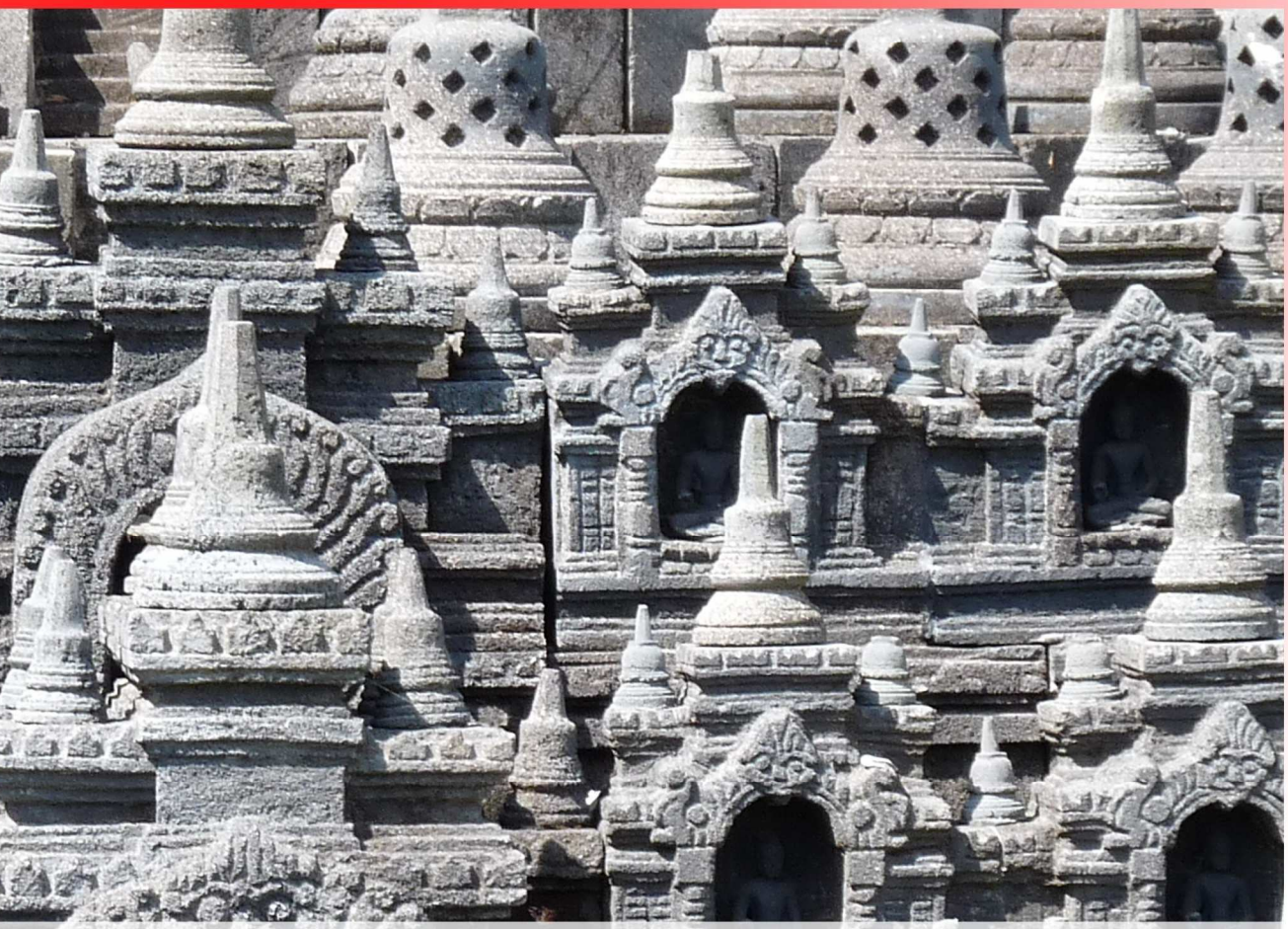
Republic of Indonesia

NATIONAL AIDS COMMISSION



Republic of Indonesia
Country Report on the Follow up to the Declaration of Commitment On HIV/AIDS (UNGASS)
Reporting Period 2010 - 2011

Indonesian National AIDS Commission 2012

Executive Summary

Indonesia, a country with a population of 237.5 million in 2010 has an estimated HIV prevalence of 0.27% among the 15-49 years age group (MoH, Mathematic Model of HIV Epidemic in Indonesia 2008-2014). Indonesia's HIV and AIDS epidemic is concentrated amongst key affected population resulting from a mix of two modes of transmissions, sexual transmission and drug injecting.

While most provinces face a concentrated epidemic amongst key affected populations, by 2006 evidence showed that across the two provinces of Papua and West Papua (Tanah Papua) a low-level general population epidemic was underway, with HIV prevalence of 2.4% among the general population. It is fueled almost completely by unsafe sexual intercourse (MoH, IBBS Tanah Papua, 2006).

The cumulative number of reported HIV infections in Indonesia has risen sharply from 7,195 in 2006 to 76,879 by 2011 (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2006 and 2011). According to the 2009 national estimates of HIV infection, about 186,257 people were infected with HIV and 6.4 million people were at risk (MoH, Estimation of at-risk Adult Population, 2009). By 2014, two main targets of the Indonesian response to HIV and AIDS are to achieve coverage of 80% of key affected populations[1] and the general population in Tanah Papua and PLHIV with at least 60% of those reached practicing safe behavior (NAC, National AIDS Strategy and Action Plans, 2010-2014).

In the past 2 years, the commitment of the Government of Indonesia to respond effectively to the epidemic and to reach national and international

[1] PWID, sex workers (male, female and transgender), men who have sex with men, high risk men, and prisoners

targets has also been reflected at regional level. The occasion of the 19th ASEAN Summit in November 2011 was used to mobilize Heads of State/Government of the Association of Southeast Asian Nations to declare their commitment towards "an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths" by 2015.

Prior to this, the Presidential Instruction 3/2010 on *Just Development* (Indonesia) had raised the national commitment to accelerate the national response on goals of MDGs including HIV. As a prerequisite to the implementation of the Presidential Instruction, an MDG acceleration Action Plan 2011-2015 had been developed and helped to keep AIDS high on the national agenda, calling also for a stronger response from sub-national level. The nation also highly concerned about evolution of the epidemic in the two eastern most provinces of Indonesia which are experiencing a generalized HIV epidemic. Responding to a range of challenges, two new policy actions have been taken: 1) Presidential Regulation No. 65/2011 on Acceleration of Development in Papua and West Papua and 2) Presidential Regulation 66/2011 on Acceleration of Development Unit in Papua and West Papua.

The total spending on AIDS was US$ 56,576,587 (2006) and has gradually been increasing, reaching US$ 69,146,880 (2010). Indonesia's total investment in AIDS also increased every year, from 27% in 2006 to 40% in 2010 of the total spending. During the same period, provincial and district budgets increased around 2.5 times from US $ 4,329,167 to US $ 10,935,417 (NAC, National AIDS Spending Assessment, 2009-2010).

In the past two years, AIDS Commissions in Indonesia have grown in skill and importance from national to province and district/city level. The NAC was initially established in 1994. In 2006 it was restructured and strengthened with the Presidential Regulation no. 75/2006. The NAC has become a multi-sectoral body directly responsible to the President of Indonesia, and tasked

with providing leadership, management and coordination far more "intensive, comprehensive, integrated and coordinated response". In 2011 there have been functioning AIDS commissions in all 33 provinces and in 200[2] priority districts and cities, an increase from 100 districts in 2007.

Sexual transmission

In the beginning, prevention of sexual transmitted of HIV focused on an individual approach. Evidence indicated this was not enough to bring about the change needed in the existing socio-cultural environment. The new structural approach promoting 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 across Indonesia, was developed. It was launched in 159 districts/cities in all 33 provinces of Indonesia during the reporting period, (NAC Program Monitoring, 2011).

Coverage of some categories of key affected populations is now approaching the national target. In 2011, the NAC recorded that over two thirds of direct Female Sex Workers (FSW) and transgender people had been contacted as well as between one to two thirds of indirect FSW. One indicator also relates to behavior e.g. the percentage of people reporting condom use at last sex. FSW, transgender and MSM have all met at least one of the national targets (MoH, IBBS, 2011). The rising numbers of condoms distributed to key affected population suggest improvements in condom availability, acceptability, and use. On the other hand, less than one third of men who have sex with men (MSM) and high risk men had been reached (NAC, Program Monitoring, 2011).

[2] 163 districts are supported by Global Fund, and 37 districts are self-funded (the NAC 2011)

HIV transmission related to Injecting Drug Use

Harm reduction programs have benefitted from supportive regulations and program scale-up. At least eight national regulations have been enacted since 2010 to strengthen supportive environment for harm reduction (see Table 1. Creation of supportive environment for Harm Reduction). Locations of Needle and Syringe Program (NSP) and Methadone Maintenance Therapy (MMT) services have both increased from 120 and 11 in 2006 to 194 and 74 in 2011 (MoH, 2006 and 2011). MMT units are also being selectively embedded in Community Health Centers (CHC) and prisons. By the end of 2011, two third of PWID and almost 80% of the estimated prisoners based on the 2009 estimate, had been reached by harm reduction activity (NAC, Program Monitoring, 2011). The reported rate of needles and syringes sharing was low: 87% PWIDs reported not sharing needles and syringes in the last injection and already 63% of PWIDs did not share needles and syringes in the last week injection (MoH, IBBS, 2011).

Increased availability of VCT and ART

Strong evidence has accumulated around the globe in recent years of the benefits of early diagnosis and early treatment of HIV infection. In Indonesia serious attention has been given to scaling up HIV testing and counseling sites. Their number and distribution have increased dramatically from only 25 in 2004 to 500 in 2011 (MoH, Year end Report on the Situation of HIV and AIDS in Indonesia, 2004 and 2011). The combination of the rapidly rising establishment of HIV test sites and improving outreach has led to the increasing proportion of people of key affected populations, IBBS 2011 reported at least 70% of each key affected population (except client of sex workers) who have been tested (MoH, IBBS, 2011).

ARV treatment for AIDS patients was launched as part of public health service scaled up in 2005, initially with support from Global Fund. Data of

MoH indicates that by the end of that first year 2,381 patients were receiving ART. By December 2011, 24,410 people were receiving ART regularly from 303 sites across the country (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2005 and 2011).

Women and Children

While the priority of the national response remains focused on efforts to work for and with people of key affected populations, the steadily increasing numbers of reported HIV positive women has made scaling up of PMTCT services a priority concern. By 2011, it was estimated 8,170 pregnant women are HIV positive in Indonesia (MoH, Mathematic Model of HIV Epidemic in Indonesia , 2008-2014).

Looking ahead

This 2012 UNGASS report provides data showing encouraging progress in some aspects of the response such as harm reduction, for example, in some locations there has been important strengthening of local leadership and commitment to increase condom use among sex workers and their partners. An increase is also important in the number of distribution sites for HIV and TB testing and for ARV. The AIDS Commission system and effectiveness of the national M&E and growing success in resource mobilization. Nonetheless, challenges still remain in Indonesia. In order to achieve UNGASS targets and reach Universal Access for prevention, care, support, and treatment, building on its experience, and under the leadership of the NAC and AIDS Commissions at provincial, district and city levels, Indonesia must continue to select, prioritize, and scale-up effective interventions while promoting and strengthening local, national, and international networking and partnerships.

Indonesia's contribution to "the Global AIDS Response Progress Reporting 2012" has been written with participation of relevant government

departments, civil society, PLHIV, the academic community, and international development partners.

List of Abbreviations

AIDS:	Acquired Immune-Deficiency Syndrome
ART:	Anti Retroviral Therapy
ARV:	Anti Retroviral Drugs
ASEAN:	The Association of Southeast Asian Nations
AusAID:	The Australian government's overseas aid program
AID	Agency for International Development
IBBS:	Integrated Biological and Behavioral Surveillance
CBS:	Central Bureau of Statistics
CDC:	Directorate General of / Centre for Communicable Disease Control
CHC:	Community Health Center
DFID:	United Kingdom Department for International Development
IDHS:	Indonesian Demographic and Health Survey
FHI:	Family Health International
FSW:	Female Sex Worker
GFATM:	The Global Fund to fight AIDS, TB and Malaria
HCPI	HIV Cooperation Program for Indonesia (Australian supported program in Indonesia)
HIV:	Human Immunodeficiency Virus
PMTS	Comprehensive approach to prevention of sexual transmission (in Indonesian: *Pencegahan Infeksi HIV Melalui Transmisi Seksual/PMTS*)
IBBS:	Integrated Bio-Behavioral Surveillance
ILO:	International Labor Organization
MDG:	Millennium Development Goals
M&E:	Monitoring and Evaluation
MMT:	Methadone Maintenance Treatment
MoH:	Ministry of Health
MSM:	Men who have Sex with Men
NAC:	National AIDS Commission
NASA:	National AIDS Spending Assessment
NCPI:	National Composite Policy Index
NGO:	Non-Governmental Organization

NSP:	Needle and Syringe Program
PLHIV:	People Living With HIV
PITC:	Provider's Initiative (HIV) Testing and Counseling
PMTCT:	Prevention of Mother to Child Transmission
PWID:	People who Inject Drugs
OVC:	Orphans and Vulnerable Children
STI:	Sexual Transmitted Infection
TB:	Tuberculosis
UA:	Universal Access
UNAIDS:	Joint United Nations Program on HIV and AIDS
UNDP:	United Nations Development Program
UNESCO:	UN Educational, Scientific and Cultural Organization
UNFPA:	UN Fund for Population Activities
UNICEF:	United Nations Children's Fund
UNGASS:	United Nations General Assembly Special Session
USAID:	United States Agency for International Development
VCT:	Voluntary Counseling and Testing
WHO:	World Health Organization

Terminology: Consider addition of note to the reader, ***Community Health Center***. In this report the "community health center" refers to all registered facilities providing primary health care services both those in the government public health system and others, for example, which might be run or financed by faith-based groups, NGOs, or private sector.

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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.

March 2012

Foreword

This country report presents information specifically focused on achievements of the Government and civil society in Indonesia related to the Declaration of Commitment on HIV and AIDS of UNGASS in the past two years, 2010-2011. This report is a collaborative effort reflecting the perspectives of both the Government and a wide range of civil society participants in this field.

For the period covered by this report, UNAIDS has stipulated 30 indicators to measure progress in the response to HIV and AIDS. Indonesia can report what has been accomplished related to indicators relevant to concentrated epidemics. However, information related to some indicators is not available, as they refer to aspects of generalized epidemics that are not widely found in Indonesia except the provinces of Papua and West Papua.

The Government of Indonesia has shown strong commitment to mounting and sustaining an effective response and it endorses a broad range of activities run by many stakeholders. During the period under review, management of Indonesia's response has improved. Presidential Instruction no. 3/2010 on *Just Development* put in place a roadmap for GOI to accelerate the achievement of the MDGs including all those relevant to HIV and AIDS. This regulation ensures synergy amongst ministries and between central and local governments and communities as well as identifying possible financial mechanism for the allocation of funds and incentives for HIV and AIDS control.

Although much remains to be done, there has been great progress in the past two years. Indonesia notes with appreciation the contribution of the government, the private sector, and nongovernmental organizations, both domestic and international, who have helped the country address the challenges presented by the twin epidemics of HIV and injecting drug use across Indonesia. Activities responding to the needs and aspirations of those infected and affected have become more diverse and accessible.

Preparing this report has been a useful exercise for all of us. We are pleased to be part of this global process. We hope its publication and circulation will not only fulfill an obligation as a UN member but will lead to improvements in our national monitoring and evaluation system as well as providing good evidence and data to support our continuing efforts to mount an ethical, humane and effective response to HIV and AIDS.

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

I. Status at a Glance

1.1. Participation of stakeholders in the report writing process

A range of partners have been actively engaged in producing and analyzing the data used in this report. Data collection and analysis was done in coordination with the Monitoring and Evaluation Working Group of the NAC that was composed of representatives of government departments, donors and civil society. The principle governmental departments' responsible for data collection and analysis were the Ministry of Health and the NAC.

The National AIDS Spending Assessments is carried out by the NAC and a team from the University of Indonesia. An analysis of program and data were reported, discussed and agreed to in a series of consultation meetings with the Monitoring and Evaluation Working Group beginning in January 2012. Civil society was actively involved in preparation of this report as was the case in the previous rounds of UNGASS reporting including participation in discussion forums related to the National Commitment and Policy Instruments. The comprehensive report on the National Commitment and Policy Instruments is reported in chapter 3.

While there is some variation from place to place, it can be said that thanks to the generally conducive environment for civil society participation, today people living with and affected by HIV and key affected population are well represented in many discussions, monitoring and evaluation of the national progress on UNGASS indicators.

1.2. The Status of the Epidemic

Change in mode of transmission requires an adjustment in the strategy of Indonesia's response:

The dominant mode of transmission of HIV infection at this time in Indonesia is through 1) unprotected sex particularly among people with a high numbers of partner and 2) unsafe injecting behavior.

In a mathematic model of the HIV epidemic in Indonesia, the MoH projected that without an acceleration of prevention, 541,700 people will be HIV positive by 2014. It also projected a shift in the main mode of transmission from injecting drug use to sexual transmission. New infection among PWID was projected to decrease from 40% in 2008 to 28% in 2014, while infection through sexual transmission will rise from 43% to 58% (MoH, Mathematic Model of HIV Epidemic in Indonesia, 2008-2014). In facts cumulative reported AIDS cases shows the majority was due to heterosexual transmission, rising from 37% (2001-2005) to 71% (2011), while infection from drug injecting use dropped from 53% to 34% during the same period.

Relatively high HIV prevalence has been reported in the 2011 IBBS especially among transgender sex workers (43%), male sex workers (34%), and direct FSW (10%). Prevalence of HIV infection among PWID has declined from 52% (IBBS 2007) to 36% (IBBS 2011).

The prevalence of unsafe injecting behavior is much lower than unsafe sexual behavior, but is not yet reflected in the prevalence among PWID over time given that the prevalence of HIV in PWID population remains high.

The level of condom use reported by people of key affected populations when having last commercial sex is high (MoH, IBBS, 2011). A detail discussion on needles and syringe sharing and condom use of people of key affected populations will be found in chapter 3.

Further analysis shows that the proportion of FSW and PWID who are infected in their first year of engagement is high overtime (2007 and 2011) at 6% and 4% (FSW), and 27% and 13% (PWID). Although programs are having an impact, improvement is still needed in prevention programs.

In the two provinces of Tanah Papua, Papua and West Papua, in the extreme east of Indonesia, this situation is different. Comprising only 1% of Indonesia's population, reports show the AIDS level 15 times higher[3] than the national average. The mode of transmission in Tanah Papua remains predominantly by heterosexual transmission. The prevalence rate amongst males in the general population age 15 – 49 is 2.9% in males, and 1.9% in females, resulting in Tanah Papua being classified as a low level generalize population epidemic region (MoH, IBBS Tanah Papua, 2006).

The national surveillance shows MSM often reported having non-commercial partners (84%), while most of the FSW clients are married or have regular sexual partner (70.5%) or have irregular partners (14%) (MoH, IBBS, 2011). Multiple partners, more frequent sexual intercourse, low level of demand for condoms, low condom use and access have all increased the risk of transmission not only among key affected population, but for women who are sexual partners of clients of sex workers or PWID. New efforts are now being made to attract more men high risk and general population to have an HIV test hoping to reduce transmission to women. In 2011, 3% of women who visited ANC and were tested for HIV in 2011 were HIV-infected (MoH, Program Monitoring in Universal Access Report, 2011). There was a HIV modeling by MOH projecting a rise in number of HIV positive women from 4,560 in 2008 to 8,170 in 2014. Subsequently, the projection of HIV-infected children is also showed an increase from 1,070 in 2008 to 1,590 in 2014 (MoH, Mathematic Model of HIV Epidemic in Indonesia , 2008-2014).

[3] December 2011 the MoH CDC. Comparing the reported AIDS case rates (number of confirmed AIDS cases per 100,000 population) found that the case rate for the province of Papua at 133.07 was just over 15 times that of the national rate of 8.66

National spending on treatment will be required to meet the needs of the population. In 2011, the number of ART participants has increased to 24,410 people (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2011). This equals 40% of the total estimate of people eligible for ART (MoH, Mathematic Model of HIV Epidemic in Indonesia, 2008-2014). In the absence of reduction in new infection, the need for ARV therapy among the 15-49 age groups is projected to increase three fold from 30,100 in 2008 to 86,800 in 2014 (MoH, Mathematic Model of HIV Epidemic in Indonesia , 2008-2014).

1.3. Partnerships, Policy and Programmatic Response 2010-2011

Indonesia has embraced a broad and comprehensive approach to the AIDS epidemic including prevention, care, support, treatment, and mitigation of social and economic impact. Implementation of this approach requires partnerships among all actors in the response, development of relevant policies, and prevention and treatment programs for the broad range of key affected populations. This is the key to breaking the cycle of infection and changing the direction of the epidemic.

Even in the setting dominated by a concentrated epidemic, programs addressing the general population are also important to introduce basic information about HIV and AIDS, non discrimination and principles of human rights; practical messages of mutual fidelity between husband and wife; and reinforcement of religious values.

In work with PLHIV, as with people of key affected populations, emphasis has been given to promoting knowledge, skills, and activities to support self reliance, personal responsibility to avoid transmission of infection to others, and adherence to medication while living a full and fulfilling life. Each set of concerns those related to the key affected populations, the general population, and the community of PLHIV has a place in Indonesia's national response

(NAC, The Response to HIV and AIDS In Indonesia 2006 – 2011: Report on 5 Years Implementation of Presidential Regulation No. 75/2006 on the NAC, 2011)

Partnerships

The enactment of Presidential Regulation 75/2006 intensified diversified the national programmatic response to AIDS in the country. As an inter-ministerial body responsible to the President of Indonesia, the NAC was restructured to be more inclusive in membership and strengthened to promote a more intensive, comprehensive, integrated and coordinated response. The role of the AIDS Commissions system was, at the same time strengthened from national to local level. Since 2008, AIDS Commissions have been functioning in 33 provinces and in 200 priority districts and cities, an increase from 100 districts in 2007, as well as the National level. The management support at district level has been followed by the gradual launching of comprehensive programs[4] from 68 districts in 12 provinces (2008) growing to 137 districts in 33 provinces in mid 2011 (NAC, The Response to HIV and AIDS In Indonesia 2006 – 2011: Report on 5 Years Implementation of Presidential Regulation No. 75/2006 on the NAC, 2011).

Because of stigma and discrimination, some people of key affected populations do not yet make extensive use of available HIV services in CHCs. Self treatment among key affected population is still high. Outreach services are not only provided to educate but also to assist the sex workers to increase utilization of health services. The involvement of non-government organizations (NGOs) providing outreach services have been improving especially since the infusion of Global Fund resources, with the most

[4] The "comprehensive response to HIV and AIDS"in Indonesia includes provision of the necessary information, supplies, and services for comprehensive counselling 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 ongoing capacity development and system building necessary to sustain, modify, and continue the response in the future.

influential Muslim religious group, Nahdatul Ulama, and the National Family Planning Association (PKBI) serving as a principle recipient (PR).

Between 2006 and 2009, five national networks of the key affected populations[5] were established at the national level. Development has been uneven but all have started the process of organizing local branches, some of which are thriving and active in many provinces.

Several international development partners have been longstanding, supportive actors in the response to HIV and AIDS contributing both funds and technical support. The development of the NAC since Presidential Regulation no. 75/2006 has formalized organization in working with international development partners.

The private sector, through the Indonesia Business Coalition for AIDS, has mounted a response to HIV and AIDS in the form of public-private partnerships for the prevention of sexually transmitted diseases, including HIV amongst Indonesia's large, mobile, male work force.

As of May 2011, 32 (15%) of 218 hospitals with private CST services were reported, providing ARV treatment for 4,440 patients amounting to 21% of those receiving ARV (MoH, Report on Situation of HIV and AIDS in Indonesia, May 2011).

Policy

Since Presidential Regulation no. 75/2006, numerous policies have been issued by government ministries to strengthen and sustain the response to HIV. Home Affairs Regulation no. 20/2007 (art 13) states that the cost required for carrying out the work of AIDS Commission at National, Provincial and District/City shall be borne by respective government levels. However, adequate funding is not yet guaranteed, even though 16 provinces and 34

[5]National network of key affected people: 1. Sex Workers, 2. Gay-Transgender-Lesbian, 3. PLHIV, 4. Women who are HIV positive, 5. Victims of narcotics, psychotropic drugs and other addictive substances

districts/cities already have local regulations on HIV and AIDS. Experience thus far has been that in local AIDS budgets depend mostly on the personal commitment of the governor, district head, mayor and members of the legislature (DPRD). The 2010-2014 planning and budgeting of the national response has been integrated in the National Mid-Term Development Plan (RPJMN-Rencana Pembangungan Jangka Menengah Nasional 2010-2014). This will assure some measure of support from the National Budget at least until 2014.

Presidential Instruction 3/2010 on *Just Development* has focused national attention on acceleration of efforts to achieve the Millennium Development Goals, including Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV and AIDS. The Action Plan (2011-2015) for implementation of this instruction has been developed and keeps AIDS high on the national agenda and calls for a stronger response from sub-national level, as well.

The commitment of the government to respond effectively to the epidemic and to reach national and international targets has been strengthened across the Southeast Asia region. The occasion of the 19th ASEAN Summit in November 2011 was used to mobilize Heads of State/Government of the Association of Southeast Asian Nations to declare their commitment towards an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths. This commitment should contribute to strengthening of the legal environment and financial commitment to full and equitable response to the epidemic.

Implementation and effectiveness of these supportive policies and budget commitments still need impact-oriented monitoring and evaluation mechanisms which will provide information on the quality of program implementation and its effectiveness in addressing the epidemic. Current available epidemiological data on the status of the epidemic is still uneven.

For example, surveillance data for general population in Tanah Papua is still based on IBBS 2006/2007, and national AIDS related estimates data are from 2009. A new national estimate and the IBBS among the general population in Tanah Papua are both planned for 2012. Another health survey related to HIV and reproductive health among married men and women, as well as unmarried youth (IDHS and IYARHS) is planned for 2012.

Programming

Sexual Transmission Prevention Program

Evidence of the rise in the sexual transmission of HIV led the secretariat of the NAC to diversify approaches both to improve effectiveness and to reach more people involved in high risk sex through a comprehensive approach to prevent sexual transmission.

Financial support in 2011 was provided by the Global Fund and the National Budget. The National Population and Family Planning Board and Family Health International in turn also provided support in the form of condoms.
As of December 2011, the MoH reported 643 STI services units available through CHCs, private clinics and company clinics. Condom promotion programs have been provided in numerous sites and reached about 70% of FSW, 18% of their clients, 75% of transgender male sex workers, 9% of MSM and 58% of PWID (NAC, Program Monitoring, 2011).

Harm Reduction Program

Indonesia has responded to the PWID HIV epidemic by developing policies, regulations and programming to address the problem. Hospitals and Community Health Centre services provide needle syringe programs (NSP) and methadone maintenance therapy (MMT) with an increase in the number

of facilities and the geographical distribution over several years. The evolvement of policy that has been contributing to the growing movement of harm reduction programming is presented in Table 1 below.

Table 1. Creation of supportive environment for Harm Reduction

Year	*Policy*
2003	MoU between the NAC and National Narcotic Bureau on integrated HIV and AIDS prevention and prevention of injecting drug abuse
2006	Decree of Minister of Health 567/Menkes/SK/VIII/2006 on guidelines for implementation of harm reduction for narcotics, 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	Regulation of the Minister of Health 422/ MENKES /SK/III/2010 Guidance on Medical Treatment of Drug Abusers
2010	Circular letter of the Supreme Court no 4/ 2010 (Drug users/addicts to be referred to treatment)
2010	Regulation of Minister of Justice and Human Rights no. 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
2011	Presidential Instruction 12/2011 on registration of, and medical and social rehabilitation for Drug Users
2011	Regulation of the Minister of Health 1305/MENKES/SK/VI/2011 (Designating appointed 131 health centers for far registration of accept drug users and to provision drug rehabilitation and services
2011	Regulation of the Minister of Health 2171/MENKES/SK/X/2011 on Drug Registration Procedure
2011	Circular letter of the Supreme Court no 3/ 2011 on referral of Drug Users to Medical and Social Rehabilitation
2012	Regulation of the Minister of Social Affairs 3/2012 on standardization of social rehabilitation centers for drug users

Source: 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

Harm reduction services are now available in Community Health Centres (CHC), correctional institutions, and NGOs where staff carry out some or all of the nine basic components of comprehensive harm reduction. The number

of sites which provide NSP has increased, from 120 sites in 2006 to 194 by the end of 2011. During this same period, MMT has been made available in 74 sites across the country a significant increase from 11 sites in 2006 (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2006 and 2011).

HIV Testing and Care, Treatment and Support

HIV infection is asymptomatic, and a blood test is the only way to know if a person is infected with HIV. Early diagnosis will improve the possibility of PLHIV receiving timely treatment, as well as encouraging them to avoid infecting others. A local study (Riyarto S, 2010) found the underlying factor for delayed diagnosis of HIV is the lack of knowledge about the improved prognosis of early ARV treatment, and a fear of being stigmatized by the community. Increased availability of HIV testing at CHC, combined with improved knowledge of the prognosis of HIV treatment among key affected population, and the community at large and may improve earlier testing.

In December of 2011 the Ministry of Health reported 500 active VCT sites located in 142 districts/ cities across Indonesia including 45 in correctional facilities (prisons and detention centers) of the Ministry of Law and Human Rights across the country (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2011). There has also been progress in scaling up collaborative TB/HIV activities. Some studies on the quality of services makes clear that, with adequate training, supervision, and motivation, facilities can provide consistently acceptable services. It is hoped that Provider Initiated Counseling and Testing (PICT), which is already underway in some areas and scheduled for expansion will help increase utilization of HIV testing.

The network of hospitals providing ART had increased from 148 in 2007to 235 hospitals with 68 associated satellite CHC in 2011 (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2011). Future programming will

need to identify and develop strategies to address both the delivery side and demand side of ARV-related services to improve the level of its intake and continuation.

