, for example) or outside.

Comprehensive services in Department of Corrections : Prison systems around the world are noted as settings of a variety of activity, including sexual activity, placing prisoners at high risk of HIV infection. Faced with this challenge and with increasing numbers a of prisoners entering prison already HIV+, the Director General of Corrections of the Ministry of Justice and Human Rights working with the National AIDS Commission determined to develop a comprehensive response to HIV and AIDS in the prison community. The first Strategy for this work covered the period 2005-2009. Following on from that, they developed a policy and strategy for the period 2010-2014, carried out management training for officials at national, provincial and institutional level, ar-

* MoH. "substitution" = 1 or more ARV medications has been changed but still within 1st line treatment.

* MoH. "transfer out"= change location of service on referral.

* MoH. "switched"= 1 or more ARV medication has been switched from 1st to 2nd line medication.

ranged technical-medical training for heath service staff in the system, and developed some information and communication materials for prisoners. The program has received important technical support from the Australian supported program (HCPI) and major funding from Global Fund as a sub-recipient of the NAC secretariat.

This combination of partnerships, policy, and action have achieve notable results : between August 2008 and March 2010, 4,913 people used VCT service (1,006 were HIV+). The system as a whole is now in place and providing information and service in 120 prisons in 25 provinces (with Global Fund support) and in an additional 10 institutions (prisons, detention, and parole centers) in Java and Bali with some program support from HCPI. It is noteworthy that what initially started out as a narrowly focused program to address drug use, HIV and associated problems has developed into a comprehensive service program covering HIV-TB, Hepatitis, a range of issues related to addiction and sexually transmitted infections. While the beginning of this efforts was heavily dependent on financing from international development partners, with an eye to future sustainability budgets are beginning to grow within the Department. In 2006 the overall AIDS budget was Rp. 0.09 billion. For 2011 that amount has risen to Rp. 5,000 (million).*

Support by and for PLHIV : While some people get all the support they need from close friends and family, as discussed earlier many find association with a "peer support group", a group of other people infected or directly affected by HIV, of great value. A recent study on the quality of life of positive people (PLHIV), examined this issue.[83,84] The findings demonstrated conclusively the strong positive association between a sense of "good quality of life" among positive people and participation in peer support activities with 86.9% of those involved in peer support groups reporting themselves to have high qualty of life as contrasted with less than fifty percent (48.9% of those not in a peer support group. (see **Table 21**).

Table 21 : Self declared evaluation of quality of life and association with Peer Support Group

Quality of Life	Active in Peer Support Group	Not active in Peer Support Group
High	86.9%	48.9%
Low	13.1%	51.1%

Source : Yayasan Spiritia, Universitas Hamka, and KPA Nasional. 2011. Pengaruh Dukungan Sebaya Terhadap Mutu Hidup ODHA. [The influence of membership in a peer support group on quality of life of PLHIV] Jakarta.

* Sectoral budgets. Confirmed in April and May coordination meetings (2011).

The research included HIV positive people who are in peer support groups and those who are not and focused on experience and attitudes of respondents related to 5 core concerns :

- personal self confidence related to one's HIV status,
- knowledge about HIV and AIDS,
- access to and utilization of relevant care, support, and treatment,
- personal responsiblity to avoid transmitting infection (sexual, through injection, vertical from parent to child, donating blood, in connection with any surgical procedures)
- pro-active involvement in life – professional work, community activity, personal hobby etc – to sustain interest in life

The study involved both qualitative and quantitative segments. The quality of a respondent's life was self evaluated by the respondent.

Community activities in Bali

However, the findings also made clear that the positive impact of peer support groups was higher for people in groups which were part of a "full" support network -- a three tiered system with a "catalyst" group* at provincial level and a catalyst group at district/ city level providing support and in-put for individual peer support groups. As seen in the **Table 22** (below), there is a drop of 12 percentage points in the those lacking the full network.

The study, being finalized in late 2011, provides useful insights to inform further work in this field, a subject of direct importance to all of Indonesia's PLHIV and their support networks. It is relevant, as well, to successful implementation of the National AIDS Strategy and Action Plan, 2010-2014.

* *Kelompok Penggagas* = "catalyst group". Terms used in the network of peer support groups supported by Spiritia.

Table 22 : Influence of peer group support system on effectiveness of group

Quality of Life	"Complete" peer support system - Prov, Dist/ city, local group	Peer support system exists - not complete	No peer support system
High	71.1%	59.3%	50.0%
Low	28.9%	40.7%	50.0%

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

HIV-TB : TB has consistently been the most common co-infection reported among AIDS patients since 2006. It is widely found among PLHIV,[85] more common than other opportunistic infections such as candidiasis, PCP (Pneumocystis Carinii Pneumonia), Toxoplasmosis, Cryptosporidiosis and others). TB is also the leading cause of death among PLHIV (40%-50%).[86] At the same time, the HIV epidemic is an important cause of the rise in TB cases. In fact, neither TB nor HIV can be effectively addressed without controlling both. Good HIV and AIDS treatment must incorporate prompt diagnosis and treatment for TB to ensure mortality from TB is kept to a minimum. Likewise TB patients should be counseled and tested for HIV and if positive given appropriate counseling and treatment.

Responding to this situation, in 2009 the Ministry of Health developed and issued a national guideline on TB-HIV collaboration and a training module. Beginning in 2010 selected TB and HIV program managers and operational staff in hospitals providing service related to HIV and AIDS have been trained on TB-HIV collaboration. Training for HIV managers and staf has been carried out with appropriate staff of 159 hospitals spread across all 33 provinces. Training in HIV-TB collaboration for managers and staff for TB programs has covered 20 provinces. Thus far 226 trainers for collaboration have been prepared and have trained 314 people.

Prevention of Mother To Child Transmission (PMTCT) : HIV infection can be transmitted from an HIV+ pregnant woman to her child during pregnancy, at the time of birth, and in breast feeding. However it is now possible to reduce the risk of infection being passed in this way with appropriate ARV prophylaxis (PMTCT) which has been used successfully around the world and in Indonesia.

There are four essential components in the PMTCT program :

- Primary prevention of HIV infection among men and women of reproductive age
- Avoiding unintended pregnancies among women who are HIV positive

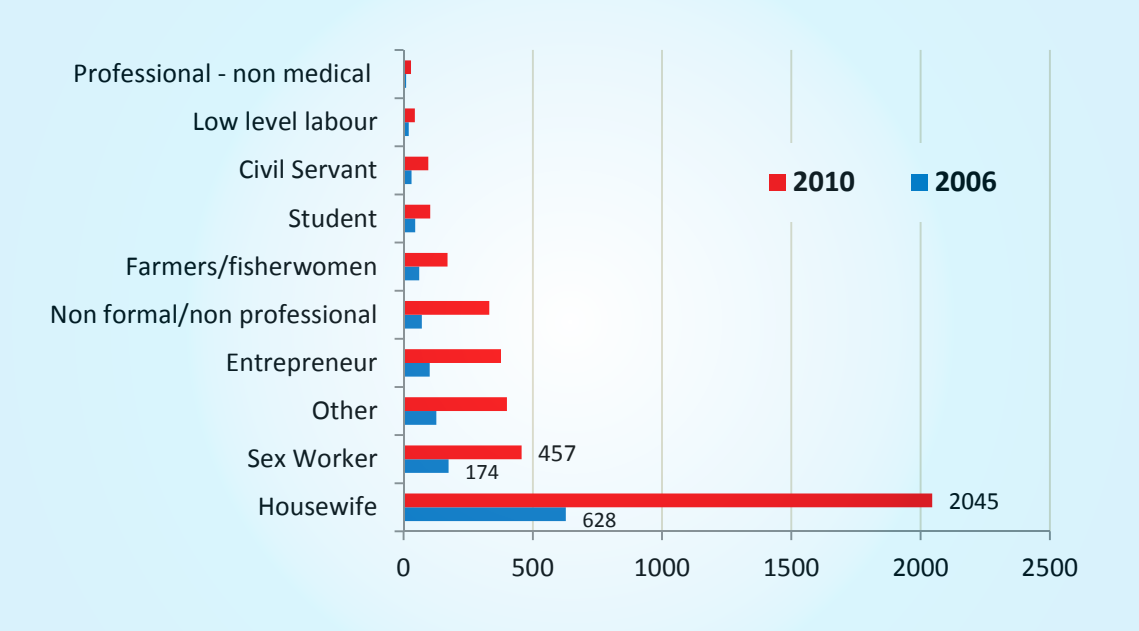
- Preventing HIV transmission from a pregnant HIV+ woman to her infant
- Providing appropriate care, support, and treatment to mothers who are HIV+, their children and families

Supporting women to avoid HIV infection and avoid unintended pregnancy are both part of Indonesia's national health program and part of the national response to HIV. The necessary information, supplies, and services can be made available to women through local health services and through community based civil society action programs related to family planning and to HIV and AIDS.

Counseling and testing is for all. Special efforts are made to meet special needs of pregnant women

With appropriate prophylaxis[87] the risk of a pregnant HIV+ woman transmitting infection to her child can also be much reduced. The newborn child is given ARV (pediatric dose) from birth as well as exclusive breast feeding for six months. PMTCT information and services (including the offer of testing for expectant mothers who do not know their HIV status) are being integrated with the standard package of antenatal care in Indonesia. Guidelines and the necessary training module have been issued and training of appropriate teams has begun. As of June 2011 seventy-nine (79) PMTCT teams were providing service in 22 provinces with activities being reported by 67 referral hospitals, 10 satellite hospitals and 2 public health centers.

Chart 11 : Women who are AIDS. 2006 – 2010. (By Occupation)



Source : Ministry of Health

Given the steadily increasing numbers of women reported HIV+ and the wide distribtion of infection, scaling up of integrated delivery of PMTCT services is a priorty concern. With this goal in mind UNICEF provided support for a number of strategic PMTCT activities including revision of the basic policy guidelines. Thereafter, a national action plan for PMTCT (2010-2014) was prepared by working group assembled for that purpose with membership from NAC, other relevant sectors, NGO activists including PLHIV and IPPI.

Reviewing the status of technical health services it is clear that strengthening of the public health system's capacity to respond to the epidemic has made some important progress in the past 5 years. Technical health system policy has been established for a range of HIV- related issues and related manuals, training modules, and guidelines have been developed. Systems are now better distributed, better able to serve the diversifying needs of the growing numbers of men, women, and children who are infected and affected by HIV. Working partnerships among health services, social and community systems, the HIV management systems including local government and planning authorities are better established and better utilized than 5 years ago.

However, it is also true that overall capacity to provide the full range of HIV related technical health services -- whether through government, non government, private sector, or faith based facilities -- is still well below what is needed to halt and begin to reverse the spread of HIV and AIDS. There are not yet enough facilities and they

are not sufficiently widely distributed. Continuing strategic scale-up of well targeted services is needed where it is documented that the epidemic is particularly intense. Networks of service providers and community organizers/ outreach workers/ local peer support groups need strengthening and development to assure full utilization of services which are available. Particularly in areas heavily affected by the epidemic and where transportation and communication are difficult, for example in parts of Tanah Papua and Kalimantan, extra effort is also needed for accelerated expansion of comprehensive health services including those particularly related to HIV and AIDS -- VCT, CST, TB-HIV, PMTCT to underserved groups of people.

The health sector is not expected to address the challenges of HIV and AIDS on its own, nonetheless they accept their paramount role to lead on-going health system development related to HIV including capacity raising within the health sector, among community and private sector partners through training and development of technical guidelines. Expansion of these activities is reflected in Health Sector's partnership in the scale-up of the comprehensive national response through their own budget and with Global Fund support with the target to have 1,182 sites in place by 2014.[88]

C. Managing The Response

1. Building the system : In line with responsibility assigned in Presidential Regulation 75/ 2006, to "promote more intensive, holistic, integrated and coordinated prevention and management of the response to AIDS" the National AIDS Commission has overall responsibility for leading, managing and coordinating the national response. Carrying out this assignment and the specific duties set forth in article 3 (see **Box 4**, below) the NAC secretariat has been called upon to manage multi level and multi partner activity at national, provincial, district, and city level as well as work with international partners both in Indonesia and abroad. It has required dialogue, collaboration, and partnership including the many elements of both executive and legislative sides of government, with representatives of partner governments, with civil society, the private sector and the media.

Performance of these duties has called for creation of a network of policy, systems, and relationships all focused on the task of mounting and carrying out a humane, efficient, and effective effort to halt the spread of infection and limit the damage and disruptions which could be caused to individuals, families, communities, and the nation if the epidemic was not brought under control.

Box 4 : Duties of Indonesian National AIDS Commission, Presidential Regulation 75/ 2006

CHAPTER I, ESTABLISHMENT, POSITION AND DUTIES, article 3

The National AIDS Commission shall have the duties of :

a) Stipulating national strategic policies and plans as well as general guidelines for preventing, controlling and managing the response to AIDS;
b) Stipulating strategic steps required to implement activities;
c) Coordinating the implementation of activities for provision of information, prevention, delivery of services, monitoring, controlling and managing the response to AIDS
d) Disseminating accurate information on AIDS to a wide range of mass media in such a way as not to result in social unrest;
e) Undertaking regional and international cooperation within the framework of efforts to prevent and manage the response to AIDS;
f) Coordinating the management of data and information on issues related to AIDS;
g) Controlling, monitoring and evaluating the implementation of activities for prevention and management of the response to AIDS;
h) Providing direction to AIDS Commissions at the Provincial and District/ City levels respectively within the framework of efforts to prevent, control and mange the response to AIDS.

Source : Presidential Regulation 75/ 2006

2. Planning and monitoring the response and its impact : To this end, an early priority was preparation of an evidence-based national strategy for the period 2007-2010 and immediately thereafter a costed action plan to focus the response and serve as the common basis for further planning, action, advocacy, and mobilization of resources at all levels.

In 2006, the new National AIDS Commission and its secretariat had no choice but to develop a response to address a highly diverse epidemic -- diverse both in modes of transmission and settings. While most provinces were faced with a concentrated epidemic with dominant impact among key affected populations (PWID, sex workers – male, female and transgender – men who have sex with men, and high risk men), the evidence (IBBS 2006, Tanah Papua) was already clear that across the two provinces of Tanah Papua a low-level generalized epidemic was underway and that prevalence was running higher in rural areas with difficult access and low levels of education than in the cities.

Young people and the World AIDS Day

Likewise, as previously discussed, Indonesia was faced with diversity in terms of HIV transmission with both injecting drug use and sexual transmission playing important roles. Given the role of sexual transmission as a principle force behind growth of the epidemic it was clear that condom use has a very important role in the national response while both nationally and locally in many areas there were some segments of society that were vocal and influential in their opposition to any open condom promotion.

The NAC secretariat therefore was challenged to develop an action plan which was epidemiologically sound but allowed latitude in implementation to accommodate to local conditions related to the nature of the epidemic and the response. The plan needed to be comprehensive including not only attention to "front end" prevention activity and delivery of services but also including attention to the broader concerns of managing the response including capacity- and system- building for the longer term.

Given the urgency of expanding coverage and strengthening effectiveness of the national response across the country while, at the same time building toward sustainability of the effort, management also required a well conceived and smooth-running monitoring system to assure collection, analysis, feedback, and utilization of strategic information and to ensure that the response was on track and was having the desired impact -- that the response was achieving adequate coverage, was effective in promoting safe behavior, and in mitigating the impact of the epidemic. Analysis of results of monitoring along with data from periodic surveillance and incidental studies also

facilitated prompt recognition of any changes in the nature of the epidemic which might require adjustment in local or overall responses. Development, maintenance, and utilization of these mutually interactive systems of planning and monitoring have been central to management and phased scaling up of the response under Presidential Regulation 75/ 2006.

Building on available data,* late in 2006 and early in 2007 geographic priority areas (based on estimated totals of key populations and PLHIV) were identified. Seventeen (17) provinces accounting for 80% of the key affected populations were given priority along with the two provinces of Tanah Papua where the integrated bio behavioral surveillance (IBBS 2006) had pegged HIV prevalence at 2.4% among the general population aged 15 – 49.

Box 5 : Increase of local participation : planning, refinement of locations, program needs

- **Preparation of the 2007-2010 strategy and action plan :** Decisions on priority locations and key components were based on distribution of key affected populations and PLHIV as recorded in the 2006 national estimate of populations at risk. Priority Provinces were selected.
- **Preparation of the 2010-2014 strategy and action plan :** Key program components in the strategy stayed the same, however, building on the results on mid-term review (2009) and with more experienced and better trained provincial staff, the planning process had more input from the provincial level -- provincial designation of priority districts and cities based on their knowledge of the epidemic locally.
- **Preparing for implementation of Global Fund round 8 (2009) :** By the time preparation for implementation of Global Fund support was underway, it was possible to go one step further in targeting work. A cascade exercise was carried out:
  1) guidelines for field mapping and interviews were prepared by the planning team of the NAC secretariat,
  2) training in these tools was provided for provincial AIDS Commission staff,
  3) Provincial AIDS Commission teams worked together with district/ city AIDS Commission staff, as well as local members of key populations and active NGOs to pin-point within their own districts and cities the location of "hot spots" the neighborhoods which were well recognized centers of high risk where programming attention should be focused.

  This exercise produced a well documented list of 137 "hotspots" across the nation, at least three in every province and a much improved inventory of program needs and potential partners for implementation.

* Among others, MoH and BPS, Estimate of Adults Vulnerable to HIV Infection. 2009, MoH and BPS IBBS Tanah Papua. *Situasi Perilaku Berisiko dan Prevalensi HIV di Tanah Papua 2006.* Jakarta. 2007.

Over time, as the information base and planning skills throughout the system grew, successive planning exercises have been able to refine still further geographic targets as well as the needs, location, and population size of the people to be served. (**Box 5**).

Plans in hand laid the foundation for system building, action programs, advocacy, and mobilization of resources combined with a good monitoring system. They support responsible reporting processes, (a requirement of all funders domestic or international) as well as providing the information for on-going evaluation of effectiveness and program redesign or innovation.)

For Indonesia's national response to HIV and AIDS three kinds of information are particularly important : (1) epidemiological, (2) program implementation, (3) institutional development, focused on development of the AIDS Commission system. The second and third areas of monitoring are the purview of the National AIDS Commission.

As of 2010 the structure for institutional monitoring of the AIDS system consists of 11 indicators - 3 input, 4 process, and 4 output. (see **Annex 10**)

The skills and technology for planning and monitoring have not stood still during the years covered in this report and every effort has been made for the secretariat of the National AIDS Commission at all levels A number of staff have participated in longer or shorter training both in Indonesia and overseas to raise skills of planning and analysis. Computer software has also been added, to make computer based mapping, mathematical projections, and modeling possible.

Likewise, in connection with monitoring, technical improvements have been introduced and are still under way to strengthen speed and accuracy of data reporting related to program implementation. While for some time computers have been used in all districts, cities, and provincial AIDS Commission offices and e-mail contact has been regular with many, the situation at the district/ city level has been more uneven and there has been no dedicated tie-up among the different levels. During 2011 an on-line data entry system was put in place as part of the monitoring system of the national response. As of July 2011 all 33 provinces and 137 districts and cities (locations included in the Global Fund supported scale-up of the comprehensive response) are reporting to the NAC monitoring office on program activity using this on-line system.

Different methods of monitoring and information sharing about the national response are used at the national level among government sectors who are actors in the response to HIV and AIDS. As mentioned earlier, the Executive Team, as designated in Presidential Regulation 75/ 2006 and chaired by the Secretary of the National AIDS

Commission, is the mechanism for coordination, information sharing, advocacy, and planning among government sectors. In line with broad policy of the NAC every effort is made for HIV-related activity to work through existing systems thus sectoral planning, budgeting, and reporting go through their normal channels. For advocacy purposes and as a source of technical assistance to sectors in planning the BAPPENAS-NAC Budget and Planning Forum is an important partner but sectoral action stays within the framework of the respective sector.

3. Developing the system : The concern in this process has been the development of a decentralized, multi-level, multi partner system with common goals and shared ownership of the national work plan as well as clear, evidence-based local plans. The system was to be open, inclusive, and accountable in its work; strategic in decision making related to its efforts to reduce new infection, improve the quality of life of people who were HIV+ and eliminate the stigma associated with HIV.

The evolution of the AIDS Commission system across Indonesia was monitored by tracking progress on the 11 indicators previously mentioned (**Annex 10**). Comparing results on four particularly important indicators it is clear there has been some progress on an institutional basis. The status of all provincial AIDS Commission has been confirmed by a gubernatorial decree. 33 Provinces have at least some local AIDS budget and the number of active districts/ city AIDS Commissions has gone from 95 to 175.

Table 23 : Development of AIDS Commission System (2007 and 2011)

Indicators	2007	2011
Provincial AIDS Commission w Gubernatorial decree	22	33
Plan (Renstra to 2010)(*)	19	22
Local budget (APBD)	22	32
Number of active districts/ cities	95	175

Source : Monitoring of National AIDS Commission, and IPF

(*) The planning process changed somewhat following issuance of Presidential Instruction 10/ 2010 calling for acceleration of Indonesian efforts to achieve the MDGs, including goal six related to HIV and AIDS. Flowing from this decree an integrated planning process was to be launched under the leadership of BAPPEDA and including local AIDS Commissions at the provincial and district/ city level. The pace and effectiveness of this process has varied somewhat from area to area with varied impact on planning and budgeting related to HIV and AIDS.

IPF support provided the National AIDS Commission secretariat the necessary resources to initiate a succession of phased planning, training, and management de-

velopment activities immediately upon receiving their newly defined responsibilities in 2006. Flowing from the collaborative system with which the IPF resources were managed at the national level, they also became a tool which stimulated important dialogue and participation among partners to the national response. Overtime, collaboration broadened beyond the meeting room with members of the Partnership Fund Management Committee (IMC) also participating in periodic field mentoring, monitoring, and evaluation of IPF funded activity.

Table 24 : Support of AIDS Commission staff and some operational expenses by Indonesian Partnership Fund. (2006 – 2011)

	2006	2007	2008	2009	2010
District/ City	105	105	170	170 (Jan-Jun) 102 (Jul-Dec)	102 (Jan-Jun) 9 (Jul - Dec)
Province		22	33	33 (Jan-Jun) 21 (Jul-Dec)	21 (Jan - Jun)
National	100%	100%	88%	77%	71%

With the national plan in place, the National AIDS Commission began supporting the process of development of local action plans and advocacy for local funds, a process involving staff training and mentoring for AIDS Commission staff of provincial, district/ city level from the 19 designated priority provinces. IPF also provided funding to the National AIDS Commission in issuing Guidelines on Management of Local Finance[89].

By the end of 2007 23 provinces and 105 districts and cities had their own plans in place. The process was underway. Planning was sometimes carried out at the provincial or district/ city level, sometimes in the context of a multi-location planning exercise and sometimes involved both steps. For example in 2007 when Indonesia was preparing a new proposal for Global Fund support part of the planning process was location-specific and parts were centralized in Jakarta.

4. Financial management : Building the comprehensive response needed by Indonesia would be impossible without a fully developed, accountable, punctual, financial management system. This would be equally necessary for effective mobilization of national or international resources. The secretariat of the AIDS Commission proceeded to develop a single system which met Indonesian and international accounting standards, could accommodate the varying reporting requirements of different sources of funding, and which could grow as the resources managed would grow for expenditures at all levels -- national provincial, district, and city.

Getting this system up and running was no small task. In 2005, the government of Indonesia, DFID, (donor of the start-up funds for the Indonesian Partnership Fund), and UNDP had decided together that the secretariat of the AIDS Commission did not, at that time, have the capacity to manage the funds DFID was offering Indonesia. It was agreed, therefore, that the UNDP would be paid a fee out of the grant funds to act as Fund Manager for Indonesia's IPF funds while the secretariat developed systems and capacity to take over full management of the funds.

That transition is to take place at the end of 2011. In the years since 2005 the secretariat of the NAC has acquired a relatively small but well qualified staff, established in-house financial management systems which have stood up well under a variety of assessments and audits (**Table 25** below), and supported and supervised training and capacity development for financial management as needed at provincial, district/ city level.

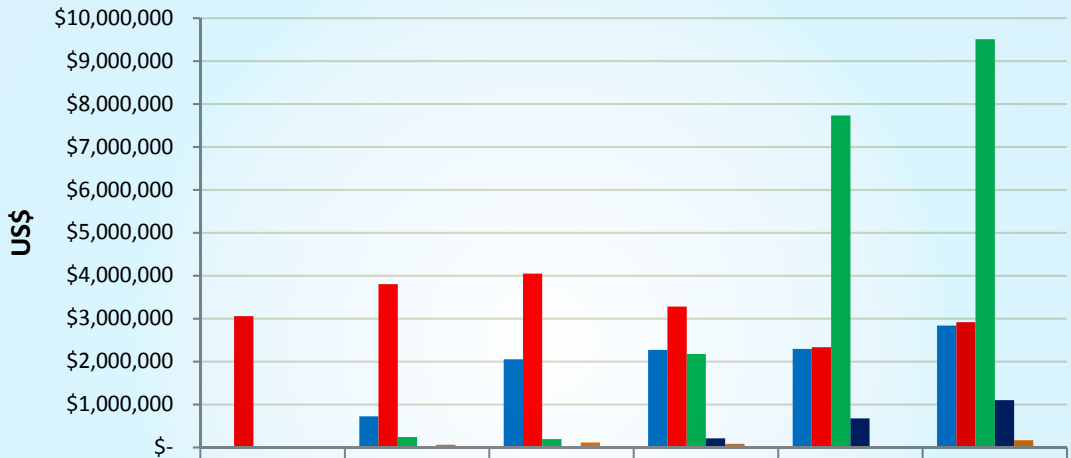
There has been growth in both diversity and volume of the resources managed by the secretariats of AIDS Commissions at all levels between 2006 and 2011. For example, at the national level in 2006 the secretariat had only US$ 3,060,516 from one source. That had risen to US$ 16,540,839 from five sources in 2011.

Table 25 : Audits on funds managed by NAC Secretariat and outcome 2007 - 2010

	2007	2008	2009	2010	Audit by
APBN	Approved annually without reservation				BPK[1]. Through the office of Coordinating Minister of People's Welfare/ Chair, Nat AIDS Commission
IPF	Approved annually without reservation (*Wajar tanpa syarat*)				BPKP[2]
GF	No Funds to NAC		Funding begins	Approved with no reservation	Local Fund Agent for GF = Price Waterhouse Cooper. Office of Syarief Basir Account and Co
UNDP	moderate risk	Low risk	Low risk	Low risk	HACT[3] assessment of UN system

Source : Comment or Auditor's reports in records of National AIDS Commission

Chart 12 : Funds managed by NAC secretariat, 2006 - 2011



	2006	2007	2008	2009	2010	2011
APBN		$727,532	$2,053,400	$2,272,727	$2,297,628	$2,840,828
IPF	$3,060,516	$3,806,924	$4,052,000	$3,283,091	$2,333,392	$2,916,800
GF		$242,222	$192,800	$2,176,000	$7,735,798	$9,512,227
AUSAID				$211,000	$675,980	$1,102,984
UNAIDS/UNFPA		$64,000	$114,080	$84,000		$168,000
Total	$3,060,516	$4,840,678	$6,412,280	$8,026,818	$13,042,798	$16,540,839

Source : Indonesian Partnership Funds, 2011

5. Capacity building and mentoring to increase the pool of Indonesians trained for HIV program management and development : Part of the on-going work of the National AIDS Commission for the past five years has been contributing to preparation of the human resources needed for development, planning, management, and monitoring of the expanding and multi faceted HIV and AIDS response. Training and education have been arranged at many levels and, by design, have included participants (women and men) from government as well as civil society and the military. Some of the work has been short term, task-specific, introductory training for people with little or no background in either HIV or organizational management. At the other extreme there have been people who pursued higher education with specialization in AIDS programming or related fields and earned university degrees.

Early in 2007 the Minister of People's Welfare/ Chair of the National AIDS Commission issued a succession of policy directives to clarify and support the new AIDS Commissions at provincial and district/ city level. Directives included :

- a basic manual on organization and work of AIDS Commissions at each level issued (Regulation of the Coordinating Minister of People's Welfare/ Chair of NAC number 04/ 2007)[90]

- a directive on structure and division of labor of the National AIDS Commission (Regulation of the Coordinating Minister of People's Welfare/ Chair of NAC number 05/ 2007[91]
- the membership and purpose of the executing team established in Presidential Regulation 75/ 2006, Part 2, Article 5 (Regulation of the Coordinating Minister of People's Welfare/ Chair of NAC number 06/ 2007)[92]
- a basic national manual/ guidelines on monitoring, evaluation, and reporting on HIV and AIDS throughout Indonesia (Regulation of the Coordinating Minister of People's Welfare/ Chair of NAC number 08/2007)[93]

Provision of support, supervision, mentoring, and monitoring have been a regular part of the work of the National AIDS Commission staff with a division of labor among program, finance, M and E, and general management staff.

Indonesia, as a whole, is divided into four regions for management purposes by the NAC -- (1) Sumatera, (2) Java and Bali, (3) Sulawesi and Kalimantan, (4) Eastern Indonesia. Work related to each region is coordinated at NAC by a general Regional Support team working, as needed with staff from finance, planning, and monitoring and evaluation. The Regional Support officers spend some time traveling in their respective regions supporting overall institutional development for AIDS Commissions and mentoring of AIDS Commission staff in program, finance, and monitoring and evaluation.

In addition, since 2007 each region has had an annual regional meeting for representatives of AIDS Commissions. The agenda in these meetings has included one program-focused activity selected in line with priority concerns in the region and other sessions on role and responsibilities of the AIDS Commissions, basic and more advanced skills for financial management and reporting, monitoring and evaluation (including use of software). Depending on up-coming activity in the region or special need there has sometimes been additional training in planning, advocacy etc.