Overview Table: Data and Indicators

Table 2. Overview of The 2012 Report on UNGASS Indicators

Indicators	Numbers				Data Sources
TARGET 1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50 PER CENT BY 2015					
1.1. Percentage of young women and men aged 15-24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	**Age**	**Males**	**Females**	**All**	IDHS 2007
		%	%		
	15-19	11.7	12.9	-	
	20-24	16.7	20.1	-	
	All	13.7	15.1	14.3	
1.2. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**Age**	**Males**	**Females**	**All**	IDHS 2007
		%	**%**		
	15-19	0.4	0.3		
	20-24	0.3	0.04		
	All	0.33	0.21	0.28	
1.3. Percentage of women and men aged 15-49 who have had sexual intercourse with more than 1 partner in the last 12 months		**Males**	**Females**		IDHS 2007
		%	**%**		
	All	0.3	-		
	15-19	-	-		
	20-24	0.2	-		
	25-49	0.3	-		
1.4. Percentage of women and men aged 15-49 who have had more than one partner in the last 12 months reporting the use of a condom during their last sexual-intercourse	Indicator is not relevant to Indonesia				
1.5. Percentage of women and men aged 15-49 who received an HIV test in the 12 months and who know their results	Indicator is not relevant to Indonesia				
1.6. Percentage of young people aged 15-24 who are HIV infected	Indicator is relevant, but national data are not available				
1.7. Percentage of sex workers reached with HIV prevention		**Sex Workers**			Integrated Bio Behavior Survey

programs		%		IBBS 2011
	All	18.48		
	Males	11.85		
	Females	19.91		
	<25	14.1		
	25+	24.3		
1.8. Percentage of sex workers reporting the use of a condom with their most recent client		**Sex Workers**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	58.0		
	Males	49.4		
	Females	59.9		
	<25	49.5		
	25+	61.7		
1.9. Percentage of sex workers who have received an HIV test in the last 12 months and who know their results		**Sex Workers**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	79.4		
	Males	89.2		
	Females	77.0		
	<25	78.0		
	25+	79.81		
1.10. Percentage of sex workers who are living with HIV		**Sex Workers**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	9.0		
	Males	18.3		
	Females	7.0		
	<25	8.0		
	25+	9.4		
		Female SW		
	< 1yr	4.1		
	1+ yr	7.6		
1.11. Percentage of men who have		**MSM**		Integrated Bio

sex with men reached with HIV prevention programs		%		Behavior Survey (IBBS) 2011, CDC MoH
	All	23.4		
	<25	20.4		
	25+	25.2		
1.12. Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner		**MSM**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	59.8		
	<25	63.8		
	25+	58.1		
1.13. Percentage of men who have sex with men that have received an HIV test in the last 12 months and who know their results		**MSM**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	92.0		
	<25	92.3		
	25+	91.8		
1.14. Percentage of men who have sex with men who are living with HIV		**MSM**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	8.5		
	<25	6.1		
	25+	9.8		
TARGET 2. REDUCE TRASMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50 PER CENT BY 2015				
2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe program	7 syringe per person who inject drugs per year = 689,662 syringes/105,784 people who inject drugs			NAC Program Monitoring, Estimation 2009 the MoH
2.2. Percentage of people who inject drugs who report the use of a condom the last sexual intercourse		**PWID**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	51.6		
	Males	N/A		
	Females	N/A		
	<25	56.0		
	25+	50.2		
2.3. Percentage of people who		**PWID**		Integrated Bio

inject drugs who reported using sterile injecting equipment the last time they injected		%		Behavior Survey (IBBS) 2011, CDC MoH
	All	87.0		
	Males	N/A		
	Females	N/A		
	<25	82.2		
	25+	88.6		
2.4. Percentage of people who inject drugs that have received an HIV test in the last 12 months and who know their results		**PWID**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	90.6		
	Males	N/A		
	Females	N/A		
	<25	83.7		
	25+	92.1		
2.5. Percentage of people who injecting drugs who are living with HIV		**PWID**		Integrated Bio Behavior Survey (IBBS) 2011, CDC MoH
		%		
	All	36.4		
	Males	N/A		
	Females	N/A		
	<25	11.6		
	25+	43.9		
TARGET 3. ELIMINATE MOTHER TO CHILD TRANSMISSION OF HIV BY 2015 AND SUBSTANTIALLY REDUCE AIDS RELATED MATERNAL DEATHS				
3.1. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of MTCT	2010: 9.78% (=468/4,784 X 100%) 2011:15.7% (= 813 /5,171 x 100%)			CDC MoH program monitoring 2010, 2011,
3.2. Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2 months of birth	National data is not available			
3.3. Mother to child transmission of HIV (modelled)	National data is not available			

TARGET 4. HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015				
4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy	2010:38.8% (=19,572/50,400 x 100%) 2011: 84 % (= 24,410/29,012 x 100%)			CDC MoH, 2010, 2011
4.2. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		2010	2011	CDC MoH, 2010, 2011
	Adults & children	70%	67.7%	
TARGET 5. REDUCT TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50 PER CENT BY 2015				
5.1. Percentage of estimated HIV-positive incident TB cases who received treatment for TB and HIV		2009	2010	2011	
	All			3.9%	CDC MoH, 2011
	Males			2.5%	
	Females			1.4%	
	<15			0.1%	
	15+			3.8%	
TARGET 6. REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE (us$22-24 BILLION) IN LOW-AND MIDDLE INCOME COUNTRIES				
6.1. Domestic and International AIDS spending by categories and financing sources	Spending	2009 $	2010 $	National AIDS Spending Assessment 2011, Indonesia National AIDS Commission
	Total	60,285,420	69,146,880	
	Domestic	21,318,844	27,779,280	
	International	38,966,576	41,367,600	
TARGET 7. CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS				
7.1 National Commitments and Policy Instruments (NCPI)	Please see chapter 3			Indonesia NAC, 2011
7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Indicator is relevant but national data is not available			

7.3. Current school attendance among orphans and among non-orphans aged 10-14		**Orphans**	**Non-orphans**		Indonesia Demographic Health Survey (IDHS) 2007, Statistic Indonesia
		%	**%**		
	All	87.2	92.6		
	Males	83.8	91.8		
	Females	91.2	93.5		
7.3. Proportion of the poorest households who received external economic support in the last 3 months	**Rice for Food** 70.0 %	**Conditional Cash Transfer** 3.2 %			ILO Report 2011

II. Overview of AIDS Epidemic

The Indonesian HIV epidemic has not changed from a concentrated epidemic since the 2010 UNGASS report, with high HIV prevalence in some populations (key affected population), namely People who Inject Drugs (PWID) (36%), transgender people (43%), FSW (7%), and MSM (8%).

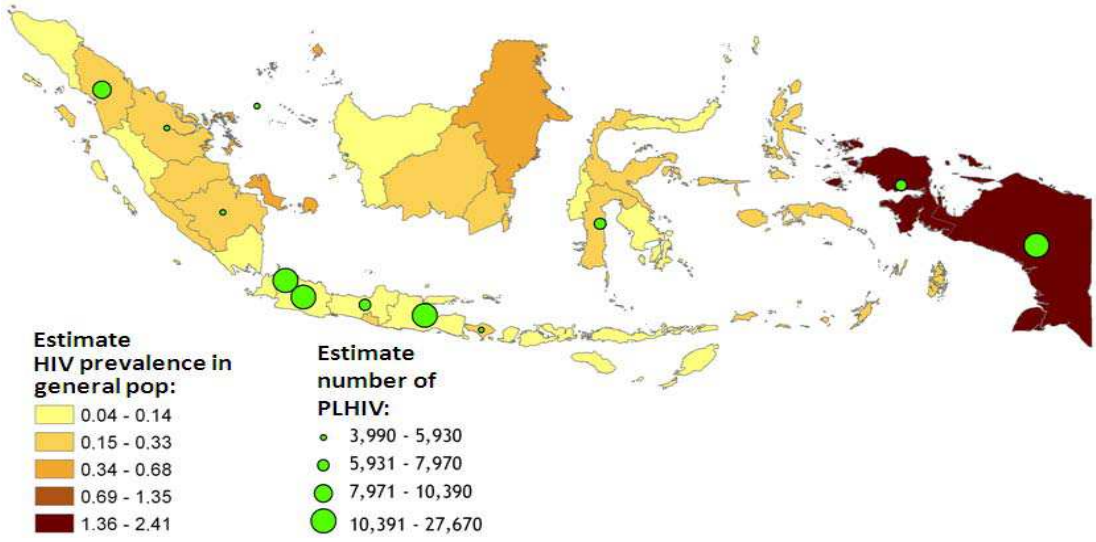
In the last 4 years, there has been a noticeable shift in the predominant mode of infection among reported AIDS cases (cumulative) from 2,873 (2007) to 29,879 (2011). Unsafe injecting is no longer the dominant mode of infection. While in 2007, 49.8% of new reported AIDS were drug related and 41.8% were the result of heterosexual transmission, by 2011 that situation had changed with only 18.7% of the total new reported AIDS cases associated with drug injecting, and 71% were the result of heterosexual infection (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2007 and 2011).

The HIV epidemic in Tanah Papua is generalized, and different from the rest of the country, and driven largely by commercial sex. As of 2006, HIV prevalence in Tanah Papua was reported 2.9% in men and 1.9% in women (age 15-49). It was higher in rural than urban areas.

Reports on HIV infection and related statistics at province and district/city level allow us to observe the intensity and distribution of the epidemic. The most recent estimate was done in 2009, which serves as a critical point of reference for discussions about the status of the epidemic and for planning the response. In 2009, 6,396,187 people were estimated to be at high risk of HIV with 186,257 people estimated to be living with HIV (MoH, Estimation of at-risk Adult Population, 2009). The reports which map the epidemic shows HIV and AIDS are unevenly distributed across the country (see Map 1. Distribution

of HIV and AIDS prevalence, and people living with HIV across Indonesia based on 2009 estimate). Infection has been reported in 300 districts in 32 provinces.[6]

Map 1. Distribution of HIV and AIDS prevalence, and people living with HIV across Indonesia based on 2009 estimate



Source: MoH estimate 2009, Mapping NAC

Indonesia reported continuing new and cumulative HIV infection and AIDS cases climb from a combined total of 79,979 in 2010 to a combined total of 106,758 in 2011, indicating 42,622 new PLHIV had been identified during the 2 year period. During the same period the number of facilities for counseling and testing increased more than four times from 156 in 27 provinces in 2009 to 500 reporting VCT sites in 33 provinces in 2011 (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2011). High numbers in reported HIV cases reflects, among other things increase in the availability and utilization of counseling and testing (VCT and PITC), an important step forward in the national response. Choosing to be tested is an activity of high importance in efforts to reduce new infection and to improve the quality of life of PLHIV. The IBBS also indicates a rising number of people of key

[6] At time this map was published in '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', Indonesia has 33 provinces, and according to information from Ministry of Home Affairs 524 districts/cities

affected populations reporting to have an HIV test, which suggests that stigma and discrimination in relation to HIV and AIDS may be declining compared with earlier times in the epidemic. These 2011 IBBS findings are discussed in details in chapter 3.

Table 3. Reported New and Cumulative HIV and AIDS, 2010-2011

	HIV		AIDS	
	New	Cumulative	New	Cumulative
2010	21,591	55,848	4,158	24,131
2011	21,031	76,879	4,162	29,879

III. National Indicators

The IBSS findings presented in this report were collated between 2010 and 2011. To show the trends, this report also uses some the IBBS findings that were collated between 2006 and 2007, as target groups in both IBBS were surveyed in the same selected districts/cities.

In the case of FSWs, transgender people, high risk men and MSM, two-stage cluster sampling design method was employed, while random sampling was used to select both sample locations (clusters) and respondents. In the IBBS on PWID, cluster sampling was employed for sample selection and data collection purposes. Respondent Driven Sampling was employed, with data being collected during face-to face interviews between NGO officers and the respondents. In this case, bias might have occurred as the sample through networks is basically the same as service provision networks.

Indonesian data is available on only a few indicators about risk behavior among the general population. At the national level where the epidemic is, for the most part, a concentrated epidemic they have limited relevance. The last complete data on the general population in Tanah Papua was collected in 2006-2007, while the 2011-2012 data collection was still in progress during the reporting period. We are therefore not yet able to track trends in risk behavior and HIV prevalence due to some aspects of the national responses.

Target 1. Reduce sexual transmission of HIV by 50 percent by 2015

General Population

1.1. **Indicator: Percentage of young women and men aged 15-24 with comprehensive knowledge about HIV-AIDS**

It is vital to educate young people about HIV transmission before they are exposed to situations that put them at risk of HIV infection. Comprehensive

knowledge for young people means knowing how HIV is transmitted, how to prevent it (including abstinence or delay in sexual debut, reduction in the number of sexual partners, monogamy, and correct and consistent condom use for those who are sexually active), and knowledge about availability of services for those who are HIV positive. It also includes knowledge about misconceptions about HIV transmission or prevention: that HIV cannot be transmitted by mosquito bites, or by sharing food with a person who has AIDS, or attributed to witchcraft.

Findings from the 2007 IYARHS report showed that at that time only 3 percent of unmarried women and 1 percent of unmarried men has comprehensive knowledge about HIV and AIDS. Comprehensive knowledge about HIV and AIDS was better, among married people at the same age group although still low. The IDHS survey from 2007 show that 9.5% of ever married women and 14.7% of currently married men aged 15-24 had comprehensive knowledge about HIV and AIDS.

A recent rapid study showed that comprehensive knowledge about HIV and AIDS among the general population aged 15-24 years was increasing from 11.4% in 2010 to 20.6% in 2011, with similar proportion between men (20.2%) and female (20.3%) respondents.

Almost two third of young people (57% women, 56% men) reported that AIDS cannot be transmitted by sharing food with a person with AIDS, and over two thirds of young people (68.1% of women and 67.3% of men) responded correctly to the question about whether or not a healthy-looking person can have the AIDS (MoH Rapid Study on HIV comprehensive knowledge in 5 cities in 5 provinces 2011).

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

Female virginity has a high value among Indonesian youth with 98-99% of women and men aged 15-24 saying that it is important for a woman to maintain her virginity. Values about virginity might help delay age at sexual debut among young Indonesian with surveillance showing that only 1% of women and 6% of men in the 15-24 year age group reportedly having had a sexual experience. Unmarried respondents who reported having sex before age 15 among male age group 15-19 age group and 20-24 is similar, which is 1% and 0.9%.

In IDHS survey, 26.2% percent of ever married-women currently aged 15-17 years reported having had sex before the age of 15. This may have to do with the tendency of girls (especially in rural areas) to marry at a relatively young age.

1.3. Indicator: percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months

Individuals who have multiple sexual partners increase their risk of contracting HIV as each new relationship introduces another pathway for potential HIV transmission. Thus, multiple partnerships with inconsistent condom use can contribute to the spread of HIV.

Findings from the IDHS in 2007 show that 3 in 1000 currently married men had engaged in sexual intercourse with an extramarital, non-cohabitating partner in the previous 12 months meaning that these men have had sexual intercourse with more than one partner. The actual number may be larger considering some respondents may be reluctant to provide information on their recent sexual behavior particularly if it departs from the socially acceptable monogamous norm. It should also be noted that only married men

were asked this question. No women were asked about multiple sexual partners within the previous year.

A Tanah Papua surveillance found high risk sexual behavior among adults, with 25 % of married men and 7% of married women reportedly having extramarital or non-cohabiting partners in the previous year. Of those who had extramarital or non-cohabiting sexual relationships, men have been more likely to have multiple sexual partners (20% men compared to 8% women) (MoH, IBBS Tanah Papua, 2006).

1.4. Indicator: percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report use of a condom during their last intercourse

The indicator is not available at this time in Indonesia

1.5. Indicator: percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

The indicator is not available at this time in Indonesia

1.6. Indicator: Percentage of young people aged 15-24 living with HIV

The indicator is relevant to Indonesia but national data are not available.

In 2011, there was sentinel surveillance available from 2 sites - one in the western Indonesia (Riau province) and one in the eastern Indonesia (Tanah Papua) of Indonesia- to young women who visited ANC. However the data is not yet available.

It is interesting to look at HIV prevalence in those aged 15 to 24 years who are already involved in the sex industry and drug injecting. Transgender HIV and syphilis increased with the age. Condom use by FSW is lower in younger FSWs compared to older FSWs although a lower proportion of transgender people aged 25 years or more reported using condoms during the last commercial sex. See Table 4. HIV and Syphilis Prevalence and Condom Use at Last Commercial Sex for FSW and Transgender People by Age Group for further information.

Table 4. HIV and Syphilis Prevalence and Condom Use at Last Commercial Sex for FSW and Transgender People by Age Group (NAC, MoH, UNICEF 2006-2007)

Key affected Population	Age Group	HIV prevalence (%)	Syphilis Prevalence (%)	Used condom last commercial (%)
FSW	15-19	5	6	52
	20-24	8	6	63
	25+	7	9	68
Transgender	15-19	5	10	61
	20-24	14	11	65
	25+	19	24	58

The percentage of young MSM who had sex with more than one partner in the past 1 year was highest in the 20-24 year age group and they also had the highest average number of sex partners, although STI ad HIV prevalence was highest in those aged 25 years or more. Levels of reported condom use at last sex with commercial partners were high between 55% - 59%, and less condom use with non-commercial partners (43% - 45%).

Table 5. MSM prevalence of HIV and STIs, proportion with more than 1 partner, and average number of sex partner in the last year

(NAC, MoH, UNICEF 2006-2007)

Age Group	HIV prev. (%)	STI prev. (%)	More than 1 partner in the last year (%)	Average number of sex partners	Used condom last non commercial (%)	Used condom last commercial (%)
15-19	2	2.4	43	2.5	43	55
20-24	5	5.7	55	4	45	59
25+	7	7.3	52	3.5	45	58

PWID who are aged 25 years or older have higher HIV and syphilis prevalence than younger age groups, although a higher proportion of those aged 15-19 shared needles and syringes.

Table 6. HIV and Syphilis Prevalence and Condom Use at Last Commercial Sex for FSW and Transgender People by Age Group
(NAC, MoH, UNICEF 2006-2007)

Age Group	HIV prevalence (%)	Syphilis Prevalence (%)	Used condom last commercial (%)
15-19	6	0	52
20-24	30	0.8	33
25+	50	1.3	30

Sex Workers

1.7. Percentage of sex workers reached with HIV prevention program

One of the methods to measure reach of HIV prevention programs among sex workers is by asking respondents if a) they know where to go to receive an HIV test, and b) if they had received a condom at anytime in the last three months.

At first glance, program reach seems low with less than one fifth of sex workers knowing where to find HIV test providers and having received condoms within the last 3 months.

However, by disaggregating variables for different sub-populations, we find exposure to programs varies. Almost two third (60%) of male sex workers know where to get an HIV test, yet few (16%) reported having been given a free condom in the past 3 months. Male sex workers may not have intensive contact with outreach workers who usually give free condoms. Yet many male sex workers seem to be aware of HIV test sites from other sources such as friends or the internet.

Among FSW, a moderate result was obtained with 37% reporting knowing where to get An HIV test and 38% had received a condom in the last 3 months respectively (MoH, IBBS 2011).

It is noteworthy however, that condoms are now being heavily promoted. Consumption of condoms, free and for purchase has more than doubled in the past 5 years from 94,806,211 in 2006 to 194,213,765 in 2011 (see Table 7. Consumptions of condoms in Indonesia 2006-2011)

Table 7. Consumptions of condoms in Indonesia 2006-2011

(Source: NAC Program Monitoring 2006-2011)

	2006	2007	2008	2009	2010	2011
Sales of condoms	80,406,211	90,586,014	103,055,102	108,325,648	120,389,355	158,500,289
Managed by KPAN				947,613	3,931,015	15,414,225
Managed by the National Population and Family Planning Board	14,400,000	4,335,264	3,080,016	19,537,920	34,704,720	20,299,248
Total Condom distributed in Indonesia	**94,806,211**	**94,921,278**	**106,135,118**	**128,811,181**	**159,025,090**	**194,213,762**

Respondents of IBBS surveillance reported various sources for condoms; many (36%) obtained them from pharmacy and stores, 21% from pimps and establishments, 8% from outreach workers, and 5% from STI clinics indicating that there has been a growth in the sources of condoms among individual, community and STI service providers (MoH, IBBS 2011).

Surveillance data indicates sex workers had greater exposed to programs as they get older. It shows that young people remain at the centre of the epidemic and lack access to information, prevention and services.

Figure 1. Percentage of sex workers reached with HIV prevention program, by Sex

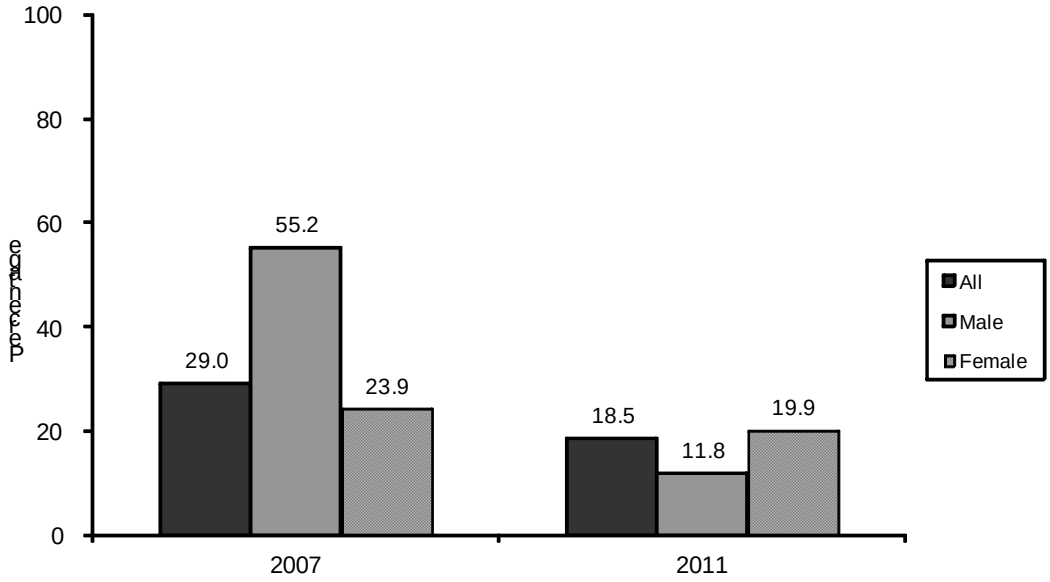
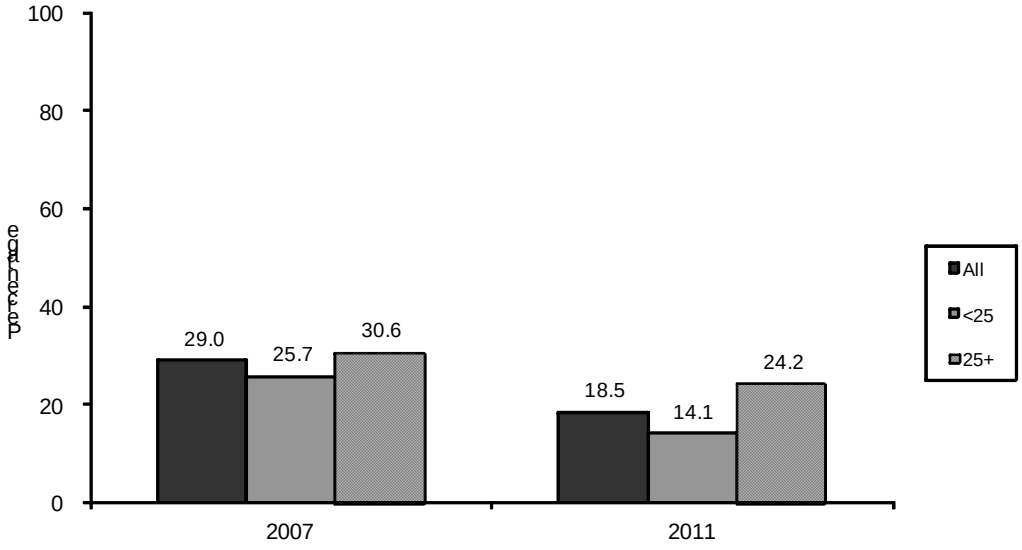


Figure 2. Percentage of sex workers reached with HIV prevention program, by Age

(IBBS 2007, IBBS 2011)



1.8. Percentage of sex workers reporting the use of a condom with their most recent client

The percentage of condom use at last sex with client reported by sex workers was high yet shows a downward trend (see Figure 3. Percentage of sex workers reporting the use of a condom with their most recent client, by Sex). Sex workers reports on condom use are very consistent with clients reporting that their last sexual intercourse with a sex worker took place mostly with a condom (58%), with less condom use with male sex workers (49%) compared to FSW (60%).

In some cities, the reported condom use level among direct FSW has risen such in Batam (from 66% to 79.9%), in Jakarta (from 39% to 49.4%), in Denpasar (from 79% to 90%), and among indirect FSW in cities such Bandung (from 64% to 72%), Surabaya (from 54% to 85.2%) as well as in Jayapura among both direct and indirect FSW (direct FSW: from 80% to 95%, indirect FSW: from 42% to 57.7%). But, a low percentage of FSW reported that they

had used a condom with their most recent client was in Jayawijaya (Direct FSW: 28.8%) and in Lampung (Indirect FSW: 17.6%). There was also a decrease in reported condom use in Deli Serdang (from 43% to 36.4%) among direct FSW, in Semarang (from 80% to 74.2%) among indirect FSW, as well as in Bekasi and in Malang for both direct and indirect FSW. The combination of these results related to condom use contributed a major portion of the decrease in overall results.

It remains a challenge to reach young sex workers. Their condom use is high, but not as encouraging as sex workers 25 years of age or more (Figure 4. Percentage of sex workers reporting the use of a condom with their most recent client, by Age).

Figure 3. Percentage of sex workers reporting the use of a condom with their most recent client, by Sex

(IBBS 2007, IBBS 2011)

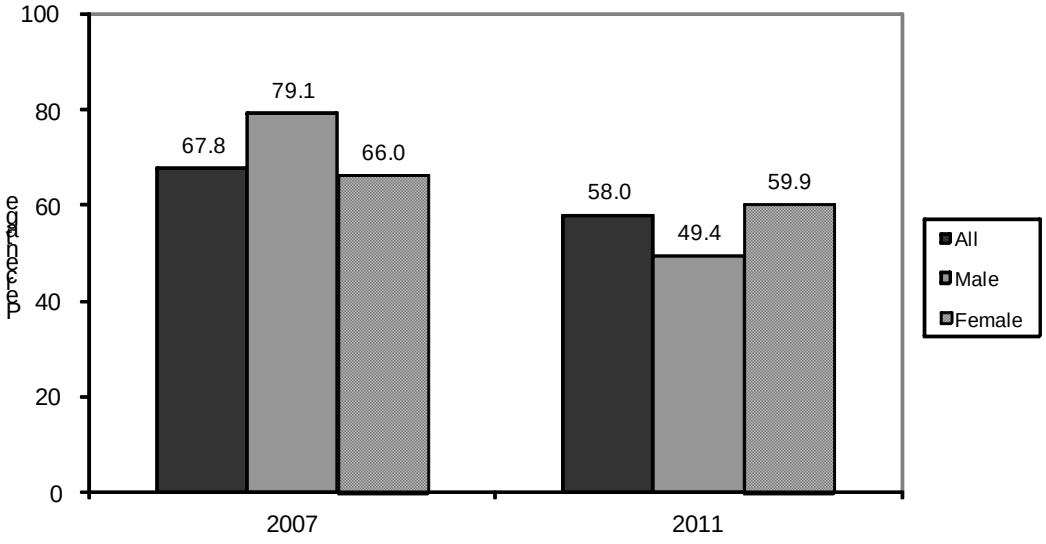
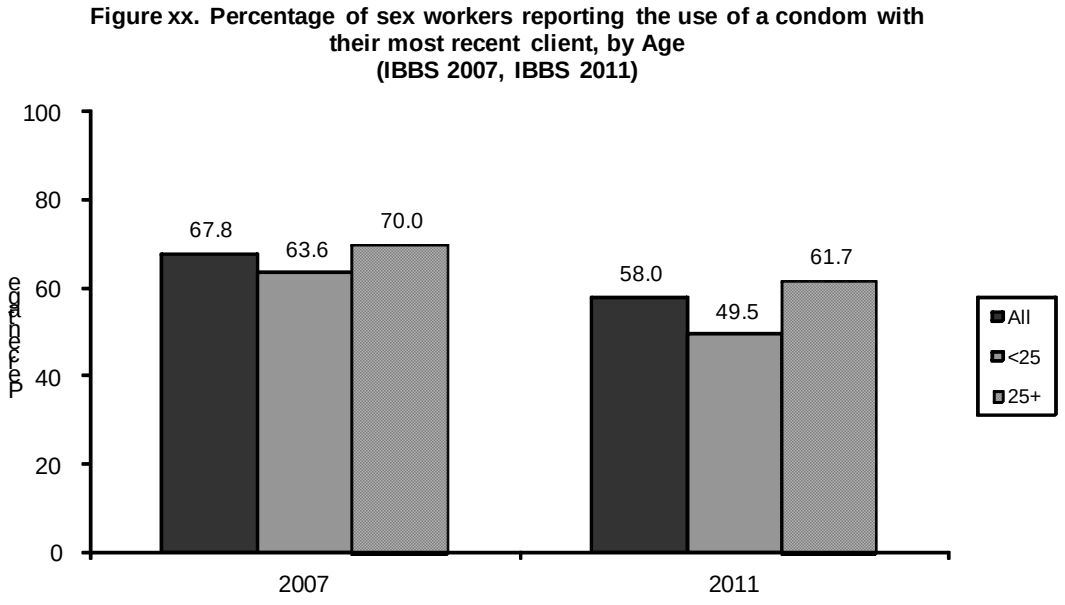


Figure 4. Percentage of sex workers reporting the use of a condom with their most recent client, by Age

(IBBS 2007, IBBS 2011)



1.9. Percentage of sex workers who have received an HIV test in the past 12 months and know their results

Ten years ago, sex workers in Indonesia reported routinely experiencing stigmatization and discrimination in health care settings. For the past 4 years, training of health staff in CHC has been scaled up to understand more about HIV and promote the adoption of comprehensive HIV prevention. The MoH has designated at least 643 CHC across Indonesia to provide STI treatment, and some are able to provide HIV testing and TB/HIV treatments (MoH, Year end Report on Situation of HIV and AIDS in Indonesia, 2011).