Where international partners were active, they have often supplemented the general training with provincial, district, and city AIDS Commissions. During the early "start up" years of the restructured AIDS Commissions (2006 - 2008) the Australian supported AIDS program and the US supported Aksi Stop AIDS program with Family Health International responsible for field operations with additional support from the Indonesian Partnership Fund were working in a total of 11 provinces* From 2008 to 2010 a newly constituted Australian program, HIV Cooperation Program for Indonesia (HCPI), was active with its own program in 9 provinces.

* *Aksi Stop AIDS* and the Australian program were both working in Jakarta, West Java, and Papua. In addition *Aksi Stop AIDS* was working in North Sumatera, the Riau Islands, Central Java ,East Java, and West Papua. The Australian program was also in Bali, East Nusa Tenggara, South Sulawesi.

Group discussion at a training session

Starting in 2009 new funds became available for 12 provinces as Global Fund (GF) started a third multi -year grant to Indonesia (GF Round 8 support from 2009 to 2014).[94] The National AIDS Commission was one of 3 Principle Recipients (PR)[95] and it was possible to scale-up this modest capacity building effort in a big way. Combining the new resources from Global Fund with budget from APBN, the Indonesian Partnership Fund, and the Australian HCPI, between July of 2009 and the end of May 2011, thirty rounds of general management training (planning, monitoring, evaluation, and finance), orientation to Global Fund were organized for staff of the national AIDS Commission, AIDS Commissions of 23 provinces, civil society, and sectoral partners. A total of 2,000 people were reached (1,135 men, 804 women, and 61 transgender) with basic management training and orientation to Global Fund management.[96]

Table 26 : Capacity building. men, women, and transgender

Year	Male	Female	Transgender	Total
July 2009	256	208	13	**477**
2010	732	476	46	**1,254**
to May 2011	147	120	2	**269**
TOTAL	**1,135**	**804**	**61**	**2,000**

Source : National AIDS Commission report on utilization of Global Fund support

As indicated below, (an example) each program area also has a full program of technical capacity building to support technical accuracy of programs across the country. Planned to meet program needs, activity, as shown here, was often funded from multiple sources.

Table 27 : Example - capacity raising related to harm reduction (2009-2011)

Activity	When	Number of participating Prov, Dist. and Cities	Participants			Funding
			M	F	Total	
1. Training : comprehensive harm reduction for program acceleration.	Jakarta, 2-4 July 2009	6 Provinces	22	6	28	APBN
2. Training : Harm reduction related to injecting drug use.	Jakarta, 26 - 29 July 2009	6 Provinces	30	13	43	GF and HCPI
3. Workshop : development of discussion guidelines for PWIDs Meeting	Cisarua, 13 - 15 October 2009	2 Provinces	11	4	15	APBN
4. TOT for needle syringe program.	Jakarta, 9 - 11 Nov 2009	10 Provinces	27	12	39	IPF
5. Multi-sectoral meeting to strengthen understanding of harm reduction.	Jakarta, 21 - 24 June 2010	4 Provinces, 14 Dist/City	29	8	37	GF
6. Comprehensive training on harm reduction.	Ciloto, 26 Sept - 1 Oct. 2010	6 Provinces, 22 Dist/City GF SSF Group B	39	20	59	APBN and GF
7. Evaluation of discussion guidelines for PWIDs Meeting.	Jakarta, 12 - 14 April 2011	10 Provinces, 26 Dist/City GF SSF Group A	30	22	52	APBN
8. Comprehensive training on harm reduction and addiction. (Round 1)	Batam, 22 - 26 February 2011	6 Provinces, 9 Dist/City	21	17	38	GF
9. Comprehensive training on harm reduction and addiction. (Round 2)	Surabaya, 21 - 25 March 2011	9 Provinces, 14 Dist/City	35	19	54	GF
10. Comprehensive training on harm reduction and addiction. (Round 3)	Bogor, 26 - 30 April 2011	5 Provinces, 21 Dist/City	39	35	74	GF
		TOTALS	**283**	**156**	**439**	**4 sources**

Academic training : Aside from the program-specific capacity building discussed above the need was recognized for more advanced skills -- academic and practical -- in AIDS- related fields. In 2007 the secretary of the National AIDS Commission opened discussions with the Royal Institute of Tropical Medicine in the Netherlands (Koninklijk

Instituut voor de Tropen, KIT) to explore possibilities for collaboration. So far two staff from the AIDS Commission secretariat, a naval officer, and one staff from the Ministry of Health, have earned Masters of Public Health degrees with specialization in HIV.

Collaboration with KIT continued when they hosted (2009) a team of 20 Indonesians from 5 provinces and various universities (Padjajaran University, University of Indonesia, Atmajaya University, Gadjah Mada University, Airlangga University, Hasanuddin University, staff from the Ministry of Health and the National AIDS Commission. A special 6 week training was prepared for the Indonesian team of 20 to help prepare them to develop HIV related curricula for integration into the training of health care professionals.

After returning home, as planned the team drafted multiple curricula -- one each for the use of medical faculties, for faculties of public health, and two each (S1 and D3) for nursing and midwifery. During 2011 the curricula were tested/ evaluated for ultimate adoption/ integration at the Center of Education and Training for Health at the Human Resource Development Center of the Ministry of Health (BP2SDM). This phase of the program is a collaborative enterprise carried out under a Memorandum of Understanding between the Secretary of the National AIDS Commission and the Ministry of Health. Discussion of the work has aroused interest in other Universities and there are now indications that the curricula will be adopted and adapted more widely than initially expected.

A number of Indonesian participants* have also attended programs at the UNAIDS Collaborating Center at the East-West Center in Hawaii for training in use of the Asian Epidemic Model, projection, program and financial modeling, data management and utilization of data for advocacy.

6. Promoting enabling environments : The social and legal environment within which the response to HIV and AIDS is carried out has major impact on its pace as well as success or failure. It influences budgets, public image of the challenges to be resolved, attitudes toward the people involved, and options for solutions. The environment is determined by law, public policy and public opinion. These, in turn are influenced by and influence leaders in government and the community. Because of this, an issue of concern of the National AIDS Commission and its secretariat since Presidential Regulation 75/ 2006 came into effect has been working to build and support informed leaders and conducive environments within which the policy, programs, and actions needed to control HIV and AIDS can be discussed and become well established. This has been done in many ways, primarily working to support development of a positive

* 1 each from BAPPENAS, MoH, and HCPI (Australia) plus 3 from the NAC secretariat.

policy network for the national and local response and through advocacy and public education among leaders and the general public about the urgency of action.

Policy development : In 2006 the regulatory environment was not yet developed to support a wide ranging, multisectoral response to the epidemic. Public opinion, was cautious, sometimes even hostile to efforts to discuss HIV, modes of infection, the spread of HIV and AIDS within Indonesia and alternatives for prevention. There were important individual and institutional exceptions, who understood the issues and agreed that a more assertive, pro-active response to the epidemic was in Indonesia's best interests. However, there were far more people in most communities who were uninformed, unconcerned, unengaged and sometimes scared. Across the country there were a few scattered places, mostly from among the original provinces of the "Sentani Commitment", where constructive action was underway supported by a positive policy. However, there were not enough areas and they were not bound together in any unified system to have an impact on the epidemic.

At the same time, also building on interest in HIV and AIDS triggered by the Sentani Commitment and supported by various domestic and international partners, there had been a number of initial steps taken to advance national policy related to HIV and AIDS in 2004. The Ministry of Education issued a National Strategy for Prevention of HIV and AIDS through Education,* the Ministry of Labor and Transmigration adopted a ground breaking policy on prevention of HIV and AIDS in the work place† establishing non discrimination in the workplace as national policy. The Minister of Health designated the first 25 hospitals to be treatment sites for ARV (SK MenKes 781/MENKES/SK/ VII/2004) and shortly thereafter published national guidelines for ARV treatment (see **Annex 9**). Notwithstanding these efforts there was little consensus about the need to take action with the result that there remained many gaps in the legal and policy infrastructure. At the same time, persistent public habits of marginalization of sex workers, people who used drugs, and men who have sex with men all contributed to an atmosphere tolerating stigma and discrimination toward people who were HIV+ or perceived to be as high risk of infection and limited effectiveness of HIV-related program efforts. Along with mobilization of resources and attention to scale-up of technical programs, early priority was given by the Chair of the National AIDS Commission and the secretariat to correcting this weakness.

National Level : The secretary of the NAC immediately began working with the office of the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission and other government sectors, members of the NAC Executing Team, or creating

* *Strategi Nasional Pencegahan HIV/AIDS Melalui Pendidikan (2004).*

† *Keputusan Menteri Tenaga Kerja dan Transmigrasi Republik Indonesia nomor : KEP. 68/MEN/IV/2004 ttg Pencegahan dan penanggulangan HIV/AIDS di Tempat Kerja.*

of a fuller network of guidance and public policy specifically related to HIV and AIDS. Concern focused on 1) issues of general community management and responsibility related to HIV and AIDS (the Ministry of Home Affairs as the lead sector working with the secretariat of the National AIDS Commission) as well as 2) technical issues such as availability and quality of service in a variety of settings, concerns of Ministries such as Health and Justice and Human Rights. (For examples of the evolution of policy specifically related to harm reduction see **Box 2**; For more examples of multisectoral policy development and action on other issues see **Box 6** below).

Box 6 : Some highlights from development of multi sectoral policy framework

Coordinating Minister of People's Welfare and National AIDS Commission Secretariat. 2007. Successive regulations and instructions related to organization and work of AIDS Commissions; Designation of the Executing Team of the National AIDS Commission; Release of the National AIDS Strategy 2007-2010; Guideline on monitoring, evaluation and reporting on HIV and AIDS in Indonesia; National policy on prevention and control of HIV and AIDS through harm reduction; **2008**. Guidance on development of provincial, district/ city policy on HIV & AIDS; Guideline for AIDS Commission secretariats.; Strategy on prevention of AIDS among Women; Strategy for prevention and control of AIDS among Children and Adolescents; **2010**. National AIDS Strategy and Action Plan 2010-2014.

Ministry of Home Affairs. 2007. On establishment of provincial and district/ city AIDS Commissions and empowerment of the community related to prevention and control of HIV and AIDS; **2008**. related to the AIDS response at the sub national level and funding of AIDS Commissions. **2009-2010**. Instructions on work and funding of sub- national AIDS Commissions.

Ministry of Health. 2006. Laboratory standards for testing of HIV and opportunistic infection; Guidelines for implementation of harm reduction; **2007**. Designation of referral hospitals for treatment of HIV and AIDS; Guideline on PMTCT **2008**. Designation of hospitals and satellite program for methadon maintenance and accompanying guidelines; Guideline for integration of harm reduction into public health center service program **2009**. Guideline for collaboration on controlling TB and HIV; Sectoral action plan on HIV and AIDS 2010-2014

Indonesian Armed Forces. 2006. Strategy for prevention and control of HIV-AIDS within the Ministry of Defense and the armed forces of Indonesia 2006-2010; Integrated bio behavioral surveillance in the armed forces as a basis for planning and policy development; **2008**. Guideline on universal precautions in military hospitals. **2010**. Strategic plan for prevention and control of HIV-AIDS in the Ministry of Defense and the armed forces of Indonesia 2010-2014.

Ministry of Justice and Human Rights, Directorate General of Corrections. 2005. National Strategy for prevention and control of HIV/AIDS and drug abuse in prison system 2005-2009. **2006**. National coordination meeting for operationalizing prison system AIDS and drug strategy; **2008**. VCT begins in 15 prisons **2010**. Strategy and Action plan for control of HIV and drug abuse in the prison system 2010-2014.

Sub-national level : Another effort to improve the environment for AIDS work was support for development of local policy and regulations to encourage and provide legal status for the response to HIV. Technical support and training, including appropriate

legal training, was provided by a team from NAC to representatives of AIDS Commissions at the sub-national level working toward formulation of gubernatorial decree or legislative decision. As of June 2011, fifteen provinces had adopted a provincial regulation on AIDS*, one province (West Java) has a Gubernatorial decree on HIV and AIDS. In five more provinces a regulation is being developed. At the next level of government 34 districts/ cities (across 11 provinces) have adopted local regulations on HIV and AIDS. Three, all in the province of Papua,† were adopted in 2003 The remaining 31 were all products of the period 2006 – 2010. (see **Annex 7**)

The clear task from the President in Regulation 75/ 2006 had been to mobilize a national response -- not just activity at the national level. For this reason the work was carried out at all levels. As seen above, the objective of much early policy work was to energize AIDS Commissions and their multi-sectoral members at the provincial, district/ city level, to systematize their work through development of well sustained, quality services systems distributed across the country. Likewise, guidance for monitoring, evaluation, and reporting was also provided.

Partnership among all stakeholders including religious and community leaders, as well as private sector.

Reflected in the concern with building systems there was also consistent effort to 1) assure a legal framework to protect the rights of PLHIV and people who worked with them; 2) destigmatize the subject of HIV and AIDS 3) to protect and facilitate the development and integration into existing government systems, particularly the public health system and other public service systems, the services needed by all PLHIV or people vulnerable to infection.

* **Provincial regulation :** Riau, Kepulauan Riau, Banten, DKI Jakarta, Jawa Tengah, DI Yogyakarta, Jawa Timur, Bali, Kalimantan Barat, Kalimantan Timur, Sulawesi Utara, Sulawesi Selatan, Nusa Tenggara Barat, Nusa Tenggara Timur, **Gubernatorial Decree :** Jawa Barat.

† **2003 :** Kabupaten Jayapura, Naibire, Merauke.

This structural approach to changing the environment led the way to scale-up of harm reduction in the public health service and partnership with the new intensified efforts for prevention of sexual transmission (PMTS). The process was in no way a denial of the important contribution of the early activists concerned with either sexual or drug-related transmission. Rather, having learned much from them and PWID, it was clear that young people needing and entitled to counseling, care support and treatment represented an important group of Indonesia's population who would always be under and inadequately served unless their needs were met within the overall framework of the public health service.

Changes in policy and program of the sort mentioned above combined with development of necessary services, and collaboration with the hard working, active community of PWIDs have brought about reductions in HIV prevalence among PWID, have made it possible for many PWID to return to independent, responsible community and family life through the availability of methadone maintenance therapy, and have made Indonesia a destination for field study about management of HIV and injecting drug use by other countries. Although the new structural approach to sexual transmission, PMTS, was only launched in 2009 indications are that it is generally well received where introduced and results have been encouraging with involvement of multiple stakeholders positive and calls for free and commercial condoms rising rapidly.

Public opinion and public attitudes

Public attitudes and actions related to HIV and AIDS are influenced by law and public policy and the rapid progress in that area from 2006 onwards was helpful. But evidence in Indonesia and around the world is clear that public education about HIV and AIDS and positive people through the media and other channels of public information plays an important role in determining how open or closed a society may be about the epidemic and its impact in the community.