Some establishments refer their FSW for regular screening of STI, as well as routine HIV testing. The numbers of direct sex workers and male sex workers tested for HIV has been climbing, indicating progress in expansion of HIV testing and promotion during the last 2 years.

Figure 5. Percentage of sex workers who have received an HIV test in the past 12 months and know their results, by Sex

(IBBS 2007, IBBS 2011)

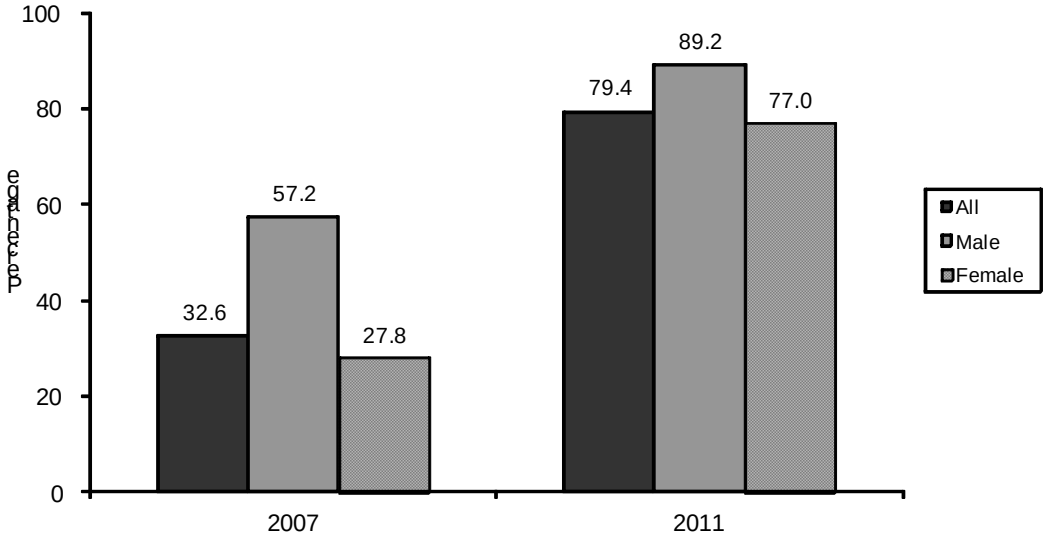
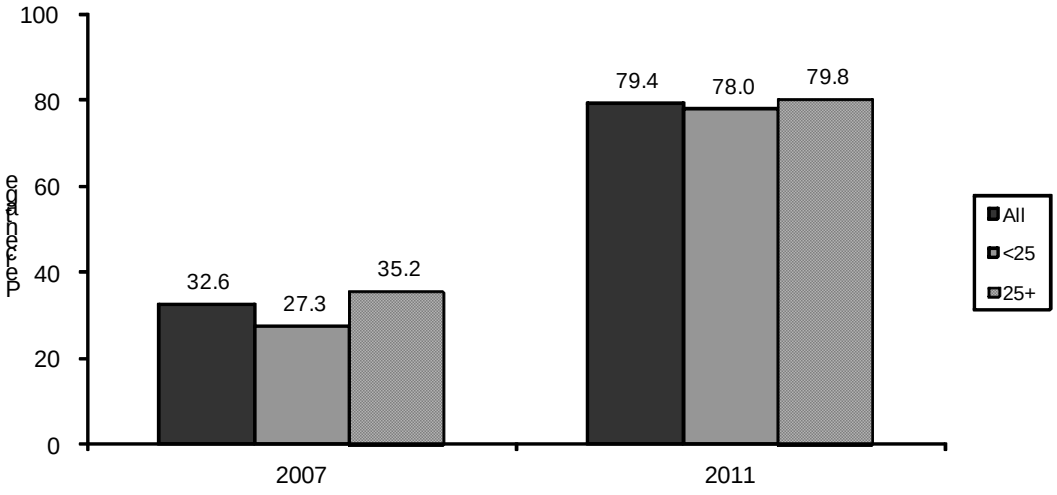


Figure 6. Percentage of sex workers who have received an HIV test in the past 12 months and know their results, by Age

(IBBS 2007, IBBS 2011)



1.10. Percentage of sex workers who are living with HIV

Among key affected populations, male sex workers have the second highest HIV prevalence at 18%. The prevalence among direct FSWs has never been lower than 10% in the last 4 years, while indirect FSWs are 3%.

HIV prevalence among indirect female sex workers has decreases in cities such Batam, Jakarta, Medan and Semarang. In Batam from 9% in 2007 to 6.9% in 2011, Jakarta from 6% (2007) to 5.2% (2011), Medan from 4% (2007) to 3.2% (2011) and Semarang from 2% (2007) to 0.8% (2011) respectively. In Surabaya prevalence has been stable remaining low at 2%. The highest HIV prevalence was among direct female sex workers in Jayawijaya (25%) and Batang (20%) and there was an increase in Denpasar and Jayapura (from 14% to 16%). These increases and decreases explain the comparatively unchanged in overall prevalence among direct FSW.

Surveillance data also indicated FSW were becoming exposed to HIV at early initiation of their sex work with 4.1% of newer sex workers were infected (see

Figure 9. Percentage of female sex workers who are living with HIV, by length of participation **in sex work**). Among direct female sex workers who work in brothels and on the streets, and who have worked less than a year there was no significant increase or decrease in prevalence from 2007 to 2011 in all the sites studied. Aggregate prevalence in this group is about 8%.Two thirds of new FSWs started their career in karaoke, massage parlor, bar, restaurant, or street sex workers. HIV prevalence among indirect female sex workers who have been involved in sex work for less than a year in the hospitality industry, has decreased by two thirds from almost 10% to 3% from 2007 to 2011 (MoH, IBBS 2011).

Figure 7. Percentage of sex workers who are living with HIV, by Sex

(IBBS 2007, IBBS 2011)

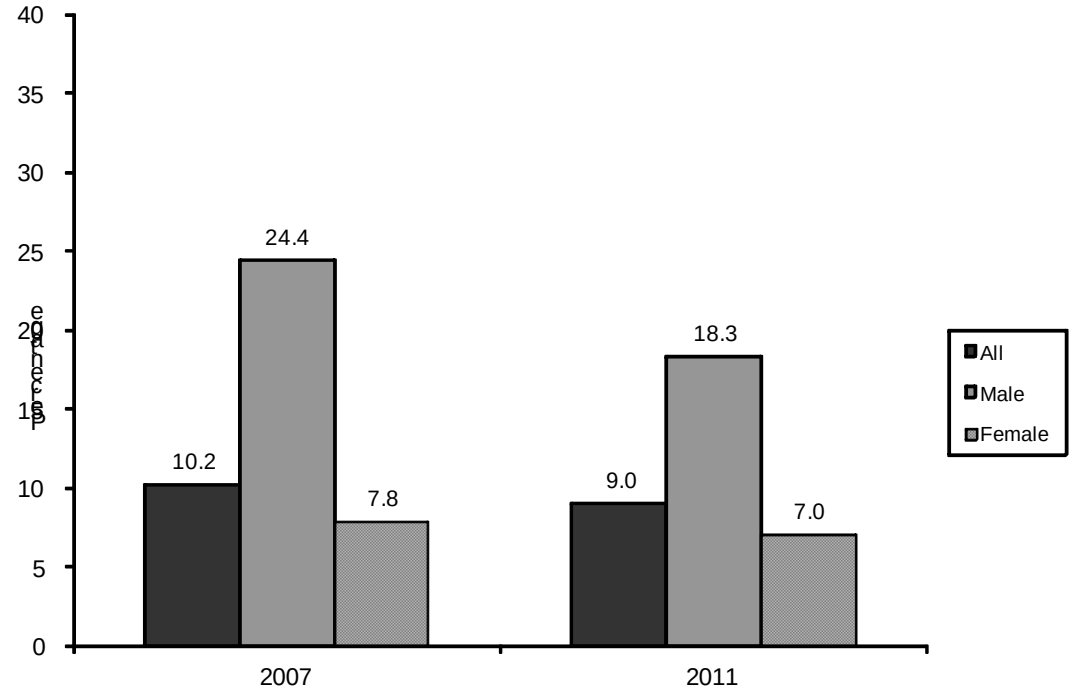


Figure 8. Percentage of sex workers who are living with HIV, by Age

(IBBS 2007, IBBS 2011)

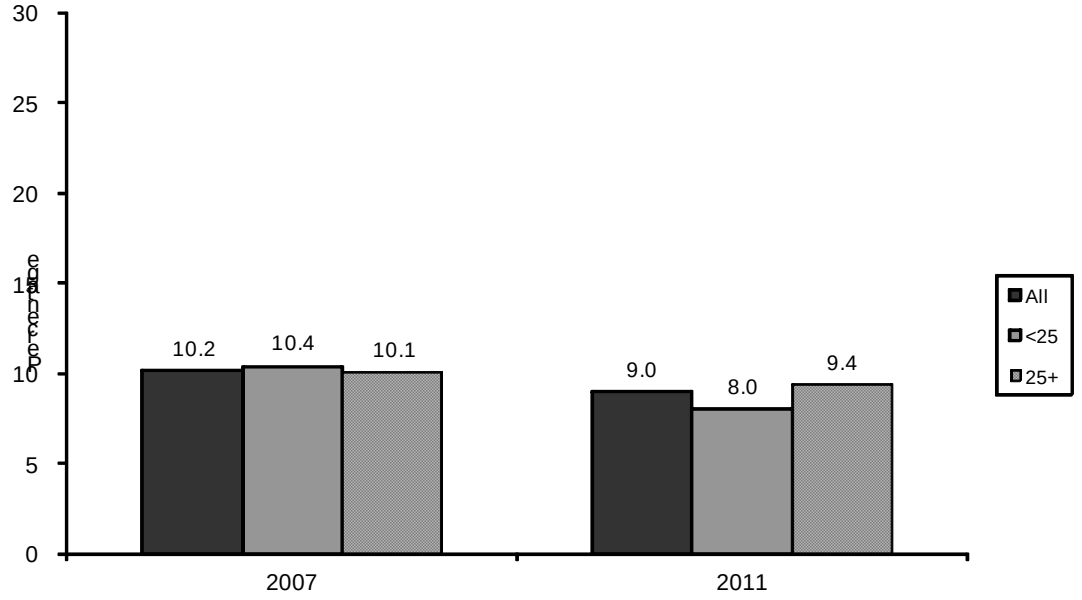
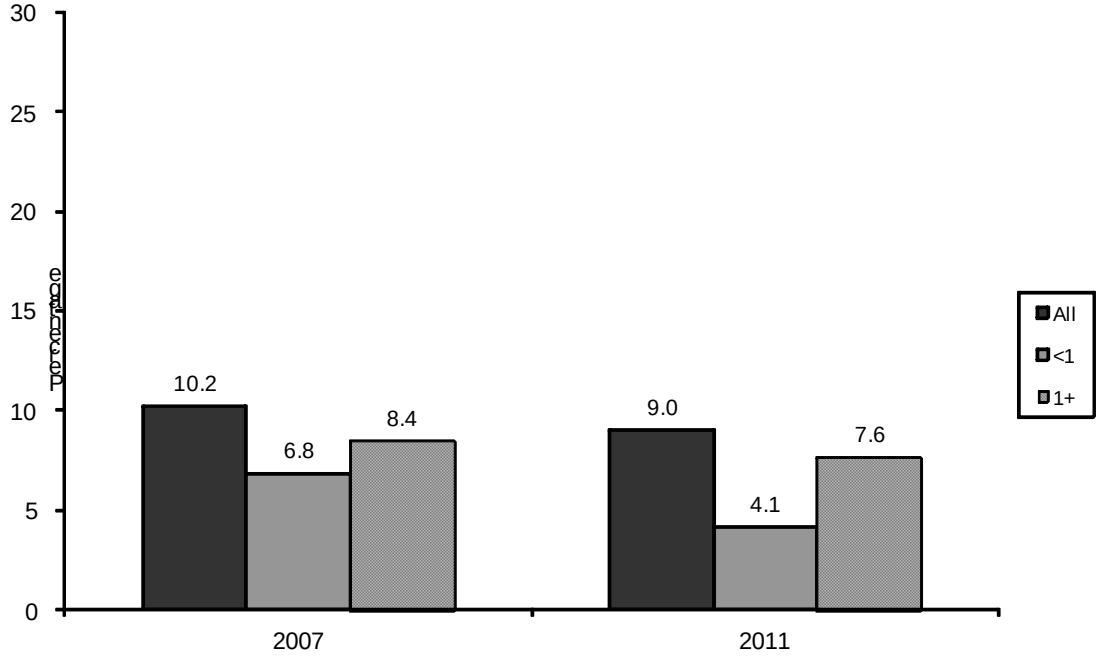


Figure 9. Percentage of female sex workers who are living with HIV, by length of participation in sex work
(IBBS 2007, IBBS 2011)



MSM

1.11. Indicator: Percentage of men who have sex with men reached with HIV prevention programs

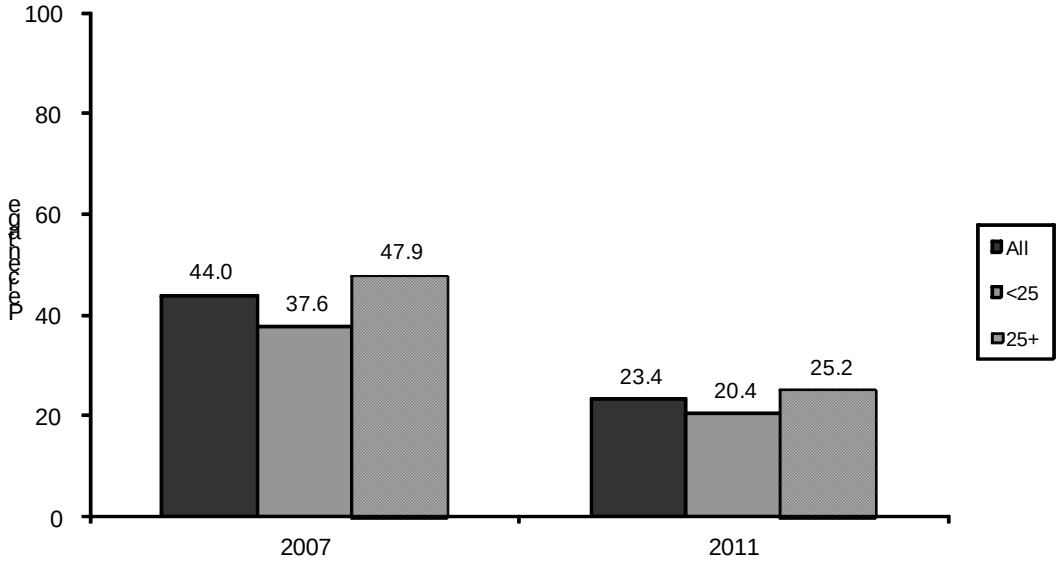
Findings from the 2011 IBBS report show that the percentage of MSM who know where to go to get an HIV test 47% and been given condoms in the last 3 months (30%) has decreased compared to the results of the IBBS from 2007. There was a high number of MSM in Malang and Jakarta who reportedly knew where to get HIV test (72% and 52%) and had been given condoms in the last 3 months (62% and 40%), while only 11% of MSM in Bandung and 7% in Semarang who had been given condoms in the last 3 months.

Monitoring found that the program coverage for MSM almost halved in 2011 (12,960 people) compared to 2010 (26,232 people). Surveillance confirmed the program records that there was a slight decrease of MSM who had ever been reached by outreach workers within the last 3 months, from 37% (2007) to

26% (2011). However, the number of MSM who search for information about HIV on the internet is promising (41,650 total visits[7] per year), suggesting this could be a good way to reach MSM.

Figure 10. Percentage of men who have sex with men reached with HIV prevention program, by Age

(IBBS 2007, IBBS 2011)



1.12. Indicator: percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Most MSM (84%) reported having had non-commercial and casual partners. However, only 20% of MSM bought sex. Condom use among MSM reporting use at last anal sex with a partner has shown increases in some areas of decreases in other. No of 57% in 2007 to 60% in 2011 (60%) pattern is apparent, yet. In Surabaya and in Malang from 65% to 75% and from 66% to

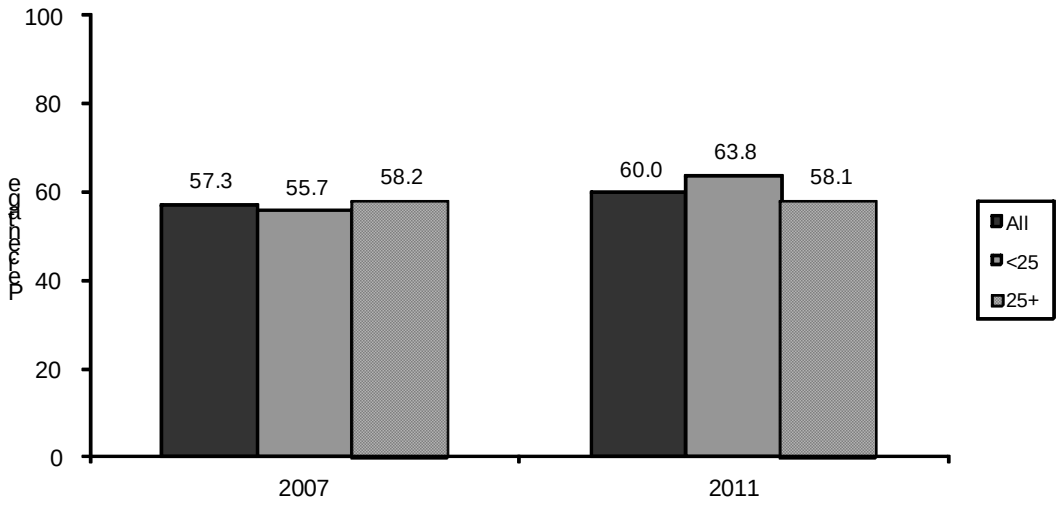
[7] Indonesian Gay, Transgender and Lesbian Network website record Mar 2010- Feb 2012

77%. Use increased in Bandung (from 83% to 49%), in Jakarta (from 77% to 65%) and in Semarang (from 55% to 34%) it decreased.

Rates of consistent condom use among MSM remained at 30%. The consequence of risky behavior is reflected in the rising rate of STIs overtime, from 4% to 13% for Syphilis and 1% to 33% for Gonorrhea and/or Chlamydia (MoH, IBBS 2007 and 2011).

Figure 11. Percentage of men reporting the use of a condom the last time they had anal sex with male partner, by Age

(IBBS 2007, IBBS 2011)

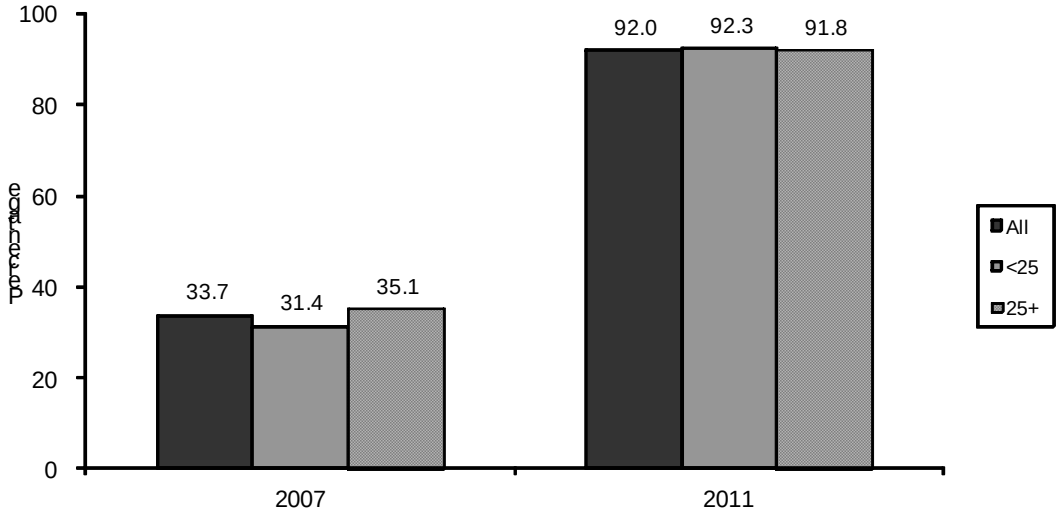


1.13. Indicator: percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

The numbers of MSM in Indonesia who have had a HIV test has risen dramatically from 34% to 92%, as a result of increasing availability of information among MSM (see indicator 1.11), and expanding of HIV testing in community health centers during the last 2 years.

Figure 12. Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results, by Age

(IBBS 2007, IBBS 2011)



1.14. Indicator: percentage of men who have sex with men who are living with HIV

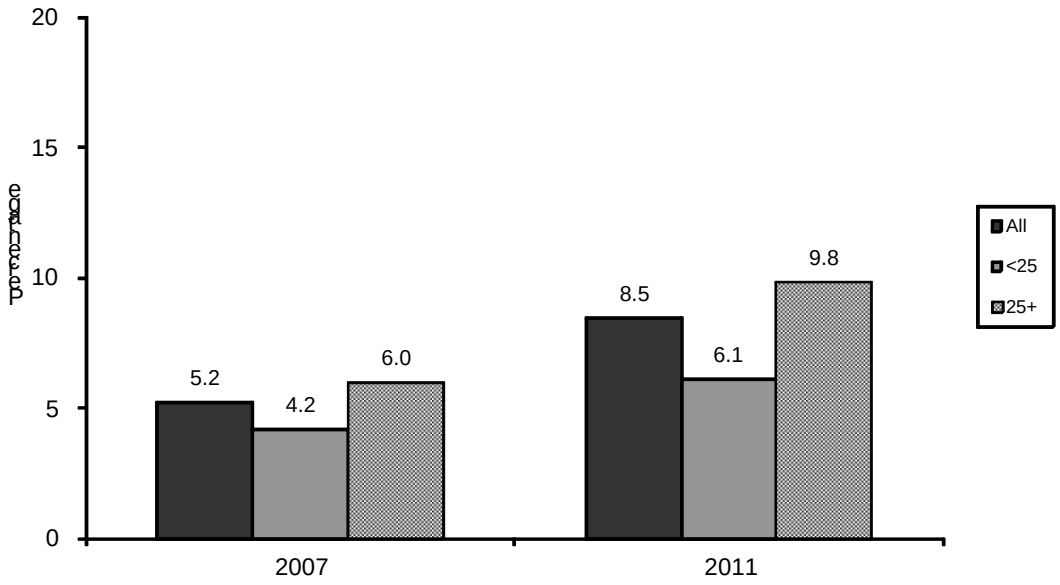
A report on HIV and AIDS in Indonesia shows that only 4% of reported AIDS cases identify the source of their infection as homosexual transmission. This figure might reflect underreporting as a result of the unacceptability of homosexuality in the community. Some male clients may be reluctant to provide information about a male sexual partner.

In big cities such Jakarta, Bandung and Surabaya where prevalence among MSM was high, it rose between 2007-2011 from 8% to 17.2%, from 2% to 10.4%, and from 6% to 9.6% respectively, over four years (IBBS 2007, IBBS 2011). The surveillance data indicates that young MSM tend to have increasing HIV prevalence overtime (see Figure 13. Percentage of men who

have sex with men who are living with HIV, by Age), thus the program must reach each generation of MSM.

Figure 13. Percentage of men who have sex with men who are living with HIV, by Age

(IBBS 2007, IBBS 2011)



Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015

Unfortunately it is not possible to disaggregate these data by gender since the gender of respondents was not recorded in the 2011 IBBS questionnaire.

2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe program

The number of needles and syringes distributed by programs in 2011 was 690,000 to 61,637 PWID. The estimated PWID population is 105,784 (MoH estimate 2009). The provision of needles and syringes should match the demands of PWID. If surveillance data are used to calculate demand, the

minimum number of needles and syringes needed is over 38,5 million, based on 364 per PWID per year, based on an average of 7 needles and syringes (IBBS 2011) per week per PWID. The current level of needles and syringes distribution means that, on average, each PWID receives 7 needles and syringes per year.

Surveillance data indicates drop in centers (33%), outreach workers (32%), and CHC (20%) are the primary sources of sterile needles and syringes among PWID. In Indonesia, harm reduction services are also embedded in the health care system, with CHC services providing NSP and methadone substitution therapy. Purchasing of sterile needles and syringes at pharmacies (and stores) has proven the cheapest strategy for distribution to PWID globally (Geneva 2004) and is rising in importance in Indonesia. Purchase was reported by two thirds (58%) of respondents in 2011 (MoH, IBBS 2011).

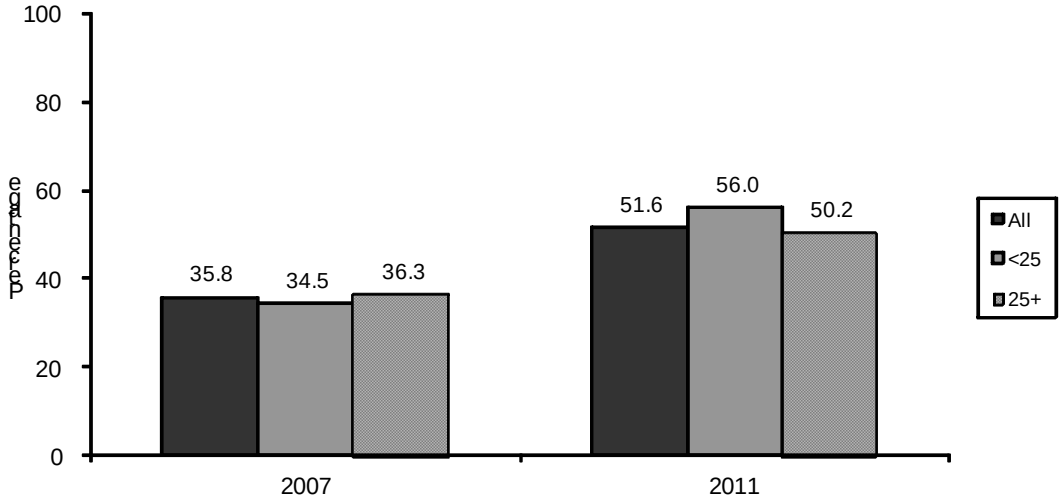
2.2. Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

Sexual behavior of PWID has high potential for HIV spread to non-injectors because prevalence among PWID is still high and unprotected sex is common. Some 36% of PWID are married or live with a steady sexual partner, 25% reported having had sex with an irregular partner, and 24% with sex workers. Reported condom use at last sex among PWID is not as good as among sex workers and MSM, but much better than that of clients of sex workers. Consistent condom use was reported by more than 40% of PWID who had sex with sex workers, and nearly 50% of PWID who had sex with casual partners. The report of protected sex with extra-marital partners is consistent with the moderate syphilis rate (2%).

There was a dramatic increase in percentage of PWID who reported condom use at last sex in Surabaya with both regular partner (from 16% to 49%) and casual sex partner (27% to 45%) and in Jakarta with regular partner from 29%

to 50%, while in Bandung condom use among MSM at last anal sex was were decreasing from 42% to 34% (regular partner) and from 63% to 50% (casual sex partner).

Figure 14. Percentage of people who inject drugs who report the use of a condom at last sexual intercourse, by Sex (IBBS 2007, IBBS 2011)



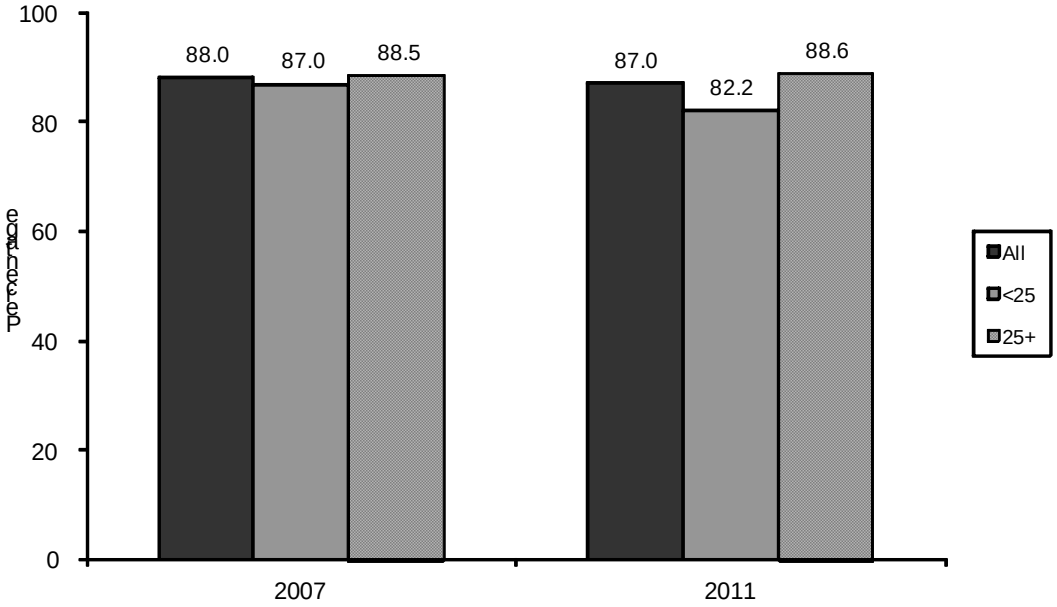
2.3. Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

Surveillance data suggests the positive impact of supportive regulation on harm reduction. The reluctance to carry needles and sterile needles and syringes because of fear of arrest for PWID has been reduced with the subsequent increase of carrying needles and syringes (30% PWID carrying needles and syringe in 2011, while 25% of PWID in 2007), and 50% of PWID reported participating in NSP in the last week of survey. The number of PWID receiving methadone is growing. Program records suggest a proportion of injectors (39%), continue to inject while on MMT, particularly in the early months of treatment (NAC, HCPI and AusAID, HIV Cooperation

Program for Indonesia Annual Survey among Harm Reduction Program Participants in 7 provinces, 2011)

Figure 15. Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected, by Age

(IBBS 2007, IBBS 2011)

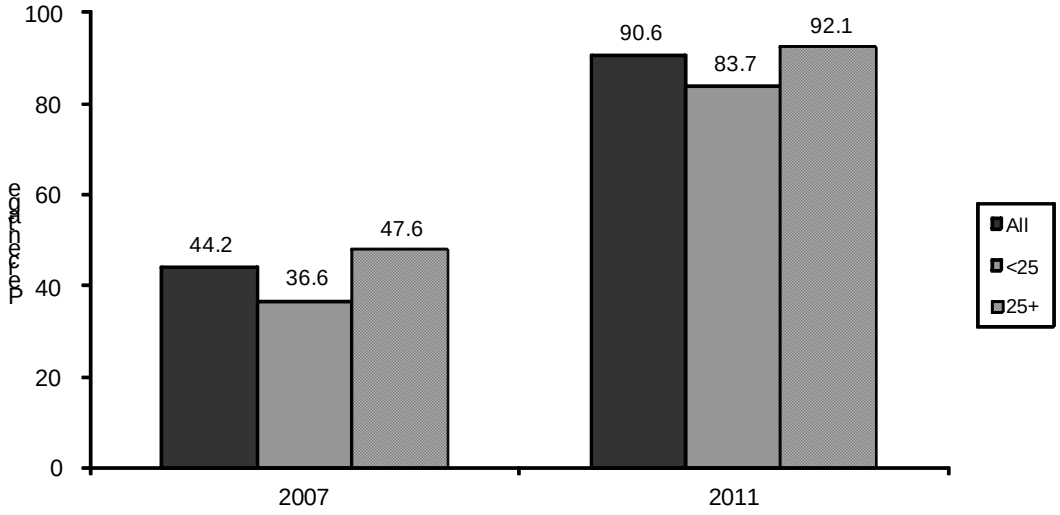


2.4. Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

Surveillance data, depicted in Figure 16. Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results, by Age) shows a great increase in the proportion of PWID reported to have had a test for HIV after the increase of supportive regulations on harm reduction and integration of NSP in CHCs services. Among NSP participants, 56% had had an HIV test. HIV test attendance among methadone clients was nearly 100%, as enrollment in MMT service requires an HIV test. NSP and methadone services clearly provide a good opportunity to reinforce secondary prevention messages such HIV testing for PWID.

Figure 16. Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results, by Age

(IBBS 2007, IBBS 2011)



2.5. Percentage of people who inject drugs who are living with HIV

Overall, HIV prevalence among PWID was lower in 2011 than in 2007. The decrease in prevalence in 2011 compared to 2007 was mainly due to decreases in Medan from 56% to 39%, in Surabaya from 56% to 49%, and in Bandung from 43 to 25%. HIV prevalence was also lower among those injecting for two years or less in Malang at 6% and in Bandung at 10%. In Medan there has been significant progress since 2007 with a decrease in prevalence of 24%. However, prevalence at the time of IBBS 2011 was still 17%. For PWID in the same category (injecting for two years or less) prevalence reached 22% in Surabaya and 38% in Jakarta. Among newer PWID (less than 1 year involvement) there has been marked progress with infection declining from 27% (IBBS 2007) to 12.3% (IBBS 2011).

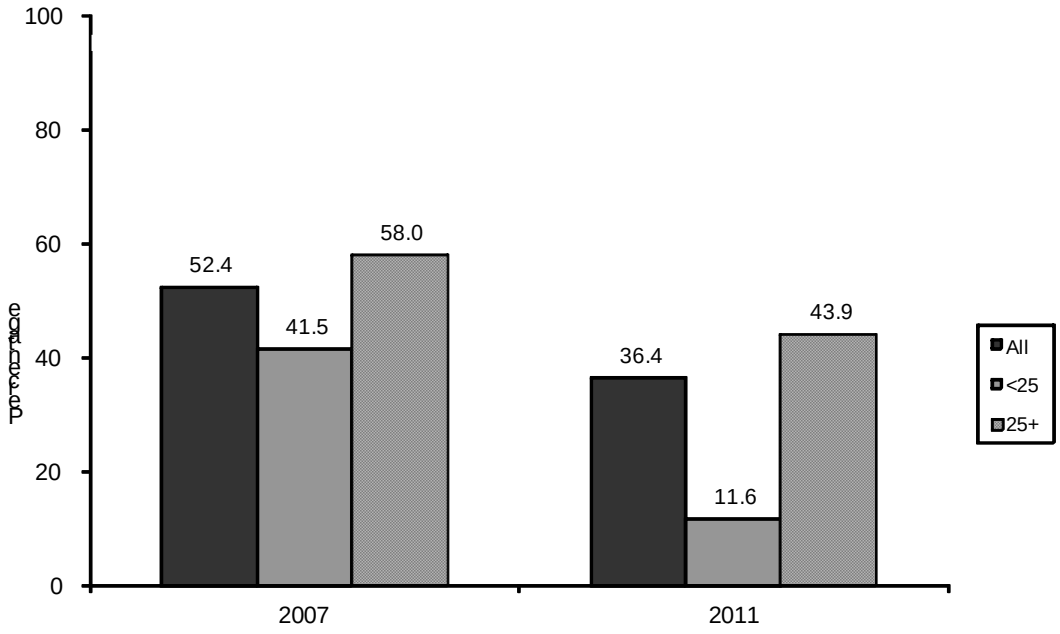
While gratified to see some improvements within the community of PWID, nonetheless continuing work is needed and planned including more peer

education, NSP, testing and treatment, and an increased availability of a combination of harm reduction services in the community and in the prison system, encourage and support maintenance of safe behavior thus preventing new infection.

Although the sample size was small, subgroup analysis of people who have been injecting less than two years in the city of Jakarta found that prevalence rose from 33% to 44% over four years (2007 to 2011).

Figure 17. Percentage of people who inject drugs who are living with HIV, by Age

(IBBS 2007, IBBS 2011)

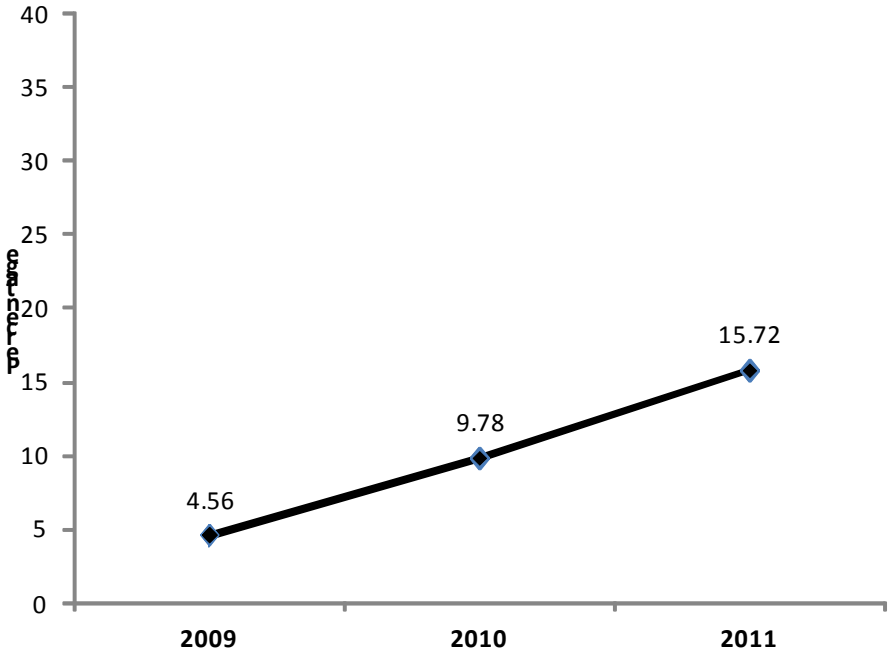


Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

3.1. Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother to child transmission

Figure 18. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to child transmission

(UA 2009, UA2010, UA2011)



The MoH estimated that there were 5,060,637 pregnant women in 2011, and 0.4% (21,103) of them has been tested for HIV and received the results (MoH Program Monitoring 2011). Of those who were tested for HIV, 2.5% (534 pregnant women) were HIV positive. The proportion of pregnant women known to have received ARV prophylaxis is increasing and the target by 2014 is 3,175 HIV-infected pregnant women (MoH, Program Monitoring in Universal Access Report 2011).

Women, who are likely to visit antenatal clinics on their own, have generally not thought about having an HIV test prior to being offered the opportunity

as part of their antenatal care so most of these women have not talked with their partner prior to having an HIV test. The 2007 IDHS showed low involvement of a father during their partner's pregnancy, with only 32% of fathers talking to health care providers about the pregnancy care and health of their wife during their wife's last pregnancy.

The dilemmas women face when deciding whether or not to share results with their sexual partners and family may be substantial, as ART requires life-long adherence and is much more likely to be sustained in a supportive situation.

To accelerate the elimination of mother to child transmission, more assertive promotion of HIV testing and treatment among men is urgent to reduce transmission of infection to wives or other sexual partner. The nation is also challenged to promote counseling for couples, and community based initiatives (leaders, clerk, priest, community volunteers) to assist women prior to, during and post disclosure addressing negatives outcomes should they occur (e.g. mediation, shelter environment for access social support and if needed support for legal sanction in cases of severe violence). Without such initiatives, the ARV treatment rate among (pregnant) women may remain low.

3.1. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

Indicator is relevant to Indonesia but national data are not available

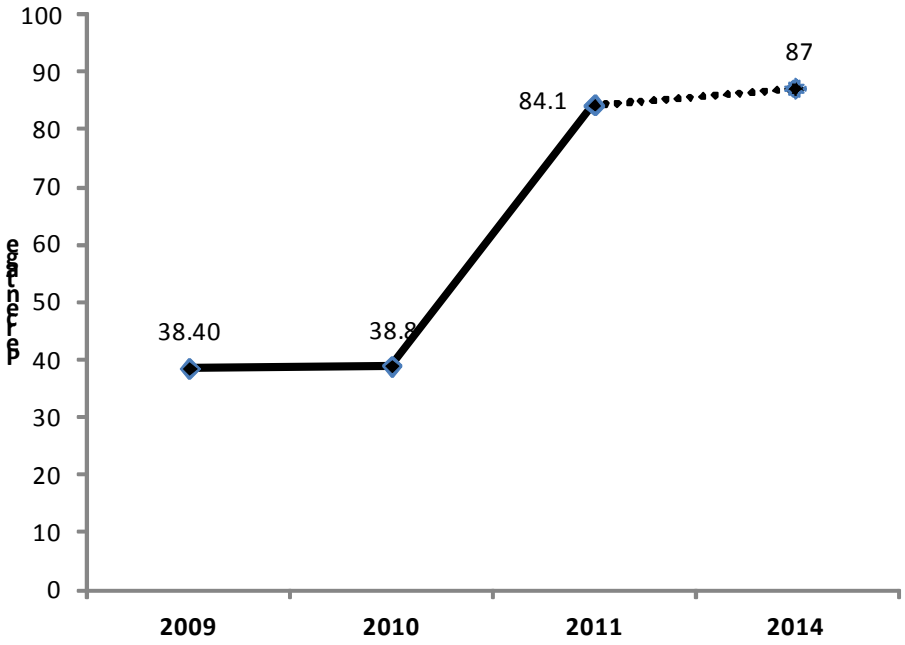
3.2. Mother-to-child transmission of HIV (modeled)

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy

Figure 19. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

(UA 2009, UA 2010, UA2011, MoH target by 2014)



An estimated 186 thousand Indonesian were infected with HIV in 2009: In 2011 more than 24,410 HIV-positive people was receiving ARV treatments (the MoH program monitoring 2011). Adults make up 96% (23,390 people) of those receiving ARV treatment with children under the age of 14 make up 4% (1,020 children) of the total. Of ARV patients, 23,274 people (95%) were on 1st line ARV, and 1,136 people (5%) had been switched from first to second line ARV. At this time, it is not possible to disaggregate these data by gender (MoH, Program Monitoring in Universal Access Report 2011).

To increase access to ART, Indonesia has been working to assure continuity of supplies and address issues of adequate and sustainable financing, affordable prices, and reliable supply systems.

Initially, external resources (Global Fund) funded a 100% anti retroviral procurement for Indonesia. ART was provided through the public health systems and private practices.

In terms of adequacy and affordability of the drugs, since 2000 there has been a sharp drop in the global price of ARVs (resulting from better manufacturing methods, negotiated drug deals and competition from generic producers). This helped make the goal of universal access to ARVs more economically feasible. In 2003, an Indonesian pharmaceutical company started to manufacture ARV using imported materials. Although there are still challenges, local manufacturing should mean drugs will be cheaper and more easily accessed in cases of stock-outs.

Along with strong government involvement in prevention and treatment, by 2011 the costs for ARV in Indonesia were 100% covered by the national budget. This gives significant savings and sustainable financing for the nation's growing treatment program.

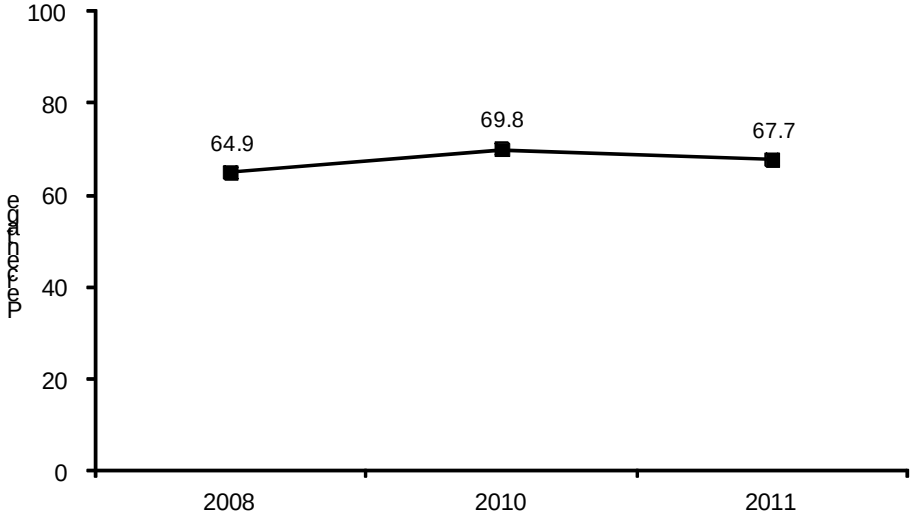
4.2. **Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy**

Death prior to treatment is still relatively high with 1 of 4 of HIV cases is not identified until they present with AIDS (the MoH case report from 2007 to 2011). The number of PLHIV who are alive and receiving ART after one year of initiating treatment has been 67.7% (2011) and 70% (2010). In addition to the proportion of PLHIV who are receiving ART and are still alive, there are those who are lost to follow up (18.6%), have stopped treatment (0.4%) or die (12.7%) (MoH, Program Monitoring in Universal Access Report 2011).

Great care needs to be used in hypothesizing or interpreting patients' reasons for not continuing ART. Thus far, local studies of this issue are limited. However, some issues are easily identified which present challenges: geographical distance, high cost associated with testing (laboratory tests, transport, and lost wages due to travel time). These are among the issues for those living in rural areas who do not continue ART. Providing equitable and accessible ART to people in rural areas has not yet been adequately resolved. The ART itself is no longer a problem as it is available for free. However, other medication can present cost obstacles to low income PLHIV.

Figure 20. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

(ART Monitoring, CDC MoH, 2008, 2010, 2011)



Target 5. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

5.1. **Percentage of estimated HIV positive incident TB cases that received treatment for both TB ad HIV**

Indonesia ranks third in number after India and China in term of the burden of TB cases, and those three countries contribute over 50% of the overall cases in the 22 high burden countries. WHO estimates that 4% of TB patients are HIV positive people. Due to the lack of immunity of those with HIV, TB has been the commonest opportunistic infection that leads to their death. Of the estimated 450,000 incident cases of TB in 2010, 9.9 to 29 thousand (2% - 6%) were among PLHIV, with a best estimate of 18 thousand (4%) (WHO 2011).

Between January to December 2011, the MoH reported a slight increase (1.3%) of the estimated HIV positive incident TB cases that have received treatment for both TB and HIV from 2008. To improve the accuracy of the number of people reached by the program, the new National Strategy for TB Control 2010-2014 has revised the recording and reporting system (WHO 2011). There are also 223 CHCs are providing HIV and TB integrated treatment for patients (MoH, Year end Report on Situation of HIV and AIDS in Indonesia 2011). By 2014, all PLHIV receiving ART (100%) will be assessed for TB by anamnesis and physical examination (MoH).

Figure 21. Percentage of estimated HIV positive incident TB cases that recieved treatment for both TB and HIV, by Sex

(UA 2009, UA 2011 the MoH)

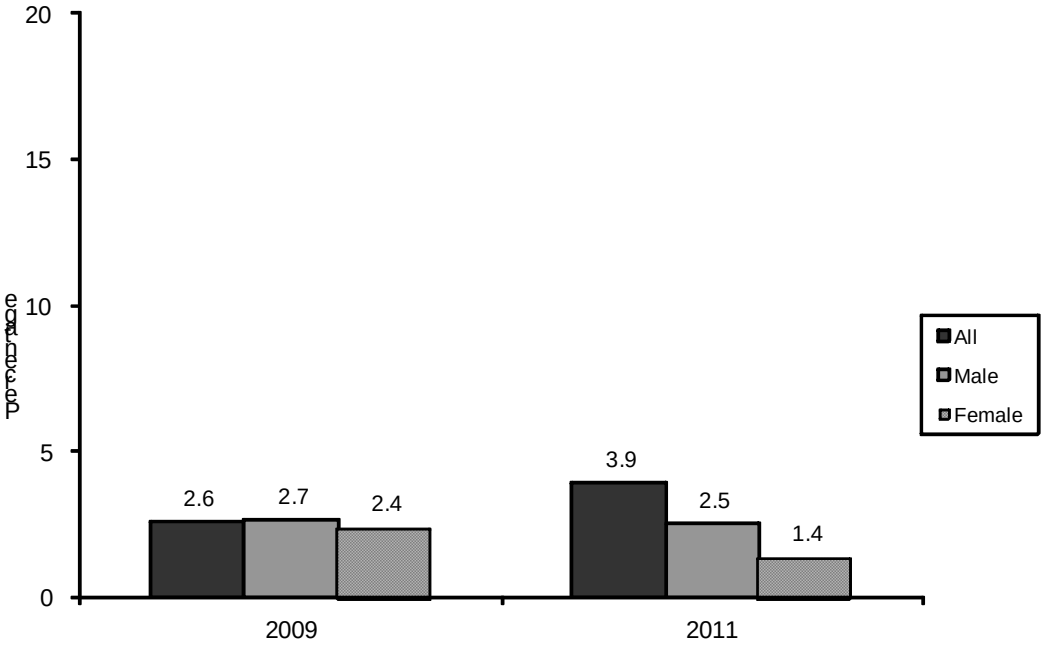
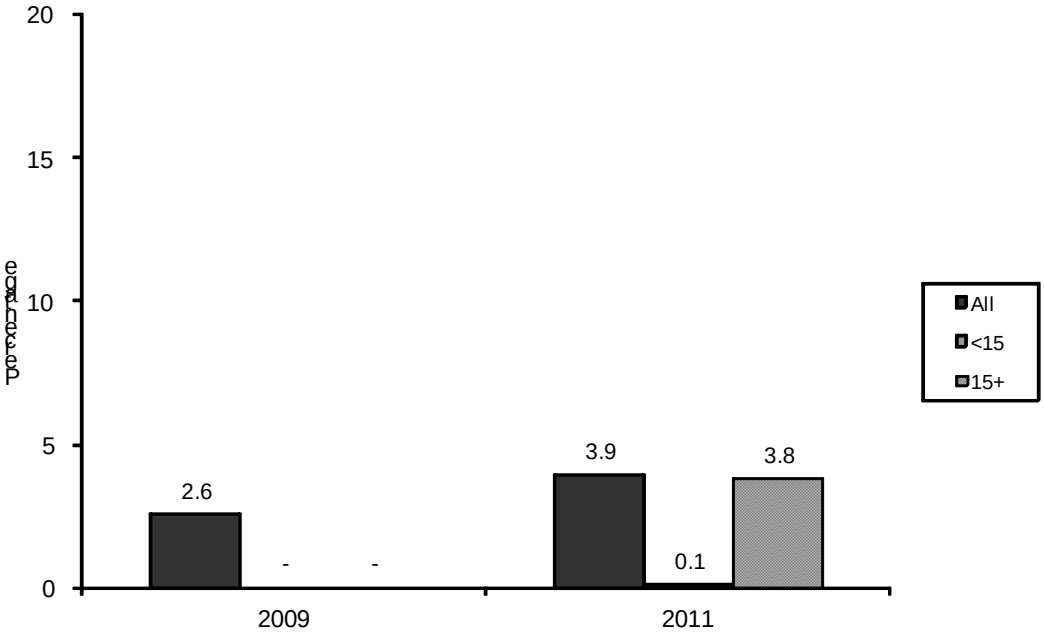


Figure 22. Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV, by Age

(UA 2009, UA 2011 the MoH



Target 6. Reach a significant level of annual global expenditure (US$ 22-24 billion) in low and middle-income countries

6.1. Domestic and international AIDS spending by categories and financing sources

Funding for AIDS program is measured and projected annually. The national forum for planning and budgeting for AIDS was established in 2009 and is coordinated by the National Board for Planning and Development. The board is expected to be able to raise budget allocation for national government sectors for their respective AIDS program. Mobilization of financial support from international development partners is managed by the NAC so that all support will be focused on priorities as mentioned in the National AIDS Strategy and Action Plan 2010-2014.

The report on AIDS expenditure in Indonesia in 2009 and 2010 (NASA report) explains funds spent for AIDS program from both government and international sources of funds. That report indicates that in 2009 the country spent USD 60,285,420 while in 2010 it spent USD 69,146,880. The report shows that Indonesia spent more money in 2009-2010 compared to figures shown in the previous years' assessment.

Table 8. Annual AIDS expenditures 2006-2010 and source domestic or international

(Source: the NAC, NASA reports 2009-2010)

	2006	2007	2008	2009	2010
Domestic	$ 15,038,057	$ 15,421,976	$19,839,380	$ 21,318,844	$ 27,779,280
International	$ 41, 538,530	$ 43,258,421	$ 30,991,725	$ 38,966,576	$ 41,367,600
TOTAL	**$56,576,587**	**$ 58,671,397**	**$ 50,831,105**	**$ 60,285,420**	**$ 69,146,880**

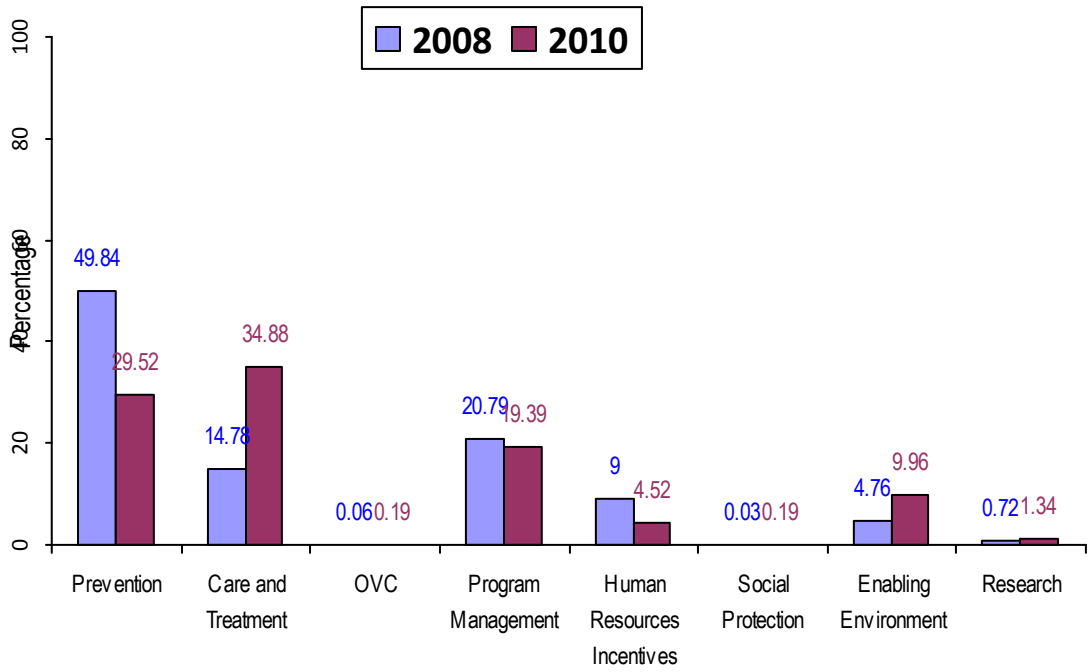
In 2009, more than 65% of expenditures or USD 38,966,576 came from international funds and 35% or USD 21,318,844 from government sources. In 2010, the proportion of government and international fund contribution changed slightly, with the Indonesian government contribution increasing to 40% or USD 27,779,280 while international funding decreased to 60% or USD 41,367,600. In 2009 and 2010, government sectors as the member of NAC have spent USD 13,883,455 and USD 17,731.539 respectively. The remaining government budget is made up of Provincial, District and City funds. The Ministry of Health spent most of their resources on treatment in the last 2 years. Information on local expenditure on AIDS in 2009 and 2010 were obtained from 12 provinces and totaled was USD 7,435,388 and USD 10,047,741. Although data not gathered for this report, it should be mentioned that all provinces in Indonesia (33) are now receiving some Global Fund report and have allocated some dedicated AIDS budget as counterpart for that support.

Funding from international partners either bilateral or multilateral in 2009 and 2010 totaled USD 38,966,576 and USD 41,367,600 respectively. In both years, the proportion of expenditures for care, support and treatment activities was 35% while previous NASA data showed prevention activities absorbed most of the expenditures. In 2009-2010 spending assessment, 30% of all expenditures were for prevention activities.

The NAC reported that during 2010 Indonesia's national response to HIV and AIDS focused primarily on prevention of HIV infection by sexual transmission as well as injecting drug transmission and continued to support care and treatment programs. Activities included improving the capacity to provide ART, HIV testing, treatment of STIs and strengthening the capacity for effective action among stakeholders working on sexual transmission.

Figure 23. Percentage of AIDS Expenditure 2008 and 2010 by Category

(Source: the NAC, NASA reports 2009-2010)



Target 7. Critical Enablers and Synergies with Development Sectors

7.1. Indicator: National Commitments and Policy Instruments

The National Commitments and Policy Instruments measures progress in the development and implementation of national-level HIV regulations, laws, policies as well as the national HIV Strategic Plan.

NCPI has always been an interesting process, as it provides an opportunity to involve key players in the national response in taking stock of progress made and to discuss what they think and perceive as to where we are in terms of the program and what needs to be done to support an effective and efficient HIV response. Each discussion was attended by different participants, with different set of experiences and backgrounds, hence results are not comparable among different years of UNGASS reporting. The results are better understood by interpreting them in the context of the reporting period.

We have learned over time that the results of the group discussion do not necessarily accurately reflect progress and obstacles in the response. Accordingly, the following discussion is not based exclusively on the questionnaire related to NCPI but takes fuller stock of the issues discussed by recording both results of the discussion and a record of relevant events during the reporting period.

The discussion process to generate the consensus was based on the UNGASS guideline. Prior to the report writing process, one workshop was held to complete the NCPI. Participants were briefed about the previous NCPI result.

Four critical features about completion of the NCPI data are as follows:

1. There has been a change in the mode of posing some questions compared to the previous instruments. However, the new system has assisted the participants in reflecting on the existing situation.
2. Effective facilitators and more systematic questionnaires have helped to minimize different perceptions and interpretations related to questions among participants during the discussions. Nonetheless, huge discrepancies in scoring specific items were inevitable amongst the groups, and created difficulty in explaining the conclusion offered on some of the issues under discussion.
3. Participants agreed that lower grades in question scoring was not always because the national HIV response was worsening, but also resulted from participants setting a higher standard for the response.
4. The data gathering processes prior to the workshop were not well done due to time limitations. There was a lack of reliable of comprehensive evidence which led to more reliance on information from staff of HIV programs sometimes indicated who had been involved in the HIV program only in the last two years. Consequently, discussions on some

topics were driven more by individual information, experience, and impression of the participants (subjectivity) and less by objective discussion of the facts.

To portray results of the group discussion results, it is very important to review the issues in a holistic manner rather than of taking only results of the rating on selected question. We have understood of this issue we review them in a holistic manner providing both comprehensive tables containing selective critical questions with clear responses, as follows.

Table 9. Results of NCPI Part A (Government Officials) year 2011

Question & Response
I. Strategic Plan
Has the country developed a national multisectoral strategy to respond to HIV? → **Yes**
Has the country integrated HIV into its general plans? → **Yes**
Has the country evaluated the impact of HIV on its socioeconomic development for planning? → **No**
Does the country have a strategy for addressing HIV issues among its national uniformed services? → **Yes**
Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS? → **Yes**
II. Political Support and Leadership
Do the following high officials speak publicly and favorably about HIV effort in major domestic forums at least twice a year A. Government ministers → **Yes** B. Other high officials at sub-national level → **Yes**
Does the country have an officially recognized national multisectoral HIV coordination body? → **Yes**
Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programs? → **Yes**
What percentage of the national HIV budget was spent on activities implemented by civil society in the past year? → **No Response**
What kind of support does the National HIV commission provide to civil society organizations for implementation of HIV-related activities?