In line with this concern and related to the effort to increase local budgets for AIDS, the National AIDS Commission immediately launched multiple efforts to mobilize leaders and provide information to the general public.

Work with the media was extensive at both national and local level providing news briefs and resource people for radio and TV. Training was periodically made available to journalists at both national and local level. The media were alerted to any newsworthy major AIDS-related event – commemoration of World AIDS Day (December each year) and the candle light memorial (May of each year), the launch of a new program, hosting or participating in national or international meetings. In a number of provinces the local AIDS Commission organized networks of journalists interested in HIV to share information about HIV and support each other.

Table 28 : Chair, responsible for national commemoration of World AIDS Day

Year	Responsible Person
2013	Chair, Indonesian Business Coalition on AIDS
2012	State Minister for Empowerment of Women and Child Protection
2011	Minister of Labor and Transmigration
2010	Minister of National Education
2009	Chair, The Indonesian Association of Public Health Specialists
2008	State Minister of Youth and Sport
2007	Head, The National Family Planning Coordinating Board
2006	Minister of Health

While much information is very basic, what is sometimes referred to informally as "AIDS 101" (what is HIV? modes of infection? alternatives to avoid infection? where to get more information?) some work with the media has focused on bringing information to particular audiences who may be hard to reach in other ways. For example, beginning in 2009 the IPF supported a Community Radio service to 6 provinces providing information specifically of interest to men who have sex with men, sex workers and PWID, audiences often difficult to reach in other ways. The program has expanded and by 2011 was supported by both APBN and IPF and was reaching audiences in 8 provinces.

But the need for information never ends. The NAC website and Facebook page (with 2000 members), as well as web pages of Spiritia and other HIV activist organizations, make a wide range of information related to HIV and the national response available to a broad audience across the country. The NAC publications program (see **Annex 11** : publication list, 111 titles) has reflected the NAC concern with both information sharing and accountability.

The NAC secretary and other speakers have also been regularly involved providing high level technical input at meetings of medical specialists, for example OB-GYN, national association of public health, and national association of midwives and others.

As the pace of the national response has picked up and demand for information has diversified, communications development has been a special focus of the current Australian AIDS program, HCPI, since 2008. In partnership with the NAC, HCPI has supported development of various communications strategies – a national communications strategy, one to advance work with the general population in Tanah Papua (developed with local organizations of positive people, AIDS service organizations,

and provincial AIDS Commissions of Papua and West Papua), and one with and for men who have sex with men.

The field of public education – formal, non formal, and informal – also has a contribution to make. Starting from the adoption of the National Education Strategy (2004)* there have been some efforts to develop educational materials at the national level. At the sub-national level a number of provinces have proceeded with education programs of their own, as well. As discussed earlier, the most fully developed effort, supported by both a gubernatorial decree and sectoral policy, is found in the province of Papua. Monitoring and evaluation of the experience in Papua as that policy is put into practice will provide important information for possible broadening of this approach to advance basic education about reproductive health and HIV and improve of the general public attitudes towards prevention and control of HIV and AIDS.

While much work in this area has focused on information sharing there has also been an important advocacy and promotion role played by high profile leaders as they have appeared as speakers in the media or at public events. At the highest level in Indonesia, the participation of President Susilo Bambang Yudhoyono at the opening of the ninth International Congress of AIDS in Asia and the Pacific (ICAAP IX) is illustrative. In his opening remarks the president spoke appreciatively of the work of the 5 networks of positive people (IPPI, JOTHI, OPSI, PKNI, GWL-Ina) and the importance of their participation in Indonesia's national response to HIV and AIDS. For many people that opening address provided a moment of great satisfaction. However, the impact did not stop there. The ripple effect of the President's remarks was still felt long after. In 2011 in New York during discussion of formulation of the Political Declaration at the High Level Meeting on HIV and AIDS (June 2011) his comment was quoted again as confirmation of national policy in Indonesia to encourage other countries toward agreement of the more inclusive language which was, in the end, adopted.

D. Building the National Response through partnership

1. Domestic partnerships : The spirit and practice of partnership have been crucial to the achievements of the national response throughout the past five years. Actors in the response have grown in number, diversity, and interests. The national response has benefited from this growth. At its best, partnerships have helped to assure that work related to HIV and AIDS addresses the needs of those people most directly affected, is sensitive to issues such as gender and human rights, and mobilizes and makes the best use possible of available interest, skills, and resources.

* *Strategi Pencegahan HIV/AIDS Melalui Pendidikan. 2004.*

Box 7 : The contribution of Partnership

Activism in the response to HIV has taken many forms. Partnership is the mechanism to maximize everyone's contribution. There are people who volunteer time, some individuals and organizations for whom HIV is a full time work. There are groups who provide financial and technical support or professional services. There are educators, advocates, researchers, trainers, private sector business managers, community leaders, faith-based activists, outreach workers, and service providers. There are NGOs, members of the media, government establishments, and international organizations contributing to human resources and systems development. All of these are crucial to both the immediate concerns of reducing new infection and raising the quality of life of PLHIV and their families as well as longer term sustainable effectiveness.

Focus and synergy in partnership has been promoted by the fact that the responsibility and authority of the NAC to manage the response is clear in Presidential Regulation 75/ 2006 and that successive National AIDS Strategy and Action Plans (2007-2010 and 2010-2014) are generally acknowledged as the overall umbrella for work in this field.

At the national level, partnership is evidenced in the multitude of collaborative/ consultative working groups all of which include members from government, civil society, representatives of key affected populations, and the NAC secretariat as well as international development partners as appropriate to the subject. While partners themselves will vary according to the objective of work, the pattern of dialogue and partnership is in practice across the country. Progress in institutionalizing the policy has varied over time, in different locations. However, the principle is clear -- it is national policy that the response to HIV and AIDS will be inclusive, collaborative, and synergistic.

Some examples from the NAC secretariat illustrate this pattern of work :

Related to fund management and program development :

- **IPF Steering Committee** (ISC, the top oversight body) and **Management Committee** (IMC, providing technical program advice and, on occasion, taking part in field mentoring and monitoring of IPF supported activity). Membership in both committees includes representatives of the Indonesian government plus donors to IPF representatives of key affected populations including PLHIV and civil society.
- Multi-level and multi-partner collaboration, consultation, and coordination was part of the program **development process and continues in implementation of Global Fund - supported scale-up** of the comprehensive response in 33

provinces and 137 districts/ cities. As mentioned earlier (see **Box 3** and **Table 19**) the complete program would not be possible without this partnership from planning through operations including monitoring and evaluations.

Specifically, within the GF supported activities for which NAC is responsible the proposal development process involved representatives of stakeholders at national as well as provincial level. Implementation is decentralized, carried out largely by local committees, NGOs, and independent operators of local outlets for sale/ distribution of condom, lubricants, and with program guidance and monitoring from local AIDS Commission secretariats supported by staff of the NAC secretariat using a combination of field visits as well as telephone and e-mail communication.

Day to day financial management of GF-supported work, meeting Indonesian and Global Fund standards and practices, likewise, is decentralized. The NAC secretariat provides training and support in financial management to all provincial and district/ city recipients of GF resources but they do their fund and program management locally. The NAC secretariat, as Principal Recipient, ultimately receives the program and financial reports from district, city, and provincial levels and is accountable to Global Fund for overall management and reporting on use of their grant money awarded to NAC. Cooperation and collaboration in this case is multi level and multi partner.

Related to program issues of on-going concern : There are multi-partner NAC working groups designated with letters of appointment[97] by the Secretary of the AIDS Commission and with on-going assignments, for example a working group on gender and human rights, a national working group on Papua, one on research, and there is an expert advisory group comprised of individuals and organizations with specialize knowledge and skills needed for balanced and technically up-to-date development of the response. Membership in each of these groups brings together representatives of key affected populations including PLHIV as well as drawing on relevant government sectors, NGOs, international development partners, and staff of the NAC secretariat.

Task-specific assignments : There are work groups/ teams with specific assignments. For example, development of successive National Strategy and Action Plans, development of communication strategy, strategy for men who have sex with men and others have all been developed in this way.

Within government at the national level, the two primary mechanisms/ vehicles promoting partnership and synergy among participants are the Executing Team of the NAC, established by article 5 of Presidential Regulation, and the BAPPENAS-based Forum for Planning and Budgeting for HIV and AIDS[98] which played an important role

in supporting increases in sectoral budgets to reach the levels reflected in Table 12 and integration of HIV and AIDS as a cross cutting concern of importance in Indonesia's mid term development plan.[99]

Multi-level partnership within government (national, provincial, district, city) : It is challenging to build multi level partnership across the breadth of the nation. Nonetheless, the NAC secretariat has used various devices to promote multi-level partnership, consultation, and collaboration with provincial AIDS Commissions and their partners as well as to encourage exchange of experience among provincial teams. In the first three years after Presidential Regulation came into effect (2007-2009) the NAC supported four regional meetings each year - one per region per year.

The Secretary of the National AIDS Commission travelled extensively to provincial, district, and city level for advocacy and consultation purposes. Likewise, the national staff work in regional support teams of three people (one each from M and E, finance, and technical program support) with one team focused on each of the four regions. The work of the regional support teams supplement on-going technical program support. This pattern of work, already in place by the time of the first round of regional meetings, grew in importance with the scale-up of the national response to 33 provinces as the successive Global Fund grants including NAC as a principle recipient came on line starting in July 2009.

As previously discussed, **partnership with civil society** in the national response -- the networks of key affected populations including PLHIV, the faith-based communities and the wide range of national and local AIDS education, advocacy, and service organizations -- as well as the private sector and media has been of high importance throughout. This has taken place in on-going dialogue, interaction, with key affected populations represented in the executing team of the national AIDS Commission, with civil society in working groups, strategy and policy development, program review, research design and other activity. Increasingly, Indonesian civil society organizations have also been hired as consultants to take part in program development or evaluation. Participation of civil society has not stopped at Indonesia's national borders. Civil Society partners in the response have been supported for participation in regional and international meetings on occasion sharing their experience, teaching practical skills related to prevention and management of HIV and AIDS, learning from the experience of others.

The five years since the Presidential Regulation on the National AIDS Commission have seen important, growing interest in HIV and AIDS in the **academic community** both as a subject for research and as a field increasingly recognized as important in the teaching curriculum. Where in 2006 the field would generally have had attention

only where an individual academic happened to be interested, now it is the focus of an evolving network of universities stretched across the country. Universities from Papua to Aceh have also provided critical input for evaluation and development of the national response as consultants taking part in program development and evaluation.

As with many other partnerships related to HIV and AIDS, each of the academic institutions has its own activity -- research and teaching -- but they are also working together on various projects. For example one group, is working on development of curricula for use in medical faculties - Faculty of Medicine, Faculty of Public Health and Faculties and Schools of nursing and midwifery. Consultations include discussion of teaching methodologies, key topics to be included in the curricula, and ethical issues involved and so forth. Having started with a small number of Universities, interest has grown among relevant faculties at other Universities with the result that the number of institutions included in consultation meetings on medical education and HIV has increased over time.

An exciting new initiative in 2010 has given birth to collaboration between some key affected populations, in this case men who have sex with men (MSM), a number of Indonesian Universities,* and LaTrobe University of Australia. They are working together on a project combining capacity building for field research and specific work with and for men who have sex with men. Activity will include issues related to research and instrument design, MSM mapping, a study of MSM norms and practices, a study of stigma, and one of how young people learn about sexual health. Noting the large number of men involved (an estimated 695,000 (2009), and their relative youth (perhaps as many 13% below the age of 19 and another 19% aged 19 – 24 this is an effort of great importance both in human terms and in terms of the response to HIV and AIDS. (see **Tables 3** and **4** with data on young people; **Annex 3** for MoH estimates of key affected populations, 2006 and 2009).

High Risk Men Another effort launched during 2011 is a public-private partnership for prevention of sexually transmitted diseases sexual transmission of infections including HIV among Indonesia's large, mobile, male work force. This new initiative is part of the overall effort to intensify, broaden, and increase effectiveness of prevention of sexual transmission.

2. International cooperation and partnerships : Chapter I, article 3, of Presidential Regulation calls for "regional and international cooperation within the framework of efforts to prevent and manage the response to AIDS." Such cooperation has taken two forms

* Among others, Hasanuddin University, Makassar, South Sulawesi; Udayana, Denpasar, Bali

1. participation in and hosting regional and international meetings/ discussions of HIV and AIDS; and
2. working on day to day basis with bilateral and multilateral partners.

The First Lady, Ibu Ani Yudhoyono as Indonesian AIDS Ambassador hosting the AIDS Ambassadors from Asia and the Pacific at ICAAP IX August 2009, Bali

Involvement in regional and international meetings :

Indonesia's highest profile, in-country involvement in an international event related to HIV and AIDS was hosting of the 9th International Congress of AIDS in Asia and the Pacific, (ICAAP) 9 - 13 August 2009 in Bali. The Congress was preceded by a meeting of AIDS Ambassadors and Champions from across the region hosted by Ibu Ani Bambang Yudhoyono and was opened by His Excellency President H. Susilo Bambang Yudhoyono.

Supported by the NAC secretariat, the Australian Government (AusAID), the AIDS Society of Asia and the Pacific (ASAP), the Global Fund for AIDS, TB and Malaria (GF), the World Health Organization (WHO), the Joint UN program on AIDS (UNAIDS), and the United Nations Fund for Population (UNFPA), the local organizing committee for ICAAP 9 involved people in both Jakarta and in Denpasar, Bali, where the Congress was held. By closing day the Congress has been visited by more than 6,000 people

from 78 countries nearly 4,000 of whom (3,824) were registered for the full meeting. Drawing on funds from the sponsors of ICAAP scholarships were provided to 229 delegates from 27 countries (130 full scholarships and 99 partial).

On the substantive side the meeting included skills building workshops, oral abstract presentation sessions, poster-based discussion, 24 symposia, and 68 satellite meetings and 5 major plenary sessions. A major exhibition area, the Asia-Pacific Village, provided a venue for display and information sharing about practical programs and field experience which was visited by 521 participants during the time it was open.

The media turned out in full force for the Congress with 262 media delegates registered and following events. An impressive 389 people contributed their services to the local organizing committee, among others, 218 volunteers working throughout the Congress.[100]

In the past five years Indonesians have participated in international meetings in countries as near-by as Singapore and Australia and as far away as Brazil, Namibia, and Poland. Indonesian activists are in attendance and almost always among invited speakers, panelists, and presenters at the larger, periodic global AIDS meetings -- the World AIDS Conference[101] and International Conference on Harm Reduction.[102] Often invited to share experience about the development of harm reduction in a country which is predominantly Muslim, Indonesia has also been asked to talk about working with faith based communities, mobilization of the multi sectoral national response to AIDS. The Secretary of the National AIDS Commission had been requested to speak at numerous international meetings, including donor meetings, on these subjects as well as issues related to gender and human rights, in the context of AIDS programming as well as development and management of the multi-sectoral response.