Yes for Capacity Building, Coordination with other implementing partners, Information on priority needs, Procurement and distribution of medicine or other supplies, and Technical Guidance
Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies? → **Yes**
III. Human Rights
Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? → **Yes for PLHIV, Migrants/ mobile populations, OVC, People with disability, PWID, Prison inmates, Women and girls, and Young women/young men**
Does the country have general law on discrimination? → **Yes**
Does the country have laws, regulations or policies that present obstacle to effective HIV prevention, treatment, care and support for key populations and vulnerable groups? → **Yes**
IV. Prevention
Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to general population? → **Yes**
Does the country have a policy or strategy to promote life-skills based HIV education for young people? → **Yes**
Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations? → **Yes**
Has the country identified specific need for HIV prevention programmes? → **Yes**
V. Treatment, Care and Support
Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services? → **Yes**
Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV? → **Yes**
Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV? → **Yes**
Does the country have access to regional procurement and supply management mechanisms for critical commodities? → **Yes**
Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children? → **Yes**
VI. Monitoring and Evaluation
Does the country have one national Monitoring and Evaluation (M&E) plan for HIV? → **Yes**
Does the national Monitoring and Evaluation plan include? → **Yes to all items**
Is there a budget for implementation of the M&E plan? → **Yes**
Is there a functional national M&E unit? → **Yes**
Is there a national M&E Committee or Working Group that meets regularly to

coordinate M&E activities? → **Yes**
Is there a central national database with HIV-related data? → **Yes**
Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year? → **Yes**
How are M&E data used? **Yes, For program improvement, In developing/revising the national HIV response, For resource allocation, and for others**
In the last year, was training in M&E conducted? → **Yes at the national level, and at sub-national level**

Table 10. Results of NCPI Part B (Representatives of NGOs, bilateral organizations and UN agencies) year 2011

Question & Response
I. Civil Society Involvement
On scale of 0-10, how would you rate the efforts to increase civil society participation in 2011? → **5**
II. Political Support and Leadership
Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and program implementation? → **Yes**
III. Human Rights
Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? **Yes for PLHIV, MMP, OVC, People with disabilities, PWID, Prison inmates, Women and girls, and other**
Does the country have a general law on non-discrimination? → **Yes**
Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations? → **Yes**
Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV? → **Yes**
Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy? → **Yes**
Is there a mechanism to record, document and address cases of discrimination experienced by PLHIV, key populations and vulnerable populations? → **Yes**
Does the country have a policy or strategy of free services for the following? **Yes for ART and HIV prevention services; and provided but only at a cost for HIV-related care and support interventions**
Does the country have a policy or strategy to ensure equal access for women and

men to HIV prevention, treatment, care and support? → **Yes**
Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support? → **Yes**
Does the country have a policy or law prohibiting HIV screening for general employment purposes? → **No**
Does the country have the following human rights monitoring and enforcement mechanism? → **No**
In the last 2 years, have there been the following training and/or capacity-building activities → **Yes**
Are the following legal support services available in the country? **No for legal aid system for HIV casework, and Yes for private sector law firms or university-based centers to provide free or reduced-cost legal services to PLHIV**
Are the programmes in place to reduce HIV-related stigma and discrimination? → **Yes**
IV. Prevention
Has the country identified the specific needs for HIV prevention programmes? → **Yes**
V. Treatment, Care and Support
Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services? → **Yes**
Agree response for The majority of people in need have access to: **PEP, Psychosocial support for PLHIV and their families, STI management, TB infection control HIV treatment and care facilities, TB preventive therapy for PLHIV, TB screening for PLHIV, and treatment of common HIV-related infections**
Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children? → **Yes, Ministry of Social Affairs provide support on financial and microfinance activities to poor families of infected or affected by HIV**

Following are highlights of some topics where participants discussion and scores indicate need for additional attention in the future: the role of civil society, law and regulations and universal access.

1. Civil society participation

Strategic action formulated by the government of Indonesia has involved civil society from the planning stage to the monitoring and evaluation process. This involvement of civil society, endorsed by Presidential Regulation (No. 75/2006), was part of the formulation stage of the National Strategy and National Action Plan 2007-2010 and National Strategy and Action Plan (SRAN) 2010-2014.

Unlike the previous NCPI response where civil society representatives criticized their involvement as being merely symbolic, in the last 2 years comments they indicate appreciation that civil society has been consulted at all levels of decision making within the NAC. In a broader context, civil society still feels they have more limited access than they wish to national forums in finalizing the government-wide work plans related to HIV and AIDS. This forum is an occasion for National Development Planning Body to outline the draft government-wide work plan and to solicit any changes at the margin, as well as an important input to district/city governments' budget formulation process. These observations were was discussion was commented on by the representative of the representative of the National Development Planning Body in group discussion. It was explained that at each step of the process in developing the National Development Plan, including follow up and finishing the sector work plans, a forum for consultation with the civil society was, in fact, always consulted.

At the local level, it is also reported that some districts/cities have adopted transparent practice in the local budgeting process and civil society organization were reported active participate in these forums.

In relation to the use of strategic information, representative of civil society mentioned that they have been facing a dilemma between the need to develop evidence-based program/action plans with and limited timely access to national surveillance data especially from the MoH. It should be noted that issues related to the release of data were shared by all actors in the response.

2. Law and Regulations

Indonesia has a number of laws and government regulations to protect particular categories of people who inject drugs and vulnerable people such as youth, prisoners, and migrant populations from any discriminatory acts.

Most participants in government group and some participants in civil society group were familiar with the essence of large number of regulations, both some long standing and some newer products of regulations:

- Law no. 7/1984 (ratification of CEDAW: Convention on the Elimination of all forms of discrimination against women)
- Law 5/1998 on the Ratification of the Convention against Torture and Degrading Treatment or Punishment is cruel, inhuman or degrading (CAT)
- Law no. 39 year 1999 on Human Rights;
- Child Protection Act No. 23/2002
- Elimination of Domestic Violence Act No. 23/2004
- Anti-trafficking Law no 21/2007
- Regulation No 2/2007 on harm reduction among injecting drug users issued by the Coordinating Minister for People's Welfare
- National Law no 35/2009 on narcotic drugs about decriminalizing PWID and recognizing PWID as victims entitled to treatment
- National Law No 36/2009 on Health
- Government Regulation no.9/1999 on gender mainstreaming Head of National Police Regulation No 8/2009 on human rights approach in

carrying out National Police tasks. Article no. 20 in this regulation particularly emphasizes the special approach to women

- Presidential Instruction 1/2010 on *Pro Poor Development*
- Presidential Instruction 3/2010 on *Just Development* to accelerate MDGs achievement for the period of 2011-2015
- Circular Letter of the Supreme Court No. 3 year 2011 about the employment of victims of substance abuse in the Rehabilitation Institute;

There is a continuing concern about the lack of documentation about discrimination both AIDS related and more general discrimination experienced by PLHIV of people of key affected populations as well as their families. There are efforts to improve documentation of discriminations through a variety of procedures and bodies. As suggested by the discussion group, they are potentially able to assist the NAC in monitoring complaints mechanism and ensuring the effective application of regulations and laws. The groups:

1. National Human Rights Commission
2. The Ad HOC Court as judicial bodies against human rights violations
3. The Indonesian Child Protection Commission
4. The National Commission on Violance against Women
5. Service Center for Women's Empowerment and Child Protection (P2TP2A/Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak).

Despite existing provisions to protect vulnerable groups of people, both participants of civil society and the government in NCPI discussions deemed bylaws based on religious law which prohibiting sex work to be counter-productive, and impediments to HIV prevention efforts. Repressive methods and discriminating statements by a few high level officials (ministerial, community, and faith based leaders) are at odds with instructions of the President and Vice President to fight the disease from the in the past 2 years.

Advocacy, coordination and education among government and law enforcements bodies needs to be increased as well as assuming affective legal protection to KAPs and vulnerable groups to reduce violations of human rights.

3. Universal Access

Despite some domestic funding having been made available, the total presently available from domestic sources cannot support the entire needs for a comprehensive HIV response in Indonesia. ARV drugs are directly supervised by the AIDS Directorate of the MoH and are freely available across the country. A hundred per cent of ARV drugs are locally produced and budget allocated from the national government budget. However, the group observed that death among people of reproductive age and the number of orphan and other vulnerable children (OVC) is increasing. Early infant diagnosis remains a challenge as it only available in 2 sites across the country (both are in Tanah Papua).

Comprehensive services should be made more widely available in particular at district/city levels. However, decentralization leaves much of the decision making about funding and service provision in the hands of over 500 district/city level officials, some of whom are newly appointed and may have very limited skill or familiarity with epidemiological analyses and health planning and financing skills. Local legislators likewise, may not understand or support the need to provide services to people of key affected population.

Despite what the group discussion had come up with, it is important to also note the progress in fields. As of December 2010, a total of 1,609 female health providers and 1,163 male health providers out of hospitals, mental hospitals, public clinics, lung clinics, prisons, NGOs, private sectors and other clinics. A

total of 500 VCT sites in 142 districts/cities are providing their services as of June 2011. Mobile testing provided by the health offices in some location has now been adds as of method to reach people who have difficulties to access the public services at conventional times and places. Provider Initiated Counseling and Testing (PICT) also holds promise to contribute early detection particularly when the patients are not aware of their risks to HIV infection. As of 228 health care providers, and a mix of professionals from seven provinces[8] had been PICT training. As of June 2011, 21,775 people were regularly receiving ARV.

7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months

Indicator is relevant to Indonesia but national data are not available.

According to the 2011 annual report of National Commission on the Elimination of Violence against Women, women victims numbered about 105,103, during the year violence pattern against women is still dominated by Domestic Violence (KDRT) and Courtship Violence (KRP) at about 96% (equal to 101,128 victims). The report identifies VAW perpetrator as husbands, ex-husbands, boyfriends and ex-boyfriends (Komnas Perempuan 2011).

Globally, violence is one common reason for women avoiding disclosure of HIV positive status to their partner. While this has not been investigated in Indonesia, one might hypothesize this is also true in Indonesia.

7.3. Current school attendance among orphans & non orphans aged 10-14

Data shows that 0.7% of children in Indonesia (118 children) between 10-14 years have lost both parents. In the same age group, 80 % of children are

[8] Aceh, West Sumatera, DKI Jakarta, Central Java, East Java, West Kalimantan, and NTT

living with both parents, and 6.4% children have two parents alive but are living with at least one parent. School attendance of orphans is 10% lower than attendance by non orphans (IDHS 2007).

A survey among PLHIV households indicates the school drop-out rates for boys (66%) is much higher that girls (34%), without distinguishing between children who lost both parents or lost only one. Data are not available to explain reasons for high drop out of boys but it may due to them seeking employment, due to behavioral difficulties or other reasons (JOTHI, et al. 2009).

Figure 24. Current school attendance rate of orphans aged 10-14 , by Sex

(IDHS 2002-2003, IDHS 2007)

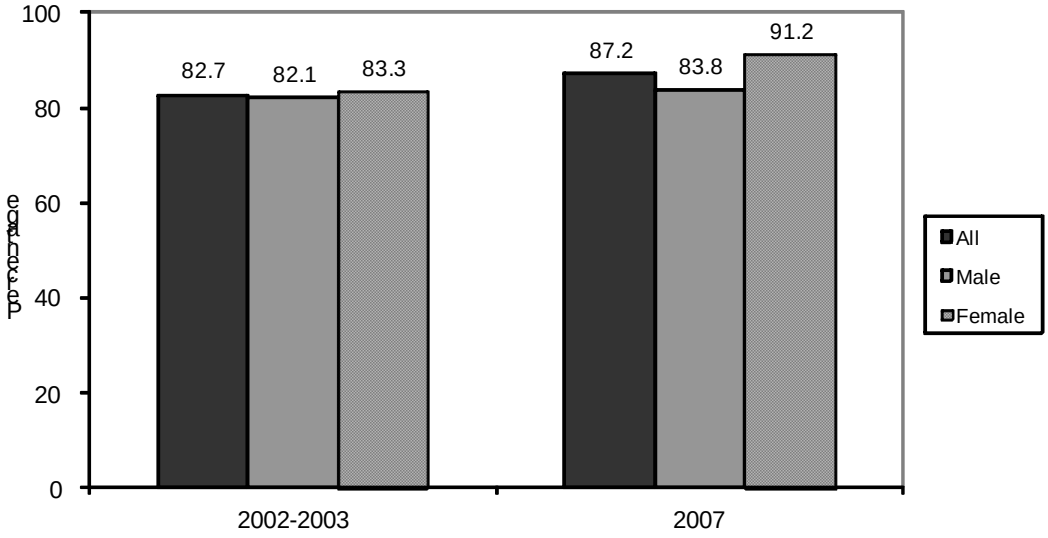
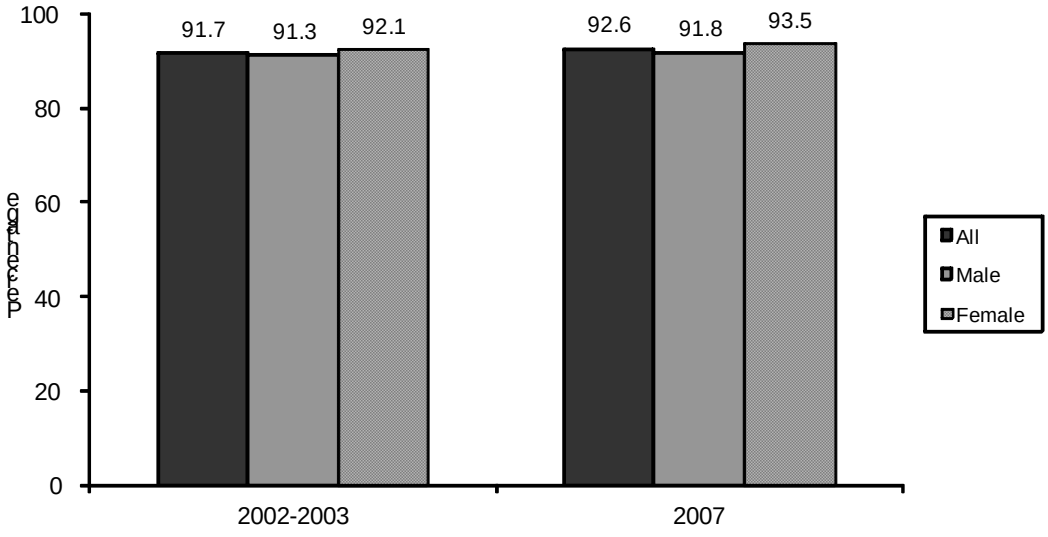


Figure 25. Current school attendance rate of orphans aged 10-14 both of whose parents are alive and who live with at least one parent, by Sex

(IDHS 2002-2003, IDHS 2007)



7.4. Proportion of the poorest households who received external economic support in the last 3 months

The national socio-economic impact of HIV at the individual and household levels survey calculated that the average amount of financial assistance received by PLHIV households was more than double compared to the support received by non-PLHIV households. The amount of external economic support makes a clear contribution to meeting the needs of PLHIV households yet has not overcome the burden of greater medical expenditures on PLHIV households compared to non PLHIV households.

The majority of PLHIV have to resort to borrowing from friends/relatives (60%) and assistance from NGOs (57%) to address economic difficulties (JOTHI, et al. 2009). One kind of assistance was skill development. One of NGO working with PLHIV reported the skills development was offered to 29,300 active PLHIV in support groups in the course of 2011 (Spiritia 2011).

Thirty-seven percent of PLHIV participate in the existing national health insurance scheme for the poor to cover their medical expenditures. Although unfortunate liquidation of savings (64%) and assets (34%) is the most common way of resolving financial difficulties, this sacrifices the economic future of other family members. Adult women (wife or other elder female members) often become breadwinner in PLHIV households (25%) compared to non-PLHIV households (15%).

Unemployment is higher among PLHIV households than non PLHIV households. It has also been found that family income can be reduced by 55% through a combination of factors related to caring for the sick. This highlights the economic vulnerability of PLHIV households to fall into irreversible poverty (JOTHI, et al. 2009).

The following data suggest that specific support programs for PLHIV have been combined in the last 2 year with broader anti poverty and development program in order to strengthen the ability of PLHIV households to cope with

challenges they encounter. Social, food and livelihood assistance is provided to PLHIV households by NGOs and government institution such as Ministry of Social Affairs. In 2011, this Ministry added a staple food program for 1,500 PLHIV into their existing government support program. In 2011, the Indonesian social security for people who work in the formal sectors (JAMSOSTEK, including coverage the health insurance and other aspects of social security) has provided cash transfers at US $ 1,075 per year for their members and/or their dependent who are PLHIV.[9]

Presidential regulation 15/2010 on Accelerating Poverty Reduction is another example of the national commitment for poverty reduction and the development of national programs for social protection. In 2010, of 25.2 million poor households of Indonesian, 70% have received subsidized rice and 3.2% have received conditional cash transfers. Details of provisions to the poor targeting and benefit individuals and community are presented in Table 11. Social Protection Framework.

[9] Based on JAMSOSTEK Board Decree 310/10-2011

Table 11. Social Protection Framework

(Source: ILO Report 2011)

Target group	Types of benefits	Program	Supervisory Ministries	2010 Target
Poor households	Free health care	Jamkesmas	Ministry of Health	76.4 million beneficiaries
	Subsidized rice	Raskin	Coordinating Ministry of People's Welfare	17,500,000 households
	Conditional cash transfer for households and children**	PKH, PKSA	Ministry of Social Affairs	816,0000 households
	Cash assistance (IDR 300,000 /month) for the disabled and vulnerable elderly	JSPACA and JSLU	Ministry of Social Affairs	
	Scholarships for poor students	Scholarships for the poor	Ministry of Education	4,100,000 students*
Small and micro enterprise	Small and micro enterprise empowerment through micro-credit program	KUR	Ministry of Economy	
Universal	Free childbirth care	Jampersal	Ministry of Health	
	Block grants to schools	BOS	Ministry of Education	44,100,000 students
*The Conditional Cash Transfer National Coordination meeting suggests that all students that are covered by the Conditional Cash Transfer program should also receive the scholarship ** Recipient households are 3.83 percent less likely to be poor compared to their counterparts				

IV. Best Practices

4.1. Building a comprehensive approach to prevention of sexual transmission of HIV in Indonesia

The Challenge

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. There are efforts to prevent sexual transmission of HIV in Indonesia to eliminate the risk of infection for people in all of these settings giving particular attention to those who are at highest risk.

The importance of sexual transmission in the HIV epidemic is growing in Indonesia. In 2011 sexual transmission was the cause of 54.3% of new reported HIV and 74.9% of new AIDS cases. The Ministry of Health's most recent estimate of people at risk of infection (2009) totaled 6,396,187 people – including PWID, sex workers (female, trans-gender, and males) and their clients, MSM, prisoners, and regular sex partners of all (including husbands and wives). But in Indonesia, calculation of people at risk needs to be expanded to include the floating domestic workforce, made up largely of men between the ages of 15 and 50, responding to growing employment resulting from more widely distributed investment opportunities across the country in commercial agriculture, mining, forestry, manufacturing and related networks of land, sea, and air transportation. Many of these men, our 4Ms – mobile men with money in macho environments – become involved in high risk sex.

In the early years of the national response, with support of the World Health Organization and others, Indonesia invested considerable effort in the approach called "100% condom use" which had been successfully pioneered and implemented in some areas of Thailand. The principle aspects of this

approach in Thailand had included: 1) restriction of the sale of sexual services to specific locations; 2) requirement that condoms be used in all risky sex; 3) requirement that sex workers have regular check-ups for sexually transmitted infections; 4) fining of the management of a sex worker's place of employment if he/ she were found to be infected and responsibility of the management to pay for treatment. Furthermore, according to the law, the place of business could be closed if they do not comply.

In Indonesia, appropriate policy was put in place and 100% condom use was included as a strategy in the Indonesian National AIDS Strategy of 2003 – 2007. By 2008, however, results of the IBBS (2007) suggested that 100% condom use was having little impact on infection levels in Indonesia. Various unresolved challenges were identified: (1) condom use among clients of sex workers remained low even when readily available; (2) in other locations, the mechanisms for distribution of condoms and lubricants continued to fall short of need; (3) public opinion and local leadership often didn't support promotion of condoms and in some areas were explicitly hostile to discussion of the topic. In addition, 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 services.

The response

Acting on these observations and while 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 in the national response to brainstorm together for a more effective approach to sexual transmission in Indonesia. Participants included individuals and representatives of organizations with experience in the field of sexual

transmission, representatives of relevant government departments and members of the secretariat of the NAC. Participants analyzed obstacles to 100% condom use in Indonesia and discussed experience internationally and in a few locations in Indonesia where there had been rising levels of condom use and declining rates of sexually transmitted infections.

By April 2009 a preliminary model was agreed upon and a small pilot program was begun in 6 locations. Drawing on results of those pilot locations and supplementary discussions during the 9th International Congress on AIDS in Asia and the Pacific (2010), a new and consolidated approach to prevention of sexual transmission of HIV was formulated which came to be known as PMTS, an abbreviation of the Indonesian name - ***P****encegahan HIV* ***M****elalui* ***T****ransmisi* ***S****eksual*.

PMTS was designed as a structural intervention (working to bring about change in the existing systems and the local environment). The policy and program concerns and components made a comprehensive package. Its management and operations were broadly inclusive with participation from local authorities, the community health service, sex workers and others involved in the sex industry. It was built around 4 mutually supportive action components:

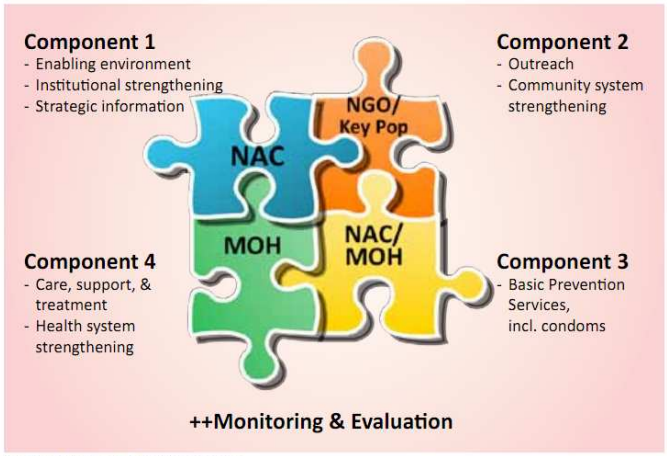
1. Mobilizing a wide range of stakeholders in areas where sexual transactions took place – sex worker, community leaders, condom sales people, local officials - to share concern and responsibility for creating the regulatory and social climate to facilitate and promote condom use as part of a common effort to improve community health;
2. Implementation of behavior change communication to raise concern of sex workers for their own health as well as empowering them with the knowledge and skill to increase their efficacy in negotiating condom use thus protecting their own health and that of their clients;

3. Improved management and availability of condoms and lubricants achieved through development much increased numbers of condom outlets
4. Comprehensive management – diagnosis and treatment - of sexually transmitted infections

The final, critical component was and continues to be close monitoring and evaluation by program managers from local to national level.

As graphically portrayed in the box below, close partnership is essential for effective implementation and sustainability of PMTS. In Indonesia's Global Fund-supported PMTS the partners are the NAC, two NGOs, and the Ministry of Health. In other setting institutional partners might be different but the components and the need for a clear division of labor and mechanisms to facilitate collaboration among partners would be the same.

Figure 26. Schematic representation of partnership in structural intervention for prevention of sexual transmission in Indonesia



Source : National AIDS Commission

Although initially Indonesia used Global Fund resources for scale-up, some aspects of this program are now jointly funded with support coming from the national government budget (APBN) and an Indonesian basket fund, the Indonesian Partnership Fund for HIV and AIDS. Additional support for implementation of PMTS has also come in the form of condoms contributed

by the National Population and Family Planning Board (BKKBN) and Family Health International.

Training, retraining, of all actors in PMTS and supportive supervision have played an important role in establishment of this work now in 159 locations across Indonesia. In 2011, alone more than a thousand sex workers from 66 different locations in 23 provinces were trained, as were 144 members of the local civil defense force (Satpol PP) from 16 provinces; 3-person management teams from 76 districts/ cities including members of local AIDS Commission, local Health Departments, and NGO partners. Likewise managers of 263 condom outlets were trained, 64 of whom were women.

Beginning in 2011 efforts to bring sexual transmission under control were broadened still further specifically to reach these "high risk men" – previously mention who, out of boredom and egged on by co-workers may become involved in recreational sex, excessive consumption of alcohol, drugs, and sex stimulants. Working with employers, the Ministry of Manpower, local AIDS Commissions and linking with PMTS where it they already underway a combination of activity and services have been identified and launched with the goal of accelerating reductions in new infection among men.

Impact

By June of 2011, with the exception of MSM, outreach/coverage was making good progress toward the targets set for 2014.

Table 12. 2011 coverage against 2009 estimate and 2014 target of key affected populations

(NAC 2011, MoH 2009, MoH 2008-2014)

People Covered	Number covered	% of total estimated population	2014 Coverage target
Female sex workers - direct	82,384	78%	90%
Female sex workers – indirect	58,244	54%	90%
Transgender people	23,269	73%	100%
MSM	54,836	8%	80%

Recognizing the importance of doing better with the MSM community a combined research and action program was undertaken with the national MSM network, several local branches, and a number of leading universities to learn more about the MSM community and to improve the design and implementation of the response.

Given the important role of the condom in prevention of sexual transmission we have also been monitoring condom use closely. Although condom use rates in Indonesia are still considered low relative to total population, nonetheless, information on condom distribution (Table 13. Condom PMTS operations, July 2009 – June 2011, below) and sales suggest that the structural approach of PMTS and new efforts to improve outreach to high risk men is a beginning to have a positive impact.

Table 13. Condom PMTS operations, July 2009 – June 2011

(NAC Program Monitoring 2011)

Distribution Jul 2009 – Dec 2011	Global Fund Support	Other support	Outlets	No of prov.	No of Dist/ Cities
Lubricants (1)	1,937,228	6,724		33	137
Male condoms (2)	17,961,141	1,712,686	7,235	33	137
Female condoms (3)	None	619,025	1,000	33	137

Commercial condom sales are encouraging with total condom sales rising from 69,587,608 pieces in 2006 to 158,500,289 by the end of 2011 with a particularly large increase beginning in 2009 and continuing through 2011. This would seem to suggest possible ”demand creation” as increasing numbers of men have positive experience with condoms and become more willing to buy and use them on their own initiative.

What lies ahead?

Basic systems are in place for the prevention of the sexual transmission of HIV infection. Close monitoring of both program and epidemiological indicators will continue to determine whether the basic design and operationalization of existing interventions is “about right” and sustainable or if and what fine tuning might increase positive impacts still further.

4.2. HIV Intervention in Prisons and Detention Centers in Indonesia

Prisons and detention centres are considered high risk environments for the transmission of HIV (WHO Europe 2005). The Indonesian Ministry of Law and Human Rights has produced a *National Action Plan for HIV and AIDS Control in Prisons and Detention Centres, 2010 to 2014* to address harm reduction in prisons and detention centres and is based on public health principles and human rights. Current HIV prevention, care and treatment programs that are in some prisons and detention centres in Indonesia include: educational programs; voluntary counseling and testing (VCT) services; MMT; referral for anti retroviral therapy (ART); support and rehabilitation groups; condoms; and bleach for sterilizing equipment for injecting, tattooing and piercing activities.

A national biological and behavior survey was conducted in Indonesian prisons and detention centers in 2010. This study provided baseline information for the Government of Indonesia about the national HIV and syphilis prevalence in prisoners as well as prisoner knowledge, risk behaviors and access to HIV related services, based on a random selection of prisons and detention centers and male and female prisoners. The HIV prevalence was 1.1% in male and 6.0% in female respondents and the prevalence of syphilis was 5.1% in male and 8.5% in female respondents. Factors associated with HIV for male respondents included having a history of injecting drugs and for females included testing positive for syphilis and illicit drug use. Of those who had a history of injecting drugs, almost twice the proportion of female respondents (12.0%) tested positive for HIV compared to male respondents (6.7%). Knowledge of the main HIV risk factors was high although common misconceptions were also high. Half the male and 64% of female respondents had previously received HIV information with a higher proportion of females having comprehensive knowledge of HIV than males.

Access to educational programs in prison was under 50% with 41% of male and 35% of female respondents receiving information from a prison officer. HIV test had been offered to 40% of the female and 29% of the male respondents with most receiving the offer in prison or detention. Those who had received training about HIV were almost six times more likely to have had an HIV test than those who had not (Ministry of Law and Human Rights 2010).

A study is planned for 2012 in Indonesian prisons designated for prisoners sentenced for drug-related crimes including producing, dealing, possessing or using any type of illicit drug. The narcotic prisoner population has significantly increased from 7,122 (10% of prisoners) in 2002 to 37,295 (26% of prisoners) by the end of September 2009 (Ministry of Law and Human Rights October 2009). Results of a National Narcotics Bureau (BNN) and Central Bureau of Statistics (BPS) study about narcotics prisoners in nine prisons in nine provinces found that almost 90% of "narcotic prisoners" had consumed an illicit drug and more than one third had injected heroin (BNN and BPS 2004). Few prisoners reported injecting in prison in the 2010 Indonesian prisoner survey (Ministry of Law and Human Rights 2010). Other research has shown that some prisoners who are IDUs are still injecting drugs in prison, although the frequency is decreased, and that some of them stop injecting while in prison (HCPI October 2009 and Shewan D 1994). There are some prisoners who injected drugs for the first time while in prison due to the psychological problems they encounter while in prison (HCPI October 2009 and Hughes RA 2000). In Indonesia, based on the IBBS conducted in 2007-2009 among the PWID population in 10 cities, 0.5% - 4% of IDUs injected for the first time while in prison (MoH, IBBS 2011)

There has been advocacy for needles and syringes programs (NSP) to be provided to prisoners in Indonesia. There are over 19 prison-based NSPs in Europe[9] and evaluations of these programs found less sharing of needles and

syringes in prisons and no newly identified cases of HIV, hepatitis B, or hepatitis C (Dolan K 2003) or problems with needles and syringes being used as weapons (Nelles J 1998). Needles and syringes have usually been available through dispensing machines or prison health personnel in prison programs (University of California San Francisco April 2006).

Current regulations in Indonesia prohibit tattooing, piercing, inserting genital accessories, sexual activities as well as injecting drugs in prison and detention. As these activities are in fact occurring in prisons and detention centers (Ministry of Law and Human Rights 2010) regulations may need to be reviewed to allow a more realistic response to the current situation. More enabling regulations are recommended to ensure that prisons and detention centers can provide safer and healthier environments for prisoners.