With the limited resources at its disposal for such activity, it has been a matter of policy, that NAC scholarships for participation in such meetings are given only for participants who will be actively presenting. Furthermore priority has been given to representatives of NGOs, key affected populations, women, and/ or participants from provincial and district/ city areas with limited access to resources.

Collaboration with international development partners.
Partnerships with international players in the field of HIV and AIDS are diverse and have an important role in Indonesia's national response. There is support to civil society work particularly with key affected populations, faith based groups, and NGO advocacy, education, and service groups working at the individual and community level. There is support for generation of new knowledge and skills through support to research, studies, and training. Equally important in the long run, there is important support to system building -- community systems, health system strengthening, and building of the AIDS Commission system for management of the overall response. Support takes various forms with funding, technical support, and training at home and abroad the most important.

During the years 2006 - 2008 the UK, the US and Australia were Indonesian's crucial partners both programmatically and financially and made possible launch of the consolidate national response. Thereafter, while Australia and the US continued their important active partnership, the Global Fund became by far the single largest source of financial support with its expenditure of US$ 20.2 million in 2009 followed by US$ 19.9 million in 2010. Overall, for the period 2006-2010, financial support came 31% from Global Fund, 19% each from Australia and the US, 18% from the UK, and 10% from the UN Family of agencies.

Table 29 : Cumulative financial support

Source of Funding	% of external support to national response 2006-2010
Global Fund	**31.07%**
Australia	**18.99%**
USA	**18.70%**
UK	**18.23%**
UN Agencies	**10.21%**
Other	**2.80%**
TOTAL	**100 %**

Source : Natonal AIDS Commission. NASA, 2006-2010

Support of the United Kingdom took the form of generous multi year financial support (the initial funds for the Indonesian Partnership Fund) for scale-up of service programs and development of the multi sectoral management system -- the AIDS Commission system -- across the country. Their grant monies began to flow in late 2005. The IPF was under Indonesian control and, as we have seen throughout this report, provided an

infusion of flexible resources which during the early years after Presidential Regulation was critical to the national response.

The US (USAID) and Australia (AusAID) both have long histories supporting HIV and AIDS work in Indonesia, both starting before Presidential Regulation 75/ 2006. They have worked extensively in 11 provinces* -- in some cases overlapping, in some cases alone. Both countries have given particular attention to supporting civil society work with and for key affected populations - PWID, male, female, and transgender sex workers. The work of both Australia and the US has included skill training, provision of technical support (sometimes longer term staff accompanying local staff, sometimes incidental support to help with particular issues), studies, and evaluation. Both have worked with local AIDS Commissions in the provinces where they were active. While there are these broad similarities there have been distinctions as well.

The Australian program underway at the time the Presidential Regulation was issued (Indonesian HIV/ AIDS Prevention and Care Project - IHPCP) had been developed in consultation with Indonesian institutions at various levels.

The current program, HCPI, was developed in the new context, in close cooperation and consultation with the NAC secretariat. The result was a productive, on-going partnership with periodic planning and evaluation meetings continuing as the program is under way. Development of the new program was an opportunity to integrate the technical and service support offered by Australia within the overall context of Indonesia's national response. Australia embraced this new opportunity and, as requested, gave priority in the new program to support of harm reduction, institutional development for the overall AIDS management system, human resource development for professionalization of the response, and the comprehensive program in the prison system. They have also supported the Clinton Health Access Initiative (CHAI) providing Technical Assistance related to procurement and supply management of ARV, some technical assistance to the NAC on procurement and supply issues related to condoms and lubricants plus high level clinical mentoring for doctors in two districts and one city in Papua, Jayapura and Jayawijaya Districts and the city of Jayapura.

Development of this program also provided opportunity to rationalize the work supported by Australia and the US. With coordination and leadership from the National AIDS Commission it was agreed that in areas of geographic overlap (high priority areas) the Australian program would focus on building capacity for harm reduction outreach and services and the US would continue work focusing on sexual transmis-

* USAID : Sumatera Utara, Kepulauan Riau, Jakarta, West Java, Central Java, East Java, Papua and Papua Barat. AusAID : 2006-2008 DKI Jakarta, West Java, Bali, Sulawesi Selatan, Papua. 2008 to present DKI Jakarta, West Java, Central Java , Yogyakarta, East Java, Banten, Bali, Papua Barat and Papua.

sion. In addition to their work on Harm Reduction the Australian program is also supporting important capacity building of the AIDS Commission system in 14 provinces across Indonesia with training and technical support. An additional component in the partnership with Australia is focused on research and studies producing critical new knowledge about the epidemic, the response, and its effectiveness through collaborative research efforts of Australian and Indonesian teams.

In Tanah Papua, with its low level generalized epidemic where both the US and Australia have been supporting work for some time, the evolution of activity has been somewhat different. In the years 2006-2008 Family Health International worked in Tanah Papua supported by both USAID and IPF. Work concentrated on provision of technical support to an undertaking of the health sector to strengthen their capacity for VCT and to diagnose and deliver appropriate care, support and treatment related to HIV and AIDS in 11 priority districts and cities. Complementing this work and aiming for some kind of synergy among activities, FHI worked in the same districts and cities with civil society groups concerned with sexual transmission, support for PLHIV and community as well as faith based groups doing basic AIDS education throughout the two provinces. During that time the Australian program worked on different aspects of AIDS education and communication (for example multi media, radio) and capacity building with local AIDS Commissions.

As the new Australian program cycle kicked-in (2008), the agreement for clearer "division of labor" between the work they supported and the work supported by USAID (also moving toward a new program cycle) had a positive effect in Tanah Papua as well as elsewhere. Work related to sexual transmission and support for NGOs working with and for key affected populations continued as a focus with the USAID supported work. The Australian program at the same time scaled up their work in AIDS education and communication, took on support for civil society groups working with general population (which FHI had been supporting earlier) and continued their support to institution building of the AIDS Commission network at the local level.

In 2011, among multilateral partners the Global Fund is the largest contributor in financial terms and in terms of "coverage". As previously mentioned, the national scale-up of the comprehensive response supported by Global Fund had reached 137 districts/cities in all 33 provinces by 2010 and in 2011 will have reached 159. (see **Annex 4**).

The UN family of agencies have contributed to the national response in line with their respective areas of expertise :

- **UNICEF** and **UNFPA**[103] : particularly related to the situation and needs of young people (practical field programs as well as policy development, advocacy, research and analysis as input to the national response),[104]

- **UNODC**[105] : important support related to advocacy for harm reduction in both community and prison settings as well as important technical assistance for comprehensive HIV prevention and treatment of drug addiction
- **WHO**[106] : working with the health system both piloting new approaches as needed and supporting on-going health systems strengthening related to HIV and AIDS with development of guidelines, training and other approaches
- **UNESCO**[107] : occasional activity related to education policy and materials
- **ILO**[108] : related to workplace policy and programs, particularly in connection with the planning and development of the 2011 initiative to take effective programming for prevention of sexual transmission to and from high risk men and migrant workers
- **UNAIDS**[109] as coordinator of UN information and activity on HIV and AIDS supported the strengthening of the Global Fund Country Coordinating Mechanism Secretariat with particular attention to support related to HIV and AIDS

Meeting held by the Global Fund and Japanesse Ministry of Foreign Affairs in Tokyo, May 2008. Left to right: Dr. Peter Piot, Executive Director UNAIDS; Dr. Nafsiah Mboi, Indonesian National AIDS Commission Secretary; Mr. William Bowtell, Executive Director, Pacific Friends of GF-ATM; Dr. Nafis Sadik, Special Envoy (HIV and AIDS) of the Secretary General of the United Nations; Dr. Michel Kazatchkine, Executive Director, Global Fund to Fight AIDS, TB, and Malaria.

Partnership with UN agencies varies somewhat from one agency to the next. Some agencies arrange regular consultation with the NAC secretariat, seek dialogue and search for ways to contribute to Indonesia's national response as laid out in successive national strategy and action plans. Others appear to have less scope to adapt existing plans, or launch new activity.

Over the five years 2006 - 2011 there has been much improvement in collaboration, coordination and partnership with the UN as they have come to understand the assignment of the National AIDS Commission and the mutual benefit to be had from close cooperation. In general, the agencies now are good partners to the national response, well equipped to provide clearly defined expertise and help with deliberations of policy and program alternatives drawing on global literature and experience as requested. In some cases they are also able to work with Indonesian partners to supplement this global data and experience with local, Indonesian research and pilot studies. At the same time, more agencies consult with the NAC secretariat than formerly when considering HIV-related aspects in their own programming, and program sites for activity.

All of the agencies operate on limited budgets and, as is appropriate, none attempts to have national scope in the Indonesian setting. On the other hand, some have focused attention over a considerable period of time on one issue (in line with their mission) or one geographical area over a considerable period of time, with significant cumulative useful impact. For example, during most of the years since Presidential Regulation 75/ 2006 UNICEF with the support of the Dutch government has provided technical assistance to the Provincial Departments of Education in Papua and West Papua in their effort to mainstream education about HIV and AIDS in formal, non formal, and informal education. Working within government including with AIDS Commissions and technical departments such as education and health at provincial and district/ city level, UNICEF has supported advocacy, policy and curriculum and materials development, pilot testing of new approaches for delivery of services, research and data collection, as well as capacity building with partners as diverse as Bappeda, the local offices of the Bureau of Statistics, the health sector as well as education, youth and sport.

Beyond these efforts of government players there has also been important collaboration with a full range of other stakeholders with an interest in education -- faith based communities and young people themselves both in and out of school. For example, in Papua a gubernatorial decree calling for mainstreaming had been issued (28 Dec 2010).[110] In both provinces departmental policies had been developed and issued to set standards and guide the process of mainstreaming HIV and AIDS education. New curricula and accompanying teaching/ learning materials were being used. A full workplace policy had been launched emphasizing the department's responsibility to educators, learners in formal, non-formal, and informal settings, and the community for full and accurate teaching about HIV and AIDS as well as support to everyone in the "education community" (staff, learners and their family) to facilitate access to HIV related services, as needed, outside the education department's areas of expertise.

At the national level, UNICEF has worked with the secretariat of the National AIDS Commission on a number of important activities focused on identifying and taking action to reduce vulnerability to HIV infection among children and young people. Principle activities included supporting the development of the "National Strategy for Children, Youth and HIV (2007 - 2010)" as well as analysis of age disaggregated survey and research data focused on the situation of most at risk young people (age 15 - 24 years) vis a vis their risk of HIV infection as well as their access to information and services.[111] They have also provided technical assistance for development of action programs related to most at risk youth (MARY) and most at risk adolescents (MARA).

Partnership with UNODC likewise has been effective and extremely useful during the past 5 years of intensive work on issues related to drugs, drug use and the HIV epidemic. UNODC provided technical assistance for policy and program development for HIV prevention among PWID and comprehensive treatment of drug addiction. They supported wide ranging policy discussions as well as facilitating and encouraging domestic and international exchange of experience, specifically, as previously mentioned South-South dialogue.

The work of a number of International NGOs both large and small[112] is hardly seen in the macro measures of the national response such as NASA. On the other hand, in their respective fields of expertise or particular geographical area of work, their efforts are often much appreciated and make a real contribution to the national response. Activities have included technical support, training, materials development, support for service programs that have helped empower local NGOs and the communities they serve to mobilize themselves to acknowledge and work to address the threat of HIV and AIDS in their own community.

04 Looking Ahead

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.

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

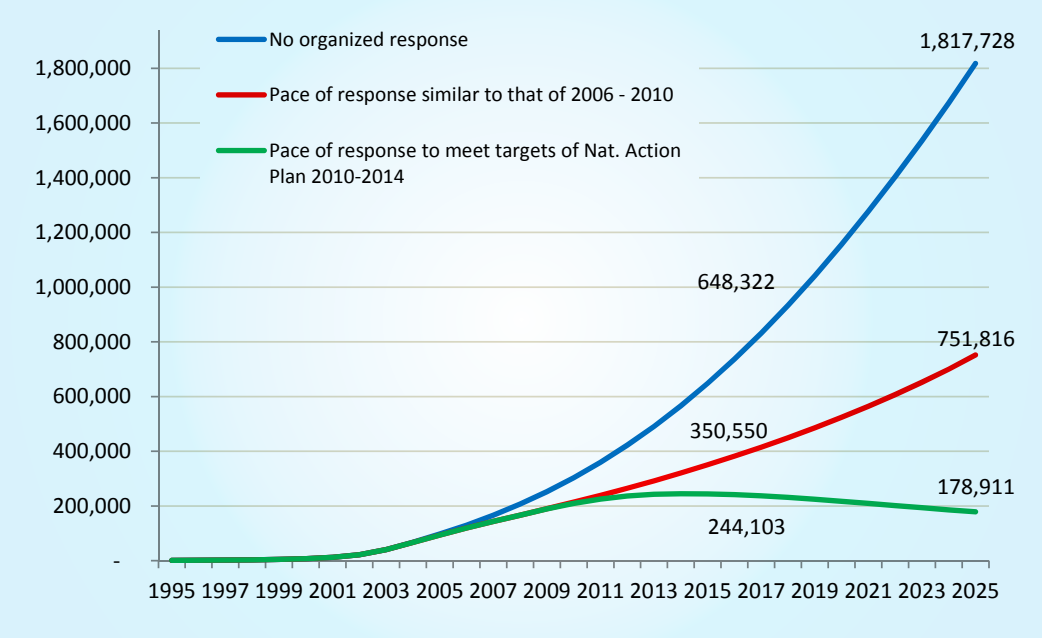
1) With **no organized action**, it is estimated that infection would follow the trajectory of the blue line (**Chart 13**, below), reaching 648,322 people by 2015.

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 13**)

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. (see **Chart 13**)

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.

Chart 13: Modeling the impact of 3 scenarios responding to the HIV epidemic in Indonesia

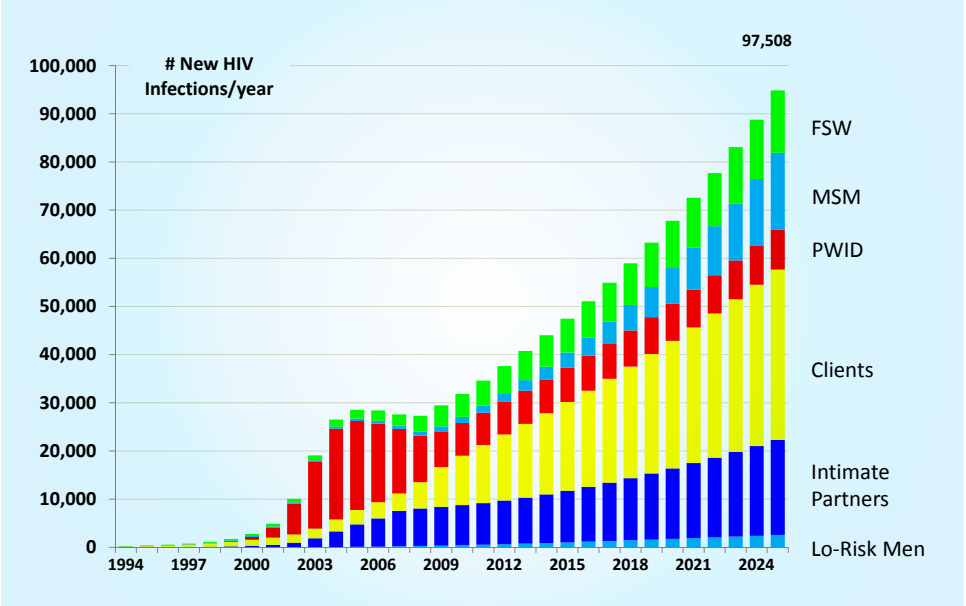


Source: National AIDS Commission

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 14**, 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 or 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. (see **Chart 14**)

Although the pace of increase will be slowing nonetheless, the total number of people (women, men, and children) living with HIV will 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 a primary concern.

Chart 14: Projected impact of HIV and AIDS to 2025



Source: National AIDS Commission

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, and 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 20/2007 of the Minister of Home Affairs (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 may assure APBN through 2014. Nonetheless, the amount allocated is inadequate to meet the needs of the national response that if external resources (GFATM, AusAID, USAID etc.) were to decline or stop altogether the current comprehensive work would be seriously threatened. In ad-

dition, 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 guaranteed.

At this time there are 16 Provinces and 34 district/ cities with regulations on HIV and AIDS. In these areas, the AIDS budget depends on the personal commitment of the governor, district head, mayor, and members of the legislature (DPRD). (**Annex 7** : Provinces, districts/ cities with local AIDS regulations, 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 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 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 and other sex stimulants needs 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 with growing interest and activity by KPA.

  Comprehensive prevention of sexual transmission with structural intervention (PMTS): Prevention of sexual transmission needs strengthening with increase of outreach and strengthening of quality 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 ship's crews, 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 whether between husband and

wife, casual hetero- sexual sex, homo- sex, or bi-sex will continue a priority concern. In an effort to understand and assure access to the widest possible range of options for prevention, the National AIDS Commission is also 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 both for the women and families involved and as part of the comprehensive response to HIV and AIDS and 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 staff training necessary.

- **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 the 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, mutual support groups of PLHIV (KDS – *Kelompok Dukungan Sebaya*), organizations of people who are HIV+ and the community in general as well as income generating and other activities to mitigate the social-economic impact of the HIV epidemic.

- **Partnership of government and civil society:** The number of civil society organizations/ activists and their role in the response to HIV and AIDS has grown significantly in both number and importance in the past five years –
  1) 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 secretariats and working groups;
3) Five national networks of key affected populations – IPPI, GWL-Ina, OTHI, PKNI and OPSI – have been formed each of which has received since from founding support for operational costs and activities from the secretariat of the National AIDS Commission; **(Table 9**)
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[39] and totaled Rp. 251.678.843.635 (US$ 29,609,276).

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 sys-tem strengthening is also needed to expand the capacity for 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.

Conclusion : "The Response to HIV and AIDS in Indonesia, 2006 – 2011 : Report on 5 Years Implementation of Presidential Regulation 75/ 2006" has been written with participation of relevant government departments, civil society, PLHIV, the academic community, and the international development partners.

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. In closing, the drafting committee hopes 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.

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42 Announcements through newspaper, word of mouth, information to AIDS Commissions across the country, and through the internet.
43 The Indonesian name is *Pencegahan HIV Melalui Transmisi Seksual* , hence the abbreviation PMTS. PMTS uses the structural approach to reduce sexual transmission reaching out to sex workers, their clients and the full spectrum of stakeholders in the area -- local government, local police, pimps, shop keepers, health care providers. There are four components to the PMTS approach - (1) strengthening the positive engagement of stakeholders, (2) behavior change communication, (3) management of condoms and lubricants, (4) treatment of sexually transmitted infection.
44 Evaluation was carried out in 7 provinces – Papua, Bali, East Java, West Java, DKI Jakarta, Riau, and the Riau Islands. A multi sectoral team took part in each province with the following signatories to the Commitment joining the evaluation team for 1 or more provinces : Office of the Coordinating Minister of People's Welfare, Indonesian Parliament, National Narcotics Board, Indonesian Forum of Parliamentarians for Population and Development, Department of Health, Department of Social Affairs, Department of National Education, National Family Planning Coordinating Board, UNAIDS.
45 National AIDS Commission. *One Year of the Sentani Commitment : Report on a Participatory Evaluation Process in Indonesia and Some Conclusions.* Feb 2005, p 19.

46 *Peraturan President 05/2010 ttg. Rencana Pembangunan Jangka Menengah Nasional (PRJMN) 2010-2014).* 20 January 2010.
47 *Instruksi President 03/2010 ttg Program Pembangunan yang Berkeadilan.* 21 April 2010.
48 *National AIDS Strategy and Action Plans of 2007-2010 and 2010-2014*
49 MoH and NAC. *Laporan Nasional : Estimasi Populasi Dewasa Rawan Terinfeksi HIV Tahun 2006* (23 Nov 2006)
50 NAC. *Meningkatkan Penggungaan Kondom Pada Setiap Hubungan Sexual Berisiko. 2007* (unpublished)
51 Support from GF, APBN, and UNFPA. GF supported the vast majority of male condoms - 12,209,888 -- and packets of lubricant -1,067,866. Female condoms were supplied by initially by FHI, latterly and in larger quantities by APBN and UNFPA.
52 Sales report of DKT. July 2011.
53 Although the total number of people in the national secretariat did not change during the first year, 2006 – 2007, the personnel and configuration of the secretariat underwent major change. Likewise, the gender balance changed moving from 31% women and 69% men to almost exactly half and half men and women, where it has stayed since then.
54 As agreed by the governments of Indonesia and the UK, the UNDP would act as Fund Manager for IPF (paid a fee of 7%) until such time as it was agreed that the NAC secretariat was in a position to take over that responsibility. The transition to full management by the NAC secretariat is scheduled to take place in January 2012.
55 For example, among other activities the Australian project worked particularly closely supporting the National AIDS Commission secretariat and the USAID-supported work provided extensive technical support to the Health Department.
56 Decrees of the Minister successively numbered 03 on structure, tasks, and membership of the National AIDS Commission; 04 on guidelines and work systems of AIDS Commissions of national, provincial, and district/ city level; 05 on organization and work of National AIDS Commission; on the executing team of the National AIDS Commission; 08 on guidelines for national monitoring, evaluation, and reporting related to HIV and AIDS throughout Indonesia. *[No 3 ttg susunan, tugas dan keanggotaan Komisi Penanggulangan AIDS Nastional; no 4 ttg. Pedoman dan Tata Kerja Komisi Penanggulangan AIDS Nasional, Provinsi, dan Kabupaten/ Kota; No 5 ttg. Organisasi dan Tata Kerja Komisi Penanggulangan AIDS Nasional; No 8 ttg. Pedoman Nasional Monitoring, Evaluasi dan Pelaporan HIV dan AIDS di Seluruh Indonesia.]*
57 Decree number 07/ PER/ MENKO/ KESRA/ III/ 2007 of the Coordinating Minister of People's Welfare/ Chair of the National AIDS Commission on the National AIDS Strategy 2007-2010. *[no 7 ttg Strategi Nasional Penanggulangan HIV dan AIDS Indonesia 2007-2010.]*
58 The 2006 MoH and BPS *estimate of population at risk and PLHIV and the results of their bio behavioral surveillance in the two provinces* of Tanah Papua (data collected late 2006, sharing of results in early 2007)
59 *Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2007- 2010.*
60 National AIDS Commission. *National AIDS Spending Assessment. 2006-2007.*
61 Primarily with Australia and the US but there was also modest support from the Dutch, Japan, EU and others.
62 Regulation of the Minister of Home Affairs 20/ 2007 with guidelines for establishment of AIDS Commissions and Empowerment of Communities for the response to HIV and AIDS at the provincial, district/ city level. *Peraturan Menteri Dalam Negeri No 20/ 2007 tentang Pedoman umum Pembentukan Komisi Penanggulangan AIDS dan Pemberdayaan Masyarakat Dalam Rangka Penanggulangan HIV dan AIDS di Daerah. 17 April* 2007.

63 Regulation of the Minister of Home Affairs 59/ 2007 on the change in Regulation 13/ 2006 on guidelines on management of funds at the provincial, district/ city level. *Peraturan Menteri Dalam Negeri No 59/ 2007 ttg. Perubahan atas Peraturan Menteri Dalam Negeri no 13/ 2006 ttg pedoman pengelolaan keuangan daerah*. 26 October 2007.
64 Preliminary NASA data on AIDS expenditures 2009-2010.
65 Reported sectoral budgets.
66 Presidential regulation 05/ 2010 on the National Mid Term Development Plan. *Peraturan Presiden 05/ 2010 ttg Rencana Pembangunan angka Menengah Nasional (RPJMN).*
67 Presidential instruction 03/ 2010 on the program of just development. *Instruksi Presiden 03*/2010 *ttg. Program Pembangunan yang berkeadilan*. Instruction for intensification of efforts for just development including effort to achieve MDG goals.
68 MoH. Report on the situation of HIV and AIDS. 2nd quarter (30 June) 2011.
69 MoH and Central Bureau of Statistics. *National Report on Estimates of Adults Vulnerable to HIV Inection in Indonesia, 2009.*
70 Key tools for monitoring impact of efforts to bring the epidemic under control, surveillance was carried out in 2002, 2004, and 2007and results published. Surveillance was successfully carried out in 2011 but as of writing results were not yet available.
71 NAC. "*Meningkatkan Penggunaan Kondom Pada Setiap Hubungan Seksual Berisiko*". Unpublished. 2007
72 Pencegahan HIV Melalui Transmisi Sexual (PMTS).
73 NAC. Notes on progress, inventory and partnership in PMTS provided by relevant program officer. 30 July 2011.
74 From MoH records, July 2011
75 Decree of the Minister of Health No 1507/Menkes/SK/X2005 on guidelines for HIV/ AIDS counseling and testing. [*Keputusan Menteri Kesehatan No 1507/Menkes/SK/X2005 tentang pedoman Pelayanan Konseling and Test HIV/AIDS secara sukarela*.]
76 142 districts/ cities = 29% of all districts/ cities in Indonesia.
77 MoH. Report on the Situation of HIV and AIDS in Indonesia. 2nd quarter (30 June) 2011.
78 MoH. Report on the Situation of HIV and AIDS in Indonesia. 2nd quarter (30 June) 2011.
79 Data on breakdown of ARV status taken from Report on the Situation of HIV and AIDS in Indonesia. 2nd quarter (30 June) 2011, Bagan 2.1, p 20 as corrected 28 July 2011.
80 Patients dying who are on ARV.
81 MoH. Report on Development of HIV and AIDS in Indonesia. 2nd quarter (June) 2011.
82 The study involved both qualitative and quantitative segments. The quality of a respondent's life was self evaluated by the respondent
83 Yayasan Spiritia, Universitas Hamka, dan KPA Nasional. 2011. *Pengaruh Dukungan Sebaya Terhadap Mutu Hidup ODHA*. Jakarta.
84 MoH Table "*Opportunistic Infection Reported in AIDS cases*" included in quarterly report on status of HIV and AIDS in Indonesia. Report for June 2011 indicates 12,304 as opportunistic infection out of a total of 32,319 reported, 38.07%.
85 MoH data. July 2011.
86 The mother gets ARV from the second trimester of pregnancy.
87 MoH. Information provided Jul 2011.
88 IPF. *Scaling Up the Indonesian AIDS Response : Report on the Indonesian Partnership Fund for HIV and AIDS*. 2005-2008. June 2008.

89 Peraturan Menteri Koordinator Bidang Kesejahteraan Rakyat no 4/ 2007 *ttg Pedoman dan Tata Kerja Komisi Penanggulangan Nasional, Provinsi dan kabupaten/ Kota.* [Translation, see note xcvii)

90 *Peraturan Menteri Koordinator Bidang Kesejahteraan Rakyat no 5/ 2007 ttg Organisasi dan Tata Kerja Komisi Penanggulangan AIDS Nasional* [Translation, see note xcvii)

91 *Peraturan Menteri Koordinator Bidang Kesejahteraan Rakyat no 6/ 2007 ttg Tim Pelaksanan Komisi Penanggulangan AIDS Nasional* [Translation, see note xcvii)

92 *Peraturan Menteri Koordinator Bidang Kesejahteraan Rakyat no 8/ 2007 ttg pedoman nasional monitoring, evaluasi dan pelaporan HIV dan AIDS di seluruh Indonesia* [Translation, see note xcvii)

93 Global Fund Grants to Indonesia. Round 1 (2003-2007), Round 4 (2005-2010).

94 Principle Recipient. Terminology used in by Global Fund to Fight AIDS, TB, and Malaria for their direct grantees. Principle Recipients are authorized to work with sub recipients but the Principle Recipient is the grantee receiving and accountable for funds.

95 Data from National AIDS Commission reports on utilization of Global Fund resources.

96 Surat keputusan. Working groups on education, harm reduction, prevention of sexual transmission (PMTS), workplace, Papua, gender and human rights.

97 Forum Perencanaan dan Penganggaran HIV dan AIDS. [Forum for HIV and AIDS planning and budgeting]

98 *Rencana Pembangunan Jangka Menengah Nasional 2010-2014* (RPJMN). [National Mid-term Development Plan 2010-2014.]

99 Data on ICAAP from closing remarks and final report.

100 2006 in Toronto, 2008 in Mexico City, 2010 in Vienna.

101 2007 in Warsaw, Poland, 2008, Barcelona, Spain, 2009 in Bangkok, Thailand, 2010 in Liverpool, England, 2011 in Beirut, Lebanon.

102 United Nations Children's Fund, United Nations Population Fund.

103 For example UNICEF recently organized a analysis of data about young people, age 15 - 24, at increased risk of HIV infection because of life style choices or occupation.