A collaboration between the Ministry of Health and The Indonesian Ministry of Law and Human Rights has ensured a better HIV recording and reporting system and a better partnership with the Ministry of Health has developed to improve the health care of inmates. The monthly monitoring system in prisons for HIV-related data has shown a gradual decrease in the number of deaths of prisoners from AIDS and increased access to ART since 2010. There are now more comprehensive services available for female prisoners as well as male prisoners.

There has been advocacy for achieving better access to national and local budgets for HIV-related activities in prisons so that adequate funding is provided for programs and to ensure sustainability.

UNODC has produced a framework for a national response to HIV in prisons, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings* (WHO, Joint United Nations Program on HIV/AIDS 2006). The framework outlines 11 principles and 100 actions to promote an effective national response to HIV/AIDS in prisons. In 2008 UNODC released a toolkit for policymakers, program managers, prison officers and health care providers in prison

settings based on requirements of international law and standards, scientific evidence and best practice experience. It recommends comprehensive HIV prevention measures, provision of ART, equivalent health services to those available in the community, and reducing prison populations and improving prison conditions. Indonesia has most of the elements of comprehensive HIV prevention measures in prisons including: education on HIV and AIDS; voluntary HIV testing and counseling; condom provision; drug-dependence treatment and substitution treatment; and provision of bleach (UNODC 2008). Programs that are still not available in Indonesian prisons include NSP, STI detection and treatment and preventive measures for mother-to-child transmission for the women prisoners although there is advocacy for these measures to be provided in the future. It is hoped that diversion sentencing of drug users will increase in the future which would help decrease the overcrowding in Indonesian prisons.

V. Major Challenges and Remedial Actions

During the last two years since the previous UNGASS country progress report, which was submitted in 2010, some progress has been made. In the report of 2010, program coverage for most at risk populations did not meet the Universal Access targets and were considered inadequate. There have been improvements in program coverage of people who inject drugs although coverage among MSM and clients of FSW, as well as their respective partners, remains very low. However, the difference between the previous reporting period and now is that programs addressing these populations are now in place. The impact of programs for the previous two years of implementation is evident for PWIDs and indirect FSWs when looking at IBBS results for those recently starting to inject or commencing sex work and we expect to see better outcomes for all high risk populations in the next few years.

Program coverage has already been discussed in this report, and special attention is recommended to increase coverage of programs that prevent mother to child transmission given the concern about low coverage. Although progress is still limited and not reaching the numbers needed, an increase in coverage has been reported.

The 2010 UNGASS report raised the issue of barriers in scaling up prevention programs for sexual transmission of HIV. Specifically, programs were dealing with a lack of support from local authorities. The situation is somewhat improved now that the Government of Indonesia had responded to this situation, a response which started in 2008. By making an effort to draw a pool of experts and resources to assist programs to increase the level of consistent condom use among those involved in transactional sex, programs have now reached an implementation phase building on lessons learnt and improvements are now underway. The concept of a comprehensive approach

to prevention of sexual transmission of HIV is now better understood by local implementers as well as by different level of authorities. Guidelines, extensive training and a system to provide technical assistance, particularly from the province to district level have been made available. Strong support from the Ministry of Home Affair all the way through to local governments is now in place, including local police who have now become an important part of the program, backing HIV and STI prevention programs amongst people who engage in sex work. More details about this endeavor is in the best practice section on "Building a comprehensive approach to prevention of sexual transmission of HIV in Indonesia".

With references to program sustainability, which was discussed in the previous UNGASS report, there is modest but steady progress domestic resources available for programs have increased from 39% (2008) to 42% (2010). Although the rise in the proportion of available domestic funds is not so dramatic compared to that of two years ago, the work towards that end has been increased and the Ministry of National Planning and Development is taking the lead in the process. Further discussion is presented below.

Effectiveness of the health care system and the community system to support HIV and AIDS people and programs in the response, as well as other diseases, may not differ significantly to those two years ago and is raised as one of the challenges. Positive changes in community health providers have been in some areas observed and they now work more closely with the key affected populations. This is not however the case in all locations across the country. More work is needed to build systems in an integrated manner, as discussed below.

The quality of program implementation at the field level, which was questioned in the previous report, is improving. The leadership of District AIDS Commissions is stronger: logistic management is better, particularly for ARV, condoms, and sterile needles and syringes supplies; coordination and

partnerships among local stakeholders have now become a routine-based activity and networks are broader; progress on the M&E is also apparent. AIDS Commission in many areas has earned wider recognition in both government and community circles. More information on M&E will be discussed in Chapter VII.

The challenges

Work to be accomplished in the future and some challenges that lie ahead include:

1. 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 NAC 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 has been integrated in the National Mid-Term Development Plan 2010-2014 as well as Presidential Instruction 3/2010 on *Just Development*. This will assure some measure of support from APBN through to 2014. Nonetheless, however, the amount allocated has been inadequate to meet the needs of the national response. If external resources (GFATM, AusAID, USAID etc.) were to decline or stop altogether the current comprehensive work would be seriously threatened. Although domestic budgets, particularly APBD, are increasing and in several areas planning and budgets for AIDS are integrated in RPJMD

(Local Mid-Term Development Plans), 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. In other words, continuity and sustainability of the Indonesian response is not assured. Because of this, mobilization of resources and institutional strengthening to that end are of great importance during the next five years and beyond.

2. Prevention:

Prevention continues to need priority attention and on going, well focused strengthening during the next five years with attention to coverage, effectiveness, and sustainability of work with and for people of key affected populations.

Prevention among PWID has had considerable success, but the use of drugs will continue to need attention, especially outreach and provision of effective harm reduction activity, in particular NSP 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 Ministry of Health, Ministry of 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 programs and improvement in the quality of activity. Expansion of the comprehensive PMTS approach is also needed to assure adequate coverage and service. In "hotspots", locations known for sexual and other transactions such as ports, transport terminals and brothels, placing people at

high risk of infection with STIs including HIV. PMTS will also scale up work related to high risk men, including: migrant workers; sailors and other crew members; police and military with long term assignments away from their family; miners; construction workers; commercial estate agriculture workers; and MSM. Prevention of sexual transmission of HIV is needed whether sex is between husband and wife, casual heterosexual sex, homosexual sex, or bisexual sex. In an effort to understand and assure access to the widest possible range of options for prevention, the NAC is will also to explore 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 and as part of the comprehensive response to HIV and AIDS. PMTCT is also important for the contribution it will make to the overall effort to bring the epidemic under control. In line with this, the MoH is planning to expand integration of PMTCT services into basic Mother and Child services along with the necessary staff training.

3. Health system strengthening for care, support, and treatment of PLHIV:

During the past five years the MoH 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 positive. They have also developed the necessary regulations, guidelines, and manuals to promote consistent application of proven good practices and established policy. In the five years to come, comprehensive health system strengthening will need to focus on expanding availability and strengthening the quality of services for key affected populations including services related STIs, HIV-related illnesses and ARV. Comprehensive services

for PLHIV, including health promotion, prevention of infection, treatment and rehabilitation, need to be provided within a health care setting free of stigma and discrimination. The health care system needs to function with a high level of professionalism both technically and in terms of human relations welcoming and encouraging people of the key affected populations.

Strengthening of the public health care system needs to be accompanied by strengthening of community based support systems for PLHIV including: family support, peer support groups of PLHIV , organizations of people who are HIV positive and the community in general. Income generation and other activities to mitigate the socioeconomic impact of the HIV epidemic will need to be strengthened, as well.

4. Partnership of government and civil society:

The number of civil society organizations and activists and the importance of their role in the response to HIV and AIDS has grown significantly in the past five years –

1) Some AIDS-related NGOs and community groups are members of the NAC and local AIDS Commissions, although not yet in all provinces and district/ cities;
2) Individuals have become members of AIDS Commission secretariat and are in the technical and policy 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 financial support (operational costs and activities) from the secretariat of the NAC;
4) Since Presidential Regulation 75/2006 went into effect, AIDS NGOs and the networks of key affected populations, including PLHIV, have been included in key activities of the NAC such as mapping, planning, resource mobilization, monitoring and evaluation.

5) NGOs and 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);
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 NAC for civil society including NGOs came from 8 sources and totaled 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 care system strengthening is needed in the coming five years, so community system strengthening is also needed to reinforce and consolidate 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.

VI. Support from the Country's Development Partners

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 and 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.

During the first three years of Presidential Regulation 75/ 2006, three bilateral donors -- the UK, USAID, and AusAID -- 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 from the Global Fund (US$ 19.9 million), the fourth major contributor, during the same period became more important in the following years (see Table 14).

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 NAC with UNDP hired as Fund Manager until such time as the NAC secretariat was ready to assume that responsibility (2012). 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 activities designed by a donor's own design team, sometimes provision of supplies or services. At times, international donors provide full funding for activities and at other times they join with Indonesia or others for co-financing of activities.

Increasingly, as international partners seek maximum impact for their investment in the national response they consult with the NAC 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 NAC 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), and the National M & E Framework.

The NAC 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 conformity with Indonesian standards, guidelines, and practices. In addition, the secretariat of the NAC often involved international partners in technical discussions or teams assembled for operational program development, field evaluation, mentoring and monitoring. 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 NAC secretariat led a participatory process conceptualizing and formulating 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 NAC 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 (2) responsible management of funds demonstrated by full, accurate and timely accounting and reporting. For this reason the secretariat of the NAC 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 a 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 NAC 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 14. Global Fund support to phased development of Indonesian national response

Source: NAC

Province	GF Round	Years	Grant Support	Launching Date	Program Focus
5 Prov	GF 1	2003 - 2007	US$ 12 million		Prevention
19 Prov	GF 4	2005 – 2010	US$ 65 million		Care Support and Treatment
12 Prov	GF 8	2009 – 2014	US$ 130 million	Launch Jul 2009	Comprehensive
23 Prov	SSF yr 1	2010 – 2015	US$ 87 million	Launch Jul 2010	Comprehensive
33 Prov	SSF Phase 2	2012 – 2015	US$ 83 million	Requested for 2012-2015	Comprehensive

Shortly thereafter, the Technical Working Group, still chaired by the Secretary of the NAC, continued work and proceeded to develop a proposal for Global Fund Round 9. Given the wide distribution of reported HIV infections, high mobility of Indonesia's population, the increasingly well documented fact that there were cases in all 33 provinces districts/ cities ("hot spots"), priority areas needing attention in the response as well as Indonesia's increasingly integrated transportation networks on land, sea, and air and 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 NAC 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

although they provided no guarantee of effectiveness. Program and financial management capacity and systems need to be developed and systematized if Indonesia's response is to be effective and sustainable in the long run.

VII. Monitoring and Evaluation Environment

The second national monitoring and evaluation assessment of M&E systems for HIV in Indonesia was conducted in November 2010. The assessment aimed to determine the status, gaps and corresponding recommended strategies to improve the 12 components of the M&E system as guided by the M&E System Strengthening (MESS) tool. The points below reflect the status of current M&E systems, including some key results from the M&E assessment.

Organizational Structure for HIV M&E Systems and Human Capacity

The Indonesian NAC is coordinating the M&E of the HIV national response in Indonesia. Currently there are 33 provinces and 172 districts that use the national M&E guideline as reference and report progress relative to national indicators regularly. These reports provide information related to program coverage, including line ministries and local NGOs. The guideline provides information on setting and defining indicators, applying routine and non-routine reporting systems, and the timing of data collection and reporting. Collation of national HIV program data is conducted by the NAC M&E team. There is 6 full time professional M&E staff working for NAC, as well as 33 program staff in provinces and 172 staff in districts who have M&E responsibilities.

Partnership to Plan, Coordinate and Manage the HIV M&E System

The mechanism for M&E planning, coordination and data sharing is through routine M&E working group meetings. The working group is comprised of members of the NAC including government sectors, civil society and international partners and representatives of key affected populations and PLHIV. Each meeting involves discussions about many M&E topics,

including: coordination of M&E activities; harmonizing indicators; data sharing for preparing country reports; and M&E update among members. Critical issues to improve M&E system implementation are also discussed.

National, Multi-sectoral HIV M&E Plan and Costed HIV M&E Workplan

The NAC has developed the national HIV strategic action plan which includes the M&E work plan. Some ministries have also developed their own action plan including an M&E work plan including the Ministry of Health (MoH), the Ministry of Law and Human Right, and the Ministry of Social Affairs. The NAC and MoH allocate 7-10% of the national HIV budget for M&E activities. The other ministries do not have dedicated budgets for M&E activities.

Advocacy, Communication and Culture of HIV M&E

The NAC uses collated data for advocacy and sharing information on progress of the national response progress to different stakeholders. M&E advocacy is routinely conducted by the NAC and international development partners through different mechanisms, including: the NAC executing team meetings; the Country Coordinating Mechanism (Global Fund); and Technical Working Groups of the GFATM and IPF management committees.

Surveys and Surveillance

A 2000 review of HIV-related information in Indonesia led to a decision by the the MoH in 2001 to build up a Second Generation Surveillance system. Indonesia has conducted Behavior Surveillance Surveys among the key affected populations in 2002 and 2004 and three Integrated Biological-Behavior Surveys (IBBS) in 2007, 2009 and 2011. The IBBS for general population was conducted in Tanah Papua in 2006, and was scheduled to

have the similar IBBS in 2012. In 1998, the Sub-Directorate for AIDS and STDs at the Ministry of Health established guidelines for standardized sampling, unlinked anonymous testing, and routine reporting of HIV surveillance. By 2012, 64 sentinel sites among FSW and 2 sites among ANC services operated around the country. Size estimation among key affected populations and PLHIV has been conducted four times (2002, 2004, 2006 and 2009), and the upcoming estimation is scheduled for 2012. A Mathematical modeling report was produced by the MoH in 2008 using the Asian Epidemic Model. The NAC conducts both rapid surveys about the impact of HIV prevention programs for sexual transmission for sex workers, and rapid surveys among people who inject drugs to complement the national data. Annual client behavior and service satisfaction surveys are also conducted for clients of health services and NGOs HIV prevention programs.

Routine HIV Program monitoring

Routine program monitoring related to HIV prevention, including financing and policy development, is coordinated by the NAC. Program coverage is well defined and results of monitoring are disseminated regularly through the M&E Working Group and also the GFATM TWG. Data from health facilities related to care, support and treatment are coordinated by the MoH. Integration of reporting and recording formats from different stakeholders remains a challenge. Reporting flow of data and information starts from the district to the province and finally to the national level. At district and province level, regular meeting are conducted to validate and verify data before sending it to the national level. This is to ensure good quality data is being collected. Data analysis is done at each level and this increases sense of ownership and the use of M&E results to improve programs.

While this analysis is already part of the formal reporting and M & E system, local skill and benefit from this is unknown. This is an issue which will receive continuing attention in the coming period.

National and Sub-National HIV Databases

The M&E team monitors the input, process, output, outcome and impact indicators laid out in the National AIDS Strategy and Action Plan and accompanying M & E framework. Since mid 2011, routine output data from 137 districts are reported using a web-based system known as "online recording and reporting". Indonesia also contributes to the Asia data hub website that can be found at www.aidsdatahub.org.

Supportive Supervision and Data Auditing

Supervision guidelines are included in the national M&E guideline. Supervision activities are conducted regularly at sub-national level. Supervision results are recorded and fed back to those providing data. Joint supervision among stakeholders is still a challenge. Although data auditing is regularly conducted, there is not yet a plan for continues data auditing.

HIV Evaluation and Research

The HIV related national research agenda has been developed and is regularly updated. Research activities are coordinated by the NAC through the National Research Working Group. Research results are disseminated and discussed regularly. Annual, mid-term and end term reviews of National Strategic and Action Plans are conducted regularly.

Data Dissemination and Use

The use of M&E results to inform policies and program direction is increasing. The main national indicators include UNGASS input indicators, Universal Access indicators and Millennium Development Goals indicators. At national level, indicators provide information to assist program improvement and are used to inform the new AIDS strategic action plans, decision making and resources mobilization. For the last two years, key line ministries have begun to realize the importance of using these data, to understand the progress HIV programs within their respective institution and in the context of the national AIDS response. At local level, the M&E results become valuable information for local authorities to better respond to the AIDS situation in their respective area. International partners need M&E results to inform the development of plans for HIV-related assistance to the country. Mechanisms for the dissemination of data are through: the NAC executing team meetings; the NAC working groups; the NAC website; dissemination of printed reports and fact sheets.

Capacity Building

Capacity building at the sub-national level is of paramount importance. Program sustainability is a matter of increasing human resource capacity in managing and conducting HIV-related programs. Due to the geographical variation and uneven availability of training, the capacity among managers varies. To help address this situation, the NAC organizes annual district/city meetings among all provincial M&E program managers and district program managers to learn about various M&E topics, and provide updates on new M & E issues, as well as to discuss lessons learned and gaps in implementing M&E in the field. Those topics discussed include data analysis, mapping high risk populations, writing a good report, and developing fact sheets. Those

skills support the respective local government to optimize the use of data for both program improvement and advocacy related to policy design, funding and program.

Annexes

Annex A: Completed Questionnaires of NCPI Part A and B

Annex A: National Commitments and P olicy Instrument (NCPI) 2012

COUNTRY:

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

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Date of submission: _____

Instructions

The following instrument measures progress in the development and implementation of national HIV policies, strategies and laws. **It is an integral part of the core indicators and is to be completed and submitted as part of the 2012 Country Progress Report**.

This fifth version of the NCPI is the first revised version since the tool's name changed from the National Composite and Policy Index (NCPI) to the National Commitments and Policy Instrument (NCPI), The NCPI has been updated to reflect new HIV programmatic guidance and to be consistent with the new 2011 Political Declaration on HIV/AIDS. Additional guidance has been included to increase validity of the responses and comparability across different countries. The majority of questions are identical to the 2005, 2007 and 2009 NCPI to allow for trend analyses. Countries are strongly advised to conduct a trend analysis and include a description of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included as well as a trend analysis on the key NCPI data since 2003, where available[30].

I. STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into **two parts**, (the different sections under part A and part B have been slightly reorganized since last reporting round).

Part A to be administered to government officials.

Part A covers:

I. Strategic plan
II. Political support and leadership
III. Human Rights
IV. Prevention
V. Treatment, care and support
VI. Monitoring and evaluation

Part B to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations.

Part B covers:

I. Civil Society involvement
II. Political support and leadership
III. Human rights
IV. Prevention
V. Treatment, care and support

Some questions occur in both Part A and Part B to ensure that the views of both the national government and nongovernmental respondents, whether in agreement or not, are obtained.

For questions that pertain to key populations at higher risk for HIV (heretofore referred to as "key populations" and other vulnerable populations, the following definition is applied: Key populations are defined as **most at risk for HIV (heretofore referred to as "key populations")** within a defined epidemiological context, that have: significantly higher levels of risk of acquiring and transmitting HIV; higher rates of mortality and/or morbidity; limited access or uptake of relevant services. Population groups that require explicit attention include people who inject drugs, sex workers, and men who have sex

30 Compare NCPI in Guidelines on construction of core indicators, UNAIDS 2003, 2005, 2007, 2009 respectively, for selecting questions for which trends can be calculated.

with men. Other populations that may be vulnerable to HIV are women and girls; transgender persons; clients of sex workers; prisoners; refugees, migrants or internally displaced populations; adolescents, and young people; vulnerable children and orphans; people; ethnic minorities; people in low-income groups; people living in rural or geographically isolated settings or other group(s) specific to the country context.

It is important to submit a fully completed NCPI. Please check the relevant standardized responses as well as provide further information in the open text boxes where requested. This will facilitate a better understanding of the current country situation, provide examples of good practice for others to learn from, and pin-point some issues for further improvement. NCPI responses reflect the overall policy, strategy, legal and programme implementation environment of the HIV response. The open text boxes provide an opportunity to comment on anything that is perceived to be important but insufficiently captured by the standardized questions (e.g. important sub-national variations; the level of implementation of laws, policies or regulations; explanatory notes; comments on data sources etc). In general, draft strategies, policies, or laws are not considered 'in existence' (i.e. there is no opportunity yet to expect their influence on programme implementation) so questions about whether such a document exists should be answered with 'no'. It would, however, be useful to state that such documents are in draft form and any specifics about them in the relevant open text box.

The overall responsibility for collating and submitting the information requested in the NCPI lies with the national government, through officials from the National AIDS Committee (NAC) (or equivalent).

II. PROPOSED STEPS FOR DATA GATHERING AND DATA VALIDATION

The NCPI is ideally completed in the last 6 months before submission (i.e. between October 2011 and March 2012 for the 2012 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.

1. **Designate two technical coordinators (one for part A; one for part B)**

   Technical coordinators should be given responsibility to undertake the desk review, to carry out interviews as needed, to bring together relevant stakeholders, and to facilitate collating and consolidating the NCPI data. Preferably, the technical coordinator for Part A is from the NAC (or equivalent) and for Part B is a person outside the government. They should ideally have understanding of the national policy and legal environment, a monitoring and evaluation background, and knowledge of the main actors in the national HIV response.

2. **Agree with stakeholders on the NCPI data gathering and validation process**

   Accurate completion of the NCPI requires the involvement of a range of stakeholders including representatives of a variety of civil society organizations. It is strongly recommended to organize an initial workshop with key stakeholders to agree on the NCPI data-gathering process including relevant documents for desk review, organizational representatives to be interviewed, the process to be used for determining final responses, and the timeline.

3. **Obtain data**

   The submitted NCPI data should represent the most recent stock-taking of the policy, strategic and legal environment. As the process involves a range of stakeholders and data need to be consolidated before official submission to UNAIDS, it is important to allow adequate time for completion.

   Each section should include completion of the following tasks:

   (i). Desk review of relevant documents.

   If not already the case, it is useful to collate all key documents (i.e. policies, strategies, laws, guidelines, reports etc) related to the HIV response in one place which allows easy access by all stakeholders (such as a website).This will not only facilitate validation of NCPI responses but, even more importantly, increase awareness about and encourage use over time of these important documents in the implementation of the national HIV response.

(ii). Interviewing (or other ways of obtaining the information efficiently) key people most knowledgeable about the specific topic including, but not restricted to the following:

- For Strategic Plan and Political Support sections: the Director or Deputy Director of the National AIDS Programme or National AIDS Committee (or equivalent), the Heads of the AIDS Programme at provincial and at district levels (or equivalent decentralised levels).
- For Monitoring and Evaluation section: Officers of the National AIDS Committee (or equivalent), Ministry of Health, HIV focal points of other ministries, the national monitoring and evaluation technical working group.
- For Human Rights questions: Ministry of Justice officials and human rights commissioners for questions in Part A; representatives of human rights and other civil society organizations, including representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations , and legal aid centres/institutions working in the area of HIV for questions in Part B.
- For Civil Society Participation section: key representatives of major civil society organizations working in the area of HIV. These specifically include representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations.
- For Prevention and Treatment, Care and Support sections: Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and networks of people living with HIV.

Note that interviewees are requested to provide responses as representatives of their institutions or constituencies, not their own personal views.

4. Validate, analyse and interpret data

Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed.

It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's HIV epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available.

It is strongly recommended to organize a final workshop with key stakeholders to present, discuss and validate the NCPI responses and the write-up of the findings before official submission. It is expected that representatives from civil society organizations working in the area of HIV are invited to participate. These specifically include representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations. It is also important that persons with gender expertise and expertise with other key populations be involved in the review and validation process. Ideally, the workshop would review the results from the last reporting round highlighting changes since that time and focus on validation of the NCPI data. Agreement on the final NCPI data does not require that discrepancies, if any, between overlapping questions in Part A and Part B be reconciled; it simply means that when there are different perspectives, that Part A respondents agree on their responses, Part B respondents agree on their responses, and that both are submitted. If there are no established mechanisms in place, the workshop can also provide an opportunity to discuss further collaboration between relevant stakeholders to address key gaps identified through the NCPI process.

5. Enter and submit data

Submit the final NCPI data before 31 March 2012, using the dedicated software provided on the Global AIDS Progress reporting website (www.unaids.org/AIDSReporting). If this is not possible, an electronic version of the completed questionnaire should be submitted as an appendix to the Country Progress Report before 15 March 2012 to allow time for the manual entry of data in Geneva.

National Commitments and Policy Instrument (NCPI)

Data Gathering and validation process

Describe the process used for NCPI data gathering and validation:
In filling out the form NCPI, participants were divided into two groups, Government (Part A) and Non-Government (Part B). Each group was guided by two facilitators who were members of the group. Each group was subdivided, the group A into 5 sub-groups and group B into two sub-groups. The choice of sub-groups was based on their specialization. In sub-groups, each question was discussed. Once discussions were completed, the sub-group results were then discussed in a large group, and the group agreed on a final position.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
Discussions were open with each sub-group member free to give their opinion without pressure. If no agreement was reached within sub-groups with a wide variation in opinions, these differences were noted, although participants appreciated a joint decision about questions.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
Some data and information still requires confirmation, for example data about orphans. But in general the participants agreed with the final outcomes of the meetings.

NCPI Respondents

*[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]*

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
Kemenkes	Trijoko				V	V	
Kemdagri	Sri Wahyuni						V
Kemhukham	Tholib		V	V			
TNI	Ghufron S.		V	V			
Kemhan	Adi Priyono						V
Kemnakertrans	Muzakir						V
Kemenag	Hamim				V	V	
Kemenpora	Abdul Rafur		V	V			
BKKBN	Djafar				V	V	
Bappenas	Nurul	V					
Kemlu	Risha Julian		V	V			
KPPPA	Dessy Oktarina		V	V			
Kemsos	Enang Rochana				V	V	
Set. KPAN	Suriadi G.	V					
Kemdagri	Herman M						V
Kemhukham	Diah Ayu N.H	V					
Kemhukham	Emi				V	V	

Add details for all respondents.

Notes:

- Kemenkes: Ministry of Health
- Kemdagri: Ministry of Home Affairs
- Kemhukham: Ministry of Law and Human Rights
- TNI: Indonesia Armed Forces
- Kemhan: Ministry of Defense
- Kemnakertrans: Ministry of Man Power and Transmigration
- Kemenag: Ministry of Religion Affairs
- Kemenpora: Ministry of Youth and Sports
- BKKBN: National Population and Family Planning Board
- Bappenas: National Development Planning Board
- Kemlu: Minstry of Foreign Affairs
- KPPPA: Ministry of Women's Empowerment and Child Protection
- Kemsos: Ministry of Social Affairs
- Sekretariat KPAN: Indonesian National AIDS Commission Secretariat

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
IPPI	Cia Wibisono	V		V		
PKNI	Meike Teja	V		V		
OPSI	Aldo	V		V		
GWL Ina	Tono Permana	V		V		
YPI	Husein Habsyi		V		V	V
YKB	Siti Hidayati		V		V	V
PMI	Eka Wulan		V		V	V
PKBI	Nanang	V		V		
NU	Helwiyah	V		V		
IBCA	Yuli W		V		V	V
IKAI	Erry		V		V	V
IPIPPI	Puji Suryantini		V		V	V
UNAIDS	Lely Wahyuniar		V		V	V
UNFPA	Deni A.F		V		V	V
UNESCO	Ahmed Afzal	V		V		
UNODC	Gray Sattler	V		V		
SUM1	Nasrun Hadi	V		V		
ILO	Risya Kori	V		v		

Add details for all respondents.

Notes:

- IPPI: Indonesia Association of Positive HIV Women
- PKNI: Indonesia Association of Drug User Victims
- OPSI: Indonesia Association of Sex Workers
- GWL Ina: Indonesia Association 0f Gay, Transgender and MSM
- YPI: Pelita Ilmu Foundation
- YKB: Kesuma Buana Foundation
- PMI: Indonesia Red Cross
- PKBI: Indonesia Family Planning Association
- NU: Nahdatul Ulama (Indonesia Islamic Organization)
- IBCA: Indonesia Business Coalition on AIDS
- IKAI: Indonesia Addiction Counselor Association
- IPIPPI: Indonesia Behavior Changes Practitioner Association
- SUM1: Scaling Up Most at Risk Population (FHI)

National Commitments and Policy Instrument (NCPI)

Part A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

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

Yes√	No

IF YES, what was the period covered *[write in]*: 2007

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

IF NO or NOT APPLICABLE, briefly explain why.

- 2010 - 2014 = Strategies and action plans are combined in one document with the title SRAN (Strategy and Action Plan) for HIV and AIDS in Indonesia.
- 2007 - 2010 = Strategies and action plans separately in 2 (two) documents the Strategic Plan for HIV / AIDS in Indonesia and the National Action Plan for HIV / AIDS in Indonesia.
- 2003 - 2007 Strategic Plan = HIV / AIDS in Indonesia
- 2000 - 2003 = No policy as Minister Coordination of Peoples Welfare was disbanded
- 1994 - 1999 = Strategic Plan for HIV / AIDS in Indonesia

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

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*: Indonesia National AIDS

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes√	No	Yes√	No
Health	Yes√	No	Yes√	No
Labour	Yes√	No	Yes√	No
Military/Police	Yes√	No	Yes√	No
Transportation	Yes√	No	Yes√	No
Women	Yes√	No	Yes√	No
Young People	Yes√	No	Yes√	No
Other *[write in]*: Justice and Human Rights	Yes√	No	Yes√	No

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

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes√	No
Migrants/mobile populations	Yes√	No
Orphans and other vulnerable children	Yes√	No
People with disabilities	Yes	No√
People who inject drugs	Yes√	No
Sex workers	Yes√	No
Transgendered people	Yes√	No
Women and girls	Yes√	No
Young women/young men	Yes√	No
Other specific vulnerable subpopulations[31]	Yes√	No
SETTINGS		
Prisons	Yes√	No
Schools	Yes√	No
Workplace	Yes√	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes√	No
Gender empowerment and/or gender equality	Yes√	No
HIV and poverty	Yes√	No
Human rights protection	Yes√	No
Involvement of people living with HIV	Yes√	No

IF NO, explain how key populations were identified?