104 United Nations Office on Drugs and Crime.

105 World Health Organization.

106 United Nations Education and Cultural Organization.

107 International Labor Organization.

108 Joint United Nations Program on HIV and AIDS.

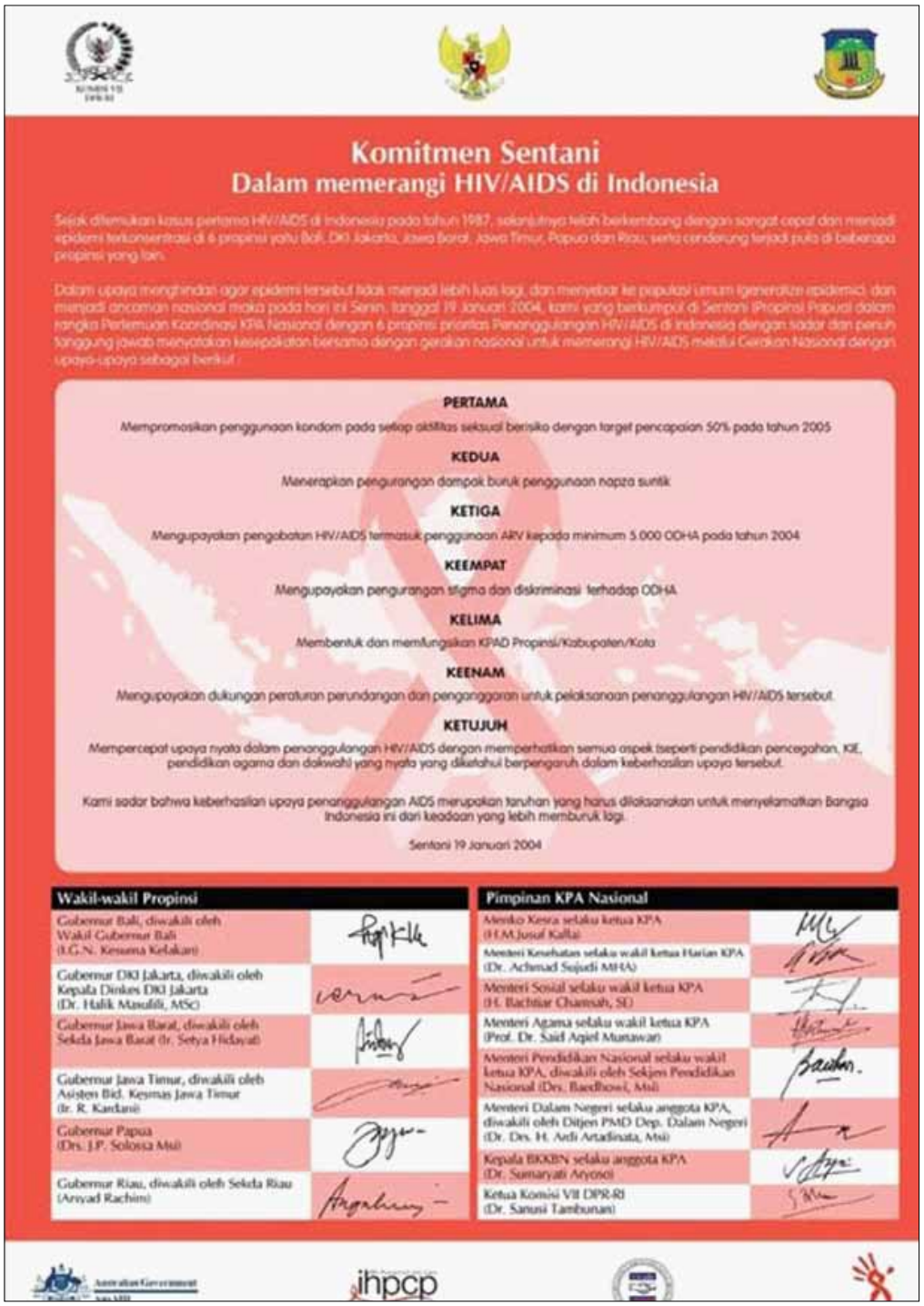
109 *Regulation 26/ 2010 of the Governor of Papua on mainstreaming of HIV and AIDS in education.* Peraturan Gubernur Papua No 26 Tahun 2010 ttg Pengarusutamaan HIV dan AIDS Melalui Pendidikan. 28 Dec 2010.

110 NAC and UNICEF. Report : Age Group Disaggregated on Survey and Research Data. Pre-publication review. Scheduled for publication 2011

111 The following list is suggestive, not definitive with no distinction made between organizations with shorter or longer term involvement in the field : Asia Pacific Network of People Living with HIV and AIDS,Care, CordAID, HIVOS, IMPACT, INTERNA, Lutheran World Federation, Oxfam, Project Concern International (PCI), Medicin du Mond, Medicin Frontier, Salvation Army, Save, World Relief.

Annexes

Annex 1



Komitmen Sentani
Dalam memerangi HIV/AIDS di Indonesia

Sejak ditemukan kasus pertama HIV/AIDS di Indonesia pada tahun 1987, selanjutnya telah berkembang dengan sangat cepat dan menjadi epidemi terkonsentrasi di 6 propinsi yaitu Bali, DKI Jakarta, Jawa Barat, Jawa Timur, Papua dan Riau, serta cenderung terjadi pula di beberapa propinsi yang lain.

Dalam upaya menghindari agar epidemi tersebut tidak menjadi lebih luas lagi, dan menyebar ke populasi umum (generalize epidemic), dan menjadi ancaman nasional maka pada hari ini Senin, tanggal 19 Januari 2004, kami yang berkumpul di Sentani (Propinsi Papua) dalam rangka Pertemuan Koordinasi KPA Nasional dengan 6 propinsi prioritas Penanggulangan HIV/AIDS di Indonesia dengan sadar dan penuh tanggung jawab menyatakan kesepakatan bersama dengan gerakan nasional untuk memerangi HIV/AIDS melalui Gerakan Nasional dengan upaya-upaya sebagai berikut :

PERTAMA

Mempromosikan penggunaan kondom pada setiap aktifitas seksual berisiko dengan target pencapaian 50% pada tahun 2005

KEDUA

Menerapkan pengurangan dampak buruk penggunaan napza suntik

KETIGA

Mengupayakan pengobatan HIV/AIDS termasuk penggunaan ARV kepada minimum 5.000 ODHA pada tahun 2004

KEEMPAT

Mengupayakan pengurangan stigma dan diskriminasi terhadap ODHA

KELIMA

Membentuk dan memfungsikan KPAD Propinsi/Kabupaten/Kota

KEENAM

Mengupayakan dukungan peraturan perundangan dan penganggaran untuk pelaksanaan penanggulangan HIV/AIDS tersebut.

KETUJUH

Mempercepat upaya nyata dalam penanggulangan HIV/AIDS dengan memperhatikan semua aspek (seperti pendidikan pencegahan, KIE, pendidikan agama dan dakwah) yang nyata yang diketahui berpengaruh dalam keberhasilan upaya tersebut.

Kami sadar bahwa keberhasilan upaya penanggulangan AIDS merupakan taruhan yang harus dilaksanakan untuk menyelamatkan Bangsa Indonesia ini dari keadaan yang lebih memburuk lagi.

Sentani 19 Januari 2004

Wakil-wakil Propinsi	
Gubernur Bali, diwakili oleh Wakil Gubernur Bali (I.G.N. Kesuma Kelakan)	
Gubernur DKI Jakarta, diwakili oleh Kepala Dinkes DKI Jakarta (Dr. Halik Masulili, MSc)	
Gubernur Jawa Barat, diwakili oleh Sekda Jawa Barat (Ir. Setya Hidayat)	
Gubernur Jawa Timur, diwakili oleh Asisten Bid. Kesmas Jawa Timur (Ir. R. Kardana)	
Gubernur Papua (Drs. J.P. Solossa Msi)	
Gubernur Riau, diwakili oleh Sekda Riau (Arsyad Rachim)	

Pimpinan KPA Nasional	
Menko Kesra selaku ketua KPA (H.M.Jusuf Kalla)	
Menteri Kesehatan selaku wakil ketua Harian KPA (Dr. Achmad Sujudi MHA)	
Menteri Sosial selaku wakil ketua KPA (H. Bachtiar Chamsah, SE)	
Menteri Agama selaku wakil ketua KPA (Prof. Dr. Said Aqiel Munawar)	
Menteri Pendidikan Nasional selaku wakil ketua KPA, diwakili oleh Sekjen Pendidikan Nasional (Drs. Baedhowi, Msi)	
Menteri Dalam Negeri selaku anggota KPA, diwakili oleh Ditjen PMD Dep. Dalam Negeri (Dr. Drs. H. Ardi Artadinata, Msi)	
Kepala BKKBN selaku anggota KPA (Dr. Sumaryati Aryoso)	
Ketua Komisi VII DPR-RI (Dr. Sanusi Tambunan)	

Annex 2

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 3

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 4

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

Annex 5

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 6

Active care, support and treatment.

Hospitals (218) and satellites (68 - hospitals and public health centers)

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 Prov.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

Juni 2011. Active care, support and treatment

Hospitals (218) and Satellites (68 - Hospitals and Public Health Centers)

No	Province	District/City	Hospital	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	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	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 7

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 regulations at district/ city level : 34

Annex 8

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.

1

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
18. Dja'far, DIrektorat Penanggulangan Masalah Kesehatan Reproduksi BKKBN
19. Tarwadi, Kedeputian Bidang Teknologi Agroindustri dan Bioteknologi, BPPT
20. Ediani Rahardjanti, Sub Direktorat Komunitas Terapeutik, Direktorat Penguatan Lembaga Rehabilitasi Komponen Masyarakat, Deputi Rehabilitasi, BNN
21. Buyung Nazili, Direktorat Kesehatan Kuathan, Dephan
22. Andie Endrijatno, Perwakilan SAM PU Bidang Hubungan Antar Lembaga Kementerian Pekerjaan Umum
23. Dindin Wahyudin, Direktorat Sosisal Budaya dan OINB, Ditjen Mulitlateral, Kementerian Luar Negeri
24. Daeng Faqih, Perwakilan Pengurus Besar Ikatan Dokter Indonesia, PB.IDI
25. Husein Habsyi, Perwakilan Ikatan Ahli Kesehatan Masyarakat Indonesia
26. Exkuwin Suharyanto, Perwakilan Pengurus Pusat PMI bidang Kesehatan dan UTD
27. Nina Tursina, Komite Tetap Perdagangan Internasional KADIN Indonesia
28. Christine Wahyuni, Yayasan Spiritia
29. Omar Syarif, Kornas JOTHI
30. Sunarsih, Kornas IPPI
31. Tono Permana, Kornas GWL INA
32. Susi Nurti Feriana, Kornas OPSI
33. Samuel Nugraha Kornas PKNI
34. Evodia Iswandi Country Program, IBCA

TIM PENULIS

KETUA: Kemal N. Siregar

SEKRETARIS: Wenita Indrasari
KONSULTAN: Karen H. Smith

ANGGOTA:

1. Mohamad Subuh, Direktur P2M, Kemkes
2. Tony Wandra, KaSubDit AIDS dan IMS, Kemkes
3. Chabib Aswan, Asdep Urusan Pencegahan dan Penanggulangan Penyakit Kementerian Koordinator Bidang Kesejahteraan Rakyat
4. Enang, Direktorat Tuna Sosial Kementerian Sosial

5. Dyah Ayu N.H, Direktorat Jenderal Pemasyarakatan Kementerian Hukum dan Hak Asasi Manusia
6. Adhi Setyo M., Direktorat Kesehatan dan Gizi Masyarakat, Bappenas
7. Mayda Wardianti, Direktorat Jenderal Pelayanan dan Rehabilitasi Sosial, Kementerian Sosial
8. Budi Utomo, Universitas Indonesia
9. Robert Magnani, Family Health International
10. Nurcholis Madjid, Family Health International
11. Abby Ruddick, HCPI
12. Nancy Fee, UNAIDS
13. Irawan Kosasih, WHO
14. Nadiar, Sekretariat KPA Nasional
15. Suriadi, Sekretariat KPA Nasional
16. Asep Kurniawan, Sekretariat KPA Nasional
17. Roberta Taher, Sekretariat KPA Nasional
18. Irawati Atmosukarto, Sekretariat KPA Nasional

Annex 9

Ministerial Decree
KepMenKes : 781/MENKES/SK/VII/2004 : 7 Jul 2004

Rumah Sakit Rujukan Bagi Orang Dengan HIV dan AIDS
Referral hospital for HIV and AIDS

1 DKI Jakarta	1		RS Dr. Cipto Mangunkusumo
	2		RS Fatmawati
	3		RS Persahabatan
	4		RS Kanker Dharmais
	5		RS Duren Sawit
	6		RSPI Sulianti Saroso
	7		RSPAD Gatot Soebroto
	8		RSAL Mintohardjo
	9		RS POLRI Kramat Jati
2 Jawa Barat		Bandung	RS Dr. Hasan Sadikin
3 Jawa Tengah		Semarang	RS Kariadi
4 DI Yogyakarta			RS Sardjito
5 Bali		Denpasar	RS Sanglah
6 Sumatera Utara		Medan	RS H Adam Malik
7 Sumatera Selatan		Palembang	RS M. Hoesin
8 Sulawesi Selatan		Makasar	RS Dr. Wahidin Sudirohusodo
9 Jawa Timur		Surabaya	RSUD Dr. Soetomo
10 Riau		Pekanbaru	RSUD Pekanbaru
11 Kalimantan Barat		Pontianak	RSUD Dodarso
12 Sulawesi Utara		Manado	RSUD Malalayang
13 Papua	1	Jayapura	RSUD Jayapura
	2	Merauke	RSUD Merauke
	3	Sorong	RSUD Selebes Solu
	4	Timika	RS Mitra Masyarakat
14 Kepulauan Riau		Batam	RS Budi Kemuliaan

Annex 10

Indicators of institutional development

No	Indicators which are evaluated		score 0, if	score 2, if	score 3, if	Sources of Information
I	INPUT	Human Resources	There is neither a full time secretary nor program or admin officer	There is not a full time secretary and/ or program and/ or admin officer	There is full time secretary as well as program officer, and administrative officer	Regional coordinator M & E
		Finance	All funding, both program and operational expenses, comes from the National AIDS Commission	Funding for operations and program are from a combination of local resources (APBD) and National AIDS Commission, both for AIDS Commission secretariat and government departments (SKPD)	Whole budget -- operational and for secretariat - is cover by local funds (APBD)	Reg. coordinator - Finance
		Infrastructure	Do not have either satisfactory secretariat or office facilities	Have either secretariat or satisfactory office facilities but not both	There is an appropriate/ adequate secretariat and facilities	Reg coordinator - M & E
II	Process	Working Group	There are no working groups	Working group(s) exist but not yet active.	There are active working groups.	Reg. Coordinators M & E and Pgm
		Network of key affected people	Network(s) of Key Affected People not yet organized	Network of Key Affected People exists.	There is/ are networks of key affected populations which are active	Reg coordinators Pgm
		Planning Forum	There is not yet a planning forum	A planning forum exists but is not yet active	There is a planning forum which is active (active = there are regular meetings)	Reg. Coordinators M & E and Pgm
		Assistance Team	Assistance Team not yet organized	Assistance Team is organized and active but does not yet have routine meetings	Assistance Team active and has routine meetings	Reg. Coordinators
III	Output	Local Regulation (originating in legislature)	There is no local AIDS regulation	Local regulation still in draft only	There is local regulation	Reg. Coordinator M & E
		Local Action Plan	There is not yet a plan	Action plan is in draft.	There is local plan	Reg. Coordinator M & E
		AIDS budget from local resources (APBD)	There is no local budget (APBD)	There is some local budget (APBD) but all with government departments	There is local budget managed by AIDS Commission Secretariat	Prov AIDS Commission
		Local AIDS policy (originating on executive side of government - governor, or any technical department)	There is no local AIDS policy	Local policy still in draft	There is local policy	Reg. Coordinator M & E and Pgm

Annex 11

Publication List, Indonesian National AIDS Commission. 2006 - 2011

Title	Category	Publisher	Year
Kementrian Koordinator Bidang Kesejahteraan Rakyat RI, Perempuan dan Anak Indonesia 2005 (Bahasa Inggriss)	Affected Communities	KEMENKOKESRA	2006
Menyediakan Layanan Berbasis Komunitas , Prinsip-Prinsip Bekerja Dengan Komunitas Untuk Pemulihan Perempuan Korban Kekerasan	Affected Communities	KPA N	2006
Laporan Nasional Estimasi Populasi Dewasa Rawan Terinfeksi HIV Tahun 2006	Education and Communication	KPA N & DEPKES RI	2006
PertemuanRegional III, Koordinasi dan Peningkatan Program Akselerasi Penanggulangan HIV/AIDS	AIDS Congress and Conference	KPA N	2006
Buku Alamat dan Daftar Rumah Sakit	Directory	KPA, Bakti Husada	2006
Peta Pelayanan Perawatan, Dukungan dan Pengobatan Untuk ODHA di Indonesia	Mapping	KPA N	2006
Laporan Negara Tindak Lanjut Terhadap Deklarasi Komitmen HIV dan AIDS (UNGASS) Periode Pelaporan 2004-2005	Monitoring and Evaluation	KPA N	2006
Pedoman Nasional Monitoring, Evaluasi dan Pelaporan HIV dan AIDS	Monitoring and Evaluation	KPA N	2006
Buku Pedoman Pelaksanaan Akselerasi Penanggulangan HIV/AIDS di 100 Kabupaten/Kota	National AIDS Strategy	KPA N	2006
Rencana Strategis Penanggulangan HIV-AIDS Tahun 2006-2010	National AIDS Strategy	KPA NAD	2006
Rencana Strategis Penanggulangan HIV dan AIDS 2006-2010	National AIDS Strategy	KPA SUMUT	2006
Laporan Nasional Estimasi Populasi Dewasa Rawan Terinfeksi HIV tahun 2006	National Report	KPA N	2006
Situasi Perilaku Beresiko dan Prevalensi HIV di Tanah Papua 2006	National Report	KPA N	2006
Third Quarterly Report April to June 2006 (Bahasa Inggris)	National Report	KPA N	2006
National Report on Estimates of Adults Vulnerable to HIV Infection in Indonesia, 2006 (Bahasa Inggris)	National Report	KPA N	2006
Yayasan Spiritia Report on Activities 2005/2006 (Bahasa Inggris)	National Report	KPAP DKI Jakarta	2006
Penanggulangan HIV/AIDS dan Penyalahgunaan Narkoba Pada LAPAS/RUTAN di Indonesia (Sebuah Analisa)	Prisons	KPA N	2006
PLHIV and Health Service Access (Bahasa Inggris)	Research	KPA N	2006
Lentera: Lembaran Tentang Realita AIDS	Advocacy	KPAP Bali	2007

Title	Category	Publisher	Year
Abstrak Pertemuan Nasional HIV dan AIDS Menyatukan Langkah Untuk Memperluas Respon, 4-8 February 2007	AIDS Congress and Conference	KPA N	2007
Pertemuan Nasional HIV dan AIDS ke 3, Menyatukan Langkah Untuk Memperluas Respon	AIDS Congress and Conference	KPA N	2007
Pertemuan Nasional HIV dan AIDS Menyatukan Langkah Untuk Memperluas Respon, 4-8 February 2007 (Program)	AIDS Congress and Conference	KPA N	2007
Rapat Koordinasi KPA Nasional dan Propinsi , 23-25 April 2007	Education and Communication	KPA N	2007
Project Report National Condom Week 2007 (Bahasa Inggris)	Condoms	KPA N	2007
Peraturan Menteri Koordinator Bidang Kesejahteraan Rakyat Indonesia Nomor 02/PER/MENKO/KESRA/ I/2007	Govermental Decress and Regulation	KPAP DKI Jakarta	2007
Pelatihan Kader Muda untuk Program Pengurangan Dampak Buruk Pengguna Napza Suntik , Surabaya, 4-7 Desember 2007	Harm Reduction	KPA N	2007
Pelatihan Kader Muda Untuk Program Pengurangan Dampak Buruk Penggunaan Napza Suntik	Harm Reduction	KPA N	2007
Pelatihan Set- Up Layanan Jarum Suntik di Puskesmas	Harm Reduction	KPA N	2007
Memecah Kebisuan HIV dan AIDS di Afrika	HIV and Religion	KPAP Papua	2007
Program Akselerasi di 14 Kota	Monitoring and Evaluation	KPA N	2007
Umpan Balik Pelaksanaan Program Akselerasi di Kabupaten/ Kota Prioritas Periode Juli- Desember 2006	Monitoring and Evaluation	KPA N	2007
Laporan Umpan Balik Program Akselerasi di 14 Kota, Periode Mei 2007-Desember 2007	Monitoring and Evaluation	KPA N	2007
Selayang Pandang Kegiatan Penanggulangan HIV/AIDS di Kabupaten Belu NTT	Monitoring and Evaluation	KPA Belu	2007
Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2007-2010	National AIDS Strategy	KPA N	2007
Strategi Nasional Penanggulangan HIV dan AIDS 2007-2010	National AIDS Strategy	KPA N	2007
Arahan Kebijakan Perencanaan dan Penganggaran Penanggulangan AIDS 2007-2010	National AIDS Strategy	KPA N	2007
Petunjuk Pengelolaan Keuangan dan Penyusunan Laporan Untuk Dana Bantuan	National AIDS Strategy	KPA N	2007
Pedoman Keuangan KPA Nasional, Pedoman Keuangan Sekretariat Komisi Penanggulangan AIDS Nasional	National AIDS Strategy	KPA N	2007
Pedoman Pelaksanaan Hari AIDS Sedunia Tahun 2007	National Campaign	KPA N	2007
Laporan Pelaksanaan Peringatan Hari AIDS Sedunia 2007, Tema: Kepemimpinan	National Campaign	KPA N	2007

Title	Category	Publisher	Year
Sambutan MENKOKESRA selaku Ketua Komisi Penanggulangan AIDS Nasional Dalam Rangka Peringatan HAS 2007	National Campaign	MENKOKESRA	2007
Laporan KPA Nasional Januari-Juni 2007	National Report	KPA N	2007
Laporan Kegiatan Pelatihan Kader Muda Untuk Program Pengurangan Dampak Buruk Penggunaan Napza Suntik, Banten 19-22 November 2007	National Report	KPA N	2007
Laporan Kegiatan Pelatihan Advokasi Staf Sekretariat KPA Kab./Kota	National Report	KPA N	2007
Laporan KPA Nasional 2007	National Report	KPA N	2007
Simposium Perkembangan Terakhir HIV di Papua Nugini dan Indonesia Khususnya Propinsi di Tanah Papua	National Report	KPA N	2007
Estimasi Orang Dengan HIV/AIDS (ODHA) di Kabupaten / Kota Provinsi Bali 2007	National Report	KPAP Bali	2007
Program Penanggulangan HIV-AIDS Lapas/Rutan di Indonesia	Prisons	KPA N	2007
Buku Saku Staf lapas/ Rutan	Prisons	KPA N	2007
Master Plan, Rencana Penguatan Sistem dan Penyediaan layanan Klinis Terkait HIV dan AIDS di Lapas/Rutan 2007-2010	Prisons	KPA N	2007
Petunjuk Pelaksanaan dan Petunjuk Teknis (Layanan Perawatan, Dukungan dan Pengobatan HIV dan AIDS di Lapas/Rutan	Prisons	KPA N	2007
Direktori Lembaga PBB dan Internasional Bidang HIV dan AIDS	Directory	KPA N	2008
11 Langkah Memahami HIV dan AIDS	Education	KPA N	2008
Panduan Organisasi dan Tata kerja Sekretariat Komisi Penanggulangn AIDS di Daerah	Govermental Decress and Regulation	KPA N	2008
PedomanProsedur Pelaksanaan Program Pengurangan Dampak Buruk Bagi Pengguna Napza Suntik di Puskesmas	Govermental Decress and Regulation	KPA, Bakti Husada	2008
Peraturan Daerah Provinsi DKI Jakarta Nomor 5 Tahun 2008	Govermental Decress and Regulation	KPAP DKI Jakarta	2008
Pedoman Advokasi Penanggulangan HIV dan AIDS	Govermental Decress and Regulation	KPAP DKI Jakarta	2008
Pedoman Prosedur Pelaksanaan Program Pengurangan Dampak Buruk Bagi Pengguna Napza Suntik di Puskesmas	Harm Reduction	KPA N	2008
Scaling Up the Indonesian AIDS Response, Report on the Indonesian Partnership Fund for HIV and AIDS (Bahasa Inggris)	Monitoring and Evaluation	KPA N	2008
Strategi Komunikasi Penanggulangan HIV dan AIDS di Indonesia	National AIDS Strategy	KPA N	2008
Strategi Nasional Penanggulangan HIV dan AIDS Pada Anak dan Remaja 2007-2010	National AIDS Strategy	KPA N	2008

Title	Category	Publisher	Year
Strategi Penanggulangan HIV dan AIDS Pada Perempuan	National AIDS Strategy	KPA N	2008
Pertemuan Harm Reduction ke-2, 15-18 Juni 2008 Makassar Sulawesi Selatan	National Campaign	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional	National Report	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional Januari- Juli 2008	National Report	KPA N	2008
HIV di Indonesia, Report 2008	Education and Communication	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional	National Report	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional April 2008	National Report	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional Mei 2008	National Report	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional Juni 2008	National Report	KPA N	2008
Laporan Pelaksanaan Kegiatan Sekretariat KPA Nasional Juli 2008	National Report	KPA N	2008
Laporan Triwulan KPA Nasional Januari-Maret 2008	National Report	KPA N	2008
Twelfth Quarterly Report (July- September 2008) (Bahasa Inggris)	National Report	KPAP DKI Jakarta	2008
11 Langkah Memahami HIV dan AIDS	VCT	KPA N	2008
HIV dan AIDS Sekilas Pandang (Edisi Kedua)	Advocacy	KPA N	2009
HIV dan AIDS Sekilas Pandang , Beberapa Dasar Program Penanggulangan HIV dan AIDS untuk Tanah Papua	Advocacy	KPA Prov.Papua	2009
HIV/AIDS Research Inventory 1995-2009 (Bahasa Inggris)	Biomedical research	KPA N	2009
Makalah Seminar Pekan Kondom Nasional	Condoms	KPA N	2009
Lokakarya Diseminasi Pedoman Pemulihan Adiksi Berbasis Masyarakat Jakarta, 20-23 Oktober 2009	Govermental Decress and Regulation	KPA N	2009
Laporan Pelatihan Komprehensif Pengurangan Dampak Buruk Penggunaan Napza Suntik (Harm reduction)	Harm Reduction	KPA N	2009
HIV-AIDS dan Sirkumisisi (Sunat)	HIV and Religion	KPAP Papua	2009
Akses Universal dan Hak Asasi Manusia, Membangun Komitemn, Membangun Sinergi	Human Rights and Law	KPA N	2009
Informasi Dasar Penanggulangan HIV dan AIDS di Indonesia Seri 3: Pemetaan Populasi Kunci-2009 di 12 Provinsi Dukungan GF ATM Round 8	Mapping	KPA N	2009
Rumusan Kebijaksanaan PerencanaanPenanggulangan HIV dan AIDS Untuk Rancangan RPJMN 2010-2014	Monitoring and Evaluation	KPA N, BAPPENAS	2009
Status Monitoring dan Evaluasi Penanggulangan HIV dan AIDS di Indonesia 2009	Monitoring and Evaluation	KPA N	2009
HIV dan AIDS Sekilas Pandang Edisi Kedua	Monitoring and Evaluation	KPA N	2009

Title	Category	Publisher	Year
Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS 2010-2014	National AIDS Strategy	KPA N	2009
Panduan Pelaksanaan Peringatan Hari AIDS Se-Dunia Tahun 2009	National Campaign	KPA N	2009
Laporan LOKNAS Forum Perencanaan dan Penganggaran Penanggulangan HIV dan AIDS	National Report	KPA N	2009
Laporan Penyelenggaraan Lomba Penulisan HIV dan AIDS	National Report	KPA N	2009
Report on The Indonesia Partnership Fund January - June 2009 (Bahasa Inggris)	National Report	KPA N	2009
Kesehatan Seksual (Pencegahan HIV Melalui Transmisi Seksual)	Reproductive Health	KPA N	2009
Rencana Aksi Nasional (RAN) Penanggulangan HIV-AIDS dan Penyalahgunaan Narkotika di UPT Pemasyarakatan di Indonesia Tahun 2010-2014	Harm Reduction	KPA N	2010
Informasi Dasar Penanggulangan HIV dan AIDS di Indonesia	Mapping	KPA N	2010
Rumusan Kebijakan Perencanaan Penanggulangan HIV dan AIDS untuk Rancangan RPJMN 2010-2014	National Report	KPA N	2010
Laporan Kegiatan Fasilitasi Perencanaan dan Penganggaran Program Penanggulangan AIDS di 12 Provinsi	National Report	KPA N	2010
Laporan fasilitasi Perencanaan dan Penganggaran	National AIDS Strategy	KPA N	2010
Perpres 75/ 2006 dan PerMendagri 20/ 2007 (reprint)	National AIDS Strategy	KPA N	2010
Buku Peta epidemi HIV di Indonesia	National Report	KPA N	2010
Laporan RI untuk UNGASS 2008-2009	International	KPA N	2010
Buku Pedoman Pelaksanaan Program Harm Reducation Bagi Penasun di Puskesmas (reprint)	Harm Reduction	KPA N	2010
Buku Saku Pengenalan HIV dan AIDS	Education and Communication	KPA N	2010
Ringkasan SRAN 2010-2014 (ver Indonesia)	National AIDS Strategy	KPA N	2010
Ringkasan Sran 2010-2014 (ver Inggris)	National AIDS Strategy	KPA N	2010
Buku Pedoman Diskusi Penasun	Harm Reduction	KPA N	2010
Buku SRAN 2010-2014	National AIDS Strategy	KPA N	2010
Cetak buku Pemoman Pencegahan Melalui Transmisi Seksual	Reproductive Health	KPA N	2011
Ringkasan SRAN (ver Indonesia) reprint	National AIDS Strategy	KPA N	2011
Buku Profil HIV dan AIDS di 33 Propinsi	National Report	KPA N	2011
Buku Pedoman PABM	Harm Reduction	KPA N	2011
Buku Peta Epidemi HIV	National Report	KPA N	2011

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

●/○ 173 Districts / cities with activities of the comprehensive response to HIV and AIDS underway.

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