31 Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the

***country** [write in]?*

KEY POPULATIONS
1. Injecting drug users 2. Sex worker 3. Sex Workers clients 4. Transgender/waria 5. MSM 6. Prisoners 7. Youth 8. PLWHA

1.5. Does the multisectoral strategy include an operational plan?

Yes√	No

1.6. Does the multisectoral strategy or operational plan include:

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

1.7. Has the country ensured "full involvement and participation" of civil society[32] in the development of the multisectoral strategy?

√Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
In preparation SRAN 2010 - 2014 civil society representatives were involved from the design up to the finalization of the document so that the various needs of civil society is reflected in the programs set SRAN.

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

32 Civil society includes among others: networks and organisations of people living with HIV,women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes√	No	N/A

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

√Yes, all partners	Yes, some partners	No	N/A

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

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

Yes√	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes√	No	N/A
National Development Plan	Yes√	No	N/A
Poverty Reduction Strategy	Yes√	No	N/A
Sector-wide approach	Yes√	No	N/A
Other *[write in]*:	Yes√	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	Yes√	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes√	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes√	No	N/A
Reduction of stigma and discrimination	Yes√	No	N/A
Treatment, care, and support (including social security or other schemes)	Yes√	No	N/A

Women's economic empowerment (e.g. access to credit, access to land, training)	Yes√	No	N/A
Other[write in below]:	Yes	No	N/A

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

Yes	No√	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

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

Yes√	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS? [33]

Yes√	No

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	No√

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

√Estimates of Current and Future Needs	Estimates of Current Needs Only	No

5.3. Is HIV programme coverage being monitored?

Yes√	No

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

Yes√	No

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

Yes√	No

33 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

IF YES, for which population groups?
1. Injecting drug users 2. Sex worker 3. Sex Workers clients/High risk man 4. Transgender 5. MSM 6. Prisoners 7. PLWHA
Briefly explain how this information is used:
For program planning and resources mobilization

(c) Is coverage monitored by geographical area?

Yes√	No

IF YES, at which geographical levels (provincial, district, other)?
National, Provincial and district Level
Briefly explain how this information is used:
For program planning and resources mobilization

5.4. Has the country developed a plan to strengthen health systems?

Yes√	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
The MoH has approved over 270 hospitals and 80 satellite (smaller and private hospital) to provide ART. The Staff in the hospitals have been trained to promote ART. ARV is provide free of charge.

6. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
1. The existence of a national strategy that involves multi-sector coordination by Bappenas 2. Expansion of the scope and coverage, particularly IDUs, prisoners, MSM and High Risk Youth Man 3. Increased allocation of domestic funds (state budget and regional budgets) 4. Increasing the number of district /municipal bylaw and allocated funds for HIV-AIDS programs
What challenges remain in this area:
Domestic funding for HIV- AIDS prevention program in the District / City is still inadequate

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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

A. Government ministers

Yes√	No

B. Other high officials at sub-national level

Yes√	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes√	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
On World AIDS Day 2011, Vice President officially opened and gave a speech in Jakarta, capital city of Indonesia

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

Yes√	No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes√	No
Have active government leadership and participation?	Yes√	No
Have an official chair person?	Yes√	No
IF YES, *what is his/her name and position title?* **HR. Agung Laksono, MD. (Ministry Coordinator of Peoples Welfare**		
Have a defined membership?	Yes√	No
IF YES, *how many members?* ***32 member, consist of Minister and Head of Government Body, key population network, privat sector***		
Include civil society representatives?	Yes√	No
IF YES, *how many?****3organizations***		
Include people living with HIV?	Yes√	No
IF YES, *how many?****2 national network of people living with HIV and AIDS***		
Include the private sector?	Yes√	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes√	No

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

Yes√	No	N/A

IF YES, briefly describe the main achievements:
1. Coordination meeting of the Cabinet / Minister led by Coordinating Minister of People's Welfare 2. Every three months a meeting of the Implementation Team 3. There are regular reporting mechanisms for each sector, which contains the program and related activities on AIDS prevention. 4. National AIDS Conference every 4 years
What challenges remain in this area:
Financial support from the state budget is still low. In addition, in coordination meetings, officials representing each sector often change affecting the continuity of the program of the Ministry/Agency. Lack of socialization of important issues related to HIV / AIDS.

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

	%

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

Capacity-building	Yes√	No
Coordination with other implementing partners	Yes√	No
Information on priority needs	Yes√	No
Procurement and distribution of medications or other supplies	Yes√	No
Technical guidance	Yes√	No

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

Yes√	No

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

Yes√	No

IF YES, name and describe how the policies / laws were amended
Eg Law. 22/1997 converted into Law No.35/2009 on Narcotics.
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
1. Law no. 22/1997 does not include rehabilitation for drug addicts, while the Law. 35/2009 includes an obligation for the rehabilitation of drug addicts. 2. The issuance of Circular Letter Supreme Court No. 3/2011 on Narcotics Abuse Victims Placement in Rehabilitation Institutions; 3. Reviewing local regulations that are incompatible with national policy.

*7. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
1. Policy formulation ministerial decree, Commander of the Armed forces, and other regulations that support the HIV / AIDS program. 2. Increased proportion of domestic resources for the national budget on HIV / AIDS (40% compared to the international financial support).
What challenges remain in this area:
1. There are still policy makers (Minister-level officials) who do not understand HIV / AIDS comprehensively, for example, some still consider that HIV / AIDS is the responsibility of the Ministry of Health. 2. The lack of information for religious leaders and community members who do not understand the impact of HIV AIDS, resulting in stigma in the community.

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes√	No
Men who have sex with men	Yes	No√
Migrants/mobile populations	Yes√	No
Orphans and other vulnerable children	Yes√	No
People with disabilities	Yes√	No
People who inject drugs	Yes√	No
Prison inmates	Yes√	No
Sex workers	Yes	No√
Transgendered people	Yes	No√
Women and girls	Yes√	No
Young women/young men	Yes√	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes√	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
1. Law no. 7/1984 (ratification of CEDAW: Convention on the Elimination of all forms of discrimination against women 2. Law no. 39/1999 on Human Rights; 3. Law no. 5/1998 on the Ratification of the Convention against Torture and Degrading Treatment or Punishment is cruel, inhuman or degrading (CAT); 4. Circular Letter Supreme Court. No 3/2011 concerning the placement of victims of substance abuse in the Rehabilitation Institute; 5. Regulation of Gender Responsive Budget Planning 6. Child Protection Act No. 23/2002 7. Elimination of Domestic Violence Act No. 23/2004

Briefly explain what mechanisms are in place to ensure these laws are implemented:
1. Establishment of National Human Rights Commission as a watchdog of human rights implementation in Indonesia; 2. Establishment of the Ad HOC Court as judicial bodies against human rights violations 3. Establishment of the Indonesian Child Protection Commission 4. Establishment of the National Commission for Women, National Commission for the Elderly, etc.

Briefly comment on the degree to which they are currently implemented:
Mechanism is already running and still in the process of optimization.

2. Does the country have laws, regulations or policies that present obstacles[34] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes√	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes√	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes√	No
Prison inmates	Yes	No
Sex workers	Yes√	No
Transgendered people	Yes√	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[35] [write in below]:	Yes	No

34 These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

35 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
Some local bylaws in certain districts and municipals forbid prostitution, which complicates efforts to control the spread of HIV / AIDS and is not in line with the national policy. Bylaw in Aceh province prohibit homosexuality. Police still criminalize drugs user in certain areas.
Briefly comment on how they pose barriers:
These policies make it difficult to access group who are fearful of persecution. There is a need to harmonize local legislation with the legislation / national policy, for example, through the Ministry of the Interior (close to the regional government to repeal laws that are not aligned) and the Regional AIDS Commission.

IV. PREVENTION

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

Yes√	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes√	No
Avoid commercial sex	Yes√	No
Avoid inter-generational sex	Yes√	No
Be faithful	Yes√	No
Be sexually abstinent	Yes√	No
Delay sexual debut	Yes√	No
Engage in safe(r) sex	Yes√	No
Fight against violence against women	Yes√	No
Greater acceptance and involvement of people living with HIV	Yes√	No
Greater involvement of men in reproductive health programmes	Yes√	No
Know your HIV status	Yes√	No
Males to get circumcised under medical supervision	Yes√	No
Prevent mother-to-child transmission of HIV	Yes√	No
Promote greater equality between men and women	Yes√	No
Reduce the number of sexual partners	Yes√	No
Use clean needles and syringes	Yes√	No
Use condoms consistently	Yes√	No
Other [write in below]:	Yes	No

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

Yes√	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes√	No

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No√
Secondary schools?	Yes	No√
Teacher training?	Yes√	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes√	No

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

Yes√	No

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

Yes√	No

Briefly describe the content of this policy or strategy:
Indonesia has mapped vulnerable sub-populations and has conducted educational and promotional information and health interventions. Related to the curriculum in schools, including boarding schools, there are some provinces that already includes the basic information of HIV in the education curriculum, such as Papua, East Java and Bali.

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

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

	IDU[36]	MSM[37]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations[38] *[write in]*
Condom promotion	√	√	√	√		
Drug substitution therapy	√				√	
HIV testing and counseling	√	√	√	√	√	
Needle & syringe exchange	√					
Reproductive health, including sexually transmitted infections prevention and treatment	√	√	√	√	√	
Stigma and discrimination reduction	√	√	√	√	√	
Targeted information on risk reduction and HIV education	√	√	√	√	√	
Vulnerability reduction (e.g. income generation)	√		√		√	

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
In the prevention program: 1. AIDS National Strategic Action Plan 2010-2014 2. National AIDS Commission and government sectors have establish Working Groups
What challenges remain in this area:
1. Condom use program is still not accepted in the community 2. Still a lack of coordination of various sectors 3. Reporting and the documentation is still not optimal 4. Low levels of support from policy makers at the central and local levels. 5. Most of the sector still facing difficulties to allocate budgets for HIV/AIDS in state as well as regional budgets.

36 IDU = People who inject drugs

37 MSM = men who have sex with men

38 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

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

Yes√	No

***IF YES,* how were these specific needs determined?**
Providing IEC to the following groups: 1. Youth group 2. Workers at the seaport, bus terminals, truck stops, airports, industrial centers – based on the high prevalence of HIV in FSWs and their clients 3. Prison inmates – based on the high risk behaviour of prisoners as indicated by the 2010 prison survey 4. Vulnerable groups, such as street children, vagrants and beggars

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

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4√	N/A
Condom promotion	1	2√	3	4	N/A
Harm reduction for people who inject drugs	1	2	3√	4	N/A
HIV prevention for out-of-school young people	1	2√	3	4	N/A
HIV prevention in the workplace	1	2	3√	4	N/A
HIV testing and counseling	1	2√	3	4	N/A
IEC[39] on risk reduction	1	2√	3	4	N/A
IEC on stigma and discrimination reduction	1	2√	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3√	4	N/A
Prevention for people living with HIV	1	2√	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2√	3	4	N/A
Risk reduction for intimate partners of key populations	1	2√	3	4	N/A
Risk reduction for men who have sex with men	1	2	3√	4	N/A
Risk reduction for sex workers	1	2	3√	4	N/A
School-based HIV education for young people	1	2√	3	4	N/A
Universal precautions in health care settings	1	2	3	4√	N/A
Other*[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6√	7	8	9	10

39 IEC = information, education, communication.

V. TREATMENT, CARE AND SUPPORT

1. ***Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?***

Yes√	No

If YES, Briefly identify the elements and what has been prioritized:
1. ARV drugs provide free of charge (MoH) 2. Integrated prevention, treatment, care and support of HIV

Briefly identify how HIV treatment, care and support services are being scaled-up?
1. 278 PLWHA referral hospitals for ART 2. Satellite health centers and hospitals increased to 87 unit 3. 342 Test and counseling Clinics (including prisons) 4. The existence of a comprehensive and integrated service SOP

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

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4√	N/A
ART for TB patients	1	2	3	4√	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3√	4	N/A
Early infant diagnosis	1	2√	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2√	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4√	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3√	4	N/A
Nutritional care	1	2	3	4√	N/A
Paediatric AIDS treatment	1	2	3√	4	N/A

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women	1	2	3√	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3√	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4√	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4√	N/A
Sexually transmitted infection management	1	2√	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4√	N/A
TB preventive therapy for people living with HIV	1	2	3	4√	N/A
TB screening for people living with HIV	1	2	3	4√	N/A
Treatment of common HIV-related infections	1	2	3	4√	N/A
Other*[write in]*:	1	2	3	4	N/A

2. ***Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?***

Yes√	No

Please clarify which social and economic support is provided:
1. Economic empowerment of PLWHA through Productive Enterprises 2. Social assistance for the fulfillment of basic needs of PLWHA

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

Yes√	No	N/A

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

Yes√	No	N/A

IF YES, for which commodities?
1. ART 2. Condoms 3. STI and opportunistic infection drugs 4. Oral substitution (Methadone)

5. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
1. ARVs are free 2. Condoms are available and distributed 3. The drugs are always available 4. ARV recipients more than the target set in 2011 (target 45% achievement of 87%) 5. Counseling and testing target Above 15 years 800.000, 600 000 achievement

What challenges remain in this area:
1. More sources of funding from domestic sources the present proportion of government to foreign funding is 1: 2 2. The persistence of stigma and discrimination 3. ARV adherence levels vary, approximately 60% - 70%

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

Yes√	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes√	No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes√	No

6.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes√	No

6.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6√	7	8	9	10

Since 2009, what have been key achievements in this area:
Ministry of Social Affairs provide support on financial and microfinance activities to poor families of infected or affected by HIV
What challenges remain in this area:
1. PLWHA referred to hospitals has a 100% target but only 20% achieved 2. Geographical natural and social conditions are not the same in all provinces 3. Government policy on health is not the same as in all provinces/district due to decentralized authority.

VI. MONITORING AND EVALUATION

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

Yes√	In Progress	No

Briefly describe any challenges in development or implementation:
Not all partners have a M&E system or plan due to their different policies. In addition, infrastructures to support M&E related activities still needs to be improved.

***1.1. IF YES, years covered** [write in]:* 2010

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

Yes, all partners	Yes, some partners√	No	N/A

Briefly describe what the issues are:
Some partners do not have a M&E unit, M&E system or plan, making integration of their M&E activities into the national M&E plan difficult, including indicators harmonization.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes√	No
IF YES, does it address:		
Behavioural surveys	Yes√	No
Evaluation / research studies	Yes√	No
HIV Drug resistance surveillance	Yes√	No
HIV surveillance	Yes√	No
Routine programme monitoring	Yes√	No

A data analysis strategy	Yes√	No
A data dissemination and use strategy	Yes√	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yesv	No
Guidelines on tools for data collection	Yes√	No

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

Yes√	In Progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

10%

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

Yes√	In Progress	No

Briefly describe any obstacles:
Limitation in resources (human, financial and supportive facilities) for national M&E related activities management in order to improve quality of implementation of national M&E system.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?	Yes√	No
In the National HIV Commission (or equivalent)?	Yes√	No
Elsewhere *[write in]*?	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]	6		
ME Coordinator	1		2007
ME Coordinator Assistant for Sumatra	1		2009
ME Coordinator Assistant for Java-Bali	1		2008
ME Coordinator Assistant for Kalimantan	1		2007
ME Coordinator Assistant for Eastern Indo	1		2011
ME Coordinator Assistant for National	1		2007

MoH (AIDS Sub-Directorat)	17		
	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes√	No

Briefly describe the data-sharing mechanisms:
Implementing partners at district level submit their report regularly (once a month) to District AIDS Commission which is then compiled and sent to the National AIDS Commission. National implementing partners submit their report regularly (quarterly) to National AIDS Commission using standardized formats. All reports are reviewed and the highlights are shared in the national report.
What are the major challenges in this area:
Some partners are not yet committed to share their reports regularly because they do not have a M&E officer, no budget to conduct M&E activities, and no M&E system.

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

Yes√	No

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

Yes√	No

IF YES, briefly describe the national database and who manages it.
The national database is being managed and is limited to data on program coverage performed by key stakeholders. This needs improvement to ensure all important data can be recorded into a national database. The database is managed by national M&E staff. Each partner manages their ownb database related to implementation of their program.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above√	Yes, but only some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?

6.2. Is there a functional Health Information System[40]?

At national level	Yes√	No
At subnational level	Yes√	No
IF YES, at what level(s)? *[write in]*		

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

Yes√	No

40 Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

8. How are M&E data used?

For programme improvement?	Yes√	No
In developing / revising the national HIV response?	Yes√	No
For resource allocation?	Yes√	No
Other *[write in]*: • Development of National Strategy • Development of Government policy for HIV AIDS prevention • Advocacy for HIV AIDS prevention	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Quarterly reports on HIV & AIDS published by the Ministry of Health shows the epidemic situation in all regions. This epidemic data is used for developing prevention strategies either for that specific region or for national policy makers. One of the examples is epidemic data for the improvement of the AIDS budget. Challenges: AIDS program sometimes not included in list of program priorities in a region so it will take some time for the region to decide to increase their budget allocation for AIDS.

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

At national level?	Yes√	No
IF YES, what was the number trained: Training on National AIDS Spending Assessment, 3-6 May 2011, Participant 34		
At subnational level?	Yes√	No
IF YES, what was the number trained		
At service delivery level including civil society?	Yes√	No
IF YES, how many?		

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

Yes√	No

IF YES, describe what types of activities
Workshops, seminar, congress and national meeting on AIDS

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
• Development of online reporting and recording system for 33 provinces. • Mapping of MARP at district/city level. • Integrated Bio Behavioral Survey 2009 and 2011 • Rapid Behavioral Survey for FSW and IDUs in 2009 and 2010 • Annual Epidemiology Surveillance • National AIDS Spending Assessment 2009-2010
What challenges remain in this area:
• Harmonization of program indicators among program implementers • Commitment for sharing reports regularly.

National Commitments and Policy Instrument (NCPI)

Part B

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

I. CIVIL SOCIETY[41] INVOLVEMENT

1. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?***

LOW					HIGH
0	1	2√	3	4	5

Comments and examples:
Civil society (CS) is defined as: KAP/MARP, women, youth, faith-based organizations. The emphasis is still on KAPs. CS' contribution in terms of its relation to the NAC has been great as at all levels of decision-making at the NAC, CS were consulted. But in the AIDS response in general, the contribution of CS has been limited. This is clear as there are still some regulations, laws and rules that are violating human rights, in particular those of marginalized groups (ie.MSM, IDUs, PLWHIV, etc) either at national or local levels. At the national level, the role of CS has been limited to the NAC, while other sectors rarely involve KAP groups in decision making meetings.

2. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?***

LOW					HIGH
0	1	2√	3	4	5

Comments and examples:
The involvement of civil society can be described as follows, according to the stages of planning: - During the formulation of the National AIDS Strategy, civil society had full involvement and consultation. - In terms of implementation of programs, the role of civil society is increasing. - But in terms of budgeting, particularly at the national level, the system doesn't provide a forum for civil society to be involved in the decision making process. At local level, civil society groups in some districts are involved in the formulation of the AIDS budget.

41 Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

3. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:***

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4√	5

b. The national HIV budget?

LOW					HIGH
0	1	2√	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4√	5

Comments and examples:
NGOs are providing services, mostly using international funds. These are included in the National Strategy (please refer to No.2, and the budgeting (please refer to No.2). In terms of reports, NGOs have been reporting to International funders or to national NGOs. At regional level, they report to local KPA which in turn reports to National KPA.

4. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?***

a. Developing the national M&E plan?

LOW					HIGH
0	1√	2	3	4	5

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

LOW					HIGH
0	1	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2√	3	4	5

- Civil society is encouraged to use data/evidence/scientific analysis. Some examples:
  - GWL used data to formulating the GWL National AIDS Strategy and Action Plan
  - JOTHI uses data and actively carries out research
  - IPPI has limited usage of data.
- Civil society is not accustomed to using data for decision making, as they are lacking the necessary skills. More technical assistance is needed for civil society groups to increase the capacity to collect, analyze and use data.
- Data from MOH needs to be made available and published in reports.

5. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?***

LOW					HIGH
0	1	2	3√	4	5

Comments and examples:

Compared to prior periods, the role of civil society is increasing but greater efforts and emphasis to push for an active involvement. Capacity building is needed here.

6. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:***

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3√	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3√	4	5

Comments and examples:

- There is transparancy in terms of funds used through the CCM forum for GFATM funded projects. All PRs which are the MOH, KPAN, PKBI and NU are open and transparent.
- Proposals submitted by civil society for funding usually get revised with decreased funds made available than that proposed in budgets
- Civil society is lacking information and capacity to initiate some HIV activities.

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

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	>75%
Men who have sex with men	<25%	25-50%	51–75%	>75%
People who inject drugs	<25%	25-50%	51–75%	>75%
Sex workers	<25%	25-50%	51–75%	>75%
Transgendered people	<25%	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor										Excellent
0	1	2	3	4	5√	6	7	8	9	10

Since 2009, what have been key achievements in this area:

What challenges remain in this area:
• The Minister of Social Affairs has made statements naming prostition as societal diseases (penyakit masyarakat) and some brothels have been closed down, making it more difficult to reach sex workers • Stigma and discrimination of MARPS still exists

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes√	No

IF YES, describe some examples of when and how this has happened:
• Greater involvement in terms of program design particularly supported by GFATM from planning to implementation through the CCM forum • Involvement at the national level has been optimal with all groups involved in meetings and policy making

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes√	No
Men who have sex with men	Yes	No√
Migrants/mobile populations	Yes√	No
Orphans and other vulnerable children	Yes√	No
People with disabilities	Yes√	No
People who inject drugs	Yes√	No
Prison inmates	Yes√	No
Sex workers	Yes	No√
Transgendered people	Yes	No√
Women and girls	Yes√	No
Young women/young men	Yes	No√
Other specific vulnerable subpopulations *[write in]*:	Yes√	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes√	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
• Review laws and regulations that discriminate KAP: Laws on human rights, health, domestic violence, etc.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
• The role of civil society in terms of control and monitoring of law enforcement has been minimum, due to lack of capacity. • Parliamentarians (DPR, DPD) do not represent neither do they articulate the problems of civil society especially KAPs
Briefly comment on the degree to which they are currently implemented:
• Enforcement of laws is limited and in some cases non-existent

2. Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes√	No

42 These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yesv	No
Men who have sex with men	Yes√	No
Migrants/mobile populations	Yesv	No
Orphans and other vulnerable children	Yes	No√
People with disabilities	Yes	No√
People who inject drugs	Yes√	No
Prison inmates	Yes	No√
Sex workers	Yes√	No
Transgendered people	Yes√	No
Women and girls	Yes√	No
Young women/young men	Yes	No√
Other specific vulnerable populations[43] *[write in]*:	Yes	No

Briefly describe the content of these laws, regulations or policies:
• Local rules and regulations (PERDA) that criminalize PLWHIV (Jatim, Bali), Pornographic laws, • Laws concerning migrant workers and the Narcotics Law (contains many contradictions)
Briefly comment on how they pose barriers:
• Laws that are criminalizing provide a difficult environment for harm reduction programs

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes√	No

43 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of the policy, law or regulation and the populations included.
• Women the Domestic law No: 23/2004 • Sexual harassment towards men, transgender

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

Yes√	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
• The 2010-2014 National AIDS Strategy and Action Plan, one of the principles of good response to AIDS includes : "law enforcement": to embody rule of law that is fair for all parties, without exception/discrimination, upholding human rights and local values.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No√

IF YES, briefly describe this mechanism:
• Documentation of human rights violation is done by civil society for drug users and HIV positive people. No process exists for sex workers. • The National Human Rights Commission has the authority to investigate reported violations. • Workplace regulations to protect the rights of workers exist.

6. ***Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).***

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes√	No	Yes	No	Yes	No
HIV prevention services[44]	Yes√	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes√	No

If applicable, which populations have been identified as priority, and for which services?
• All service are free including HIV testing, harm reduction and needle syringe programs, except for administrative fees • There are no standard administrative fees, it varies among hospitals (private hospitals) • Follow up treatments are not free • TB treatments are free, but tests and other related needs are not free • There are no set priorities

7. ***Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?***

Yes√	No

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

Yes√	No

8. ***Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?***

Yes√	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
There are no differences, there is equal access

44 Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes√	No

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

Refer to the SRAN 2010-2014.

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

Yes	No√

IF YE,S briefly describe the content of the policy or law:

- Law No.39/2004 concerning migrant workers → ongoing amendment process
- Between laws and regulation related to AIDS in the workplace, there are contradictions in terms of screening and it being a reason for dismissal.

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

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

Yes	No√

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

Yes	No√

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

- National commission for the protection of women and children
- But none at other commissions such as: Human rights, Ombudsman

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[45]?

Yes√	No

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

Yes√	No

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

a. Legal aid systems for HIV casework

Yes	No√

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

Yes√	No

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

Yes√	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes√	No
Programmes for the media	Yes√	No
Programmes in the work place	Yes√	No
Other *[write in]*:	Yes√	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3√	4	5	6	7	8	9	10

45 Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

46 Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

Since 2009, what have been key achievements in this area:
Amendment to the Narcotics Law, regulatory improvement in terms of harm reduction.
What challenges remain in this area:
• Sex workers → need protection with brothels closed down • Inconsistency in laws and regulations • Dependence on the political situation and individual leadership

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2√	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
There are no significant improvement or obstacles
What challenges remain in this area:
• Contradictory laws and regulations • Law enforcement • Formal government documents such as planning documents (RENSTRA) are not being implemented appropriately

IV. PREVENTION

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

Yes√	No

IF YES, how were these specific needs determined?
• NAC has done initial assessments to map out the AIDS epidemic based on transmission risks and patterns, focusing on prevention efforts • NAC also mapped out resources available
IF NO, how are HIV prevention programmes being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3√	4	N/A
Condom promotion	1	2√	3	4	N/A
Harm reduction for people who inject drugs	1	2	3√	4	N/A
HIV prevention for out-of-school young people	1	2√	3	4	N/A
HIV prevention in the workplace	1	2√	3	4	N/A
HIV testing and counseling	1	2	3√	4	N/A
IEC[47] on risk reduction	1	2√	3	4	N/A
IEC on stigma and discrimination reduction	1	2√	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2√	3	4	N/A

47 IEC = information, education, communication

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV	1	2	3√	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3√	4	N/A
Risk reduction for intimate partners of key populations	1	2√	3	4	N/A
Risk reduction for men who have sex with men	1	2	3√	4	N/A
Risk reduction for sex workers	1	2v	3	4	N/A
School-based HIV education for young people	1	2v	3	4	N/A
Universal precautions in health care settings	1	2	3√	4	N/A
Other*[write in]*:	1	2	3	4	N/A

2. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6√	7	8	9	10

Since 2009, what have been key achievements in this area:

- PMTS or Prevention of sexual transmission has started
- A special strategy for high risk men and MSM has started
- There are preventive strategies for migrant workers but not all are being appropriately implemented
- Program for youth, in particular through peer educators, has started
- Increasing coverage across all provinces
- More companies (IBCA) are showing attention and implementing AIDS in the workplace programs

What challenges remain in this area:

- Condom promotion is still problematic: in brothels, nightclubs, use of condoms is still low. Some of the obstacles are perceptions and advocacy by religious leaders. Young people and unmarried adults are having difficulties accessing condoms
- Local regulations and the closing down of brothels
- Lack of networks, united efforts to mobilize resources
- Sustainability of programs

V. TREATMENT, CARE AND SUPPORT

1. ***Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?***

Yes√	No

IF YES, Briefly identify the elements and what has been prioritized:
ARV treatment: government covers ARV costs of 60% There are 175 referral hospitals providing ARV
Briefly identify how HIV treatment, care and support services are being scaled-up?
• PMTCT services • CD4 needs to be increased • Services should be made more accessible in particular at disctrict/city levels

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

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3√	4	N/A
ART for TB patients	1	2	3√	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3√	4	N/A
Early infant diagnosis	1	2√	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2√	3	4	N/A
HIV testing and counselling for people with TB	1	2√	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2√	3	4	N/A
Nutritional care	1	2√	3	4	N/A
Paediatric AIDS treatment	1	2√	3	4	N/A
Post-delivery ART provision to women	1	2√	3	4	N/A

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2√	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3√	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3√	4	N/A
Sexually transmitted infection management	1	2	3√	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3√	4	N/A
TB preventive therapy for people living with HIV	1	2	3√	4	N/A
TB screening for people living with HIV	1	2	3√	4	N/A
Treatment of common HIV-related infections	1	2	3√	4	N/A
Other*[write in]*:	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7√	8	9	10

Since 2009, what have been key achievements in this area:
There are no significant improvement or obstacles
What challenges remain in this area:

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

Yes √	No

V. TREATMENT, CARE AND SUPPORT

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes √	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes √	No

2.3 . IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes √	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8√	9	10

Since 2009, what have been key achievements in this area:
• Ministry of social affairs has carried out programs at provincial levels, in particular for PLWHIV. • NGOs efforts
What challenges remain in this area:
• Migrant workers have no access to support and ARV treatment yet • OVC and mitigation are still dependent on NGOs, no national program has been made available, not yet a priority. • Increasing number of cases, no permanent monitoring system has been set

Annex B: National AIDS Spending Assessment (NASA) Matrix

Cover Sheet Indicator 6.1: National Funding Matrix — 2009, 2010 & 2011

Country	INDONESIA	
Date of Data Entry	29-Mar-12	day/month/year example: 20/02/2012

1) Which institutions/entities were responsible for filling out the indicator forms?

	NAC or equivalent	(NAC or equivalent, NAP or Others)
If Others, please specify:		

2) Who is the person responsible for submission of the report and for follow-up if there are questions regarding Indicator No. 1?

Name / title:	Yanti Susanti
Address:	National AIDS Commission-Menara Topas Floor 9, Jl. MH Thamrin Kav 9, Central Jakarta
Email:	yanti.susanti@aidsindonesia.or.id
Telephone:	62213901758

3) Name of Local Currency:		Indonesian Rupiah	
4) Amounts reported in:	2009:	US Dollars	(Local Currency or US Dollars)
	2010:	US Dollars	(Local Currency or US Dollars)
	2011:		(Local Currency or US Dollars)
5) Amounts expresed in:	2009:	Units (x 1)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2010:	Units (x 1)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2011:	Units (x 1)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))

6) Average exchange rate with US dollars during the reporting cycle:

2009:	9000.00	Local Currency per 1 US Dollar
2010:	9000.00	Local Currency per 1 US Dollar
2011:		Local Currency per 1 US Dollar

7) Reporting cycle:	2009:	Calendar Year	(Calendar Year or Fiscal Year)
	2010:	Calendar Year	(Calendar Year or Fiscal Year)
	2011:		(Calendar Year or Fiscal Year)

8) Please indicate month and year (M/YYYY) of reporting cycle:

2009	Month	Year
From:	1	2009
To:	12	2009

2010	Month	Year
From:	1	2010
To:	12	2010

2011	Month	Year
From:		
To:		

9) Methodology used:

2009:	National AIDS Spending Assessment (NASA)	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2010:	National AIDS Spending Assessment (NASA)	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2011:		(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)

10) Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

11) Budget Support: Is general budget support from an international source reported under Public Sources of financing (e.g. a bilateral donor to Ministry of Finance)?

2009:	**No**	(Yes or No)
2010:	**No**	(Yes or No)
2011:		(Yes or No)

Country:	INDONESIA
Reporting cycle:	Calendar Year
Data Measurement Tool	National AIDS Spending Assessment (NASA)
Amounts reported in:	US Dollars
Please indicate month and year (M/YYYY) From:	Month: 1 / Year: 2009
To:	Month: 12 / Year: 2009
Name of Local Currency	Indonesian Rupiah
Currency expressed in:	Units (x 1)
Average Exchange Rate for the year (local currency to USD)	9000.000

Financing Sources

2009 AIDS Spending Categories	TOTAL US Dollars	Public Sources						International Sources							Private Sources (optional for UNGASS reporting)			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL **US Dollars**	**60,285,420**	**21,318,844**	**13,883,455**	**7,435,388**	**0**	**0**	**0**	**38,966,576**	**14,894,922**	**0**	**0**	**0**	**24,071,654**		**0**	**0**	**0**	**0**
1. Prevention (sub-total)	**19,411,106**	**3,795,143**	**1,568,977**	**2,226,166**	**0**	**0**	**0**	**15,615,963**	**6,432,103**	**0**	**0**	**0**	**9,183,860**		**0**	**0**	**0**	**0**
1.01 Communication for social and behavioural change	1,731,400	908,186	534,716	373,470	0	0	0	823,214	555,313				267,901		0			
1.02 Community mobilization	1,092,976	489,298	200,695	288,663	0	0	0	603,709	475,308				128,401		0			
1.03 Voluntary counselling and testing (VCT)	189,448	129,907	41,308	88,599	0	0	0	59,541	25,898				33,643		0			
1.04 Risk-reduction for vulnerable and accessible populations	308,564	219,620	42,160	177,460	0	0	0	88,943	0				88,943		0			
1.05. Prevention - Youth in school	452,061	186,817	0	186,817	0	0	0	265,245	44,265				220,980		0			
1.06 Prevention - Youth out-of-school	320,573	37,167	0	37,167	0	0	0	283,406	0				283,406		0			
1.07 Prevention of HIV transmission aimed at people living with HIV	398,001	125,212	72,518	52,694	0	0	0	272,790	263,653				9,136		0			
1.08 Prevention programmes for sex workers and their clients	604,968	353,520	92,304	261,215	0	0	0	251,448	68,039				183,410		0			
1.09 Programmes for men who have sex with men	23,211	0	0	0	0	0	0	23,211	23,211				0		0			
1.10 Harm-reduction programmes for injecting drug users	1,474,163	173,009	132,321	40,688	0	0	0	1,301,155	1,194,425				106,730		0			
1.11 Prevention programmes in the workplace	111,176	106,176	53,892	52,284	0	0	0	5,000	0				5,000		0			
1.12 Condom social marketing	4,785	4,785	1,111	3,674	0	0	0	0	0				0		0			
1.13 Public and commercial sector male condom provision	35,775	5,689	0	5,689				30,086	0				30,086		0			
1.14 Public and commercial sector female condom provision	164,780	164,780	133,715	31,065				0	0				0		0			
1.15 Microbicides	0	0	0	0				0	0				0		0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	140,536	117,003	0	117,003				23,533	0				23,533		0			
1.17 Prevention of mother-to-child transmission	107,532	62,532	0	62,532				45,000	0				45,000		0			
1.18 Male Circumsicion	0	0	0	0				0	0				0		0			
1.19 Blood safety	20,889	20,889	0	20,889				0	0				0		0			
1.20 Safe medical injections	27,859	0	0	0				27,859	0				27,859		0			
1.21 Universal precautions	53,760	53,760	7,290	46,470				0	0				0		0			
1.22 Post-exposure prophylaxis	3,556	3,556	0	3,556				0	0				0		0			
1.98 Prevention activities not disaggregated by intervention	0	0	0	0				0	0				0		0			
1.99 Prevention activities not elsewhere classified	12,145,084	633,259	257,037	376,222				11,511,825	3,781,992				7,729,833		0			
2. Care and Treatment (sub-total)	**21,082,574**	**14,139,312**	**11,079,721**	**3,059,590**	**0**	**0**	**0**	**6,943,262**	**2,473,071**	**0**	**0**	**0**	**4,470,191**	**0**	**0**	**0**	**0**	**0**
2.01 Outpatient care	134,289	61,958	0	**61,958**	**0**	**0**	**0**	72,332	**72,332**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2.01.01 Provider- initiated testing and counselling	221,701	149,369	22,222	127,147				72,332	72,332				0		0			
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	129,126	56,794	0	56,794				72,332	72,332				0		0			
2.01.03 Antiretroviral therapy	11,280,191	11,207,859	11,057,499	150,360				72,332	72,332				0		0			
2.01.04 Nutritional support associated to ARV therapy	79,577	79,577	0	79,577				0	0				0		0			
2.01.05 Specific HIV-related laboratory monitoring	870,867	261,680	0	261,680				609,187	609,187				0		0			
2.01.06 Dental programmes for PLHIV	0	0						0	0				0		0			
2.01.07 Psychological treatment and support services	189,222	189,222		189,222				0	0				0		0			
2.01.08 Outpatient palliative care	0	0		0				0	0				0		0			
2.01.09 Home-based care	27,900	27,900		27,900				0							0			
2.01.10 Traditional medicine and informal care and treatment services	39,446	39,446		39,446				0							0			
2.01.98 Outpatient care services not disaggregated by intervention	48,927	48,927		48,927				0							0			
2.01.99 Outpatient Care services not elsewhere classified	0	0						0							0			
2.02 In-patient care	8,061,327	2,016,578	0	**2,016,578**	**0**	**0**	**0**	6,044,749	**1,574,558**	**0**	**0**	**0**	**4,470,191**	**0**	**0**	**0**	**0**	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)	1,605,076	1,605,076		1,605,076				0							0			
2.02.02 Inpatient palliative care	0	0						0							0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0			
2.02.99 In-patient services not elsewhere classified	6,456,251	411,502		411,502				6,044,749	1,574,558				4,470,191		0			
2.03 Patient transport and emergency rescue	0	0						0							0			
2.98 Care and treatment services not disaggregated by intervention	0	0						0							0			
2.99 Care and treatment services not-elsewhere classified	0	0						0							0			
3. Orphans and Vulnerable Children (sub-total)	**82,261**	**7,261**	**0**	**7,261**	**0**	**0**	**0**	**75,000**	**0**	**0**	**0**	**0**	**75,000**	**0**	**0**	**0**	**0**	**0**
3.01 OVC Education	39	39		39				0							0			
3.02 OVC Basic health care	0	0						0							0			
3.03 OVC Family/home support	0	0						0							0			
3.04 OVC Community support	82,222	7,222		7,222				75,000					75,000		0			
3.05 OVC Social services and Administrative costs	0	0						0							0			
3.06 OVC Institutional Care	0	0						0							0			
3.98 OVC services not disaggregated by intervention	0	0						0							0			
3.99 OVC services not-elsewhere classified	0	0						0							0			
4. Program Management and Administration Strengthening (sub-total)	**9,162,412**	**2,114,454**	**861,301**	**1,253,153**	**0**	**0**	**0**	**7,047,959**	**3,558,354**	**0**	**0**	**0**	**3,489,605**	**0**	**0**	**0**	**0**	**0**
4.01 Planning, coordination and programme management	1,460,585	690,312	414,523	275,787				770,273	128,777				641,496		0			
4.02 Administration and transaction costs associated with managing and disbursing funds	958,021	416,964	172,139	244,825				541,057	424,179				116,878		0			
4.03 Monitoring and evaluation	827,481	403,595	155,901	247,684				423,809	306,553				117,343		0			

4.04 Operations research	6,058	6,058	0	6,058				0					0		0				
4.05 Serological-surveillance (Serosurveillance)	68,811	68,811		68,811				0					0		0				
4.06 HIV drug-resistance surveillance	0	0	0	0				0					0		0				
4.07 Drug supply systems	834,721	136,029	2,103	133,926				698,692	698,692				0		0				
4.08 Information technology	74,886	67,122	21,761	45,361				7,764	0				7,764		0				
4.09 Patient tracking	103,685	103,685	81,016	22,669				0							0				
4.10 Upgrading and construction of infrastructure	22,503	22,503		22,503				0							0				
4.11 Mandatory HIV testing (not VCT)	56	56		56				0							0				
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0	0	0				0							0				
4.99 Program Management and Administration Strengthening not-elsewhere classified	4,805,606	199,329	13,855	185,474				4,606,277	2,000,153				2,606,124		0				
5. Incentives for Human resources (sub-total)	**1,528,423**	**648,614**	**250,155**	**398,459**	**0**	**0**	**0**	**879,810**		**0**	**0**	**0**	**879,810**	**0**	**0**	**0**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	0	0						0							0				
5.02 Formative education to build-up an HIV workforce	0	0						0							0				
5.03 Training	0	0						0							0				
5.98 Incentives for Human Resources not specified by kind	0	0						0							0				
5.99 Incentives for Human Resources not elsewhere classified	0	0						0							0				
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**243,101**	**243,101**	**58,250**	**184,851**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6.01 Social protection through monetary benefits	16,767	16,767	0	16,767				0							0				
6.02 Social protection through in-kind benefits	10,667	10,667	0	10,667				0							0				
6.03 Social protection through provision of social services	42,472	42,472	3,200	39,272				0							0				
6.04 HIV-specific income generation projects	81,994	81,994	55,050	26,944				0							0				
6.98 Social protection services and social services not disaggregated by type	0	0	0	0				0							0				
6.99 Social protection services and social services not elsewhere classified	91,201	91,201		91,201				0							0				
7. Enabling Environment (sub-total)	**8,017,047**	**268,499**	**27,990**	**240,509**	**0**	**0**	**0**	**7,748,548**	**2,172,088**	**0**	**0**	**0**	**5,576,460**	**0**	**0**	**0**	**0**	**0**	**0**
7.01 Advocacy	607,585	264,007	27,990	236,017				343,578	78,638				264,939		0				
7.02 Human rights programmes	221,281	0						221,281					221,281		0				
7.03 AIDS-specific institutional development	1,750,670	47		47				1,750,623	1,750,623						0				
7.04 AIDS-specific programmes focused on women	19,503	3,111		3,111				16,392	15,826				566		0				
7.05 Programmes to reduce Gender Based Violence	0	0						0							0				
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0				
7.99 Enabling Environment and Community Development not elsewhere classified	5,418,007	1,333		1,333				5,416,674	327,000				5,089,674		0				
8. Research (sub-total)	**758,495**	**102,461**	**37,061**	**65,400**	**0**	**0**	**0**	**656,034**	**259,306**	**0**	**0**	**0**	**396,728**	**0**	**0**	**0**	**0**	**0**	**0**
8.01 Biomedical research	0	0		0				0							0				
8.02 Clinical research	0	0		0				0					0		0				
8.03 Epidemiological research	2,296	2,296		2,296				0					0		0				
8.04 Social science research	77,916	31,916		31,916				46,000					46,000		0				
8.05 Vaccine-related research	0	0						0							0				
8.98 Research not disaggregated by type	216,189	461		461				215,728					215,728		0				
8.99 Research not elsewhere classified	462,094	67,788	37,061	30,727				394,306	259,306				135,000		0				

Country:	INDONESIA
Reporting cycle:	Calendar Year
Data Measurement Tool	National AIDS Spending Assessment (NASA)
Amounts reported in:	US Dollars
Please indicate month and year (M/YYYY) From:	Month: 1 / Year: 2010
To:	Month: 12 / Year: 2010
Name of Local Currency	Indonesian Rupiah
Currency expressed in:	Units (x 1)
Average Exchange Rate for the year (local currency to USD)	9000.000

Financing Sources

2010 AIDS Spending Categories	TOTAL US Dollars	Public Sources						International Sources							Private Sources (optional for UNGASS reporting)			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL **US Dollars**	**69,146,880**	**27,779,280**	**17,731,539**	**10,047,741**	**0**	**0**	**0**	**41,367,600**	**13,173,742**	**0**	**0**	**0**	**28,193,858**	**0**	**0**	**0**	**0**	**0**
1. Prevention (sub-total)	**20,413,354**	**5,373,017**	**1,155,301**	**4,217,717**	**0**	**0**	**0**	**15,040,337**	**4,130,815**	**0**	**0**	**0**	**10,909,522**	**0**	**0**	**0**	**0**	**0**
1.01 Communication for social and behavioural change	1,930,279	1,064,105	498,213	565,892				866,174	611,174				255,000					
1.02 Community mobilization	1,361,603	670,495	185,260	485,235				691,108	449,606				241,502					
1.03 Voluntary counselling and testing (VCT)	175,151	89,225	0	89,225				85,926	55,693				30,233					
1.04 Risk-reduction for vulnerable and accessible populations	656,069	184,980	0	184,980				471,089	0				471,089					
1.05. Prevention - Youth in school	692,578	298,001	20,498	277,503				394,577	148,890				245,687					
1.06 Prevention - Youth out-of-school	356,635	85,120	24,333	60,787				271,515	0				271,515					
1.07 Prevention of HIV transmission aimed at people living with HIV	600,042	249,100	0	249,100				350,942	323,535				27,407					
1.08 Prevention programmes for sex workers and their clients	1,045,229	256,994	19,952	237,042				788,235	38,087				750,148					
1.09 Programmes for men who have sex with men	149,713	26,286	20,055	6,231				123,427	77,575				45,852					
1.10 Harm-reduction programmes for injecting drug users	2,059,758	68,732	26,315	42,397				1,991,026	1,436,627				554,419					
1.11 Prevention programmes in the workplace	93,812	91,875	14,803	77,072				1,937	1,937									
1.12 Condom social marketing	7,821	7,821	0	7,821				0										
1.13 Public and commercial sector male condom provision	279,137	119,787	119,296	491				159,350					159,350					
1.14 Public and commercial sector female condom provision	751,402	126,111	126,111	0				625,291	0				625,291					
1.15 Microbicides	0	0						0										
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	252,339	247,080	0	247,080				5,259	0				5,259					
1.17 Prevention of mother-to-child transmission	85,364	35,660		35,660				49,704					49,704					
1.18 Male Circumsicion	0	0		0				0										
1.19 Blood safety	21,651	21,651		21,651				0										
1.20 Safe medical injections	0	0						0					0					
1.21 Universal precautions	16,974	16,974		16,974				0										
1.22 Post-exposure prophylaxis	3,556	3,556		3,556				0										
1.98 Prevention activities not disaggregated by intervention	0	0						0										
1.99 Prevention activities not elsewhere classified	9,874,342	1,709,586	100,566	1,609,019				8,164,755	987,691				7,177,066					
2. Care and Treatment (sub-total)	**24,120,328**	**17,707,923**	**14,266,685**	**3,441,238**	**0**	**0**	**0**	**6,412,405**	**1,505,723**	**0**	**0**	**0**	**4,906,682**	**0**	**0**	**0**	**0**	**0**
2.01 Outpatient care	14,527,975	14,384,489	14,266,685	117,804	0	0	0	143,486	143,486	0	0	0	0	0	0	0	0	0
2.01.01 Provider- initiated testing and counselling	1,151,801	1,008,315		1,008,315				143,486	143,486									
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	188,932	45,446		45,446				143,486	143,486									
2.01.03 Antiretroviral therapy	14,494,180	14,350,694	14,266,685	84,009				143,486	143,486									
2.01.04 Nutritional support associated to ARV therapy	134,770	134,770		134,770				0										
2.01.05 Specific HIV-related laboratory monitoring	284,424	22,642		22,642				261,782	261,782									
2.01.06 Dental programmes for PLHIV	0	0						0										
2.01.07 Psychological treatment and support services	104,228	104,228		104,228				0										
2.01.08 Outpatient palliative care	0	0						0										
2.01.09 Home-based care	25,922	25,922		25,922				0										
2.01.10 Traditional medicine and informal care and treatment services	127,402	127,402		127,402				0										
2.01.98 Outpatient care services not disaggregated by intervention	0	0						0										
2.01.99 Outpatient Care services not elsewhere classified	0	0						0										
2.02 In-patient care	84,496	84,496	0	84,496	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections (OI)	1,184,456	1,184,456		1,184,456				0										
2.02.02 Inpatient palliative care	0	0						0										
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0										
2.02.99 In-patient services not elsewhere classified	0	0						0										
2.03 Patient transport and emergency rescue	0	0						0										
2.98 Care and treatment services not disaggregated by intervention	0	0						0										
2.99 Care and treatment services not-elsewhere classified	6,078,428	501,748		501,748				5,576,680	669,998				4,906,682					
3. Orphans and Vulnerable Children (sub-total)	**128,658**	**53,658**	**0**	**53,658**	**0**	**0**	**0**	**75,000**	**0**	**0**	**0**	**0**	**75,000**	**0**	**0**	**0**	**0**	**0**
3.01 OVC Education	0	0						0										
3.02 OVC Basic health care	881	881		881				0										
3.03 OVC Family/home support	0	0						0										
3.04 OVC Community support	127,778	52,778		52,778				75,000					75,000					
3.05 OVC Social services and Administrative costs	0	0						0										
3.06 OVC Institutional Care	0	0						0										
3.98 OVC services not disaggregated by intervention	0	0						0										
3.99 OVC services not-elsewhere classified	0	0						0										
4. Program Management and Administration Strengthening (sub-total)	**13,405,850**	**3,211,597**	**1,834,192**	**1,377,405**	**0**	**0**	**0**	**10,194,253**	**4,751,891**	**0**	**0**	**0**	**5,442,362**	**0**	**0**	**0**	**0**	**0**
4.01 Planning, coordination and programme management	2,866,124	611,503	325,371	286,192				2,254,503	249,333				2,005,226					
4.02 Administration and transaction costs associated with managing and disbursing funds	1,366,459	820,322	597,952	222,370				546,137	155,450				390,687					
4.03 Monitoring and evaluation	1,377,397	587,990	342,833	245,151				789,413	338,535				450,878					

4.04 Operations research	731	731		731				0	0						0				
4.05 Serological-surveillance (Serosurveillance)	204,787	172,972	91,947	81,025				31,815	31,815						0				
4.06 HIV drug-resistance surveillance	0	0	0	0				0	0						0				
4.07 Drug supply systems	2,215,619	59,820	0	59,820				2,155,799	2,155,799						0				
4.08 Information technology	256,999	222,664	87,171	135,493				34,335	26,135				8,200		0				
4.09 Patient tracking	161,448	161,448	98,933	62,515				0							0				
4.10 Upgrading and construction of infrastructure	35,636	35,636	0	35,636				0							0				
4.11 Mandatory HIV testing (not VCT)	0	0	0	0				0							0				
4.98 Program Management and Administration Strengthening not disaggregated by type	48,889	48,889	0	48,889				0							0				
4.99 Program Management and Administration Strengthening not-elsewhere classified	4,871,764	489,571	289,987	199,584				4,382,193	1,794,822				2,587,370		0				
5. Incentives for Human resources (sub-total)	3,132,355	868,703	322,527	546,176	0	0	0	2,263,652	9,391	0	0	0	2,254,258	0	0	0	0	0	0
5.01 Monetary incentives for human resources	0	0						0							0				
5.02 Formative education to build-up an HIV workforce	0	0						0							0				
5.03 Training	0	0						0							0				
5.98 Incentives for Human Resources not specified by kind	0	0						0							0				
5.99 Incentives for Human Resources not elsewhere classified	0	0						0							0				
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	134,091	134,091	74,797	59,294	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	30,278	30,278	27,778	2,500				0							0				
6.02 Social protection through in-kind benefits	556	556	556					0							0				
6.03 Social protection through provision of social services	46,464	46,464	46,464					0							0				
6.04 HIV-specific income generation projects	15,022	15,022		15,022				0							0				
6.98 Social protection services and social services not disaggregated by type	41,771	41,771		41,771				0							0				
6.99 Social protection services and social services not elsewhere classified	0	0						0							0				
7. Enabling Environment (sub-total)	6,886,595	294,423	8,448	285,975	0	0	0	6,592,172	2,401,317	0	0	0	4,190,855	0	0	0	0	0	0
7.01 Advocacy	475,837	188,820	5,089	183,731				287,017	77,257				209,760		0				
7.02 Human rights programmes	0	0						0							0				
7.03 AIDS-specific institutional development	1,964,301	25,581	3,359	22,222				1,938,720	1,936,316				2,404		0				
7.04 AIDS-specific programmes focused on women	92,805	34,661		34,661				58,144	58,144						0				
7.05 Programmes to reduce Gender Based Violence	0	0						0							0				
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0				
7.99 Enabling Environment and Community Development not elsewhere classified	4,353,651	45,361		45,361				4,308,290	329,600				3,978,690		0				
8. Research (sub-total)	925,649	135,866	69,589	66,277	0	0	0	789,783	374,602	0	0	0	415,181	0	0	0	0	0	0
8.01 Biomedical research	0	0						0							0				
8.02 Clinical research	0	0						0							0				
8.03 Epidemiological research	0	0						0							0				
8.04 Social science research	77,833	31,833		31,833				46,000					46,000		0				
8.05 Vaccine-related research	0	0						0							0				
8.98 Research not disaggregated by type	389,544	9,444	9,444					380,100	160,000				220,100		0				
8.99 Research not elsewhere classified	458,272	94,589	60,145	34,444				363,683	214,602				149,081		0				

Country:		INDONESIA	
Reporting cycle:		0	
Data Measurement Tool		9	
Amounts reported in:		0	
Please indicate month and year (M/YYYY)	From:	Month	Year
		0	0
	To:	0	0
Name of Local Currency		Indonesian Rupiah	
Currency expressed in:		Units (x 1)	
Average Exchange Rate for the year (local currency to USD)		0.000	

2011 AIDS Spending Categories	TOTAL	Financing Sources																		
		Public Sources							International Sources								Private Sources (optional for UNGASS reporting)			
											Multilaterals									
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Prevention (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.01 Communication for social and behavioural change	0	0						0							0					
1.02 Community mobilization	0	0						0							0					
1.03 Voluntary counselling and testing (VCT)	0	0						0							0					
1.04 Risk-reduction for vulnerable and accessible populations	0	0						0							0					
1.05. Prevention - Youth in school	0	0						0							0					
1.06 Prevention - Youth out-of-school	0	0						0							0					
1.07 Prevention of HIV transmission aimed at people living with HIV	0	0						0							0					
1.08 Prevention programmes for sex workers and their clients	0	0						0							0					
1.09 Programmes for men who have sex with men	0	0						0							0					
1.10 Harm-reduction programmes for injecting drug users	0	0						0							0					
1.11 Prevention programmes in the workplace	0	0						0							0					
1.12 Condom social marketing	0	0						0							0					
1.13 Public and commercial sector male condom provision	0	0						0							0					
1.14 Public and commercial sector female condom provision	0	0						0							0					
1.15 Microbicides	0	0						0							0					
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	0	0						0							0					
1.17 Prevention of mother-to-child transmission	0	0						0							0					
1.18 Male Circumsicion	0	0						0							0					
1.19 Blood safety	0	0						0							0					
1.20 Safe medical injections	0	0						0							0					
1.21 Universal precautions	0	0						0							0					
1.22 Post-exposure prophylaxis	0	0						0							0					
1.98 Prevention activities not disaggregated by intervention	0	0						0							0					
1.99 Prevention activities not elsewhere classified	0	0						0							0					
2. Care and Treatment (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01 Outpatient care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.01 Provider- initiated testing and counselling	0	0						0							0					
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0						0							0					
2.01.03 Antiretroviral therapy	0	0						0							0					
2.01.04 Nutritional support associated to ARV therapy	0	0						0							0					
2.01.05 Specific HIV-related laboratory monitoring	0	0						0							0					
2.01.06 Dental programmes for PLHIV	0	0						0							0					
2.01.07 Psychological treatment and support services	0	0						0							0					
2.01.08 Outpatient palliative care	0	0						0							0					
2.01.09 Home-based care	0	0						0							0					
2.01.10 Traditional medicine and informal care and treatment services	0	0						0							0					
2.01.98 Outpatient care services not disaggregated by intervention	0	0						0							0					
2.01.99 Outpatient Care services not elsewhere classified	0	0						0							0					
2.02 In-patient care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections (OI)	0	0						0							0					
2.02.02 Inpatient palliative care	0	0						0							0					
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0					
2.02.99 In-patient services not elsewhere classified	0	0						0							0					
2.03 Patient transport and emergency rescue	0	0						0							0					
2.98 Care and treatment services not disaggregated by intervention	0	0						0							0					
2.99 Care and treatment services not-elsewhere classified	0	0						0							0					
3. Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.01 OVC Education	0	0						0							0					
3.02 OVC Basic health care	0	0						0							0					
3.03 OVC Family/home support	0	0						0							0					
3.04 OVC Community support	0	0						0							0					
3.05 OVC Social services and Administrative costs	0	0						0							0					

3.06 OVC Institutional Care	0	0						0							0				
3.98 OVC services not disaggregated by intervention	0	0						0							0				
3.99 OVC services not-elsewhere classified	0	0						0							0				
4. Program Management and Administration Strengthening (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.01 Planning, coordination and programme management	0	0						0							0				
4.02 Administration and transaction costs associated with managing and disbursing funds	0	0						0							0				
4.03 Monitoring and evaluation	0	0						0							0				
4.04 Operations research	0	0						0							0				
4.05 Serological-surveillance (Serosurveillance)	0	0						0							0				
4.06 HIV drug-resistance surveillance	0	0						0							0				
4.07 Drug supply systems	0	0						0							0				
4.08 Information technology	0	0						0							0				
4.09 Patient tracking	0	0						0							0				
4.10 Upgrading and construction of infrastructure	0	0						0							0				
4.11 Mandatory HIV testing (not VCT)	0	0						0							0				
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0						0							0				
4.99 Program Management and Administration Strengthening not-elsewhere classified	0	0						0							0				
5. Incentives for Human resources (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5.01 Monetary incentives for human resources	0	0						0							0				
5.02 Formative education to build-up an HIV workforce	0	0						0							0				
5.03 Training	0	0						0							0				
5.98 Incentives for Human Resources not specified by kind	0	0						0							0				
5.99 Incentives for Human Resources not elsewhere classified	0	0						0							0				
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0						0							0				
6.02 Social protection through in-kind benefits	0	0						0							0				
6.03 Social protection through provision of social services	0	0						0							0				
6.04 HIV-specific income generation projects	0	0						0							0				
6.98 Social protection services and social services not disaggregated by type	0	0						0							0				
6.99 Social protection services and social services not elsewhere classified	0	0						0							0				
7. Enabling Environment (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.01 Advocacy	0	0						0							0				
7.02 Human rights programmes	0	0						0							0				
7.03 AIDS-specific institutional development	0	0						0							0				
7.04 AIDS-specific programmes focused on women	0	0						0							0				
7.05 Programmes to reduce Gender Based Violence	0	0						0							0				
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0				
7.99 Enabling Environment and Community Development not elsewhere classified	0	0						0							0				
8. Research (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.01 Biomedical research	0	0						0							0				
8.02 Clinical research	0	0						0							0				
8.03 Epidemiological research	0	0						0							0				
8.04 Social science research	0	0						0							0				
8.05 Vaccine-related research	0	0						0							0				
8.98 Research not disaggregated by type	0	0						0							0				
8.99 Research not elsewhere classified	0	0						0							0				

Annex C. List of Documents consulted

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Annex D. Member of Extended Monitoring and Evaluation Working Group

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Harto	Ministry of Law and Human Rights	Ari Wibowo	Nahdatul Ulama (Faith-based Organization)
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Ghufron Solihin	Indonesian Armed Forces	Cahyo Heri	National Family Planning Association
Suminto	National Population and Family Planning Board	Sumedi Ryan	Care for AIDS Forum – Jakarta province branch
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Sabarinah Prasetyo	University of Indonesia	Yanti Susanti	NAC

Annex E. Member of the NAC Executing Team

Coordinating Minister for People's Welfare	National Population and Family Planning Board
Ministry of Health	Ministry of Foreign Affairs
Ministry of Home Affairs	Ministry of Religion Affairs
Ministry of Law and Human Rights	Ministry of Youth and Sports
Ministry of Social Affairs	National Development Planning Board
Ministry of Culture and Tourism	Ministry of Education
Ministry of Man Power and Transmigration	Ministry of Information and Communication
Ministry of Women's Empowerment and Child Protection	The National Development Planning Agency
Ministry of Transportation	Ministry of Technology and Research
Secretariat of the Ministry of the Republic of Indonesia	Indonesian National AIDS Commission Secretariat
Ministry of Finance	Ministry of Public Works
Ministry of Defense	Armed Forces
Indonesian National Police	National Narcotics Agency
Agency for the Assessment and Application of Technology	Indonesian Chamber of Commerce and Industry
Indonesian Doctors Association	Indonesia Business Coalition on AIDS
Indonesian Public Health Association	Indonesia Red Cross

IPPI: Indonesia Association of Positive HIV Women	GWL-Ina: Indonesia Association of Gay, Transgender and MSM
PKNI: Indonesia Association of Drug User Victims	OPSI: Indonesia Association of Sex Workers
JOTHI: Indonesian PLHIV Network	Spiritia